#	Category	Standard- Residential Crisis Stabilization	Notes/Comments
1	Service Definition/ Required Components	This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization on a short-term basis. Specific services may include: 1. Psychiatric medical assessment; 2. Crisis assessment, support and intervention; 3. Medication administration and management; 4. Individual, group and/or family counseling; and 5. Linkage to other services as needed. Medicaid State Plan Definition: Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, individual, group and family therapy, and peer support in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization but need overnight care. The purpose is to stabilize the individual, provide treatment for acute withdrawal, when appropriate, and re-integrate him back into the community, or other appropriate treatment setting, in a timely fashion. These units provide a non-hospital residential setting and services 24-hours per day, seven (7) days per week, 365 days per year. The estimated length of stay for children is three (3) to five (5) days. The estimated length of stay for adults is seven (7) to 10 days. Every CSU shall have written policies and procedures for proper management of pharmaceuticals, consistent with the requirements of 902 KAR 20:440, Section 14. Every CSU shall have written policies and procedures for handling medical emergency cases which may arise subsequent to a person's admission. All staff shall be familiar with the policies and procedures. There shall be one person on the premises at all times who is certified in cardiopulmonary resuscitation (CPR) and proficient in choke relief techniques. Training shall be documented in the	

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		personnel record of the employee.	
2	Provider Requirements / Qualifications	Behavioral Health Services Organizations providing residential crisis stabilization services shall comply with the provisions of 902 KAR 20:440, 907 KAR 15:070, 907 KAR 15:075 and 922 KAR 1:390. Community Mental Health Centers providing residential crisis stabilization services shall comply with the provisions of 902 KAR 20:091 and 908 KAR 2:090. The Residential Crisis Stabilization providers must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criterial: • Capacity to employ practitioners and coordinate service provision among rendering providers. • Capacity to provide the full range of services included in the Residential Crisis Stabilization service definition. • Ability to provide Residential Crisis Stabilization services on a 24/7/365 basis. • Access to a board-certified or board-eligible psychiatrist or APRN on a 24/7/365 basis. <u>Rendering Practitioners Practicing as Part of a Licensed Organization</u> • Licensed Psychologist (LP) • Licensed Psychological Associate (LPA)* • Licensed Psychological Practitioner (LPP) • Licensed Clinical Social Worker (LCSW) • Certified Social Worker, Master Level (CSW)* • Licensed Professional Clinical Counselor (LPCC) • Licensed Professional Counselor Associate (LPCA)* • Licensed Professional Art Therapist (LPAT) • Licensed Professional Art Therapist Associate (LPATA)* • Licensed Marriage and Family Therapist (LMFT) • Licensed Alcohol and Drug Counselor (LADC)* • Marriage and Family Therapy Associate (MFTA)* • Physician • Psychiatrist • Advanced Practice Registered Nurse (APRN)	

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		• Physician Assistant (PA) working under the supervision of a Physician* • Peer Support Specialist* • Certified Alcohol and Drug Counselor (CADC)* *Billed through Supervisor <u>Billing Providers</u> Licensed Organizations	
3	Staffing Requirements	Residential crisis stabilization programs shall maintain the following staff composition: • A Board certified or Board eligible psychiatrist or APRN available to evaluate or consult, provide behavioral health treatment on-site or by telephone and participate in the resident's treatment plan; • A nurse available to oversee the administration of medications; • A Qualified Mental Health Professional (QMHP) available on-site or by telephone to oversee staff, and complete involuntary hospitalization certifications. • A Qualified Intellectual Disabilities Professional (QIDP) available for consultation and treatment planning, to oversee staff; • Other staff may be paraprofessionals with a minimum of a high school degree or GED; • A licensed physician or APRN available daily to evaluate or consult and provide medical treatment related to physical health issues. • A Certified Peer Support Specialist The minimum requirement for direct care staffing is one direct care staff member for every 4 clients during normal working hours and one direct care staff member for every 6 clients during normal sleeping hours. Sufficient numbers and types of qualified staff shall be on duty and available at all times to provide necessary and adequate safety and care. The program policies and procedures shall define the types and numbers of clinical and managerial staff needed to provide individuals with treatment services in a safe and therapeutic environment. Medicaid State Plan Requirement:	Per 902 KAR 20:091 and 902 KAR 20:440.

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		Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis. CSU Program Directors are responsible for ensuring appropriate training for their staff on the use of evidence-based treatments and services for the individuals they serve. All CSU staff shall receive appropriate training to include at least the following topics: • Emergency and safety procedures; • Crisis assessment; • Crisis intervention and management, including de-escalation; • Community resources; • Suicide prevention, assessment and management; • Crisis prevention, crisis prevention planning, safety planning; • Documentation. All direct care staff who do not possess a medical license who are delegated the function of overseeing medication administration must be trained by the provider's medical staff prior to making medication available to CSU residents and their medication administration duties must be supervised by the medical staff.	
4	Supervision Requirements	BHDID is committed to quality service through regular, ongoing, strength-based, skill building supervision of all staff that provides direct services to all individuals. Each provider shall have clear lines of accountability and a clearly described supervision structure for all employees and independent contractors. All staff providing direct services must annually attend, successfully complete, and document in their personnel file at least six (6) hour of continuing education directly related to crisis services per calendar year. Treatment team meetings and individual supervision, although expected, do not apply towards the required six (6) hours. Training may be provided as part of regular staff meetings or during group supervision sessions. Supervision does not include training or administrative discussions. Supervision does include utilizing a combination of methods such as case reviews, direct observation, coaching, and role modeling to improve the level of staff skill. Providers must have policies and procedures and the mechanism to ensure supervision of all	Clinical supervision is the process of control and direction of a client's crisis services by which a clinical supervisor accepts full professional responsibility for the supervisee's actions and decisions, instructs the supervisee in his/her work, and oversees or directs the work of the supervisee. A clinical supervisor must be available on a 24-hour basis for urgent consultation as required by the client's needs or the situation. Clinical supervision:

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		direct services professionals and paraprofessionals. The provider is responsible for maintaining and tracking supervision records. A supervising professional shall be available for consultation when non-licensed staff are providing services. Supervision shall be provided by a licensed professional. The provider must have a specific training plan detailing how and when staff will be trained.	• May occur individually or in a small group; and • Shall be focused on the client's treatment and review of progress toward goals.
5	Admission Criteria	The individual is eligible for this service when the following criteria are met: A. Axis I Diagnosis or exhibits acute symptoms of mental illness; B. The individual or family is experiencing an acute, immediate crisis; and the individual or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; C. The individual or family members evidence impairment of judgment, impulse control, cognitive or perceptual disabilities; D. The individual's condition reflects that a less intensive or less restrictive psychiatric treatment program would not be adequate to provide safety for the individual or others or to improve the individual's functioning; E. It is expected that the resources and treatment associated with this level of care will lead to successful discharge into the community. F. The provider has agreed to accept the individual's admission; G. The individual must voluntarily accept admission into the CSU; and H. Able to perform daily living skills with minimal assistance OR does not require nursing facility level of care.	Typical Exclusionary Criteria: • Actively and intensely suicidal and/or homicidal • Serious criminal charges • Medically fragile • Victims of domestic violence seeking protection • In need of temporary placement or housing services only • Sexual perpetrator
6	Program Planning & Documentation	The component services of residential crisis stabilization are screening, assessment, service planning, psychiatric services, individual therapy, family therapy, group therapy and peer support. Residential Crisis Stabilization involves all supports and services necessary to provide integrated Crisis Assessment, Crisis Prevention Planning, Treatment Planning, and Continuity of Care Recommendations. Residential Crisis Stabilization begins with a crisis assessment, which includes identification of presenting problem, current mental status, and a risk assessment that identifies the client's	Residential Crisis Stabilization services are provided that are appropriate for the client's phase of life and development, specifically considering what is appropriate for children, adolescents, transition age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. Specifically, when treating children and adolescents,

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		personal and environmental factors that may increase risk of suicide and/or violence. The crisis assessment shall be provided within three (3) hours of the determination of need of services. When a crisis assessment reveals medication issues that need to be addressed immediately, the provider shall consult the on-call psychiatrist or APRN. Residential Crisis Stabilization includes individualized crisis treatment planning during the client's stay in the crisis stabilization unit. Practitioners shall monitor clients' mental status on a daily basis to determine if changes are needed to the client's crisis treatment plan, length of stay, or level of care. Planning for ongoing services after residential crisis stabilization should begin upon admission to the crisis stabilization unit. Continuity of care recommendations will be offered based on the person's treatment and support needs. Continuity of care recommendations are not limited to, but may include, the following: • Referral to outpatient treatment; • Referral for medical and non-medical detoxification services; • Referral to partial hospitalization program; • Referral for continued work with current Case Manager, ACT Team, or other treatment providers to address unmet needs; • Referral for evaluation for hospitalization; • Outpatient crisis stabilization support; • In-home supports; • Support and involvement by family members, peers, and other natural supports; and • Referral to local peer services, support groups, warm lines, and other resources (e.g., NAMI Kentucky, Kentucky Partnership for Families and Children, People Advocating Recovery, AA, etc.) as appropriate. Residential Crisis Stabilization includes crisis prevention planning to reduce an individual's distress, the incidence of first-time crisis, and recurring crises. Crisis prevention supports and services should be specified in an individual's Crisis Prevention Plan. The Crisis Prevention Plan identifies resources and alternative coping strategies to assist individuals and families feel more	practitioners shall provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver driven with respect to children and adolescents. When treating adults, the individual client's desires and functioning are considered and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. Adult clients, especially those with a history of recurring crises or at high risk of hospitalization or future crises, should be educated about Advance Directives, KRS 202A.420-202A.432. If the client has a crisis plan or Advance Directive, it should be utilized to help manage the crisis. Interventions provided should honor the client's/family's wishes/choices by following the plan/Advance Directive as closely as possible in line with appropriate clinical judgment.

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		in control and identify options that are compatible with their particular situation. Access to lethal means should be assessed, including firearms, prescription and over-the-counter medications, alcoholic beverages, poisons, and knives. Crisis Intervention providers must develop a Crisis Prevention Plan before discharge (unless the individual is transferred to a higher level of care). The Crisis Prevention Plan should be provided to the individual, caregivers (if appropriate), and any agencies that may provide ongoing treatment and supports after the crisis has been stabilized. For individuals who already have a Crisis Prevention Plan developed, the existing Crisis Prevention Plan components should be reviewed and revised as needed. At a minimum, follow-up contact with the individual must be made within 48 hours of discharge from the CSU. Follow-up services can be telephone call(s) or face-to-face contact(s) between crisis staff and the individual following crisis intervention to ensure the safety of the individual until treatment begins and/or the crisis is alleviated. Follow-up services can include crisis services staff contacting the individual only one time or can include several contacts per day for several days, as deemed appropriate by crisis staff. Residential Crisis Stabilization includes 24-hour telephone service to provide an immediate telephonic response to assess a caller's crisis and determine the appropriate intervention. Providers should operate their own crisis line or have a formal linkage with a regional or state level crisis line. The modification or removal of suicide precautions shall require clinical justification determined by an assessment and documentation in the clinical record. Each CSU shall develop policies and procedures for implementing suicide precautions addressing: assessment, staffing, levels of observation and documentation. Every CSU shall have written policies and procedures for handling medical emergency cases which may arise subsequent to a person's admission. All staff shall be familiar with the policies and procedures. There shall be one person on the premises at all times who is certified in cardiopulmonary resuscitation (CPR) and proficient in choke relief techniques. Training shall be documented in the personnel record of the employee.	

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		Every CSU shall have written policies and procedures governing client grievances which shall include the following:
		• A process for filing a written client grievance;
		• An appeals process with time frames for filing and responding to a grievance in writing;
		• Protection for a client from interference, coercion, discrimination, or reprisal;
		• Conspicuously posting in a public area of the grievance procedures informing a client of:
		  ○ A right to file a grievance;
		  ○ A process for filing a grievance; and
		  ○ The address and telephone number of the cabinet's ombudsman.	

7	Continued Stay Criteria	Following a psychiatric emergency or crisis involving an agency consumer, in conjunction with the consumer, the agency creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises for the consumer and their family.	
8	Discharge Criteria	Any of the following criteria are sufficient for discharge from this level of care. A. The client has regained their baseline level of functioning. B. A plan for continued services at a higher or lower level of care has been implemented. C. The individual/family concur that the crisis has subsided. The agency has policies establishing care coordination expectations with programs that can provide inpatient psychiatric treatment, with medical and non-medical detoxification, post-detoxification step-down services, and residential programs to provide those services for agency consumers. The agency has established protocols and procedures with Emergency Departments, inpatient psychiatric, detoxification, and residential settings for transitioning individuals. Any of the following criteria is sufficient for transfer from this level of care: A. The individual manifests behavioral, substance-related and/or psychiatric symptoms that require a more intensive level of care. B. The individual manifests behavioral, substance-related and/or psychiatric symptoms that require a less intensive level of care. C. Treatment of the individual requires complex changes to medications. D. The individual is at imminent risk of causing serious physical harm to self/others. E. The symptoms are a result of or complicated by a medical condition that warrants admission	The agency coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities to facilitate wellness and recovery of the whole person.

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		to a medical setting for treatment. F. Any other medical condition which the staff deems not safe for admission to a non-medical unit. G. Individuals who are non-ambulatory or unable to perform activities of daily living. H. The CSU staff has determined that the individual is an inappropriate referral for admission.	
9	Service Setting	Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, peer support, individual therapy, group therapy and family therapy (as appropriate), in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals experiencing a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization but need overnight care. The agency offers 24 hour admission into residential crisis stabilization and the service shall be delivered within three hours. Protocols and agreements for the involvement of law enforcement are in place to reduce delays for initiating services during and following a psychiatric crisis. Every CSU shall have housekeeping and maintenance standards. Assurance of the following must be provided: • Facilities shall be clean, in good repair, and free of hazards such as cracks in floors, walls, or ceilings, warped or loose boards, tile, linoleum, hand rails or railings, broken window panes; and any similar type hazard. • The interior and exterior of the building shall be painted, stained or maintained so as to keep it reasonably attractive. • Loose, cracked or peeling wallpaper or paint shall be promptly replaced or repaired to provide a satisfactory finish. • All furniture and furnishings shall be attractive, clean and in good repair, and contribute to creating a therapeutic environment. • An adequate supply of linen shall be maintained to provide clean and sanitary conditions for each person at all times.	
10	Service Limitations / Exclusion	Per the Kentucky State Plan Amendment, the following services will NOT be covered by Medicaid: • Services provided to residents of nursing facilities.	If using DBHDID funding, the provider must comply with facility specifications included in the CMHC

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		• Services provided to inmates of local, state or federal jails, detention centers or prisons. • Services to those with developmental and intellectual disabilities, without documentation of an additional psychiatric diagnosis. • Telephone calls, emails, texts or other electronic contacts (exclusive of billable telehealth interventions authorized in Medicaid regulations). • Travel time. • Field trips, recreational, social, and physical exercise activity groups. • Provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient. • Time spent "on call" and not delivering services to recipients. • Job specific skills services such as on the job training. • Outreach services to potential recipients. • Room and board. • Crisis response services by a hospital or residential facility to a recipient of that facility. Kentucky Medicaid and DBHDID will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds for individuals between the ages of 22 and 64.	licensure regulation (i.e. "a community-based homelike residential treatment program").
11	Unit of Service	Per Diem	
12	Service Codes	**HCPCS code**: S9485 **BHDID Service Code:** 138 – Adult Crisis Stabilization **BHDID Service Code**: 139 – Children's Crisis Stabilization	
13	Program Evaluation / Quality Improvement	Providers shall evaluate on a regular basis their residential crisis stabilization performance in safety, quality and effectiveness. The quality assurance team may also consider reviewing the following: • The admission is necessary and appropriate; • The service is the least restrictive means of intervention; • Individual rights are being protected; • Family or significant others are involved in the treatment and discharge planning process	Best practice is to also review referral sources on a regular basis for safety, quality, and effectiveness of services provided.

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		as much as feasible with the consent of the person receiving services; • Treatment plans are comprehensive and individualized, relative to the full range of the needs of the person receiving services at the CSU; • Minimal standards for clinical records are being met; • Medications are prescribed and administered appropriately; • There has been appropriate handling of medical emergencies; • Special treatment procedures, for example, seclusion and restraint, are conducted according to facility policy; • High risk situations and special cases are reviewed within 24 hours. These shall include: suicides, death, serious injury, violence, and abuse of any person; • All incident reports are reviewed by the facility director within 2 working days; • The length of stay is supported by clinical documentation; • Continuity of care is encouraged and supported at discharge; • Delay in receiving services is minimal; and • Referral agencies are providing safe and effective services. The agency has the capacity to collect and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) consumer outcomes.	

14	Program Principles	<u>Kentucky Emergency Services Guiding Principles</u>
		• Respect: Emergency services programs and staff:
		  ○ Respect the needs and wishes of each person in crisis; and
		  ○ Value and protect the rights, privacy, and confidentiality of each person in crisis, unless the person presents an imminent risk and confidentiality would compromise the required intervention; and
		  ○ Consider the strengths and resources of the person in crisis, the family, and the community; and
		  ○ Collaborate with others involved with the person in crisis, whenever appropriate and possible.
		• Timeliness: Quick response times are a critical feature of an effective behavioral health emergency system.
		• Least Restrictive Setting: Emergency services preserve community placement whenever possible and prevent institutionalization, hospitalization or increased levels of care. Services
			Crisis Stabilization Units must follow the regulations outlined in 902 KAR 20:440, 902 KAR 20:091, 907 KAR 15:07, and 907 KAR 15:075.

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		preserve natural supports of the individual experiencing the emergency to the greatest extent possible. • Accountability: The emergency service system is accountable to individuals, their caregivers, families, communities and funding sources. • Collaboration: Program design and delivery should be developed through a collaborative process that includes all pertinent stakeholders, including clients, youth and family members, private and public hospitals and law enforcement. • Data Informed: Decision making at the individual and system level is guided by data. • Evidenced Based Practice: Emergency services responses need to be delivered in a holistic manner using evidenced based and best practices. • Cultural Competence: Emergency services are provided by staff that is culturally and linguistically competent. Every CSU shall have written policies and procedures to ensure that the rights of a client are protected, including a statement of rights and responsibilities which shall be: • Provided at the time of admission; • To the client; or if the client is a child, to the child and the client's parent, guardian, or other legal representative; • Read to the client or client's parent, guardian, or other legal representative if either cannot read; • Written in a language that is understandable to the client; • Conspicuously posted in a public area of the facility; and • Cover the following: o The right to treatment, regardless of race, religion, or ethnicity; o The right to recognition and respect of personal dignity in the provision of all treatment and care; o The right to be provided treatment and care in the least restrictive environment possible; o The right to an individualized plan of care; o The right of the client, including the client's parents or guardian if the client is a child, to participate in treatment planning; o The nature of care, procedures, and treatment that the client shall receive; o The risks, side effects, and benefits of all medications and treatment procedures	

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		used; o The right to be free from verbal, sexual, physical or mental abuse; and o The right, to the extent permitted by law, to refuse the specific medications or treatment procedures and the responsibility of the facility if the client refuses treatment, to seek appropriate legal alternatives or orders of involuntary treatment, or in accordance with professional standards, to terminate the relationship with the client upon reasonable notice. • A residential crisis stabilization unit's written policies and procedures concerning client rights shall assure and protect the client's personal privacy within the constraints of his or her plan of care, including: o Visitation by family or significant others in a suitable area of the facility; o Telephone communications with family or significant others at a reasonable frequency; • If a privacy right is limited, a full explanation shall be given to the client or the client's parent or guardian if the client is a child. • Documentation shall be included in the client's record of any extraordinary privacy limitations. • Critical incident reporting shall be included in the agency's policies and procedures. • Information shall be provided to the client, or the client's parent or guardian if the client is a child, regarding the use and disposition of special observation and audio visual techniques, which may include the following: (a) One (1) way vision mirror; (b) Audio recording; (c) Video tape recording; (d) Television; (e) Movie; or (f) Photographs. • If the residential crisis stabilization unit serves children as described in Section 10(4)(b) of this administrative regulation, written policy and procedures shall be developed in consultation with professional and direct-care staff to provide for behavior management of residents, including the use of a time-out room. • Behavior management techniques shall be explained fully to each client and the client's parent, guardian, or other legal representative.	

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		• The unit shall prohibit cruel and unusual disciplinary measures including the following: ○ Corporal punishment; ○ Forced physical exercise; ○ Forced fixed body positions; ○ Group punishment for individual actions; ○ Verbal abuse, ridicule, or humiliation; ○ Denial of three (3) balanced nutritional meals per day; ○ Denial of clothing, shelter, bedding, or personal hygiene needs; ○ Denial of access to educational services; ○ Denial of visitation, mail, or phone privileges for punishment; ○ Exclusion of the resident from entry to his or her assigned living unit; and ○ Restraint or seclusion as a punishment or employed for the convenience of staff. Searches and Seizures. Whenever there is a reason to believe that the security of a facility or the health of anyone is endangered or that contraband or objects which are illegal to possess are present on the premises, a search of an individual's person, room, locker, or possessions shall be conducted if authorized by the program director or designee, as defined in program policies and procedures. ○ Whenever feasible, the individual shall be present during a search. ○ When it is impossible to obtain the individual's physical presence, the individual shall be given prompt written notice of the search and of any article taken. ○ Written reports of all searches shall be placed in the individual's clinical record. A written inventory of items confiscated shall be forwarded to the program director or designee.	