

KENTUCKY SYSTEM OF CARE FAMILIES – INVOLVED! VALUED! EMPOWERED! (SOC FIVE)

EXPANDING THE SYSTEM FOR CHILD WELFARE- INVOLVED CHILDREN AND THEIR FAMILIES

Kentucky's SOC FIVE aims to improve behavioral health outcomes for children and youth (birth to age 21) *who meet criteria for having a severe emotional disability (SED) and their families and who have child welfare involvement (For this project, child welfare-involved families are those for whom a child abuse and/or neglect investigation results in a substantiation or services-needed finding and for whom DCBS does not have custody.*

SOC FIVE Goals and Selected Activities

Enhance interagency infrastructure to support the implementation, expansion, and integration of the System of Care approach for the population of focus.

- Make annual policy recommendations to the SIAC for inclusion in Annual Report to Governor & LRC
- Develop and Implement Strategic Financing Plan
- Expand Respite Tracking & Monitoring System to include providers outside of foster care system
- Host Secondary Traumatic Stress Organizational Assessments and Break-through Series learning collaboratives for regional behavioral health and child welfare agency staff

Improve availability of and access to high quality, culturally- and linguistically-competent, evidence-based/evidence-informed mental health services for the population of focus in the geographic catchments.

- Support Community Mental Health Centers as public behavioral health safety net to streamline access to population of focus
- Contract with behavioral health providers to expand targeted, high-need services (24/7 mobile crisis, intensive in-home, respite care, and targeted case management via high fidelity wraparound)
- Host learning collaboratives in evidence-based practices including but not limited to those in Kentucky's Title IV-E Prevention Plan

Implement strategies to promote & sustain the voice of children, youth, and their families with child welfare involvement at all levels of the system of care.

- Increase availability of peer support services to families with child welfare involvement
- Increase targeted outreach and engagement strategies for birth, foster, and adoptive parents and relative and fictive kin through the statewide family network organization

SOC FIVE Grant Facts

- Funded by federal Substance Abuse & Mental Health Services Administration (SAMHSA)
- Awarded to KY Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID)
- Co-administered by DBHDID Commissioner's Office and Children's Behavioral Health & Recovery Services Branch
- Builds upon 4 previous SOC grants
- Support FFPSA and other child welfare transformation work
- Awarded for period of September 30, 2019 – September 29, 2023
- Funded for up to four years at up to \$3,000,000 per year
- Requires cost-sharing/match
- Partners with: DCBS, KPFC, EKU, UK-HDI, CMHCs, others

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Kentucky Determination Criteria Checklist for Severe Emotional Disability (SED) Determination

Relates to KRS 200.503(3) and 907 KAR 15:060, 15:065, 15:050, and 15:055

Per KRS 200:501 – Children with a SED who are receiving institutional care or are at risk of institutional placement shall be given priority for services pursuant to KRS 200:501–200.509.

Individual's Name _____

Identification Number _____

Diagnostic Code(s) _____

The following table illustrates the criteria that shall be met for an individual to be designated as SED. In order to make an SED designation, Sections 1, 2 and 4 are required and at least two of five in Section 3.

Yes	No	Criteria
		<p>Section 1: Age Is a person under age 18 or under age 21 who was receiving services prior to eighteenth birthday and that must be continued for therapeutic benefit.</p>
		<p>Section 2: Diagnosis</p> <ul style="list-style-type: none"> ◆ Individual with a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that is listed in the current edition of the APA's Diagnostic and Statistical Manual of Mental Disorders. ◆ Excludes those children who are singularly diagnosed an intellectual disability.
		AND
		<p>Section 3: Limitations Presents substantial limitations in at least 2 of the following 5 areas that have persisted for at least 1 year or are judged by a behavioral health professional to be at high risk of continuing for 1 year without professional intervention:</p> <ul style="list-style-type: none"> a) <u>Functioning in Self-Care</u>: Impairment in self-care is manifested by a person's consistent inability to provide, sustain and protect him or herself at a level appropriate to his or her age. (e.g., significant basic hygiene or self-care needs, pattern of self-injurious behavior, pattern of physically reckless decision-making, eating disorders, failure to address serious health, nutrition, safety, or medical needs, threatens or attempts suicide) b) <u>Functioning in Interpersonal Relationships</u>: Impairment of interpersonal relationships (including community relationships) is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving. Inability to maintain safety without assistance; a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement. (e.g., repeated or serious aggressive interactions with peers or adults in the community, isolated or withdrawn much of the time, behavior which consistently alienates peers.) c) <u>Functioning in Family Life</u>: Impairment in family function is manifested by the inability to live in a family or family type environment. This can include a pattern of emotional or disruptive behavior exemplified by repeated and/or unprovoked aggravating or violent behaviors aimed at others in the home (siblings and/or parents and/or other caretakers such as relative caregivers, foster parents) and seriously disrupts the home; disregard for safety and welfare of self or others in the home (e.g., fire setting, serious and chronic destructiveness, self-injurious behavior, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being.

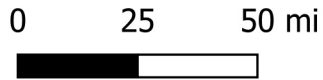
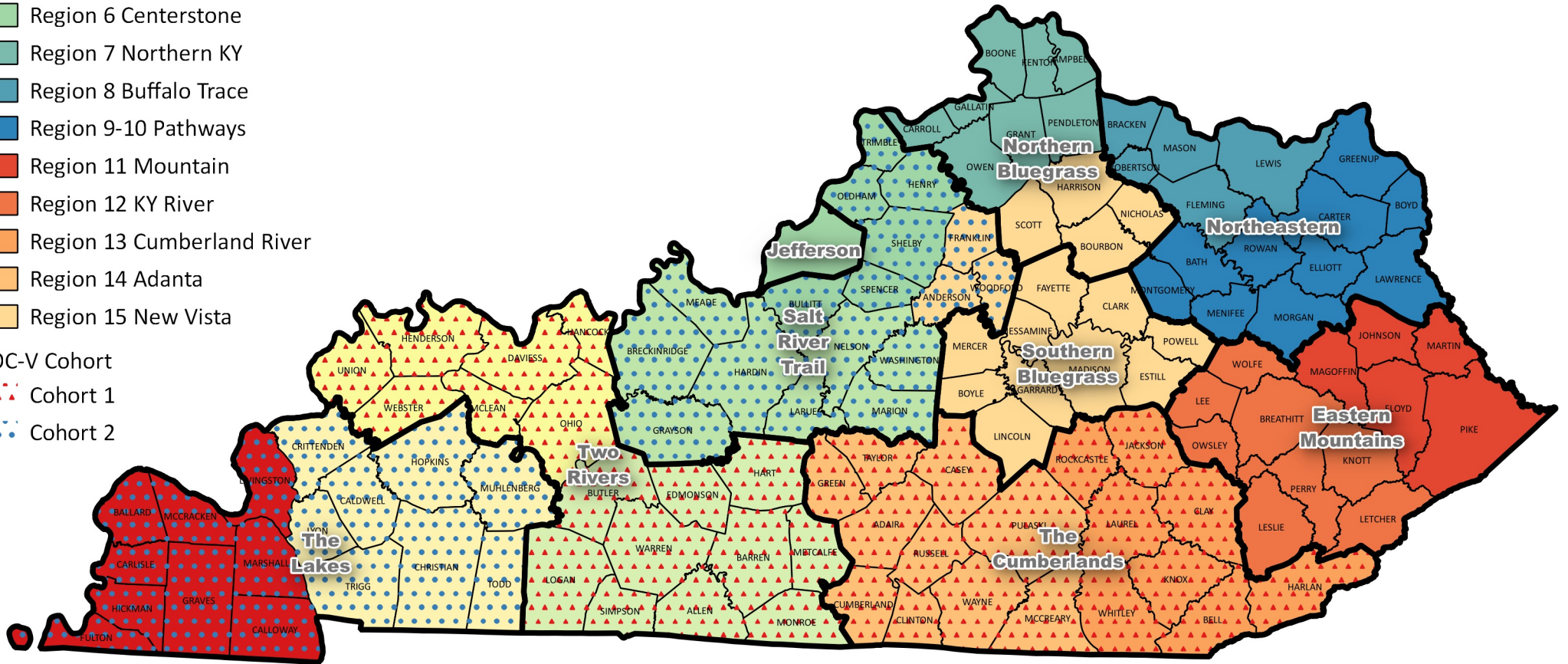
DCBS Service Regions, Community Mental Health Center Regions, and SOC-V Cohorts

CMHC Regions

- Region 1 Four Rivers
- Region 2 Pennyroyal
- Region 3 River Valley
- Region 4 LifeSkills
- Region 5 Communicare
- Region 6 Centerstone
- Region 7 Northern KY
- Region 8 Buffalo Trace
- Region 9-10 Pathways
- Region 11 Mountain
- Region 12 KY River
- Region 13 Cumberland River
- Region 14 Adanta
- Region 15 New Vista

SOC-V Cohort

- Cohort 1
- Cohort 2



DCBS Service Regions

Northern Bluegrass

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 Fax 859-525-6796

Northeastern

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 Grayson KY 41143
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 Fax 606-474-6623

Jefferson

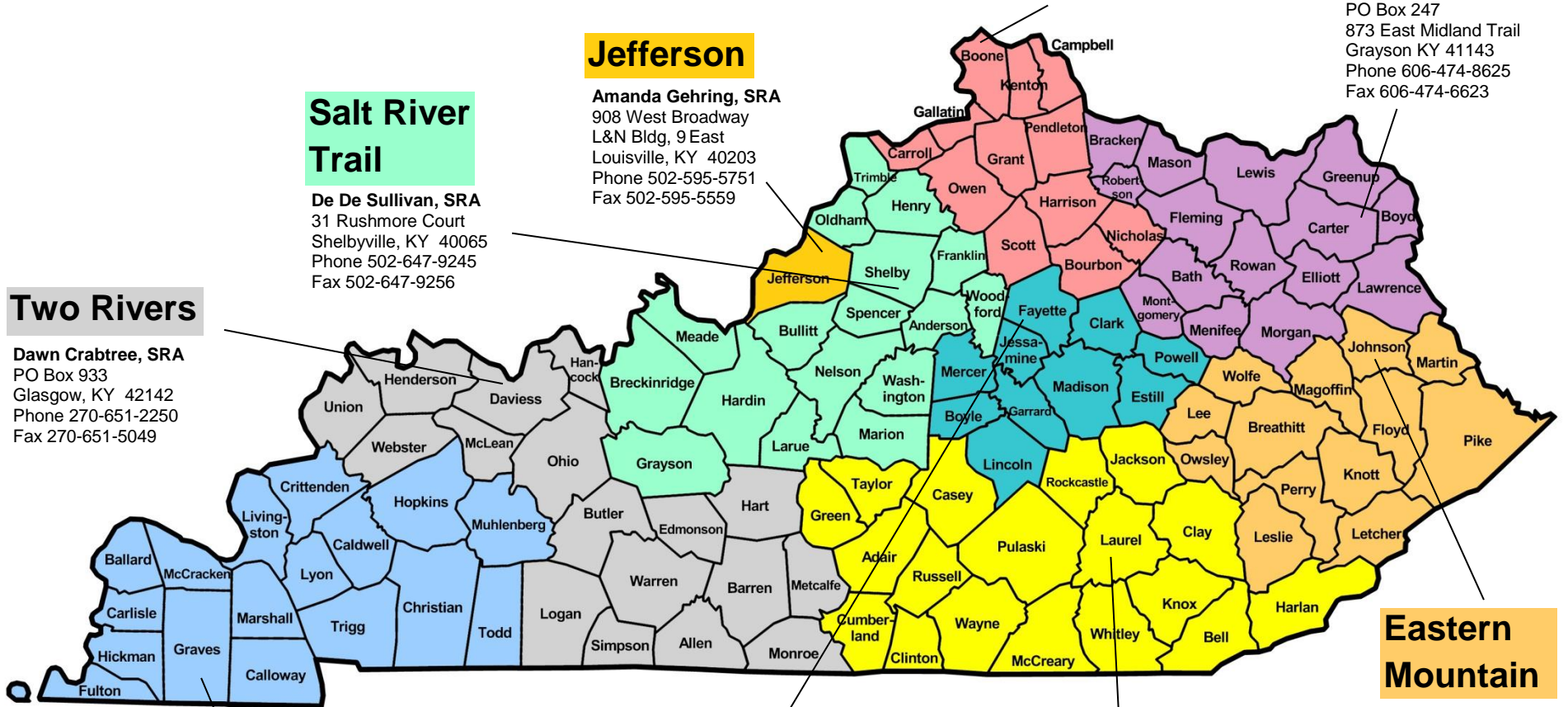
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Eastern Mountain

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 Fax 606-788-7117

The Lakes

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 Phone 270-247-5126
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Southern Bluegrass

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Appendix A. SAMHSA Required and Allowable Services

SAMHSA Required Services

Note: not all required services must be available in every agency, rather they must be available within the larger System of Care

A full array of mental health and support services must be established in order to address the clinical and functional needs of the children, youth and families receiving services through this initiative. This array must consist of, but is not limited to, the following:

- Diagnostic and evaluation services;
- Cross-system care management processes;
- Individualized service plan development inclusive of caregivers;
- Community-based services provided in a clinic, office, family's home, school, primary health or behavioral health clinic, or other appropriate location, including individual, group and family counseling services, professional consultation, and review and medication management;
- Emergency services, available 24 hours a day, seven days a week, including mobile crisis outreach and crisis intervention;
- Intensive home-based services available 24 hours a day, seven days a week, for children and their families when the child is at imminent risk of out-of-home placement, or upon return from out-of-home placement;
- Intensive day treatment services;
- Respite care;
- Therapeutic foster care;
- Therapeutic group home services caring for not more than 10 children (i.e., services in therapeutic foster family homes or individual therapeutic residential homes);
- Assistance in making the transition from the services received as a child and youth to the services received as a young adult;
- Family advocacy and peer support services delivered by trained parent/family advocates.

SAMHSA Allowable Services

Allowable Services. In addition to the mental health services described above, the system of care may provide the following optional services:

- Screening assessments to determine whether a child is eligible for services;
- Training in all aspects of system of care development and implementation, including evidence-based, practice-based or community-defined interventions;
- Therapeutic recreational activities;
- Mental health services (other than residential or inpatient facilities with ten or more beds) that are determined by the individualized care team to be necessary and appropriate and to meet a critical need of the child or the child's family related to the child's mental health needs;
- Customized suicide prevention and intervention approaches to promote protective factors and intervene as needed to address the needs of children who have been identified as at risk for suicide (e.g., previous suicide attempts, suicidal ideation, etc.);
- Customized suicide prevention interventions which identify children and youth at risk for suicide, including those who need immediate crisis services because of an imminent threat or active suicidal behavior. Include in the general portfolio of interventions the promotion of protective factors.

Service	Definition	Service Standards	Notes
Respite	<p>Respite care services are short-term, intermittent services intended to assist in maintaining a goal of living in a natural community home. Services are provided to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands.</p> <p><i>Short-term</i> means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).</p> <p><i>Intermittent</i> means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.</p>	<ul style="list-style-type: none"> ▪ Must meet DCBS respite provider requirements (e.g., at least 18 years of age, pass background check) ▪ Location (private home, foster home, CSU, residential) ▪ Must include plans for hourly and overnight service provision 	<p>While a critical support in the System of Care, respite is not a Medicaid-reimbursable service for behavioral health.</p> <p>Decisions about the methods and amounts of respite should be decided by a team that includes family and providers (e.g., DCBS Family Team Meeting, HFW Child & Family Team meeting, TCM team meeting etc.)</p>

Service	Definition	Service Standards	Notes
Intensive In-home (IIH)	Intensive in-home interventions are behavioral health services and supports that are provided to the child/youth and family to prevent out-of-home placement, including foster care, hospitalization, residential treatment, etc.	<p>IIH components include:</p> <ul style="list-style-type: none"> ▪ Individual and family therapy ▪ Skills training ▪ Behavior management interventions ▪ Crisis response, stabilization, and safety planning ▪ Care coordination (targeted case management, solution based casework, or other approach) ▪ Resource and support building ▪ Cross-system coordination with child welfare, school, behavioral health providers, health care providers, other involved systems ▪ Trauma-focused interventions ▪ Referral to and coordination with substance use treatment and other services for child/youth and/or family members <p>IIH Program requirements include:</p> <ul style="list-style-type: none"> ▪ Strong partnerships with families and children/youth as a central component ▪ Frequency: average 4-7 hours/week ▪ Duration: average 3-7 months ▪ Caseload: 4-6 families for 1 staff person, 8-12 families for a 2-person staff team ▪ Appointments offered at <i>convenient times</i> for families, including evenings and weekends ▪ 24/7 on-call availability for crisis response or crisis resource linkage 	<p>A variety of approaches may be used in IIH, including existing in-home models such as:</p> <ul style="list-style-type: none"> ▪ Homebuilders ▪ Multi-Systemic Therapy ▪ Functional Family Therapy ▪ Multi-dimensional Family Therapy ▪ Intensive In-home Child and Adolescent Psychiatric Services <p>Alternately, multiple evidence-based approaches may be combined and provided within the intensive in-home structure.</p>

Service	Definition	Service Standards	Notes
24/7 mobile crisis	<p>Kentucky Medicaid State Plan service definition: Mobile Crisis is a multi-disciplinary team-based intervention that ensures access to acute mental health and substance use services and supports. The service aims to affect symptom or harm reduction, or to safely transition an individual in acute crisis to the appropriate least restrictive level of care.</p> <p>Mobile Crisis should</p> <ul style="list-style-type: none"> ▪ <i>Defuse, de-escalate, and stabilize</i> mental health emergencies ▪ <i>Prevent unnecessary out-of-home placements</i> ▪ <i>Serve as short-term initial intervention</i> (72 hours or less) to resolve immediate crisis with child and family ▪ <i>Provide stabilization in-home or short-term crisis placement</i> to avert need for psychiatric inpatient treatment ▪ <i>Address acute needs</i> and link the child and family with ongoing services and supports 	<ul style="list-style-type: none"> ▪ Provided face-to-face and available in locations outside the provider’s facility (e.g., home or community) 24 hours per day, 7 days per week and 365 days per year ▪ Delivered by an individual or team that is on call and available to respond ▪ Be provided <i>in the home or any setting</i> where crisis is occurring ▪ May be comprised of professionals and paraprofessionals (including peer support) trained in crisis intervention skills ▪ Works collaboratively with law enforcement 	<p>See supporting documents for additional information and resources:</p> <p>Mobile Crisis Service Standards</p> <p>National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary Full Report</p>

Service	Definition	Service Standards	Notes
<p>Targeted Case Management delivered via High Fidelity Wraparound process</p>	<p>High Fidelity Wraparound (HFW) is a highly individualized planning process facilitated by specialized service coordinators. HFW utilizes a Child and Family Team (CFT). CFT members are determined by the child and family and representing multiple agencies and informal supports. The CFT creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, and other community services and supports. The Wraparound plan should also consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with the child/youth and family, and other community agencies.</p>	<p>Meet all requirements included in KY DMS and DBHDID Targeted Case Management regulations:</p> <ul style="list-style-type: none"> ▪ Coverage 907 KAR 15:060 ▪ Reimbursement 907 KAR 15:065 ▪ Staff eligibility and training 908 KAR 2:260 <p>Support a minimum of 2 HFW facilitators and 1 supervisor (supervisor does not have to be 1.0 FTE on HFW)</p> <p>Maintain a HFW facilitator: child/youth ratio no greater than 1:10</p> <p>Maintain a HFW supervisor: HFW facilitator ratio no greater than 1:7</p> <p>HFW facilitators positions are 100% HFW facilitation, no traditional TCM or other caseload</p> <p>Flexible funds for services/supports not available via other means must be included in the budget, as well as a policy regarding how funds are requested and accessed for families</p> <p>Abide by all expectations outlined in attached document KY HFW Expectations</p>	<p>Grant funds may not be used to supplement Medicaid TCM rate</p> <p>Resources:</p> <p>Resource Guide to Wraparound</p> <p>Wraparound Implementation and Practice Quality Standards</p> <p>Variety of Resource Guides</p>

NOTE: Specific evidence-informed interventions and culture-specific interventions can be included in each type of service and/or modular approach that identifies and trains providers in core components across multiple evidence-based practices

High Fidelity Wraparound

Program Description:

High Fidelity Wraparound (HFW) shall adhere to the principles and phases of the wraparound process as defined by the National Wraparound Initiative (<http://nwi.pdx.edu/NWI-book/>).

Fidelity to this model shall be measured using tools selected from the Wraparound Fidelity Assessment System (<http://nwi.pdx.edu/assessment-and-fidelity/>) and others as determined by DBHDID and SOC FIVE staff.

Eligibility Requirements:

Eligibility for entry into HFW is determined via a multi-step process including:

- 1.-- Agency-developed HFW Nomination Form;
- 2.--Documentation via the use of the *Kentucky Determination Criteria Checklist for Severe Emotional Disability (SED) (SED Checklist)* of meeting the statutory definition of SED [KRS 200.503 (3)] to ensure the child/youth meets criteria for SED;
- 3.--Documentation of need for assistance with coordination of services across two (2) or more child-serving agencies/systems;
- 4.--Completion of an age-appropriate tool that assists with determination of level of service intensity. Allowable instruments are as follows:
 - a.--For children age birth through five (5) (under six (6), the Early Childhood Service Intensity Instrument (ECSII), and
 - b.--For children and youth age six (6) through seventeen (17) (under eighteen (18), the Child and Adolescent Service Intensity Instrument (CASII).

On the CASII and ECSII, those with a four (4) or above meet eligibility criteria.

HFW SERVICES

Targeted case management services shall be provided via HFW to children/youth up to age twenty-one (21) who meet objective eligibility criteria listed above, and whose behavioral health needs are not being met through traditional services (outpatient therapy, targeted case management, etc.). For those HFW youth whose insurance providers deny coverage, SOC FIVE grant funds may be used for the provision of short-term targeted case management services during the appeal process for up to sixty (60) days. Each child/youth enrolled in HFW shall participate on a service team, the membership of which is selected based on child/youth and family choice as well as providers and other natural and community supports who are involved with the child/youth and family.

The service team shall develop, implement, monitor, and revise an individualized Wraparound plan that builds upon the child/youth and family's needs and strengths to identify beneficial services, supports, and areas of growth. Services and supports may include behavioral health services for which the child/youth is eligible, other agency services, and community-based and natural supports, and others as identified by the team.

HFW DELIVERABLES

- 1.--Maintain staffing dedicated to serve as the HFW Supervisor to oversee implementation of HFW and supervise HFW Facilitators. A ratio of one (1.0) FTE HFW Supervisor to seven (7) HFW Facilitators shall be maintained.

- 2.--Maintain number (#) of HFW Facilitators included in the agency's response to the Notice of Funding Opportunity (NOFO).
- 3.--Ensure HFW Facilitators maintain a total caseload of no greater than ten (10) cases of HFW families only. Mixed caseloads are not permitted.
- 4.--Ensure HFW Facilitators and HFW Supervisors:
 - a.--Complete initial HFW training sponsored by DBHDID prior to implementing HFW, and
 - b.--Engage in ongoing coaching and practice refinement related to HFW as scheduled by DBHDID.
- 5.--Ensure Wraparound fidelity is assessed using instruments as approved and provided by DBHDID.
- 6.--Ensure program evaluation activities are completed as scheduled, including process, outcome, and cost data.
- 7.--Ensure each HFW team and all meetings of the team include meaningful involvement of parents/caregivers and youth (when age appropriate) including input into plan development and implementation.
- 8.--Ensure HFW Facilitators engage in a HFW statewide community of practice as evidenced by participation in peer group meetings, coaching, and practice refinement sessions scheduled by DBHDID, High Fidelity Wraparound listserv, and other opportunities supported by DBHDID.
- 9.--Determine eligibility for HFW using a standardized tool that assists with determination of level of service intensity. The level of service intensity tool shall be administered as part of the eligibility determination process and at least every ninety (90) days thereafter for outcome monitoring purposes until transition. The tool shall be used to track significant events. Allowable instruments are as follows:
 - a.--For children age birth through five (5) (under six (6), the Early Childhood Service Intensity Instrument (ECSII), and
 - b.--For children and youth age six (6) through seventeen (17) (under eighteen (18), the Child and Adolescent Service Intensity Instrument (CASII).

HFW REPORTING

Ensure that HFW Facilitators submit client baseline and follow-up data on all clients served in High-Fidelity Wraparound in accordance with the IMPACT Outcome Management System (IOMS) Requirements available on the DBHDID website.

HFW MONITORING

1.—SOC FIVE staff may conduct a program performance and compliance site review of the agency's HFW program. Monitoring will consist of an off-site review of data and documentation as well as an on-site review of operations and documentation. A summary report will be provided to the agency and may require submission of a corrective action plan.

3.--DBHDID may participate in and disseminate information at regularly scheduled, virtual and in person meetings/phone calls with key staff within the agency that provide services to children/youth and families.

#	Category	Standard- Mobile Crisis	Notes/Comments
1	Service Definition/ Required Components	<p>Medicaid State Plan service definition: Mobile Crisis is a multi-disciplinary team based intervention that ensures access to acute mental health and substance use services and supports. The service aims to affect symptom or harm reduction, or to safely transition an individual in acute crisis to the appropriate least restrictive level of care. Mobile crisis services are provided face-to-face and available in locations outside the provider’s facility (e.g., home or community) 24 hours per day, 7 days per week and 365 days per year.</p> <p>Mobile crisis involves all supports and services necessary to provide integrated crisis prevention, assessment, disposition, intervention, continuity of care recommendations, and follow-up services.</p> <p>Authorized providers will offer services in a manner accessible and available to individuals in their community. Significant aspects of accessibility and availability include the need for access at times and places convenient for those served, prompt intake and engagement in services, access to adequate crisis services, and client and family choice in treatment planning and services.</p> <p>Use of peer, recovery, and clinical supports in the community and increased access through the use of telehealth/telemedicine and mobile in-home supports will also further the availability and access to services.</p>	<p>Mobile Crisis is provided for all persons who are, or appear to be, experiencing a psychiatric or psychosocial crisis.</p> <p>Mobile Crisis calls come from individuals experiencing a crisis as well as from family members or other concerned individuals such as friends, law enforcement officers, school personnel, co-workers, landlords, etc.</p> <p>Best practice is for providers to have clearly established relationships with local Emergency Departments in medical hospitals and with local law enforcement to reduce delays for initiating services, facilitate care coordination, discharge and follow-up.</p>
2	Staffing Requirements	<p><u>Rendering Practitioners Practicing as Part of a Licensed Organization</u></p> <ul style="list-style-type: none"> • 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) • Marriage and Family Therapy Associate (MFTA)* 	

#	Category	Standard- Mobile Crisis	Notes/Comments
		<ul style="list-style-type: none"> • Physician • Psychiatrist • Advanced Practice Registered Nurse (APRN) • Physician Assistant (PA) working under the supervision of a Physician* • Peer Support Specialist* • Certified Alcohol and Drug Counselor (CADC)* <p>*Billed through Supervisor</p> <p><u>Billing Providers</u></p> <ul style="list-style-type: none"> • Licensed Organizations <p><u>Billing Providers</u></p> <ul style="list-style-type: none"> • Licensed Organizations <p>A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid. This organization must also meet the following criteria:</p> <ol style="list-style-type: none"> a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky; b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided; c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements; d. Use a financial management system that provides documentation of services and costs; and e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements. <p><u>Authorized Providers</u></p> <p>The Mobile Crisis practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:</p> <ul style="list-style-type: none"> • Capacity to employ required practitioners and coordinate service provision among the rendering practitioners; 	<p>The board-certified or board-eligible psychiatrist will be available to consult with</p>

#	Category	Standard- Mobile Crisis	Notes/Comments
		<ul style="list-style-type: none"> • Capacity to provide the full range of mobile crisis services on a 24/7/365 basis; • Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis. 	and advise mobile crisis providers and hospital emergency department physicians on issues relating to medical evaluation and medication treatment of clients when clinically indicated.
3	Supervision Requirements	A supervising professional shall be available for consultation when non-licensed staff are providing services. Supervision shall be provided by a licensed professional.	Clinical supervision: <ul style="list-style-type: none"> • May occur individually or in a small group; and • Shall be focused on the client's treatment and review of progress toward goals.
4	Admission Criteria	<p>The individual is eligible for this service when the following criteria are met:</p> <p>A. 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;</p> <p>B. The individual or family members evidence impairment of judgment, impulse control, cognitive or perceptual disabilities;</p> <p>C. The individual is intoxicated or in withdrawal, in need of substance use disorder treatment and unable to access services without immediate assistance.</p> <p>Mobile crisis is available for individuals of all age groups to restore an individual to his or her previous level of functioning.</p>	
5	Service Planning / Documentation	<p>Mobile Crisis involves all supports and services necessary to provide integrated Crisis Assessment, Crisis Prevention Planning, Intervention, and Continuity of Care Recommendations.</p> <p>Mobile Crisis begins with a <u>crisis assessment</u>, which includes identification of presenting problem, current mental status, and a risk assessment that identifies the client's personal and environmental factors that may increase risk of suicide and/or violence.</p> <p>When a crisis assessment reveals potential medication issues that need to be addressed immediately, the provider shall assist with connecting the client with his or her prescriber or another community resource.</p> <p><u>Intervention</u> primarily involves psychotherapy with an individual or family to</p>	Mobile Crisis is provided that are appropriate for the clients 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, 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

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		<p>restore an individual to his or her previous level of functioning and to minimize the potential for psychological trauma. It also includes mobilization of resources to defuse the crisis and restore safety, identification and development of a natural support system</p> <p>Mobile Crisis includes <u>crisis prevention planning</u> 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. 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.</p> <p><u>Continuity of care recommendations</u> 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:</p> <ul style="list-style-type: none"> • Referral to outpatient assessment and treatment; • Referral to partial hospitalization program; • Referral for continued work with current Case Manager, and/or other treatment providers to address unmet needs; • Referral for medical and non-medical detoxification services; • Recommendations to individualized treatment plan; • Referral for evaluation for hospitalization; • Residential crisis stabilization; • Outpatient crisis stabilization support; • In-home supports; • Support and involvement by family members, peers, and other natural supports; • Referral to local peer services, support groups, warm lines, and other resources (e.g., NAMI Kentucky, Kentucky Partnership for Families and 	<p>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.</p> <p><u>Follow-Up Services</u></p> <p>For individuals with any elevated suicide risk, best practice is to provide follow-up contact within 24 hours. 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. A follow-up appointment should be made.</p> <p>Clients with a history of recurring crises or at high risk of hospitalization or future crises should be educated about Advance Directives, KRS 202A.420 to 202A.432.</p> <p>A <u>safety plan</u> is a specialized crisis plan that should be developed for clients who have made a suicide attempt, have suicide ideation, have psychiatric disorders that increase suicide risk, or who are otherwise determined to be at a high risk for suicide.</p>

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		<p>Children, People Advocating Recovery, AA, etc.) as appropriate.</p> <ul style="list-style-type: none"> Peer services that might be considered include: peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transition between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services; and <p>Mobile Crisis includes <u>24-hour telephone service</u> 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. Callers should not encounter a busy signal, a long wait time, a voice messaging system or untrained staff.</p>	<ul style="list-style-type: none"> It is a prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises. The safety plan should identify anyone who is a support for the individual and their contact information and include emergency telephone numbers. When possible, the safety plan should always be completed with the family/support in attendance so that they are aware of the plan, can assist with means restriction, and provide support. <p>A crisis assessment may include any of the following:</p> <ul style="list-style-type: none"> Demographic and diagnostic information, if applicable and/or known. Presenting problem (in client's own words) and precipitating events. Evidence of co-occurring medical, substance abuse, developmental and psychiatric conditions that may have a potential impact on the course and/or treatment of the presenting condition(s). The extent to which environmental assistance through the family, community or service providers are available and able to provide safety or support for the individual. Evaluation of the need for emergency intervention. Risk of harm to self and others (e.g., current and history of suicidal and homicidal impulses, thoughts and behaviors; trauma history, risk of victimization, and/or abuse or neglect;

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			<p>physically and/or sexually aggressive impulses or behaviors; and ability for self-care and use of environment for safety).</p> <ul style="list-style-type: none"> • Evaluation of the need for an immediate medical assessment. • Functional status (e.g., self-care/hygiene; ability to maintain social/interpersonal relationships; changes/disturbances in biologic functioning such as sleep, eating, activity level, etc.; and school and/or work performance). • Medication history and current use of medications. • Current and past experiences with treatment and services, including the existence/availability of a crisis plan (including response to treatment; ability to manage recovery; ability to engage in treatment process; history of psychiatric hospitalization; history of involvement with crisis services; resiliency following setbacks, etc.). <p>A primary objective of crisis intervention is to identify natural supports in the client's environment. Ongoing contact between family members and mobile crisis response teams provides the family members with needed support and it provides the crisis response workers with the information they require to make appropriate decisions about treatment.</p> <p>Whenever possible, the same crisis services staff should be involved throughout the course of a crisis episode.</p>

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			Individuals and families shall receive appropriate educational information that is relevant to their diagnosis. This includes information about the most effective treatment for the individual's behavioral health disorder.
6	Continued Stay Criteria	Client continues to meet admission criteria.	
7	Discharge Criteria	<p>Any of the following criteria are sufficient for discharge from this level of care.</p> <ul style="list-style-type: none"> 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. <p>The individual/family concur that the crisis has subsided.</p>	
8	Service Setting	Mobile Crisis services are provided face-to-face and available in locations outside the provider's facility (e.g., home or community) 24 hours per day, 7 days per week and 365 days per year. This service is provided in duration of less than of less than 24 hours and is not an overnight service.	To assure safety for persons in crisis and staff, crisis staff will determine the appropriate site for the intervention, always choosing the least restrictive environment and the least disruptive manner of access for the client and family.
9	Service Limitations / Exclusion	<p>Per the Kentucky Medicaid State Plan Amendment, the following services will NOT be covered by Medicaid:</p> <ul style="list-style-type: none"> • Services provided to residents of nursing facilities. • 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. 	

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		<ul style="list-style-type: none"> • 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. 	
10	Unit of Service	1 hour	
11	Service Codes	HCPCS code: S9484 CMHC code: 176	
12	Program Evaluation / Quality Improvement	Providers shall evaluate on a regular basis their mobile crisis program’s performance in safety, quality and effectiveness of services.	Best practice is to also review referral sources on a regular basis for safety, quality, and effectiveness of services provided.
13	Program Principles	<u>Kentucky Emergency Services Guiding Principles</u> <ul style="list-style-type: none"> • Respect: Emergency services programs and staff: <ul style="list-style-type: none"> ○ 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 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. 	

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		<ul style="list-style-type: none"> • Collaboration: Program design and delivery should be developed through a collaborative process that includes all pertinent stakeholders, including law enforcement, private and public hospitals, consumers, youth and family members. • 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. 	