#	Category	Standard- Mobile Crisis	Notes/Comments
1	Service Definition/ Required Components	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. Mobile crisis involves all supports and services necessary to provide integrated crisis prevention, assessment, disposition, intervention, continuity of care recommendations, and follow-up services. 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. 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.	Mobile Crisis is provided for all persons who are, or appear to be, experiencing a psychiatric or psychosocial crisis. 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. 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.
2	Staffing Requirements	<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) • Marriage and Family Therapy Associate (MFTA)*	

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		• 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)* *Billed through Supervisor <u>Billing Providers</u> • Licensed Organizations <u>Billing Providers</u> • Licensed Organizations 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: 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. <u>Authorized Providers</u> The Mobile Crisis practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria: • Capacity to employ required practitioners and coordinate service provision among the rendering practitioners;	The board-certified or board-eligible psychiatrist will be available to consult with

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		• Capacity to provider 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: • 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	The individual is eligible for this service when the following criteria are met: 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; B. The individual or family members evidence impairment of judgment, impulse control, cognitive or perceptual disabilities; C. The individual is intoxicated or in withdrawal, in need of substance use disorder treatment and unable to access services without immediate assistance. Mobile crisis is available for individuals of all age groups to restore an individual to his or her previous level of functioning.	
5	Service Planning / Documentation	Mobile Crisis involves all supports and services necessary to provide integrated Crisis Assessment, Crisis Prevention Planning, Intervention, and Continuity of Care Recommendations. 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. 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. <u>Intervention</u> primarily involves psychotherapy with an individual or family to	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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		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 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. <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: • 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	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. <u>Follow-Up Services</u> 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. 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. 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.

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		Children, People Advocating Recovery, AA, etc.) as appropriate. • 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 Mobile Crisis 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. Callers should not encounter a busy signal, a long wait time, a voice messaging system or untrained staff.	• 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. A crisis assessment may include any of the following: • 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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			physically and/or sexually aggressive impulses or behaviors; and ability for self-care and use of environment for safety). • 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.). 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. Whenever possible, the same crisis services staff should be involved throughout the course of a crisis episode.

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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	**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. The individual/family concur that the crisis has subsided.	
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	Per the Kentucky Medicaid State Plan Amendment, the following services will NOT be covered by Medicaid: • 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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		• 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>
		• 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 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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		• 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.	