DBHDS

Virginia Department of Behavioral Health and Developmental Services

Commonwealth of Virginia Crisis Continuum Best Practices

November 2025

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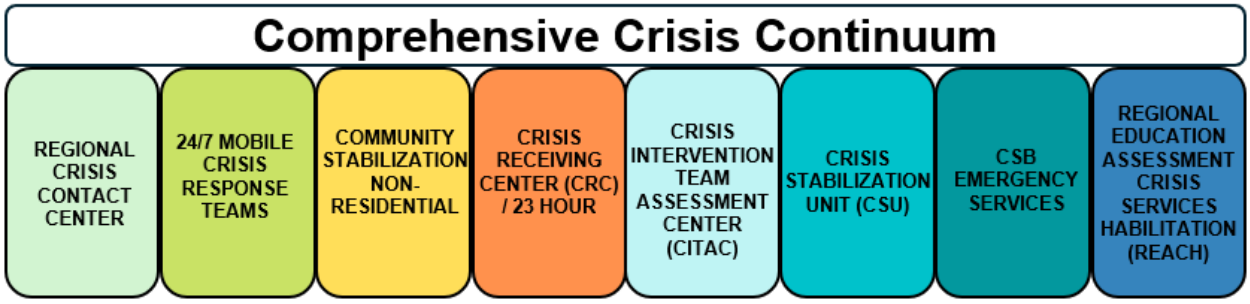
Overview

The Commonwealth of Virginia is in a paradigm shift in how Virginians care for each other during a behavioral health crisis. This transformation is moving away from a system of primary law enforcement engagement to a statewide, integrated crisis continuum of care with someone to call, someone to respond, and somewhere to go. These services are intended to ensure safety, support, stabilization, and connection that can facilitate healing and growth. The crisis continuum is inclusive, serving all Virginians regardless of disability, age, or circumstance. This transformation will align the Commonwealth's crisis continuum with national best practices.

The purpose of this document is to provide the Department of Behavioral Health and Developmental Services' (DBHDS' or "the department's") explanation of best practices for the crisis continuum.



Behavioral health crises are dynamic and fluid, so the appropriate response must be, too. The crisis continuum will integrate key services, including regional crisis contact centers, mobile crisis response, community-based stabilization, crisis receiving and stabilization centers, community services board[1] (CSB) emergency services, and REACH. This integration allows care to be responsive and meet the level of care needed at any time during a crisis.

The crisis system has five designated regional hubs across the Commonwealth:

- Region 1 – Region 1 Project Office operated out of Region Ten CSB.
- Region 2 – Region 2 Project Office operated out of Fairfax/Falls Church CSB.
- Region 3 – New River Valley CSB.
- Region 4 – Richmond Behavioral Health Authority.
- Region 5 – Western Tidewater CSB.

[1] The term "community services board" or "CSB" shall include Behavioral Health Authority (BHA).

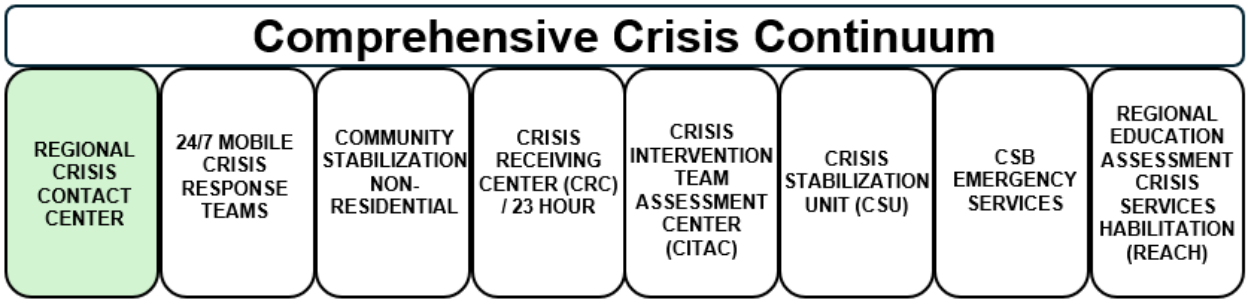
Additional information on DBHDS Regional Designations is available here.

These regional hubs are responsible for consistently implementing the Commonwealth's crisis continuum as outlined in the DBHDS Community Services Performance Contract with the CSBs. This includes, but is not limited to, financial accountability, utilization of the contact center and established components of the crisis platform by employees, required licenses and certifications as applicable to services, training requirements, and engagement in memorandums of understanding (MOUs) or business agreements with private providers. The new crisis system is designed to be implemented consistently across the Commonwealth with regionally approved nuances to incorporate the specific needs of the regions. Standardized processes have been developed to maintain consistency across the Commonwealth.

This crisis continuum best practices document is a comprehensive approach to outline the services and components of the crisis system, including system requirements and best practices for implementing crisis services. These best practices were developed to maintain consistency across the Commonwealth and apply to both private and state-funded service providers. The best practices outlined in this document also include embedded website links that can be accessed to obtain additional information related to crisis services and regional programs.

All terms referenced, if not defined within this document, can be defined in 12VAC35-105-20. Definitions, § 37.2-311.1, and DMAS Provider Manual

Service: Regional Crisis Contact Centers



Service Overview

This is not a licensed service. Therefore, this section is solely for informational purposes. To request more information, contact DBHDS.

A regional crisis contact center (RCCC) offers real-time access to trained crisis workers 24 hours per day, seven days per week. These employees are clinically supported to provide telephonic crisis intervention services to all callers, chatters, and texters. A RCCC is required to meet National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offer air traffic control (ATC) quality coordination of crisis care in real-time.

A RCCC is required to take all calls and maintain expertise in delivering telephonic intervention services, triaging the call to assess for additional needs, and coordinating connections to additional supports based on assessment and the preferences of the caller. All RCCCs are required to work closely with regional hubs to help individuals access the continuum of crisis services as well as coordinate other statewide initiatives and priorities, such as 911 diversion under the Marcus Alert legislation.

Program Qualifications

- National Suicide Prevention Lifeline (NSPL) membership and accreditation by a NSPL endorsed accreditation body is required for participation.
- Holding a contract with at least one of the five Virginia regional hubs is required for participation.

Minimum Expectations to Operate as a Regional Crisis Contact Center

A regional crisis contact center must:

- Operate 24 hours a day, 7 days a week, and 365 days a year.
- Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received.
- Assess risk of suicide and imminent risk in a manner that meets NSPL standards and adheres to Virginia's Marcus Alert policies within each call.
- Coordinate connections to resources and the crisis continuum of services.
- Operate within DBHDS' Virginia Crisis Connect system.

Best Practices to Operate as a Regional Crisis Contact Center

To fully align with best practice guidelines, RCCCs will meet the above minimum expectations and:

- Incorporate caller ID functionality.
- Implement GPS-enabled technology in collaboration with mobile crisis response (MCR) to more efficiently dispatch care to those in need.
- Utilize real-time regional bed registry technology to support efficient connection to needed resources.
- Schedule outpatient follow-up appointments with appropriate engagement to support connection to ongoing care following a crisis episode.

Provider Qualifications, Credentialing, and Training Elements

Minimum Training Requirements for Contact Center Agents

- Virginia DBHDS Contact Center Training (included in agency specific training).
- NSPL Safety and Risk Assessment.
- Suicide prevention training.

Once fully trained, the minimum expectations for contact center agents and crisis workers can be found in the "Behavioral Health Crisis Services: Three Essential Elements" section of this document.

Service Delivery and Expected Outcomes

Each regional hub maintains a contract with a RCCC. There are different regional expectations and requirements for participation in the crisis continuum.

Substance Abuse and Mental Health Services Administration (SAMHSA) published the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit which includes recommended system level monitoring and specific recommended performance metrics each crisis contact center should collect. Please reference the System Evaluations Tools section of the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.

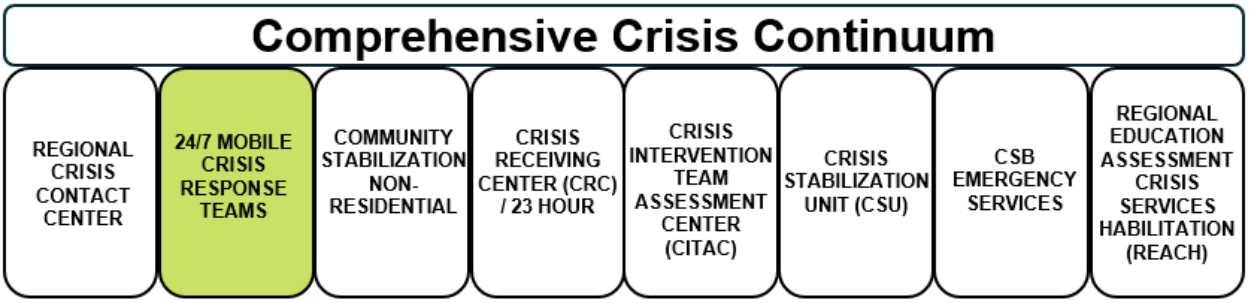
Vibrant, the current administrator for 988, requires crisis contact centers to collect specific data on each call for quality assurance purposes. The data consists of contact metrics, individual demographics such as age and gender, risk factors, and primary presenting concern. No personal information will be reported. For additional information regarding contact center data collection, please contact DBHDS' Division of Crisis at crisis_services@dbhds.gov

Monitoring and Evaluating Service Outcomes

- After the first year, all collected data will be evaluated by region and the DBHDS Office of Crisis Operation and will be used to set baseline performance standards for future years.
- DBHDS is ultimately responsible for setting specific regional performance metrics for the contact center to meet.
- DBHDS provides funding to the RCCC, and any metrics associated with funding requirements.

Service utilization will be evaluated by examining the data collected from the measures listed above along with the number of referrals. The service will be further evaluated based on the percentage of referrals followed up on successfully. Collected data will be evaluated by region after the first year and will be used to set baseline performance standards for future years.

Service: Mobile Crisis Response



Service Overview

Mobile crisis response (MCR) is an essential component of the comprehensive crisis care system. This service is provided 24 hours a day, seven days a week. The service is defined as providing rapid response, conducting a *comprehensive* assessment, and providing early intervention to individuals experiencing a crisis. The comprehensive assessment, to be conducted by a LMHP-type, must indicate an individual's history, but also why they are experiencing a crisis in that specific moment. The purpose of MCR includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention, and development of an immediate, person specific plan to maintain safety to prevent the need for a higher level of care. The primary goal of MCR is to provide intervention and mitigate risk, working to keep people in the community whenever possible. MCR aims to reduce the utilization of hospitals when there are other options available, however an individual presenting signs of significant risk may require hospitalization.

Mobile Crisis Response is appropriate for individuals who have emergent behavioral health needs that require immediate assessment, crisis support, and care coordination to resolve the potential for harm to self or others.

Mobile crisis responders are expected to consistently commit to the delivery of crisis interventions while ensuring the safety of the individuals served and their support systems. The expected response time for most MCRs is one hour (urban areas) or two hours (rural areas) from the time of dispatch. Mobile crisis services may be provided for up to 72 hours after the initial contact, during which the MCR delivers immediate and direct intervention, offers care coordination, and provides other follow-up support. Care coordination consists of facilitating appropriate engagement to support connection within the community, including assessment, treatment planning, and follow-up. MCR teams must be available to provide services to an individual in an environment where they are most comfortable, including their home, workplace, or other convenient and appropriate setting. Teams must be able to provide services 24 hours per day, 7 days per week.

While MCR can be provided for up to 72 hours, it is best practice, when possible, to handoff as soon as practical to a community-based stabilization team or other service best designed to meet the individual's needs. This is especially true for youth and individuals with developmental disabilities.

In order to obtain access to DBHDS's Virginia Crisis Connect (VCC) system, provider agencies must submit a formal access request for each MCR team member, regardless of license type or certification. Additionally, each team member must provide proof of completed MCR Provider Training prior to being granted access.

It is important to note that MCR is dispatched to an individual experiencing a crisis and should not be actively recruited by providers. This service is analogous to an ambulance responding to an individual's medical emergency—intervening only when a crisis arises, rather than being sought out as a pre-arranged service. Therefore, crisis response times should *not* consistently occur in less than one minute. DBHDS collects real-time data, such as dispatch acceptance rates, dispatch completion, time-to-response data, etc. Response times consistently below average will result in a referral to the regional HUB and a potential quality service review. Additionally, if an individual in crisis walks into a provider's office, MCR would not be the appropriate intervention, as the individual is already in a setting where support can be provided. In accordance with 12VAC35-105-70. Onsite Reviews, all records, charts, and data are available to DBHDS upon request.

Refer to the DMAS Mental Health Services manual for program requirements and service definitions: Appendix G – Comprehensive Crisis Services

Program Qualifications

- The provider will engage with the DBHDS Virginia Crisis Connect (VCC) platform as required by DBHDS.
- MCR providers will be licensed by DBHDS as a provider of outpatient crisis stabilization services and must be enrolled with DMAS as a provider with active specialty codes for mobile crisis and community stabilization (MCR: 920 and Stabilization: 902)
- MCR providers will have an active, DBHDS-approved memorandum of understanding (MOU) or contractual agreement with the regional crisis hubs and update it as necessary. Providers must meet the criteria set forth by regional MOU requirements, however not every provider will receive one.
- Providers must have an active MOU before obtaining a DMAS enrollment.
- MCR providers will follow all general Medicaid provider requirements specified in Chapter II (Provider Participation Requirements) of this guide.
- Employees will complete required MCR training as provided through the regional HUBs or Sentara.
- Providers and employees will upload the required documents and proof of training to register with VCC and make an account.

Provider Qualifications, Credentialing, and Training Elements

Refer to DMAS Mental Health Services manual for staffing requirements for Mobile Crisis Response: Appendix G - Comprehensive Crisis Services

When staffing MCR teams, providers must follow the guidelines outlined in the DMAS manual. If there is only one team member on a dispatch, they *must* be licensed. Teams of two or more may consist of a team of QMHPs, however that team composition cannot consist of 2 QMHP-Ts.

Minimum Training Requirements

All provider employees are required to complete DBHDS-approved MCR training. This includes LMHP and LMHP types, as they are considered to be a part of the mobile team (even if they are only conducting assessments via telemedicine). For information regarding accessing training, see the DBHDS website. The MCR training covers the entire lifespan in an all-encompassing, intensive approach. All employees of MCR provider agencies are required to complete and pass this training at hire, as mandated by DBHDS and DMAS. Provider employees will not be permitted access to VCC until they complete the MCR training. For more information on training, visit the Division of Crisis Services website.

Service Delivery and Expected Outcomes

Refer to the DMAS Mental Health Services manual for service components, required activities, billing criteria, and discharge criteria for MCR: Appendix G - Comprehensive Crisis Services

Except for the assessment, which may be provided through telemedicine, mobile crisis response services must be provided in-person. A telemedicine only interaction does not fulfill the requirement of being dispatched as a mobile crisis response.

Services may not be provided to more than one individual at a time, even in situations where a team of employees are present.

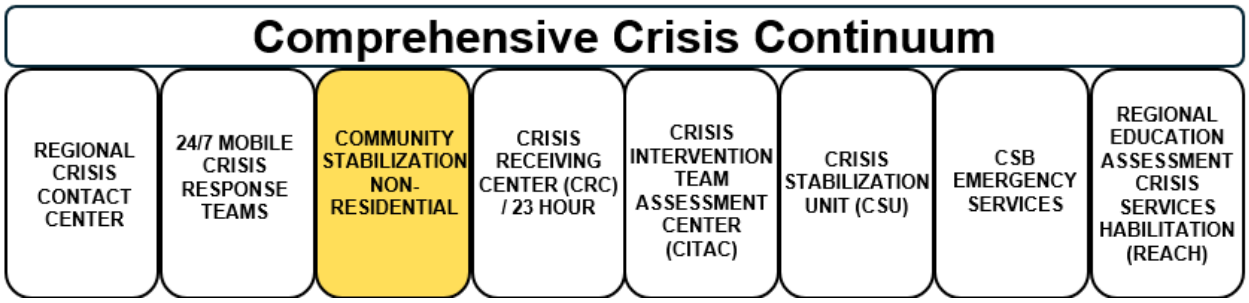
The individual's clinical record must reflect the resolution of the crisis which marks the end of the current episode. The record must also indicate the development of a safety plan, which should be based on the crisis assessment with the participation and informed choice of the individual receiving services. The safety plan shall include any plans to allocate care to appropriate services focused on managing the ongoing symptoms associated with the crisis.

The clinical record must also indicate the location in which the service took place, including the initial dispatch location and any secondary locations.

Monitoring and Evaluating Service Outcomes

1. Refer to DMAS Mental Health Services manual for documentation and utilization review requirements: DMAS - Chapter VI
2. Each MCR program is expected to have established policies and procedures that ensure all documents and data submitted through the Virginia Crisis Connect platform are reviewed for accuracy and quality in a timely manner. The program will have an identified point of contact that will be available to resolve questions and concerns related to data submissions.
3. Expected outcomes and reporting requirements are outlined in the Virginia Crisis Data Platform.

Service: Community Stabilization- Non-residential



Service Overview

Community stabilization services are available 24 hours a day, seven days a week, to provide short-term assessment, crisis intervention, and care coordination to individuals who have recently experienced a behavioral health crisis. This service acts as a bridge to support individuals when there is a gap in available services, providing coverage from the end of one service until the next is available. Services may include brief therapeutic and skill-building interventions, engagement of support system, interventions to integrate supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Services also involve care coordination, which requires active engagement with other service providers such as making referral calls, confirming appointments, and facilitating hand-offs and documenting these efforts clearly in the individual's record.

The goal of Community Stabilization services is to stabilize the individual within their community and support the individual and their support system in the following situations:

- Between an initial Mobile Crisis Response (MCR) and entry into an established follow-up service if the appropriate level of care is identified but not immediately available for access.
- As a transitional step-down from a higher level of care if the next level of care is identified but not immediately available.
- As a diversion from a higher level of care.

Refer to DMAS Mental Health Services manual for program requirements and service definitions. Appendix G – Comprehensive Crisis Services

Program Qualifications

Providers must have an active, DBHDS approved, MOU or contractual agreement with the regional crisis hubs prior to providing mobile crisis response services. (Appendix G – Comprehensive Crisis Services)

Community Service Boards (CSBs) must operate under performance expectations identified in their respective performance contract with DBHDS.

Performance contracts specify the services to be provided by the CSB or Behavioral Health Authority (BHA) and the costs of those services, include all revenues used to support the services, list state and federal statutory and regulatory requirements applicable to the CSB or BHA, and contain outcome and performance measures for the CSB or BHA

Provider Qualifications, Credentialing, and Training Elements

Refer to DMAS Mental Health Services manual for staffing requirements for Community Stabilization: Appendix G – Comprehensive Crisis Services

Service Delivery and Expected Outcomes

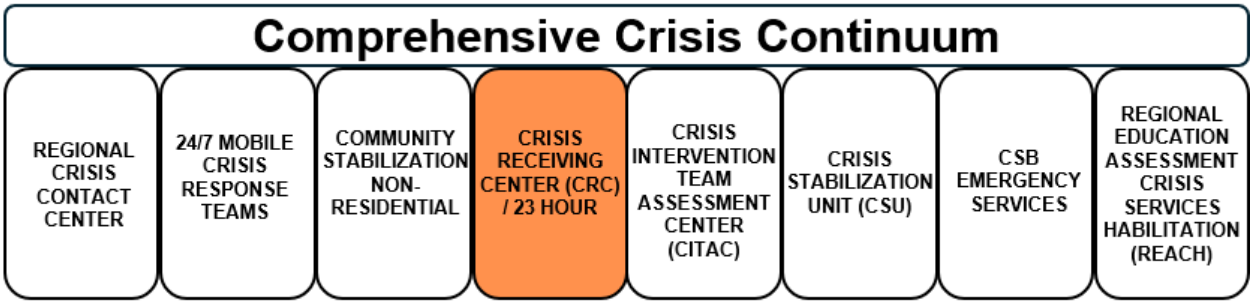
The individual's clinical record must reflect either resolution of the crisis which marks the end of the current episode or the discharge plan to an appropriate service or resource to manage the underlying needs associated with the crisis.

Refer to the DMAS Mental Health Services Manual for requirements, activities, admission criteria, exclusions, billing criteria, and discharge criteria for Community Stabilization: Appendix G – Comprehensive Crisis Services and the "Requirements for All Services" section of DMAS- Chapter IV

Monitoring and Evaluating Service Outcomes

- Refer to DMAS Mental Health Services manual for documentation and utilization review requirements: DMAS- Chapter VI
- Each Community Stabilization program is expected to have established policies and procedures that ensure all documents and data submitted through the DBHDS Crisis Data Platform are reviewed to ensure accuracy and quality in a timely manner. The program will have an identified point of contact that will be available to resolve for questions and concerns related to data submissions.
- Expected outcomes and reporting requirements are outlined in the Performance Contract and regional MOU. Exceptions to this would require approval from the Division of Crisis Services with DBHDS.

Service: Crisis Receiving Center



Program Overview

Crisis Receiving Centers (CRC) provide licensed site-based crisis observation and outpatient assessment and treatment for a period of up to 23 hours and 59 minutes. CRCs aim to rapidly address the needs of a person to promote de-escalation and stabilization. CRCs fill a critical role in an effective crisis system by accepting referrals from crisis lines, mobile crisis teams, or law enforcement, and through walk-ins and self-referrals. CRC goals are to determine the immediate needs of the individual in crisis, provide appropriate treatment for 23 hours, and coordinate care

for continued psychosocial needs as well as health literacy counseling for the individual's return to the community.

CRCs must be licensed by DBHDS, provide all guests access to minimum core services, and meet minimum standards as provided in the Department of Medical Assistance Services Mental Health Services manual: Appendix G – Comprehensive Crisis Services.

Guests of a CRC must be voluntary at the time of entry; however, they may be referred directly from an emergency custody situation, if appropriate. CRCs should assess and triage individuals experiencing a behavioral health in any level of acuity crisis 24 hours a day. There may be instances when a guest is assessed to need a higher level of care, such as acute hospitalization, and should instead be pre-screened for the appropriate care. CRCs in Virginia serve everyone from their target population and referral sources. These services are for anyone, anywhere, anytime. The very limited disqualifiers for service are generally, but not specifically limited to, heightened medical acuity or obvious chronic medical need that may require care that is only available at a medical facility, or a level of physical aggression that is likely to endanger the safety of other guests or employees.

This service is analogous to individuals receiving medical care at a Med Express. The service is sought out by the individual and is short term, unless referral to a more long-term level of care is necessary. The service will never be long-term at this current level, just like how a Med Express will never treat someone long-term.

Program Qualifications

Licensing For a 23-Hour Program

Services included in 23-hour observation must be provided in a licensed location that meets DBHDS physical site requirements within the Licensing Regulations. The licensed location must be identified on the provider's DBHDS license. Services may not be provided in other locations outside of a DBHDS licensed site. Therefore, CRCs are not the same as mobile crisis responses and should not be completed as such. 23-Hour Crisis Stabilization service providers must be appropriately licensed by DBHDS as an Outpatient Crisis Stabilization provider and enrolled with DMAS (Specialty 921: 23-Hour Crisis Stabilization).

Provider Qualifications, Credentialing, and Training Elements

Refer to the DMAS mental health services manual for staffing requirements for CRCs: Appendix G – Comprehensive Crisis Services.

Service Delivery and Expected Outcomes

Crisis Receiving Centers will provide services in line with nationally accepted best practice models of crisis service. CRCs will accept guests at any level of crisis, however, optimal utilization as a site-based crisis service occurs in conjunction with crisis contact centers, mobile crisis teams, and law enforcement as referrals, in addition to acceptance of guests who seek services on their own. CRCs are not intended as a step-down from a higher level of care and should not be used as such.

Voluntary guests at any level of behavioral health emergency are accepted at CRCs with deferrals in cases such as acute medical concerns or dangerous aggression. Additionally, guests

with an active TDO status should also be deferred. Guests may be referred from any source, including but not limited to mobile crisis, law enforcement, CSB employees, support system, community members, or self-referrals. Guests who begin involuntarily at a co-located CIT Assessment Site and are determined not to meet TDO status must be able to voluntarily agree to further care following an initial assessment to be accepted at the CRC.

The managing CSB or provider is expected to establish linkages with public and private services as appropriate to support ongoing care of guests following discharge from the CRC. Regardless of the individual's clinical status, the service requires that individuals be discharged within 23 hours and 59 minutes. The linkage, discharge, or transition should depend on the unique needs of the individual at the time of 23-hour discharge. This may include a determination for level of care and service availability. Each provider is expected to develop policies and procedures for guests whose discharge plan is not yet actionable approaching 23 hours.

Services must be provided in person, except for the psychiatric evaluation and care coordination. Therefore, the LMHP is expected to conduct the 23-hour program clinical assessment face-to-face and in person with the individual in crisis. An LMHP does not need to be onsite 24/7, however they must be available to come in and complete assessments as needed.

Clinical Assessment

Guests of the CRC shall receive a clinical assessment by a Licensed Mental Health Professional (LMHP). This assessment may or may not include a formal pre-admission screening as defined in Va. Code § 37.2-809 at the discretion of the clinician. The clinician must provide a DBHDS defined and approved assessment to determine the appropriate level of treatment for each individual who presents to the CRC. Provider policy should describe how the LMHP will be contacted and how they will respond in person to complete this assessment.

Medical Evaluations

Upon entry to the program, guests are to receive an evaluation by medical personnel as or under the direction of an RN or medical doctor. This evaluation shall determine the medical stability of the guests as well as provide diagnostic information including but not limited to laboratory results to support any necessary medical care or psychiatric medication to be administered during the stay.

Peer Services

When possible, guests to CRCs may receive the offer of accompaniment throughout the 23-hour assessment and treatment. A Peer Recovery Specialist shall accomplish this from the entry point through discharge from the CRC.

Psychiatric Evaluation

All guests to the CRC must undergo a psychiatric evaluation, which may be provided in person or through telemedicine and must be available 24 hours per day, seven days per week. A nurse practitioner or physician's assistant working under the licensed psychiatrist may provide this coverage for the psychiatrist. Medicaid providers must follow the requirements for the provision of telemedicine including the use of telemedicine modifiers described in the "Telehealth Services Supplement" of the Department of Medical Assistance Services Mental Health Services Manual.

MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

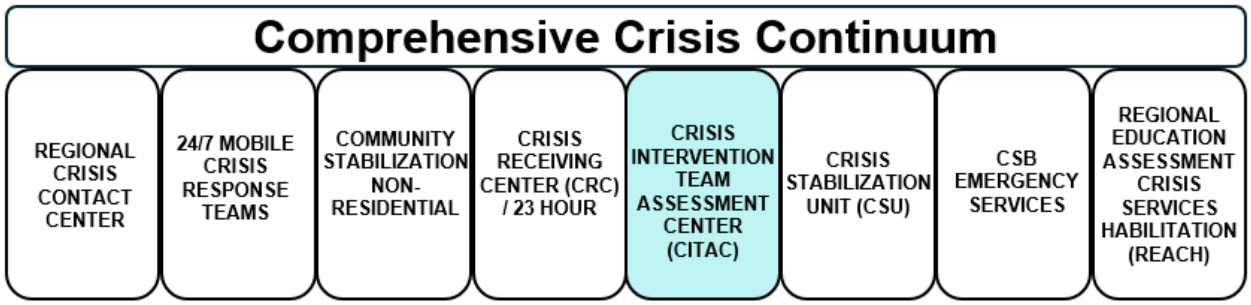
The Crisis Department expects that CRC providers will comply with DBHDS Office of Licensing Regulatory requirements for risk management and service evaluation protocols.

Monitoring and Evaluating Service Outcomes

Refer to the DMAS manual for documentation and utilization review requirements: DMAS-Chapter VI.

Each CRC is expected to have established policies and procedures that ensure all documents and data submitted through the DBHDS crisis data platform are reviewed to ensure accuracy and quality in a timely manner. The program will have an identified point of contact that will be available to resolve for questions and concerns related to data submissions.

Service: CITAC



Service Overview

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A crisis intervention team assessment center (CITAC) is a designated facility where law enforcement officers can transport individuals who are in behavioral health crisis and are voluntarily seeking behavioral health support or are under an Emergency Custody Order (ECO) to a safe and caring environment for a comprehensive evaluation by a mental health professional. This model offers a therapeutic alternative to emergency rooms or jail, focusing on de-escalation and appropriate care. CITACs offer 24/7 support through partnerships between local behavioral health agencies, law enforcement, and healthcare providers. Once at the center, programs will begin the code-mandated preadmission screening as soon as practicable, whether in person or by secure virtual communications. As available, people with lived experience (peer recovery specialists or PRS) are encouraged to be available during the de-escalation and evaluation process to provide emotional support and feedback about the involuntary custody process throughout the individual's stay at the CITAC.

Program Qualifications

Oversight for the CITAC program is managed by DBHDS Central Office through a designated program coordinator. This oversight includes:

- The granting process

- Management of funding
- Data tracking and analysis
- Program reporting to programs, public access, DBHDS leadership, the Governor's Administration, and the General Assembly and its associated public bodies.

The recipient of and fiscal agent for CIT assessment site funds must be a Community Services Board (CSB) or behavioral health authority (BHA) in Virginia as defined in § 37.2-100 of the Code of Virginia.

Provider Qualifications, Credentialing, and Training Elements

CITACs are operated by CSBs or BHAs, who must meet the qualifications, credentialing standards, and training components that are outlined in the performance contract.

Service Delivery and Expected Outcomes

CITACs are expected to accept individuals in behavioral health crisis who have encountered law enforcement due to actions or symptoms related to the crisis. Exceptions for admission to the program may be granted to safely accommodate the individual in crisis based on acuity of medical need, safety of the individual, other program guests or employees, or program capacity.

Once accepted into the CITAC, custody of an individual under an ECO will be transferred either to a law enforcement officer on duty at the CITAC or to the facility itself in those circumstances when a CITAC is not staffed with a sworn law enforcer per § 37.2-808 E of the Code of Virginia. The individual in crisis will be provided with a space to de-escalate, as well as appropriate comfort items including at a minimum food, water, and clean clothing, as appropriate. When possible, a PRS should be available to provide accompaniment and guidance to the person in crisis.

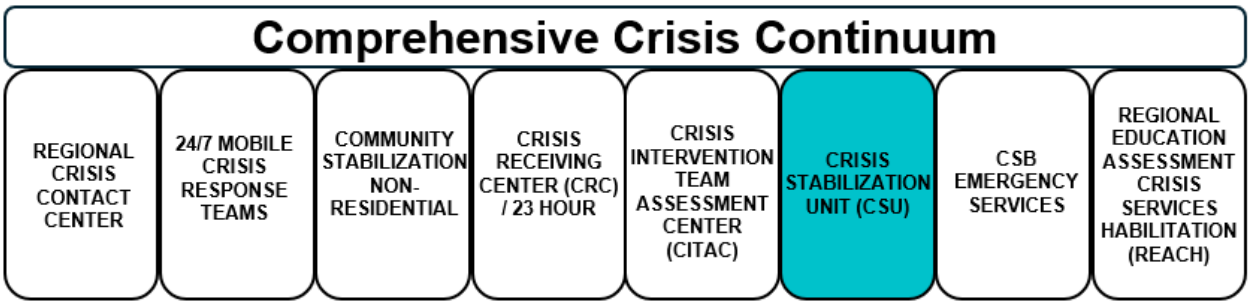
Any individual in crisis and under an ECO shall be provided with a preadmission screening by a qualified employee of the CSB. Any individual not in custody under an ECO may receive a preadmission screening or other screening and evaluation, as determined appropriate by clinical employees that are either present on location or providing guidance to onsite employees, and upon agreement of the individual in crisis.

Monitoring and Evaluating Service Outcomes

DBHDS will conduct ongoing evaluation of CITAC programs through the following activities:

- Collection of assessment data as outlined in the "Performance Procedures and Protocol for CIT Assessment Site Programs".
- Analysis of collected data to determine program utilization and efficacy.
- Reporting on program status to include data, funding utilization.

Service: Crisis Stabilization Unit



Service Overview

The goals of a Crisis Stabilization Unit (CSU) service include, at a minimum, to stabilize the individual in a community-based setting and support the individual and the individual's natural support system; reduce acute symptoms; and identify and mobilize available resources including support networks. This service occurs in a non-hospital/community-based crisis stabilization unit with no more than 16 beds. CSUs may co-locate with 23-hour crisis stabilization services. However, CSUs and 23-hour crisis stabilization (Crisis Receiving Centers) must be licensed with two separate service licenses by DBHDS Office of Licensing.

The crisis therapeutic home (CTH) is the short-term crisis component of REACH and is used when community-based crisis services or supports are not effective or clinically appropriate. See the subsection, "REACH - Crisis Therapeutic Home - Adult and Youth" for further information.

Refer to the DMAS mental health services manual for program requirements and service definitions, Appendix G – Comprehensive Crisis Services.

Program Qualifications

All CSUs must be licensed by DBHDS. Refer to the current prioritization list at this link for more information on licenses.

If a CSU provides serves an individual under a Temporary Detention Order (TDO), the provider will have a stipulation on its DBHDS license authorizing the provider to serve individuals who are under TDOs in accordance with 12VAC35-105-580.

This service will be provided in a DBHDS-licensed location that meets the physical site requirements within DBHDS Licensing Regulations. The licensed location will be identified on the provider's DBHDS license, as well as the number of beds licensed for use. Services will not be provided in locations other than the licensed site.

CSU providers will follow all general Medicaid provider requirements. See the DMAS mental health services manual: DMAS- Chapter II.

Provider Qualifications, Credentialing, and Training Elements

Refer to 12VAC35-105-1840 and DMAS Mental Health Services Manual for staffing requirements for CSUs: Appendix G – Comprehensive Crisis Services. Also see Addiction and Recovery Treatment Services (ARTS benefit).

Service Delivery and Expected Outcomes

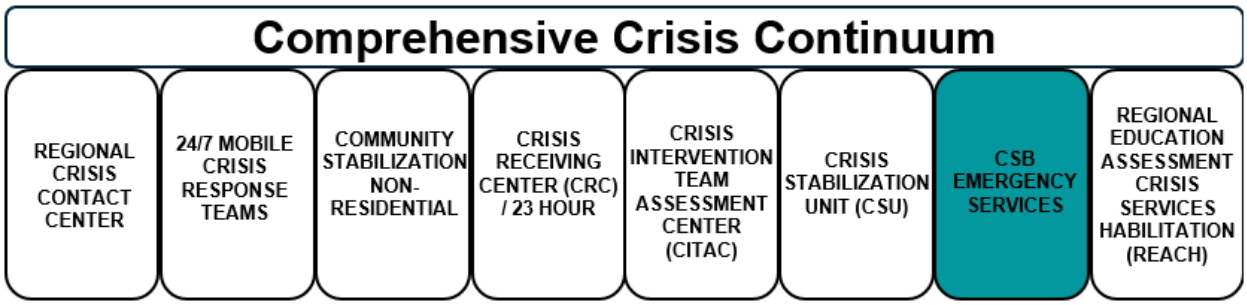
The individual's clinical record must reflect either resolution of the crisis, which marks the end of the current episode, or the discharge plan to an appropriate service to manage the ongoing symptoms associated with the crisis.

Refer to the DMAS mental health services manual for requirements, activities, admission criteria, exclusions, billing criteria, and discharge criteria for Community Stabilization: Appendix G – Comprehensive Crisis Services and the "Requirements for All Services" section of DMAS Chapter IV.

Monitoring and Evaluating Service Outcomes

- Refer to the DMAS manual for documentation and utilization review requirements: DMAS- Chapter VI.
- Each community stabilization program is expected to have established policies and procedures that ensure all documents and data submitted through the DBHDS crisis data platform are reviewed to ensure accuracy and quality in a timely manner. The program will have an identified point of contact that will be available to resolve for questions and concerns related to data submissions.
- Engagement with facility referral as outlined in § 37.2-308.1. Acute psychiatric bed registry.

Service: CSB Emergency Services



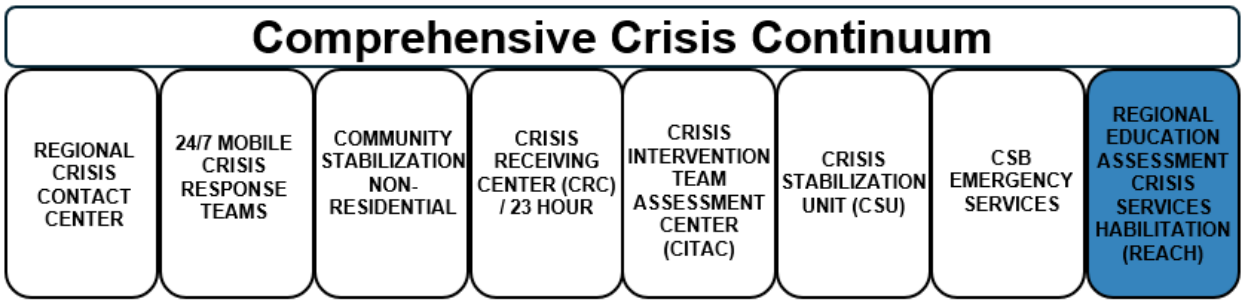
Service Overview

Emergency services employees complete preadmission screening and civil commitment hearing activities as required by Chapter 8 of Title 37.2 of the Code of Virginia. Other services provided may vary by Community Services Board (CSB).

Per § 37.2-809, "Designee of the local community services board" means an examiner designated by the local community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has completed a certification program approved by the Department, (iii) is able to provide an independent examination of the person, (iv) is not related by blood or

marriage to the person being evaluated, (v) has no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment interest in the facility detaining or admitting the person under this article, and (vii) except for employees of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

Service: REACH



REACH
Developmental Disabilities Crisis Supports

Definitions

REACH Advisory Councils

The REACH advisory councils are made up of regional community stakeholders who review the REACH outcomes and challenges while representing the needs and values of the service recipients and community. A regional council may have responsibility for both the adult and youth programs if regional representation is equally encompassing of both youth and adult services and supports. There is one REACH advisory council per service region.

Service Overview

The REACH program was established to provide a statewide crisis system of care that serves individuals diagnosed with a developmental disability (DD) who reside in the Commonwealth of Virginia. This statewide system is designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing a behavior health or behavior related crisis event that puts them at risk for homelessness, incarceration, hospitalization, or danger to self or others. The mission of the REACH program is to provide services and supports that allow individuals to live the most inclusive life possible in their community, including access to appropriate and effective crisis and prevention services.

REACH serves a target population of youth and adults with co-occurring diagnoses of developmental disabilities and behavioral health needs in addition to those presenting with challenging behavior. REACH services enhance local capacity and provide collaborative, cost-effective support to individuals and their families through clinical services, education, accessing and linking supports, mentoring, and training. REACH programs are collaborative with other agencies and families and are committed to finding a way to serve *all* individuals with DD who are at risk for a behavior related or behavior health crisis. When standard services are not

appropriate, REACH employees are committed to developing interventions to support the individuals within the system. At times, this will mean supporting the individual through identifying other services, working with DBHDS to secure additional resources, or assisting with the psychiatric hospitalization process and providing transition and step-down services. All services are provided within the context of ongoing attention to service outcomes.

The goal of REACH is to provide services to individuals for a period of at least 90 days post stabilization of a crisis event, with the potential for a longer period of support when necessary. Individuals may easily be re-enrolled in REACH as needed. REACH personnel do not prescreen individuals for inpatient admission.

The intent of the REACH program is to support all individuals who are eligible for REACH services; however, in some instances an individual may be denied services by the REACH program. For example, the program may be at capacity or may not have the resources to adequately support an individual's unique needs. The REACH program is also unable to serve individuals who are actively abusing substances or requiring medically managed detox treatment

Prior to denying services to an eligible individual, REACH will contact DBHDS to discuss the reasons that the program feels they cannot address the individual's needs. Should there be a determination to deny service, the REACH employees will work in concert with the individual, the individual's support system, and the department to link the individual to appropriate services.

Program Qualifications

Program Oversight, Operation, and Licensure

DBHDS is responsible for oversight of the REACH program. Each of Virginia's five regional hubs operate an adult and youth REACH program through a designated lead Community Services Board (CSB) or Behavioral Health Authority (BHA).

REACH services are licensed by DBHDS. Refer to the current prioritization list for more information on licenses.

MOU and BAA Agreements

All regions have a formal Memorandum of Understanding (MOU) with their respective REACH program. This MOU is standardized across the state to keep consistency within the REACH services. REACH develops relationships with community partners to bridge service gaps and improve service outcomes. Formal MOUs are important for defining those partnerships. "Affiliates" are partners with signed MOUs or business associate agreements (BAAs) with which the REACH programs maintain frequent and ongoing collaboration as part of the infrastructure.

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

Performance Contract

"Appendix D" of the Community Services Performance Contract addresses the business agreement between DBHDS and each of the REACH regional operators. By entering into this agreement, the regional REACH operators agree to oversee certain activities and responsibilities required for operating or contracting the REACH Adult and Youth Crisis Services Program. The agreement includes, but is not limited to, areas such as CSB responsibilities, DBHDS responsibilities, payment terms, use of funds, performance outcome measures, and reporting requirements.

Provider Qualifications, Credentialing and Training Elements

Each of the REACH regional programs must have active licenses from DBHDS for the services offered under REACH; residential group home with crisis stabilization and non-residential crisis stabilization. Refer to the previous information provided in this document for specific license descriptions. Additionally, the program must follow the guidelines set forth under the crisis support options in the DMAS revised version of the Developmental Disabilities Waivers (BI, FIS, CL) Services Manual to maximize utilization of the DD Waiver services when providing crisis and prevention services to those individuals who have a waiver.

The provider is responsible for maintaining current relevant credentialing for existing employees and obtaining credentials for new employees in a timely manner to ensure that all applicable service requirements comply, and billing is maximized for the REACH program.

REACH employee roles also include a REACH program director, a crisis therapeutic home (CTH) manager, clinical director/oversight manager, medical director, hospital liaison, nursing, medication technician (CTH only), REACH support coordinators, mobile support workers, QMHPs and QDDPs, recreation and activities oversite (Youth CTH) and direct support providers.

The employees of the REACH programs are to follow the credentialing requirements associated with MCR and community stabilization services described in previous sections of this document.

For those individuals who have a DD waiver and are receiving crisis services, the following manuals, which include crisis prevention services, can be located here: DMAS DD Waiver Services Manual.

Employee Training

The REACH mobile crisis teams consist of qualified employees who are educated and trained to provide crisis services to individuals with DD. Additionally, the REACH director is responsible for ensuring that all REACH employees comply with the guidelines required by the respective governing board regarding the license/practice standards and billing regulations. See section of this document titled "Service: Mobile Crisis Response" for more information. Any employee whose job responsibility involves providing mobile crisis response will complete the MCR training.

MCR training covers both youth and adult across the lifespan response skills. All MCR providers including LMHP types are required to complete and pass this training before they can access the VCC platform, as mandated by DBHDS. Refer to the section of this document titled "Service: Mobile Crisis Response – Subsection "Provider Qualifications, Credentialing, and Training

Requirements" for more information on the MCR training and required completion deadlines. In addition to the MCR courses, required training by the REACH provider, and the program operator's regional crisis intervention training, employees will be required to complete a minimum of 12 additional hours of training within one year of their hire date. Recommended areas to focus training are as follows: understanding of the REACH model and how services relate within the model and connect to system supports; required documentation including CEPP completion and related data entry at all points of service within the REACH model; understanding the individual who has autism spectrum disorder (ASD) and related supports needed to aide in the prevention of crisis; the impact of medical and pharmacological needs for the individual with DD; communication barriers that impact on the stability and related care needs of the individual; and caregiver fatigue and related self-care strategies for REACH employees.

All direct service professional (DSP) employees at the REACH CTH will complete the standardized DBHDS DSP competencies that are required to bill waiver services within the timeframes set forth by DBHDS. Except for nurses, all employees that may administer medications will complete the medication aide training curriculum designated per their agency policy. The links to these training requirements are as follows: Virginia Board of Nursing - Medication Aide Education Programs and Required Training - Virginia Department of Behavioral Health and Developmental Services.

Annually, all employees, regardless of licensure or certification status, will complete at least 12 hours of continuing education (CE). All training should be commensurate with the level of expertise of the receiving staff and related to their respective job. For those that are completing continuing education for a license or certification, these credits may count towards the 12 required hours. DSPs may attend training related to their respective job responsibilities that are not a formal CE program. For example, review of the DBHDS Office of Integrated Health (OIH) (reviewing an OIH newsletter and having a related discussion) or how to implement key sections of a Crisis Education and Prevention Plan (CEPP) may count as part of the 12 annual hours. The completed 12 hours of continuing education training will be documented in the employee's personnel record and be available for review as needed by DBHDS staff.

In addition to training, REACH employees must receive supervision and mentoring, which consist of:

- All new hires in DSP positions and those designated as QDDPs will have weekly supervision sessions for the first 90 days, and then monthly thereafter. These supervision sessions may be individual or in groups and will be documented.
- All new hires who are licensed or certified must have supervisory sessions as per the respective regulatory board requirements.
- All mobile crisis employees will be shadowed for a minimum of two onsite (in person) responses by a supervisor, after which the supervisor will be responsible for deciding if further supervision is required. The shadowing should take place within 30 days of hire.
- All new clinical hires will develop and have at least one CEPP peer reviewed within 90 days of hire.
- All new clinical hires will complete at least one training of a CEPP under the guidance of their supervisor within 90 days of hire.

Service Delivery and Expected Outcomes

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

- Crisis services will be available twenty-four hours a day, seven days a week.
- Timely crisis interventions will be provided to individuals who are experiencing a crisis event of a behavioral or behavior health nature, as well as providing support to families and other care providers.
- MCR and community-based crisis assessments or direct crisis services will be provided to address and resolve immediate stressors. The risk of the individual losing their current living arrangement will be eliminated or mitigated and additional prevention services will be developed to help mitigate future events
- Information and training on the REACH program will be provided so that REACH services are contacted early in the escalation period, ideally while the individual is still at home to divert out of home placement.

REACH coordinators (license-eligible) are the primary point of entry into each REACH program, and they serve as liaisons across the individual's systems of care. Coordinators work to facilitate cooperative communication by bringing all partners to the table to discuss the individual's plan of care.

Program Admission Criteria

All individuals receiving Adult REACH services must be aged 18 or older and have a diagnosis of a DD with a co-occurring mental illness or significant behavioral challenge that is active or cyclical in nature. For Youth REACH services, the youth may receive services up until their 18th birthday, at which time they will be transitioned into the adult program. The youth must also have a diagnosis of DD with a co-occurring mental illness or significant behavioral challenge that is active or cyclical in nature.

Having been diagnosed with DD is not the sole criteria for admission to the REACH program. Individuals must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric or behavioral nature that puts the individual at risk of psychiatric hospitalization or disruption to their residential stability. This includes difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization, homelessness, or isolation from social supports or difficulty in activities of daily living (ADLs), such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, managing finances, or recognizing basic safety risks to such a degree that health or safety is jeopardized. In addition, any behavior that is inappropriate to the point that immediate intervention by mental health, social services, or the judicial system is necessary suggests the need for REACH services. An individual diagnosed with a traumatic brain injury may access REACH services if the injury occurred before the individual reached the age of 22 and demonstrates mental illness (MI) or significant behavioral challenges.

Individuals who meet eligibility requirements to receive REACH services and are unable to pay will not be refused services.

There may be instances when an individual transitions across regions for community-based services as well as for receipt of residential crisis services in an out of a region or regional CTH. Guidelines have been set forth in the "REACH Cross Region Transfers Guide" for processing the transition of services while maintaining consistency across the statewide system of care.

Once the individual accepts REACH services, it is expected the Support System/Provider/CSB Support Coordinator will actively be involved throughout the duration of REACH services, participate and collaborate in ongoing team meetings, promptly respond to REACH correspondence, participate in CEPP training, and actively participate in discharge planning.

Referrals and Response Time

REACH receives both emergent and non-emergent referrals from a variety of sources, including community providers and case managers. Referrals are to be made to the program either in writing or through the "Regional Crisis Contact Center or REACH Crisis Line" staffed 24 hours a day, seven days a week. The program has a standardized "Program Referral Form" for referral of an individual to any REACH program. All referrals are documented upon receipt.

For a non-crisis referral, sources are contacted by REACH Crisis Team Members when the referral is received, and follow-up is initiated within 24 hours or on the next business day. All referrals must be documented by the respective regional program.

Further follow-up is as follows:

- Intakes into the REACH program are scheduled within 10 business days of the initial contact with the referring party. When they occur, exceptions to the 10-day rule are made to accommodate the referring party. If an exception occurs, information will be documented in the individual's record as to reasons for the delay in meeting the deadline and any related attempts to eliminate the reason for a delay.
- If a referral source does not respond after an initial contact in which they previously indicated interest in the program, the program will attempt two follow-up phone calls to schedule an in-person intake assessment. If there is no response to the calls, a letter to the referral source will be sent 30 days after the initial referral date indicating closure of the referral. This letter will also include contact information for the crisis line should the person need support in the future.

For a referral that comes into the regional crisis contact center, the on-call employee triages the contact and contacts REACH where appropriate. (Refer to the *"*Regional Crisis Contact Center*"* section of this document for more information).

It is the intent that REACH be notified early in the crisis to prevent the need for the support network to seek law enforcement or emergency service involvement. However, when emergency service employees screen someone for potential acute psychiatric admission, REACH should be contacted as early in the process as possible so that collaboration takes place between emergency services, hospital employees, REACH, the individual, and support system to formulate the best treatment outcome. REACH employees will be physically present for all psychiatric pre-screenings to determine if REACH services can sufficiently mitigate the immediate crisis or

prevent hospitalization, ensure that REACH services are fully activated, and provide initial crisis stabilization efforts through the prescreening process.

If a referral is determined to be a crisis in nature, the goal of the REACH employee is to respond to the site within one hour of the dispatch of the MCR team. The maximum response time will be within one hour in urban areas (Region 4 and Region 2) and two hours in rural areas (Regions 1, 3, and 5).

Mobile Crisis Response (MCR)

REACH employees will follow the process outlined in the "Mobile Crisis Response" section of this document when responding to a crisis call.

If an emergency custody order (ECO) or a temporary detention order (TDO) is issued, REACH employees will make all efforts to remain with the individual until an appropriate bed is located or the individual is stabilized within the emergency room setting. In cases where the individual has stabilized and may no longer meet commitment criteria, REACH and the Certified Preadmission Screening Clinician (CPSC) will reassess and adhere to ***subsection C to § 37.2-813*** to determine if the individual can be released from the TDO prior to the commitment hearing. If committed at the hearing, the REACH hospital liaison will have weekly contact for the purpose of offering support to the individual and team and to participate in the coordination of discharge plans and follow-up services. When a REACH program is notified that an individual was voluntarily hospitalized or made known to the program after commitment, the hospital liaison will contact the respective hospital and support system to offer REACH services.

REACH teams provide crisis support based on the location of the crisis. If an individual is active in a region but then moves into another region's area, the regional program where the residence is located has the primary responsibility for services.

For REACH crisis services, the CEPP functions as the person-centered safety plan and is initiated during the MCR.

When a call comes into REACH and an employee determines the caller is not requesting an in-person response, the employee will offer support for resolution of the situation. The following kinds of support are typically offered on these calls:

- Implementation of the individual's CEPP or any individualized protocols.
- Providing information to linkage of other support networks.
- Linking the caller to other REACH employees for information.
- Other forms of crisis prevention.

Community Stabilization – Non-Residential

REACH employees will follow the process outlined in the "Service: Community Stabilization – Non-Residential" section of this document regarding the provision of service.

These services are provided in the individual's home and community setting. REACH employees work directly with the individual and their current support provider or support system. Techniques and strategies are provided via mentoring, coaching, teaching, modeling, role-playing, problem solving, or direct assistance. Examples of support provided are assisting with

skill-building (such as self-care and ADLs), independent living skills, self-esteem building activities, appropriate self-expression, coping skills, emotion recognition and regulation, and monitoring of medication compliance through daily check-ins.

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

The services and supports provided are tailored to the individual's needs and environment and typically average two hours per session, with outcomes resulting in further refinement of the individual's CEPP.

REACH – Crisis Therapeutic Home – Adult and Youth

Service Overview and Program Description (including exclusionary criteria)

The crisis therapeutic home (CTH) is the residential component of REACH and will be used when community-based crisis services or supports are not effective or clinically appropriate. The CTH is not intended to be a long-term residence or respite. REACH programs admit persons to CTH for stabilization of a crisis, a planned prevention, or as a step-down from a state hospital, state training center or jail. The therapeutic techniques utilized at the CTH are designed to support individuals in crisis or post crisis (prevention and step-down) and thus, the CTH environment is designed around these supports rather than a long-term residence. In most cases, the CTH environment is more restrictive than a group home. Lack of a discharge disposition will not be a barrier to admission to the CTH. Crisis admissions are prioritized over those individuals being admitted for planned prevention or step-down admission. However, if a step-down admission is imminent, that individual may take priority over an individual requesting a crisis admission. The CTH can provide assessments, a change in setting to allow for stabilization, and a highly structured and supportive environment to improve coping skills and work on other goals that aide in stabilizing the current crisis or prevent future occurrence. CTHs are coeducational and have a capacity for six individuals. The Adult CTHs support individuals 18 years of age and older in each of the five DBHDS service regions of the state. There are two Youth CTHs that support individuals up until their 18th birthday. One home operated by the Region 2 REACH Program supports Region 2 (Northern VA) and Region 1 (Western VA), while the second home operated by the Region 4 REACH Program supports Region 4 (Central VA), Region 5 (Eastern VA), and Region 3 (Southwestern VA).

The intent of the CTH is to support all individuals who are eligible for services; however, some instances may require an individual be denied services by the CTH. In the case of a denial, contact will be made with the referring party immediately after reaching the decision. This

contact will consist of a follow-up letter to inform the referring party of the disposition, including a rationale for denial, and will be sent within three business days. Upon denying services to an eligible individual, the CTH director, in conjunction with the REACH program director, will forward a completed "DBHDS CTH/ATH Denial Notification Form" to the department within two business days of the denial being issued. DBHDS employees will review the denial form and respond to the sender within 24 hours of receipt or next business day. The Denial Notification Form is not necessary in those instances where the individual did not meet admission criteria as noted earlier in this document. Should a service denial be determined necessary, the REACH adult and youth crisis services will work with the individual, the individual's support system, and the department to link the individual to appropriate services.
REACH is also unable to accept individuals into the CTH who have met criteria for a TDO by an emergency service certified prescreener. REACH personnel do not prescreen individuals for inpatient admission.

Program Service Delivery and Expected Outcomes

Information requested for admission is standardized throughout the statewide program. Admission to an Adult CTH is the responsibility of the local regional REACH programs. Since the Youth CTH supports individuals from more than one REACH regional program, a small team will be responsible for processing an admission request. This team will consist of the CTH manager and a regional REACH director or designee from each of the regional REACH programs that are supported by the CTH. This group will be responsible for prioritizing admissions if there are competing requests given bed availability. The ultimate decision lies with the regional director in consultation with DBHDS if a decision on an admission or prioritization of an admission cannot be reached by the group. Youth admitted to the CTH who are under 14 years of age will be accepted only after a written agreement with their legal guardian. Youth 14 years of age and older who are accepted to the CTH must sign a consent to treatment along with the legal guardian. To ensure informed choice, the decision to consent to treatment must be made based on an understanding of the REACH program's mission and guidelines and other available options for treatment outside of the REACH program. Youth cannot be court ordered to the REACH CTH. If at any time the consenting legal guardian of a minor or a minor 14 years of age or older objects to further treatment, the minor shall be discharged from the CTH within 48 hours with support offered by the REACH program.

Within two hours of receiving all required documentation, the accepting director or designee will make an admission decision. Admissions to the CTH adhere to all applicable state licensing standards and require standing orders and copies of current medication orders, when relevant to the individual's care. A TB screening may be completed by nursing staff upon admission to the CTH. REACH staff should actively and proactively obtain all other necessary documentation in advance of admission, including identification materials and a signed copy of the REACH CTH program guidelines or house rules.

REACH employees provide direct therapeutic care to individuals admitted to the CTH. If a CEPP was previously developed or initiated, admission to the CTH will be guided by information from the CEPP and it will be updated during the stay to include strategies to be implemented after discharge. The treatment plan will detail specific outcomes that are measurable and observable through objectives that support the overarching outcome. Employees will assist with skill-building in areas such as self-care, communication strategies, and effective

coping skills. They will monitor medication compliance and conduct daily therapeutic groups and activities (i.e., self-esteem building, wellness groups, appropriate self-expression, problem solving, coping skills, relaxation strategies, and recreational, social, and leisure activities). Although both the adult and Youth CTH have core curriculums to assist employees in the skill-building and support groups, the curriculum applications are tailored to the needs of the individuals in residence. The parent is responsible for notification to the local school system of the admission to the REACH Youth CTH to arrange for any related supports that will be provided by the youth's school system during stay at the program. In addition, the parent is also responsible for notification to the school of the date of discharge from the Youth CTH.

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

Types of CTH Admissions

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

   Admission to the CTH must stem from a face-to-face assessment conducted by REACH staff. This assessment typically originates because of the crisis call. CTH procedures include:

   - Obtaining authorizations/releases.
   - Obtaining physician's orders.
   - Developing a transportation plan.
   - Completing an intake.
   - Developing a staffing plan, i.e. customized rate requirements, one-to-one support needed.
   - Developing a safety plan.
   - Entering data into the electronic health record (EHR) and billing services.
   - Convening an admissions meeting within 72 hours of admission.
   - Updating existing or initiating a CEPP within 72 hrs. of admission.
   - Completing training of the CEPP and safety plan with CTH staff.
   - Convening weekly discharge planning meetings that include case management staff.

- Providing weekly updates regarding the status of those individuals with "no dispositions" or a length of service (LOS) anticipated to be beyond 30 days to DBHDS regional crisis managers.
- Ongoing medication reviews (including any PRN administration) and side effect monitoring.
- Updating the CEPP and training the provider on information in this document prior to discharge.
- Finalizing discharge and follow-up steps.

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

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

Discharge from a REACH crisis prevention admission is predetermined, scheduled at the time of admission, and agreed upon by all parties. Recommended length of stay is three to five days per admission. Discharge meetings are required at the conclusion of the stay and are intended to communicate skills learned, inform care providers of progress made, and discuss ways to generalize skills to the home environment.

No more than one crisis prevention stay per month is recommended. Crisis prevention admissions should not exceed five consecutive days per stay unless warranted by clinical presentation and the individual's need. An individual needing a crisis stabilization admission to the CTH will overrule a crisis prevention admission. If the need for a crisis stabilization admission occurs, the crisis prevention admission will be rescheduled.

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

As a part of this service, REACH employees will:

- Attend the person's hearing (if under a TDO).
- Establish contact with the hospital or training center social worker.
- Participate in team meetings at the treating facilities and maintain weekly contact with the individual during discharge preparation. Visits to the treating facility are intended to provide support and connection to the individual as well as on-the-spot education and training to facility staff.

- Complete a consultation note at the conclusion of each visit to an outside treatment setting. A copy of this note will be provided to nursing employees for inclusion in the individual's medical record according to the protocol for the treating facility. This note will document the visit and provide written recommendations as needed.
- Complete an intake and assessment while the individual is at the hospital, training center, or jail.
- Work on discharge planning with the individual, support system, hospital or training center treatment team, and provider.

Responsibilities regarding a crisis, prevention, or step-down admission to the CTH in respect to the REACH program, provider, support system, and CSB are as follows:

REACH Responsibilities (Required Prior to Admission)

- Triage with CTH Team.
- Face-to-face crisis assessment to ensure stability 24-72 hours beforehand (may be accomplished via discharge or planning meeting for step-downs; completed by the home region if an out of region referral)
- Release of information (if out of region referral).
- Signed stabilization service plan.
- Signed CTH program guidelines or house rules.
- Provisional crisis plan (or full CEPP), if known to REACH.
- If out of region referral, the home region coordinates a call with accepting region and CSB for 'hand off.'

Provider and Support System Responsibilities (Required Prior to Admission)

- Appropriately labeled and bottled medications or prescriptions (minimum of two-week supply) for both physical and mental health needs.
- Coordination of transportation needs with REACH.
- Signed parent agreement (for Youth CTH).
- Notification to school system by the support system for youth admission.

CSB Support Coordinator (SC) (Required Prior to Admission)

- REACH Medical Orders Form (signed physician orders).
- REACH Medical Screening Form (signed medical clearance by a healthcare professional).
- If referral is out of region, participate in a call with the accepting and home region.
- Transportation coordination (if the provider or support system are unable to transport).
- If previously unknown to REACH:
    - Program referral form.
    - Consent for treatment.
    - Release of Information (ROI).
    - Provider choice form.

Hospital Responsibilities (Required Prior to Step Down Admission)

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

Additional Requests (May Occur Subsequent to Admission)

- If billing Waiver (center-based crisis support), request SAR to be opened by the SC.
- Admission or discharge planning calls scheduled with all available team members.
- Copy of ID (SC).
- Copy of insurance card (SC).
- Verification of guardianship (SC).

Responsibility for Appointments, Obtaining Personal Supplies, and Contact During the Stay at CTH

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

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

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

Extensions to the 30-Day Admission Rule

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

- The REACH program director will request an extension for any person needing a stay in the CTH that will last more than 30 days for adults and 15 days for youth. Extensions will be approved in 30-day increments for adults and 15-day increments for youth. Requests

for further extensions will be made by updating the original request and resubmitting it 5 days prior to the extension end date. Extension requests will include:

- Client name
- Region
- Date of admission
- Reason for extended stay
- Length of extension requested

- Within 24 hours of receiving a request for an extension of a crisis therapeutic admission, DBHDS will inform the regional REACH director of whether the individual is eligible for continued stay.

No Case Manager or No Disposition

When an individual is admitted to the CTH without a case manager or without a place to return to upon discharge from the program, the REACH director of the program will update the department weekly on the individual.

- If the individual does not currently have a CSB case manager, the REACH director will contact the CRC to discuss a referral to the regional support team (RST) for assistance with resolution of placement needs.
- REACH management will collaborate with the individual's system of care to facilitate timely discharge and summarize discharge planning on the "REACH No Disposition Worksheet."

Monitoring and Evaluating Service Outcomes

The regional CTH management will request that all individuals receiving services complete a focus survey regarding their stay at the CTH. This information will be reviewed internally at REACH to address concerns and improve service delivery.

Crisis Prevention Services

Prevention is a core component of REACH services to reduce the chances of an individual cycling into crisis repeatedly. The service also enables REACH employees to provide recommendations and link individuals to other programs in the service system.

Prevention calls reflect the daily challenges and stressors that individuals will experience as they navigate their social environment. At these times, REACH employees can intervene to assist the individual with problem solving, providing reassurance, or coaching in working through the application of a coping skill. These types of responses are vital to building independence and personal self-efficacy. They also provide natural opportunities to practice implementing coping skills in response to real stressors. These calls are preventive in nature by focusing on skill-building and helping address the immediate situation before it escalates.

Contact by REACH employees for the purpose of prevention and continued stabilization will be offered at least once a week during the first month after the crisis event, and subsequently offered monthly until the individual is stabilized for 90 days. The frequency of contact by REACH employees will be adjusted if clinical assessment of the individual's needs indicates an augmented frequency of delivery. All supports provided by employees are in accordance with professional licensing regulations and service provisions.

Initial, Updated, and Revised Crisis Education and Prevention Plan (CEPP)

From the collaboration that occurred during the intake and assessment, an initial CEPP is developed. This form is standardized and used by all regional programs. Employees will initially train the people supporting an individual on the procedures included in this plan and again after any changes that would affect implementation of supports.

The CEPP serves as the foundational document that explains the rationale for various interventions and describes those interventions operationally so that they can be implemented effectively by the system of care. Every individual who is accepted and utilizes services from REACH will receive a CEPP. Ideally, meetings are scheduled within seven days of receiving the initial referral and are conducted as soon as possible thereafter. These meetings are scheduled to include as many people from the individual's support network as possible. Team members should include the REACH coordinator, the individual, supported decision-maker, guardian, and any other relevant parties. The purpose of the meeting is to gather information, discuss goals, and begin to develop a plan to assist the individual and the caregivers during times of difficulty. Following the initial meeting, REACH employees will complete additional assessments, meet with informants, and conduct behavioral observations within the individual's primary settings.

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

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

- Enhancement of the crisis intervention steps including:
    - Defining behaviors indicative of mental health struggles.
    - Defining behaviors not indicative of mental health struggles.
    - Refined description of presenting behaviors at baseline, during escalation, crisis, and post-crisis (cool down).
    - Description of environmental triggers and setting events.
    - Description of antecedents to presenting behaviors (before escalation and crisis).
    - Refined support and intervention strategies (including alternate skill-building procedures).
    - Who and when to call for help and support.
- Description of the debriefing protocol for the individual and staff.
- Needed linkages and coordination to additional services.
- Training signatures for both plans.
- Updated employee and individual signatures.

On-Going Follow-Up by REACH

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

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

The meeting will review:

- On-call updates
- Crisis plans, discharges, and any jail or psychiatric discharges or step downs staffed
- Individual updates
- New referrals, including transfers from another region.
- Transition requests
- Electronic notification of admissions to psychiatric hospitals
- CTH updates

Multidisciplinary and Clinical Team Meetings: This meeting is held at least monthly but may occur more frequently if needed. This meeting incorporates an in-depth processing of the status of some individuals, brief trainings, updates on operations, troubleshooting of staffing, and reviews of admission and discharge status of individuals.

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

Procedure to Refer Individuals from One Reach Program to Another (Other Than CTH Referrals)

The REACH programs are operated by separate providers, regionally distributed according to DBHDS regions. REACH programs work together to ensure that appropriate services are always available and to all individuals regardless of geographic location. Therefore, an individual may receive services from a REACH program outside of their residential area if they move to a new region. In these cases, transfers from one REACH service to another will be facilitated from one REACH director to another. The individual or guardian must sign an Authorization to Release Personal Health Information (PHI) Form to permit information from one REACH program to be provided to another.

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

Discharge Planning

Mobile Supports: Discharge planning will occur as part of the supports offered. As part of the ending of mobile sessions or prevention services, the CEPP will again be reviewed with the individual, support system, and provider to update and finalize. An individual will be discharged from the REACH program 90 days after stabilization. A written discharge report will be completed within five business days of discharge. This document is to include a brief description of the course of treatment in relation to treatment goals and follow-up recommendations.

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

Individuals will be discharged from REACH support services upon the individual's request (if they refuse or decline services), upon the guardian or authorized representative's request, if the individual moves to another state or out of the catchment area, or if the individual has not had contact with the REACH coordinator within the past 30 days despite the coordinator's attempts. An individual's case can be transferred to another REACH program if they relocate within Virginia.

Follow-Up Post Discharge

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

Training And Outreach

In addition to training specific individuals, the REACH programs offer outreach and training to all community partners, including people with disabilities, families, hospitals, law enforcement, CSB staff, private providers, or other agencies that provide services to the DD community. REACH programs will offer trainings to community partners at least quarterly and more often, if necessary, to meet training requests from the community. These trainings may be conducted by REACH employees or sponsored by the REACH program in cases where other professionals are

providing expert training. For each training session, a training log that includes the date, duration, and title of the training, along with each attendee's name, role, and agency affiliation will be completed.

Finally, REACH employees develop trainings on specific topics of interest to the field. Topic-specific trainings may be requested by community stakeholders or may be offered by REACH to address regional trends observed in the clinical population being served. As with required trainings, documentation of attendance, training title, date, time, and duration of the training is required.

Emergencies and Use of Restraints

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

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

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

Within 45 days of hire, all employees must complete the regional operator's crisis management program that addresses restraint and behavior management. This program should be approved by DBHDS prior to implementation. Employees must also be retrained annually according to the specifications of each program.

As per REACH procedures, the rare implementation of physical restraints follows the DBHDS "Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Disabilities" (Human Rights Regulations, 12VAC35-115). All program-related restrictions incorporated as part of the CTH environment follow the Human Rights Regulations, are written in the CTH house rules, and are in accordance with treatment appropriate for a short-term crisis program. Individual restrictions follow all applicable Human Rights Regulations for review.

Monitoring and Evaluating Service Outcomes

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

A. Quality Monitoring and Evaluating

The REACH programs fully participate in the evaluation and quality assurance activities mandated by DBHDS or other funding sources. Each REACH program's planning and evaluation system is oriented to the mission and purpose of the program and gives primary emphasis to services and outcomes, priorities, needs, and constituencies (consumers and communities). Planning and evaluation are characterized by a long-term perspective and ongoing analysis. The planning and evaluation system is also designed to encourage participation, awareness, and review by the REACH Advisory Council members, employees and volunteers, consumers, and the public. Results of evaluation are used for planning and modification of REACH activities. It is essential that all REACH programs continue to evaluate service needs and outcomes through the continuous process of data collection and evaluation, both for reporting purposes and to improve service effectiveness over time.

B. REACH Crisis Services Quarterly Qualitative Review Process:

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

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

- Conference call that includes:
    - A data review of the respective regional REACH program's quarterly report.
    - Review of compliance with REACH program standards (1st and 3rd quarters only).

    - Review of compliance with the Performance Contract (2nd and 4th quarters only).
- Adult and youth chart reviews.
- Review of corrective action plans from previous reporting periods, as appropriate.
- An in-person review of designated topics centering on service provisions or clinical improvement.

C. Data Collection:

All data will be entered into and maintained as per DBHDS specifications. Data elements relevant to assessing the quality and effectiveness of the REACH programs will be documented, with reports built at the department's request. Additionally, each regional program will track trends in the use of crisis services and gather information about the population served (i.e. age, nature of disability, geographic area, etc.) in their respective region. In addition to establishing needed clinical information, the data will be useful in service and financial planning. Data elements related to crisis response will be entered into VCC as per a standardized process. Requests by DBHDS for additional data will be honored and responded to promptly.

D. REACH Advisory Council

Regional advisory councils meet at least twice annually once the program has been established for two years to provide support and review the progress of the program. Regional advisory councils enhance our capacity to remain accountable to everyone involved. Based on regional needs, Regional advisory councils may meet more frequently.

E. Complaint Process:

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

1. Each region will develop a complaint form that is offered to any stakeholder or support provider who is expressing a significant concern.
2. Complaint forms must include space for the nature of the complaint, actions taken to resolve, and the name and contact information of the person making the complaint.
3. Completed complaint forms will go to the fiscal agent of the program or designee. A copy should be submitted electronically to DBHDS. DBHDS will not respond to complaints at this level but will use the information for tracking purposes.
4. Upon receipt of the written complaint, the fiscal agent or designee will contact the agency, provider, or support provider making the complaint. This initial contact should be made within 48 hours of the complaint being received. Next steps should be determined and documented on the complaint form.
5. Within 10 days from the point of initial contact, a resolution should be presented to the complaining party. If this is accepted, the case is closed. If no resolution is

garnered, the complaint should be forwarded to the DBHDS Regional Manager (RM).

6. The assigned Regional Manager will review the complaint and any relevant DBHDS regulations or policies and consult with the Director of Crisis Services to determine whether DBHDS should:
    - Proceed with consultation only.
    - Serve as a neutral investigator.
    - Act as mediator between the parties.
    - Refer the concern to another division (e.g., Licensing, Human Rights).
7. If the issue appears to involve regulatory or rights violations, the RM will escalate immediately to the appropriate DBHDS office.

References

Marcus Alert State Plan_technical_July2021

SAMHSA National Guidelines for Behavioral Health Crisis Care

Appendix G- Comprehensive Crisis Services

Virginia CSB Preadmission Screening Requirements

DMAS DD Waiver Services Manual

Addiction and Recovery Treatment Services

Addiction and Recovery Treatment Services | MES