STATE OF WYOMING

WYOMING DEPARTMENT OF HEALTH

BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES SECTION

REQUEST FOR APPLICATION

CRISIS SERVICES CONTINUUM OF CARE

PROPOSAL DUE DATE AND TIME

FRIDAY, FEBRUARY 23, 2024

5:00 PM MT

Emailed to Agency Contact

AGENCY CONTACT:

DANI SULLIVAN

dani.sullivan1@wyo.gov

307-777-7728

GUIDANCE

The following contains information about the guidance necessary to complete the request for application.

DESCRIPTION

Mental health and substance use disorders (SUDs) are among the leading causes of disability for people in the United States.[1] To compound this statistic, many of those individuals do not receive care due to workforce shortages, including lack of staff with higher credentials or licensing. Add in the rural/frontier make-up of Wyoming and the gap of available services gets wider.

Crisis services should provide intervention at the point of a behavioral health crisis and provide care at the most appropriate level. The intent is to divert individuals from higher levels of care like an emergency department or emergency detention which may lead to an involuntary hospitalization.

The Behavioral Health Division is looking for providers to deliver crisis services on the continuum of care. Applicants may choose to apply to provide one or more of the listed services on the continuum. Applications will be reviewed on a competitive basis and funding awarded to the provider(s) with the highest scores based on available funding. Submission of application is not a guarantee of funding award or contract.

FUNDING

Approximately $3,000,000 in funding is available for the crisis continuum services. The number of applications funded and amounts awarded will be based upon requests received.

APPLICATION PROCESS

Applications will be accepted until Friday, February 23, 2024 at 5:00:00 PM MST. The successful applicant(s) will be awarded funding with the anticipated contract term of May 2024 through April 2025. There is **no guarantee** of continued funding. Incomplete applications will be returned to the applicant without review.

The Wyoming Department of Health, Behavioral Health Division (Agency) will convene a team to review and score the applications. The evaluation will be based on the demonstrated capabilities of the applicant in relation to the needs as set forth in this request for application. The merits of each proposal will be evaluated individually according to the proposal objective scoring criteria described in this document. The Agency may contact the Applicant to clarify information in the proposal, as applicable. The Agency reserves the right to accept or reject any proposal, and to waive any minor irregularities in the proposals.

Applicants shall receive written notice as to whether the application has been approved to be funded wholly, in part, or not funded. Funded applicants will begin the contract process with the Agency. All funded services must be completed within the term of a Contract. Payment for services is through reimbursement upon receipt and approval of a monthly invoice. There is no guarantee of continued funding.

CRISIS SERVICES

Services included in the continuum are listed below. Detailed information for each service, including admission criteria, continued stay/discharge criteria, response time and staff requirements can be found in

[1] U.S. Burden of Disease Collaborators 2018.

Attachment A, Crisis Continuum of Care Service Definitions. You may apply for one or more of the services listed.

- Crisis Intervention Services
- 23 hour Observation Services
- Sub-Acute Crisis Residential
- Crisis Stabilization Services

The anticipated term for service delivery is May 2024 through April 2025.

REQUIREMENTS

1. Provider must be registered to do business in the State of Wyoming and provide documentation evidencing that authority.
2. Electronically submitted monthly invoice and summary reports are due to the Division by the 15th of each month following the previous month of service. These documents will include a summary of activities completed and number of individuals served.
3. Complete a final annual report, due no later than June 30, 2025, submitted electronically. This report will include a summary of services delivered during the contract term including a unique client count, total clients served, services delivered and types of referrals made.

UNALLOWABLE EXPENDITURES AND USE OF FUNDING

The following services are unallowable costs under this funding:

1. Capital construction projects or purchase of a building.
2. Programs currently funded through any other source, including but not limited to, federal grant funding, contracts with Department of Health (all divisions), or other State Agencies, City or County funding.
3. Payment of expenses for lobbying.
4. Pay for administrative and promotional items including rent, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags.
5. Purchase, prescribe, or provide marijuana or treatment using marijuana.
6. Make direct payments to individuals being served.

APPLICATION

Please provide the below information in a written electronic format (Word, PDF, etc.) to be emailed for submission by Friday, February 23, 2024 at 5:00:00 PM MST to dani.sullivan1@wyo.gov. Budgets may be completed within the same document or submitted as a separate document using electronic spreadsheets.

KEY DATES

Event Description	Date	Time (Mountain Time)
RFA Submission Due Date *Sent to dani.sullivan1@wyo.gov* *Subject line: Crisis RFA Application*	February 23, 2024	5:00:00 P.M.
Tentative Award Date	March 5, 2024	N/A
Tentative Work Begins	May 2024	N/A

COVER PAGE

Please provide the following information:

1. Proposer's legal name, address, and contact information;
2. Name, title, and contact information of the individual authorized to negotiate contract terms; and
3. Name, title, and contact information of the individual/s to be included as signors.

DESCRIPTION

Provide a description of how your agency will deliver the service(s) in accordance with the service definitions and expectations outlined in Attachment A. Description shall include location(s) where service(s) will be delivered, a listing of staff including credentials, listing of partners and collaborators for service delivery (include any formal agreements already in place), method of service delivery (in-person, telehealth or combination). Additionally, please include how you will work with the 988 call centers as a provider receiving referrals for an individual in crisis.

COST PROPOSAL

Payments will be made as a fee for service rate. The cost proposals shall by submitted as a per diem rate with a number of beds for the service(s) indicated, as applicable.

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SCORING CRITERIA

Each application received will be reviewed for completeness prior to scoring. Incomplete applications will be returned to the applicant without scoring. Each complete application will be scored using the following:

Cover Page..... 50 pts max
Description
- *Location(s)*..... 50 pts max
- *Staffing including credentials* ..... 100 pts max
- *Description of Services* ..... 100 pts max
- *List of partners/collaborators*..... 50 pts max
- *Formal Agreements included* ..... 50 pts. max
- *Method of Service Delivery* ..... 75 pts. max

Referrals from 988 ..... 25 pts max

Total Scoring Available..... 500 pts max

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Proposal Price Sheet and Signature Page
Wyoming Department of Health

Crisis Services Continuum of Care

Applicant: check the box next to the name of the service(s) applying to deliver. Provide a per diem cost for the service(s) and an all-inclusive price for service(s) listed on page 3. Service definitions and expectations can be found in Appendix A.

- ❑ Crisis Intervention Services

  Per diem cost: _____ # of beds _____

- ❑ 23 hour Observation Services

  Per diem cost: _____ # of beds_____

- ❑ Sub-Acute Crisis Residential

  Per diem cost: _____ # of beds_____

- ❑ Crisis Stabilization Services

  Per diem cost: _____ # of beds_____

All Inclusive Price (all services for contract term) $ _____

_____ _____
Signature Date

_____ _____
Name Title

The State will negotiate payment terms based upon a schedule to be determined by the proposer and the State. Payment of invoices will be based upon the proposer meeting stated deadlines for deliverables and upon the Agency's written acceptance of the deliverables.

Appendix A - Crisis Continuum of Care Service Definitions

Crisis Services must start as soon as an individual identifies they need help. This can occur in person, telephonically or via online access including email, Facebook, or, other social media platforms. It can be through any portal of entry – Crisis Lines and the 988 system, onsite at the CBHO, EDs, engagement with First Responders, entering the criminal justice system, or anywhere in the community.

There are no Exclusionary Criteria for Crisis Services, except as defined at the end of this appendix, only the need to determine the appropriate Level of Care (LOC) placement. Barriers to care must be removed. This includes replacing historical practices that interfere with collaborative care models with practices that support them.

All providers are required to use the DLA-20 and ASAM Criteria with fidelity as part of their assessment and service delivery for individuals in crisis. In addition to the DLA 20 and ASAM Criteria, CBHOs are expected to use situationally appropriate, evidence-based symptom monitoring tools which would include PHQ-9, CSSR-S, AUDIT, GAD-7, and others to determine baseline symptoms and monitor progress.

Rapid access to crisis care is the cornerstone of a "Non-Four Walls, No Wrong Door" system. The need for rapid access necessitates the linkage with the 988 call centers in Wyoming to develop a process for referrals.

Service Definitions

CRISIS INTERVENTION SERVICES

Crisis intervention is designed to support an individual experiencing an abrupt change in behavior which is usually associated with a precipitating situation. The individual usually presents with:

- Marked increase in personal distress.
- An inability to recognize solutions to the current situation.
- Significant Functional Impairment including failure to utilize personal coping strategies.

It is frequently the first contact an individual or his or her family/responsible caregiver(s) have with the Behavioral Health System. Crisis services are time-limited and present-focused addressing the current crisis and linking the individual and their support system to the appropriate LOC services. Crisis intervention may involve the person, his or her family/responsible caregiver(s), and/or significant other, as well as other service providers.

Identifying if an Advanced Directive, WRAP Plan, or other Safety Plan exists is critical as it will guide the engagement and intervention. All interventions provided should honor and be respectful of the individual's and when appropriate, the family's wishes/choices by following the plan as closely as possible modified only as needed based on current presentation and clinical judgment. At the end of the crisis, the plan should be reviewed and updated with any additional actions that were of benefit.

If this is a first contact, or no Crisis Plan exists, the last action of the Crisis intervention should be the development of an Advanced Directive or Safety Plan if possible. If this is not possible, this should be communicated to the follow up treatment provider so they can address this as they develop the Individual

Recovery Plan (IRP).

Interventions that may be used to de-escalate a crisis include:

- Situation Assessment including a suicide and violence risk analysis
- Active listening and empathic responses to help relieve emotional distress
- Monitoring for warning signs of crisis related behavior with effective use of verbal and behavioral responses to decrease and prevent the development of crisis responses
- Assistance with active problem solving, involving the individual to the extent possible in developing a plan for action and situation resolution
- Facilitating access to the correct LOC placement needed to manage the crisis and/or provide rapid follow up to prevent a recurrence
- Mobilization of natural support systems
- Brief therapeutic engagement to initiate active treatment
- Acute evaluation for psychiatric medications
- Other crisis interventions as appropriate to the individual and current circumstances

Care coordination activities must include setting appointments for services within 7 days including next day care when indicated or arranging for transport to a higher level of care based on client need. They will provide at a minimum 72 hour and 7-day follow-up contact post crisis resolution for all individuals served. At least three attempts will be made at these specific check-ins with appropriate documentation regarding engagement and client progress.

Other support services may be billed as needed to provide linkage and initiation of services. This can include:

- Individual Therapy
- Evaluation and Management (E/M) Services
- Peer Support Services

Admission Criteria

- Treatment at a lower intensity has been provided and failed or is deemed not appropriate for the current situation AND
- The person has a known or suspected mental health diagnosis or substance related disorder and is expressing or demonstrating a need for emergent behavioral healthcare services OR
- The person is at risk of harm to self, others, and/or property. The risk may range from mild to imminent and one or both of the following:
- The individual has insufficient or severely limited resources and/or skills necessary to cope with the immediate crisis OR
- The person demonstrates a lack of judgment and/or impulse control and/or cognitive/perceptual abilities AND

Continued Stay Criteria

Crisis Intervention may be used multiple times during an individual's recovery process and course of treatment. However, each engagement with this LOC is intended to be a discrete time-limited service that stabilizes the individual and transitions them to the appropriate LOC, usually within a few hours.

Exclusionary

All individuals are eligible for Crisis Intervention Services. Crisis Intervention staff will assess and rapidly transition those in need of more intensive services to a higher LOC.

Discharge Criteria

- The crisis has resolved, and a follow up plan has been established which includes care coordination and a warm handoff process AND
- An Advanced Directive/Crisis Plan has been discussed, created, or updated OR
- The individual has been transferred to a higher LOC

Staff Requirements

- Practitioners recognized as able to provide individual Counseling as required by state statute who have specific training and experience in Crisis Management
- Individuals with Case Management and/or Peer Counseling Credentials as defined by state statute who have specific training and experience in Crisis Management.
- Care Coordination Services under state approved intervention services

Response Time

Emergent care should be provided within 60 minutes but no longer than 2 hours. This is a critical quality measure of Crisis Service Delivery and will be monitored closely. All barriers that prevent this level of response should be identified. All stakeholders need to assist in the development and support of identified solutions.

Service Accessibility

- Services are available 24-hours/ day, 7 days per week, and may be offered by telephone, telemedicine, and/or face-to-face in community settings (home, school, community, clinic) and the ED.
- Crisis Services ensure those with Limited English Proficiency (LEP) or who are deaf or hard of hearing are able to receive services using telephonic or video interpreter tools.

23 HOUR OBSERVATION

In addition to the criteria outlined under Crisis Intervention, individuals served in 23-Hour Observation facilities need ongoing evaluation and intervention beyond an initial crisis assessment and referral process. This service allows additional time to:

- Complete a Comprehensive Biopsychosocial Assessment

- Complete a Comprehensive Psychiatric Evaluation
- Complete the DLA 20
- Resolve Acute Intoxication with time to monitor for withdrawal symptoms and determine the need for detoxification services
- Manage medical conditions
- Complete additional diagnostic testing
- Obtain collateral information and clarify information provided
- Activate SDOH Resources
- E/M Services for Medication Management of Behavioral Health Conditions
- Provide extended Crisis Counseling
- Determine LOC Placement

This additional time can support diversion from higher levels of care, promoting resiliency and recovery focused self-management, and engagement of natural supports. This allows individuals to receive treatment in the least restrictive environment possible which is the most cost-effective approach to service delivery.

Disposition and discharge planning should start as soon as the individual enters the 23-Hour Service Facility. This includes preparing to transition the individual to a higher level of care as soon as it becomes clear the crisis cannot be resolved in the allotted time frame.

23-Hour Crisis Service Centers (CSC) can exist as free-standing facilities, be embedded in Emergency Departments (EDs), or be collocated with other Behavioral Health Services. Facilities are open 24/7. Services can be accessed directly by consumers or via drop off by Law Enforcement Officers and other first responders, integrated medical, psychiatric, and clinical services are necessary at this level of care.

This level of care requires onsite nursing with behavioral health services that include Psychiatric and Clinical Treatment, Care Coordination and Case Management, Peer Supports, and trained mental health technicians (MHTs). Psychiatric and clinical services must be available within 60 minutes and can be provided using telehealth. Rapid access to medical management of detoxification and other medical concerns requires strong partnerships with hospital systems.

When CSCs are embedded in the ED, nursing, medical management, and MHTs are usually provided by the ED and the CBHO provides behavioral health resources including Clinical and Psychiatric Services, Care Coordination, and Peer Supports. WDH requires that regardless of the location, all wrap-around services must be available.

Clinical Operations

WDH and Medicaid will create a 23 Hour Bed Rate. Overlay services offered will be individualized to address the specific elements of the current situation. Crisis Units (CPT codes 90839 or 90840) are used to specifically address the Acute Crisis needs of the individual. The time billed under these codes requires the staff member to devote their entire effort to the individual in crisis which may include engagement with family members/supports and collaboration with all providers involved in managing the crisis.

CSCs require Psychiatric oversight and supervision for the quality management of services delivered.

Care coordination activities must include setting appointments for services within 7 days including next day care when indicated or arranging for transport to a higher level of care based on client need. They will provide at a minimum 72-hour and 7-day follow-up contact post crisis resolution for all individuals served. At least three attempts will be made at these specific check-ins with appropriate documentation regarding engagement and client progress.

Other support services will be billed as needed to provide medical stabilization, linkage, and initiation of services. This can include:

- Psychiatric Assessment and E/M Services
- Nursing Assessment and monitoring under the supervision of an RN
- Observation by trained MHTs
- Medical evaluation and management of detoxification and other health conditions
- Individual Therapy
- Peer Support Services
- Medication will be administered by credentialed medical personnel in accordance with state statute.

Admission Criteria

- Treatment at a lower intensity has been provided and failed or is deemed not appropriate for the current situation **AND** the client continues to have serious unmet behavioral health concerns after Crisis Intervention Services have been rendered **AND**
- The person has a known or suspected mental health diagnosis or substance related disorder and is expressing or demonstrating a need for emergent behavioral healthcare services **OR**
- The person is at risk of harm to self, others, and/or property. Risk may range from mild to imminent and one or both of the following:
- The individual has insufficient or severely limited resources and/or skills necessary to cope with the immediate crisis **OR**
- The person demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities **AND**
- The individual does not meet criteria for Crisis Stabilization or Inpatient Hospitalization **OR** Criteria for admission to this level of care is met but it is anticipated the current crisis should be resolved within the 23 Hour Time Frame. This is based on either the naturally expected course of the clinical/medical situation, individual history of rapid resolution of crisis situations or the expectation that available interventions can and will assist the individual in transitioning to a lower level of care.

Exclusionary Criteria

- Free Standing CSCs cannot accept Individuals under emergency detention status as defined by state statute; these individuals must be directed to the nearest available Designated Emergency Receiving Facility.
- All facilities must comply with state established minimum standards of medical care available based on their location and status as a CSC and will only exclude admissions based on the WDH defined state Exclusionary Criteria (See Appendix D).

Continued Stay Criteria

- Time has not exceeded 23 hours.
- Continued Need for Crisis Stabilization

Discharge Criteria

- The crisis is resolved or referral to an appropriate level of care has been made with care coordination having arranged for the transfer of care.
- The maximum length of stay has been met

Staffing Requirements

- Staffing resources can be shared with collocated services and must include:
- Nursing Staff able to provide physical and behavioral health evaluations and monitoring; must be available 24/7
- MHTs able to assist nursing staff with monitoring and engagement available 24/7
- Primary Care Physicians and/or their APRN/PA designees able to assess and treat medical conditions including safe detoxification
- Psychiatrist and/or their APRN/PA designees competent in Behavioral Health assessment and management
- Clinicians recognized as able to provide individual Counseling as required by state statute who have specific training and experience in Crisis Management
- Individuals with Case Management and/or Peer Counseling Credentials as defined by state statute who have specific training and experience in Crisis Management.
- Individuals with Care Coordination experience and training in addressing crisis needs
- State contracts for this service may list additional staffing requirements. In the event of conflicting requirements, providers must adhere to the most stringent requirement.

Response Time

- Nursing and MHT onsite
- Psychiatric, Clinical, and Medical Providers must be available within one hour; other support services must be available within two hours. All overlay services may be provided through telehealth if appropriate.

Service Accessibility

- The service is available 24 hours a day, 7 days a week, 365 days a year.
- Crisis Services will ensure those with Limited English Proficiency (LEP) or who are deaf or hard of hearing are able to receive services using telephonic or video interpreter tools.

SUB-ACUTE CRISIS RESIDENTIAL

Short Term Sub-Acute Residential Services, also referred to as Crisis Residential Treatment Programs (CRTP), time-limited therapeutic housing programs with embedded and individualized overlay services. They are designed to provide 7-14 days of respite and stabilization for individuals who do not need Crisis Stabilization Unit services or Hospitalization **OR** individuals stepping down from a higher level of care including the State Hospital **OR** as part of a reentry plan for those treated for mental health and SUD in the Criminal Justice System. This service can be key to breaking the cycle of readmission and CJS Recidivism which has become far too common for individuals with serious mental illness (SMI) and substance use disorders (SUD).

They operate under psychiatric oversight and supervision to ensure the complex biopsychosocial needs of the individuals served are met. Programming is designed to address the needs of individuals with limited or compromised social supports who are dealing with psychiatric symptoms, SUD including mild to moderate withdrawal or post-acute withdrawal symptoms, and/or high risk for increased symptom development or relapse.

The collocation of individuals with different needs requires CRPT staff to be co-occurring competent and trained to assist each resident based on their individual needs and conditions. Ensuring programming addresses the diversity of the populations served and creating a therapeutic milieu that promotes mutual respect and support among the residents are essential elements of these programs.

CRTPs are voluntary programs, and **individuals must be able to function independently.** Residents are expected to actively engage in treatment. They are responsible for working with case management and care coordination staff on disposition planning and self-directed engagement with resources to increase their resilience and self-efficacy. The treatment goals for this level of care include:

- Development and implementation of an individualized stabilization plan
- Crisis resolution
- Emotional and behavioral stabilization
- Symptom reduction
- Life skills development
- Connection with community resources and natural supports
- Re-establish a sense of functionality and independence
- Linkage to Behavioral Health and Primary Care Services, and services that can assist with SDOH

By focusing on the whole health needs of individuals, medical services (behavioral health and primary care), clinical services, case management, and peer supports work as a team to support residents in achieving these goals. Interventions include:

- Motivational engagement,
- Psychosocial Rehabilitation Groups,
- Individual Counseling,
- Medication Management
- Care Coordination.

Clinical Operations

CRTPs require Psychiatric oversight and supervision for the quality management of services delivered.

Care coordination activities must include setting appointments for follow up services within 7 days including next day care when indicated or arranging for transport to a higher level of care based on client need. They will provide at a minimum 72-hour and 7-day follow-up contact post discharge for all individuals served. At least three attempts will be made at these specific check-ins with appropriate documentation regarding engagement and client progress.

Services offered will be individualized to address the specific needs of each resident. Required services include:

- Nursing Assessment, monitoring of medication observation and medication self-management practices in compliance with state statute, nursing care as ordered and provision of healthcare groups.
- 24/7 Observation by trained MHTs
- Medical management of routine primary care health conditions
- Psychiatric Evaluation and Management Services
- Medication Management of Addictions including detoxification of mild to moderate withdrawal as defined by CIWA/COWs Scores including the use of Post-acute Withdrawal Symptom (PAWS) Protocols at all locations, Medication Assisted Treatment (MAT) including induction and monitoring per an established protocol through existing local resources, and Opioid Antagonist Therapy using Naltrexone for Opioid Use Disorder and Alcohol Use Disorder.
- Individual and Group Services are provided at a minimum of 6 hours per day using psychosocial rehabilitation principles, WDH approved Manualized Programming, and involving family members and other identified supportive individuals.
- Care Coordination and Case Management Services available a minimum of 40 hours per week including weekend coverage
- Peer Support Services are available a minimum of 20 hours per week including weekend coverage. MHTs may provide this service if they are properly credentialed as Peer Support Specialists.
- Routine Crisis Respite support with a minimum of one face-to-face (FTF) contact per day that is documented in the record. During the initial 72 hours, a minimum of three (FTF) contacts (Morning, Afternoon, and Evening) will be required. This enhanced level of contact should be maintained on an individualized basis, but if the need for this level of contact continues past the first three days, the supervising psychiatrist must be informed, and a daily treatment team discussion must take place until routine engagement is established.
- Crisis Plan development or plan review and refinement must be completed prior to discharge
- Addressing barriers to resolving SDOH documented using individual client logs monitoring actions taken by staff and by the client, status updates and, outcomes including denials.
    - Apply for vital records (Birth Certificates, Social Security Cards) within three business days.
    - Initiate appropriate entitlement applications within three business days.
    - Establishing housing goals, providing resources, and assisting with housing search activities including application processes within three days.
    - Establishing vocation and return to work goals, providing resources, and assisting with employment search activities including application processes.

The program will follow a posted daily schedule that supports therapeutic engagement and assists the individual in developing a personal schedule that will assist them post discharge in accessing care and addressing SDOH. The schedule must include:

- Sleep and Wake Times
- Mealtimes

- Medication Access Times
- Individual and Group Services
- Assigned Task Completion Time
- Leisure and unstructured time

During the initial 72 hours, all individuals must have a behavioral health assessment or update if completed prior to admission, a functional assessment, and a comprehensive risk/needs assessment focused on SDOH. Providers must develop a contingency plan in case the primary housing plan does not actualize during the maximum length of stay period.

All programming and interventions will be designed to facilitate a successful return to the community within 14 days. Admission processes must be streamlined. Requests for admission must be timely as outlined below and transition into the program should occur within 24 hours of acceptance. CRTP services must provide basic room and board expectations as defined by state statute. Bedrooms must allow a minimum of 100 sq feet per individual with beds, mattresses, and adequate storage space for personal belongings. Other expectations include:

- Provision of three (3) nutritious meals per day and nutritional snacks.
- Provision of clean linens/towels
- Provision of personal hygiene products if the individual is unable to supply their own.
- Adequate bathroom and bathing facilities that must not require access through another individual's bedroom.
- Access to laundry facilities
- Maintenance of a clean and safe environment. Residents are expected to participate in the upkeep of their personal space and common areas as part of their rehabilitative process.

Programs are encouraged to use Video Conferencing Resources to support client engagement with community resources, but transportation assistance should be available when needed.

Admission Criteria

- Individuals with an SMI or SUD that interferes significantly with their ability to reside safely in the community and at least one of the following
    - Transitioning or recently discharged from a psychiatric inpatient or crisis stabilization unit, **OR**
    - Frequent admissions are defined as three or more admission within the past 12 months **OR** extended stays are defined as 30 days within the past 12 months in a psychiatric inpatient facility or crisis stabilization unit **OR**
    - A recent release from the state hospital **OR**
    - A recent release from jail or prison where they had been receiving care or been identified as needing care for SMI or SUD conditions **OR**
    - Chronically homeless is defined as one (1) extended episode of homelessness for one
- or more years **OR** four (4) episodes of homelessness during a three (3) year period **OR**
    - Frequently seen in EDs for behavioral health needs defined as three (3) or more visits within the past year
- Individuals with the following conditions will be accepted into these programs if they are able to participate appropriately and can benefit from the program and its resources **AND** will not significantly disrupt the milieu for other individuals in the program. Any denial of service to this population will require documentation review and discussion with WDH.

    - Traumatic Brain Injury or other Neurocognitive Disorders
    - Autism
    - I/DD
- The individual must be able to reside safely in an open, community-based placement
- The individual demonstrates a need for short-term crisis support which could delay or prevent admission to a higher level of care **OR** needs respite and support to address destabilizing circumstances impacting their current living situation.
- The individual is free of medical conditions that require daily nursing or physician care unless the individual is eligible for home healthcare that can be provided through their insurance without disruption to the milieu or the individual's engagement in programming.
- The individual is willing to abstain from all substance use while in residence.
- Individuals discharging from a state hospital shall receive priority admission status.

Exclusionary Criteria

- Actively using substances or be at risk for significant and serious withdrawal.
- Active intent for self-harm or harm to others
- Medical conditions requiring daily nursing or physician care except as outlined above
- WDH defined exclusionary conditions (See Appendix D).

Continued Stay Criteria

- The individual continues to meet medical necessity and admission criteria **AND**
- The individual is actively engaged in their treatment and discharge planning **AND**
- The maximum length of stay has not been met

Discharge Criteria

This service is short-term and transitional in nature, intended to support successful community transition and integration. As such, discharge planning begins upon admission.

- Individual requests discharge
- Creation of an appropriate follow up plan with successful linkage by care coordination and the individual to all appropriate services
- Maximum benefit has been reached as evidenced by:
    - No longer engaging in programming or self-directed efforts to implement a discharge plan
    - Medical necessity is no longer met as defined by the admission criteria
- The maximum length of stay has been met

Staffing Requirements

- Onsite MHT trained to perform medication observation activities, run manualized groups and leisure activities, obtain VS as requested, and identify changes in client behavior that would require additional intervention or transition to a different LOC. May qualify as a Peer Support specialist.
- Nursing staff a minimum of 20 hours per week including 24/7 on call availability with a response time of 30 minutes or less, provide nursing assessments within 24 hours of admission Monday through Friday and no later than the next business day for weekend admissions, oversee onsite medication management, perform medical monitoring and interventions as

ordered by providers and provide manualized nursing groups on topics related to healthcare based on the needs of residents present in the facility.

- Psychiatric oversite of 0.1 FTE including quality of care management and on call with a response time of 30 minutes or less
- Appropriately Credentialed therapists a minimum of 20 hours per week able to perform intake assessments and provide co-occurring competent therapeutic groups and individual therapy using short term models such as Interpersonal, Solution Focused, and Accept and Commitment Therapies, and skilled in the use of Motivational Engagement and CBT Principles. Saturday coverage is required.
- Peer Support staff a minimum of 20 hours per week including weekend coverage. Peers may function as MHT but must provide specific engagement and coaching to support individualized problem solving and recovery planning.

Response Time

- Referrals will be accepted 24/7
- Response to admissions requests will occur as quickly as possible but no later than 6 hours after referral. Final determination for admission may take up to 24 hours after all required information has been received.

Service Accessibility

- Admissions accepted 7 days per week between the hours of 8 AM and 3 PM
- Length of Stay – 7-14 days
- Referrals for Weekend Admissions may occur from referral sources, but the individual must arrive medically stable with an adequate supply of all medications needed through the next business day to allow time for a nursing assessment to be completed.
- Crisis Services will ensure those with Limited English Proficiency (LEP) or who are deaf or hard of hearing are able to receive services using telephonic or video interpreter tools.

CRISIS STABILIZATION UNIT (CSU)

Crisis Stabilization Units are medically driven, short term programs with 24/7 nursing coverage, daily rounding by a psychiatric provider, and comprehensive clinical and care coordination services designed to address the needs of individuals struggling with acute emotional, behavioral, mental health, and SUD conditions that severely impact their ability to care for themselves and/or put them at risk of harming themselves or others. Primary Care conditions including moderate to severe detoxification are routinely managed in this setting.

These facilities are locked, and in many jurisdictions, individuals may be admitted under voluntary or involuntary status. Individuals involved in the first two phases of a Title 25 hold should be considered for treatment at this level of care if allowed by statute and local ordinance. If an individual is placed on an involuntary hold at a 110 hearing, they could remain on the CSU while awaiting transfer to the state hospital for ongoing stabilization in a safe and familiar environment. This could result in sufficient stabilization for safe discharge to a lower LOC.

CSU Services start with a Comprehensive Biopsychosocial Assessment which includes the use of evidence-based functional and symptom-based measurement tools to establish current, baseline functioning and monitor treatment effectiveness. A Psychiatric Evaluation should be completed

within 24 hours of admission. Medical management of all behavioral health and primary care conditions is provided including management of acute psychosis with emergency medications and safe, but minimal use of seclusion and restraint to address safety concerns. Individual and Group Activities focus on the development of coping strategies and building resilience. This includes working to engage family and other natural supports in the recovery plan.

Discharge planning begins at the time of admission and addresses all behavioral health and primary care needs as well as relevant SDOH concerns. Active Care Coordination takes place throughout the admission to support access and engagement with step down services which may include:

- Psychiatric and Primary Care follow up
- Behavioral Health Treatment
    - Psychosocial Rehab, Clubhouse, and Drop in Center Services
    - Case Management
    - Individual, group, and family counseling
    - Therapeutic Residential Services for Mental Health and/or SUD
    - Ongoing Crisis assessment support, and intervention
    - Organizations that can assist with SDOH concerns

The following requirements must be established:

- All services provided within the CSU must be delivered under the direction of a psychiatrist. The psychiatrist or appropriate designee must conduct initial and ongoing assessments, address issues of care, and write orders as required.
- Medication must be administered by licensed or credentialed medical personnel under the supervision of a physician or registered nurse per state statute.
- A physician-to-physician consultation is required for all CSU denials that occur when the CSU has an open/available bed.
- CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, substance use disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CSU is unable to stabilize the individual and the process for having them returned to the CSU when the condition has stabilized if they continue to meet the criteria for admission.
- All CSU Staff must be trained and maintain certification in de-escalation and crisis prevention/intervention techniques, and proper use of restraints. Organizations must provide training by certified trainers using nationally recognized models such as MANDT®, Crisis Prevention Intervention® (CPI), Pro-Act® or Therapeutic Options™.
- CSU policies and procedures will comply with state statute and WDH standards which will include the use of:
    - Emergency medications that are the standard treatment for an individual's psychiatric or medical condition in compliance with state statute and WDH policy

- **Seclusion and restraint utilization will exclude the following:**
    - The use of aversive techniques for the purpose of modifying or reducing behavior
    - Standing or PRN orders for seclusion or any form of restraint.
    - Prone manual or mechanical restraints
    - The use of handcuffs for an individual not under the jurisdiction of the criminal justice system.
- Debriefing will occur after all uses of seclusion and restraint for CQI purposes to evaluate the de-escalation actions taken, seclusion and restraint techniques utilized and determine the need for adjustments in the individual's current treatment plan

Clinical Operations

CSUs should comply with the following standards:

- The program has the capability to admit persons 24 hours per day, 7 days per week.
- The program conducts a written, crisis focused assessment of each person served upon admission to the program which includes:
    - Presenting concerns
    - SDOH that contribute to the current crisis
    - Current medication and adherence
    - Use of alcohol and other substances
    - Risk factors for:
        - Suicide
        - Self-harm and risk-taking behavior
        - Violence towards others
    - History of Trauma
    - Current medical conditions
    - Current treatment providers
    - History of crises and outcomes
    - Personal strengths, needs, abilities/interests, and preferences.
    - Cultural and spiritual background
    - Advanced directives
    - Legal status
- The assessment includes a written interpretive summary that identifies all disabilities, comorbidities, and disorders and is used to develop an initial crisis stabilization plan.
- A psychiatrist must evaluate the individual within 24 hours of arrival at the CSU.
- A physical examination must be completed within 24 hours of arrival at the CSU.
- Staffing includes 24/7 on-site awake personnel, availability of supervisory personnel, and access to appropriate medical personnel 24/7 with a response time of less than 15 minutes.
- Provision of nutritious meals that meet the dietary needs of the persons served.

- The program provides or arranges for the following services:
    - Medication Management of all Psychiatric, SUD, and Primary Care conditions under appropriate supervision and appropriate level of medical monitoring based on individual needs. Medical input into the treatment plan must be part of the care delivery system.
    - Individual, group, and family/support system counseling
    - Skills building and Self-care Planning
    - Peer support
    - Care coordination
    - Interpretation services
- The program has a written daily schedule of wellness-based activities as well as opportunities to engage in unstructured activities.
- The program reduces barriers between persons served and personnel and actively promotes engagement and interaction.
- Physical Plant provides a calming environment that affords personal privacy, security of personal items, and adequate space for:
    - Group interactions
    - Quiet activities
    - Self-de-escalation
    - Visitation with family/support system
    - Therapeutic activities
    - Cultural and spiritual activities
    - Meals, recreation, sleep, and hygiene activities
    - Access to outdoor settings if possible
- The program demonstrates continuous vigilance in monitoring the environment to safeguard against access to items that could be used to harm self or others and has a response plan to address identified risks.
- The program has written procedures for searches of persons, belongings, and the facility as part of their safety plan. Procedures will protect privacy, preserve dignity and be consistent with Trauma Informed Care best practices.
- The program utilizes indicators to measure the successful transition to community-based services at the time of discharge with established targets that are monitored and used to develop and implement action plans as part of continuous quality improvement.
- The program arranges for Care Coordination contact to occur within 48 hours of discharge.
- Written procedures are in place to address:
    - Bed assignment and capacity management
    - Involvement of first responders
    - Management of personal belongings
    - Levels of observation
    - Management of legal status
    - Persons served that are leaving the premises
    - Mail, telephone, and electronic communication

    - Use of personal electronics
    - Visitation with family/support system
    - Involvement of family/support system/ legal representatives and others that have the legal right to consent on behalf of the person served
- All direct service personnel receives documented competency-based training at orientation and at regular intervals in First Aid, CPR, and the use of emergency equipment.
- Based on personnel's roles and responsibilities, they will receive documented competency-based training that reflects the input of persons with lived experience at orientation and at regular intervals in:
    - De-escalation techniques
    - Engagement of persons in acute crisis
    - Legal status
    - Risk assessment
    - Trauma-informed approaches
- In partnership with first responders, the program demonstrates efforts to educate them on its procedures for their involvement in the program and how to safely manage persons experiencing acute emotional, mental health, and/or substance use crises.

The average length of stay on a CSU is 5 to 7 days. Individuals under involuntary status or needing an alternative decision maker may have extended LOS.

Care coordination activities must include setting appointments for services within 7 days including next day care when indicated or arranging for transport to a higher level of care based on client need. They will be provided with a minimum 72-hour and 7-day follow-up contact post discharge for all individuals served. At least three attempts will be made at these specific check-ins with appropriate documentation regarding engagement and client progress.

Admission Criteria

- Individuals with an SMI, SUD or behavioral health symptoms that interfere significantly with their ability to reside safely in the community **OR** experiencing a severe situational crisis **AND**
- Demonstrating evidence of dangerousness which includes:
    - Risk or harm toward self
    - Risk of harm toward others
    - Evidence of self-neglect and inability to care for self even with the support of willing and able family members or other natural supports
    - Risk of damaging property
- Risk of harm may range from mild to imminent **AND** the following may be contributing factors:
    - The individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis **OR**
    - The individual demonstrates lack of judgment **OR**

    - Exhibits impaired impulse control **OR**
    - Impaired cognitive/perceptual abilities needed to cope with an immediate crisis
- Can be safely managed within the scope of services and staff available on the unit.
- Medical clearance is only required when there is clear evidence of an active medical condition that needs to be stabilized prior to admission.

Continued Stay Criteria

- Continues to meet Medical Necessity as defined under admission criteria.

Discharge Criteria

- They are no longer demonstrating the risk of dangerousness towards themselves or others and have demonstrated the ability to safely and adequately care for themselves in the community.
- The individual can be managed in a less restrictive, community-based treatment setting.
- A Discharge Plan is established with follow up scheduled and Care Coordination prepared to provide check-in services and assist with linkage.

Exclusionary Criteria

- Active medical conditions that cannot be safely managed with the resources available at the crisis unit as defined by WDH (See Appendix D)
- Dangerousness that cannot be managed with emergency medical management and limited use of 1:1 staffing.

Staff Requirements

- Charge nurse 24/7 who must be an RN. An LPN may aid and support the charge nurse within the scope of practice allowed under state law. If an APRN is functioning as the charge nurse, he/she may not simultaneously serve as the accessible medical provider during the same shift.
- Psychiatrist who will round daily and be available on call 24/7 with a response time of less than 30 minutes. A psychiatrist may be assisted by a PMHP or PA with Psychiatric experience who is practicing within the scope of practice allowed under State Law.
- Full time Nursing Administrator who is an RN and available on call 24/7 with a response time of less than 30 minutes.
- Sufficient MHTs onsite to maintain state required staff to patient ratios and safety in the milieu. MHTs will be trained to perform client checks every fifteen minutes, run manualized groups and leisure activities, obtain VS as requested, and identify changes in client behavior that would require additional intervention or transition to a higher level of care.
- A licensed or licensed prepared individual available 7 days per week to provide clinical services and discharge planning.
- A licensed clinical supervisor available for consultation and signature when needed on documents.
- A Care Coordinator available 7 days per week to assist with discharge planning and provide follow up monitoring during the initial 7 days post-discharge or until the

individual has successfully transferred care to community-based services.

- Peer Support staff a minimum of 20 hours per week including weekend coverage. Peers may function as MHTs but must provide specific engagement and coaching to support individualized problem-solving and recovery planning.

Response Time

Individuals meeting the criteria for CSU Services have immediate access to a CSU. First responders must be able to drop off individuals who meet admission criteria. Individuals may present independently for evaluation and be admitted if they meet medical necessity requirements. Referrals and documentation from other facilities must be evaluated within two hours and decisions regarding admission will occur within 60 minutes after all necessary information is provided.

Service Accessibility

- CSUs admit individuals 24 hours per day, 7 days per week, 365 days per year.
- Crisis Services will ensure those with Limited English Proficiency (LEP) or who are deaf or hard of hearing can receive services using telephonic or video interpreter tools.