

RFP 09-11 ADOLESCENT CRISIS RESIDENTIAL PROGRAM

**REQUEST FOR PROPOSALS:
CONTRACTOR SERVICES FOR
BEHAVIORAL HEALTH PROGRAMS
UNDER PENNSYLVANIA'S HEALTHCHOICES REINVESTMENT INITIATIVE**

**ISSUED BY
The County of Northampton
Department of Human Services
HealthChoices Division**

PROJECT OFFICER

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I. INTRODUCTION

For background information on Pennsylvania's Behavioral HealthChoices Program in general and Northampton County's Behavioral HealthChoices Program specifically, refer to Northampton County's Web site at <http://www.northamptoncounty.org>. From within Northampton County's Web site, select Human Services then Behavioral HealthChoices for a variety of background information to address this Request for Proposal (RFP).

II. OBJECTIVE

As the primary contractor of the HealthChoices program, Northampton County's HealthChoices project has the ability to retain capitation revenues and investment income that was not expended during the contract year to reinvest in programs and services within Northampton County. These dollars are called Reinvestment Funds. Reinvestment funds must be spent in accordance with a Department of Public Welfare (DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) approved reinvestment plan. Important information about the use of reinvestment funds can be found on the Northampton County Web site <http://www.northamptoncounty.org>. To access this information from Northampton County's Web site, select Human Services then select Northampton County Behavioral HealthChoices, and finally select Reinvestment Planning.

DPW review of plans submitted by Northampton County is in various stages of the formal approval process. The plan being reviewed and addressed by this RFP is:

Priority 1: Adolescent Crisis Residence.

The actual plan submitted to DPW for each of the Priorities and Programs above can be found in Appendix 1 of this RFP.

The goal of the Northampton County HealthChoices Reinvestment RFP is to solicit proposals in order to select behavioral health providers interested in establishing and enhancing the array of behavioral health services referred to above. The County HealthChoices Program has the flexibility to select a proposal based upon the strengths, creativity and experience of the provider.

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III. NORTHAMPTON COUNTY HEALTHCHOICES PROGRAM MODEL

Refer to Northampton County's Web site at <http://www.northamptoncounty.org>. To access this information from Northampton County's Web site, select Human Services then select Northampton County Behavioral HealthChoices, and finally select Northampton County Behavioral HealthChoices Organization Chart.

IV. PROPOSAL TIMEFRAMES

ACTION	DATE
RFP Released:	September 12, 2011
Applicant Questions on RFP Due Address questions to: Deborah A. Nunes dnunes@northamptoncounty.org	September 19, 2011
County Responses Posted: http://www.northamptoncounty.org	September 30, 2011
RFP Responses Due:	October 10, 2011 Noon
Proposal Review Dates	October 12 – 21, 2011
Applicant Interview Dates	October 26 - 28, 2011 9:00 AM – 4:00 PM
Applicant Selection Date:	October 31, 2011 9:00 AM – 4:00 PM
Applicant Notification Date:	October 31, 2011

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V. KEY INSTRUCTIONS

1. Applicants must respond to all components of this RFP and work within the page limits where indicated. Failure to comply may result in disqualification.
2. **All responses to the RFP are due October 10, 2011 on or before 12:00 Noon Eastern Time, ATTN: Deborah A. Nunes, HealthChoices Program Coordinator.** The County may disqualify any and all proposals received after this date and time.
 - A stamped original of your response must be submitted for the “Response to Technical Proposal”. In addition a copy in MS Word must be submitted on CD. The Technical Proposal should not contain any references to pricing or cost.
 - A stamped original must be submitted for the “Response to Financial Proposal”. In addition, a copy in MS Excel must be submitted on CD (same CD as that containing the Technical Proposal).
 - One (1) transmittal letter must be submitted for each proposal (Response to Technical Proposal, Response and Financial Proposal), and shall be signed by an official who has the legal authority to bind the company to the terms of the proposal for the required 180 days.
3. It is the County’s policy to solicit proposals with a bona fide intention to execute a contract. This policy notwithstanding, any proposal shall be submitted with the following expressed understanding:
 - This Request for Proposal is not subject to the competitive bidding process and any contract entered into as a result of any proposal will not be based on the concept of the “lowest responsible applicant.” Furthermore, the County has the right to reject any and all proposals.
 - The County may procure any service by any other means.
 - The County may modify the selection process or the scope of the project or the required responses.
4. All costs of developing proposals and any subsequent expenses related to contract negotiations are entirely the responsibility of the applicant.
5. Best and final negotiations may occur.
6. The County will select finalists with which it will begin the interview and selection process prior to contract negotiations.

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7. Reinvestment Plan Proposals must:

- Demonstrate an integrated and innovative approach to care/treatment management.
- Demonstrate a process for effective coordination of care by treatment providers.
- Demonstrate member advocacy initiatives related to consumer services on the local level, supported by input from the member.

8. This program may require creative solutions to long-standing systemic issues. Priority will be given to those proposals demonstrating creative and cost effective solutions.

9. Consideration will be given to those proposals that identify training initiatives and development as part of the technical proposal.

10. LINKS to resources that may be helpful in the preparation of Proposals

Northampton County

<http://www.northamptoncounty.org/>

Pennsylvania HealthChoices Website

<http://www.dpw.state.pa.us/Health/BehavHealthChoices/>

Appendix T – Medical Necessity Criteria

<http://www.dpw.state.pa.us/omap/rfp/lcbhrfp/lcbht.pdf>

VI. ADDITIONAL INFORMATION FOR APPLICANTS

A. ISSUING OFFICE

The Program Coordinator listed below is the sole point of contact for this RFP. **Contact with any other state or County officials concerning this RFP, unless authorized by the Project Officer, is grounds for disqualification.** Note that, following the release of this RFP, all questions should be submitted to the Project Officer in writing (telephone calls will result in a request to submit information and/or questions in writing). These written questions shall be forwarded via e-mail with the subject heading “Northampton County RFP Questions” to dnunes@nothamptoncounty.org.

The Project Officer is: Deborah A. Nunes, Program Coordinator

B. CONTRACT

Successful bidders will be expected to enter into a standard service contract with the County of Northampton and, if providing a HealthChoices in-plan or supplemental service must become a network provider of the BHMCO. Contracts are typically for a one-year period, but may be executed for longer periods at start-up.

C. REJECTION OF PROPOSALS

The County may reject any and all proposals received as a result of this RFP, and may negotiate separately with competing applicants. If all proposals are unacceptable, the County reserves the right to reject the proposals and to issue a new RFP, if indicated. The County reserves the right to reject a proposal at any time during the process.

D. INCURRING COSTS

All costs of developing proposals and any subsequent expenses relating to contract negotiation are entirely the responsibility of the applicant.

E. AMENDMENTS TO RFP

If it becomes necessary to revise any part of this RFP, the County will issue an amendment to all applicants that received the original RFP.

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VII. INFORMATION REQUIRED FROM APPLICANTS

A. GENERAL INFORMATION

This section includes instructions for preparing the Technical as well as the Cost Proposals. Applicants should review the instructions carefully. Failure to comply with these instructions in full may result in disqualification. To be considered, the proposals must include responses to all requirements in each respective part of the proposal(s). Any other information thought to be relevant, but not applicable to the enumerated categories, should be provided as appendices to the proposals. If an applicant supplies publications in response to a requirement, there must be a reference to the document number and page number. This will afford a quick reference for the evaluators. Proposals not furnishing this reference will be considered to have no reference material included in the additional documents.

The proposals must consist of:

- Transmittal letters;
- Technical Proposal, so identified;
- Cost Proposal, so identified .

Applicants must strictly adhere to the page limits indicated for each section

B. TRANSMITTAL LETTER

The transmittal letter must be on official letterhead and signed by an individual with legal authority to bind the applicant. The transmittal letter must include the name and title of the Chief Executive Officer or other individual authorized to legally bind the applicant, and include the identification of a primary contact, that person's title, address, telephone and telefax numbers and email address. The letter must state that the applicant accepts the terms, conditions, criteria and requirements set forth in the RFP.

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VIII. TECHNICAL PROPOSAL

For each question below, respond by restating the question and providing a one-page description. Each question and its description should be on a separate page. All appendices must be referenced in the body of the description.

- 1) In one (1) page or less, describe why your organization decided to submit this proposal and how you see it complementing the Behavioral HealthChoices Program in Northampton County.
- 2) Provide a program and services description, including program rationale, philosophy and why this service or approach is expected to improve the health outcomes for the persons targeted, program structure, staff responsibilities, supervisory responsibilities, target population, program capacity and annual program outcome evaluation. This program description shall be in a format that is comprehensive enough to serve as a description for approval by OMHSAS for licensure, Magellan's Network and Northampton County's contract work statement.

The following points should be included in the service description:

- a) Discuss diversity and cultural competency issues as they affect the program and this specific geographic area, including the medical, educational, social status, racial, language and economic needs of the Medical Assistance members. Discuss means to identify special skills or abilities to serve priority populations, and related recruitment, training and retention strategies.
 - b) Describe the process for coordination of care and assisting the population to negotiate the treatment environment.
 - c) Describe your case management process and understanding of the Pennsylvania medical necessity criteria.
- 3) In no more than two (2) pages describe the standard parameters, monitoring systems, and objective measures for auditing quality of care. Describe methods for monitoring critical incidents and fraud or abuse. Describe the process for evaluating and targeting program deficiencies and implementing a corrective action plan. These must address the outcomes per the Reinvestment Plan.
 - 4) In no more than one (1) page provide a description or chart outlining timeframes from contract award to full start-up.

IX. FINANCIAL PROPOSAL

An Excel format is required for the Reinvestment Budget. The provider must prepare a budget **on the attached Excel worksheets**. An Excel or Word format is acceptable for the Narrative. One workbook must be completed for 6 month startup and one for a full year. Provider must include detail of how the per diem is calculated on a separate Excel spreadsheet.

Again, utilize the Excel worksheets for the budget workup that are provided on the following links:

http://www.northamptoncounty.org/northampton/lib/northampton/depts/healthchoices/ACR_startup.xls

and

http://www.northamptoncounty.org/northampton/lib/northampton/depts/healthchoices/ACR_full.xls

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The provider must submit service utilization data in the format outlined below. Both forms must be completed (**FOR THE PERIOD ENDING JUNE 30, 2012 and JULY 1, 2012 THRU JUNE 30, 2013**)

FOR THE PERIOD JUNE 30, 2012				
Enter best estimate of service to be provided by reinvestment dollars. Do not leave blanks. Enter zeros if there is no estimated number. DPW requires an estimate of Non-HealthChoices members to be served (use your best estimate).				
Define the period of time covered by the estimates below (i.e. no. of months):				
	HealthChoices	Not in HealthChoices, but are MA	NOT MA	Total
	Eligible	Eligible	Eligible	
TOTAL Unduplicated members to be served				
< 18 years old				
TOTAL Unduplicated units of service				
< 18 years old				
Define a unit of service:				
Reinvestment Unit Cost (Total cost charged to reinvestment/total unduplicated units):				

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JULY 1, 2012 THRU JUNE 30, 2013				
Enter best estimate of service to be provided after start-up year. Do not leave blanks. Enter zeros if there is no estimated number. DPW requires an estimate of Non-HealthChoices members to be served (use your best estimate).				
	HealthChoices	Not in HealthChoices, but are MA	NOT MA	Total
	Eligible	Eligible	Eligible	
TOTAL Unduplicated members to be served				
< 18 years old				
TOTAL Unduplicated units of service				
< 18 years old				
Define a unit of service:				
Unit Cost (Full year cost/total unduplicated units):				

Refer to DPW Reinvestment Plan Parameters Published By OMHSAS, April 23, 2003 on the Northampton County's Web site <http://www.northamptoncounty.org> for specific guidelines on use of reinvestment funds. To access this information from Northampton County's Web site, select Human Services then select Northampton County Behavioral HealthChoices, and finally select Reinvestment Planning. It should be noted that DPW is generally not accepting start-up costs from reinvestment that exceed one year. In the second year, it is expected that the program will be fully supported by capitation revenue with no reinvestment funding.

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X. LEGAL ASSESSMENT REPORT

Please complete this Questionnaire as part of your response to the RFP.

Question #1: Organization Structure and Legal Standing

- A. Describe your organization's structure and formation; i.e., is it a corporation, partnership, joint venture, limited liability entity, etc. Be very specific.
- B. Are you a for-profit or not-for-profit business? If a not-for-profit entity, under what section of the Internal Revenue Code?
- C. If a corporation, in what state are you incorporated?
- D. If a limited partnership or other limited liability entity, in what state are you registered?
- E. In what other states are you registered and qualified to do business?

Question # 2: Other dealings with the County

For the past two (2) years, please describe and list any and all dealings, relationships (contractual or otherwise), whether or not compensated, of Subcontractor with the County at any level for any purpose or function, together with the name(s) and, if relevant, the telephone number(s), of the contact person at the County with whom you dealt.

Question # 3: Outstanding Litigation

- A. List all outstanding litigation in which you are a defendant, and for which the amount of recovery being sought by plaintiff is in excess of \$25,000.
- B. List all judgments and settlements in excess of \$25,000 in the last two (2) years.

Question # 4: Recent Developments and Miscellaneous Information

Please describe your existing compliance plan and program, and provide us with a detailed history of your compliance experience, including any investigations, reviews, audits, notices, claims or communications from any federal or state agency or government, or a third party payer regarding you, your parent and affiliated and related entities.

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**APPENDIX 1
HEALTHCHOICES REINVESTMENT PLAN PRIORITY**

County Northampton

Reinvestment Plan from contract year 2009-2010 Date of Submission 8-3-2011

Name of Service: Adolescent Crisis Residence Continuation Plan _____ New Plan X

Reinvestment Service or Program – (check all categories that apply)

In-Plan Start-up _____

Non-Medical Only _____

Supplemental – In Lieu of X
Approved _____ Procedure Code _____
Newly Proposed _____

Budget a. Clinical* _____
Budget b. Operating** X
Bricks and Mortar X
One-time only _____

Supplemental – In Addition to _____
Budget a. Clinical* _____
Budget b. Operating** _____

Priority 1 **of** 1 **Submitted** **Year(s) in which funds are to be spent** 2011-2013

Target Population:

The target population is Lehigh and Northampton County MA eligible male and female adolescents ages 13-17 who have been identified as needing out of home placement as a result of a behavioral crisis which requires stabilization and assessment (i.e. meets medical necessity requirements) in a structured, secure setting to ultimately determine appropriate placement and ongoing treatment needs. The adolescent Crisis Residence will consist of 8 beds (waiver request will be submitted for 2 additional beds bringing total beds to 10) serving approximately 120 Lehigh and Northampton County adolescents per year with an average length of stay of 5 days. Any additional time beyond the 5 days will be authorized based on the individual clinical needs of the adolescent and recommendation by the doctor.

Description of Program or Service:

This proposed co-ed CR program will be licensed as a Crisis Residential Program (CR DPW 5240 regulations). The CR will provide stabilization, assessment and evaluation, case management and focused treatment intervention. The program will have an active, structured schedule based on a 15-16 hour day. This program will also be licensed by the Office of Children, Youth and Families under the 3800 regulations.

Staffing:

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Clinical:

The below listed Crisis Residence program and the clinical staff/tx team will be directed by a Crisis Residence Director who holds one of the following credentials; LCSW, LSW, LPC.

- Licensed Professional Family Therapist (LCSW, LSW, or LPC): Family Therapy trained, FTE – 40 hr. flex schedule.
- Child Psychiatrist: On-site 3 days regular schedule and PRN basis. On Call 24/7
- Case Manager: Bachelors level minimum with Family and Systemic Training and experience. FTE – 40 Hour flex schedule.
- Registered Nurse: Trained and experienced in Pediatric Behavioral Health. Trained to complete intakes/admissions. 16 hours (7am-10pm), on site 7 days/wk. Non-awake hours, PRN basis for on-site and on call 10pm-7am, 7 days/wk.
- Certified Addictions Counselor: On-site 3 days per week, on call PRN.
- Licensed Psychologist: On site, PRN basis.

Direct Care:

Milieu Counselors will be staffed at a ratio of 3:1 during awake hours and 8:2 during non-awake hours. Recognizing the need to be flexible and responsive to the needs of the milieu at any given time, the Crisis Residence will employ an on call system in the event additional staff need to be “on the floor” to safely facilitate programming. Milieu Counselors assigned to this program will be Bachelors level credentialed with Mental Health, Family Systems, De-escalation and Restraint, and Trauma Informed Care training.

The clinical program

A Primary Therapist with intensive caseload of no more than 4 cases and a case manager with a shared caseload of no more than 4 cases. This team approach affords the ability to both focus the clinical work necessary to further stabilize the child and address his/her behavioral health needs as well as to effectively identify and coordinate post discharge resource and services planning to insure a seamless transition and long term progress toward treatment goals, following reunification.

Youth and their family receive the following:

- Intensive systemic family treatment by a family trained, licensed Therapist offering an in-depth integrated summary which assesses the child and family’s overall functioning, diagnosis, medications, legal, academic placement, and details of family dynamics contributing to the precipitating events (historic and current) that led to the need for removal from the home and warranted admission to the Crisis Residence program, as well as treatment and aftercare planning required for both the youth and family members.

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- Case Management by a trained, Bachelors level or higher professional. The CM will work in tandem with the assigned Crisis Residence Therapist to assist in all aftercare planning related duties and responsibilities to insure timely, seamless, and successful discharge and post discharge objectives are effectively met. The CM will have a shared caseload with the Crisis Residence Therapist.

The “team” will have minimum weekly face to face counseling sessions with the child and family.

- A Psychiatric evaluation by a child Psychiatrist which addresses the child’s medication regimen, provides diagnostic impressions, and contributes to the recommendations for the child and family’s aftercare.
- An Alcohol Tobacco and Other Drug (ATOD) AS NEEDED assessment administered by a Certified Addictions Counselor addresses any substance abuse concerns for the child and/or family member exposure or use, provides diagnostic impressions, and contributes specific recommendations for the child and family’s treatment and aftercare.
- Psychological assessment and testing by a licensed psychologist, on a PRN basis; the Psychologist identifies strengths and strategically identifies interpersonal areas that contribute additional diagnostic impressions and further specialized recommendations for aftercare planning.
- A medical assessment by a MD, CRNP, or PA who also monitors the child’s medication regimen in consult with the Psychiatrist, provides diagnostic impressions, and specifies recommendations for the child and family’s aftercare.
- Education in a certified school with licensed education staff who evaluates each child’s academic functioning, learning styles and specific behavioral and learning challenges in the academic setting.
- An Activities Specialist provides an assessment and a daily recreational program which emphasizes pro-social, cooperative teamwork and reaching personal recreational strengths.
- A registered nurse (RN) will be required to oversee the medical assessment and services as well as admission/intake responsibilities during day and evening programming seven days a week. Overnight staffing includes nursing coverage that may be provided by an RN or LPN and will also have medical and admission responsibilities. The nursing staff will be supervised by a nursing supervisor. A certified nurse practitioner or physician’s assistant will also be on staff up to 20 hours per week to provide medical and physical assessments and to provide medical treatment when needed.

Clinical Assumptions:

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The Crisis Residence program is designed to offer highly intensified, outcomes and recovery focused short-term stabilization and treatment for youth and families who are in need of extended clinical assessment and stabilization. The Primary Therapist and Intensive Case Manager work as a team in collaboration with involved family, home community resources and services, and involved systems (e.g. Children and Youth, School) during the youths stay to insure continuity of ongoing treatment goals are met following discharge. The program at a minimum will deliver the following results during and post treatment experience:

- Reduced readmission rate to AIP/ level of care placement
- Reduced readmission rate to RTF or other out-of-home placement.
- Improved, self initiated level of community resource utilization by family.
- Improved school, home, and community activity functioning and behavior demonstrated in these settings and situations.
- Reduced level of youth/family's reliance on crisis intervention services.
- PRN medications, orders per patient
- AIP, RTF History

Outcomes Monitoring:

As part of ongoing data collection and outcomes monitoring process for all admissions, the program will be assigned with designated data indicators consistent with monitoring and measuring the objectives outlined above. Clear, measurable indicators to measure the efficacy of this project will include:

- Length of Stay
- Post Discharge Placement/Service(s) type, frequency, etc.
- Post Discharge reentry to out-of-home (AIP, crisis residence, RTF) 90 day, 180 day, 1 yr post interval monitoring.

Other data to be measured, analyzed, and shared with involved pilot project stakeholders include:

- Diagnosis
- Age and Gender

Data Analysis and Expected Outcomes

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Crisis Residential HealthChoices supporting data:

1. HealthChoices Children and Adolescents AIP admissions for Jan 2009 through Dec 2010
 - LE County = 690
 - NH County = 517
 - Total = 1,207 admissions over a two year period
2. HealthChoices Children and Adolescents AIP admissions for Jan 2011 through May 2011
 - LE County = 160
 - NH County = 117
 - Total = 277 for 5 months ended May 31, 2011. This number annualized = 665 admissions for 2011
3. Total HealthChoices Children and Adolescents AIP admissions from Jan 2009 through Dec 2011 (annualized) = 1,872
4. Average HealthChoices Children and Adolescents AIP admissions annually = 624
5. 10 crisis residential beds at an ALOS of 5 days would mean we need 73 admissions out of 624 annually to keep the program at 90% capacity.
6. Analysis of HealthChoices AIP admissions from 2009-2011 through June indicate that 60% of the admissions were in the 13 to 17 age range.
7. Rationale for referrals to this program:
 - Program will serve both LE and NH Counties HealthChoices Adolescents
 - C&Y and JPO will have the option to use this program as needed
 - Youth will either be diverted from AIP or stepped down from AIP

Bricks and Mortar

Finances have been set aside for either purchase of a building that is approved for zoning that might need renovations or construction of a new facility. This will be determined after a provider has been selected.

Request for Proposal

The RFP process will be conducted in order to select a provider for this plan in the months following the approval of the plan by OMHSAS.

Stakeholder Involvement in Decision Making:

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5/19/2011 HealthChoices Advisory Board Meeting. The adolescent crisis residential idea was shared with the group with requests for initial feedback. The members approved of the idea with no refusals. We will provide the completed plan for them in a future meeting.

5/25/2011 Community Healthcare Alliance. The adolescent crisis residential idea was introduced to this group for feedback and all seemed to agree. There were no rebuttals. The plan would be shared at the next meeting.

6/9/2011 All Human Service Departments in Northampton County were notified regarding the adolescent crisis residential idea and asked for feedback and support.

7/15/11 Contacted Recovery Partnership to select reviewers for the completed plan. There will be reviews with this alliance in the next few months.

August 2011 Additional reviewers from Lehigh County will be reviewing the plan at a meeting to be arranged. The Adolescent Crisis Residential plan will be distributed at the next Community Health Care Alliance meeting as well as the upcoming HealthChoices Advisory meeting.

8/5/11 The plan was emailed to a peer specialist and a family member in Lehigh County and in Northampton County. 3 out of the 4 responses were returned by 8/12/11. Responses were in favor with the program as well as suggestions/concerns with a few areas in the plan itself.

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Appendix 2

PROPOSED RULEMAKING

Annex A

TITLE 55. PUBLIC WELFARE

PART VII. MENTAL HEALTH MANUAL

**Subpart D. NONRESIDENTIAL
AGENCIES/FACILITIES/SERVICES**

Article I. CHAPTER 5240. CRISIS INTERVENTION SERVICES

Subchap.	Sec..
A. GENERAL PROVISIONS	5240.1
B. TELEPHONE CRISIS SERVICE.....	5240.71
C. WALK-IN CRISIS SERVICE	5420.91
D. MOBILE CRISIS SERVICE	5240.101
E. MEDICAL MOBILE CRISIS TEAM SERVICE.....	5240.121
F. CRISIS RESIDENTIAL SERVICE	5240.141

Subchapter A. GENERAL PROVISIONS

GENERAL

Sec.	Policy.
5240.1	Policy.
5240.2	Definitions.
5240.3	Organization.

Article II. ELIGIBILITY

5240.11	Provider participation.
5240.12	Service eligibility.

Article III. RESPONSIBILITIES

5240.21	Responsibilities of county administrators.
5240.22	Responsibilities of providers.
5240.23	Recordkeeping.
5240.24	Case records.

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Article IV. REQUIREMENTS

- 5240.31. Staff requirements.
- 5240.32. Quality assurance and utilization review.
- 5240.33. Conflict of interest.

CONSUMER RIGHTS

- 5240.41. Consumer participation.
- 5240.42. Notice of confidentiality.

Article V. PAYMENT

- 5240.51. Payment for MHCI services.

Section 5.01 GENERAL

§ 5240.1. Policy.

Crisis intervention services are immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress which are provided to adults, adolescents and children and their - families` who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. The services provide rapid response to crisis situations which threaten the well-being of the individual or others. MHCI includes intervention, assessment, counseling, screening and disposition services which are commonly considered appropriate to the provision of mental health crisis intervention.

§ 5240.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Adolescent-An individual 14 to 18 years of age or to 21 years of age if enrolled in special education.

CSP (Community Support Programs) - An organized network of caring and responsible people committed to assisting persons with long-term mental illness to meet their needs and develop their potentials and to avoid becoming unnecessarily isolated or excluded from the community.

CASSP (Children, Adolescent Service System Program Agencies) - Mental health, mental retardation, child welfare, drug and alcohol, education, health and juvenile justice agencies which serve children and adolescents and their families.

Children - Individuals under 14 years of age.
Responsibilities of county administrators. Responsibilities of providers.
Case records.

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County administrator - The MH/MR administrator who has jurisdiction in the geographic area.

Consumer - An individual who has received mental health treatment or case management services in the past who is currently receiving these services, including MHCI services.

County plan - A county plan and budget which describes how crisis intervention services will be made available, including the anticipated expenditures for the services.

Crisis - An immediate stress producing situation which causes acute problems of disturbed thought, behavior, mood or social relationships requiring, immediate intervention.

Department - The Department of Public Welfare of the Commonwealth.

Enrolled provider - A county MH/MR program or private agency specifically identified as a provider of crisis intervention services in the county plan which has been approved by the Department and enrolled by the Office of Mental Health for claims processing through the Office of Medical Assistance Programs.

Facility - A building or a part of a building in which a provider is located and renders service.

Family members - Parents, as defined in this section, siblings and other relatives living in the home.

License - A certificate of compliance issued by the Department authorizing the operation of crisis intervention services at or from a given location, or a specific period of time according to appropriate Departmental program licensure or approval regulations.

MA - Medical Assistance. __.

MH/MR - Mental Health/Mental Retardation.

MHCI - Mental Health Crisis Intervention..

***Medical clearance* - An evaluation by a licensed physician who affirms that no medical conditions are present which preclude involvement in the placement.**

Mental health direct care experience – Working directly with adult, adolescent, or child mental health service consumers, providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care or social rehabilitation in a mental health facility or in a facility or program that provides services to mental health consumers, or in a nursing home, a juvenile justice agency or a child and adolescent service agency.

Parent - The biological or adoptive mother or father or the legal guardian of the child or a responsible relative or caretaker with whom the child regularly resides.

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Provider - The agency responsible for the day-to-day operation and management of the crisis intervention service.

Special populations - Persons with a serious mental illness who are homeless, elderly, hearing impaired, dually diagnosed (mental illness with substance abuse or mental retardation, or both), HIV positive, involved in the criminal justice system (forensic), members of racial or ethnic minority groups, or persons with unique needs requiring specially designed mental health services or coordination with other State agencies.

Staff - Persons employed by the MHCI providers either directly or under contract, who through education and experience are qualified to oversee or directly provide MHCI services under this chapter.

Unit - The term refers to a provider organization as distinct from the physical facility.

§ 5240.3. Organization.

(a) Each county or joinder shall assure 24 hours a day, 7 days a week availability of MHCI telephone service. MHCI telephone service shall serve as a referral source to other MHCI service providers with other referral sources approved by the county administrator.

(b) A licensed MHCI service provider may be approved for one or more MHCI services:

- (1) Telephone crisis service.
- (2) Walk-in crisis service.
- (3) Mobile crisis service.
- (4) Medical-mobile crisis service.
- (5) Residential crisis service.

(c) Each MHCI service, unit shall, be separately identified with an identified unit supervisor within the provider organization.

(d) An MHCI supervisor may oversee more than one service within a single provider organization.

(e) An area served by a medical-mobile. crisis service shall also be served by a mobile crisis service.

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Article VI. ELIGIBILITY

§ 5240.11. Provider, participation.

(a) County MIV MR programs and public and private agencies are eligible to enroll under the MA Program to provide MHCI services if they are specifically designated as MHCI providers in the currently approved county plan.

(b) Providers approved by the Department shall sign a provider agreement, as specified in Chapter 1101 (relating to general provisions), to participate as providers of MHCI services.

(c) Providers shall complete an enrollment information packet which will permit Federal share reimbursements through MA.

(d) Providers approved by the Department as meeting the provisions of this chapter shall be licensed and eligible to provide specific, approved MHCI services.

(e) A provider shall be in compliance with Chapter 20 (relating to licensure or approval of facilities and agencies).

(f) If there is conflict or inconsistency with the provisions of another regulation, this chapter prevails.

§ 5240.12. Service eligibility.

Mental health crisis intervention services shall be reimbursable when provided to adults, adolescents and children and their families who exhibit an acute problem of disturbed thought behavior, mood or social relationships.

Article VII. RESPONSIBILITIES

§ 5240.21. Responsibilities of county administrators.

The county administrator shall:

(1) Assure that providers that receive public funds and provide services described in this chapter are licensed as MHCI providers and abide by this chapter.

(2) At least annually monitor and evaluate MHCI providers to ensure that services are provided in compliance with requirements of the county plan and this chapter.

(3) Provide fiscal and program reports as required by the Department under § 4200:32 (relating to powers and duties).

(4) Certify that State matching funds are available for Medicaid compensable services.

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§ 5240.22. Responsibilities of providers

Each MHCI provider shall:

- (1) Comply with this chapter.
- (2) Submit reports as required by the Department and the county administrator.
- (3) Establish a written training plan for each MHCI service provided, which shall:
 - (i) Specify training for each staff classification that shall be completed before a staff member may provide MHCI services. .
 - (ii) Establish ongoing training requirements for staff members.
 - (iii) Have as its primary objective enabling staff persons to identify a crisis and provide MHCI services to, adults, adolescents and children in an age "appropriate and culturally-competent manner in accordance with CASSP and CSP principles. See Appendix A (relating to CASSP and CSP principles).
 - (iv) Be approved by the county administrator and reviewed yearly. .
- (4) Each provider shall establish a written protocol for each MHCI service which shall state the policy and guidelines for responding to . specific situations, including threats of harm to self or others and other common or foreseen crisis situations: The protocol shall:
 - (i) Address services to children, adolescents and their families and special populations to be served.
 - (ii) Address the notification of family members of children, adolescents and adults.
 - (iii) Address procedures which will provide continuity of care for individuals and monitor outcomes to the greatest extent possible.
 - (iv) Be approved and reviewed annually by a physician (preferably a psychiatrist), a licensed psychologist, a licensed social worker, a certified registered nurse practitioner in the area of
psychiatric nursing or a registered nurse with a master's degree in nursing and a major in psychiatric nursing. .
- (5) Providers authorized to administer medication shall maintain a written protocol for the storage and administration of drugs which has been approved by a physician and reviewed yearly.
- (6) The primary responsibility of providers is to respond, to and seek to resolve a crisis situation. The provision of services shall take precedence over intake.

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(7) An agreement shall be on file assuring that psychiatric or other physician back-up is available by telephone within 1 hour.

(8) Providers shall have available a list of community resources for adults, adolescents and children in crisis.

(9) Providers shall post consumer rights and notify individuals and family members of their rights.

§ 5240.23. Recordkeeping.

(a) Providers shall maintain records for a minimum of 4 years.

(b) Provider records shall, at a minimum, contain the following:

(1) Copies of required inspection reports, certifications or licenses by Federal, State and local agencies.

(2) Documents which verify employee work schedules, such as payroll records and employee time sheets.

(3) A job description for each employee.

(4) A schedule of fees or charges.

(5) Affirmative action policies.

(6) Documents which verify employee qualifications and training as described in this chapter.

(7) Training and service protocols.

(8) A medication protocol, if appropriate.

(9) A record of supervision and training.

(10) Letters of agreement with frequently used referral sources such as CASSP agencies, police, hospitals and other MHCI service providers.

(11) A record of an appeals process, which conforms to Chapter 275 (relating to appeal and fair hearing).

(12) A schedule of medical/psychiatric back-up.

§ 5240.24. Case records.

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(a) Records for each MHCI service shall be specifically identified and may be integrated with the consumer's` other service records which are maintained by the provider.

(b) The case record shall contain, at a minimum, the following information:

(1) Identifying information on the persons served.

(2) A description of the contact encompassing the reason for the contact, staff involved, services provided, crisis resolution referrals and outcomes.

(3) For crisis residential services. only, a medical clearance is required. (See Subchapter F. (relating to crises residential service)).

(c) Entries shall be signed by the staff person providing the service or by the senior staff person if services are team delivered.

(d) Entries shall show the dates of service and the time of the beginning and end of each service.

Article VIII. REQUIREMENTS

§ 5240.31. Staff requirements.

(a) To qualify as a mental health professional under this chapter, an individual shall have at least one of the following:

(1) A master's degree "in social work, psychology, rehabilitation, activity therapies, counseling, education or related fields and 3 years of mental health direct care experience.

(2) A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education or a related field, or be a registered nurse; and 5 years of mental health direct care experience, 2 of which shall include supervisory experience.

(3) A bachelor's degree in nursing and 3 years of mental health direct care experience.

(4) A registered nurse license, certified in psychology or psychiatry.

(b) MHCI service crisis workers who are not mental health professionals shall be supervised by a mental health professional and one, of the following:

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(1) Have a bachelor's degree with major course work in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, nursing, counseling, education or a related field.

(2) Be a registered nurse.

(3) Have a high school diploma or equivalency and 12 semester credit hours in sociology, social welfare, psychology, gerontology or other social science and 2 years of experience in public or private human services with 1 year of mental health direct care experience.

(4) Have a high school diploma or equivalency and 3 years of mental health direct care experience in public or, private' human services with employment as a mental health staff person prior to January 1, 1992.

(5) Be a consumer or a family member who has 1 year of experience as an advocate or leader in a consumer or family group, and has a high school diploma or equivalency.

(c) Staff persons employed by a provider who' have 5 years experience as a supervisor, of mental health services in a mental health agency prior to January 1, 1992, are exempted from this section.

(d) An MHCI service medical professional is one of the following:

(1) A psychiatrist.

(2) A physician with 1 year of mental health service experience in diagnosis, evaluation and treatment.

(3) A certified registered nurse practitioner authorized in accordance with. 49 Pa. ,Code § 21.291 (relating to institutional - health care facility committee; committee determination of standard policies and procedures) to diagnose mental illness.

(e) An MHCI service medical assistant is one of the following:

(1) A licensed practical nurse.

(2) A certified paramedic.

(3) A physician's assistant

(f) An MHCI service aide or mobile aide has the following:

(1) A high school diploma or equivalency.

(2) Completed the provider's approved training requirements.

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(g) Staff of a program serving children and adolescents under 18 years of age shall have clearance in accordance with 23 Pa.C.S. § 6344 (relating to information relating to prospective child-care personnel).

§ 5240.32. Quality assurance and utilization review.

The quality of each crisis intervention service shall be ensured by written provider procedures which include quarterly staff conferences and case reviews, required attendance at training

programs for staff members and other oversight. Services are subject to review by the Department and appropriate agencies in accordance with §§ 1101.71-1101.75 and by authorized, agents of the county government.

§ 5240.33. Conflict of interest.

When an agency that provides MHCI services also provides other mental health services, the responsible county administrator shall ensure that the provider agency:

(1) Does not restrict the freedom of choice of an individual in crisis, or the parent if the individual is a child, when non-emergency referrals are made or other services are solicited in a non-emergency situation.

(2) Fully discloses that other services which the provider agency performs could be obtained from another agency if the consumer so desires.

(3) Makes available to each individual in crisis and parent, if the individual is a child, a listing of mental health treatment, rehabilitation and support services available within a reasonable proximity to the individual's home where needed services could be obtained and if the individual in crisis or parent, if the individual is a child, so desires, the MHCI worker shall assist the individual in accessing those services. This information shall be made available to family members of adults in crisis if there is documentation of the adult's assent.

Article IX. CONSUMER RIGHTS

§ 5240.41. Consumer participation.

(a) An individual or parent, if the individual is a child under 14 years of age, has the right to refuse medication; or placement in a crisis residence, or terminate service without prejudice to other parts of the treatment program and future services.

(b) An adolescent 14 to 18 years of age may consent to, or reject service under the Mental Health Procedures Act (50 P. S. §§ 7101-7503).

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(c) Parents shall be notified prior to intervention if the individual is a child. If an individual is 14 years of age or older, parents shall be notified and parental involvement shall be sought unless the individual in, crisis objects.

(d) A, service decision may not be made in violation of an individual's civil rights.

(e) Consumers have the right to appeal the provision of service in accordance with Chapter 275 (relating to appeal and fair hearing).

(f) A provider may not discriminate against consumers or staff persons on the basis of age, race, sex, religion, ethnic origin, disability, economic status or sexual preference and shall comply with applicable State and Federal statutes, including Chapter 5100 (relating to mental health procedures) and section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. § 794), relating to nondiscrimination on the basis of handicap or disability, and the Americans with Disabilities Act (42 U.S.C.A.: §§.12101 - 12213).

§ 5240.42. Notice of confidentiality.

Individuals receiving services are entitled to confidentiality of records and information as set forth in §§ 5100. 31-5100.39 (relating' to confidentiality of mental health records) and other applicable Federal and State requirements.

Article X. PAYMENT

§ 5240.51. Payment for MHCI services.

To receive payment for MHCI services under this chapter the following apply:

(1) A provider shall comply with Chapter 4300 (relating to county mental health and mental retardation fiscal manual).

(2) There is liability for billable services under Chapter 4305 (relating to liability for community mental health and mental retardation services) unless superseded by this chapter. The individual in crisis who is receiving service is the liable person under Chapter 4305.

(3) MHCI services are exempt from MA co-payment charges.

(4) Payment for a unit of service is made at a Departmentally-established fee-for-service rate.

(5) Fees which are based on costs shall be reconciled annually.

(6) Emergency psychiatric/medical services, provided by a hospital emergency room or ambulance personnel are not reimbursable under this chapter.'

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- (i) Referrals to an ambulance or hospital emergency room provider are reimbursable.
- (ii) MHCI services and emergency or other treatment services are compensable on the same day.

Subchapter B. TELEPHONE CRISIS SERVICE

§ 5240.71. Service description.

The telephone crisis service is a 24-hour a day, 7 days a week "hot-line" service available- in each MH/MR catchment area throughout the state which screens incoming calls and provides appropriate counseling, consultation and referral to individuals who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. Service is also provided to callers who represent or seek assistance for individuals who are exhibiting these problems.

§ 15240.72. County administrator's responsibilities.

Administrators shall be responsible to assure telephone crisis service availability 24 hours a day, 7 days a week throughout the geographic area.

§ 5240.73. Provider responsibilities.

(a) A written plan, approved by the county administrator, shall be on file showing how services are provided. The telephone shall be answered by a member of the crisis staff, not by a recording or other mechanical device.

(b) A written plan shall show the organizational structure of the program.

(1) Overall supervision of the unit, as well as individual supervision, shall be carried out by a mental health professional.

(2) MHCI telephone crisis services shall be provided by mental health professionals and workers qualified under § 5240.31 (relating to staff requirements).

§ 5240.74. Payment conditions.

(a) Only the time spent indirect - telephone contact with a person in crisis, or a parent if the person is a child, may be billed at the unit rate. Costs necessary for other activities required for the service are built into the rate.

(b) A unit of service is 15 minutes or a major portion thereof.

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Article XI. Subchapter C. WALK-IN CRISIS SERVICE

§ 5240.91. Service description.

The walk-in crisis service is service provided at a provider site in face-to-face contact with individuals in crisis or with individuals seeking help for persons in crisis. Service is available at a designated facility. Service includes assessment, information, and referral, crisis counseling, crisis resolution, accessing community resources and back-up, including emergency services and psychiatric or medical consultation. The service also provides intake, documentation, evaluation and follow-up.

§ 5240.92. County administrator's responsibilities.

(a) Administrators shall assure that providers adhere to this chapter and provide prompt service availability.

(b) Administrators shall maintain a record of providers of walk-in crisis services showing service availability.

§ 5240.93. Provider responsibilities.

(a) A written plan, approved by the county administrator, shall be on file showing how services are provided.

(b) A written plan shall show the organizational structure of the program.

(1) Overall supervision of the unit, as well as individual supervision shall be carried out by a mental health professional.

(2) MHCI walk-in crisis services shall be provided by mental health professionals and workers qualified under § 5240.31 (relating to staff requirements).

§ 5240.94. Payment conditions.

(a) Only the time spent in face-to-face contact with a person in crisis is billable at the unit rate. Administrative and other costs necessary for the service are built into the rate.

(b) A unit of service is 15 minutes or a major portion thereof.

Article XII. Subchapter D. MOBILE CRISIS SERVICE

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§ 5240.101. Service description.

The mobile crisis service is service provided at a community site which is the place where the crisis is occurring or a place where a person in crisis is located. The service shall be available with prompt response. Service may be individual or team delivered by mental health professionals or workers. Service includes crisis intervention, assessment, counseling, resolution, referral and follow-up. Extended service by mobile crisis aides is available. The service provides back-up and linkages with other services and referrals. Access to mobile crisis service shall be obtained through approved sources.

§ 5240.102. County administrator's responsibilities.

(a) Administrators shall assure that providers adhere to this chapter and, provide prompt service availability.

(b) Administrators shall maintain a record of providers of mobile crisis service showing service availability.

(c) Administrators shall approve and maintain a list of approved referral sources. This list shall be reviewed and approved yearly.

§ 5240.103. Provider responsibilities.

(a) A written plan, approved by the county administrator, shall be on file showing how prompt service availability is assured.

(1) A list of referral sources authorized to activate the service shall be on file.

(2) The list of referral sources shall be approved by the county administrator and reviewed annually.

(b) A written plan shall show the organizational structure of the program.

(1) Overall supervision of the unit, as well as individual supervision, shall be carried out by a mental health professional.

(2) MHCI mobile crisis service shall be provided individually or in teams by mental health professionals and workers qualified under § 5240.31 (relating to staff requirements).

(3) Mobile crisis aides may be assigned by a provider to be with a consumer who has received crisis service to monitor and help stabilize the consumer's behavior. Each assignment of mobile crisis aides shall be approved by a physician or a supervisor who is a mental health professional.

(4) Referrals for ongoing service for publicly funded consumers may be made through the county administrator or a licensed or approved mental health service provider who provides case management.

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§ 5240.104. Payment conditions.

- (a) Only the time, spent by a staff member, mental health professional or worker, at a site which results in a face-to-face contact with a person in crisis, is billable at the unit rate. A unit of service is 15 minutes or major portion thereof.
- (b) The time, spent by a mobile crisis aide onsite with the person in crisis is billable at the unit rate. A unit of service is 4 hours or a major portion thereof.
- (c) Administrative and other costs necessary for the service are built into the rate.

Article XIII. Subchapter E. MEDICAL MOBILE CRISIS TEAM SERVICE

The medical mobile crisis team service provided in the community directly to an individual in crisis by a team consisting of a person authorized to administer medication and a mental health professional or a crisis worker. Unless one team member is a physician, there shall be mobile telephone linkage with a physician for medical back-up and authorization to administer medication. The medical mobile crisis team shall be called in situations where it is known or anticipated that medication will be required. The service shall supplement rather than be a substitute for mobile crisis services in the area. The service is accessed through approved sources.

§ 5240.122. County administrator's responsibilities.

- (a) Administrators shall assure that providers' adhere to this chapter and provide prompt service availability.
- (b) Administrators shall maintain a record of providers of medical mobile crisis service showing service availability.
- (c) Administrators shall approve and maintain' a list of approved referral sources. This list shall be reviewed and approved yearly.

§ 5240.123. Provider responsibilities.

- (a) A written plan, approved by the county administrator, shall be on file showing how service is provided.
 - (1) A list of referral sources-authorized to activate the service shall be on file.
 - (2) The list of referral sources shall be approved by the county administrator and reviewed annually.
- (b) A written plan shall show the organizational structure of the program.

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(1) Service is provided by treatment teams composed of one medical professional, an RN, or medical assistant qualified to administer medication and another person who is a mental health professional or worker. Staff persons shall qualify under '§ 5240.31 (relating to staff requirements). A treatment team shall have either a medical professional or mental health professional present.

(2) Supervision of the unit and individual supervision shall be provided by a medical professional, or mental health professional.

§ 5240.124. Payment conditions.

(a) Only the time spent by a medical mobile crisis team at a site which results in a face-to-face contact with a person in crisis, is billable at the unit rate. Administrative and other costs necessary for the service are built into the rate.

(b) A unit of service is 15 minutes or a major portion thereof.

Article XIV. Subchapter F. CRISIS RESIDENTIAL SERVICE

§ 5240.141. Service description.

The crisis residential service is a service provided at small facilities that provide residential accommodations and continuous supervision for individuals in crisis. The service provides a temporary place to stay for consumers who need to be removed from a stressful environment or who need a place in which to stay to stabilize or until other arrangements are made. Access shall be provided through approved referral sources.

§ 5240.142. County administrator's responsibilities.

(a) Administrators shall assure that providers adhere to this chapter and provide prompt service availability.

(b) Administrators shall maintain a record of providers of crisis residential service showing service availability.

(c) Administrators shall approve and maintain a list of approved referral sources. This list shall be reviewed and approved yearly.

§ 5240.143. Facility requirements.

(a) Facility capacity is limited to eight beds.

(b) The facility shall meet National, State, and local laws relating to building codes and access and food preparation and handling.

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(1) The facility shall be appropriate for the purpose for which it is used.

(2) One facility may not serve both adults and children.

(3) Staff persons of adolescent and children's units shall have training in child's mental health as well as access to mental health and medical professionals with education and training in child development and child mental health issues.

(4) Facilities for children and adolescents shall be age appropriate. They may include distinct units for older children or adolescents, or both.

(c) A facility shall be unlocked from the inside and occupancy shall be voluntary.

§ 5240.144. Provider responsibilities.

(a) A written plan, approved by the county administrator, shall be on file showing how service is provided.

(b) The provider shall have on file a list of referral sources approved by county administrator. This list shall be reviewed and approved annually.

(c) The provider shall ensure that individuals have medical clearance prior to placement in the facility.

(d) Provider services includes:

(1) Intake.

(2) Examination and evaluation. Assurance that a medical examination and diagnosis is made for consumers housed over 24 hours.

(3) Room and board.

(4) Counseling and crisis stabilization.

(5) Limited recreational activities.

(6) Linkages and referrals through county mental health case management service providers for publicly funded consumers.

(7) Administration of medication.

(e) Organizational requirements are as follows:

(1) The crisis residential service shall be separately identified with a full-time supervisor.

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(2) Overall supervision of the service and individual supervision shall be provided by a medical professional or a mental health professional.

(3) Additional staff may be mental health workers, medical assistants or aides.

(4) Staff persons shall qualify under § 5240.31 (relating to staff requirements).through:

(f) Two staff members shall be on duty at all times, one of whom shall be a medical professional or mental health professional.

(1) A person authorized under State law to administer medication shall be available for prompt response at all times.

(2) There shall be a physician back-up to authorize the administration of medication.

§ 5240.145. Payment conditions.

(a) Service is billable while the consumer is in residence.

(b) A unit of service is 8 hours or a major portion thereof.

(c) A maximum stay is 120 hours. An additional stay is authorized if recommended by a physician, psychiatric nurse practitioner, licensed psychologist or licensed social worker and approved by the county administrator.

Article XV. APPENDIX A. CASSP AND CSP PRINCIPLES CASSP Principles

CASSP Principles

(a) *Core values for the system of care.*

(1) The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

(2) The system of care should be community-based, with the focus of services as well as management and decision making responsibility resting at the community level.

(b) *Principles of services for children and adolescents in this Commonwealth.*

(1) Children and adolescents deserve to live and grow in nurturing families.

(2) Children and adolescents' needs for security and permanency in family relationships should pervade all planning.

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(3) The family setting should be the first focus for treatment for the child or adolescent. Out-of-home placement should be the last alternative. Young children should not need to be in a State hospital to receive appropriate mental health treatment.

(4) Communities should develop a rich array of services for children and their families so that alternatives to out-of-home placement are available, such as home-based services, parent support groups, day treatment facilities, crisis centers and respite care.

(5) Parents and the child should participate fully in service planning decisions.

(6) The uniqueness and dignity of the child or adolescent and his family should govern service decisions. Individualized service plans should reflect the child or adolescent's developmental needs which include family, emotional, intellectual, physical, and social factors. The older adolescent's right to risk should be considered. Children and adolescents should not need to be labeled in order to receive necessary services.

(7) The community service systems which are involved with the child and family should participate and share placement, program, funding and discharge responsibilities.

(8) The primary responsibility for the child or adolescent should remain with the family and community. Pre-placement planning should include a discharge plan.

(9) Case management should be provided to each child and family to ensure that multiple services are delivered in a coordinated, time-limited, and therapeutic manner which meet the needs of child and family.

(10) Each child should have an advocate.

CSP Principles

The CSP philosophy is embodied in a set of guiding principles, emphasizing client self-determination, individualized and flexible services, normalized services and service settings and service coordination.

(1) Services should be consumer-centered. Services should be based on and responsive to the needs of the client rather than the needs of the system or the needs of providers.

(2) Services should empower clients. Services should incorporate consumer self-help approaches and should be provided in a manner that allows clients to retain the greatest possible control over their own lives. As much as possible, clients should set their own goals and decide what services they will receive. Clients also should be actively involved in all aspects of planning and delivering services.

(3) Services should be racially and culturally appropriate. Services should be available, accessible and acceptable to members of racial and ethnic minority groups and women.

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(4) Services should be flexible. Services should be available whenever they are needed and for as long as they are needed. They should be provided in a variety of ways with individuals able to move in and out of the system as their needs change.

(5) Services should focus on strengths. Services should build upon assets and strengths of - clients in order to help them maintain a sense of identity, dignity and self-esteem.

(6) Services should be normalized and incorporate natural supports. Services should be offered in the least restrictive, most natural setting possible. Clients should be encouraged to use the natural supports in the community and should be integrated into the normal living, working, learning and leisure time activities of the community.

(7) Services should meet special needs. Services should be adapted to meet the needs of subgroups of severely mentally ill persons, such as elderly individuals in the community or in institutions, young adults and youth in transition to adulthood, mentally ill individuals with substance abuse problems, mental retardation, or hearing impairments; mentally ill persons who are homeless; and mentally ill persons who are inappropriately placed within the correctional system.

(8) Service systems should be accountable. Service providers should be accountable to the users of the services and monitored by the State to assure' quality of care and continued relevance to client needs. Primary consumers and families should be involved in planning, implementing, monitoring and evaluating services.

(9) Services should be coordinated. In order to develop community support. services, services should be coordinated through mandates or written agreements that require ongoing communication and linkages between participating agencies and between the various levels of government. In order to be effective, coordination shall occur at the client, community and State levels. In addition, mechanisms should be in place to ensure continuity of care and coordination between hospital and other community services.