Crisis Stabilization and Intervention

March 2017
Crisis Intervention

Service Definition
Crisis intervention shall provide immediate mental health care to assist individuals (of all ages) who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention services must be available 24 hours a day, seven days per week.

Objectives of Crisis Intervention
• Prevent the exacerbation of a condition
• Prevent injury to the individual or others
• Provide treatment in the least restrictive setting
Crisis Stabilization

Service Definition
Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation.

Objectives of Crisis Stabilization
- Avert hospitalization or rehospitalization
- Provide normative environments with a high assurance of safety and security for crisis intervention
- Stabilize individuals in psychiatric crisis
- Mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery
Service Planning
Person Centered Planning: Individual Service Plan

- The ISP is a comprehensive and regularly updated document that integrates both physical and behavioral health, service coordination and integrated care goals specific to the needs of the individual being treated and meeting the defined specific service requirements. [CMHRS manual Chap IV pg 17]

- Is based on the understanding of the person gained during the assessment

- Is the road map for the work to be done by the member, family, and provider

- Emphasis in person-centered service planning is on the strengths and preferences of the member, rather than the problems or the deficits

- Focuses on the member’s life vision by incorporating his/her hopes, dreams, and goals
Person Centered Planning: Individual Service Plan [cont.]

• Should be developed by a team of professionals in consultation with the individual and the individual’s parents, legal guardians, or others in whose care the individual will be released after discharge.

• Participation in the specific service should not be a goal or objective when writing the individual service plan.

• The ISP should include specific methods of interventions and strategies designed to meet goals and objectives.

• Describe how the provider is working with related community resources to ensure a continuity of care with the individual’s family, school, and community.

• Emphasizing member’s strengths will help member achieve life goals and dreams.

• The ISP should identify barriers (the roadblocks that interfere with achievement of the goals) and how to address them, but these barriers should not be the exclusive focus of the plan.
Goals of Service Planning

• Partner with the Member to identify their needs and strengths

• Guides care

• Outlines progress in a realistic and achievable way

• Identifies path to discharge

• Identifies how member can strengthen community supports to be as healthy as possible
Service Planning Example

Robert’s Reported Goal: “I want to feel better, and not hurt myself.”

Objectives
1. Robert will take his depression medication every morning.
2. Robert will talk a short walk around his neighborhood 4 out of 7 mornings after breakfast.
3. Robert will begin going to a PSR program.
4. Robert will call his brother 4 out of 7 evenings after dinner.
5. Robert will watch a funny television show before bed 6 out of 7 evenings.

Barriers: Robert easily forgets his schedule. Robert worries about traffic in his area.

Interventions
1. By 4/1/2017, staff will help Robert develop a reminder system for his medications.
2. By 4/1/2017, staff will help Robert identify a safe route for his walk.
3. By 4/3/2017, staff will provide Robert with a list of PSR programs in his area, and help him chose 1 to visit.
4. By 4/1/2017, staff will help Robert set a reminder to call his brother.
5. By 4/1/2017, staff will help Robert get a TV schedule for the shows he enjoys.
6. By 4/2/2017, staff will help Robert write 5 reasons of why this goal is important to him.
7. By 4/3/2017, staff will help Robert develop ways to remind himself of his reasons to achieve this goal.
Discharge Planning
Person Centered Discharge Planning

• Service plans shall incorporate an individualized discharge plan that describes transition from current services to other appropriate less intensive services.

• The discharge plan must summarize an estimated timetable to achieving the goals and objectives in the service plan and describe the methods that will be used to facilitate a successful transition to services.

• Ongoing consultation with the member and person-centered service planning team to reassess the member's changing strengths, preferences, functional levels, social and cognitive capabilities assures that the comprehensive needs of the member will be addressed at time of discharge.
Person Centered Discharge Planning [cont.]

- Active treatment and comprehensive discharge planning for aftercare placement and treatment *must begin at admission* and shall incorporate how the member envisions discharge

- Discharge planning, at a minimum, should be an on-going discussion with the individual about managing symptoms, accessing and using resources, etc. upon discharge

- A lack of family or guardian involvement in discharge planning does not mean that discharge planning is not conducted
Person Centered Discharge Planning [cont.]

- During discharge planning, members and families should receive verbal and written information on the range of services and available options that will be available in the member's community at time of discharge.

- Members and families should be given the opportunity to select the providers of services whenever possible.

- Referral mechanisms with community providers occur in a timely, systematic fashion in order for the member to gain access to identified resources.

- The process concludes with the coordination and implementation of services and transition to the least restrictive level of care in keeping with the member's needs and wishes.

- Discharge plans are expected to be specific to the needs of the individual at the time the service needs are reviewed.
Goals of Discharge Planning

• Allow integrated care for member with a ‘warm’ handoff

• Help member transition smoothly to a lower level of care

• Help member avoid further crisis

• Help member meet their needs in the community

• Show that services have helped the member achieve their goals
Discharge Planning Example

• Robert has an appointment with his Psychiatrist, Dr. Fralin, at New River Valley CSB on Thursday, May 11th.
  • Robert has filled his most recent prescription and has enough medications to last until the end of May.
  • Robert has filled his weekly pill box for this week.
  • Robert has put a daily reminder in his calendar to take his medications, and a weekly one to fill his box.
  • Robert’s brother and case manager are both aware of this appointment and will help him arrange transportation.

• Robert has an appointment with New River Valley CSB, to meet with his case manager Rebecca Smith on Monday, April 24, 2017 at 3pm.
  • Robert’s brother is willing to pick him up and take him, and remind him the night before.

• Robert will meet with Stephanie Grayson at Grove Hill Place (a PSR program) on Monday, April 24, 2017 at 9am.
  • Grove Hill Place will pick him up at his home for this initial tour.
  • Robert has written a reminder for himself in his schedule.
  • Robert has been provided Ms. Grayson’s contact information of 804.555.1919.

• Robert will keep using his daily schedule on his yearly planner to remind him to use his coping skills (walking, talking with brother, watching comedy shows) each day.
  • Robert will leave this on his kitchen counter where he will see it everyday.

• Robert's brother has agreed to drop by and talk with Robert face to face at least twice a week.
Common Questions
Service Limits

Crisis Intervention

• Limited to 720 units (one unit = 15 minutes) annually

Crisis Stabilization

• Up to 15 days per episode as long as member continues to meet medical necessity criteria
• Up to 60 days annually
• Facility must have no more than 16 beds
• Not for room and board
• Services provided must align with ISP
• Can be provided in licensed community based facility, member’s home, or the home of member’s caregiver
Service Registration

Crisis Intervention

- Must be registered with Magellan within one (1) business day of the completion of the SSPI, or the provision of service, whichever comes first

Crisis Stabilization

- Must be registered with Magellan within one (1) business day of the completion of the SSPI
  - For GAP members this is an authorization, not a registration

- Cannot be in conjunction with Intensive In-Home Services or Intensive Community Treatment
Service Provision

Personnel
• Appropriate background checks have been completed
• Educational requirements for staff are documented
• Licenses for licensed staff are documented and up to date

Crisis Intervention
• SSPI completed by an LMHP Type or a Certified Pre-Screener
• Services provided by an LMHP Type or a Certified Pre-Screener
• May be provided during an ECO

Crisis Stabilization
• SSPI completed by an LMHP Type or a Certified Pre-Screener
• ISP must be developed within 3 calendar days
• Services provided by a QMHP Type, an LMHP Type or a Certified Pre-screener
Service Provision

Documentation

• Documenting every intervention and contact with member
• Interventions align with ISP
• Start and End times are documented
• Services are rendered by appropriately qualified staff (LMHP, QMHP)
• Location of services is appropriate

Billing

• Should be billed only for times when member is in crisis
  – If a member is no longer in crisis, but still requires room and board until housing can be found, this service should not be billed
Contact Us

If you have any questions about service provision, billing or what would meet criteria for this service you can call Magellan at 800.424.4046.

You can also reach Magellan through our website at:

http://www.magellanofvirginia.com/utility-va/contact-us.aspx
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Questions?
Thank you so much for your time