Clinical Performance Standards:

Crisis Response Center Services for Children and Adults

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Community Behavioral Health
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1. PURPOSE

A Crisis Response Center (CRC) offers a collection of integrated services 24 hours a day, seven days a week to provide immediate, crisis-oriented services designed to ameliorate or resolve precipitating stressful situations. These services are provided to individuals who exhibit an acute problem of disturbed thought, behavior, mood, or social relationships and/or have acute substance use disorder. CRCs provide rapid response, acute assessment, treatment, and referral services to address crisis situations which threaten the well-being of the individual or others.

The Crisis Response Center Clinical Performance Standards describe expectations for quality service delivery for children and adults whose services are funded through Community Behavioral Health (CBH) or Philadelphia County. They are intended as a guide for providers to design and monitor their services and for CBH to evaluate these services. The Standards support resilience through comprehensive assessment, individualized treatment planning, mobilization of supports, and comprehensive discharge planning. These Standards reflect the core values and principles of the City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines. The Standards aim to describe foundational guidelines, promote continuous quality improvement, and best practices, increase consistency in service delivery, and improve outcomes for individuals and their families.

The CRC must operate in a manner that reflects the Philadelphia system emphasis on recovery transformation, resiliency, total population health, and the DBHIDS organizing framework of Trauma, Equity, and Community (TEC)—addressing trauma and the social determinants of health along with the multilayered traumas individuals experience, achieving equity at the individual and community level, and engaging communities through inclusion while tapping into the wisdom of our communities. This holistic approach to treatment supports wellness and symptom-management, addresses the social determinants of health and mental health, and empowers individuals to achieve successful community tenure. The CRC should partner with community organizations to establish relationships that support maintaining wellness in the community and collaboration regarding shared consumers. The Philadelphia system's population health approach assumes that services are provided in a manner which is also consistent with the system transformation of behavioral health services. The DBHIDS **Practice Guidelines for Recovery and Resilience-Oriented Treatment** provide a framework for the system transformation.

CBH and DBHIDS developed these standards in collaboration with providers through a process guided by best practice research, consensus, and state regulation.

2. ADMISSIONS

2.1. Triage–Adults

Adult CRCs are available to members over the age of 18 who are experiencing a mental health or substance use related crisis that is impacting functioning and well-being.

Members should be welcomed by Peer Specialists or other CRC staff upon arrival and triaged by a Mental Health Professional (MHP) or nurse within 30 minutes of arrival. If there is imminent risk of a medical or

mental health emergency that requires acute intervention, then a medical professional must immediately assess the member, determine what services are needed, and assure their provision. Triage staff will explain Health Insurance Portability and Accountability Act (HIPAA) and have the client sign the consent form prior to entering the CRC unit. Clinical and Medical interactions are recorded in the client's health record along with progress notes every two hours and as needed.

Resolution-focused treatment begins immediately upon entry to the CRC with meaningful, supportive, and relieving care provided at every point of contact. A formal assessment appropriate for the member's needs/presenting problems must be initiated within 2 hours of arrival and completed within 4 hours of arrival or less.

If a member needs to be transferred to another CRC for treatment, the referring CRC must communicate with the accepting CRC, complete a warm hand off and arrange for transportation. No one may be turned away from a CRC regardless of type or degree of need, challenges, or insurance status. Exceptions may occur regarding involuntary presentations if the CRC is on divert status. The CRC would then follow the divert protocol with the Philadelphia Crisis Line (PCL).

2.2. Triage–Children

Children's CRCs are available to children and adolescents ages 3 through 17 years who are experiencing a mental health or substance use related crisis that is impacting functioning and well-being at home, preschool/school or in the community.

Triage staff will engage with both the client and the client's caregiver/guardian within 30 minutes of arrival to the facility. If there are existing clinical relationships that predate the child's access of crisis services, triage staff are expected to engage the appropriate clinicians or therapists as soon as possible to facilitate integrated treatment and lessen the impact of residual trauma. Triage staff will be expected to work with providers of other levels of care and CBH to ensure that the services provided are appropriate and timely. Triage staff must also work with the child's family and/or child welfare staff. Triage staff will explain HIPAA and have the client sign the consent form prior to entering the CRC unit. For children under 14 years old, parents and guardians will complete all paperwork.

The CRC should engage and collaborate with the young person and family in a meaningful, comprehensive assessment of what is occurring and develop a course of treatment aimed at ameliorating the risk/intensity of crisis. The CRC should offer information and support to the parent/guardian and develop a clear, collaborative plan for next steps. The family must be included in all decisions concerning possible next steps for the young person. The Philadelphia Department of Human Services (DHS) and its Community Umbrella Agencies (CUA) must be involved for young people who are receiving child welfare services.

If a member needs to be transferred to another CRC for treatment, the referring CRC must communicate with the accepting CRC, complete a warm hand off and arrange for transportation. No one may be turned away from a CRC regardless of type or degree of need, challenges, or insurance status. Exceptions may occur regarding involuntary presentations if the CRC is on divert status. The CRC would then follow the divert protocol with the Philadelphia Crisis Line (PCL).

2.3. Formal Assessment

2.3.1. Adults

Members should receive a complete psychiatric assessment and/or substance use assessment which utilizes the American Society of Addition Medicine (ASAM) criteria. Assessment must include all elements as required by regulatory bodies, the CBH provider manual, and the Network Inclusion Criteria (NIC) tool.

The assessment should be completed and used to facilitate recommendations for the next level of care. Assessors should be aware that members may not understand treatment terminology and may require education related to treatment process and recommended interventions. The assessment should include presenting complaint, current symptoms, complete medical and psychiatric history, medication list, detailed alcohol and substance use history (including recent and past use, assessment of current withdrawal risk, and history of any prior episodes of withdrawal), assessment for risk of harm to self and others, family history, and social history. A full and complete mental status exam should be documented. The assessment should include a physical exam when possible. At minimum, the assessor should confirm the member's access to physical health care or provide an appropriate referral. Relevant lab work and vital signs should be documented. Collaboration with existing providers and/or supports is expected. The inability to immediately complete all aspects of the comprehensive assessment should not necessarily delay or preclude medically appropriate treatment.

Collateral information from social supports or other treatment providers (with a signed release of information) should be obtained when possible. Assessment should also include determination of a member's goals and readiness for change, as well as identification of social and environmental factors that may facilitate or impede treatment. CBH expects that assessment will include integration of information from the PA prescription drug monitoring program (PDMP) which should be queried by the prescriber, or their appointed delegate, as per state guidelines.

If the person is not able to participate in the psychiatric or substance use (ASAM) evaluation(s) for physical or behavioral health reasons, the reason for the delay and a plan for administering the appropriate instruments should be documented. A plan and arrangements for any subsequent treatment should be completed no later than the fifth hour. This may include a collaborative decision to use a 23-hour bed to provide a period of supported stabilization that includes additional resolution-focused interventions as indicated. Depending on the result of the assessment for substance use disorders and/or psychiatric evaluation, the person may then be able to leave the facility. The CRC can then contact CBH or other insurers if a prior authorization for another level of care is indicated.

It is expected that during this process, staff, including but not limited to peer specialists, will be available to aid, comfort and advocate for both the person seeking services and their family members. There must be a well-developed plan for linkage to other services and staff who are capable and experienced in developing and maintaining strong linkages to community services, including community treatment centers, recovery centers, inpatient facilities, and other levels of care. The CRC presentation should be limited to between 6 to 10 hours from the client's arrival at the CRC to the time of discharge.

2.3.2. Children

The CRC will provide psychiatric and/or substance use (ASAM) assessments for children and adolescents. Although assessment is an essential component of the CRC evaluation, CRC staff must assist the child and family in obtaining crisis relief before initiating the assessment process. To be successful, the CRC must create an experience of safety and comfort offered by trustworthy staff.

When the child is sufficiently able to participate in the assessment, it should include information provided by the family and/or child welfare personnel who know the child and family as well as family assessments/interventions when indicated. If the child has come from a school, the assessment should include school-related information. The ongoing assessment and response to interventions deployed while in the crisis center are to be used as the basis for decisions concerning next steps for the child.

It is expected that during this process, staff, including but not limited to peer specialists, will be available to aid, comfort and advocate for both the person seeking services and their family members. There must be a well-developed plan for linkage to other services and staff who are capable and experienced in developing and maintaining strong linkages to community services, including community-based services such as Intensive Behavioral Health Services (IBHS), partial hospitalization services, Family-based services, and/or other relevant services. The CRC presentation should be limited to between 6 to 10 hours from the client's arrival at the CRC to the time of discharge.

2.3.3. Children with Special Needs

The CRC will be used by children and adolescents with a variety of special needs. The physical space, triage, assessment, and treatment procedures must be flexible in design to effectively treat young people with the following special needs:

- Children who are younger than five years
- Children and adolescents who have ASD, including children who do not vocalize
- Children with intellectual disabilities
- Children who are deaf or hard of hearing
- Children with concurrent serious medical issues
- Children and /or families who are not fluent in English and families and children with varying cultural contexts

2.4. Monitoring of Standard

Adherence to the NIC will be assessed during initial and recredentialing audits performed by Network Improvement and Accountability Collaborative (NIAC). The results of these audits may serve to inform Performance Improvement Plans (PIPs) requested of providers. CBH clinical, quality, and compliance departments will occasionally review assessments as part of various ongoing monitoring and/or oversight activities.

Quarterly wait time data will be assessed by CBH's Quality Management Performance Evaluation Unit for the Philadelphia Children's Crisis Response Center (PCCRC). If the provider does not meet the specified quarterly wait times requirements, a Plan, Do, Study, Act (PDSA) rapid improvement cycle or Root Cause Analysis (RCA) may be performed. A multidisciplinary provider meeting would occur bi-monthly to discuss the program and the standing of its current operations. Median time from CRC arrival to CRC departure for admitted CRC patients should be no more than six hours.

3. APPROPRIATE FOLLOW-UP CARE: ENGAGEMENT/OUTREACH

3.1. Outreach – Adult

In alignment with DBHIDS Network Inclusion Criteria Standards for Excellence Domain One which highlights Assertive Outreach and Initial Engagement, outreach efforts must include the CRC ensuring that the surrounding community is aware of the services they provide. It should also include establishing partnerships and learning exchanges with first responders and other external entities, e.g., local police departments, paramedics, school districts, healthcare providers, etc. This will create a community where individuals can be linked to care and gain access to an appropriate intervention at the earliest point possible. The establishment of Memoranda of Understanding is critical in maintaining such relationships with community supports.

Providers must also incorporate Domain Three of the NIC, which highlights Continuing Support and Early Re-Intervention practices ensuring appropriate follow-up care upon discharge. Of particular importance is facilitating adequate referrals and outreach to resources that enhance an individual's recovery capital. Established partnerships with external providers will enhance after-care efforts.

The CRC will aspire to facilitate warm transfer of patients brought in by Philadelphia police Department. The process will operate from the guiding principle of "no wrong door approach" and collaboration will include:

- Identification of a dedicated police drop off area
- Establishment of a drop off time frame to avoid extended wait periods
- Establishment of a distinct process for warm handoff that includes the exchange of demographic and clinical information as well as safety guidance.
- Communication of issues related to acuity, agitation, intoxication, medical needs

3.2. Outreach – Children and Family

It is critical to work productively with families whose children are using CRC services. CRC staff must spend time to understand the family viewpoint on the crisis, hear their beliefs about the precipitating events and provide treatment (inclusive of brief family treatment) and recommendations that they believe will contribute

to the resolution of the problem. Parent advocates should have a major role in working with families to provide advice, and help the family understand and select behavioral health resources for the young person. The overall goal is for both the family and the clinical team to agree on the choice of treatment for the child.

In addition, the experience of parenting a child with significant mental health conditions—including conditions that threaten health and safety—is generally overwhelming. It is expected that parents will have their own (normal, but in varying ways, functionally impactful) stress responses: exhaustion, fear, grief, anger, loss of control, guilt. As staff provides support to parents through these crisis states, they are better able to participate in their child's treatment, make treatment decisions, and support their child.

3.3. Outreach – Other Child Serving Systems

The success of the CRC will depend on the strength of its relationships with other child serving systems and agencies. CRC staff must maintain a positive rapport with Mobile Emergency Services staff and collaborate with them on essential information such as details on the precipitating crisis and further information on the referral source for Mobile Services.

The CRC must also have relationships with the Philadelphia Department of Human Services (Phila. DHS) including its Juvenile Justice Division and the CUAs that provide services to children and families. It will be essential to help these agencies understand their responsibilities for children using the CRC which include helping locate parents as needed, providing critical background information on the child, and assuring that the child can return to the community once stable.

It will also be essential to develop relationships with school personnel including school staff who are charged with dealing with children's crises in schools and schools which appear to have significant numbers of children sent to the CRC. In addition, the CRC must develop strong relationships with the Police Department, Family Court, and pediatric primary care providers.

Outreach should be made directly to child welfare, juvenile justice, and school districts to address matters beyond CBH authorized treatment services.

3.4. Monitoring of Standard

Standard Adherence to the NIC will be assessed during recredentialing audits performed by the Network Improvement and Accountability Collaborative (NIAC). The results of these audits may serve to inform Performance Improvement Plans (PIP).

4. LABORATORY TESTING

CRCs must be able to provide basic health screening and laboratory testing. In addition, a protocol to obtain appropriate urine or oral drug testing to assess recovery progress must be established. This protocol must ensure that there is a documented rationale for the frequency and content of such testing, as well as documented review of these results by the treatment team and incorporation of results into treatment planning.

4.1. Monitoring of Standard

CBH Compliance and Quality Management periodically monitor for appropriate utilization of laboratory testing via clinical chart audits.

5. RECOVERY/TREATMENT PLANNING

5.1. Adults

Treatment in the CRC must be guided by a co-constructed plan that adheres to the NIC Standards for Excellence Domain 2, Standard C: Advancing Excellence in Resilience/Recovery Planning and the Delivery of Services. The plan for treatment should be completed collaboratively with both the individual and treatment team.

The plan for treatment should include a clearly stated plan for the next recommended level of care, as well as other recommended interventions (medications, laboratory studies, additional monitoring such as vitals or level of observation, plans related to collaborating with family/supports/other providers, plans related to referral and/or transfer, transportation, linkages to needed resources for social determinants of health, etc.).

These plans for treatment must also adhere to the requirements detailed in the Department of Drug and Alcohol Programs (DDAP) licensing requirements.

Providers must ensure that all the member's mental, physical, and substance use challenges are considered in the development of the plans for treatment; all active challenges should be addressed by a proposed intervention or a referral to an appropriate provider.

5.2. Children and Adolescents

The CRC is expected to provide intensive treatment as well as assessment and referral services. The goal of CRC treatment is to resolve the crisis sufficiently, so the child is stable to return home with appropriate services. Treatment should focus on helping the child and family consider methods to avoid a recurrence of the crisis. Treatment is to include mental health services that go beyond medication and that are strengths-based, engaging, empowering and change activating. This should include methods that bring psychological relief, new information and understanding, and promote problem-solving. Treatment should be compassionate and directed by the needs and preferences of the young person in crisis and their family. It is expected that the CRC will work with families to provide treatment and support that will help them feel able to return home with their child.

The CRC staff will be expected to provide mental health treatment and obtain medical services and consultation as needed.

Some children who access the CRC may require treatment at an acute inpatient facility. If it is determined that the crisis cannot be resolved sufficiently for the child to return home despite full use of the acute care continuum of services provided, the CRC is expected to work with CBH to obtain a bed in an appropriate

facility. The CRC must provide the results of their assessments to the receiving facility. The parent advocate will be expected to work with the family to understand their viewpoint and concerns and ensure that these concerns are voiced and understood by the clinical team.

5.3. Monitoring of Standard

Adherence to NIC standards related to treatment planning will be assessed during recredentialing audits performed by NIAC. The results of these audits may serve to inform PIPs. NIAC findings related to treatment plans (as well as any related citations found in Office of Mental Health and Substance Abuse Services or DDAP audits) will be referred to CBH Compliance for potential assessment via probe audit or CBH Quality Management to assess for opportunities for provider quality improvement interventions.

6. CLINICAL SERVICES

Providers are responsible for the following desired treatment outcomes for Crisis Responses Centers:

- Least Restrictive Services as evidenced by average length of stay. Average length of stay (time from presentation at CRC to discharge) should not exceed 6 – 10 hours
  - Time from presentation to initiation of triage shall be no more than 30 minutes
  - Referrals shall be made to the least restrictive level of care appropriate to the consumer's presenting problem
- Consumer and family-centered services as evidenced by consumer and family satisfaction reporting. Written complaints by consumers or family members are investigated and there is a response to the consumer/family following a complaint within three business days of filing.

Additionally, each CRC should maintain a system for tracking and processing complaints. Office of Mental Health (OMH) Consumer Rights Handbooks shall be available in quantity in each CRC waiting room. The consumer may use the agency procedure or the complaint process in the Consumer Rights Handbook if they wish to file a complaint.

CRCs should have the ability to participate in quarterly (or more frequently as needed) provider meetings with CBH Clinical Care Management and Quality Management Departments.

6.1. Evidence-Based Practices

Whenever possible, treatment should be evidence-based, multimodal, and collaborative between members, their treatment team, and their supports. Motivational interviewing and engagement strategies should be integrated into treatment instead of confrontational approaches and utilized based on the member's readiness to change. Refer to the **DBHIDS Evidence-Based Practice and Innovation Center** for further information.

The Provider must adhere to all internal policies required by CBH surrounding creation and maintenance of evidence-based treatment linkage policy.

6.2. Monitoring of Standard

CBH Compliance and Quality Management will periodically monitor clinical services through routine incident analysis and reporting. CBH Complaints and Grievances department will review and address member grievances in real-time as they occur.

6.3. Medication Management

Medication for substance use or mental health challenges must follow all regulatory guidelines and adhere to the **NIC Standards for Excellence** Standard D: Ensuring Safe and Effective Medication Practices. Prescribers should utilize the Pennsylvania Prescription Drug Monitoring Program (PDMP) as per state guidelines.

6.4. Medication-Assisted Treatment (MAT)

Members with substance use disorders that have evidence-based medication approaches, such as opioid use disorder (OUD), alcohol use disorder, and tobacco use disorder, must be educated about these treatment options and a mechanism to either provide such treatment or to provide a referral for such treatment must be established.

For members with OUD, if a provider feels that medication assisted treatment is not appropriate, the rationale for this decision or a contraindication to MAT must be documented. If a member declines MAT or prefers a "medication-free" treatment, documentation should include the member's refusal, and provide evidence that the member was offered appropriate education on MAT options.

Providers should adhere to all relevant CBH **Clinical Practice Guidelines**, including OUD, AUD, and Tobacco Use Disorder.

7. AFTERCARE PLANNING/DISCHARGE

7.1. Documentation

The aftercare planning process begins during the initial stages of assessment. The process and written plan should follow all CBH/NIAC standards and requirements.

Aftercare planning/discharge documentation should include individualized crisis plans (the prevention and management of potential crises), protective factors including skills and strengths, current information regarding community resources and supports (including case management where applicable), social supports, medical concerns, DSM-5 admission and discharge diagnoses, a comprehensive list of upcoming appointments (to include the date/time of appointment, place, identified staff person, etc.), identification of appropriate housing options as needed, continuing support plans for members transitioning to another level of care and the signatures of the member receiving services.

For members transitioning to another level of care, there should also be continuing support plans that include diagnostic and assessment information, description of the course of services to that point, unique considerations (e.g., language), primary care physicians and other medical providers including consideration and review for recently prescribed medications, and current recovery/resilience plan goals. In addition, a plan for follow-up with members and families, as well as case management services if authorized should be established before they complete treatment.

Assigned clinicians should make the earliest possible member-approved attempts to arrange for family members or other significant persons, including case management, and address housing concerns to be included in discharge planning. Care coordination with all involved in a member's treatment should begin when an individual is admitted to this LOC and continue through the aftercare planning/discharge process. A plan for follow-up with members and their emergency contact is established before they leave services, particularly for members discharging Against Medical/facility Advice (AMA).

CBH expects providers to explore alternative treatment options and supports for the member to ensure continuity of care and a warm handoff when applicable. Planning should include a clear and specific plan for follow-up at the next recommended LOC. Whenever feasible, an appointment should be scheduled, and there should be a warm handoff. There should be a clearly stated plan regarding provision of medications until the member is able to engage with the next provider. Discharge plans should always include a crisis and relapse prevention plan. Unplanned discharges, including Administrative, Against Medical Advice (AMA), and Absent without Leave (AWOL) discharges, have been linked to poorer treatment outcomes. CBH expects providers to strive to reduce these events. Attempts at outreach, engagement, and linkage should be documented in the medical record.

7.2. Linkages/Coordination of Care

As a result of the CRC visit, the person in crisis should receive a maximally relieving and resolving service and be given a summary of an agreed upon plan for next steps. If inpatient hospitalization is appropriate, the CRC will locate the inpatient bed and ascertain the person's insurance coverage. If the person is to be admitted, the family should be involved in this discussion, if appropriate. For persons who are not to be admitted to inpatient treatment, including those going to residential and non-residential services or who will return home, the person and family (if appropriate) will participate in the consideration of other options for treatment and support which are not limited to formal treatment and inclusive of peer support, social services, entitlement services and other health care services. Individuals should be transferred to or linked directly with the referral provider or be provided with a referral to the appropriate level of care at the very least. CRC staff are to provide the assistance needed to facilitate follow-up to that level of care. The CRC is also expected to utilize 23-hour beds for persons who need short-term monitoring and acute treatment.

The following are the minimum expectations and requirements that the CRC needs to follow when linking members to the next level of care:

- There must be a well-developed plan to facilitate linkage to other services, such as community treatment centers, recovery centers, inpatient facilities, and other levels of care.
- Members should be moved to the next level of care within 6 hours.

- Support staff, particularly Certified Recovery Specialists or Peer Specialists, must be involved to develop a plan to initiate and maintain client engagement until discharge.
- Members who are being referred to outpatient services must be linked to follow-up treatment to occur within 7 days of discharge.

Additionally, outpatient linkage agreements will be reviewed annually to ensure that they:

- Specify how linkage information will be shared
- Include a process that enables the CRC to give consumers an appointment date and time before they leave the CRC
- Include a process through which the CRC is informed by the receiving agency as to whether an appointment was kept

7.3. Referrals

- For members being discharged with a plan for community-based follow-up, timely access to treatment is necessary. Follow-up appointments should occur within seven calendar days of their initial visit to the CRC.
- If the Member requests an appointment outside of this timeframe, the CRC must document this information in the Clinical Record.
- Clients who are discharged against medical advice should also be given information on how to obtain outpatient services.
- If the Outpatient Provider cannot accommodate the clinical treatment needs of the member or the appointment time frame, the CRC should immediately contact CBH Member Services for possible referral sources to another Provider.
- The Member should be given information on how to contact CBH for assistance and information.
- The Member may also contact CBH to request additional referral information independently.

7.4. Monitoring of Standard

Successful discharge will be measured by 7- and 30-day admission/readmission rates.

8. STAFFING

Treatment services must be culturally appropriate and available in several languages. Although translation services may be used, it is essential to have staff on site to meet the language needs of the most predominant non-English languages spoken by those who are likely use the CRC.

In addition to the personnel listed in proposed 55 Pa. Code §§ 5240.31, the CRC is required to employ staff who will assure that the program meets the intent of the Philadelphia system transformation. These staff should include peer and family peer specialists who will offer services, support and advocacy to persons using the CRC and to their families, addiction specialists and other specialized staff needed to offer a full continuum of crisis services.

8.1. Staffing Requirements

8.1.1. Adults

It is critical that providers employ strategic hiring procedures to identify highly qualified candidates who can support the mission of long-term recovery for our members. Given the diversity in racial and socioeconomic background of CBH members, hiring strategies must aim to form a treatment team whose diversity reflects that of the member population served. In addition, providers must have:

- A Mental Health Professional
- A Board Certified or eligible Psychiatrist available 24 hours a day
- A psychiatrist who is no less than a PG2 Resident on site 24 hours a day
- A Physician's Assistant or Registered Nurse on site 24 hours a day
- A Program Director who must possess, at minimum, a master's degree from an accredited program in one of the social sciences, nursing, pastoral counseling, education or other related field, have at least 2 years' experience in both mental health and addictions, and have supervisory experience
- A staff member qualified as an ASAM Assessor on-site 24 hours a day, additional certification in the drug and alcohol field is preferred
- Staff with a working knowledge of CBH mental health assessment procedures and Medical Necessity Criteria on-site 24 hours a day
- Other staff must possess a bachelor's degree in one of the same fields and a minimum of 1-year direct care experience in mental health or addictions, or a supervised practicum or high school diploma and 12 college credits in the social sciences plus 2 years' experience in mental health or addictions

The CRC must report staff vacancies or changes in position within 2 weeks of occurrence.

The CRC must have medical staff on-site or available on demand and a strong link to associated medical facilities for members with medical conditions requiring immediate treatment. Medical services are to be used for triage, evaluation, and emergency treatment. These staff may be a physician whose specialty is in physical health care or other medical professionals such as Physician Assistants or Certified Nurse Practitioners. Physical health care assessments are to be linked to behavioral health assessments and treatment and must be documented.

It is expected that a significant number of members who use the CRC will have addiction disorders. The CRC must develop and implement plans to provide appropriate, high-quality services to persons with addiction issues. To best meet the needs of persons with addiction issues, the treatment team at the CRC should include peer specialist staff and addiction specialists. There should also be designated staff who are responsible for referrals and follow-up of individuals and their families' receiving services from the CRC. Provisions should be made to include staff who will work directly with families and ensure their inclusion in decisions concerning treatment and next steps for the person in crisis.

8.1.2. Children/Adolescents

There must be at least one child psychiatrist (board eligible with a plan for board certification or board certified) onsite or available on an on-call basis at all times, both for consultation with on-site staff and with CBH. The CRC must provide a protocol for floating staff who can be at the CRC on short notice when the on-site staff are fully committed to providing services.

In addition to these staff, the CRC must employ parent peer advocates to work with and support families throughout the triage function and all other CRC services. The parent peer specialists will be essential in supporting the experience of parents, guardians, etc. whose children are in crisis, ensuring that the family is included, and their expertise sought in assessment, treatment and planning, in explaining the CRC process, answering questions and describing community services, access, and other system-orienting information.

Because the CRC is required to provide services to children as young as 3 years as well as older children and adults, there must be staff on-site with expertise in working with young children. In lieu of having a child psychiatrist with experience with young children on-site at all times, the CRC may use psychologists with expertise in early childhood development to provide treatment services/parenting advice and assessments for young children.

The staffing pattern for the CRC should be as follows:

- Crisis Response Medical Director, who is Board-Certified Child/Adolescent Psychiatrist
- Clinical Director (non-medical) with previous experience (Minimum 2 years) in emergency medicine management
- Child/Adolescent Psychiatrist
- Crisis Response Assistant Director
- Full Time Registered Nurse
- Mental Health Professionals, with credentials aligned with proposed 55 Pa. Code 5240
- Certified Family Support Specialists
- Bilingual staff/capacity to meet the language needs of the population served
- Security

- Floating Staff

All staff should have up to date child abuse clearances.

8.2. Hours of Operation

Both Adult and Children's CRCs should specify expected staffing patterns on a 24-hour basis. Because CRCs normally have the highest volume of members seeking assistance between mid-afternoon and midnight, deployment patterns of staff should reflect the expected times of high-volume use of the facility.

It is critical for applicants to develop a physical site/space that will feel welcoming and safe to persons in crisis and their families. It is also important to ensure enough privacy within the facility for people who may be concerned about sharing information in front of others and whose level of stress will increase with noise and distractions.

8.3. Staff Training

All staff should be educated regarding the importance of medication consistency in stabilizing individuals in crisis and preventing future crises. It is also important to communicate with existing treatment providers about medication lapses; to identify community practices that seem to be impacting a pattern of lapses and consult with those agencies all in the spirit of improving care experience and to prevent avoidable practices. All staff should also be educated on the benefits of medication-assisted treatment (MAT) for individuals with substance use challenges to reduce stigma and to ensure appropriate psychoeducation on the benefits of MAT.

Effective services require that all trainings and materials used be prepared and conducted in a manner culturally appropriate to the staff being trained and should include issues of cultural diversity among the population being served.

Within 90 days of employment, all staff must receive the following training:

- Administrating Narcan
- Trauma-informed care

The CRC must provide staff training annually in each of the following and be retrained annually in areas of greatest need, based on skill level and discipline.

- Crisis management (including seclusion and restraints)
- Procedures for medical emergencies
- CPR
- Substance abuse issues
- Commitment process

- Pharmacology and alternative treatments
- Identification and reporting of significant incidents
- Responding to complaints and grievances
- Fire safety
- Community resources
- Infection Control

8.4. Monitoring of the Standard

The CRC must make available upon request a record of the following:

- Course offered
- Length of course
- Date of course offered
- Staff attendance

8.5. Documentation

Documentation is required for all events related to the person seeking services. This includes assessments and evaluations, medical reports, medication and prescriptions, internal and external consultations, continuous observations and notations, contacts with external sources, linkages, safety measures and treatment modalities. The CRC must have procedures to ensure comprehensive and timely documentation takes place in the CRC. The CRC must have a plan for periodic review of documentation procedures and an internal review process to assure adherence to protocols.

The CRC must include 23-hour beds which are contiguous to the CRC. Other levels of care should utilize other CBH performance standards as available.

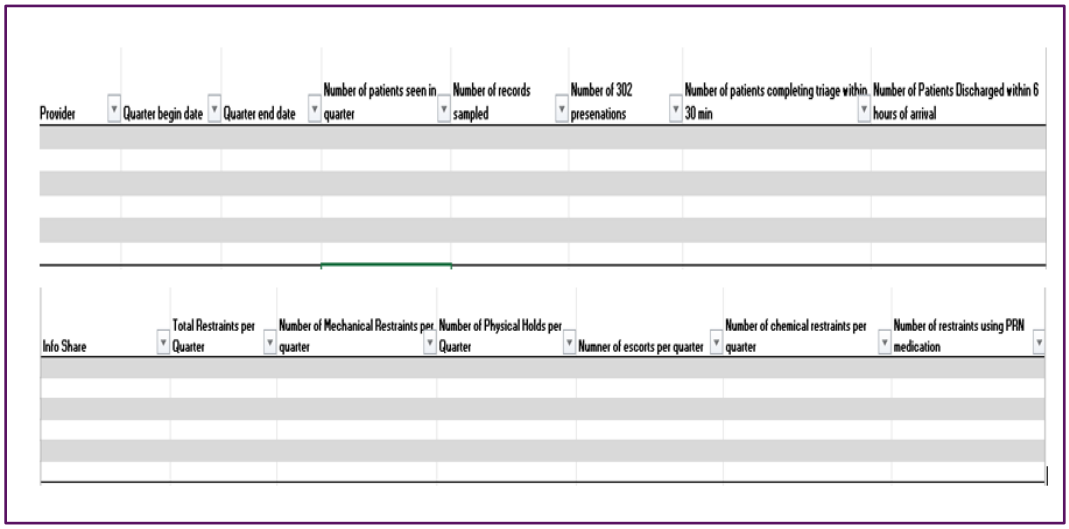
9. OUTCOME MEASURES

Measure	*Description*	*Numerator*	*Denominator*	*Data Source*
Triage/Assessment Wait Time: Median Time from CRC Arrival to CRC Departure for Admitted CRC Patients	% length of time from CRC Arrival to CRC Departure for Admitted CRC patients (expectation for discharge is within 6 - 10 hours of arrival)	Total number of members discharged within 6 hours	Total number of members admitted into CRC during the measurement period	Provider reported
Appropriate Follow-up to Care	% of CRC visits with a second non-CRC service within 7 days of the CRC visit	Total CRC visits with a second non-CRC service within 7 days of the CRC visit	Total CRC visits in the measurement period	CBH claims
Appropriate Follow-up to Care	% of CRC visits with a second non-CRC service within 30 days of the CRC visit	Total CRC visits with a second non-CRC service within 30 days of the CRC visit	Total CRC visits in the measurement period	CBH claims
Coordination of care/ Information sharing	% of CRC evaluations that made use of information sharing with Community Behavioral Health	Number of CRC evaluations that made use of information sharing with Community Behavioral Health	Total number of CRC evaluations completed in the measurement period	Provider reported
Triage/Assessment Wait Time: Door to Triage (Nursing Assessment)	% of nursing assessments initiated within 15 minutes of the completion of triage	Number of assessments initiated within 15 minutes of the completion of triage	Total number of individuals seen within the measurement period	Provider reported

All metrics associated with these Performance Standards may be shared publicly.

10. APPENDICES

10.1. Adult Data Reporting Template



Provider	Quarter begin date	Quarter end date	Number of patients seen in quarter	Number of records sampled	Number of 302 presenations	Number of patients completing triage within 30 min	Number of Patients Discharged within 6 hours of arrival

Info Share	Total Restraints per Quarter	Number of Mechanical Restraints per quarter	Number of Physical Holds per Quarter	Numner of escorts per quarter	Number of chemical restraints per quarter	Number of restraints using PRN medication

10.2. PCCRC Data Reporting Template

Provider Name	Belmont/ PCCRC
Reporting Period	
Due Date of Report	

	Quantifiable Measures	Numerator	Denominator	Percentage	Frequency of Reporting	Notes
Children's Crisis Response Center (CRC)	% of patients who initiated triage*** within 30 minutes of				Quarterly	
	% of patients who were discharged within 6 hours of arrival				Quarterly	
	% of patients who were discharged > 6 hours, but < 24 hours of arrival				Quarterly	
	% of patients who were discharged >=24 hours				Quarterly	
	% of partial pre-certifications completed within 24 hrs				Quarterly	
	% of nursing assessments initiated within 15 minutes of the completion of triage***				Quarterly	
	% of CRC evaluations that made use of information sharing with Community Behavioral Health				Quarterly	
	Instances of "divert" status				Quarterly	
	% of patients who were restrained during their stay at the facility***				Quarterly	
Restraints	**Quantifiable Measures**				**Frequency of Reporting**	
	a. Total number of restraints					
	b. Duration of restraint				Quarterly	
	c. Types of restraints				Quarterly	
	i. Chemical				Quarterly	
	ii. Escorted				Quarterly	
	iii. Physical Holds				Quarterly	
	iv. Mechanical				Quarterly	
Crisis Stabilization Unit						
Crisis Stabilization Unit	% of patients seen by a psychiatrist within 24 hours of arrival to the Crisis Stabilization Unit				Quarterly	