PROGRAM PLAN

Section 2 A 1-6, 10-11, 21-23

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A. PROGRAM OVERVIEW

Agency Mission

Houses of Hope (Fiscal Agent) provides affordable residential treatment and support services for individuals in recovery from substance dependence.

Program Philosophy

The TASC program is a collaboration between Houses of Hope, Lutheran Family Services, Blue Valley Behavioral Health and The Bridge Behavioral Health. TASC is made up of several levels of care that are intended to support and enhance emergency services currently available in the Region V service area and provides assistance to help consumers achieve and maintain a higher quality of life.

The TASC program is based upon Recovery Focused Practices such as those highlighted by the Substance Abuse and Mental Health Services Administration (SAMHSA) that define Recovery as A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Services are provided by TASC staff through individualized goals that address and support a client's health, home, purpose and community. Services are targeted to help adult behavioral health consumers function more effectively in their everyday lives. This involves working with each individual and his/her support system to develop service goals that aide in improving overall quality of life.

Services are designed and implemented to support the recovery, health or well-being of the person or families served, to enhance the quality of life of the person served, reduce symptoms or needs and build resilience, restore and or improve functioning and support the integration of person served into the community.

Program Description

The TASC Program is designed to enhance the Emergency Behavioral Health System within Region V by providing timely and efficient consumer focused services. The Crisis Response teams are designed to divert emergency protective custody (EPC) placements keeping consumers in their home communities. Likewise the case

management services provided by the TASC Program are designed to keep clients in their home communities through the education and support of client focused activities that promote autonomy, community integration and effective utilization of community resources to aid the client in this goal.

Clients receive case management and crisis intervention services from trained personnel and other qualified linkages and service providers who assist with the smooth transition in the community. Personnel are knowledgeable regarding case management and resources needed for linkages to substance abuse, mental health and psychiatric services, and assistance with housing, basic needs and team building for consumers. The services are staffed 24 hours a day through a combination of traditional office hours and on-call personnel.

The levels of care include: Crisis Response Teams (CRT), *Emergency Community Support (ERCS), Intensive Community Services (ICS), and Recovery Support (RS)*

The program covers clients that reside in Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer and York Counties.

Transition Criteria

Clients will return to or exceed pre-crisis functioning and will follow length of stay guidelines as established by their assigned programs and state service definitions and may step up or down internally, be transitioned to external programs or discharged from services. Staff will utilize extension requests when applicable and as defined by service definitions i.e. ERCS every 90 days and ICS/RS annually.

Goals:

- Enhance the quality of life
- Reduce symptoms
- Restore and/or improve functioning
- Support community integration and independence
- Reduced EPCs
- Reduced Mental Health Board Commitments
- Reduced post-commitment days
- Reduced average length of stay in crisis centers
- Reduced recidivism in emergency system

Scope of Services:

1. Population Served:
    - Adults age 19 and older or minors with age waivers regardless of sex, race, sexual orientation or physical or cognitive disabilities.
    - Clients may present with substance use disorders, mental health disorders, co-occurring disorders and personality disorders.
    - Special populations to include limited/non English speaking, homeless and Mental Health Board Commitments.

2. Settings: Clients home environment, office, community based services

3. Hours of operation: By appointment **only.** Business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

4. Days of Services**:** Provided 24 hours a day, 7 days a week, 365 days a year. Case managers each participate in an on-call rotation to manage crisis needs that occur after normal business hours.

5. Frequency of Services: Individualized by client and level of care

6. Payers and funding sources**:** The TASC Program is supported by funding provided to Region V through Nebraska's Behavioral Health reform.

7. Fees**:** The TASC Program is a non-fee for service and does not charge clients for the services provided.

8. Referral Sources**:** Emergency Behavioral Health Providers to include Hospitals, Crisis Center, Regional Center as well as Law Enforcement, Crisis Response Teams and Region V or Program Director approval.

9. Services Provided: Crisis Response and Case Management both provided directly by referral only.

B. CLIENT RIGHTS

Rights and responsibilities are reviewed and acknowledged by initials and the consumer's signature as part of the intake process. If still receiving services, they are reviewed and acknowledged annually by the consumer.

Clients have the right to: receive services regardless of race, color, religion, age, gender, sexual orientation, disability, national origin or financial status, the right to receive caring and safe services free from physical, sexual, and psychological abuse, the right to expect to be treated respectfully, impartially, and fairly and will be addressed by name in a dignified conversational form, the right to refuse service and leave the program, the right to access your clinical records unless it is clinically contraindicated, the right to communicate freely with family, friends, legal counsel, private physician, and have clinical records made available to these individuals with written request, the right to make all decisions on your own behalf (unless someone else has been legally authorized to do so)., the right to have all records pertaining to your case treated with confidentiality (no information will be released to anyone without your authorization, excluding mandates by law)., the right to be involved in your treatment and to make decisions regarding your Service Plan., the right to express dissatisfaction with the program and to file grievances according to the grievance policy outlined in the Orientation Manual, and the right to be informed of the grievance policies and procedures of the TASC Program

Clients have the responsibility to: contribute to the planning of your services, to report any changes that are pertinent to your treatment and services (i.e. changes in address, medications, physicians, or other services)., to be committed to this program, your team, and improving your quality of life, to report any infringement of your rights to staff members immediately, to follow the grievance procedure in making any complaint and of reporting to the executive director any actions taken against you by staff because of that complaint, to be considerate of the rights of TASC staff and to treat them with respect and to refrain from discriminating against staff or team members and for not using language or behavior in a manner that would imply prejudice or discrimination.

Client rights and responsibilities may be limited based on signed releases of information, duty to report obligations such as threat to self or others or mandatory reporting for child abuse and Mental Health Board commitment orders.

C. CLIENT AND FAMILY INVOLVEMENT AND ORIENTATION

All clients will complete an orientation that reviews:

a. The persons presenting condition
b. The type of services provided by the assigned program i.e. ERCS, ICS, RS,
c. A review of agency/program policies to include client rights/responsibilities
d. A description of the service process including goal identification and development, program expectations i.e. if a Mental Health Board order is in place or a guardian is assigned and if applicable any limitations of the service level of care.

As appropriate and with consent or legal right, family members of clients are encouraged to participate in educational and clinical programs to promote wellness and community integration of the individual consumer.

D. ADMISSION CRITERIA AND PROCESS

1. Crisis Response Team assistance may be requested by law enforcement within the Region V Service Area 24 hours a day, 365 days a year for any Adult or Youth in which mental health or substance abuse is a factor in the presenting issue that places an individual is at risk of an emergency protective custody placement or an Officer identifies that person does not meet EPC criteria but needs assistance or an officer is uncertain of the problem and requests a consultation

2. Case management referrals must meet established admission criteria as defined by service definition for each level of care and fall within the TASC scope of services or be authorized by waiver by a Region V representative or Program Director as in need of services and reside in the service area.

   Clients that do not meet admission criteria and do not present a risk of reentering the emergency behavioral health system do not qualify to receive services. When a client is found ineligible for services the person and/or the

referral sources is informed as to the reasons, and when appropriate recommendations are made for alternative services.

E. Assessment

Crisis Response Teams have three primary roles, Assessment, Referral/coordination and Consultation.

Assessment: This will occur when a counselor is called to assist law enforcement in determining appropriate and available resources as an alternate to EPC. The assessment will identify the presenting problem and contain a mental health triage that screens for dangerousness, support system availability and ability to cooperate with recommendations. This mental health triage will help in identifying alternatives to Emergency Protective Custody (EPC).

Referral/Coordination: This will involve a referral to the Emergency Community Support Worker and other local services as needed.

Consultation: This service will be available to law enforcement and county jails that are requesting consultation on clients that are at risk of EPC but does not involve direct contact with the client.

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Case Management

The TASC Program staff is trained to complete a non-clinical assessment that assesses specific strengths, needs, abilities and preferences of the person served and identify resources to meet those needs. This assessment will be completed within the first 30 days of admission (14 days for ERCS).

The assessment process includes an interview with the client, review of records and collateral contacts as appropriate. The assessment will also be used to identify additional referral needs to assist in meeting client goals. This may include medication management, mental health and substance abuse counseling, financial assistance, housing assistance, legal, etc.

Reassessment

The TASC Program staff will complete an annual reassessment on applicable clients within 30 days of and up to the anniversary of the original admission date. The reassessment will be strength based.

F. Individual Service Planning/Treatment Planning

The TASC Program staff will utilize Electronic Medical Records (EMR) to keep records of services provided.

Crisis Relapse Prevention Plans

These are developed during the initial contacts to start building a foundation for the management of crisis situations. They identify client demographics, warning signs and coping skills, supports and their emergency plan. This plan is reviewed/ updated every 30 days or following a crisis.

Initial Service Plan

A Notice of Initial Service Goals shall be developed that addresses urgent or immediate needs. This document also serves as a notification of goals for clients on Mental Health Board Commitments.

Treatment Plus

This document is completed following the completion of the individual assessment.. It will be developed with active participation of the person served and with involvement of family/legal guardian of the person served when applicable or permitted. The plan shall incorporate the unique strengths, needs, abilities and preferences of the person served. The plan shall document the identified strength/issue, the goal, the objective and the intervention. This is a living document and shall be reviewed as needed but at a minimum monthly for ERCS and every 90 days for Recovery Support and Intensive Community Services. A copy will be provided to the person served upon request.

A component of service planning is educating clients about peer support, local advocacy groups, self-help groups or other avenues of informal support. Staff will also educate consumers about WRAP (Wellness, Recovery and Action Plans). Person centered goals should address education components, such as symptom awareness, resources availability and utilization as it relates to promoting independence and community integration.

Progress Notes

Unless otherwise noted, each progress note is designed to be an overview of the contact and details and specific interventions will be recorded in treatment plus. Progress notes shall occur for every contact made.

Crisis Logs

Each crisis log shall be completed following a crisis call and shall document the time of the call, the person calling, the person the call pertains to and a summary of the crisis.

G. Discharge Criteria, Discharge Planning, Discharge Summary

The TASC caseworker will begin discharge/transition planning with the client/guardian from the point of intake and assessment. This is a three step process based upon the development of: Transition goals at the time of intake, Discharge preparation and a Formal discharge summary at the time of completion/termination of services.

The discharge process will include the completion of the discharge preparation form, Outcomes, Progress note and written Discharge.

A client may face Four types of unplanned transitions or discharges.

1. A referred client who has directly refused services.
   (i.e. person has asked to have services discontinued or has declined participation in the program)
2. A referred client who has indirectly refused services.
   (i.e. person has lost contact with the program, has not responded to phone calls, face to face attempts or letters)
3. An unanticipated service modification or reduction
   (i.e. funding change or other external factor that impacts the delivery of services)
4. An administrative discharge
   (i.e. program initiated discharge)

For a discharge related to a direct or indirect refusal staff will determine with the person served when possible whether further services are needed and if so will make referrals as appropriate.

When a client is impacted by an unanticipated service modification or reduction steps will be taken to ensure minimal disruption to service goals. If that is unable to be prevented continuing services will be coordinated with other providers to promote continuity of care.

When a client faces an administrative discharge from service such as indirect refusal to work with the case manager, inappropriate or aggressive behavior or other policy violations that place the program or staff at risk, referrals will be made as appropriate to ensure needed services are in place within 72 hours of the discharge. In addition to standard discharge paperwork, Region V will be notified of the discharge.

When a client is transferred from one service to another within the program, staff shall complete a Discharge demos form and re do the treatment plan. All other paperwork will transfer over and a new admission date will be assigned.

Discharge criteria for specific services are noted in attachments 1 to 5.

H. Staff/Organizational Structure

The TASC Program consists of four distinct service levels that each has its own function while at the same time functioning as one complete team. The levels include Crisis Response Teams, Emergency Community Support, Intensive Community Services and Recovery Support. These services are all supervised by the Program Director. The Director is responsible for reviewing the accuracy and referral skills of each staff member, the appropriateness and effectiveness of services for each of the clients served, direct feedback to staff to enhance their skills, review of clinical documentation through regular staffing and case reviews and quarterly file reviews and the oversight of training including cultural competency issues.

The Program Director is overseen by the Advisory Committee which is made of up of the Directors of the collaborating agencies. The Advisory Committee serves as a governing body and is available as needed to address issues of ethics, legal aspects of clinical practice and professional standards and program expansion.

The Program Director screens and assigns referrals to staff. That staff person will then be responsible for developing and implementing the person centered plan, orienting the consumer to services, promoting consumer participation, identifying and addressing gaps in services, educating the consumer on how to access community services, advocating for the consumer, completing mental health board updates as appropriate and notifying legal guardians, probation officers, courts etc. as appropriate, facilitating transitions to other levels of care or discharge and participating in an on-call rotation.

Program staff helps to empower each person served to actively participate to promote recovery and progress towards well-being and community integration. Services are provided that are consistent with the individual needs of each person served through direct interaction with that person or persons identified as appropriate to meet the clients' individual needs. This includes providing services that are culturally and linguistically appropriate to the persons served.

Each staff member will participate in weekly supervision/staffing meetings or more frequently if necessary. Non-Clinical supervision meetings shall include file reviews, case presentations, level of care needs and assessment of professional competencies and clinical skills as it relates to the provision of case management and service coordination.

If staffing/supervision identifies areas of concern with an individual staff that cannot be addressed in a team format a one-to-one meeting shall be scheduled. This may include areas related to attendance, ethics and boundaries, documentation among other areas. These meetings shall be documented in narrative form and placed in the employee file.

Supervision of paid staff, interns, trainees (this includes provisionally licensed staff), volunteers and contract personnel is provided through weekly staff meetings, clinical team meetings and/or individual supervision on a regular basis. Supervision is documented on the weekly staffing note to include clinical issues, assessment of professional competencies, productivity and utilization, effectiveness of services provided, the provision of feedback to enhance skills, and the ethical and legal aspects of clinical practice.

I. Training and Orientation Plan

Since the TASC Program is a collaboration staff will be responsible for two types of training:

1. Agency-specific training
   This is training that is required of the staffs parent agency for accreditation or policy reasons.
2. Program specific training
   This is job-specific training provided by the program. Job-specific training may include program-originated trainings and outside trainings.

Training will be monitored by the Program Director or designated staff. Training will be offered by e-learning and live trainings. Training will reflect the specific needs of the population served, clinical skills appropriate to case management to include individual plan development, interviewing skills and evidenced- based practices as well as specific trainings on behavioral health disorders.

Staff will be trained in the completion of all forms or tools utilized in providing consumer service.

J. Quality Improvement Plan

Clients will complete the Daily Living Activities (DLA-20) outcomes assessment . This tool will be completed at intake every 90 days and at discharge. Clients enrolled in Emergency Community Support will only complete the DLA-20 at intake and at discharge. This data will be compiled and utilized to improve and strengthen the quality of care.

Client files will be reviewed quarterly on a percentage of open and closed files. The review will cover three primary areas: Quality of of Service Delivery, Appropriateness of Services and Patterns of Service Utilization.

A client satisfaction survey on subjective factors (quality of services, symptom reduction, crisis management, autonomy, support system, staff competence) housing, employment, will be given to percentage of active clients on a quarterly

basis.

Efficiency: The average time for clients to be screened and accepted into TASC Program services following referral is approximately 24-48 hours. Once accepted into the program, wait time for initial appointments or contact with staff is minimal. Clients have access to staff through scheduled appointments and phone calls during office hours. Office hours are 8:00 a.m. to 5:00 p.m. weekdays. A member of Program staff is available via cell phone on an on-call rotation after regularly scheduled office hours, holidays and weekend. Service hours are flexible to meet client needs.

Effectiveness: The Program monitors areas that will indicate improved functioning of clients. The Program expects to see: a reduction in number and frequency of client EPC admissions and Regional Center admissions, stability of housing; an elimination or reduction in hospitalizations; fewer referrals to inappropriate levels of care during engagement in the services provided by the TASC Program; an increase in clients levels of independence within the community; increased periods of abstinence and/or reduction of psychiatric symptoms.

K. Emergency Preparedness Plans

The TASC Program strives to maintain a healthy and safe work environment for clients, personnel and guests. Staff receives training upon hire and annually in the following areas: health and safety practices, identification of unsafe environmental factors, emergency procedures, evacuation procedures, identification of critical incidents, reporting of critical incidents, reducing physical risks and vehicle safety. These trainings will be documented in employee e-learning record, staffing minutes and the safety manual.

Each of the following procedures represent practices that meet the requirements of applicable authorities, are appropriate for the locale and address the need for evacuation when appropriate, the safety of evacuees and the accounting of all persons served.

The TASC Program recognizes critical incidents as: communicable disease, Mental Health Board Notification, Biohazardous accidents, damage to property, use or possession of weapons, violations of privacy/confidentiality, EPC/CPC admission, office security breach, abuse and neglect, infection control, death, violence or aggression, vehicular accident, suicide or attempted suicide, verbal abuse/threats, unauthorized use or possession of licit or illicit substances, injury, emergency/911, crime at facility, safety/equipment and other incidents of note.

Personnel are expected to submit reports to document, time, date location and type of incident, persons involved, a detailed description with specifics of location , witnesses, actions taken, notifications made, signature and routing directions. Reports are reviewed by Program Director and then the Parent Agency Director as necessary. Any immediate changes in policies or recommendations for improvement are discussed in staff meetings and subsequent changes passed on to personnel at staff meetings. Debriefings are conducted following emergency situations.

An annual report is prepared by the Program Director. It will summarize causes, identify trends, and identify areas in need of improvement and performance

improvement plans. This analysis and report can provide a significant means to prevent unnecessary recurrence of such events. This report is submitted to the Advisory Committee and used by the Program to make improvements and for identification of education and staff or client training on ways to improve care, safety and outcomes for individuals receiving services from the program.

L. Client Complaint, Grievance and Abuse/Neglect Reporting

To ensure that clients have a mechanism by which formally to voice complaints or grievances.

The TASC Program values, respects and protects the dignity of clients of its services. The Program employs a Grievance Procedure by which a client may confidentially file a grievance or may appeal a decision of the program staff members or decisions of the team *without retaliation*. Further, this policy is explained to the client in a way that is educationally, developmentally, and culturally relevant. If a client is unhappy with a decision that his/her worker or the team has made or the service that they are receiving, the following process is used.

Grievances should be handled on an informal basis if at all possible. Individuals, who are dissatisfied with a TASC Program decision or action should first attempt to work out the issue with the parties directly involved in it. If this is impossible, the client should go to the Program Director. If at this time an agreement cannot be reached, clients should continue with the steps as listed below.

Clients shall have access to advocacy assistance numbers at any time during the grievance process.

1. Written complaints (Step 1) may be filed by the client within seven days following any action which is perceived to have violated the client's rights. Complaints must be submitted to the Program Director.

2. Written Grievances (Step 2) may be filed by the client within seven days of receipt of the written response to the complaint. Grievances must be submitted in writing to the TASC Program Director. The Program Director can assist the consumer in preparing the written grievance.

3. The client may appeal the decision of the Program Director to the TASC Coordinating Committee

4. The Adviosry Committee may at its discretion recommend that the appeal be turned over to the parent agency for review under its grievance process.

M. Physical Environment

The TASC office will ensure that internal and external inspections are conducted for all buildings owned/leased by the program.

See administrative manual for more detail.

External Inspection Procedures: The TASC Program leases office space and does not require any type of occupancy permits to perform day to day operations. As such, the Leasing company is responsible for all external inspections of the heating and air systems, electrical and fire suppression. Should any deficiencies be noted, the property manager will be notified by the Program Director.

Internal Inspection Procedures: The TASC Program conducts quarterly internal inspections of its offices. Inspections will be conducted by personnel knowledgeable of appropriate safety requirements. Internal inspections will assess:

1. *Emergency/Safety (first aid needs; fire exit free from blockage; fire escape sound; fire/evacuation drills documented; fire extinguisher/alarm service up-to-date)*
2. *Break areas (refrigerators/freezers clean; oven/range/microwave clean; food storage area(s) clean/orderly)*
3. *Bathrooms (fixtures clean; faucets not leaking; tub/shower clean; floors clean; walls clean/good repair)*
4. HVAC (filters changed; area surrounding furnace clear; area surrounding AC clear)
5. Offices (walls, doors, windows, carpeting/flooring, vents, trash cans, electrical, furnishings)
6. *File Room* (walls, doors, carpeting/flooring, trash cans, cabinets, shredder, copier, electrical)
7. *Common areas (walls, doors, windows, carpeting/flooring, walking surfaces, appliances, vents, trash cans, electrical, furnishings)*
8. *Entry way and stair way*

Internal inspectors will submit written reports identifying areas inspected, recommendations or areas needing improvement and actions taken to respond to these recommendations. Any deficiencies noted are addressed in a timely fashion.

Any personnel or client who notices a health or safety concern is to contact a member of the TASC team or Program Director immediately to report the issue. A repair log is maintained to document repairs. Any deficiencies noted are addressed in a timely fashion.

N. Medication Administration and/or Provision

The TASC Program does not control, prescribe, dispense or administer medication. If this is a need then the TASC staff will coordinate services with providers trained to perform this service. TASC staff also does not transport any medications unless those medications are in direct possession of the consumer to whom they are prescribed.

O. Infection Control

Training and education regarding the prevention and control of infectious and communicable diseases shall be provided for staff members and building partners. Persons served shall be provided educational information when applicable.

Staff Members

Upon hire, staff members shall receive "*Universal Infection Control Procedures*" to be used when exposed to blood-borne pathogens as well as other infectious/communicable diseases.

Persons Served

Through the screening process, health-related questions are asked of the persons served. If staff members identify a potential health-related issue (infectious or communicable disease), they shall develop, in cooperation with the client, a Safety Plan as part of the clients treatment Plan.

P. Annual Review of the Program Plan

The TASC Program will review its program plan annually and submit revisions to the Coordinating Committee for review and approval.

July 2006
July 2007
July 2008
July 2009
July 2010
July 2011
July 2012
July 2013
July 2014
July 2015
July 2016
July 2017
July 2018
July 2019
July 2020
November 2020
February 2021
March 2021

Attachment 1

Crisis Response Team (CRT) is designed to use natural supports and resources to build upon a consumer's strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance abuse screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization

Services are provided at the request of law enforcement when a crisis situation is occurring with a distraught individual that is suffering from mental illness or is under the influence of substances. .

Frequency of Contacts

This service is provided as a one-time contact

Coverage Areas

The Crisis Response Team covers municipal and county law enforcement agencies in York, Polk, Butler, Seward, Saunders, Richardson, Nemaha, Pawnee, Johnson, Otoe, Jefferson, Thayer, Fillmore, Gage, Saline and Lancaster counties. ***Crisis Response Teams are not available to the Lincoln Police Department.

Staffing Ratios, Capacity and Case Loads

CRT is comprised of on call Licensed Mental Health Practitioners. There are two counselors on call at any given time. They operate on two week rotations and together cover all 16 counties. Caseload and capacity are based upon and equal to the number of calls received.

Admission Guidelines

Law enforcement request for an adult or minor who:

1. Requires further evaluation to determine service needs.
2. Exhibits active behavioral health symptomology
3. Exhibits potential for risk of harm to self or others
4. At risk of being placed in Emergency Protective Custody

Exclusionary Guidelines

1. The only reason for the request for evaluation is transportation.

Service Expectations

1. Telephone or Face to face meeting with consumer and officer as requested as soon as possible and as fast as distance and conditions allow.
2. Perform a crisis assessment including a review of mental illness, substance abuse, dangerousness, basic needs, immediate safety needs, additional risk factors and protective factors
3. Develop a brief individualized plan with consumer and support system.
4. Provide linkage to information and referral including appropriate community-based mental health and/or substance abuse services.
5. Act as a liaison between law enforcement and hospital emergency personal, nursing home staff and community agencies as needed.
6. Arrange for post crisis follow up support as needed with Emergency Community Support workers.
7. Arrange and/or coordinate voluntary hospital or other placements as needed to avoid an Emergency Protective Custody Placement.

Length of Services

CRT is a crisis service and therefore last until the crisis is resolved

Discharge Desired Outcomes

CRT will leave the scene when the crisis is diverted or the consumer is stabilized, a voluntary admission to the hospital or community services has occurred, a referral to Emergency Community Support has been made or an Emergency Protective Custody placement has been implemented.

Attachment 2

Emergency Community Support (ERCS) is designed to assist consumers who can benefit from support due to a behavioral health need and who are either currently residing in a community setting or transitioning from a psychiatric hospital into a community setting. Emergency Community Support services include case management, behavioral health referrals, assistance with daily living skills, and coordination between consumer and/or consumer's support system and behavioral health providers.

*S*ervices are provided for adults who are in crisis to achieve goals of stabilization, increased independence, and community re-integration.

Additionally Services are provided for non-English-speaking or Limited-English Proficient (LEP) persons who need assistance with behavioral health needs, accessing and navigating community-based services.

Frequency of Contacts

This service is provided at a consumer driven frequency of contacts as needed to address the presenting problems.

Coverage Areas

The ERCS workers cover 16 counties to include: Lancaster, York, Polk, Butler, Saunders, Seward, Richardson, Nemaha, Pawnee, Otoe, Johnson, Jefferson, Thayer, Fillmore, Saline and Gage.

Staffing Ratios, Capacity and Case Loads

The ERCS team includes 4 full time staff each with a case load of 15 and a total capacity of 60.

Admission Guidelines

The following guidelines are in addition to general program guidelines.

1. Consumers currently experiencing a behavioral health crisis.
2. At risk of needing a higher level of care if support is not provided.
3. Consumer demonstrates a need for support in coordinating treatment/recovery/ rehabilitation options in the community.

Exclusionary Guidelines

Consumers may meet any one of the following guidelines to be excluded from this service.

1. Consumer has a medical condition or impairment that warrants a medical/surgical setting.
2. The primary problem is social, economic (lack of housing or financial resources)
3. The primary problem is physical health without concurrent psychiatric condition.

Service Expectations

1. Completes a screening for risk and develop a safety plan as needed within three days of the first contact of the referral or if the consumer is in an inpatient facility within three days of discharge from that facility.
2. Completes a strengths-based assessment with the consumer within 14 days the first contact
3. Complete an initial service plan within five days of first contact and in partnership with the consumer and upon completion of the assessment complete an individualized service plan.
4. Provide individual advocacy as needed
5. Assist consumer in obtaining benefits such as SSI, housing vouchers, food stamps, Medicaid. Etc.
6. Provided education to consumer/family/significant others with the consumer's permission as needed.
7. Provide referrals to appropriate community-based behavioral health services.
1. Provide pre-discharge transition services from psychiatric hospital including teaching daily living skills, scheduling appointments, limited transportation to appointments and assistance with housing search as needed.
2. Provide pertinent information to psychiatric hospital and emergency personal and community agencies as needed.
3. Establish collateral relationship with law enforcement and other emergency services including working closely with the crisis response teams to prevent Emergency Protective Custody admissions.
4. Arrange alternatives to psychiatric hospitalization as needed.

Length of Services

ERCS is a short term crisis oriented service designed to be in place for 30-90 days. Services may continue beyond that if needed for any or all of the following reasons: to support achievement of consumer's individual goals, to provide continuity for guidelines associated with Region V's Rental Assistance Program, to maintain and support recovery while consumers are waiting for ongoing services or to provide continued support when ongoing services are not available. All service extension requests must be approved by the Program Director.

Discharge Desired Outcomes

ERCS case managers will discharge consumers based on the achievement of identified and individualized discharge markers established at the time of intake and assessment. This includes the completion of individualized goals and objectives, an established safety and wellness plan, the ability to remain psychiatrically stable in a community setting of choice and the identification of a community based support system.

Attachment 3

Intensive Case Management (ICM) is designed to promote community stabilization for consumers who have a history of frequent psychiatric hospitalization through frequent case management activities responsive to the intensity of the consumer's needs. Intensive Case Management includes mobile case management addressing illness management, peer support, crisis prevention/intervention, and appropriate utilization of community-based resources and services. Intensive Case Management is provided in the community with most contacts typically occurring in the consumer's place of residence or other community locations consistent with consumer choice/need.

Services are designed to successfully support consumers in a community-based setting and reduce or eliminate their reliance and need for emergency level or high-intensity services.

Frequency of Contacts

This service is provided at a minimum of 6 hours per month (4-7 contacts per week) with the majority of these contacts being face to face and in the consumer's residence or other community locations.

Contacts of less than 4 per week for a maximum of one month are acceptable when transitioning to a lower level of care.

Coverage Areas

The ICM workers cover Lancaster County.

Staffing Ratios, Capacity and Case Loads

The ICM team includes 5 full time staff each with a case load of 10 and a total capacity of 50.

Admission Guidelines

All of the following guidelines in addition to general program guidelines must be met for admission to this level of care.

1. A diagnosis of severe and persistent mental illness and/or personality disorder including consumers with co-occurring substance abuse disorders.
2. Limited support system and difficulty sustaining community living without supports.
3. Numerous or lengthy inpatient behavioral health hospitalizations.

Exclusionary Guidelines

Consumers may meet any one of the following guidelines to be excluded from this service.

1. Consumer can be supported in a less intensive service.
2. Consumer can safely reside at a less intensive level of care.
3. A medical condition exists which warrants a medical/surgical/setting.
4. Consumer exhibits serious mental illness and is in acute/sub acute exacerbation of illness.
5. Consumer requires drug/alcohol detoxification.
6. The primary problem is social, economic (lack of housing or financial resources)
7. The primary problem is physical health without a concurrent psychiatric episode meeting guidelines for this level of care.

Service Expectations

1. A strength based assessment within 30 days of the first contact.
2. An introductory service plan completed with 10 days of first contact and an individualized service plan within thirty days that is updated every 30 days thereafter.
3. Quarterly treatment team meetings including but not limited to consumer, case manager and supervisor.
4. Frequent face to face contact and coordination with consumer's behavioral health providers.
5. Assistance in the development and implementation of a safety and wellness plan.
6. Provision of linkages, referrals and coordination between services that support the achievement of individualized goals.
7. Provide assistance in the coordination and structuring of self-medication regime.
8. Assistance in obtaining necessities such as medical services, housing, social services, entitlements, advocacy, transportation.
9. Provision of supports in health-related needs, usage of medications and symptom management.
10. Provide family/support system education and support.
11. Support and intervention in times of crisis.
12. Assistance in transitioning to lower level of care and increased community independence.

Length of Services

ICM is designed to be a long term program however length of stay is individualized and based on Admission Guidelines and continued treatment/recovery/rehabilitation as well as consumer's ability to make progress on individualized goals.

Discharge Desired Outcomes

ICM case managers will discharge consumers based on the achievement of identified and individualized discharge markers established at the time of intake and assessment.

This includes the completion of individualized goals and objectives, an established safety and wellness plan, the ability to remain psychiatrically stable in a community setting of choice and the identification of a community base support system.

Attachment 4

Recovery Support (RS) services promote successful independent community living by supporting a consumer in achieving his/her behavioral health goals and ability to manage an independent community living situation. Recovery Support is designed to advocate for consumers to access community resources and foster advocacy and self-advocacy in others through the use of wellness and crisis prevention tools. Crisis relapse prevention, case management, and referral to other independent living and behavioral health services are provided to assist the consumer in maintaining.

Services are designed to allow those who have diagnosed substance or co-occurring problems the opportunity to attain and sustain gainful employment and higher quality of life while supporting recovery through the continuation of treatment goals and objectives to include prevention and intervention related to external and internal stressors that increase the risk of relapse.

Frequency of Contacts

This service is provided at a minimum of one face to face contact per month.

Coverage Areas

The RS workers cover Lancaster County.

Staffing Ratios, Capacity and Case Loads

There are two Recovery Support workers. One specializes in consumers with mental health diagnosis and the other in consumers with substance abuse diagnoses. Each carries a case load of 40 and a total capacity of 80.

Admission Guidelines

All of the following guidelines in addition to general program guidelines must be met for admission to this level of care.

1. Diagnosed with a behavioral health disorder.
2. Demonstrated inability to sustain independent housing and living without professional support.

3. History of multiple treatment episodes and/or recent episode with a history of poor treatment adherence or outcome.
4. Requires assistance in obtaining and coordinating treatment, rehabilitation and social services.
5. Does not require more intensive intervention

Exclusionary Guidelines

Consumers may meet any one of the following guidelines to be excluded from this service.

1. Consumer does not have a serious mental illness.
2. Consumer cannot obtain or coordinate services or comply with individualized plan without higher level of care.
3. Consumer is currently served in a MRO or waiver service.

Service Expectations

1. Develop a mutual set of expectations regarding the roles of the consumer and the Recovery Support Worker and incorporated in the individual service plan within one month of admission to the program.
2. Implementation or development of a safety and wellness plan.
3. Foster advocacy and self-advocacy.
4. Support rehabilitation and service goal achievement and referral to other community resources as needed.

Length of Services

RS is designed to be a two year program however length of stay is individualized and may continue until discharge guidelines are met or consumer chooses to decline continuation of service.

Discharge Desired Outcomes

RS case managers will discharge consumers based on the achievement of identified and individualized discharge markers established at the time of intake and assessment. This includes the completion of individualized goals and objectives, an established safety and wellness plan, the demonstrated ability to maintain independent living without professional supports and the establishment of formal and informal community supports.