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Crisis Residence Program Guidance

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A. Introduction

The purpose of this document is to provide an overview of program and billing requirements for two types of crisis residence programs and guidance for the implementation of services within these programs. This guidance will address the adult crisis residences: Residential Crisis Support and Intensive Crisis Residence. These residences must have at least 3 beds and no more than 16. Children's Crisis Residence will be addressed in a separate document; however, this document will address transitional aged youth ages 18-25. Individuals ages 18 through 20 years old are eligible for all licensed crisis residences.

1. 14 NYCRR XIII Part 589

14 NYCRR Part 589 establishes standards for the operation of crisis residence programs which provide short term residential support to individuals who are exhibiting symptoms of mental illness and who are experiencing a psychiatric crisis. These regulations apply to providers seeking to operate a crisis residence licensed by Office of Mental Health. These programs are Residential Crisis Support, Intensive Crisis Residence and Children's Crisis Residence.

2. Principles of Delivery

Crisis Residence programs are an integral part of the behavioral health continuum of care and a coordinated crisis response system. They offer a safe place for the stabilization of psychiatric symptoms and a range of services from support to treatment services for children and adults. Crisis residence programs are not intended as a substitute for permanent housing arrangements. Crisis residences are intended to be located in the community and provide a home-like setting.

Crisis residences should be:

- Recovery oriented: Services are provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Services are strength based and determined by the individual's own path to recovery.
- Person-centered: The strengths, needs, preferences, experiences and cultural backgrounds of individuals are reflected in the services and supports identified in Individual Service Plans.
- Trauma-informed: Services are provided with the recognition, understanding and response to the effects of trauma.

- Culturally and linguistically competent: At the organizational level, the program implements policies and practices aimed at advancing health equity, improving quality and eliminating health care disparities for special/marginalized populations using the framework provided by the National Culturally and Linguistically Appropriate (CLAS) Standards. This includes the provision of language access services for individuals with limited English proficiency.

B. Referrals

Crisis Residences should make single points of access, such as crisis call centers and crisis stabilization centers aware of referral processes to expedite connection to crisis residential services.

- Individuals may self-refer for admission evaluation.
- Emergency Rooms, CPEPs, crisis call centers, crisis stabilization programs, community providers, families, etc. may refer an individual for an admission evaluation.
- A referral should be made with the consent of the individual being referred.
- Some programs only accept direct referrals from the individual seeking services to ensure voluntary admission. A collateral may seek information regarding the process for admission, but in some cases, the admission assessment cannot be completed without the consent of the individual referred for services.

C. Residential Crisis Support (RCS) Definition

Residential Crisis Support is a voluntary, short-term residential program for individuals who are experiencing a mental health crisis and/or are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the individual's home and community environment without onsite supports.

Situations that are appropriate for this service include, but are not limited to:

- An individual is experiencing symptoms that create imminent risk for impairment of social, emotional, or physical functioning and do not pose an imminent risk to the safety of themselves or others requiring higher level of care.
- An individual is experiencing a challenging emotional crisis which he/she is unable to manage without intensive assistance and support.
- An individual is stepping down from a higher level of care and is unable to return to the community due to the risk of an escalation of symptoms.

Expected outcomes for this service include stabilization of crisis and returning to a pre-crisis level of functioning with connections to community services and supports identified by the resident.

- 1. Admissions assessment** includes the engagement of the individual through the collection of essential information to determine admission to the program including the individual's name, date of birth, reason for admission, risk screening, identified supports, preferred language, emergency contact information and health information including allergies.

Once admission is determined, additional information can be gathered to inform the Individual Service Plan that addresses what services are needed to stabilize the crisis symptoms. Such information can include but is not limited to treatment and/or community providers, referral source, housing and employment status, goal(s) for admission, strengths, barriers & limitations, identification of what has worked and not worked in the past, cultural/linguistic/religious considerations and recovery goals.

Language access services should be provided for individuals with limited English proficiency.

2. Admission Criteria

The following are criteria are necessary for admission.

The individual:

- must be at least 18 years of age;
- is exhibiting symptoms of mental illness, psychiatric crisis; and/or
- is experiencing challenges in daily life that create risk for an escalation of psychiatric symptoms that cannot be managed in the individual's home and/or community environment without on-site supports;
- has no imminent risk to the safety of themselves or others that would require a higher level of care;
- is medically stable; and
- is willing to participate in service voluntarily.

Considerations:

- There is no exclusionary criteria and each admission must be determined on an individual basis.
- Individuals cannot be excluded from crisis residence programs solely based on homelessness or criminal record.
- Programs will provide policies and procedures which describes the process for determining admission.
- A mental health diagnosis is not necessary to be eligible for this service.

- Individuals cannot be excluded from crisis residence programs because of limited English proficiency other accessibility needs, such as deaf/hard of hearing, vision impairment or blindness.
- If an individual appears to be under the influence of a substance or admits to being under the influence, processes for determining the severity and next steps are necessary. If an individual cannot be admitted due to the severity of the substance use or withdrawal risk, arrangements must be made to refer and connect them to the recommended level of care.
- If an individual who has been admitted to the crisis residence uses substances during the admission, program staff are expected to discuss this with the individual to understand and assess for continued stay.
- Aggression or destructive behavior is not exclusionary. An assessment of the behavior in the context of the crisis and symptoms is necessary in the completion of the admission assessment or risk assessment.

3. Required Services

Services within Residential Crisis Support must be available to residents and include but are not limited to the following:

- Assistance in personal care and activities of daily living** includes but is not limited to supporting residents restore identified life skills impaired by crisis symptoms, such as self-care, self-advocacy, negotiating relationships, healthy communication skills, boundary setting, supporting the maintenance of social relationships that provide natural supports, identification of supports to access attend mental health, medical and substance use disorder appointments and treatment.
- Peer support** services actively engage the resident and their identified supports to direct the creation of the individual service plan and includes: identification and support for individual advocacy, prevention, outreach, engagement, hospital diversion, information and referral, self-help, safety/crisis planning, planning for prevention of setbacks, development of psychiatric advance directives, relaxation, resource brokering, as well as health and wellness coaching.
- Engagement with identified supports** facilitates and supports effective partnerships with the resident and their family support(s), natural supports and service providers by identifying and making connections with a support network. This collaboration can occur both on-site and off-site. This includes coordination between community providers of mental health and case management services with identified supports to facilitate transition back into the community.

- d. **Safety planning** includes the creation of a safety/wellness plan which identifies early warning signs of worsening symptoms, reviewing one's past psychiatric history, triggers of suicidal thoughts and/or relapse and includes identifying internal coping strategies, preference for care in times of crisis, identification of role of the identified provider(s), supports and methods to obtain and maintain one's overall safety and stability. One example of a suicide prevention plan includes:
https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
- e. **Integration of direct care and support services** is a flexible service that connects individuals to current support services available in the community. Once an individual is admitted into the program and an Individual Service Plan has been completed, the staff will begin working on connecting the resident to their identified service(s) both on-site and in the community. Collaboration and linkage with ongoing community services promote continuation of ongoing treatment and rehabilitation services. This is facilitated by staff to continuously build and strengthen relationships between individuals and their providers.
- f. **Case management** services which emphasize discharge planning are provided for identification, coordination, continuity and of behavioral health services received by the individual both on-site and in the community. These activities are aimed to facilitate a smooth transition back into the community and to maintain stability and support while in the community.
- g. **Medication management and training** are activities which provide information to ensure appropriate management of medication through understanding the role and effects of medication in treatment, identification of side effects of medication, and discussion of potential consequences of consuming other substances while on medication. Training in self-medication skills is also an appropriate activity, when clinically indicated.
- h. **Medication monitoring** are activities performed by staff which relate to storage, monitoring, recordkeeping, and supervision associated with the use of medication. Such activities may include reviewing the appropriateness of an existing regimen by staff with the prescribing physician. Programs must have policies and procedures for the storage and oversight of medication. Residents may keep medications locked in a lock box in their room as well as a lock on their door or programs should have the ability to provide a lock box in a secure room within the staff office, if that level of security is deemed necessary. All shall be consistent with applicable Federal and State laws and regulations. Prescribing and administration of medication is not an activity included under this service.

- i. **Crisis respite** provides the space and opportunity for an individual to separate from their immediate stressor(s), giving them the chance to rest, de-stress and relax as they work through their crisis in a safe environment.
- j. Provide access to 3 meals per day, personal care items, linens and emergency clothing. In addition, these programs include a kitchen area that allows for staff and/or resident to prepare and/or store their own meals as desired.

Room and board are not reimbursed through Medicaid. Individuals may provide their own meals if they choose.

4. The following are expected but not required services:

- a. **Engagement and support to address co-occurring disorders** is provided to residents who identify substance use and/or substance use disorder and are interested in working on their recovery. Staff will incorporate motivational interventions culturally and linguistically tailored to help increase an individual's readiness for self-management; recognizing the role of social networks in recovery and identifying ways to strengthen their immediate social environment. The crisis residence may make referrals or linkages to community services for substance use treatment and support.

Also included in this is support for individuals with Tobacco Use Disorder. The following resources may be helpful in creating policies and procedure:
[NYC Tobacco Cessation Technical Assistance Center](#)

- b. Participation in activities that promote wellness. Individuals define wellness in ways that are unique to their needs and may look different from one person to another. Watching television, engaging in conversation, yoga, exercise, meditation, and reading are a few examples.
- c. Conflict resolution skill building. Interpersonal conflict often creates or escalates mental health crisis symptoms. The opportunity to identify and practice alternative conflict resolution skills in a safe place is a necessary part of crisis stabilization.

5. Discharge and Length of Stay

- Providers must notify the MCO when the resident is discharged.
- Lengths of stay should not exceed 28 days in a crisis residence.
- There are no limits to number of days of service per calendar year.

- Lengths of stay must be related to the stabilization of crisis symptoms. Crisis residences are short term programs and are not a long term or permanent residence.
- A discharge residence should be identified at admission. It does not have to be a permanent residence.

6. Residential Crisis Support Settings Standards

Residential Crisis Support will:

- utilize a community-based site offering a supportive home-like environment with single occupancy rooms;
- provide a smoke-free environment;
- be staffed and open 24 hours a day, seven days a week;
- allow residents to leave and return as identified in individual service plan, offering flexibility to maintain employment and accomplish other daily tasks to the greatest extent possible;
- provide a safe physical environment, as evidenced by compliance with relevant building safety standards;
- allow the resident to have visitors in order to maintain contact with the people the resident considers to be their significant others. Visitation is allowed at any time that is convenient and practical for the resident, as well as the operations of the residential crisis program;
- provide guidelines and expectations that are discussed and processed throughout the admission; and
- provide services in a culturally and linguistically competent, person-centered, trauma informed manner.

7. Staffing

Recommended minimum standard:

- 1:4 clinical staff to residents, including overnight staff.
- Staff who are included in the daily staff ratio must be dedicated to that shift. Staff may not work in two programs at the same time during their shift. For example, a staff cannot work for a community residence and crisis residence during the same shift.
- On-site supervision for a crisis residence is necessary for support and ongoing training of staff. On-site supervision is not required 24/7. Program supervision must be addressed in the staffing plan.
- Program supervision must be available 24/7.
- Qualified mental health staff may be considered as supervisory staff as set forth in the staffing plan.

- Qualifications of supervisory staff should be described in the staffing plan and should demonstrate experience and training that qualifies them to function in that position.
- NYS Certified or credentialed Peers are expected to be part of the staffing plan.
- Peer support specialist staff are considered qualified mental health staff in this regulation. This definition includes peers who are not certified and may be hired under the title of para-professional staff. Programs are encouraged to hire peers considering or in the process of certification.

D. Intensive Crisis Residence (ICR) Service Definition

Intensive Crisis Residence (ICR) is a voluntary short-term, residential **treatment** service for individuals who are experiencing a psychiatric crisis, which includes acute escalation of mental health symptoms. This service is necessary to evaluate, resolve and/or stabilize the crisis symptoms.

Situations that are appropriate for this service include, but are not limited to:

- An individual at imminent risk for loss of functional abilities that may raise safety concerns for themselves and others without this level of care. This includes individuals with suicidal and homicidal ideation.
- An individual being discharged from a higher level of care that needs additional assistance due to the need for medication therapy, monitoring and oversight for symptom stabilization.
- An individual whose symptoms cannot be managed without treatment by licensed behavioral health providers through intensive interventions including counseling and medication therapy.

The immediate goal of ICR is to provide treatment and supports to help the resident stabilize and return to their previous level of functioning or as a step-down from inpatient hospitalization, if applicable.

1. Admissions Assessment includes the collection of essential information to determine admission to the program including the individual's name, preferred language, date of birth, reason for admission, risk screening, preferred language, identified supports, emergency contact information and health information including allergies. Once admission is determined a comprehensive assessment will be completed.

2. Admission Criteria

The following are criteria for necessary for admission.

The individual:

- must be at least 18 years of age;

- is experiencing an acute psychiatric crisis and/or;
- is experiencing challenges in daily life that create risk for an escalation of BH symptoms and a loss of adult role functioning;
- experiencing symptoms related to a mental health diagnosis;
- requires treatment services for stabilization of psychiatric symptoms;
- requires 24-hour monitoring;
- is medically stable;
- is willing to participate in service voluntarily.

Considerations:

- There is no exclusionary criteria and each admission must be determined on an individual basis.
- Individuals cannot be excluded from crisis residence programs solely based on homelessness or criminal record.
- Programs will provide policies and procedures which describes the process for determining admission.
- An individual may require oversight by medical professionals for psychiatric stabilization as a stepdown from inpatient hospitalization or from emergency/CPEP admission.
- A psychiatric diagnosis is necessary for treatment in this program.
- Individuals cannot be admitted due to a primary substance use disorder crisis.
- Considerations described in Residential Crisis Support apply to Intensive Crisis Residence. Because ICR is a treatment program, short-term treatments for substance use disorders may be initiated, if those treatments are related or contribute to the mental health crisis that precipitated the admission to the program.
- Individuals cannot be excluded from crisis residence programs because they have limited English proficiency or have other accessibility needs, such as deaf/hard of hearing, vision impairment or blindness.
- If an individual appears to be under the influence of a substance or admits to being under the influence, processes for determining the severity and next steps are necessary. If an individual cannot be admitted due to the severity of the substance use or withdrawal risk, arrangements must be made to refer and connect them to that level of care.
- If an individual who has been admitted to the crisis residence uses substances during the admission, it would be expected that the program staff would discuss this with the individual to understand and assess continued stay. Nursing staff and/or Psychiatrist/Nurse Practitioner must perform immediate evaluation due to possible interaction with prescribed medications and on-going treatment planning.
- Aggression or destructive behavior is not exclusionary. An assessment of the behavior in the context of the crisis and symptoms is necessary in the completion of the admission assessment or risk assessment

3. Services

Intensive crisis residence includes services provided in Residential Crisis Support **and** the following treatment services which include but are not limited to:

- a. **Comprehensive assessment** includes, but is not limited to the resident's present episode, risk assessment, personal preferences and desired life roles, physical, medical, emotional, social, residential, recreational, cultural, language, religion and spiritual beliefs and, when appropriate, vocational and nutritional needs.

A risk assessment identifies hazards and risk factors that have the potential to cause physical and/or mental harm to the resident and/or others. If appropriate, this information, with the resident's consent, may be obtained from the resident's most recent mental health service or other community provider(s).

The assessment process must engage each resident as an active partner in developing, reviewing and modifying a service plan that supports their progress toward recovery. The comprehensive assessment should inform the Individual Service Plan.

- b. **Medication therapy** is the process of determining the medication to be utilized during the course of treatment; reviewing the appropriateness of the resident's existing medication regimen through review of the resident's medication record, consultation with the resident and, as appropriate, their identified supports. It also includes prescribing and/or staff administration of medication; and monitoring the effects and side effects of the medication on the resident's mental and physical health. Programs will develop policies and procedures for the administration, storage and oversight of medication. All shall be consistent with applicable Federal and State laws and regulations.
- c. **Individual and group counseling:** Short-term recovery-oriented counseling focused on the identified crisis to re-establish baseline functioning. This service includes individual, family and group therapy.
- d. **Engagement and support to address co-occurring disorders** is a required service in Intensive Crisis Residence programs. It is required in this program to ensure that residents receive support services for co-occurring conditions and specific interventions to support this process as identified in the Individual Service Plan.

The following are expected activities:

- a) **Monitoring for high risk behaviors.** This includes observation and assessment of a resident's actions and activities for a prescribed duration that would result in identification of potential causes of physical and/or mental harm to themselves

and/or others. This information could aid in the development of interventions to support crisis stabilization and ongoing wellness.

- b) **Wellness activities** included in Residential Crisis Support are expected to be provided in Intensive Crisis Residences when requested or indicated as a need.
- c) **Medications** to support tobacco cessation may be prescribed in Intensive Crisis Residence programs.

4. Intensive Crisis Residence Settings Standards

Intensive Crisis Residence will:

- utilize a community-based site offering a home-like, supportive environment with single occupancy rooms;
- be staffed and open 24 hours a day, seven days a week;
- provide a safe physical environment, as evidenced by compliance with relevant building safety standards;
- provide a smoke-free environment;
- allow the resident to have visitors to maintain contact with the people the resident considers to be their significant others. Visitation is allowed at any time that is convenient and practical for the resident, as well as the operations of the residential crisis program;
- provide services in a culturally and linguistically competent, person-centered, trauma informed way.

5. Staffing

Staffing patterns should be based on projected volume and should include the following:

- Supervisor/Program Director should be Professional staff
- Nursing staff
- Para-professional Staff
- Professional Staff
- NYS Certified or credentialed Peers and Peer Support Specialist
- Psychiatrist and/or Psychiatric Nurse Practitioner
- Minimum standards:
 - On-site and on-call Psychiatry 24/7. As an intensive treatment service, residents must have access to psychiatric services when needed.
 - Program supervision must be available 24/7.
 - Supervisory staff must be on-site or on-call when not at the site of the crisis residence. It is recommended that this treatment program employ professional staff as supervisors.
 - 24/7 1:8 clinical staff to resident ratio including awake overnight staff

- Staff who are included in the staff ratio must be dedicated to that shift. Staff may not work in two programs at the same time during their shift. For example, a staff cannot work for a community residence and crisis residence during the same shift.
- 24/7 1:8 RN to residents
- 1 Professional staff

1 RN and 1 clinical staff provide a 1:4 staff ratio 24/7. Due to the intensive nature of this service, it is expected that there will be professional staff, peers, psychiatry, and other service providers available in addition to this minimum staffing ratio in order to provide treatment and support services.

E. Transition Age Youth for ages 18- 25

For the purposes of this document, transition age youth are defined as individuals ages 18 to 25. Crisis residence services can also be provided to youth through age 20 in licensed Children’s Crisis Residences. Admission to adult crisis residences broadens the service network for transitional age youth.

Decisions for admission to the program should be based on availability, youth choice and should take into consideration the youth’s comfort with other current residents.

The following are considerations when serving this population:

- Education – does the individual have an IEP and are needs being met by services provided in school. How will this be provided during their admission?
- Employment - does this need to be addressed in discharge planning?
- Living Situation – does the individual require supports in the home? Is the youth homeless or in need of housing in the future? How can services and supports be identified and what services are needed to be wrapped around the youth to support crisis stabilization?
- Community Functioning – does the individual navigate the community successfully? Do they need social supports or outlets for social interactions? Do they need skill building in how to utilize community resources, such as transportation, public libraries, etc.?
- Ensure community-based services and supports are in place in preparation for discharge. Ensure referrals/direct linkages are made to ongoing clinical treatments and supports.

Individuals enrolled in Medicaid ages 18 through 20 admitted to an adult Crisis Residence program are covered and reimbursed under the Children’s Crisis Intervention benefit. NYS designated Adult crisis residence programs providing services to youth ages 18 to 20 must include the following services of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid State Plan Service

called Crisis Stabilization/Residential Supports for reimbursement under that authority:

- Comprehensive Intake Assessment including:
 - Mental Health and Substance Use Disorder assessment
 - Risk assessment and crisis planning
 - Health screening for physical conditions
- Individual and Family Counseling, including consulting with psychiatric prescribers and urgent psychopharmacology intervention, as needed.

*Certified or credentialed peer specialists must be under the supervision of a licensed behavioral health professional in order for the crisis residence to receive reimbursement through the Medicaid State Plan Crisis Intervention benefit.

F. Crisis Residence Documentation Requirements

1. Individual Service Plans (ISP) created for the duration of the admission include:
 - Elements of the admission and comprehensive assessment that have been identified by the resident and staff that will be addressed during the admission;
 - Strengths and needs identified collaboratively with the resident and a staff member that supports crisis stabilization;
 - Outcomes of consultation(s) with existing case manager(s) and the individual's established behavioral health provider(s), with resident's consent, if appropriate. This may include a Health Home care coordinator;
 - Service needs of the resident whether or not the services are provided directly by the crisis residence program;
 - how the identified supports, which may include family, will be involved in the service planning and implementation;
 - Safety planning;
 - Medication prescribed by the Program Psychiatrist or Nurse Practitioner, if applicable; and
 - Signature of the resident and the qualified mental health staff developing the plan. If a resident does not want to sign the plan, this must be documented in the record.

The ISP must be completed within 24 hours of the admission and be updated as additional information is gathered.

2. Case Records

There shall be a complete case record maintained at one location or electronically for each individual admitted to the crisis residence. The case record shall be confidential, and access shall be governed by the requirements of sections 33.13 and 33.16 of the Mental Hygiene Law.

The case record includes:

- identifying information about the individual and the individual's identified supports;
- preferred language, cultural attributes, religious/spiritual needs;
- admission note indicating source of referral, date of admission, rationale for admission, the date service commenced, presenting problem and initial treatment needs of the individual completed as soon as possible, but no later than 24 hours after admission;
- summary of psychiatric, medical, emotional, social and residential needs;
- summary of reports of available behavioral health and physical diagnostic examinations and assessments, including findings and conclusions;
- an individual service plan, which shall be developed within 24 hours of the individual's admission to the program;
- Daily progress notes which relate to the goals and objectives of the service plan including:
 - the time and duration of service;
 - frequency of service;
 - participants in meetings;
 - signature of staff member who provided the service or by one participating staff member when several staff members have had significant interaction with the individual;
 - occurrence of significant event(s) that affects, or potentially affects the individual's condition;
 - progress towards achieving goals of the ISP and/or if there are any proposed changes to the goals and/or objectives;
 - medication adherence and/or lack thereof and subsequent communication with provider, upon consent;
 - communication with other identified supports as applicable;
 - collateral contacts and service linkage efforts;
 - progress toward the individual's readiness to transition back into the community.
- dated and signed orders which indicate commencement and termination dates for all medications, if applicable;
- releases of information, including PSYCKES if applicable;
- a discharge summary, which includes the reasons for discharge and, if appropriate, referrals, linkage with referrals. The provision for alternative services which the individual may require must be available on day of discharge;

- Documentation that discharge summary was provided to the resident.
- More than one more than one progress note may be completed per day;
- Documentation shall be completed on the day services are delivered.

Records must be retained for a minimum period of six years from the date of the last service provided to a patient.

G. Utilization Management

Determination of admission to a crisis residence program is made after the completion of an admissions assessment.

Medicaid Managed Care Plans (MMCP) must utilize evidence-based, peer reviewed, age-appropriate medical necessity criteria that has been reviewed and approved by the Office of Mental Health, in consultation with the Department of Health, as required by the [OMH Guiding Principles](#).

Prior authorization for Medicaid Managed Care enrollees to access Crisis Residence Services is prohibited¹. Crisis Residence providers determine whether an individual is appropriate for admission based on OMH-approved admissions criteria.

MMCPs may conduct utilization management, other than prior authorization, only when State-approved predefined, clinical, and/or quality improvement-based triggers are met and only in a manner that complies with state and federal behavioral health parity laws.

If utilization management is conducted for Crisis Residence services, coverage determinations must be based on the MMCP's evaluation of all of the following domains, which should be clearly described in the MMCP's approved clinical review criteria:

- Risk of harm;
- Functional status;
- Co-morbidity;
- Level of stress and support in the recovery environment;
- Treatment and recovery history; and
- Engagement and recovery status.

In line with the OMH Guiding Principles, clinical review criteria that only take into consideration current symptoms and current level of risk in determining continued stay is not appropriate and will not be approved for use. For example, the MMCP may not

¹ *Medicaid Managed Care Model Contract*, Emergency Services- Section 10.13(e), and Mental Health Services- Section 10.21(i).

deny continued stay if an individual's crisis symptoms have stabilized but their living situation or medical comorbidity poses an imminent threat of decompensation, and a plan for the resolution of that situation is included in the Crisis Residence's service plan for that individual. Clinical review is an interactive process between the MMCP and the provider to review the progress and barriers for services, and if necessary, problem-solve challenges to discharge.

MMCPs are required to work collaboratively with Crisis Residence providers to share relevant information supporting the member's treatment, care coordination, and discharge planning. If there are barriers to discharge, a discussion between the MMCP and Crisis Residence provider can identify strategies to resolve them. The frequency of communication should reasonably reflect the complexity of the member's treatment and care coordination needs.

Crisis Residence providers must notify MMCPs within **two** business days of an enrollee's admission. OMH developed a suggested Crisis Residence Admission Notification Form. This form is not required; however, it contains the necessary information providers must submit to a MMCP within two business days of the individual's admission. MMCPs may use this form or develop their own but can only require providers to submit the information contained in the Crisis Residence Admission Notification Form.

When determined, Crisis Residence providers must notify the MMCP of the individual's discharge date. Lengths of stay cannot exceed 28 days per admission in an OMH licensed Crisis Residence.

Individuals admitted to Crisis Residence programs may still receive previously authorized community-based outpatient services or new outpatient services identified as part of the individual's Crisis Residence service plan. MMCP authorization of these services cannot be restricted because of an individual's Crisis Residence admission.

H. Provider Eligibility

Agency must possess a current license or designation until licensure to provide crisis residential services.

The agency must meet staffing qualifications and have adequate staffing resources as outlined in staffing section (B,7) and (C,7). This service will be provided by a multidisciplinary team of licensed, unlicensed and certified peer staff. Staffing plans are approved through the licensing process. Any changes to staffing that does not meet the approved plan via the PAR process must be reported to OMH.

Medicaid Enrolled Provider

In order for providers to be eligible to receive Medicaid payment, they must be enrolled as a Medicaid provider. Information on how to become a Medicaid provider is available on the eMedNY website: <https://www.emedny.org>

Enrollment Status

Providers are responsible for verifying an individual's enrollment in Medicaid and whether they are enrolled in a MMCP. Claims will not be paid if the individual is not enrolled in Medicaid or the claims are billed to the incorrect plan.

Providers can verify enrollment in Medicaid using [ePaces](#).

For residents ages 18 through 20:

Medicaid Fee-For-Service Claiming (eMedNY)

Claims for services delivered to an individual in receipt of FFS Medicaid are submitted by providers to eMedNY. See <https://www.emedny.org> for training on use of the eMedNY system. Claim submissions need to adhere to the 90-day timely filing rules for Medicaid FFS.

I. Community Service Providers

Individuals receiving services at Residential Crisis Support programs may participate in treatment programs in the community and community-based services. Attendance at clinic appointments, in-community treatment providers, or any service providers included on the Individual Service Plan are allowed. Residents are not required to participate in outside treatment or services during their admission.

Residents at the Intensive Crisis Residence may also participate in treatment programs in the community that are not duplicative of services being provided to the individual in the ICR. Where the resident receives duplicative services, a decision should be made by the resident, in consultation with program staff and the MMCP. These services must be clearly delineated in the Individual Service Plan due to the higher level of care in the ICR. This service is not intended to replace inpatient hospitalization.

Residential Crisis Services should collaborate and link to resources and referrals to community-based mental health and substance abuse treatment and rehabilitation services as determined by assessment and documented in the ISP such as but not limited to:

- Ambulatory detox;

- Intensive out-patient;
- Peer support;
- Relapse prevention planning;
- Wellness activities;
- Vocational services, including Supported Vocational and Supported Educational programs;
- Education;
- Recreation;
- Housing;
- Case management;
- Tobacco cessation services;
- Nicotine Replacement Therapies.

Ongoing communication between resident, residential crisis staff, the residents established mental health providers, natural supports and MMCP staff is necessary to assure collaboration and continuity in managing the crisis, as well transition to the community.

J. Discharge Planning

Discharge planning for each individual begins at admission. It includes, at a minimum, identification of the discharge goals and the criteria for determining readiness for discharge. Discharge plans should include current providers and additional services as needed.

Program services include the linking of individuals to service providers who are able to conduct the necessary assessments if necessary, to meet specific service needs identified on the discharge plan.

It is critical that discharge planning and follow-up services are viable. Consideration of the ability for individuals to have access to treatment providers and community services should be a factor in this planning, which may include the need for transportation and childcare, for example. It is expected that those individuals participating in treatment services in the community continue to receive those services while admitted to crisis residence, when indicated on individual service plans and are included in discharge plans.

Individuals receiving crisis residential services must be a part of their discharge planning, and an array of follow up services meeting the individual's needs should be considered, including but not limited to treatment, functional and social determinants of health needs. If an individual is not interested in follow up services or is satisfied with existing services, that decision should be respected. However, staff should make consistent efforts in engaging the individual in discharge planning and document these efforts. The timeliness of follow up appointments should match the acuity of the current needs and may include linkage to new services during a crisis residence stay, but in any event should be made as soon as possible after discharge.

Peers supporters are an important part of discharge planning with resource brokering and identifying supports in the community.

The discharge plan and summary should include:

- A description of services received;
- individual's progress;
- discharge location;
- any incidents/notable events;
- peer resources;
- scheduled follow-up services and a listing of community resources relevant to their concerns, culture, preferred language and experiences;
- reason for lack of follow-up services if not scheduled.

A discharge plan and summary should be signed by a staff member of the program and by the resident. The individual must be given a copy of the discharge plan, which includes a safety plan. With consent from the resident, discharge summaries should be provided to providers and collaterals.

It is expected that providers coordinate with the MMCP prior to discharge to discuss options, history of treatment, if relevant, and coordination of care in the development of discharge planning in conjunction with the individual receiving services. This provides opportunities for consultation, cooperation and comprehensive planning.

K. Incident Reporting

The Protection of People with Special Needs Act, or PPSNA (Chapter 501 of the Laws of 2012) created the Justice Center for the Protection of People with Special Needs ("Justice Center"). The Justice Center is a State agency charged with the responsibility to track and prevent, as well as investigate and prosecute, reports of abuse and neglect of persons with disabilities or special needs (i.e., "vulnerable persons"). The PPSNA created a set of consistent safeguards for vulnerable persons served by systems under the jurisdiction of six state agencies, including the Office of Mental Health (OMH), to protect individuals against abuse, neglect, and other dangerous conduct, to aggressively investigate and address instances of neglect and abuse, and to provide fair treatment to employees upon whom vulnerable persons depend for their care.

Residential Crisis Programs that are directly operated by OMH and providers of mental health services that have been licensed by OMH pursuant to Article 31 of the Mental Hygiene Law (including Article 31 licensed wards, wings or ambulatory services that are part of an Article 28 general hospital) are required to comply with the incident reporting requirements of the PPSNA and 14 NYCRR Part 524. For specific reporting requirements please refer to: [Incident Management Field Guide](#)

L. Rights and Responsibilities of Residents

An individual admitted to Residential Crisis Support and Intensive Crisis Residence are entitled to the rights below which include, but are not limited to

Rights and responsibilities include but are not limited to:

- Be treated with dignity and respect;
- Confidentiality;
- Freedom from coercion and restraint;
- Quality of care and treatment without discrimination and in their preferred language;
- Be treated in such a way that honors resident's beliefs, is sensitive to cultural diversity, and fosters respect for the resident's culture and cultural identity.
- Report grievances, without fear of reprisal;
- Freedom of choice regarding services and supports, and who provides them;
- An explanation of the services provided to them, as written in their Individual Service Plan;
- Participation to the fullest extent, consistent with the resident's capacity, in the establishment and revision of the Individual Service Plan;
- Engage in community life to the same degree as individuals not receiving services in the broader community;
- Continue or seek employment, education and work in the community;
- Control personal and financial resources;
- Control their own daily schedule and activities;
- Receive visitors within the hours determined by the program;
- Access to food at any time; and
- Privacy in their sleeping or living unit

A provider of service shall be responsible for ensuring the protection of these rights. Residents must be informed of their rights and responsibilities upon admission to the program.

Resident Agreements

Resident agreements are written agreements between the resident and program, are recommended and considered a best practice. These agreements outline the expectations of the program and the resident's consent to these expectations. Agreements should be reviewed with the resident verbally and written at an appropriate reading level to assure those with limited reading skills can comprehend the material being provided. Agreements may be individualized to the program but must conform to residents' rights and responsibilities. It is an allowable expectation that a resident participate in programming as a condition of ongoing stay as this service is to provide support and/or treatment; it is not transitional housing. Using these agreements as structure for conversation in the event an individual does not

abide by their agreement, allows for the exploration of situations that may relate to the current crisis and/or future planning.

M. Training Requirements

Ongoing trainings and staff development are required to ensure the design and operation of the program is consistent with and appropriate to the ethnic and cultural background of the individuals admitted to the program. This awareness of experiences of oppression is of critical importance given the inherent power dynamics between service providers, residents and their communities.

Residential Crisis providers are required to develop an orientation and ongoing training program, which may include the following recommended topics, but is not limited to:

- Trauma-informed Care
- Trauma-informed Peer Support
- Peer health navigation
- Peer wellness coaching
- Intentional Peer Support
- Mental health conditions in children and adults
- Human development
- Psychotropic medication
- Medication management
- Cultural and Linguistic competence
- Suicide Prevention
- Individual Service Planning
- Mental Health First Aid
- CPR
- Narcan administration
- Safety and Crisis Planning
- Risk assessment
- Utilization Review
- Crisis Intervention, de-escalation and debriefing
- Safety Planning
- Relaxation techniques to help reduce stress, anxiety, panic or feelings of losing control.
- Stages of Change in Addiction
- Harm Reduction
- Motivational Interviewing
- Co-occurring Disorders
- Wellness Self-Management Training
- Developmentally appropriate practices
- (Academy for) Justice informed practices

- Psychosocial Rehabilitation & Skills Training

Training policies and procedures must include all topics related to the performance of the services provided by the crisis residence.

Resources:

N. Quality Assurance

The governing body has responsibility for the operation of the program and may delegate responsibility for the day-to-day management of the program to appropriate staff in accordance with the organizational plan approved by the Office of Mental Health.

The governing body meets on a regular basis, in no event less often than quarterly, and shall maintain written minutes of all meetings as permanent record of the decisions made in relation to the operation of the program. The minutes shall be reviewed and approved by the governing body.

The governing body approves a written plan or plans that, at a minimum, address the following aspects of the operation of each crisis residence program:

- the goals and objectives of the crisis residence program, including the admission and discharge criteria;
- the plan of organization that clearly indicates lines of responsibility;
- a written plan for services and staff composition which:
 - includes the qualifications and duties of each staff position by title, and addresses all essential aspects of the operation of the crisis residence program, including clinical, administrative, supervision, fiscal, clerical, housekeeping, maintenance, dietetic, and recordkeeping and reporting functions; and
 - specifies all services available through the crisis residence program;
- the written quality assurance plan; and
- the written utilization review plan.

The governing body shall approve written policies and procedures of the crisis residence program.

O. Infection Control

Residential Crisis Programs must follow relevant infection control guidance as published by NYS OMH including guidance issued during an emergency period.

P. Billing Guidance

1. Rates

Pursuant to Section 10.13(d)(ii)(D) of the [Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract](#). MMCPs must reimburse both participating and non-participating Crisis Residence providers for services, and rates for non-participating providers must be the same rate as participating providers.

NYS developed per diem recommended rates for Crisis Residence programs, intended for use as a reference and to aid in negotiations, however, rates will be determined through MMCP and provider negotiation² and do not include room and board.

The State will reevaluate reimbursement requirements after the first year. In the event of inadequate access, the State may exercise authority to establish government rates.

2. Billing

Only Crisis Residence providers licensed by NYS OMH are permitted to bill MMCPs for services provided to a Medicaid Managed Care enrollee.

Each Crisis Residence program type has its own rate code, CPT code, and modifier combination that must be used.

All claims must be submitted with the appropriate rate code for the service provided (see below). Please see the [New York State Health and Recovery Plan \(HARP\) / Mainstream Behavioral Health Billing and Coding Manual](#) for details on MMCP claiming and encounter reporting processes.

For additional Medicaid Managed Care claiming and billing resources, please refer to the information available on the [Managed Care Technical Assistance Center \(MCTAC\) website](#) and the [MCTAC Interactive Billing Tool](#).

Program Type	Rate Code	CPT Code	Modifier	Unit Measure	Length of Stay Limit
Residential Crisis Support	4625	T2034	HE - Mental Health Program	Per Diem	28 days per admission

² These rates can be accessed on the OMH website here:
https://omh.ny.gov/omhweb/medicaid_reimbursement/

Intensive Crisis Residence	4626	T2034	ET - Emergency Services	Per Diem	28 days per admission
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For Crisis Residence services provided to youth ages 18 to 20, please use rate codes below. For more information, refer to the Children’s Crisis Residence Benefit and Billing guidance.

Program Type	Age Range	Rate Code	CPT Code	Modifier	Unit Measure	Length of Stay Limit
Residential Crisis Support	18-20	7943	H2013	HA, TF	Per Diem	28 days per admission
Intensive Crisis Residence	18-20	7944	H2013	HA, HK	Per Diem	28 days per admission

Q. Definitions

Admission criteria means those factors which are identified by the provider of service for use in determining an individual’s eligibility for admission to a crisis residence program.

Clinical staff means professional, para-professional and non-professional staff members who provide residential crisis services directly to residents.

Collaterals means an individual who is a member of the resident’s family or household, or other individual who interacts with the resident and is directly affected by or has the capability of affecting their condition and is identified in the individual service plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the individual prior to admission.

Co-occurring disorder means the diagnosis of at least one disorder in both of the following areas: substance use disorder (e.g. addiction, alcoholism, chemical dependency and drug abuse), mental health disorder (e.g. personality disorder; a mood disorder like depression, anxiety, or bipolar; schizophrenia; post-traumatic stress disorder).

Crisis residence means a short-term residential program designed to provide residential and support services to persons with symptoms of mental illness who are at risk of or experiencing a psychiatric crisis.

Discharge criteria means those factors which are used to determine that a resident is no longer in need of or eligible for treatment within a crisis residence program.

Family means those members of the resident's natural family, family or choice, or household who interact with the resident and are directly affected by, or have the capability of affecting, the resident's condition.

Individual Service Plan (ISP) means a written plan based on the assessment of the mental health status and needs of a resident, establishing their treatment and rehabilitative goals and determining what services may be provided to assist the resident in accomplishing these goals.

Mental illness means a health condition involving changes in behavior, emotion, thinking or judgment (or a combination of these) that are associated with distress and/or problems functioning in social, work or family activities.

Para-professional staff means individuals 18 years of age or older with a High School diploma or equivalent and 1-3 years of relevant experience or a bachelor's degree employed or under contract with a provider of services.

Peer support specialist or peer means an individual who is a current or former recipient of mental health services who provide support for other service users through a model of shared personal experience. Peer support specialists may include: peer advocate, family peer advocate and youth peer advocate. Peers may seek certification and provide services that include but are not limited to: systems advocacy, prevention, outreach, engagement, hospital diversion, information, referral, self-health and peer support.

Professional staff means practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness.

Psychiatric crisis means a situation that requires immediate attention in which a person with serious mental illness, as defined in Section 1.03 of the Mental Hygiene Law, cannot manage their mental health symptoms without de-escalation or intervention, or in which the challenges in daily life have resulted in, or are at risk of resulting in an escalation in mental health symptoms.

Qualified mental health staff person means:

(1) a physician who is currently licensed as a physician by the New York State Education Department;

(2) a psychiatrist who is currently licensed as a physician by the New York State Education Department, and is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that board; or is certified by the American

Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.

(3) a psychologist who is currently licensed as a psychologist by the New York State Education Department;

(4) a social worker who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department;

(5) a registered nurse who is currently licensed as a registered professional nurse by the New York State Education Department, including Clinical Nurse Specialist;

(6) a creative arts therapist who is currently licensed as a creative arts therapist by the New York State Education Department;

(7) a marriage and family therapist who is currently licensed as a marriage and family therapist by the New York State Education Department;

(8) a mental health counselor who is currently licensed as a mental health counselor by the New York State Education Department;

(9) a psychoanalyst who is currently licensed as a psychoanalyst by the New York State Education Department;

(10) a nurse practitioner who is currently certified as a nurse practitioner by the New York State Education Department;

(11) an individual having education, experience and demonstrated competence, as defined below:

(i) a master's or bachelor's degree in a human services related field;

(ii) For Purposes of Residential Crisis Support and Intensive Crisis Support, the following are included as qualified mental health staff person:

(a) an associate's degree in a human services related field and three years' experience in human services;

(b) a high school degree including GED and five years' experience in human services; or

(c) a NYS certified or credentialed peer specialist.

(13) a certified rehabilitation counselor currently certified by The Commission on Rehabilitation Counselor Certification (CRCC); or

(14) other professional disciplines which receive the written approval of the Office of Mental Health.

Resident means an individual who is receiving services at a crisis residence.