

Stabilization and Mobile Response Policy and Procedures

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Stabilization and Mobile Response Overview

Stabilization and Mobile Response is designed to maintain children and youth safely in their current living arrangement, prevent repeated hospitalizations, unnecessary emergency room visits, and law enforcement involvement, by stabilizing the current behavioral health needs. Stabilization and Mobile Response is:

- Grounded in System of Care values and principles; strengths based, child centered and family driven, community based, trauma sensitive, and culturally and linguistically mindful
- Provided to children and youth experiencing escalating emotional symptoms, behaviors or traumatic circumstances that compromise their ability to function within their family, living situation, school or community environments
- Individualized, collaborative, flexible, and intensive based on the child and families' needs
- Provided by a team of mental health professionals, care managers or family peer supports
- Available 24 hours per day, 7 days a week, year round

Population Served

All Utah families with children and youth under the age of 21, regardless of funding and custody status, including:

Children and Youth who:

- Get into trouble at school or in the community
- Display disruptive behaviors such as verbal aggression, running out of classrooms or home
- Bully others, or are bullied
- Refuse to attend school, skip school or are suspended from school
- Exhibit oppositional/defiant behaviors, such as leaving home without permission, stealing from parents, bringing strangers into the home, refusal to comply with rules, substance use
- Engage in aggressive behaviors towards siblings, peers, authority figures, parents
- Engage in destructive behaviors such as property damage, breaking siblings toys/items, putting holes in walls
- Appear to be depressed with changes in mood, sleep, and social withdrawal
- Engage in self-injurious behaviors such as cutting & sexual-risk behaviors
- May have experienced and/or witnessed trauma and/or major loss

Families and Caregivers who:

- Are overwhelmed
- Are at a point where they do not know what to do

Guiding Principles

- Every family will have a consistent quality experience accessing youth mobile crisis and stabilization services
- Parent/caregiver defines the crisis and family/professional partnership defines the response and partner in decision making throughout the process

Goals of Stabilization and Mobile Response

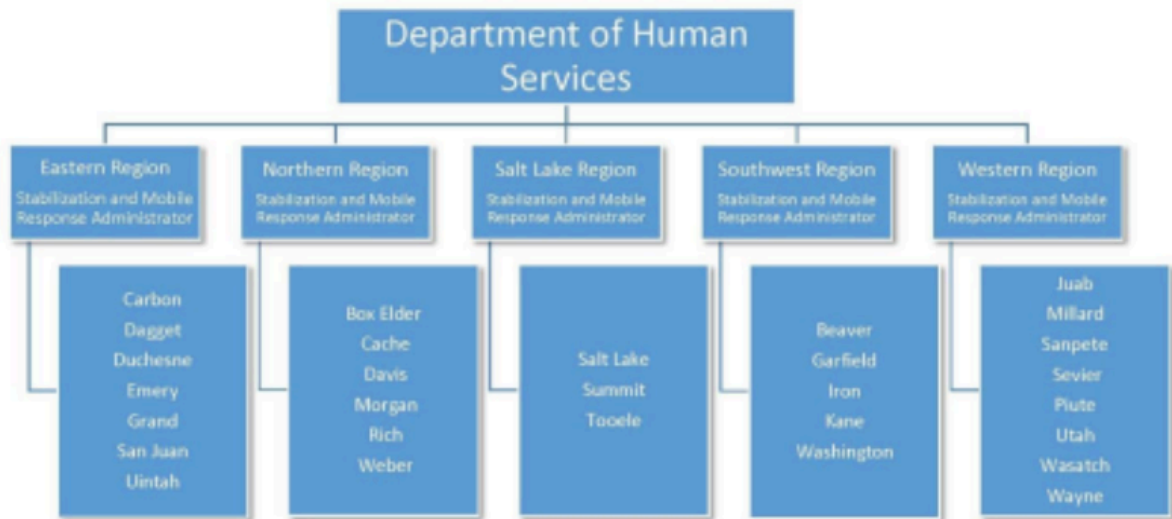
1. Provide short term intervention and de-escalation of immediate crisis
2. Engage, assess, deliver, and plan appropriate interventions to stabilize/improve child's functioning
3. Prevent the disruption of youth's current living situation
4. Ensure immediate safety of youth and his or her family/caregiver
5. Prevent/reduce the need for more restrictive/intensive services
6. Facilitate the youth and families' transition to identified resources, services, and supports

Expected Outcomes

1. Effective and efficient means to assess needs within the home environment and provide the "right" services
2. Reduce reliance on law enforcement, detention facilities
3. Reduce use of crisis services
4. Effective crisis de-escalation and stabilization
5. Strength-based approach empowers families
6. Reduce the likelihood of unnecessary emergency room visits; thus avoiding trauma for children, youth and families and high cost of medical care
7. Youth remain safely in the home
8. Working with youth at younger ages and families earlier in the crisis cycle offers earlier intervention and access to treatment

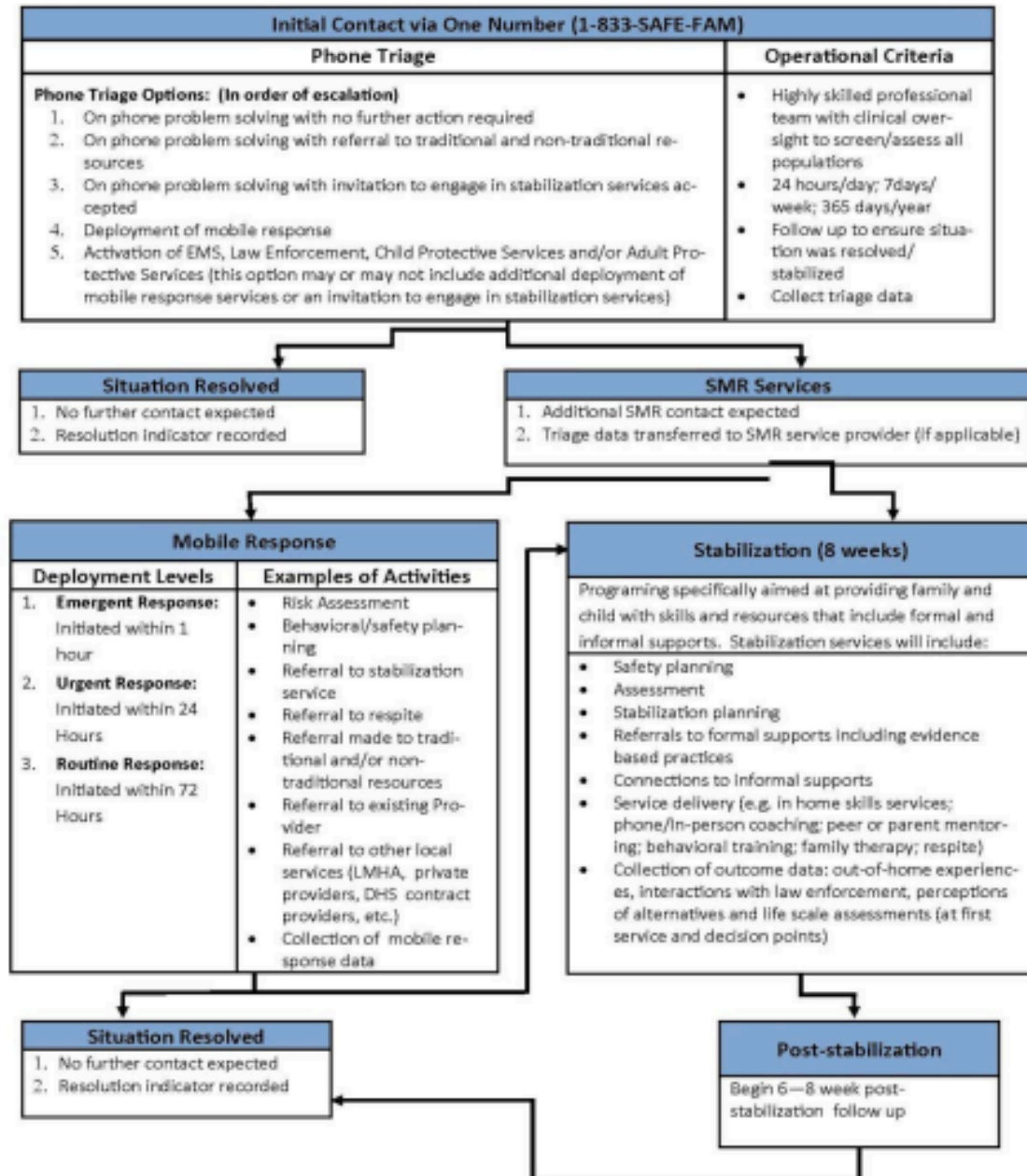
Statewide SMR Model

Of note, mobile response is currently available in all counties. DHHS is continually trying to expand stabilization services to all areas of the state.



Triage Service Guidelines

DHS Stabilization and Mobile Response (SMR)



Currently available in the Southwest and Northern Regions of the state, covering 11 counties. The goal is for statewide implementation.

Updated: January 25, 2019

Triage Service Guidelines

Purpose

Triage is available 24 hours per day, 7 days a week, year round to address immediate or current needs.

Service Description

Triage services are provided by regional Triage Teams. The team answers and responds to SMR hotline phone calls to assess the urgency of the crisis. The teams engage in immediate problem solving and determine the outcome of the call. Based on the crisis, the Triage Team may authorize Mobile Response or Stabilization Service.

Components of Triage

SMR Hotline Triage

1. Triage Team completes Triage Questions Form (Appendix A) that includes:
 - a. Presenting Issue
 - b. Risk Factors
 - c. Emotional / Behavioral Needs
 - d. Life Domain Functioning
 - e. Caregiver Strength and Needs
 - f. Substance Use
 - g. Intellectual / Developmental Disability
 - h. Previous Treatment
2. Triage Team uses Triage Rubric (Appendix B) to assist in determining outcome of call:
 - a. Emergency- Activation of EMS, Law Enforcement, Child/Adult Protective Services with possible deployment of mobile response
 - b. Request for Information only
 - c. Referral only
 - d. On phone problem solving with no further action required
 - e. On phone problem solving with referral to traditional and non-traditional resources, services and supports
 - f. On phone problem solving with an invitation to engage in stabilization service
 - g. On phone problem solving with mobile response indicated and deployed within mutually agreed upon timeframe:
 - i. Emergent Crisis Response (deployment initiated within 1 hour)
 - ii. Urgent Response (deployment initiated within 24 hours)
 - iii. Routine Response (deployment initiated within 72 hours)

Authorization of Mobile Response

When it is determined mobile response is to be deployed, the Triage Team:

1. Obtains family verbal consent
2. Ensures youth is available
3. Includes the mobile response provider on the call with family/caller for a seamless experience to:
 - a. Share essential information
 - b. Agree on time for dispatching mobile response
 - c. Complete Safety Screen for Mobile Response Deployment (Appendix C)

Authorization of Stabilization Services

The Triage Team may authorize Stabilization Services upon request or recommendation from the SMR team after initial mobile response deployment.

The Triage Team:

1. Accepts completed Stabilization Authorization Form (Appendix D) requesting authorization for Stabilization Services
2. Determines the most clinically appropriate Stabilization Service provider
3. Coordinates a seamless transition to Stabilization Service provider

Documentation

The Triage Team must document every interaction with the family. Documentation is proscribed in the Data File Format and Definitions document (Appendix E). Required documentation at triage includes:

- a. Child's name, date of birth and county of residence
- b. Callers relationship to the child
- c. Date and time of call;
- d. Triage assessment
- e. Resolution indicator

Data and Reporting

To ensure quality, standardized services are provided and guiding principles are followed, the Triage Team collects required data at the time of service and transfers data to DHS each month. Data related to Triage volume and outcomes are summarized and reported back to the Regions each month.

Mobile Response Service Guidelines

Purpose

Mobile Response Teams meet face to face with the child, youth or family in their home or chosen community setting. Mobile Response is available, at a minimum, from 7:00 am to 11:00 pm, 7 days a week, year round.

Service Description

Mobile Response Teams:

1. Respond to any non-imminent life threatening emotional symptoms and/or behaviors that disrupt the child/youth's ability to function
2. Provide immediate intervention to assist the child/youth and their caregivers de-escalate behaviors and emotional symptoms impacting the child/youth's ability to function
3. Engage, assess, deliver, and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve life functioning
4. Support the child/youth to remain in or return to their present living arrangement, and function in school and community settings
5. Prevent/reduce the need for care in a more restrictive setting (i.e. inpatient psychiatric hospitalization, detention, out of home placements, etc.) by providing timely community based interventions, services and resources
6. Facilitate the youth's and the caregiver's transition into identified formal and informal supports, resources, and services such as Stabilization Services, community based services, and natural resources

Mobile Response teams are deployed by the SAFE-FAM line. Upon deployment, the Mobile Response Team:

1. Reviews the completed Safety Screen for Mobile Response Deployment (Appendix C)
2. Deploys within the established timeframes
3. Provides initial face to face interventions to the child/youth and family to stabilize presenting needs
4. Continues to provide on-site interventions to resolve the crisis and stabilize the situation for up to 72 hours following the initial intervention to:
 - a. De-escalate presenting behaviors and/or emotional symptoms
 - b. Assess, plan and connect to resources and supports
 - c. Build skills to cope with presenting behaviors, emotional symptoms, and existing situations
 - d. Teach strategies to prevent/avoid future crises and unstable situations

Documentation

The Mobile Response Team must document every interaction with the family. Documentation must include the following:

1. Date and time of deployment

2. Duration of service
3. Service provider's Provider ID
4. The setting in which the service was delivered
5. Whether the circumstances of the service met definition of emergency or not
6. Whether the situation was resolved at the end of the service
7. Outcome indicators
 - a. Child's location at the end of the service
 - b. Child's interaction with law enforcement at the end of the service
 - c. Perceptions of alternatives (what the caregiver anticipated happening, had services not been available)

Data and Reporting

Mobile response teams will report outcomes of the deployment to the Triage Team within 72 hours of mobile response. Data required by DHHS (Appendix E) must be submitted to DHHS by the 30th of each month in the specified format. Data are summarized by DHHS and reported back to the regions at the end of each month for use in regional quality improvement processes.

Stabilization Service Guidelines

Purpose

Intensive Stabilization Services are available for up to 8 weeks with an additional 8 weeks of post-stabilization coaching and support to children, youth, and their families.. These services are available as a transition option when a child or youth continues to exhibit patterns of behavioral and emotional needs, which require continued intervention and coordination to maintain typical functioning and prevent continued emotional and/or behavioral escalation. Interventions at this level of care are intensive and focus on short term, in-home interventions to stabilize current behavioral health needs.

Service Description

Stabilization Services are individualized, collaborative, flexible, intensive and are based on the child or youth and families' needs. A licensed mental health professional provides clinical oversight of the stabilization services delivered by the provider. Services are grounded in System of Care values and principles. Care is strengths based, child centered and family driven, community based, trauma sensitive, and culturally and linguistically mindful. In order to meet the individual needs and provide specialized services, the SMR Administrator is required to have a broad flexible array of stabilization services available. The Stabilization provider may provide stabilization services in which they have expert experience. However, they are required to contract for stabilization services in which they do

not have expertise with providers who have said expertise. Interventions may include, but are not limited to:

- Behavioral assistance
- Biopsychosocial evaluation and/or behavioral assessment. If not yet completed upon referral, as completed by a qualified licensed mental health provider or other qualified professional to inform treatment and stabilization planning
- Caregiver stabilization interventions using evidenced based practices (EBP)
- Child development screenings
- Coordinate and refer to follow up or longer term services and informal supports
- Coordination with youth's school
- Crisis intervention (on call - available 24/7/365)
- Family therapy as needed and clinically indicated
- Intensive in-community services
- Medication management
- Peer/parent coaching and mentoring
- In-home skills development services using evidenced based practice
- Referral to individual therapy and supportive counseling as needed
- Respite
- Stabilization planning as guided by Utah Family and Children Engagement Tool (UFACET), psychosocial and behavioral assessments treatment goals informed by evidence based practices
- Suicide and risk assessment with appropriate safety or de-escalation planning as clinically indicated
- Support services

Virtual Considerations

SMR should be delivered and catered to the family's needs. In-person services should be prioritized and offered first. Virtual SMR services can be offered/provided if family needs indicate this need. SMR providers should be mindful of the family's ability to effectively participate in SMR services via virtual delivery and collaborate with the family. Considerations include family's internet access and reliability, child's ability to remain attentive during stabilization service, efficacy of evidence based treatment via virtual method, and family's preference/availability.

Intensive Stabilization Services

	8 Week Intensive In-Home	8 Week Post Stabilization
Location of Service	Home and Community	Home and Community
Crisis Response and Availability	24/7	24/7
Treatment Episode Duration (Total - 16 weeks)	8 weeks (Intensive Services)	8 weeks (Coaching and Crisis)
Intensity	<p>Frequency Weeks 1-4: 2-5 sessions per week; Must also make contact with the family every week day (phone or text when not in person) to ensure continued stability Duration: 4-8 hours per week</p> <p>Frequency Weeks 5-8: Titrate to a minimum of 1 in-person session per week; Must titrate additional contact with the family to 2-3 per week (phone or text when not in person) to ensure continued stability Duration: 2-4 hours per week</p>	<p>Frequency Weeks 8-16: Minimum check in with client and family every other week; Crisis coaching as needed</p> <p>Duration: As needed to ensure continued stability</p>
Active Safety Planning and Monitoring	Ongoing	Ongoing
Flexible Scheduling	Convenient to Family	Convenient to Family
Systemic Engagement and Community Teaming	Examples: child and family teaming, skillful advocacy, family partnering, culturally mindful engagement	Examples: child and family teaming, skillful advocacy, family partnering, culturally mindful engagement
Active Clinical Supervision and Oversight	Available 24/7	Available 24/7

Authorization of Services

Stabilization Services must be pre-authorized by the Regional Administrator. To request authorization, Stabilization Authorization Form (Appendix D) must be completed.

Timeline of Services

Weeks 1-4:

During the initial 4 weeks of intervention, the assigned stabilization provider(s) will meet with the family in-person for 2-5 sessions per week. At least two of these sessions must be held with the family in their home. Additional services may be provided in a community or office setting when warranted by familial need. Additionally, on days where there is no scheduled in-person service, a phone call or text message should be offered to verify continued stability and offer coaching skills. Duration of time: 4-8 hours per week. Phone and in-home crisis coaching is also made available by the service provider as needed. Family needs of a 2 person team versus a single stabilization worker should be clinically considered to maximize staffing resources.

Weeks 5-8:

Beginning at week 5, in-person stabilization sessions will titrate down to a minimum of once per week. Check-in calls and/or text messages will also titrate to 2-3 contacts per week. Duration of time: 2-4 hours per week. Phone and in-home crisis coaching continues to be provided as needed. Approximately 4-6 weeks after the initiation of stabilization services, a family and team meeting is held with identified formal and informal supports to address progress, treatment needs, identify additional supports, and make necessary changes to the stabilization plan and should begin preparing to transition the family to post stabilization follow up.

Weeks 9-16:

The stabilization service provider will check in with the family every other week (minimum) to verify continued stability. Crisis coaching is provided on an as needed basis during transition from stabilization services.

Documentation

The SMR Administrator is responsible for ensuring that the stabilization services are provided appropriately. The stabilization service provider must submit the documentation of services and interactions with the family within five business days of service delivery to the SMR Administrator. The stabilization service provider must maintain documentation that includes at minimum:

1. A written clinical assessment that evaluates the presenting complaints and stabilization needs. If this assessment has been completed by the SMR Administrator, it will be provided to the stabilization provider at the point of referral. If the SMR Administrator has not completed the assessment, it will be the responsibility of the stabilization provider to ensure that the assessment meets Medicaid standards and Preferred Practice Guidelines.

2. A completed UFACET. If this assessment has been completed by the SMR Administrator, it will be provided to the stabilization provider at the point of referral. If the SMR Administrator has not completed the assessment, it will be the responsibility of the stabilization provider to ensure that the assessment is completed following Practice Guidelines.

3. Completed Safety Plan. The safety plan must include, at a minimum, the following elements:

- a. Identification of early warning signs of a crisis (specific feelings, symptoms or behaviors that may precede a crisis)
- b. Steps the individual can take to prevent escalation of behaviors
- c. Contact number(s) to be used in the event of a crisis

4. Completed Cantril's Ladder assessment(s). The Cantril's Ladder assessment must be completed at every stabilization appointment.

5. A written individualized Stabilization Plan of care developed by a licensed mental health therapist. The Plan must include the following, at minimum:

- a. Measurable treatment goals
- b. Treatment regimen, including specific treatment methods that will be used to meet the goals
- c. Projected schedule of service delivery, including frequency and duration of each treatment method
- d. Signature and licensure or credentials of the individual who developed the stabilization plan
- e. License or credentials of the individuals who prescribed services
- f. Individual(s) present in session
- g. The focus of stabilization session plan

6. The stabilization provider must document every interaction with the family.

Documentation must include the following:

- a. Date, time, and duration of the service
- b. Setting in which the service was rendered
- c. Specific service rendered
- d. Data elements as outlined by DHS (APPENDIX E)
- e. Stabilization goal(s) addressed in session
- f. Client's progress toward goal(s) or if there was no reportable progress

g. documentation of reasons or barrier; and a signature and licensure or credentials of individual who rendered the service

7. All documentation must be maintained within the client record. If Medicaid documentation requirements conflict with this document, Medicaid requirements will prevail.

Data and Reporting

The SMR Administrator will submit data and outcome elements by the 30th of each month according to the format specified in the Data File Format and Definitions (Appendix E). Data are summarized by DHHS and reported back to the regions at the end of each month for use in regional quality improvement processes.

SMR Administrator Accountability

SMR Administrator will ensure the service provider complies with all stabilization service requirements. The SMR Administrator will audit the service provider(s) quarterly to confirm compliance.

DHHS Accountability

DHS will audit the SMR Administrator annually, at a minimum, to ensure compliance with all stabilization service requirements.

Payment

SMR Stabilization Services are provided under a bundled rate amount with a weekly payment schedule. This table is for **demonstrative purposes** only, but outlines the ability of providers to have increased funding for better program sustainability. Providers are eligible to bill \$75 per day that stabilization services are provided in accordance with Medicaid billing code H2022. Additional clarification for billing can be sought through Medicaid.

	Weekly Rate	Daily Rate
Week 1	\$750.00	\$107.14
Week 2	\$750.00	\$107.14
Week 3	\$600.00	\$85.71
Week 4	\$600.00	\$85.71
Week 5	\$450.00	\$64.29

Week 6	\$450.00	\$64.29
Week 7	\$300.00	\$42.86
Week 8	\$300.00	\$42.86
TOTAL	\$4,200.00	\$4200.00

The SMR Administrator will authorize payment on a monthly basis to the service provider. If services are not provided as detailed above or are insufficiently documented, the SMR Administrator reserves the right to deny payment or request a payback. In the event that payment is denied for insufficient documentation, the service provider will have up to 30 days to submit corrected documentation.

Billing will not be authorized for any week when billable interventions/services are not provided

- If a family is unavailable to participate in stabilization services due to an agreed upon planned absence (vacation, etc.) or
- If an unplanned disruption in services occurs, the stabilization service provider will make reasonable attempts (minimum of 3 contacts, at least one at the home) to re-engage with the family
- If the family withdraws consent to participate in stabilization services at any time, the stabilization service provider will discontinue providing services. The stabilization provider will inform the SMR Administrator and submit finaling billing for the last week services were provided. At this time, stabilization services would be documented as “resolved”. Billing will resume when the billable interventions/services are provided.
- If the family commits to continue receiving stabilization services, services and billing are resumed from the time of disruption (stabilization services do not start at week one).

The SMR Administrator will be responsible for invoicing Medicaid on a monthly basis for all stabilization services (contracted and non-contracted) provided the previous month. If services are not provided as detailed above or are insufficiently documented payment may be denied or require a payback.

SMR Administrator Responsibilities

The SMR Administrator is responsible for providing all services in the SMR model. The SMR Administrator may subcontract for one or more SMR services. If subcontractors are providing service(s), the SMR Administrator shall retain responsibility for full compliance to the SMR Model and policy and procedures. The SMR administrator must comply, and ensure contract providers comply, with the following:

1. Utah Code 17-43 and 62A-15

2. Utah Administrative Code R523 and
3. OSUMH Division Directives

Staff Training

All direct care staff providing Mobile Response or Stabilization services must complete the following trainings at a minimum:

1. CPR/First Aid
2. UFACET
3. Risk Assessments
4. De-escalation Techniques
5. Safety Planning

Medicaid

The SMR Administrator and their subcontractor(s) must be enrolled as a Utah Medicaid Provider. The SMR Administrator must adhere to Medicaid requirements for Intensive Stabilization Services (ISS) as outlined in the amended UT PCN 1115 when billing for medicaid eligible children/youth engaged in the 6-8 weeks of intensive stabilization services under ISS.

SMR Hotline Number (1-833-SAFE-FAM)

The SMR hotline number will be answered by the statewide crisis line. The statewide crisis line will refer to the appropriate administrator for outreach.

Marketing

SMR administrators will use the marketing materials provided by DHHS. SMR Administrator shall not make any changes to the marketing materials without DHHS approval.

Compliance

The SMR Administrator will audit the service provider(s) annually. At minimum, the audit will:

1. Ensure compliance to the SMR Model
2. Ensure policy and procedures are followed
3. Ensure data is collected and reported
4. Include consultation and feedback for continuous quality improvement

Payment

The SMR Administrator is responsible for payment to any subcontractors, if applicable. The SMR Administrator will:

1. Receive invoices from service provider(s)
2. Reconcile invoices with authorizations

3. Process invoices for payment on a monthly basis

The SMR Administrator is responsible for invoicing DHHS or Medicaid on a monthly basis.

DuHHS Responsibilities

DHHS is responsible for providing the SMR model and policy and procedures.

Medicaid

DHHS will coordinate with Medicaid to address billing and other issues which may arise that will affect SMR.

SMR Hotline Number (1-833-SAFE-FAM)

DHHS is responsible for providing the statewide SMR hotline number with georouting to the appropriate SMR Administrator.

Marketing

DHHS will design and approve all marketing materials for advertising SMR.

Compliance

DHHS will audit the SMR Administrator yearly. At minimum, the audit will:

1. Ensure compliance to the SMR Model
2. Ensure policy and procedures are followed
3. Ensure data is collected and reported
4. Ensure that subcontractor(s) are being audited
5. Include consultation and feedback for continuous quality improvement

Payment

DHHS is responsible for monthly payment to SMR Administrators and the state match for ISS, not exceeding the threshold agreed to in writing with each SMR provider.

Reporting

DHHS is responsible for summarizing data each month and returning data summary reports to the regions.

APPENDIX A

Triage Questions

Presenting Issue	<ul style="list-style-type: none"> • “Are you calling about a youth in crisis?” • “Please describe what is happening right now.” • If 911 emergency, stay on the line and call 911 <ul style="list-style-type: none"> ◦ If 911 emergency is NOT described: “Has this, or something similar happened before?” <ul style="list-style-type: none"> ■ If yes, “what was the outcome?” ■ If youth is described as suicidal or any person in the house is acting violently, “Does the youth or violent party have access to a weapon?”
Emotional	<ul style="list-style-type: none"> • “Tell me about the emotions, such as fear, anger or sadness, that you are seeing right now.” • “Do the emotions make sense to you, given the situation?” • “How hard is it for <emotional party> to control their emotions?”
Cognitive	<ul style="list-style-type: none"> • “Does everybody appear to be thinking clearly right now?” • If no, “please tell me a little about the trouble <involved persons> is having with his/her thought process”
Behavioral	<ul style="list-style-type: none"> • “Is anyone acting erratically or unpredictably?” (If yes, please describe) • Is anyone doing the things that might make this situation worse?” (If yes, please describe) • “Is anyone doing things that might interfere with their normal functions or tasks?” (If yes, please describe)

Appendix B - Mobile Response Triage Rubric

For use with approved Triage Script, after training on Rubric

Triage Code	Action	Examples	Affective Domain (any involved parties)	Cognitive Domain (any involved parties)	Behavioral Domain (any involved parties)
Emergency	Stay on line until help arrives	Overdose; suicide attempt/serious self-harm in progress; suicidal with desire, intent and means; violence or threats of violence with access to weapon; medical emergency; crime in progress	N/A	N/A	N/A
Emergent Crisis	Initiate Mobile Deployment within 1 hour	Suicidal ideas or threats with desire and/or intent but no means; self-harm in progress; violent or destructive behavior or threats; situation/behavior has resulted in emergency in past	Emotions such as sadness, anger or fear are uncontrollable and potentially destructive	No concrete thought; cannot reason or make decisions; misunderstanding reality in a way that threatens physical safety	Behavior is erratic; unpredictable, or harmful to self or others; unable to disengage from potentially harmful behaviors
Urgent Response	Initiate Mobile Deployment within 24 hours	Suicidal Ideation or threats of serious harm with no plan/means/ or history; rapidly increasing symptoms of psychosis or mood disorder; high risk behavior associated with symptoms of	Emotions such as sadness, anger or fear are markedly higher than situation warrants and/or very difficult to control	Inability to think about anything but situation; decision making and reason seriously impaired; perceptions may not be situated in reality	Behaviors likely to escalate situation; unable to perform normal daily functions

		mental illness, substance use, trauma, or intellectual disability related conditions; similar situation has resulted in crisis in the past			
Routine Response	Initiate Mobile Deployment within 72 hours	Significant distress associated with mental health symptoms, substance use, trauma or intellectual disability related concerns; situation has escalated in the past or is likely to escalate	Emotions may be incongruent with situation; effort required to control emotions	Difficulty thinking or concentrating; perceptions may differ from reality	Behaviors may escalate the situation; difficulty performing daily functions
Stabilization only	Initiate pre-authorization for stabilization services	Mild or moderate mental health symptoms, substance use, trauma or intellectual disability related concerns; comfortable with waiting; compliance issues; situation is not likely to escalate but is likely to reoccur	Emotions mostly under control; irritable without aggression	Some difficulty concentrating but thoughts under volitional control; problem-solving and decision making minimally impaired	Some utilization of ineffective coping behaviors; occasionally neglects tasks for daily functioning
Information only	Provide information or referrals	Caller requests advice or information about available services	Emotions under control	Problem-solving and decision-making are at typical levels	Behaviors appropriate to the situation

APPENDIX C Safety Screen - Mobile Response Deployment

Who will be in the home when SMR arrives?
Is anyone else expected to arrive to the home while SMR is dispatched?
Is anyone in the home reporting current (or previous) suicidal/homicidal thoughts?
Does anyone in the home have any current or previous history of mental illness?
Does anyone in the home have any current or previous history of domestic violence/aggression?
Does anyone in the home have any current or previous history of substance abuse? If yes, is the individual exhibiting any symptoms of being, or appear to be under the influence?
Are there any weapons in the home?
Are there any animals in the home?

APPENDIX D

Stabilization Authorization Form

The Stabilization Pre-Authorization Form is used to (a) generate authorization for stabilization services and (b) to request a second episode of stabilization services. This form collects preliminary information to guide the SMR administrator in making an informed decision. Additional information should be provided upon request of the SMR administrator.

The requesting provider will be notified by the SMR administrator when authorization for stabilization services is approved. Authorization of services allows the agency providing stabilization services to offer stabilization services to the family. Stabilization services initiated without prior authorization are not guaranteed payment. Payment is contingent upon the stabilization service provider meeting requirements to include required data submission, and if necessary, data correction.

TO BE COMPLETED BY REQUESTING PROVIDER

Client Profile

Name of child _____ Gender _____ DOB _____

Name of parent/guardian _____ Phone _____

Address _____

County of Residence _____

Insurance Type _____ Date of pre-authorization request _____

Eligibility

	YES	NO
Has the child/youth been referred by the Triage or Mobile Response Team <i>(Only child/youth whom have been referred by Triage or Mobile Response are eligible for Stabilization Services)</i>		
Does the youths needs require a less restrictive or more restrictive level of care than SMR can provide		
Does the youth's caregiver voluntarily consent for treatment		
Is the youth a resident of Utah		
Is the youth is involved in a similar program, and involvement in program would be considered a duplication of services		

Is the youth's emotional or behavioral symptoms a result of a medical condition that warrants medical treatment		
Does the child/youth meet the following:		
Is the child/youth under age 21		
Recipient of services, or an individual at risk of receiving services, from two or more Utah Department of Human Service (DHS) agencies (child welfare, juvenile justice, services for people with disabilities, mental health or substance abuse, and/or the courts)		
Experiencing significant emotional and/or behavioral challenges		
And does the child/youth meet at least one of the following:		
At risk of being placed into the custody of a state agency		
Behavioral or emotional concerns prevent the child/youth from returning home or to a permanent community-based placement or place the child/youth at risk of reverting back to a higher level of care		
Has been involved in the Juvenile Competency process		
Has been referred to the DHS High Level Staffing Committee		

Preauthorization Request Questionnaire	
What is the presenting problem that resulted in SMR contact?	
What are the identified risk factors?	

What are the family dynamics, systemic issues, barriers that have resulted in, and could be improved by, the referral for stabilization services?	
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Could the family be stabilized using other, traditional resources (i.e. case management, individual therapy)?	
Would stabilization be a duplication of existing services?	
What are the potential risks and likely outcomes if family is not engaged in stabilization services?	
If the family were to be denied, what would be the formulated plan for continuity of care with diversion services (i.e. referral to case management, therapy, etc)?	
If the family were to be approved for stabilization, what is the estimated date for termination of stabilization services and initiation of post-stabilization follow up?	

Criteria for Authorization of Stabilization Services		
Youth accepted for stabilization must meet the following criteria:	Met	Not Met
The youth's caregiver voluntarily consents for treatment.		
Based on the above referral form, youth continues to have escalated emotional and/or behavioral needs, which represent a change in baseline functioning that adversely impact typical functioning in one or more life domains to include, but not exclude: school, home, living situation, or community involvement.		

TO BE COMPLETED BY SMR ADMINISTRATOR

If youth is not exhibiting escalating behaviors but have experienced trauma and/or disrupted attachments and require support due to risk of change in functioning.		
There is evidence that timely interventions can be expected to reasonably resolve or prevent further behavioral, emotional escalation or impairment in functioning; return youth and family to baseline functioning or improve emotional symptoms or behaviors; improve coping skills or provide resource facilitation to help preserve functioning in life domains.		
Does the child/youth meet at least one of the following:		
Exhibits moderate to high level risk to self or others and requires timely intervention to maintain living arrangement and avoid placement in a higher, and more restrictive level of care.		
Has moderate to high intensity needs and without intervention will further interfere with life domains.		
Youth caregivers strengths/coping skills are exceeded by the demands of the youth's behavioral or emotional needs.		

Criteria for Extension of Stabilization Services		
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All of the following are required for continuing treatment at this level of care for up to 8 weeks:	Met	Not Met
Interventions focused on reducing risk and/or continuing to decrease behavior dysregulation and improve caregiver capability.		
Interventions target reducing movement of youth from one living arrangement to another or maintaining youth in the community.		
Mode/intensity/frequency are consistent with the outlined stabilization plan.		
Stabilization plan is appropriate to youth's condition in terms of specific goals, objectives and includes target dates for accomplishments.		
Documented evidence that progress thus far, in relation to specific symptoms or behaviors, is evident and is documented in clinical record with objective terms, yet some goals have not been achieved and adjustments can be made to stabilization plan that includes strategies for meeting unmet needs.		
If necessary, a pharmacological evaluation has been completed and ongoing treatment is initiated and monitored.		

Revisions to stabilization plan are individualized, family driven, and tailored to offer results in a time efficient manner and are consistent with clinical and evidenced based practice.		
Interventions are offered to continue to stabilize the family and improve functioning and include: <ul style="list-style-type: none"> a. Crisis intervention b. Mobile and phone coaching c. Short term, in-home, family therapy d. Behavior management planning e. Caregiver therapeutic support f. Youth and family support and education to include skills building, psycho-education, respite. g. Coordination and referrals to/with informal and formal supports 		

Criteria for Termination of Stabilization Services (to be completed upon notice of termination of stabilization services):

Any of the following criteria is sufficient for discharge:	Met	Not Met
Youth's documented goals have been met and detailed transition plan and barriers to care planning have been described and documented.		
Youth requires a higher level of care that is long term (i.e. residential substance use treatment or State Hospital Placement).		
Youth and/or caregiver have withdrawn consent for treatment.		

Stabilization Services ____ Approved ____ Denied <hr/> Signature, Credentials Date
Justification for determination (authorized, extended, terminated, denied) and recommendations for continuity of care if denied (to be completed by program administrator upon notice of termination of stabilization services):