Service Name: Crisis Stabilization Unit (CSU) Services – Child and Adolescent Autism Spectrum Disorder (ASD)

Service Definition

The ASD CSU service is a short-term residential alternative to/diversion from inpatient hospitalization for youth with ASD who present with severe and challenging behaviors that seriously and imminently compromise health, safety, and/or ability to remain in the community. The primary purpose of the ASD-CSU is to provide individualized applied behavior interventions services to decrease the challenging behaviors that place the youth and/or others at serious risk, increase communication skills and adaptive skills to help mitigate the challenging behavior, and increase a caregiver's ability to support the youth in the community. The primary treatment modalities used to achieve these goals are Applied Behavior Analysis and Clinical Behavior Analysis, utilizing trauma-sensitive approaches. Additional supports such as psychiatric stabilization and substance use treatment may be provided as clinically necessary.

Specific services include:

A. Crisis-related assessment, including: A diagnostic assessment, functional behavior assessment, adaptive skills assessment, psychiatric assessment, and medical assessment;
B. Crisis intervention planning, treatment and support, including: Behavior interventions, adaptive behavior skills treatment/training, and any needed psychiatric treatment for co-occurring behavioral health diagnoses;
C. Medication administration, management, and monitoring;
D. Nursing assessment and care, including assistance with ADLs as needed;
E. Brief individual, group and/or family counseling as needed and appropriate;
F. Discharge planning and linkage to other services
G. Parent/caregiver training
H. Treatment for behavioral health-related comorbidities

Admission Criteria

Youth must meet the following criteria in each of the primary categories (I. through IV.) below:

I. Youth is between the ages of 10 to 14, and has an Autism Spectrum Disorder (ASD) diagnosis made by a professional qualified to render diagnoses under GA law or educational classification. In addition to ASD, the youth may also have co-occurring behavioral health diagnoses and/or intellectual/developmental disabilities that present challenges requiring intervention/stabilization. Increasing severe and challenging behaviors, and the need for adaptive skills acquisition treatment/training must be significant presenting needs.

II. Harm

Child/Youth presents a serious and imminent risk of harm to self or others, so as to create a gravely endangering crisis, as **evidenced by one or more of the following:**

1. Indication or report of significant impulsivity and/or physical aggression, with poor judgment and insight, and that is imminently life threatening or gravely endangering to self or others; **AND/OR**

2. There has been at least one episode of severe and highly acute maladaptive behavior. If continued, the behavior would significantly compromise the child's/youth's ability to safely remain in their home/community, and the behavior cannot be managed at a lower level of care.

III. Crisis Management/Coping

Youth must meet **either #1 or 2, in addition to #3 below**:

1. Youth demonstrates significant deficits in adaptive skills or significant maladaptive behaviors that interfere with ability to manage the immediate crisis;
2. Youth demonstrates lack of judgement, impulse control and/or cognitive/perceptual abilities to manage the crisis;
   AND
3. Youth displays high acuity maladaptive behaviors which impact their ability to function in significant life domains: family, school, social, or activities of daily living. This impacts child/youth's ability to manage the crisis situation and remain safely in the community or be supported in a lower level of care.

IV. Distress/Disruption

The youth's current behavior supports the need for the safety and structure of treatment/support provided at a high level of care, as evidenced by **BOTH Items #1 and 2 below:**

1. Less restrictive or intensive levels of treatment/support have been tried or considered, and are not appropriate to meet the individual's needs;
   AND
2. Response to treatment and/or formal/informal support has not been sufficient to resolve the crisis.

V. Clinical Need/Level of Care

Needs short-term, involuntary (1013) or voluntary treatment that includes brief crisis intervention and stabilization, **as evidenced by one or more of the following:**

1. Treatment/services at a lower level of care have been attempted and has not been sufficient to meet the youth's needs at this time,
   OR
2. Treatment/services at a lower level of care have been given serious consideration and deemed not clinically appropriate to meet the youth's needs at this time.

<u>Continuing Stay Criteria</u>

1. Individual continues to meet admission criteria as defined above; **and**
2. A behavior support plan related to the maladaptive behavior has been created/updated and implemented, but the behavior has not stabilized to the extent that the youth can safely return to his or her home/community; **and**
3. A higher level of care is not indicated.

<u>Discharge Criteria</u>

1. Youth no longer meets admission criteria and an adequate discharge/continuing support/care plan has been established; **and**
2. Youth has achieved behavior goals directly related to the crisis (or behaviors directly related to the crisis have returned to baseline), such that the youth can be safely supported at either a lower level of care or in their natural home/setting.
   OR
3. Youth's legal guardian requests discharge; **or**
4. Youth's behaviors and/or psychiatric symptoms have not stabilized within the crisis stabilization period, and youth must be transferred to a service offering a longer duration of intensive treatment/higher level of care; **or**
5. Youth no longer displays highly acute maladaptive behaviors, however, significant maladaptive behaviors are still present and youth requires additional ongoing behavior intervention and skill acquisition treatment/training prior to being able to safely be supported in the community.

Service Exclusions

1. All other Medicaid Community Based Rehabilitation Services and DBHDD State Funded Behavioral Health Core and Specialty services are excluded until the individual has been unconditionally discharged from the CSU (with the exception of the Community Transition Planning service for youth with a co-occurring behavioral health diagnosis and who are enrolled with a behavioral health provider who is authorized to provide the service).
2. All other Medicaid-reimbursable and DBHDD State Funded Intellectual and Developmental Disability services are excluded the exception of Support Coordination, consultation with established providers of Behavioral Support Services, and training of paid caregivers.

Clinical Exclusions

1. Children/youth with a behavioral health diagnosis or I/DD diagnosis in the absence of an ASD diagnosis.
2. Children/youth requiring substance use withdrawal management.
3. While many facilities use the following as clinical exclusions, the items below are not exclusionary criteria for this service:
    a. **Medical Needs:**
        i. ADLs: Inability to independently perform ADLs, as defined below, is not an exclusion criterion for this service. A youth's dependence is defined as staff supervision, direction/prompts, and personal assistance.
            1. **Transferring: The extent of a youth's ability to move from one position to another.**
            2. **Feeding: The ability of a youth to feed oneself.**
            3. **Dressing: The ability to select appropriate clothes and put clothes on.**
            4. **Personal hygiene: The ability to bathe and groom oneself and to maintain dental hygiene, hair, and nail care.**
            5. **Continence: The ability to control bladder and bowel function.**
            6. **Toileting: The ability to get to and from the toilet, use it appropriately, and clean oneself.**

b. **Sexual Risk**: Presence of sexually inappropriate behavior is not an exclusionary criterion for this service.
c. **Elopement Risk:** Elopement behavior is not an exclusionary criterion for this service. May have recent or historical episodes of elopement behaviors that have placed the individual at imminent risk to self or others.

Required Components

1. CSUs providing medically monitored short-term residential psychiatric/behavioral stabilization services shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and certified by the DBHDD.
2. In addition to all service qualifications specified in this document, providers of this service must adhere to the DBHDD policy Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units (CSUs), 01-325, and to all other CSU policies except as specifically denoted for this service in policy CSU: Child & Adolescent Autism Spectrum Disorder, 01-353.
3. Services must be provided in a facility designated as an emergency receiving and evaluation facility.
4. A CSU must have documented operating agreements and referral mechanisms for Autism Spectrum Disorder, psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring the youth to a designated treatment facility when the CSU is unable to stabilize the youth.
5. Crisis Stabilization Units (CSU) must continually monitor the bed–board, regardless of current bed availability, and review, accept or decline individuals who are awaiting disposition on a bed-board, and provide a disposition based on clinical review. It is the expectation that this CSU accepts individuals who meet the criteria above and who are most in need.
6. CSUs are expected to review, accept or decline at least 90% of all individuals placed on a bed-board over the course of a fiscal year.
7. A physician–to-physician consult is required for all CSU denials that occur when that CSU has an open/available bed.

Staffing Requirements

1. ASD CSU services must be provided by a physician or a physician extender under the supervision of a physician, practicing within the scope of State law. All services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.
2. ASD CSU must employ a full-time (FT) Nursing Administrator who is a Registered Nurse.
3. ASD CSU must always have a Registered Nurse present at the facility and maintain the ratio of 1 nurse to 8 individuals served. A second nurse may be a Licensed Practicing Nurse (LPN).

4. If the Charge nurse is an APRN, then he/she may not simultaneously serve as the accessible physician during the same shift.
5. ASD CSU must employ a full-time-equivalent (FTE) Board Certified Behavior Analyst (BCBA), who serves as the lead for all Applied Behavior Analysis (ABA) aspects of treatment.
6. ASD CSU must employ at least one additional full-time-equivalent (FTE) Board-Certified Behavior Analyst (BCBA) or a Board-Certified Assistant Behavior Analyst (BCaBA), who provides oversight to direct care staff during awake hours (first and second shift, 7 days a week). Functions performed by the BCBA or BCaBA must be performed within the scope of their practice and aligned with their professional standards. A BCaBA must be supervised by the lead BCBA on staff.
7. Staff-to individual served ratios must be established based on the needs of individuals served and in accordance with rules and regulations. A minimum of one (1) staff member per four (4) individuals served must always be maintained. Direct care staff may consist of a combination of Registered Behavior Technicians (RBT), Qualified Autism Services Practitioner-Supervisors (QASP-S), Qualified Autism Service Practitioners (QASP), Applied Behavior Analysis Technicians (ABAT), Behavior Intervention Specialists (BIS), and Mental Health Technicians (MHT). Additional clinical staff such as nurses, clinicians and BCBAs can count towards the staffing ratio. Functions performed by an RBT, QASP-S, QASP, or ABAT must be performed within the scope of their practice, and aligned with their professional standards. RBTs must be supervised by either the BCBA or Board Certified Assistant Behavior Analyst (BCaBA) on staff. QASP-Ss, QASPs, and ABATs must be supervised by the BCBA on staff.
8. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.
9. ASD CSU must have an independently licensed/credentialed practitioner (or a Supervisee/Trainee) on staff and available to provide individual, group, and family therapy.

<u>Clinical Operations</u>

1. If a child/youth is admitted via a diagnostic impression of ASD, one of the following shall apply:
    a. If there is parental/caregiver affirmation that an actual diagnosis of ASD exists, documentation of this diagnosis must be confirmed and acquired by the CSU provider within one (1) week of admission; OR
    b. If an actual diagnosis of ASD cannot be confirmed, the CSU provider must arrange for a full diagnostic workup resulting in a confirmed and documented diagnosis of ASD within two (2) weeks of admission.

    In either case, if a diagnosis of ASD is not confirmed via documentation within the specified timeframe, the provider must immediately begin arranging for transfer of the youth to services that are more appropriate for his or her needs. To facilitate this transfer, the youth should be placed on the non-ASD-specific bed board (if youth still meets CSU level of care) so that other CSUs can determine whether they are able to meet the needs of the youth.

2. Medical Care
    a. A physician must evaluate a youth referred to a CSU within 24 hours of the referral.

b. A nurse must evaluate each youth upon admission. The nurse shall also perform medication management functions and conduct other assessments/ evaluations as needed within their scope of practice.

3. A CSU must follow the seclusion and restraint procedures included in the Department's policy: CSU: Use of Seclusion or Restraint in Crisis Stabilization Services, 01-351.
4. The following restraint practices are prohibited:
    a. The use of chemical restraint for any individual.
    b. The combined use of seclusion and mechanical, and/or manual restraint.
    c. Standing orders for seclusion or any form of restraint.
    d. PRN orders for seclusion or any form of restraint.
    e. Prone manual or mechanical restraints.
    f. Transporting an individual in a prone position while being carried or moved.
    g. Use of seclusion or restraint as a part of a Behavior Support Plan (BSP) or an Individual Recovery Plan (IRP).
    h. The use of handcuffs for an individual not under the jurisdiction of the criminal justice system.
    i. The use of medication as a chemical restraint.
5. Behavior Intervention Services
    a. A BCBA must begin a functional behavior assessment on each youth within 36 hours of admission to develop the individualized Crisis Intervention Plan and Positive Behavior Support Plan.
    b. If clinically indicated, an Adaptive behavior assessment can be completed during the initial assessment by the appropriate credentialed provider. The ASD CSU must use an established adaptive behavior assessment such as the Adaptive Behavior Assessment System, 3rd Ed. (ABAS-3), Vineland Adaptive Behavior Scales, 2nd Ed, Assessment of Functional Living Skills (AFLS), etc.
    c. As part of the needs assessment, provider must work to identify necessary behavioral health and/or I/DD treatments and supports for individuals with cooccurring diagnoses. For youth with co-occurring diagnoses, this service must target the symptoms, maladaptive behaviors, and adaptive behavior deficits related to the co-occurring diagnosis and that are relevant to the crisis event.
    d. Positive Behavior Support Plans and behavior-change programs will be conceptually consistent with behavior analytic principles. Treatment implementation, fidelity and progress monitoring will be informed by quantitative data collected on the youth's behaviors while admitted to the ASD CSU.
    e. Immediately upon admission, the provider must implement its internal policies and procedures for managing crisis situations, based upon the youth's presenting behaviors and needs.
    f. Within 36 hours of admission, an individualized crisis plan must be developed (or updated if one already exists) and implemented for each youth served.
    g. Within three (3) days of admission, a provisional Positive Behavior Support Plan must be developed (which is primarily focused on the crisis-related behavior) and implemented.
    h. Within five (5) days of admission, a finalized Positive Behavior Support Plan must be fully implemented.

6. Additional Treatment
    a. Treatment for Comorbidities- Some youth may come to the ASD CSU with psychiatric, intellectual/developmental, substance use, and/or medical comorbidities. Therefore, the Contractor shall have adequate treatment options, and referral agreements to treat various types of comorbidities, in accordance with DBHDD CSU policy. All treatment shall be administered by appropriately licensed providers.
    b. Treatment of Patients with Trauma- Some youth with ASD and related disorders are more prone to experiencing trauma. The ASD CSU shall provide a licensed clinician with experience and competence in trauma focused behavior therapy to provide therapeutic support to these youth. The ASD CSU shall educate and work with the guardian/caregiver, who should be engaged in the program with the youth, to ensure that youth with trauma are discharged to safe environments.
7. In addition to providing trauma-specific treatment interventions to children/youth for whom these are needed, the CSU will utilize trauma sensitive approaches in all aspects of support to children, youth, and families.
8. Education - The ASD CSU will manage the educational needs of the youth in accordance with Georgia law while the youth receives treatment at the ASD CSU.
9. Daily Schedule - No more than 30% of all youth's waking hours (except educational schooling, mealtimes and ADL times) should be spent in milieu activities.
10. Transitioning Youth from the ASD CSU - The ASD CSU will dedicate a staff member whose primary role is to plan the appropriate discharge of the youth from the ASD CSU. This staff will work with the ASD Case Expeditors and other identified and/or established service providers to, at a minimum, complete the following:
    a. Upon admission, provider must begin developing an individualized discharge/transition plan, to include coordination and continuity of post-discharge services and supports. The CSU's case manager must assist each youth and caregiver/family with identifying and accessing needed services/supports post-discharge and must update/coordinate with any existing supporting providers and key stakeholders.
    b. Research the available community resources and outpatient providers that meet the youth's and caregiver's/guardian's needs, including financial resources and preferences for location;
    c. Discuss the transition options with the guardian/caregiver and youth engaging in the process, as appropriate;
    d. Develop a transition plan, clearly outlining the recommended, continued treatment plan and responsibilities of the guardian/caregiver;
    e. Perform all tasks related to placing the youth with the outpatient providers;
    f. At least one (1) follow-up call within seven (7) days of discharge to ensure needed community support connections have been made, and that the discharge plan is being implemented.
11. Caregiver Training
    a. To increase the efficacy of treatment at the unit, the staff of the ASD CSU will provide training for the youth's caregivers, paid and unpaid.
    b. The ASD CSU will make accommodations to ensure that caregivers are able to participate in training regardless of their proximity in relation to the ASD CSU.

c. This training shall, at a minimum, result in the following:
    i. Comprehensive knowledge on the child's complete diagnosis;
    ii. Competence in the behavior plan developed on the unit;
    iii. Knowledge on how to respond to challenging behaviors;
    iv. Knowledge on how to prevent challenging behaviors;
    v. Knowledge on how to advocate for the child's needs; and
    vi. Knowledge on how to respond and implement the crisis safety plan.

12. A daily activity schedule (per shift) must be posted in the ASD CSU, and available to external reviewers:
    a. A significant portion of the ASD CSUs daily schedule must consist of structured activities and treatment targeted toward reduction of maladaptive behaviors, acquisition of adaptive behaviors, and mitigation of any co-occurring behavioral health symptoms related to the emanating crisis.
    b. These activities should be consistent with each youth's needs as identified in their Positive Behavior Support Plan and Individualized Resiliency Plan.

<u>Service Accessibility</u>

See Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units (CSU), 01-325.

<u>Documentation Requirements</u>

1. Individuals receiving services within the CSU shall be reported as a per diem encounter based upon occupancy at 11:59PM. At 11:59PM, each individual reported must have a verifiable physician's order for CSU level of care [or order written by delegation of authority to nurse or physician assistant under protocol as specified in § 43-34-23]. Individuals entering and leaving the CSU on the same day (prior to 11:59PM) will not have a per diem encounter reported.
2. In addition to documentation requirements set forth in Part II of this manual, the notes for the program must contain documentation to support the per diem, including admission/discharge time, shift notes, and specific consumer interactions.
3. An individualized daily schedule must be included in each child/youth's clinical record.
4. The Positive Behavior Support Plan (PBSP) provides the primary direction for/management of behavior treatment in the ASD CSU, and must therefore be included as an adjunct to the IRP.
    a. The PBSP must include the following elements:
        i. Background and Statement of Problem
        ii. Relevant Medical History/Medical Necessity
        iii. Functional Behavioral Assessment
        iv. Reinforcer Identification
        v. Baseline Data
        vi. Rationale for Current Plan and Procedures
        vii. Behavioral Objectives/Behavior Goals
        viii. Alterations to Interactions and the Environment
        ix. Replacement Behavior Teaching & Skill Acquisition Training
        x. Reinforcement Procedures
        xi. xi. Strategies for Decreasing Inappropriate Behaviors

xii. Data Recording/Fidelity Monitoring
xiii. Generalization, Maintenance, Fading Strategies
xiv. Staff Training/Caregiver Training
xv. Program Monitoring
xvi. Risks and Benefits
xvii. Consent
xviii. Data Collection Forms – Challenging, replacement behavior & skill acquisition
xix. Monitoring Forms/Fidelity Checklists
xx. Staff Training Records/Plan

b. For youth who already have an active Positive Behavior Support Plan that was developed by another service provider, the ASD CSU should use interventions from that existing Plan to inform the development of the interventions to be implemented during the crisis stabilization process.

5. All children/youth must have an individualized Crisis Intervention Plan, which includes the following elements:
    a. Operational Definition of behaviors
    b. Description of situations in which the challenging behavior typically occurs
    c. Common warning signs and/or precursor behaviors that indicate a crisis is imminent
    d. Identification of staffing needed to carry out crisis curriculum procedures
    e. Identification of equipment necessary
    f. Contact information for additional staff that may be available for assistance
    g. Specific crisis curriculum techniques to use for each challenging behavior
    h. Protocols to access community-based crisis services to include the Georgia Crisis Response System, access emergency room care or law enforcement, if the acute crisis presents a substantial risk of imminent harm to self and others must be included in the crisis intervention plan provided upon discharge
    i. Procedures for debriefing and documentation- A functionally appropriate debriefing should occur.
6. The CSU must have detailed documentation of the interventions that were identified in the Positive Behavior Support Plan, and that these were both attempted and exhausted before initiating crisis interventions.
7. The ASD CSU must maintain documentation of quantitative data, graphs and narrative analysis of behavior change programs, replacement behaviors, skill acquisition, and medication changes related to behavior intervention and the emanating crisis behaviors.
8. The ASD CSU must maintain documentation of fidelity monitoring regarding implementation of the Positive Behavior Support Plan and interventions.
9. The ASD CSU must maintain documentation of behavior support plan and intervention competency training of staff and caregivers

<u>Billing & Reporting Requirements</u>

1. This service requires authorization via the Georgia Collaborative ASO (ASO) via the Georgia Crisis and Access Line. Providers will select an individual from the Referral Board. If they accept an individual, they will assign the individual to a bed on the inventory status board (via bhlweb). Once an individual is assigned to the inventory status board a tracking number will be generated

and the information will be sent from the ASO crisis access team to the ASO care management team for registration/authorization to take place. Once an authorization number is assigned, that number will appear on and an email will be generated and sent to the designated UM of the SCB facility containing the authorization number;

2. The CSU must report information on all individuals served in CSUs no matter the funding source;
3. The CSU shall submit prior authorization requests for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.);
4. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.);
5. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span;
6. Providers must submit a discharge summary into the provider connect/batch system within 48 hours of CSU discharge.

Additional Medicaid Requirements

None