



TEXAS  
Health and Human  
Services

# Form N, Crisis Service Standards

## *Definitions*

**Adolescent** - An individual at least 13 years of age, but younger than 18 years of age.

**Adult Caregiver** - An adult person whom a parent has authorized to provide temporary care for a Child, as defined in Texas Family Code §34.0015(1).

**Assessment** - A systematic process for measuring an individual's service needs.

**Certified Peer Specialist (CPS)** - A person who uses lived experience, in addition to skills learned in formal training, to deliver strengths-based, person-centered services to promote an individual's recovery and resiliency as defined in 15 Texas Administrative Code (TAC), Subchapter N, §354.3003 (relating to Definitions).

**Child** - An individual at least 3 years of age, but younger than 13 years of age.

**Community Services Specialist (CSSP)** – As defined by 26 TAC Subchapter G, §301.303 (relating to Definitions) a staff member who:

- a. received:
  - i. high school diploma; or
  - ii. high school equivalency certificate issued in accordance with the law of the issuing state;
- b. had three continuous years of documented full-time experience in the provision of mental health rehabilitative services or case management services; and
- c. demonstrated competency in the provision and documentation of mental health rehabilitative or case management services in accordance with 26 TAC, Chapter 306, Subchapter F of this title (relating to Mental Health Rehabilitative Services) and 26 TAC, Chapter 306 Subchapter F of this title (relating to Mental Health Case Management Services).

**Continuity of Care** – As defined in 26 TAC Subchapter D, §306.153 (relating to Definitions) activities designed to ensure an individual is provided uninterrupted services during a transition between inpatient and outpatient services that assist the individual and the individual's LAR in identifying, accessing, and coordinating a local mental or behavioral

health authority (LMHA or LBHA) service and other appropriate services and supports in the community needed by the individual including:

- a. assisting with admissions and discharges;
- b. facilitating access to appropriate services and supports in the community, including identifying and connecting the individual with community resources, and coordinating the provision of services;
- c. participating in the developing and reviewing individual's recovery or treatment plan;
- d. promoting implementation of the individual's recovery or treatment plan; and
- e. coordinating notification of Continuity of Care services between the individual and the individual's family and any other person providing support as authorized but the individual, and LAR if any.

**Crisis** – As defined by 26 TAC Subchapter G, §301.303 (relating to Definitions) a situation in which:

- a. the individual presents an immediate danger to self or others; or
- b. the individual's mental or physical health is at risk of serious deterioration; or
- c. an individual believes that he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.

**Crisis False-alarm** – A designation (GJ modifier) for Crisis hotline calls that require routine follow up and are not emergent or urgent. These calls do not require the use of MCOT activation.

**Crisis Stabilization Unit (CSU)** – a Crisis Stabilization Unit providing short-term residential treatment 24 hours a day, every day of the year, in a secure and protected treatment environment licensed in accordance with Texas Health and Safety Code Chapter 577 (relating to Private Mental Hospitals and Other Mental Health Facilities)

- a. CSU services are provided by medical personnel, mental health professionals, and trained support staff with documented competency in the provision of Crisis services designed to reduce an individual's acute mental health symptoms.
- b. CSU services are provided in accordance with standards in 26 TAC, Chapter 306, Subchapter B (relating to Standards of Care in Crisis Stabilization Units) and 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards).

**Crisis Support Staff** – A staff member who is not a licensed professional or a fully qualified professional but is delegated tasks within the healthcare system. This person has Crisis training appropriate to the context they are working in and must have, at minimum, a high school diploma or its equivalent.

**Crisis Treatment Plan** - An individualized plan that develops and implements the most effective, and least restrictive, available Crisis services necessary to stabilize the Crisis episode. Used for EOU and Crisis Residential and Respite. The Crisis Treatment Plan must:

- a. Be developed by a staff credentialed, at minimum as a QMHP-CS
- b. Be based on the individual's provisional psychiatric diagnosis; and
- c. Incorporate, to the maximum extent possible, individual preferences

**Declaration for Mental Health Treatment** - A legal document that allows an individual to make decisions in advance (advanced directive) about specific mental health treatments related to psychoactive medication, convulsive therapy and emergency mental health treatment. The instructions an individual includes in this declaration will be followed only if a court believes that an individual is incapacitated to make treatment decisions. Otherwise, an individual will be considered able to give or withhold consent for the treatments noted above.

**Developmental Disability (DD)** - A severe, chronic disability attributable to mental or physical impairment or a combination of mental and physical impairments that:

- a. manifests before an individual reaches 22 years of age;
- b. is likely to continue indefinitely;
- c. reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of a lifelong or extended duration and are individually planned and coordinated; and
- d. results in substantial functional limitations in three or more of the following categories of major life activity:
  - i. self-care;
  - ii. receptive and expressive language;
  - iii. learning;
  - iv. mobility;
  - v. self-direction;
  - vi. capacity for independent living; and
  - vii. economic self-sufficiency.

**Emergency Medical Services** - Services used to respond to an individual's perceived need for immediate medical care and to prevent death or aggravation of physiological or psychological illness or injury.

**Emergency Care Services** - As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) mental health community services or other necessary interventions directed to address the immediate needs of an individual in Crisis to assure the safety of the individual and others who may be placed at risk by the individual's behaviors, including, but not limited to, psychiatric evaluations, administration of medications, hospitalization, stabilization, or resolution of the Crisis.

**General Residential Operation** – A residential Child-care operation that provides Child care for 13 or more Children or young adults according to 26 TAC Chapter 748, Subchapter B (relating to Definitions and Services). The care may include treatment services and/or programmatic services. These operations include formerly titled emergency shelters, operations providing basic Child care, residential treatment centers, and halfway houses.

**Inpatient Services** – Services including medical, nursing, and mental health professionals providing 24-hour monitoring, supervision, and interventions designed to relieve acute psychiatric symptomatology and restore an individual's ability to function in a less restrictive setting. Inpatient units must comply with 26 TAC Chapter 568 (relating to Standards of Care and Treatment in Psychiatric Hospitals).

**Individualized Crisis Treatment Plan** - An individualized plan that develops and implements the most effective, and least restrictive, available Crisis services necessary to stabilize the Crisis episode. Used for MCOT and Walk-In Services. The Individualized Crisis Treatment Plan must:

- a. Be developed by a staff credentialed, at minimum as a QMHP-CS
- b. Be based on the individual's provisional psychiatric diagnosis; and
- c. Incorporate, to the maximum extent possible, individual preferences

**Intellectual Disability (ID)** - Significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period, which is before the age 18.

**Legally Authorized Representative (LAR)** – A person authorized by law to act on behalf of an individual about a matter described in this subchapter, including, but not limited to, a parent, guardian, or managing conservator.

**Local Intellectual and Developmental Disability Authority (LIDDA)** – As defined 26 TAC Subchapter C §307.105 (relating to Definitions) an entity designated as the Local Intellectual and Developmental Disability Authority by the Health and Human Services Commission (HHSC) in accordance with Texas Health and Safety Code §533.0356.

**Local Behavioral Health Authority (LBHA)**- As defined 26 TAC Subchapter C §307.105 (relating to Definitions) an entity designated as the Local Mental Health Authority by the HHSC in accordance with Texas Health and Safety Code §533.0356

**Local Mental Health Authority (LMHA)** - As defined 26 TAC Subchapter G §301.303 (relating to Definitions) an entity designated as the Local Mental Health Authority by the HHSC in accordance with Texas Health and Safety Code §533.035(a).

**Licensed Professional of the Healing Arts (LPHA)** – As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) a staff member who is:

- a. a physician;
- b. a licensed professional counselor;
- c. a licensed clinical social worker;
- d. a licensed psychologist;
- e. an advanced practice nurse; or
- f. a licensed marriage and family therapist.

**Medical Necessity** – As defined in 26 TAC Subchapter F, §306.305 (relating to Definitions) a clinical determination made by an LPHA that services:

- a. are reasonable and necessary for the treatment of a serious mental illness; or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
- b. are provided in accordance with accepted standards of practice in behavioral health care;
- c. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- d. are at the most appropriate level or amount of service that can be safely provided; and
- e. could not have been omitted without adversely affecting the individual's mental or physical health or the quality of care rendered.

**Mobile Crisis Outreach Team (MCOT)** – Qualified professionals deployed into the community to provide a combination of Crisis services including facilitation of Emergency Care Services and provision of Urgent Care Services, Crisis follow-up, and relapse prevention to Children, Adolescents, or adults 24 hours a day, every day of the year.

**On Call** - The Code of Federal Regulation Fair Labor Standard Act states an employee is on standby duty or On Call status if the employee is restricted by official order to a designated post of duty and is assigned to be in a state of readiness to perform work with limitations on the employee's activities so substantial that the employee cannot use the time effectively for his or her own purposes.

**On Duty** – A period of time when an LMHA/LBHA employee is on the employer's premises or at any other prescribed place of work, from the beginning of the first principal activity of the work day to the end of the last principal work activity of the workday.

**Outpatient, Screening, and Assessment and Referral Services (OSAR)** – A service available to individuals interested in information about substance use services. OSAR Services are incorporated into LMHAs and LBHAs across the 11 Texas Health and Human Services Regions. The only requirement for service is that an individual is currently residing in the state of Texas.

**Person-centered Recovery Plan** – As defined in 1 TAC Subchapter N, §354.3003 (relating to A written plan that serves as a plan of care and:

- a. is developed with the person, others whose inclusion is requested by the person and who agree to participate, and the persons planning or providing services;
- b. amended at any time based on the person's needs;
- c. guides the recovery process and fosters resiliency;
- d. identifies the person's changing strengths, capacities, goals, preferences, needs, and desired outcomes; and
- e. identifies services and supports to meet the person's goals, preferences, needs and desired outcomes.

**Psychiatric Emergency Services Center (PESC)** - A Psychiatric Emergency Services Center that provides walk-in access to immediate behavioral health emergency Screening and Assessment, extended observation services, and a continuum of Crisis and behavioral emergency stabilizing treatment for individuals whose behavioral symptoms cannot be stabilized within 48 hours. A PESC must provide a combination of services that includes, at minimum:

- a. Extended Observation services, as described in Form N.IV. Extended Observation Unit A. Description, in a designated area of the PESC; and
- b. Inpatient Services in an environment designed to provide safety and security during acute behavioral health Crisis; or
- c. CSU services in a secure and protected treatment environment that complies with CSU licensure requirements.

**Qualified Mental Health Professional-Community Services (QMHP-CS)** – As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) a staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:

- a. has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA, LBHA, or Managed Care Organization in accordance with 26 TAC Chapter 301, Subchapter G of this title (relating to Competency and Credentialing) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early Childhood education, or early Childhood intervention;
- b. is a registered nurse; or
- c. completes an alternative credentialing process identified by the department.

**Routine Care Services** - As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) mental health community services provided to an individual who is not in Crisis.

**Rural** – a county with less than 250,000 residents.

**Screening** - As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) activities performed by a QMHP-CS to gather triage information to determine the need for in-depth Assessment. The QMHP-CS collects this information through face-to-face, or telephone or tele-health interviews with the individual or collateral.

**Stock Inspection** - A most recent stock and medication room inspection, including inventory of over-the-counter stock medication, inventory of client medications, controlled drug inventory, monitoring of the emergency medication kit, monitoring of medication expiration dates, and a medication room inspection, which includes monitoring of medication refrigerator temperature controls.

**Substance Use Disorder** – As defined by 15 TAC Subchapter N, §354.3003 (relating to Definitions) recurrent use of alcohol or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

**Telehealth** - In accordance with Texas Occupation Code Chapter 111, and 22 TAC Subchapter B, §174.9 (relating to Mental Health Services), which allows provision of mental health services, a health service other than a Telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to an individual at a different physical location than the health professional using telecommunications or information technology, including:

- a. compressed digital interactive video, audio, or data transmission;
- b. clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- c. other technology that facilitates access to health care services or medical specialty expertise.

**Telemedicine** - In accordance with Texas Occupations Code Chapter 111, and 22 TAC Subchapter B, §174.9 (relating to Mental Health Services), which allows provision of mental health services, a health care service delivered by a physician licensed in this state or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to an individual at a different physical location than the physician or health professional using telecommunications or information technology, including:

- a. compressed digital interactive video, audio, or data transmission;
- b. clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- c. other technology that facilitates access to health care services or medical specialty expertise.

**Urban** – a county with a population of over 250,000 residents.

**Urgent Care Services** - As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) mental health community services or other necessary interventions provided to individuals in Crisis who do not need Emergency Care Services but who are potentially at risk of serious deterioration.



# *Crisis Service Standards*

## **I. Hotline**

### **A. Definition**

A Crisis hotline is continuously available telephone service staffed by trained and competent Crisis staff to provide Crisis Screening and access to Crisis intervention services, mental health and substance use referrals support, and general mental health and substance use information to callers 24 hours per day, seven days per week.

### **B. Goals**

- Crisis resolution in the least restrictive environment
- Immediate telephone response to individuals for the purpose of linkage to appropriate services and follow-up

### **C. Description**

In accordance with Texas Health and Safety Code (THSC) §534.053(a)(1) and 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) the Crisis hotline is an integrated component of the overall Crisis program; it operates continuously and is accessible toll-free throughout the local service area. Any entity providing Crisis hotline services for any portion of the day must be accredited by the American Association of Suicidology (AAS).

The Crisis hotline serves as an immediate point of contact for mental health and substance use crises in the community, providing confidential telephonic triage to determine the immediate level of need and to mobilize emergency services for the caller if necessary. The Crisis hotline facilitates referrals to 911, Mobile Crisis Outreach Teams (MCOT), or other Crisis services and conducts follow-up contacts to ensure callers successfully accessed the referred services. The initial Screening leads to immediate and appropriate referrals, including OSAR. If an emergency is not evident after further Screening or Assessment, the Crisis hotline includes referral to other appropriate resources within or outside the LMHA/LBHA. The Crisis hotline works in close collaboration with local law enforcement and 211 and 911 systems.

### **D. Standards**

#### **1. Staffing**

- a. Community Services Specialist (CSSP) or Crisis Support Staff. A CSSP or Crisis Support Staff may answer the Crisis hotline and provide information and non-Crisis

referrals for routine calls. In accordance with 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards), if the call is deemed emergent or urgent, then the CSSP or Crisis Support Staff must refer to the QMHP- CS within one minute after the call is identified as such.

- b. Peer Support Specialist. A Peer Support Specialist may answer the Crisis hotline and provide peer services in accordance with 15 TAC, Chapter 354, Subchapter N (relating to Peer Specialist Services). If the call is deemed emergent or urgent, then the Peer Support Specialist must refer to the QMHP-CS within one minute after the call is identified as such if the staff is not also certified as a QMHP-CS.
- c. QMHP-CS. A QMHP-CS is required to provide Screening and Assessment to determine the nature and seriousness of the call.
- d. LPHA. A LPHA must be available for consultation 24 hours a day, in person or by telephone.
- e. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

## 2. Training and Competency

- a. Training. All QMHP-CSs responding to Crisis calls are required to be trained and competent in all domains of the Screening.
- b. Evidence of Crisis.
  - i. If an emergency is evident after the Screening, Crisis hotline staff must facilitate referrals to the MCOT, or other emergency care or Emergency Medical Services.
  - ii. If an emergency is not evident, the Crisis hotline staff must provide referrals to other appropriate resources within or outside the LMHA, LBHA, or LIDDA.

## 3. Crisis Hotline Screening Requirements

The Crisis hotline is required to provide a thorough Crisis Screening and documentation that incorporates the following domains:

- a. Suicide Risk Screening
  - i. Suicidal ideation – documents the wish to be dead, non-specific active suicidal thoughts without thoughts of ways to kill oneself, active suicidal ideation with any methods without intent to act, active suicidal ideation with some intent to act but without a specific plan, current access to means, and active suicidal ideation with specific plan and intent.
  - ii. Intensity of ideation – documents frequency, duration, controllability, deterrents, and reasons for ideation.
  - iii. Suicidal behavior – documents actual attempts, non-suicidal self-injurious behaviors, interrupted attempts, aborted or self-interrupted attempts, preparatory acts or behaviors, actual and potential lethality of the most recent attempt, most lethal attempt, and the initial or first attempt.

b. Homicide Risk Screening

- i. Homicidal Ideation – documents the wish for another to be dead, non-specific active homicidal thoughts without thoughts of ways to kill another, active homicidal ideation with any methods without intent to act, active homicidal ideation with specific plan and intent.
- ii. Intensity of Ideation - documents frequency, duration, controllability, deterrents, and reasons for ideation.
- iii. Homicidal behavior – documents actual attempts, non-homicidal injurious behaviors, interrupted attempts, aborted or self-interrupted attempts, preparatory acts or behaviors, actual and potential lethality of the most recent attempt, most lethal attempt, and the initial or first attempt.

c. Risk of Deterioration Screening

- i. Documents any report of suffering from severe and abnormal mental, emotional, or physical distress;
- ii. Documents experiencing substantial mental or physical deterioration of the proposed individual's ability to function independently, which is exhibited by the proposed individual's inability, except for reasons of indigence, to provide for the proposed individual's basic needs, including food, clothing, health, or safety; and
- iii. Documents inability to make a rational and informed decision as to whether or not to submit to treatment.

#### 4. Crisis Hotline Activation and Continuity

a. Screening Follow-Up and Activation in accordance with 26 TAC, Chapter 301 Subchapter G (relating to Mental Health Community Services Standards).

- i. If it is determined that an individual is experiencing a Crisis that may require Emergency Care Services, the QMHP-CS must:
  - (1) Take immediate action to address the emergency situation to ensure the safety of all parties involved;
  - (2) Activate the immediate Screening and Assessment processes, face to face in person or through Telehealth or Telemedicine, as described in 26 TAC, Chapter 301, Subchapter G (relating to Crisis Services); and
  - (3) Provide or obtain mental health community services or other necessary interventions to stabilize the Crisis.
- ii. If the Screening indicates that an individual needs Urgent Care Services, a QMHP-CS must, within eight hours of the initial incoming hotline call or notification of a potential Crisis situation:
  - (1) Perform an Assessment face to face in person or through Telehealth or Telemedicine; and
  - (2) Provide or obtain mental health community services or other necessary interventions to stabilize the Crisis.
- iii. If the Screening indicates that a call is a Crisis False-alarm, the screener must document the call. Additionally, if the Screening indicates that an individual needs Routine Care Services and the individual does not decline

services, a

QMHP-CS must perform a uniform Assessment within 14 days after the Screening.

b. Continuity of Services

- i. The Crisis hotline determines the individual's initial level of risk (i.e. emergent, urgent, or routine); and if MCOT is called to respond to the Crisis, the response time frame is established by the QMHP-CS who conducted the Crisis hotline Screening.
- ii. Continuity of services must be provided by the LMHA or LBHA upon the completion of the Screening or Assessment to ensure uninterrupted treatment during a transition between services.

## 5. Accreditation and Scoring Requirements

- a. The phone line providing Crisis hotline services must be accredited by AAS and integrated with the LMHA's or LBHA's local Crisis response system, which includes MCOT as well as other services in the LMHA's or LBHA's Crisis service array. LMHAs and LBHAs utilizing a subcontractor to provide Crisis hotline services, must ensure that the subcontracting agency's Crisis hotline maintains AAS accreditation.
- b. The Crisis hotline must also meet minimum scoring requirements outlined by HHSC under each area of the table below, excluding Lethality Assessment and Rescue Services in the 9<sup>th</sup> and 10<sup>th</sup> editions. A minimum component score of 2 is required and an area minimum score is required as shown below.
- c. The LMHA or LBHA should use the edition of the AAS Organization Accreditation Standards Manual that is applicable to the year of accreditation.
- d. If the LMHA or LBHA contracts with an outside entity to provide all or part of the Crisis hotline service, the LMHA or LBHA or subcontractor must also be accredited by AAS, meet minimum scoring requirements (outlined below), and remain contractually responsible for compliance with the applicable standards.
- e. Evidence of initial or continued accreditation by AAS must be submitted to HHSC within 30 days of receipt. Submission must include any report of accreditation review findings by AAS and LMHA or LBHA responses to these findings, if applicable.

Listed below are the minimum scores acceptable to meet HHSC standards in each area described in the 9<sup>th</sup>, 10<sup>th</sup>, 11<sup>th</sup>, 12<sup>th</sup>, and current [13<sup>th</sup> Edition of the AAS Organization Accreditation Standards Manual](#).

AREA	9th Ed MINIMUM SCORE	10th Ed MINIMUM SCORE	11th Ed MINIMUM SCORE	12th Ed MINIMUM SCORE	13th Ed MINIMUM SCORE
Administration and Organizational Structure	11	14	16	16	16

<b>AREA</b>	<b>9th Ed MINIMUM SCORE</b>	<b>10th Ed MINIMUM SCORE</b>	<b>11th Ed MINIMUM SCORE</b>	<b>12th Ed MINIMUM SCORE</b>	<b>13th Ed MINIMUM SCORE</b>
<b>Training Program (8th ed)/ Screening, Training, and Monitoring Crisis Workers</b>	16	16	16	16	16
<b>General Service Delivery</b>	16	16	16	16	16
<b>Services in Life-Threatening Situations</b>	8	8	8	8	8
<b>Ethical Standards and Practice</b>	13	13	13	13	13
<b>Community Integration</b>	9	9	9	9	9
<b>Program Evaluation</b>	10	10	10	10	10

## **II. Mobile Crisis Outreach Team**

### **A. Definition**

Mobile Crisis Outreach Teams (MCOTs) are qualified professionals deployed into the community to provide a combination of Crisis services including facilitation of Emergency Care Services and provision of Urgent Care Services, Crisis follow-up, and relapse prevention to Children, Adolescents, or adults 24 hours a day, every day of the year.

### **B. Goals**

- Crisis resolution
- Linkage to appropriate services and follow-up
- Reduction of inpatient and law enforcement interventions
- Stabilization in the least restrictive environment
- Diversion from emergency rooms when possible

### **C. Description**

An MCOT program consists of a roster of dedicated or rotating staff working in a team deployed into the community to provide Crisis intervention services in compliance with 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards). MCOT services include emergency care, urgent care, Crisis follow-up and relapse prevention to adults, Children, and Adolescents. MCOT staff coordinate with the Crisis hotline and community partners to determine when and where Crisis outreach services are needed in the community.

### **D. Standards**

#### **1. Staffing Standards**

- a. A psychiatrist must serve as the medical director for all Crisis services and must approve all policies, procedures, and protocols used in Crisis services.
- b. Urban staffing requirements:
  - i. One LPHA and one QMHP-CS must be On Duty 12 hours a day, every day of the week.
  - ii. One LPHA and one QMHP-CS must be On Call 24 hours a day, every day of the week.
- c. Rural staffing requirements:
  - i. Two QMHP-CS must be On Duty eight hours a day, every day of the week.
  - ii. One LPHA and one QMHP-CS must be On Call 24 hours a day, every day of the week.
- d. The team must have licensed medical professionals, including a physician (preferably a psychiatrist), or a PA or APRN with specialized mental health training, or an RN, who are readily available for MCOT consultation, either in person, or through telephone, or video, 24 hours a day, every day of the year.

- e. MCOT must deploy at least two staff members when clinically indicated.
- f. When a Certified Peer Specialist deploys with the team, they must provide peer services in accordance with 15 TAC Subchapter N, §354.3013 (relating to Services Provided) and cannot conduct Crisis Screenings, Assessments, or intervention.
- g. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

## 2. Availability

- a. MCOT services must be available 24 hours per day, every day of the year.
- b. LMHAs and LBHAs must ensure policies and procedures identify peak hours and staffing patterns based On Call volume and analysis of encounter data.
- c. MCOT members must deploy in person or provide services through Telehealth or Telemedicine when a call is received.
- d. Response time frames per 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) are:
  - i. Emergent care. MCOT must respond, whether face to face in person or through Telehealth or Telemedicine, to emergent care events immediately but no later than one hour.
  - ii. Urgent care. MCOT must respond, whether face to face in person or through Telehealth or Telemedicine, to urgent crises no later than eight hours.
  - iii. Routine care. The LMHA or LBHA must perform a uniform Assessment within 14 days after the Screening, if individual does not decline services.
  - iv. Follow up. Initial Crisis follow-up and relapse prevention services must be provided within 24 hours of the initial call or contact.

## 3. Policies and Procedures

The LMHA or LBHA must develop and implement written policies and procedures that are approved by the medical director and must be consistent with evidence-based or best practices. Written policies and procedures must be submitted to HHSC in conjunction with the Consolidated Local Services Plan submission every two years. Policies and procedures must include the following:

- a. Duties and responsibilities. To define the duties and responsibilities for all staff involved in the Assessment or treatment of a Crisis.
- b. Staff training. To address staff training, competency, experience, and be consistent with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- c. Location of services provided. To ensure that services reach individuals where the Crisis episode occurs or where the individual deems appropriate. At community locations like jails or emergency rooms that may provide intervention



services (medical, behavioral), MCOTs must still deploy or provide services through Telehealth or Telemedicine if they are called to provide Crisis intervention services.

- d. Law enforcement. To ensure that:
  - i. MCOT requests for a member of law enforcement to meet MCOT and the individual at the location of the Crisis when there is a significant level of risk to staff or the individual in Crisis; and
  - ii. Crisis Assessments are completed by MCOT and not delegated to law enforcement, in accordance with 26 TAC §301.351(b)(1) (relating to Screening and Assessment).
- e. Transportation to MCOT recommended treatment. To ensure MCOTs provide linkages to alternate transportation services for individuals when the MCOT is unable to provide these services.
- f. Behavioral health emergencies. To define the procedure for the most effective and least restrictive approaches to common behavioral health emergencies seen by MCOT. Policies must include procedures for:
  - i. Communicating with inpatient psychiatric service providers when referring individuals into inpatient emergency services; and
  - ii. Identifying alternate Crisis service providers, and linking individuals to these providers, when MCOT is unable to respond to a Crisis situation.
- g. ReAssessment. To define appropriate reAssessment intervals in emergent, urgent, and routine care.

#### 4. MCOT Duties and Responsibilities

- a. Crisis training and competency. The LMHA or LBHA must define competency-based expectations for each staff position and implement a process to ensure competency of staff members prior to providing services. In accordance with 26 TAC §301.331 (relating to Competency and Credentialing) all MCOT staff must receive Crisis training that includes at a minimum:
  - i. Identifying signs, symptoms, and Crisis response related to substance use;
  - ii. Identifying signs, symptoms, and Crisis response to trauma, abuse, and neglect;
  - iii. Identifying signs, symptoms, and Crisis response to individuals with Intellectual Disability and developmental disabilities;
  - iv. Identifying specialized Assessment and intervention strategies for Children, Adolescents, and families;
  - v. Assessing individuals and providing intervention;
  - vi. Conducting suicide Screenings and Assessments, homicide Screenings and Assessments, and risk of deterioration Screenings and Assessments;
  - vii. Applying knowledge and effective use of communication strategies such as a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, according to 25 TAC, Chapter 415, Subchapter F (relating to Interventions in Mental Health Services);

- viii. Completing clinical interviews in behavioral health Crisis care for all clinical staff, including a physician (preferably a psychiatrist), Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), Physician's Assistant (PA), LPHA, or QMHP-CS; and
- ix. Using Telehealth or Telemedicine technology, if applicable. Telemedicine and Telehealth competencies must be included for positions in which a staff member's job duties are related to or involve assisting with Telemedicine or Telehealth services and include adequate and accurate knowledge of:
  - (1) operation of the Telehealth or Telemedicine equipment; and
  - (2) how to use the equipment to adequately present the individual.
- b. Licensing, Credentialing, and Supervision. All MCOT team members must obtain and maintain licensing, credentialing, and supervision standards per their license, certification, or scope of practice that includes, but is not limited to:
  - i. Licensing in accordance with the respective chapter of the Texas Occupations Code;
  - ii. Credentialing in accordance with 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards);
  - iii. Supervision in accordance with the respective chapter of the Texas Occupations Code; and
  - iv. Certification in accordance with 1 TAC Chapter 354, Subchapter N (relating to Peer Specialist Services).
- c. Location of Services. These services must be delivered at the location where the Crisis occurred unless the individual, family member, Adult Caregiver, or LAR expresses preference to another location. If a Crisis presents in a community location, such as a jail or hospital, including an emergency department, MCOT must respond immediately, but in no longer than one hour, to an emergency care Crisis or eight hours to an urgent care Crisis. The LMHA or LBHA must provide services through Telehealth or Telemedicine or deploy MCOT to the location of the individual for subsequent contact or Crisis follow-up and relapse prevention services in accordance with approved policies, procedures, and protocols.

## 5. Screening and Assessment

The LMHA or LBHA must develop and implement a written policy and procedure that for:

- a. Crisis Screening. The written policy must describe the process for performing the Screening. The process must address the criteria for requesting an immediate Crisis Assessment, medical Screening and Assessment, and psychiatric evaluation. A thorough Crisis Screening and documentation must incorporate the following domains:
  - i. Suicide Risk Screening
    - (1) Suicidal ideation – documents: the wish to be dead, non-specific active suicidal thoughts without thoughts of ways to kill oneself; active suicidal ideation with any methods without intent to act, active suicidal ideation

- with some intent to act but without a specific plan; current access to means; and active suicidal ideation with specific plan and intent.
- (2) Intensity of ideation – documents: frequency; duration; controllability; deterrents; and reasons for ideation.
- (3) Suicidal behavior – documents: actual attempts; non-suicidal self-injurious behaviors; interrupted attempts; aborted or self-interrupted attempts; preparatory acts or behaviors; actual and potential lethality of the most recent attempt; most lethal attempt; and the initial or first attempt.
- ii. Homicide Risk Screening
  - (1) Homicidal Ideation – documents: the wish for another to be dead; non-specific active homicidal thoughts without thoughts of ways to kill another; active homicidal ideation with any methods without intent to act; active homicidal ideation with specific plan and intent.
  - (2) Intensity of Ideation – documents: frequency; duration; controllability; deterrents; and reasons for ideation.
  - (3) Homicidal behavior – documents: actual attempts; non-homicidal injurious behaviors; interrupted attempts; aborted or self-interrupted attempts; preparatory acts or behaviors; actual and potential lethality of the most recent attempt; most lethal attempt; and the initial or first attempt.
- iii. Risk of Deterioration Screening
  - (1) Documents any report of experiencing severe and abnormal mental, emotional, or physical distress.
  - (2) Documents experiencing substantial mental or physical deterioration of the proposed individual's ability to function independently, which is exhibited by the proposed individual's inability, except for reasons of indigence, to provide for the proposed individual's basic needs, including food, clothing, health, or safety.
  - (3) Documents inability to make a rational and informed decision as to whether or not to submit to treatment.
- b. Screening outcomes and dispatch levels. The Crisis Screening identifies the individual's level of risk, which determines the MCOT dispatch level (emergent, urgent, or routine) and protocol for Crisis response, including Crisis Assessment. The original dispatch level from the Screening may be changed, but only after information is reported that the individual is not able to participate in the Screening or Assessment due to:
  - i. Inaccessibility of their physical location;
  - ii. Level of cognitive impairment; or
  - iii. State of consciousness.
- c. Response Procedures
  - i. Emergent - An MCOT informed of an emergent dispatch must:
    - (1) Respond immediately, or within one hour of the incoming Crisis hotline call or notification of a potential Crisis situation, to initiate the Crisis response and Assessment process as described in 26 TAC Chapter 301, Subchapter G of this title (relating to Mental Health Community Services Standards);

- (2) Notify law enforcement with a request to co-respond with MCOT to secure the safety of all individuals present if an MCOT member believes their safety to be at risk when responding to a Crisis in the community;
  - (3) Perform a face-to-face Assessment in person or through Telehealth or Telemedicine services;
  - (4) Provide or obtain mental health community services or other necessary interventions to stabilize the Crisis;
  - (5) Arrange for a physician (preferably a psychiatrist) to examine an individual face-to-face in person or through Telemedicine, in accordance with 26 TAC Subchapter G, §301.351 (relating to Crisis Services), as soon as possible, but no later than 12 hours after the QMHP-CS's Assessment, to determine the need for emergency services. MCOT will provide the receiving facility or service provider all relevant Crisis documentation; and
  - (6) Develop an Individualized Crisis Treatment Plan including an intervention, outcome, follow-up plans, aftercare, and referral.
- ii. Urgent - An MCOT informed of an urgent dispatch must:
    - (1) Respond within eight hours of the initial incoming Crisis hotline call or notification of a potential Crisis situation;
    - (2) Notify law enforcement to respond with MCOT, when possible, to secure the safety of all individuals present if an MCOT member believes their safety to be at risk when responding to a Crisis in the community; Perform a face-to-face Assessment in person or through Telehealth or Telemedicine services;
    - (3) Provide or obtain mental health community services or other necessary interventions to stabilize the Crisis; and
    - (4) Develop an Individualized Crisis Treatment Plan including an intervention, outcome, follow-up plans, aftercare, and referral.
  - iii. Routine - If the Screening indicates that an individual needs Routine Care Services, a QMHP-CS must perform a uniform Assessment within 14 days after the Screening, in accordance with 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards), Routine Care Services.
  - iv. MCOT, or other staff members providing Crisis Assessment, must document in the individual's health record justification for failing to dispatch or provide Crisis response to an individual within the timeframes listed for emergent and urgent response.
- d. Crisis Assessment. A Crisis Assessment must be completed face-to-face, in person or through Telehealth or Telemedicine, in accordance with 26 TAC Subchapter G, §301.321 (b)(2). A Crisis Assessment must include historical and current information such as the following:
    - i. Mental health domain. Documents an individual's: symptomology; functionality; historical and current diagnoses and treatment for: mental health, serious emotional disturbance, or Intellectual Disability and developmental disorder diagnoses. The Assessment must include:
      - (1) A review of records of the individual's past treatment (when available);

- (2) History from collateral sources. The team must be proactive in gathering input or corroboration of events from family members, Adult Caregivers, or LARs whenever possible. Every effort must be made to engage family, Adult Caregivers, or LAR support around the individual in Crisis while maintaining confidentiality;
  - (3) Contact with the individual's current healthcare providers whenever possible; and
  - (4) If available, a history of the individual's previous mental health, substance use, Intellectual Disability or Developmental Disability treatment that includes:
    - (a) A record of past psychiatric medication, dosages, response to medications, side effects and adherence;
    - (b) An up-to-date record of all medications currently prescribed and the name of the prescribing professional; and
    - (c) Identification of social, environmental, and cultural factors that may be contributing to the Crisis;
  - (5) Attempt to determine if the individual has an active Declaration for Mental Health Treatment when interviewing the individual and the individual's collateral resources or current healthcare providers.
- ii. Suicide domain. Documents an individual's: current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;
  - iii. Violence domain. Documents an individual's current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;
  - iv. Trauma, abuse, and neglect domain. Documents an individual's: current and past trauma or abuse and neglect; where the trauma or abuse and neglect was experienced; and how long the trauma or abuse and neglect occurred;
  - v. Substance use domain. Documents an individual's: current use and how their use affects their thoughts and behaviors regarding suicide and violence; the last time of use; the history of substance use and recovery status; history of use, abuse, or overdose on alcohol, drugs, medications, or other substances;
  - vi. Physical and cognitive health domain. Evaluates and documents the presence or absence of cognitive signs suggesting delirium and need for emergency intervention and includes:
    - (1) An evaluation of the need for an immediate medical Assessment by a physician (preferably a psychiatrist), APRN, PA, or RN;
    - (2) A general medical history that identifies all medical conditions that an individual has, and includes:
      - (a) Medical considerations of how these conditions affect the individual's overall current condition and;
      - (b) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);

- (3) A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and
- (4) In emergency care, an appropriate physical health Assessment; or
- (5) In urgent care, a written procedure, approved by the medical director, is implemented to assess the need for referral for a physical health Assessment including laboratory Screening;
- vii. Support and coping skills domain. Documents an individual's:
  - (1) Current support systems; current coping skills; historical coping skills used during stressful events; and current ideas for coping with the current Crisis episode; and
  - (2) Ability and willingness to cooperate with the Individualized Crisis Treatment Plan;
- viii. Identification of social, environmental, and cultural factors that may be contributing to the emergency; and
- ix. Final outcome. Documents the creation of the Crisis and safety plan(s) and the outcome of the current Crisis episode.

## 6. Education and Documentation

- a. Education. MCOTs must provide appropriate educational information and Crisis support resources that are relevant to stabilizing the Crisis episode to individuals or family members, Adult Caregivers, or LARs.
- b. Safety plan documentation. MCOT must complete a safety plan with individuals when clinically indicated and provide the individual a copy. MCOTs document the following information self-reported by the individual in Crisis:
  - i. Warning signs - (thoughts, images, mood, situation, behavior) that a Crisis may be developing;
  - ii. Internal coping strategies – what an individual can do independently to redirect focus from problems without contacting another person (relaxation technique, physical activity, etc.);
  - iii. The names and contact information for people and places that provide distraction from problems;
  - iv. The names and contact information for people whom the individual can ask for help during a Crisis;
  - v. The names and contact information for professionals or agencies the individual can contact during a Crisis; and
  - vi. Ways of making the environment safe including: limiting access to weapons or other means of harm to the individual or others; and limiting the use, misuse, or abuse of harmful substances, including prescription and non-prescription medications.
- c. Individualized Crisis Treatment Plan documentation. An Individualized Crisis Treatment Plan must be developed and implemented for everyone. The Individualized Crisis Treatment Plan must be based on the symptomology and clinical presentation of the individual and includes, to the extent possible, individual or family members', Adult Caregiver's or LAR's preferences. The Individualized Crisis Treatment Plan must

be adjusted whenever necessary to incorporate the individual's response to previous treatment. The Individualized Crisis Treatment Plan must recommend the most effective, and least restrictive, available treatment and include:

- i. Interventions;
- ii. Outcomes;
- iii. Plans for follow-up and aftercare; and
- iv. Referrals.

## 7. Coordination of Services

- a. MCOT must provide coordination of Crisis services in accordance with 26 TAC §301.327 (relating to Access to Mental Health Community Services). Coordination of Crisis services must:
  - i. Be provided for every individual;
  - ii. Consist of identifying and linking the individual with all available services necessary to stabilize the behavioral health Crisis and ensure transition to routine care;
  - iii. Provide necessary assistance in accessing those services and conducting follow-up and relapse prevention services to determine the individual's status and need for further services; and
  - iv. Include contacting and coordinating with the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.
  - v. Referral decisions must include consideration of an individual's ability to understand and accept the need for treatment (if such need exists), the ability to comply with the treatment referral, and any treatment wishes listed in an individual's Declaration for Mental Health Treatment.
- b. Emergency Care Services. If a mental health emergency is evident after Assessment, the MCOT must provide immediate Crisis intervention. MCOT must check availability of clinically appropriate environments to ensure safety and provision of a physician's Assessment to determine further treatment for the individual, per 26 TAC §301.327 (relating to Access to Mental Health Community Services).
- c. MCOT will provide the receiving facility or service provider all relevant Crisis documentation before or at the time of the individual's admission, in accordance with 26 TAC §306.163 (relating to Most Appropriate and Available Treatment Options). The provided Crisis information must include the individual's:
  - i. identifying information, including address;
  - ii. legal status (e.g., regarding guardianship, charges pending, custody) as applicable;
  - iii. pertinent medical and medication information, including known disabilities;
  - iv. behavioral information, including information regarding CPSD;

- v. other pertinent treatment information;
  - vi. finances, third-party coverage, and other benefits, if known; and
  - vii. advance directive; and
- d. Develop an Individualized Crisis Treatment Plan including an intervention, outcome, follow-up plans, aftercare, and referral.
- e. Emergency Medical Services. If a medical emergency is evident, MCOT will arrange for immediate medical care to prevent death or worsening of physical illness or injury. MCOT must provide relevant Crisis documentation to the medical provider and coordinate services for the individual based upon the individual's health status and medical provider's recommendations.
- f. Transportation. MCOT or an individual's family member, Adult Caregiver, or LAR may transport the individual for Crisis stabilization services. If the MCOT member determines that they cannot transport the individual safely, they may arrange for or coordinate transportation with law enforcement.

## 8. Continuity of Care

- a. Upon resolution of the Crisis episode, Crisis follow up and Continuity of Care for eligible individuals must include:
  - i. Transition to a non-Crisis level of care as medically necessary;
  - ii. Crisis follow-up and relapse prevention, either by the MCOT or another community services provider, throughout a 90-day period (Level of Care 5) until the individual is stabilized or transitioned to appropriate behavioral health services; and
  - iii. Linking Children, Adolescents, and families with intensive evidenced-based treatments aimed at reducing further risk of out-of-home placement as soon as possible.
- b. If the Screening indicates that an individual needs Routine Care Services:
  - i. A QMHP-CS must perform a uniform Assessment within 14 days after the Screening, in accordance with 26 TAC §301.327(d)(2) (relating to Routine Care Services); and
  - ii. The uniform Assessment must be performed using the Assessment tool adopted by HHSC that is used for recommending an approved level of care or other HHSC-approved Assessment tool. The current tools are the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths Assessment (CANS).



### **III. Walk-In Crisis Services**

#### **A. Definition**

Walk-in Crisis services are office-based Crisis services providing immediate Screening and Assessment and brief, intensive interventions focused on resolving a Crisis and preventing admission to the least restrictive level of care. These walk-in services may be provided in psychiatric emergency services outpatient clinics, psychiatric urgent care clinics, and in routine care clinics. Form N Section IV. Extended Observation Services provides standards for Psychiatric Emergency Services Centers (PESCs) Screening, triage, and Assessment services.

#### **B. Goals**

- Prompt Screening and Assessment
- Stabilization in the least restrictive environment
- Crisis resolution
- Linkage to appropriate services

#### **C. Description**

Walk-in Crisis services are immediately accessible services for adults, Children, and Adolescents that provide Crisis Screening, Assessment and treatment. Walk-in Crisis services are designed to be intensive and time-limited and are provided until the Crisis is resolved or the person is referred to another level of care. Walk-in Crisis services are offered in LMHA and LBHA service areas based on availability of LMHA or LBHA funding.

For individuals whose Crisis Screening or Assessment indicate that they are presenting with imminent risk of harm to themselves or others in their immediate environment, rapid transfer to a higher level of care is facilitated. If extreme risk of harm is ruled out, brief Crisis intervention services are provided on-site.

#### **D. Standards**

##### **1. Availability**

- a. The LMHA or LBHA must provide immediate access to qualified staff to provide Crisis Screening, Assessment and intervention services during hours of operation.
- b. Children and Adolescent walk-in Crisis service hours must be flexible to meet family needs.

##### **2. Physical plant**

- a. The location of the walk-in Crisis services must be clearly marked from the street, and the LMHA or LBHA must include the location in printed and online service literature and social media accounts, as well as in community resource directories.
- b. The LMHA's or LBHA's offices must meet all Americans with Disabilities Act Accessibility Guidelines and Texas Accessibility Standards.

- c. The LMHA's or LBHA's offices must have at least one designated area where individuals deemed at imminent risk of harm to themselves or others in their immediate environment can be safely maintained and observed until transported to a higher level of care.
- d. The LMHA's and LBHA's office spaces must provide an individual with privacy for protection of confidentiality.

### 3. Staffing

- a. A psychiatrist must serve as the medical director for all Crisis services and approve all written procedures and protocols.
- b. Duties and responsibilities for all staff involved in Assessment or treatment must be defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice and in conformance to state standards for licensing and credentialing.
- c. All Crisis service staff members must receive Crisis training that includes but is not limited to:
  - i. Identifying signs, symptoms, and Crisis response related to substance use and use;
  - ii. Identifying signs, symptoms, and Crisis response to trauma, abuse and neglect;
  - iii. Identifying signs, symptoms, and Crisis response to individuals with Intellectual Disability and development disabilities;
  - iv. Identifying specialized Assessment and intervention strategies for Children, Adolescents, and families;
  - v. Assessing individuals and providing intervention;
  - vi. Conducting suicide Screenings and Assessments, homicide Screenings and Assessment, and risk of deterioration Screenings and Assessments;
  - vii. Applying knowledge and effective use of communication strategies such as a range of early intervention, de-escalation, mediation, problem-solving, and other nonphysical interventions according to 25 TAC, Chapter 415, Subchapter F (relating to Interventions in Mental Health Services);
  - viii. Completing clinical interviews in behavioral health Crisis care for staff such as a physician (preferably a psychiatrist), Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), Physician's Assistant (PA), LPHA, or Qualifies Mental Health Professional – Community Services (QMHP-CS); and
  - ix. Using Telehealth or Telemedicine technology, if applicable. Telemedicine and Telehealth competencies must be included for positions in which a staff member's job duties are related to or involve assisting with Telemedicine or Telehealth services and include adequate and accurate knowledge of:
    - (1) operation of the Telemedicine or Telehealth equipment; and
    - (2) how to use the equipment to adequately present the individual.
- d. Children's counseling must be provided by LPHAs with additional experience, training, and competency in Child and Adolescent treatment issues and working with Children and families in Crisis.

- e. All Crisis services staff members must be trained physicians (preferably psychiatrists), APRNs, PAs, RNs, LPHAs, QMHP-CSs or trained and competent Crisis Support Staff.
- f. All staff providing Crisis Screening, Assessment, and intervention must be physicians (preferably psychiatrists), APRNs, PAs, RNs, LPHAs, or QMHP-CSs
- g. A physician (preferably a psychiatrist), or APRN or PA must be available for telephone consultation or face-to-face in person or Telemedicine Assessment based on the Crisis Assessment.
- h. The LMHA or LBHA must develop and implement written policy and protocol ensuring access to emergency LMHA or LBHA resources when the level of risk to an individual or staff member exceeds the capability of on-site staff.
- i. Staff members who are trained in, and prepared to provide, first-responder health care, including Basic Life Support and First Aid, must be on site at all times during business hours when Emergency Medical Services are not available on site.
- j. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

#### 4. Crisis Screening, Triage, and Assessment

- a. Crisis Screening and Triage. All Screening and triage activity must be documented in the health record of an individual receiving services.
  - i. Individuals must be screened by a QMHP-CS, a APRN, PA, or RN within 15 minutes of presentation, with procedures to prioritize individuals with imminently dangerous behaviors.
  - ii. The LMHA or LBHA must provide a safe and secure location with constant staff observation and monitoring until the individual is triaged.
  - iii. Trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, etc.) must be on site at all times when Emergency Medical Services are not available on site. The LMHA or LBHA must develop and implement a written policy and procedure for Crisis Screening that addresses:
    - (1) Screening for emergency medical conditions;
    - (2) The process for accessing emergency medical intervention; and
    - (3) For determining when to call 911.
  - iv. The LMHA or LBHA must develop and implement a written policy and procedure that describes the process for performing triage. The triage process must include an evaluation of the:
    - (1) Risk of harm to self or others;
    - (2) Presence or absence of cognitive signs suggesting delirium;
    - (3) Need for immediate full Crisis Assessment;
    - (4) Need for emergency intervention;
    - (5) Need for a medical Screening or medical Assessment, including vital signs and a medical history; and

- (6) Need for lab work.
- v. The LMHA or LBHA must develop and implement a written policy and procedure to determine criteria for deciding which individuals presenting for care are served by the walk-in service provider and which individuals are referred to another health care provider or facility. Individuals considered for referral to a lower level of care must meet the following criteria:
  - (1) Low risk of harm to themselves or others;
  - (2) Have no more than mild functional impairment; and
  - (3) Do not have significant medical, psychiatric, or Substance Use Disorders.
  - (4) Referral decisions must include consideration of an individual's ability to understand and accept the need for treatment (if such need exists), the ability to comply with the treatment referral, and any treatment wishes listed in an individual's Declaration for Mental Health Treatment.
- h. Assessment. An individual who was not referred to another provider or facility for Crisis care after triage must receive a full Crisis Assessment, including a psychiatric and medical Assessment, when ordered by a physician (preferably a psychiatrist). All Assessment activity must be documented in the health record of an individual receiving services.
  - i. An Assessment must be initiated by an LPHA or RN within one hour of referral from the Screening process.
  - ii. The LMHA or LBHA must develop and implement a written policy and procedure that ensures that an LPHA or RN initiates the full Crisis Assessment process within 15 minutes of initial presentation to walk-in Crisis services for individuals who require immediate Assessment due to imminent risk of harm.
  - iii. A physician (preferably a psychiatrist), or a APRN or PA must be available to examine and complete a psychiatric Assessment for an individual in emergent Crisis between three and eight hours from presentation to the services.
  - iv. A Crisis Assessment must be completed face-to-face, in person or through Telehealth or Telemedicine, in accordance with 26 TAC Subchapter G, §301.321 (b)(2). Clinical interviews must be conducted by a physician (preferably a psychiatrist), APRN, PA, RN, LPHA, or QMHP-CS with training in behavioral health Crisis care. A Crisis Assessment must include historical and current information within the following:
    - (1) Mental health domain. Documents an individual's: symptomology; functionality; historical and current diagnoses and treatment for mental health, serious emotional disturbance, or Intellectual Disability and developmental disorder diagnoses. The Assessment must include:
      - (a) A review of records of the individual's past treatment (when available);
      - (b) History from collateral sources. The team is proactive in gathering input or corroboration of events from family members, Adult Caregivers, or LARs whenever possible. Every effort must be made to

- engage family, Adult Caregivers, or LAR support around the individual in Crisis while maintaining confidentiality;
- (c) Contact with the individual's current healthcare providers whenever possible; and
- (d) If available, a history of the individual's previous mental health, substance use, Intellectual Disability or Developmental Disability treatment that includes:
  - (i) A record of past psychiatric medication, dosages, response to medications, side effects and adherence;
  - (ii) An up-to-date record of all medications currently prescribed and the name of the prescribing professional;
  - (iii) An individual's collateral resources or current healthcare providers. Identification of social, environmental, and cultural factors that may be contributing to the Crisis; and
  - (iv) An attempt to determine if the individual has an active Declaration for Mental Health Treatment when interviewing the individual and the and the individual's collateral resources or current healthcare providers.
- (2) Suicide domain. Documents an individual's: current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;
- (3) Violence domain. Documents an individual's: current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;
- (4) Trauma, abuse, and neglect domain. Documents an individual's: current and past trauma or abuse and neglect; where the trauma or abuse and neglect was experienced; and how long the trauma or abuse and neglect occurred;
- (5) Substance use domain. Documents an individual's: current use and how their use affects their thoughts and behaviors regarding suicide and violence; the last time of use; the history of substance use and recovery status; history of use, abuse, or overdose on alcohol, drugs, medications, or other substances;
- (6) Physical and cognitive health domain. Evaluates and documents the presence or absence of cognitive signs suggesting delirium and need for emergency intervention and includes:
  - (a) An evaluation of the need for an immediate medical Assessment by a physician (preferably a psychiatrist), APRN, PA, or RN;
  - (b) A general medical history that identifies all medical conditions that an individual has, and includes:
    - (i) Medical considerations of how these conditions affect the individual's overall current condition and;

- (ii) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);
- (c) A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and
- (d) An LMHA or LBHA must ensure the creation and implementation of a written policy that describes the process used in urgent care situations to:
  - (i) assess the need for referring an individual for a physical health Assessment, including laboratory Screening; and
  - (ii) Coordinate referral to those Assessment and laboratory services.
- (e) An LMHA or LBHA must ensure the creation and implementation of a written policy that describes the process used in an emergent care situation to refer an individual to an appropriate facility, such as an emergency department, Extended Observation Unit with access to medical services, or a Psychiatric Emergency Services Center.
- (7) Support and coping skills domain. Documents an individual's:
  - (a) Current support systems; current coping skills; historical coping skills used during stressful events; and current ideas for coping with the current Crisis episode; and
  - (b) Ability and willingness to cooperate with the Individualized Crisis Treatment Plan; and
- (8) Identification of social, environmental, and cultural factors that may be contributing to the emergency; and
- (9) Final outcome. Documents the creation of the Crisis and safety plan(s) and the outcome of the current Crisis episode.

## 5. Intervention

- a. A written policy and procedure must be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the walk-in Crisis services and is approved by the medical director. The policies and procedures must be reviewed and updated as needed.
- b. A written policy and procedure must be developed and implemented for providing immediate Crisis intervention and safe transportation of an individual to an appropriate facility if Screening or Assessment indicates the need for a higher level of care to ensure safety or further treatment. The individual must be monitored continuously until transferred.
- c. A Crisis Treatment Plan that provides the most effective and least restrictive treatment available must be developed and implemented for each individual. The plan must be based on the provisional psychiatric diagnosis and incorporates, to the extent possible, individual and family preferences. The plan must address intervention, outcomes, plans for follow-up and aftercare, and referrals.

- d. Whenever necessary, the Crisis Treatment Plan must be adjusted to incorporate the individual's response to previous treatment.
- e. Individuals and families must receive appropriate educational information that is relevant to their condition, including information about the most effective treatment for the individual's behavioral health disorder.
- f. The medical director must define appropriate reAssessment intervals for emergent, urgent, and routine care.
- g. Children's counseling must be provided by LPHAs with additional experience, training, and competency in Child and Adolescent treatment issues and working with Children and families in Crisis.
- h. Services provided must link families with intensive evidence-based treatments aimed at reducing risk of out of home placement.

## 6. Coordination and Continuity of Care

- a. Coordination of Crisis services must be provided for every individual. Coordination of Crisis services consists of:
  - i. Linking the individual with all available services necessary to stabilize the behavioral health Crisis and ensure transition to routine care;
  - ii. Conducting follow-up and relapse prevention services to determine the individual's status and need for further service; and
  - iii. Contacting and coordinating with the individual's existing service providers in a timely manner and in conformance with applicable confidentiality requirements.
- b. Upon resolution of the Crisis, eligible individuals must be transitioned to an appropriate level of care (LOC) as determined by medical necessity.
- c. The individual must receive Crisis follow-up and relapse prevention either by the MCOT or from another community service provider throughout a 90-day period (LOC 5: Transitional Services) until they are stabilized or transitioned to appropriate behavioral health services.

## **IV. Extended Observation Unit**

### **A. Definition**

Extended Observation Units (EOUs) operated by a LMHA or LBHA provide adult individuals, presenting on voluntary or involuntary status, with access to emergency psychiatric care 24 hours a day, every day of the year. EOU facilities may also provide services to Children and Adolescents. EOU services are provided in a safe and secure environment and staffed by medical personnel, mental health professionals, and trained Crisis Support Staff. All EOU services must be delivered in accordance with Texas Health and Safety Code (THSC) Chapter 573 (relating to Emergency Detention); Title 26 Texas Administrative Code (TAC) Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and 26 TAC Chapter 306, Subchapter D (relating to Mental Health Services—Admission, Continuity, and Discharge).

EOUs must have the ability to serve individual with psychiatric symptoms ranging from moderate to severe, depending on the EOU's level of observation services, and coordinate an individual's transfer to a higher level of care after 48 hours when clinically indicated and ordered by a physician, preferably a psychiatrist.

### **B. Goals for Extended Observation**

- Provide prompt and comprehensive Assessment for individuals during a behavioral health Crisis, in accordance with 26 TAC §301.327(d)(C) (relating to Urgent Care Services)
- Provide immediate Crisis Assessment, psychiatric evaluation, and treatment for individuals experiencing a behavioral health emergency, in accordance with 26 TAC §301.327(d)(B) (relating to Emergency Care Services)
- Prompt Crisis stabilization in a secure environment
- Provide Crisis resolution and linkage to appropriate services
- Provide transition to clinically appropriate levels of care when a Crisis cannot be stabilized in a less restrictive setting
- Reduce inpatient and law enforcement interventions

### **C. Description**

Extended Observation services are provided under supervision of a psychiatrist. The duration of an individual's extended observation services must not exceed 48 hours. If an individual is unable to gain behavioral health stabilization after 48 hours, the treating physician must determine the next appropriate level of care for the individual. Continuity of Care services are provided to ensure that the individual is transferred to continuing treatment and linked with recommended support services.

### **D. Standards**

An LMHA or LBHA may provide extended observation services in a free-standing EOU or in an EOU in a Psychiatric Emergency Service Center (PESC). The availability of an EOU in



either location is dependent upon community needs and available funding. Standards located in D. Standards 3-10, E. Crisis Screening and Triage, F. Crisis Assessment, G. Treatment, H. Discharge Planning, and I. Medication Standards are applicable to all EOU's.

## 1. Free Standing EOU Facility

A free-standing EOU must maintain:

- a. A location near a licensed hospital or a Crisis Stabilization Unit (CSU) licensed in accordance with 26 TAC Chapter 510 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units), to provide individuals with access to urgent or emergency medical stabilization services and emergency psychiatric stabilization services; and
- b. Adherence to general facility standards described in subsections J-O of this section.

## 2. PESC Facility

A PESC includes extended observation beds and services in a secure treatment environment that is co-located in a licensed hospital or in a CSU licensed in accordance with 26 TAC Chapter 510 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units). A PESC provides walk-in access to immediate behavioral health emergency Screening and Assessment, extended observation services, and a continuum of Crisis and behavioral emergency stabilizing treatment for individuals whose behavioral symptoms cannot be stabilized within 48 hours.

- a. A PESC must provide a combination of services that includes, at minimum:
  - i. Extended Observation services, as described in A. Description of this section, in a designated area of the PESC; and
  - ii. Inpatient Services in an environment designed to provide safety and security during acute behavioral health Crisis; or
  - iii. CSU services in a secure and protected treatment environment that complies with CSU licensure requirements.
- b. The LMHA or LBHA providing PESC services must have a written agreement with the hospital or CSU with which the PESC is co-located and must ensure that the PESC facility:
  - i. Is accessible and meets all ADA Accessibility Guidelines, Texas Accessibility Standards, and applicable sections of the TAC;
  - ii. Has provisions for ensuring the personal safety of both individuals receiving services and PESC staff members;
  - iii. Has at least one designated area where individuals in acute Crisis can be safely maintained and monitored until transported to a hospital or CSU;
  - iv. Has spaces that provide privacy for the protection of confidentiality of an individual providing information and for a staff member receiving information; and

- v. maintains separate Child, Adolescent, and adult treatment and observation areas in facilities where services are provided for Children and Adolescents.

### 3. Eligibility Criteria

An EOU in any location must adhere to the following eligibility requirements:

- a. Develop and implement a written process and procedure that outlines eligibility criteria for admission into the EOU;
- b. QMHP-CS must conduct a Crisis Screening to determine if an individual meets eligibility criteria that may result in acceptance into the EOU;
- c. Admission to the EOU must be based on Medical Necessity as determined by the physician, preferably a psychiatrist; and
- d. The facility must not admit an individual whose acuity level cannot be effectively managed in the EOU as determined by a physician, preferably a psychiatrist. An individual that requires a more restrictive or less restrictive level of care must be referred to the more appropriate treatment setting.

### 4. Capacity to Consent.

An individual with capacity to consent to EOU treatment, services, and medications, as determined by a physician, preferably a psychiatrist, must give written consent to receive mental health services, including medication and laboratory services. If an individual is in a psychiatric emergency regardless of consent, the individual may be administered emergency medication in accordance with 25 TAC Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication--Mental Health Services).

### 5. Admission Status and Egress.

Regardless of voluntary or involuntary admission status at time of presentation, everyone must receive information about their rights and a Rights Handbook in accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services).

- a. Individuals presenting to an EOU on voluntary status may:
  - i. Be admitted into services by a physician, preferably a psychiatrist;
  - ii. Have access to, with or without supervision, approved areas of the EOU located away from the individual's bed or unit; and
  - iii. Receive services in the least restrictive environment available, consistent with the protection of the individual and the protection of the community.
- b. Individuals presenting to an EOU on emergency detention status may be safely maintained and observed in a locked unit, in accordance with THSC Chapter 573.
- c. Individual being detained under emergency detention must be released if:

- i. A physician (i.e., preferably a psychiatrist) determines that the individual no longer meets the criteria for emergency detention; or
  - ii. When the emergency detention 48-hour maximum hold has expired; and
  - iii. The individual shall be discharged to the community, discharged and readmitted as a voluntary admission, or transferred to an appropriate level of care.
- d. In accordance with THSC 573.021, if the 48-hour period ends on a Saturday, Sunday, legal holiday, or before 4 p.m. on the first succeeding business day, the person may be detained until 4 p.m. on the first succeeding business day. If the 48-hour period ends at a different time, the person may be detained only until 4 p.m. on the day the 48-hour period ends. If extremely hazardous weather conditions exist or a disaster occurs, the presiding judge or magistrate may, by written order made each day, extend by an additional 24 hours the period during which the person may be detained. The written order must declare that an emergency exists because of the weather or the occurrence of a disaster.
- e. An individual on voluntary status who makes a request to discharge, in any format, shall be honored as a request to leave. The individual's request for discharge shall be processed as soon as possible. The individual shall be discharged with at minimum the individual's belongings and medications. Staff shall immediately notify the LPHA and physician (preferably a psychiatrist) of the individual's request.

## 6. Length of Stay.

Extended observation services can take place for up to 23 hours or up to 48 hours, depending on the physical setting of the facility as described in subsection 7. Observation Area of this section. An individual who cannot be stabilized within that timeframe must be referred and linked to the appropriate level of care such as an inpatient hospital unit or CSU. The LMHA or LBHA must develop and implement written policies and procedures for serving individuals admitted on emergency detention after the 48 hours has expired.

## 7. Observation Area.

The LMHA or LBHA providing, or subcontracting, extended observation services must ensure the observation area of any EOU physical plant provides:

- a. A designated area where an individual experiencing acute symptoms can be observed and safely maintained until the Crisis is resolved or the individual is transported to another level of care;
- b. A separate bed for each individual in a facility providing 48-hour observation;
- c. Staff monitoring at all times for:
  - i. The area with chairs or beds in a shared room or bedrooms, in a 23-hour observation facility;
  - ii. The beds in any shared bedroom; and

- iii. Private bedroom areas, with direct observation of the individual in the bedroom conducted no more than 15 minutes apart;
- d. One-to-one continuous observation of an individual when ordered by the treating physician;
- e. Privacy for the protection of confidentiality, when an individual providing, or a staff member is obtaining any information protected under the Health Insurance Portability and Accountability Act (HIPAA) rules or other applicable federal or state laws concerning confidentiality;
- f. Separate observation areas for Children, Adolescents, and adults; and
- g. A secure environment in which exterior doors may be locked and monitored for the safety and protection of individuals and staff.

## 8. Staffing

- a. A psychiatrist must serve as the medical director for all Crisis services and approve all Crisis services policies and procedures, in accordance with 26 TAC §301.321(b) (relating to Management of key processes and functions).
- b. Staffing plans must:
  - i. Adhere to the following standards for EOUs and not follow the staffing plans of a facility that provides a lower level of care;
  - ii. Adjust nursing support staff numbers as clinically indicated to address the number and acuity of individuals served;
  - iii. Provide licensed and credentialed staff to ensure the availability of:
    - (1) A physician, preferably a psychiatrist, or a APRN or PA, to be On Call 24 hours a day, every day of the year, to evaluate an individual face-to-face or through Telemedicine services, as needed;
    - (2) At least one LPHA must be available on site every day of the year from 8:00 a.m. to 8:00 p.m., and through Telehealth after hours, as needed;
    - (3) At least one RN on site 24 hours a day, every day of the year;
    - (4) At least one QMHP-CS on site between the hours of 8 a.m. to 7 p.m. and assigned to identified individuals on each shift; and
    - (5) At least three trained and competent Crisis Support Staff on site 24 hours a day, every day of the year.
  - iv. Provide a sufficient number of available physicians, preferably psychiatrists, or APRNs, PAs, and RNs to provide initial Assessment of individuals in services through:
    - (1) An RN nursing Assessment initiated within 15 minutes of an individual's presentation to an EOU;
    - (2) An LPHA Assessment initiated within one hour of an individual's presentation at the EOU;
    - (3) A physician preliminary examination, conducted through in-person or Telemedicine services, within eight hours of an individual's presentation at the EOU.
  - v. Provide a sufficient number of available LVNs, LPHAs, QMHP-CSs, and trained

and competent Crisis Support Staff to allow for the provision of:

- (1) ReAssessment of the progress of each individual in service at a minimum of every:
    - (a) 15 minutes, by trained and competent Crisis Support Staff;
    - (b) Two hours by licensed nurses;
    - (c) Four hours by QMHP-CSs; and
    - (d) 12 hours by physicians, preferably psychiatrists, or
    - (e) APRNs or PAs;
  - (2) Active group or individual therapeutic interventions required by the individual's treatment plan and consistent with the individual's clinical state; and
  - (3) Patient and staff personal safety, including one to one observation as needed.
- c. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

## 9. Duties and Responsibilities.

An LMHA or LBHA must define in writing duties and responsibilities for all staff involved in the Assessment or treatment of individuals receiving services. Assigned duties and responsibilities must be appropriate to staff training, experience, and displayed competencies and remain in conformance with the staff's scope of practice, or state licensing and credentialing standards.

- a. A psychiatrist must serve as the medical director for all Crisis services and must approve all policies and procedures used in Crisis services.
- b. All EOU staff members must receive Crisis training and meet required competencies in accordance with 26 TAC §301.3313(a)(3)(A) (relating to Required Competencies) and with 26 TAC §301.3313(a)(3)(B) (relating to Critical Competencies).
- c. All EOU staff members involved in the Assessment or treatment of individuals in services must meet specialty competencies in accordance with 26 TAC §301.331(a)(3)(C) (relating to Specialty Competencies).
- d. All EOU staff members providing Crisis services and interventions must meet specialty competencies in accordance with 26 TAC §301.331(b) (relating to Competency of Crisis Services Providers).
- e. An LMHA or LBHA must develop and implement written policies and procedures for RNs to make assignments to LVNs, or delegate to Crisis Support Staff, nursing acts for the care of stable individuals with common, well-defined health problems with predictable outcomes, in accordance with 26 TAC §301.355(b) (relating to Medication Service Delivery). The policies must address types of nursing acts that may be delegated, the method to ensure the staff is trained and qualified to perform a delegated nursing act, and the frequency of nursing supervision.

- f. Clinical supervision must be provided and documented for all staff members, and all licensed staff members must be supervised in accordance with their practice and applicable rules, in accordance with 26 TAC §301.363 (relating to Supervision).

## 10. Service Availability.

The EOU must adhere to the following service availability requirements.

- a. Available 24 hours a day, every day of the year, throughout the participating service areas.
- b. Delivered in accordance with utilization management guidelines and authorization of services and timeframes, in accordance with 301.355(c)(1) (relating to Utilization Management). A diagnosis is not required when services are delivered in a Crisis level of care such as the services provided in an EOU. Crisis services must be authorized within two business days of presentation.

## **E. Crisis Screening and Triage**

- 1. All Screening and triage activity must be documented in the health record of an individual receiving services.
- 2. Individuals must be screened by a physician (preferably a psychiatrist), an APRN, PA, or RN within 15 minutes of presentation, with procedures to prioritize individuals with imminently dangerous behaviors.
  - a. Until the individual is triaged, they must wait in a safe and secure location with constant staff observation and monitoring.
  - b. Trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, etc.) must be on site at all times when Emergency Medical Services are not available on site. The LMHA or LBHA must develop and implement a written policy and procedure for Crisis Screening that addresses:
    - i. Screening for emergency medical conditions;
    - ii. The process for accessing emergency medical intervention; and
    - iii. For determining when to call 911 for assistance.
  - c. The LMHA or LBHA must develop and implement a written policy and procedure that describes the process for performing triage. The triage process must include:
    - i. An evaluation of risk of harm to self or others;
    - ii. The presence or absence of cognitive signs suggesting delirium;
    - iii. The need for immediate full Crisis Assessment;
    - iv. The need for emergency intervention;
    - v. The need for a medical Screening or medical Assessment, including vital signs and a medical history; and
    - vi. Lab work.
  - d. The LMHA or LBHA must develop and implement a written policy and

procedure to determine criteria for deciding which individuals presenting for care are referred to the provider or to another health care facility. Individuals considered for referral to a lower level of care must meet the following criteria:

- i. Low risk of harm to themselves or others;
  - ii. Have no more than mild functional impairment; and
  - iii. Do not have significant medical, psychiatric, or Substance Use Disorders.
- Referral decisions must consider the individual's ability to understand and accept the need for treatment (if such need exists) and to comply with the referral.

## **F. Crisis Assessment**

After triage, an individual who is not referred elsewhere for care must receive a full Crisis Assessment, including a psychiatric and medical Assessment, when ordered by a physician (preferably a psychiatrist). All Assessment activity must be documented in the health record of an individual receiving services.

1. An LMHA or LBHA must develop and implement written policies and procedures for:
  - a. Crisis Assessments. QMHP-CS Crisis Assessments must be conducted using Assessment tools adopted by the Health and Human Services Commission (HHSC) for recommending and authorizing a Level of Care (LOC);
  - b. LPHA diagnostic Assessments. LPHA diagnostic Assessments must be initiated within one hour of an individual's presentation at the EOU. The LMHA or LBHA must develop and implement a written policy and procedure that allows individuals requiring immediate LPHA Assessment to be assessed by an LPHA within 15 minutes.
  - c. Physician Assessment. An individual who receives an LPHA diagnostic Assessment must next receive a preliminary examination, comprised of medical and psychiatric Assessment, from a physician, preferably a psychiatrist, within eight hours of presentation at the EOU. The physician may conduct a face-to-face examination of an individual through an in-person or Telemedicine interview, as needed.
2. Crisis Assessments must be conducted using Assessment tools adopted by HHSC for recommending and authorizing a LOC.
3. All individuals under the age of 18 years old must receive a developmental Assessment by an LPHA with appropriate training in the Assessment and treatment of Children and Adolescents in a Crisis setting.
4. A Crisis Assessment must be completed face-to-face, in person or through Telehealth or Telemedicine, in accordance with 26 TAC Subchapter G, §301.321 (b)(2). Clinical interviews must be conducted by a physician (preferably a psychiatrist), APRN, PA, RN, LPHA, or QMHP-CS with training in behavioral health Crisis care.
5. A Crisis Assessment must include historical and current information within the following domains:



- a. Mental health domain. Documents an individual's: symptomology; functionality; historical and current diagnoses and treatment for mental health, serious emotional disturbance, or Intellectual Disability and developmental disorder diagnoses. The Assessment must include:
  - i. A review of records of the individual's past treatment when available;
  - ii. History from collateral sources. The team is proactive in gathering input or corroboration of events from family members, Adult Caregivers, or LARs whenever possible. Every effort must be made to engage family, Adult Caregivers, or LAR support around the individual in Crisis while maintaining confidentiality;
  - iii. Contact with the individual's current healthcare providers whenever possible; and
  - iv. If available, a history of the individual's previous mental health, substance use, Intellectual Disability or Developmental Disability treatment that includes:
    - (1) A record of past psychiatric medication, dosages, response to medications, side effects and adherence;
    - (2) An up-to-date record of all medications currently prescribed and the name of the prescribing professional;
    - (3) Identification of social, environmental, and cultural factors that may be contributing to the Crisis; and
    - (4) An attempt to determine if an individual has an active Declaration for Mental Health Treatment when interviewing the individual and the individual's collateral resources or current healthcare providers.
- b. Suicide domain. Documents an individual's: current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;
- c. Violence domain. Documents an individual's: current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;
- d. Trauma, abuse, and neglect domain. Documents an individual's: current and past trauma or abuse and neglect; where the trauma or abuse and neglect was experienced; and how long the trauma or abuse and neglect occurred;
- e. Substance use domain. Documents an individual's: current use and how their use affects their thoughts and behaviors regarding suicide and violence; the last time of use; the history of substance use and recovery status; history of use, abuse, or overdose on alcohol, drugs, medications, or other substances;
- f. Physical and cognitive health domain. Evaluates and documents the presence or absence of cognitive signs suggesting delirium and need for emergency intervention and includes:
  - i. An evaluation of the need for an immediate medical Assessment by a physician (preferably a psychiatrist), APRN, PA, or RN;
  - ii. A general medical history that identifies all medical conditions that an individual has, and includes:
    - (1) Medical considerations of how these conditions affect the individual's overall current condition and;

- (2) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);
    - iii. A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and
  - g. Support and coping skills domain. Documents an individual's:
    - i. Current support systems; current coping skills; historical coping skills used during stressful events; and current ideas for coping with the current Crisis episode; and
    - ii. Ability and willingness to cooperate with the Individualized Crisis Treatment Plan; and
  - h. Identification of social, environmental, and cultural factors that may be contributing to the emergency; and
  - i. Final outcome. Documents the creation of the Crisis and safety plan(s) and the outcome of the current Crisis episode.
6. Physical health Assessment. An individual must receive a physical health Assessment within four hours of presentation to the EOU, unless it has been clinically determined the individual requires immediate Assessment within 15 minutes of the clinical determination. The LMHA or LBHA must develop and implement written policies and procedures that ensures that those who require a physical health Assessment immediately can be seen and assessed within five minutes of initial presentation. The initial Assessment for physical health must be performed as ordered by a physician (preferably a psychiatrist), an APRN, or a PA. The physical health Assessment must include:
- a. A cognitive examination that screens for significant cognitive or neuron-psychiatric impairment and documents of the presence or absence of cognitive signs suggesting delirium and the need for emergency intervention;
  - b. A Screening neurological examination that is adequate to rule out significant acute pathology;
  - c. A general medical history that identifies all medical conditions of an individual, and includes:
    - i. Medical considerations of how these conditions affect the individual's overall current condition;
    - ii. A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment, including history of traumatic brain injury;
    - iii. A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and
    - iv. A review of need for immediate full Assessment, need for emergency intervention, and a medical Screening Assessment, including vital signs and a medical history, whenever possible.
  - d. Immediate access to on-site phlebotomy, urine collection, and rapid turnaround laboratory tests and evaluations must be provided, as clinically indicated. A

written policy and procedure must identify labs that will be made available and may include:

- i. A complete blood count with differential;
  - ii. A comprehensive metabolic panel;
  - iii. A thyroid Screening panel;
  - iv. A toxicology evaluation;
  - v. A pregnancy test for females of Child bearing age;
  - vi. A Screening test for tertiary syphilis;
  - vii. Psychiatric medication levels;
- e. Other tests or evaluations, as appropriate, based on the patterns of illness in the individuals served;
  - f. Screening for intoxication and, when indicated, Screening for symptoms and complications of substance withdrawal must be provided; and
  - g. A neurological examination that is adequate to rule out significant acute pathology;
  - h. On-site capability for such routine Assessments as pulse oximetry, glucometry (or stat blood glucose testing), point of care urine toxicology Screening (results available within four hours), and a targeted physical examination.

## **G. Treatment**

All treatment activities must be documented in the individual's clinical record. The LMHA or LBHA must develop and implement written policies and procedures to ensure the provision of:

1. Immediate intervention to stabilize a behavioral health emergency. These procedures must describe the most effective and least restrictive approaches to common psychiatric emergencies seen in EOUs with walk-in Crisis services, including behavioral health intervention that must always be available to prevent harm to individuals receiving EOU services and others in the facility. These procedures must be reviewed, updated and approved by the medical director every three years, with revisions submitted to HHSC annually.
2. Nursing care plans. These plans must be developed by an RN and implemented for every individual receiving services. A response to treatment must be assessed at least every two hours by an RN trained in the Assessment of individuals with acute behavioral health conditions or by a physician, preferably a psychiatrist, APRN or PA.
3. Education and Crisis Treatment and Recovery Plan
  - a. Education. Individuals and, if applicable, the individual's family members, LAR, or identified supports must receive appropriate educational information that is relevant to the individual's condition, including information about the most effective treatment for the individual's behavioral health disorder. An LPHA must be responsible for providing the individual with active treatment including:
    - i. psycho-education;
    - ii. Crisis counseling;
    - iii. substance use counseling, as indicated;

- iv. safety planning; and
- v. discharge planning that addresses potential obstacles to a successful return to the community environment.
- b. Crisis Treatment Plan. An Individualized Crisis Treatment Plan must be developed and implemented for everyone in services.
  - i. The plan must be based on the provisional psychiatric diagnosis and incorporates, to the extent possible, the individual's treatment preferences as reported or as indicated an individual's Declaration for Mental Health, and any preferences reported by the individual's family, LAR, or identified support, as applicable.
  - ii. Crisis Treatment Planning must place emphasis on providing Crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.
  - iii. The Crisis Treatment Plan must address:
    - (1) Intervention;
    - (2) Outcomes;
    - (3) Plans for follow-up and aftercare; and
    - (4) Referrals
    - (5) Safety planning for individuals found at risk of harm to self or others.
- c. Plan Implementation. An Individualized Crisis Treatment Plan must provide the most effective and least restrictive available treatment and must be adjusted as necessary to incorporate the individual's response to previous treatment.
- iv. Counseling on restriction to lethal means and safety planning must be incorporated into the Crisis Treatment Plan when than individual is indicated to be at risk of harm to self during the Crisis Assessment.
- v. The Crisis Treatment Plan must be adjusted as necessary to incorporate the individual's response to previous treatment.
- d. Follow up. The Individualized Crisis Treatment Plan must address intervention, outcomes, plans for follow-up and aftercare, and referrals.

## **H. Coordination and Continuity of Care**

The LMHA or LBHA must develop and implement written policy and procedures to ensure Continuity of Care and coordination services to develop successful linkage with the referral facility or provider. All Continuity of Care and coordination activities must be documented in the clinical record. This service includes contacting, and coordinating with, the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.

- a. A written procedure must be developed and implemented for ensuring Continuity of Care and successful linkage with the referral provider.
- b. Continuity of Care must:
  - i. Be provided for every individual;

- ii. Consist of identifying and linking the individual with all available services including the substance abuse services necessary to stabilize the Crisis and ensure transition to routine care;
  - iii. Provide necessary assistance in accessing those services and conducting follow-up to determine the individual's status and need for further service; and
  - iv. Include contacting and coordinating with the individual's existing service providers, when feasible, and in conformance with applicable confidentiality requirements.
- c. Coordination of services must include the following requirements:
- i. A discharge plan must be initiated for every individual upon admission;
  - ii. If inpatient treatment is not indicated, the discharge plan must include:
    - (1) Appropriate education relevant to the individual's condition;
    - (2) Information about the most effective treatment for the individual's psychiatric condition;
    - (3) Information about follow-up care;
    - (4) A list of medications to continue upon discharge, if there are medication changes; and
    - (5) Appropriate linkages to post discharge providers.
- d. If a physical health issue requires hospitalization, the individual must be transferred to the appropriate community hospital to address the physical health issue.

## **I. Medication Standards**

Certain conditions regarding how medications are obtained or provided may require that the facility obtain licensure in accordance with the Texas Board of Pharmacy rules described in 22 TAC, Part 15, Chapter 291 (relating to Pharmacists).

### **1. Medication storage.**

All facilities that provide or store individual's medication during the length of stay must implement written procedures for medication storage, administration, documentation, controlled substances, inventory, and disposal and must adhere to medication standards in the 26 TAC Chapter 301, Subchapter G §301.355, (relating to Medication Services).

- a. An LMHA must ensure that an individual:
  - i. must not retain their personal medications while in the facility; but
  - ii. must receive that personal medication upon discharge from the facility.
- b. Staff must be able to provide a copy of the most recent Stock Inspection.
- c. There must be evidence in the clinical records that individuals are educated about their medications including whenever medications are prescribed or changed.
- d. Medications that are kept on-site must be kept locked at all times.

## 2. Climate controlled medications.

Medications that require special climatic conditions such as refrigeration, darkness, or be tightly sealed must be stored properly.

## 3. Controlled substances.

- a. Controlled substances must be approved by a physician employed by or who contracts with the facility or LMHA or LBHA that operates the EOU.
- b. Controlled substances must be stored under double locks.

## 4. Labeling medications.

- a. The facility must ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.
- b. Medication labels must not be handwritten or changed.

## 5. Facility management.

- a. Facility management must ensure that only licensed staff have access to medications that are administered to individuals.
- b. Facility management must maintain a current list in the medication room of all staff who are licensed to prescribe medications that are dispensed from the medication room.
- c. Facility management must maintain a current list of all staff licensed to administer medications in the medication room.
- d. The facility must ensure that there is a list in, or near, or within the medication room stating the names of all staff who are authorized access to the medication room.
- e. The facility must ensure that staff never transfer medications from one container to another. However, an individual may independently transfer his or her own medications from a bottle to a daily medication reminder.
- f. The facility must maintain an emergency medication kit which must:
  - i. Be monitored using a perpetual method inventory and make use of breakaway seals; and
  - ii. Contain medications and other equipment as specified by the facility medical director. This generally includes, but is not limited to, short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications.
- g. There must be a medication guide such as a Physician's Desk Reference (PDR) or similar publication published within the last two years, is available to staff in either electronic or hard copy format.

## **J. Physical Plant**

- 1. The physical plant must provide a clean and safe environment and have written policies and procedures for monitoring environmental safety in accordance with 26 TAC Subchapter G, §301.312 (relating to Environment of Care and Safety).
- 2. Any newly constructed or renovated or remodeled unlicensed Crisis facility

must receive a pre-operational on-site review by HHSC Quality Management (QM) before opening to the public to provide services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.

3. The facility must report any changes in programming, construction or facility to the HHSC Contracts Manager.

## **K. Facility Environment**

Facility environment requirements are developed in accordance with the American with Disabilities Act (ADA) checklist for existing facilities (<http://www.adachecklist.org/>).

### **1. Water/Waste/Trash/Sewage.**

The water supply must be of safe, sanitary quality, suitable for use, adequate in quantity and pressure, and must be obtained from an approved water supply system.

- a. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
- b. Waste, trash and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
- c. Hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
- d. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.

### **2. Windows.**

Operable windows must be insect screened.

### **3. Pest control.**

An ongoing pest control program must be provided by staff or a licensed pest control company. The least toxic and least flammable effective chemicals must be used.

### **4. Storage.**

- a. Storage areas and cellars must be kept in an organized manner.
- b. Storage must not be permitted in the attic spaces.

### **5. Floors, walls, and ceilings.**

- a. Floors must be clean and maintained in good condition.

- b. Walls and ceilings must be structurally maintained, repaired and repainted or cleaned as needed.

## 6. Bathroom and laundry.

- a. At least one water closet and lavatory per every six individuals, and one tub or shower for every ten individuals must be provided in each EOU.
- b. Privacy partitions and or curtains must be provided for water closets and bathing units in rooms for multi-individual use.
- c. Tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
- d. Towels, soap and toilet tissue must be available at all times for individual's use.
- e. If laundry is processed off the site, the following must be provided on the premises: a soiled linen holding room; a clean linen receiving, holding, inspecting, sorting or folding and storage room.
- f. A laundry for individual's use, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.

## 7. Building repair/maintenance/and cleaning.

- a. The facility must be kept free of accumulations of dirt, rubbish, dust and hazards.
- b. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
- c. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in areas where individuals receive services.

## 8. Room space.

- a. The room space provided must be at least 80 usable square feet per individual in single-occupancy rooms; or 60 usable square feet per individual in multiple-occupancy rooms.
- b. Furnishings provided by the EOU must be maintained in good repair.

## **L. General Facility**

### 1. Storage.

The facility must provide sufficient, appropriate, and separate storage spaces or areas for the following:

- a. Administration and clinical records;
- b. Office supplies;
- c. Medications and medical supplies that must be locked;
- d. Poisons and other hazardous materials must be
  - i. Stored in a locked area; and



- ii. Stored separate from all food and medications;
- e. Food preparation (if the facility prepares food); and
- f. Equipment supplied by the facility for individuals' needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment.

## 2. Smoking.

Staff members must not provide or facilitate individual access to tobacco, vaping products, or electronic cigarette equipment. When a facility permits smoking, the facility must:

- a. Establish smoking regulations;
- b. Ensure that individuals have designated outdoor smoking areas of safe design; and
- c. Ensure that smoking areas contain ashtrays of noncombustible material.

## 3. Prohibitions.

The facility must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.

## 4. Telephone access.

The facility must provide at least one telephone in the facility available for use by both staff and individuals.

## 5. Main area displays.

The following must be prominently displayed in areas frequented by individuals:

- a. Contact information for the Rights Protection Officer;
- b. Contact information with instructions on how to make an abuse/neglect/exploitation report and the toll-free number for reporting abuse and neglect; and
- c. A notice stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the staff responsible for ADA compliance.

## 6. Postings.

Postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area. The facility must post:

- a. A list of names of all staff members permitted access to the medication room located in, near, or within the medication room; and
- b. 911 as the emergency contact located at, or within view, of the telephone.

## 7. Accessibility (ADA Compliance).

At least 10 percent of individuals' bedrooms and toilets, and all public use and common use areas must be designed and constructed to be accessible. The facility must also comply with standards in the most recent version of:

- a. Title 28, Code of Federal Regulations, Part 36. ([http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title28/28cfr36\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title28/28cfr36_main_02.tpl))
- b. Americans With Disabilities Acts Accessibility Guidelines (ADAAG); and
- c. Texas Accessibility Standards (TAS) and all applicable sections of TAC.

## M. Life Safety

### 1. Life Safety Code.

The facility must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code (IFC). Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.

### 2. Local fire code.

All facilities must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code as defined by the local fire authority.

### 3. Code compliance.

Facilities must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the codes referenced in subsections (1) and (2) of this section.

### 4. Fire drills.

The facility must conduct fire drills and calculate evacuation scores in accordance with the fire code under which the facility is inspected.

- a. The administration must have in effect and available to all supervisory staff written copies of a plan for the protection of all individuals in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary.
- b. The written plan must:
  - i. Identify special staff actions including fire protection procedures needed to ensure the safety of any individual;
  - ii. Indicate that all staff must be periodically instructed and informed of their duties and responsibilities under the plan;
  - iii. Be amended or revised as needed; and
  - iv. Require documentation that reflects the current evacuation capabilities of the individuals.
- c. A copy of the plan must be readily available at all times within the facility.

## 5. Disaster Planning

- a. The LMHA or LBHA must develop, implement and make available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, in accordance with 26 TAC Subchapter G, §301.312 (relating to Environment of Care and Safety).
- b. The written disaster plan must address, at a minimum, eight core functions:
  - i. Direction and control;
  - ii. Warning;
  - iii. Communication;
  - iv. Sheltering arrangements;
  - v. Evacuation;
  - vi. Transportation;
  - vii. Health and medical needs; and
  - viii. Resource management.
- c. The written disaster plan must include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the facility or during facility evacuation.

## 6. Recorded inspections.

Facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual, quarterly or other periodic inspections must be signed and dated. The following initial and annual inspections and maintenance are required and must be kept on file:

- a. Local fire safety inspection as described in subsection (6)(a) of this section;
- b. Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
- c. Annual kitchen inspection by the local health authority;
- d. Gas pipe pressure test one every three years by the local gas company or a licensed plumber, as required by facility type or licensure;
- e. Monthly inspection and annual maintenance of fire extinguishers by personnel licensed or certified to perform the inspection; and
- f. Inspection of liquefied petroleum gas systems by an inspector certified by the Texas Railroad Commission, when applicable.

## 7. Fire safety inspections.

Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal.

- a. The facility is responsible for:
  - i. Arranging these inspections and for ensuring that these inspections are carried out in a timely manner;

- ii. Ensuring the initial and ongoing reports are signed by the certified inspector performing inspection; and
- iii. Keeping the reports on file and be readily available for review by the state.
- b. All fires causing damage to the facility or to equipment must be reported to the Department's Contract Manager with 72 hours.
- c. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Notification must be by telephone if during normal business hours and by e-mail during other times with a follow-up telephone call to the Contract Manager on the first business day following the event.

## 8. Correction plan.

If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, staff must take immediate corrective action to bring the EOU into compliance with the applicable code. The facility must:

- a. Record on file the date for a return inspection by the Certified Fire Inspector to review the corrective actions;
- b. After that date, record on file documentation by the Certified Fire Inspector that all deficiencies have been corrected and that the facility is in full compliance with all applicable codes; and
- c. During the period of corrective action, take any actions necessary to ensure the health and safety of individuals residing in the facility during the time the repairs or corrections are being completed.

## 9. New facilities.

If the facility has been in operation for less than one year, the documentation of compliance with applicable fire code must be completed and signed by an architect licensed to practice in the state of Texas. Certification of such compliance must be based on the architect's inspection of the facility completed after (or immediately prior to) the facility begins operations.

## 10. Remodeled or renovated facilities.

For major remodeling and renovations, the facility must contract with an architect licensed to practice in the state of Texas. The architect must ensure that the remodel and renovation project adhere to local building code requirements.

## 11. Vehicles.

All vehicles used to transport individuals must be maintained in safe driving condition. in accordance with 37 TAC Chapter 23, Subchapter D (related to Vehicle Inspection, Items, Procedures, and Requirements).

- a. Every vehicle used for transportation must have a fully stocked first aid kit and an A:B:C fire extinguisher that is easily accessible.
- b. Any vehicle used to transport an individual must have appropriate insurance coverage.

## 12. Individual Safety.

The facility must ensure that:

- a. All staff members are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;
- b. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or to harm to a staff member;
- c. Individual bedrooms, bathrooms, and other private or unsupervised areas used by individuals must be free of materials that could be utilized by an individual in an attempt to, or to die by suicide, or to harm or kill others. Such items include but are not limited to:
  - i. Ropes;
  - ii. Cords (including window blind cords);
  - iii. Sharp objects;
  - iv. Substances that could be harmful if ingested; and
  - v. Extended ceiling fans.
- d. Individual bedrooms, bathrooms, and other private or unsupervised areas must contain:
  - i. Break-away curtains; and
  - ii. Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.

## **N. Infection Control**

### 1. Infection Control

Each facility must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

- a. The facility must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
- b. The facility must have written policies for the control of communicable disease in staff and individuals, which includes tuberculosis (TB) Screening and provision of a safe and sanitary environment for individuals and staff.

### 2. TB reporting requirement.

The facility must maintain evidence of compliance with local and state health codes or ordinances regarding staff and individual health status.

- a. Individuals. The name of any individual of a facility with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate

infection control procedures must be implemented as directed by the local health authority.

- i. A facility must screen all individuals upon admission and after exposure to TB and provided follow-up as needed.
  - ii. HHSC will provide a TB Screening questionnaire for admission Screening: <https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf>
- b. Employees. A facility employee that contracts a communicable disease that is transmissible to an individual through food handling or direct care, must be excluded from providing these services as long as a period of communicability is present.
  - i. The facility must screen all staff for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (for CDC) *Guidelines Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.
  - ii. All persons who provide services under an outside resource contract must, upon request of the facility, provide evidence of compliance with this requirement.

### 3. Universal Precautions.

Universal precautions must be used in the care of all individuals.

- a. Staff who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.
- b. First aid kits must be sufficient for the number of individuals served at the EOU.
  - i. Spill kits must be immediately accessible to all staff.
  - ii. Gloves must be immediately accessible to all staff.
  - iii. One-way, CPR masks must be immediately available to all staff.
  - iv. Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.
- c. Sharps containers must be puncture resistant, leak proof, and labeled.
  - i. Sharps containers must not be overfilled.
  - ii. Needles in the sharps containers must not be capped or bent.
- d. Disinfectants and externals must be separated from internals and injectables.
- e. Running water or dry-wash disinfectant must be available to staff where sinks are not readily available.
- f. Staff must be able to accurately describe:
  - i. The policy for handling a full sharps container;
  - ii. The actions to take if exposed to blood or body fluids;
  - iii. How to clean a blood or body-fluid spill; and
  - iv. Be able to direct a QM reviewer to all protective equipment.

### 4. Poison Control phone numbers must be posted throughout the EOU.

- a. Information regarding Emergency Medical Treatment for Poisoning must be available to staff.

5. All medical materials must be stored and labeled on shelves or in cabinets in accordance with policies and procedures.
- a. The facility must maintain a record indicating that staff regularly checks the temperature in the refrigerator.
  - b. There must be a thermometer in the refrigerator and temperatures must be maintained between 36 and 46 degrees Fahrenheit in accordance with 22 TAC Subchapter A, §291.15 (relating to Storage of Drugs).
  - c. Refrigerators used to store medications must be kept neat, clean and free of non-pharmacy / non-medical items. Lab specimens must be stored separately.

## **O. Food Preparation and Food Service**

When extended observation services are provided in a CSU or licensed hospital, food preparation and food services must also follow licensing rules and regulations appropriate to the facility type.

### **1. Kitchen Standards**

If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the individuals.

- a. Kitchen or dietary area must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.
- b. All facilities must provide a means for washing and sanitizing all dishes and cooking utensils.
- c. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans, cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.
- d. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.
- e. In kitchens and laundries, staff must implement procedures to avoid cross-contamination between clean and soiled utensils and linens

### **2. Meals Availability**

At least three meals or their equivalent must be:

- a. Served daily;
- b. Served at regular times; and
- c. Provided with no more than a 16-hour span between a substantial evening meal and breakfast the following morning.

### **3. Nutrition and Diets**

All facilities must:

- a. Provide therapeutic or special diet when ordered;

- b. Provide food and beverages to accommodate individuals who enter the facility after established meal times;
- c. Ensure that menus provide a balanced and nutritious diet, in accordance with the most recent version of the United States Department of Agriculture's guideline;
- d. Accommodate individual kosher dietary needs or other related dietary practice
- e. Maintain onsite at all times a four-day supply of staple foods and a one day supply of perishable foods.

#### 4. Food Service

An EOU must meet the general food service needs of individuals receiving services. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.

- a. Facilities that prepare meals in a centralized kitchen on site must:
  - i. Pass an annual kitchen health inspection as required by law;
  - ii. Immediately address any deficiencies found during any health inspection; and
  - iii. Post the current food service permit from local health department.
- b. Facilities that contract for food services must have a written contract that requires the food service to comply with the rules referenced in Form N, Section IV. Extended Observation Unit, N. Infection Control. The contracted food service must:
  - V. Pass an annual kitchen health inspection as required by law;
  - VI. Ensure the meals are transported to the EOU in temperature-controlled containers to ensure the food remains at the temperature at which it was prepared; and
  - VII. Ensure that at least one staff, at minimum, maintains a current food handler's permit.

#### 5. Food Storage

All facilities must ensure the:

- a. Dating of food that is subject to spoilage; and
- b. Supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period are maintained on premises.



## **V. Crisis Residential Services**

### **A. Definition**

Short-term, community-based residential, Crisis treatment and services Provided by an LMHA or LBHA to Children, Adolescent and adult individuals experiencing behavioral health crises that cannot be stabilized in a less intensive setting. Crisis residential services are provided to individuals presenting with increased risk of harm to self or others or moderately severe functional impairment. Crisis residential facilities provide a safe environment with staff on site at all times. Individuals must present on a voluntary basis and have the ability to participate in treatment and services at a minimum level of engagement, as defined by the individual's treatment team. All Crisis residential services must be delivered in accordance with Title 26 Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and 26 TAC Chapter 306, Subchapter D (relating to Mental Health Services—Admission, Continuity, and Discharge).

### **B. Goals**

- Provide immediate Crisis stabilization
- Provide a therapeutic environment to promote healing and restore sufficient functioning to allow the individual to transition to the least restrictive level of care
- Provide the individual with critical coping skills to support resilience and recovery
- Engage the individual with family, LAR, Adult Caregiver, identified support system and community resources and support
- Provide the individual with coordination of care and continuity of appropriate support services
- Reduce inpatient and law enforcement interventions through stabilization in the least restrictive setting

### **C. Description**

#### **1. Length of stay**

The length of stay may vary depending on the clinical needs of an individual with the average length of stay being between six and ten days.

#### **2. Admission criteria**

Admission is voluntary and based upon Medical Necessity, as determined by an LPHA practicing within the scope of the LPHA's professional license. Crisis residential facilities do not accept individuals who are court-ordered or court-committed for treatment.

- a. The facility must not admit individuals whose needs cannot be effectively addressed in the facility. Individuals requiring a greater or lesser level of care must be referred to a more appropriate level of care.
- b. An individual must have enough medication on arrival to ensure psychiatric

and medical stabilization for at least three days. A Crisis Residential facility may admit an individual who does not have any medication on arrival only if the facility can provide a three-day supply of both psychiatric and physical medications within eight hours of admission.

- c. An individual with capacity, as determined by a physician (i.e. preferably a psychiatrist), must give written consent to receive mental health services, including medication and laboratory services.

### 3. Egress

Crisis residential services must be provided in an unlocked facility that provides individual residents restricted entrance and unrestricted exit.

### 4. Facility standards

Crisis residential facilities must:

- a. Remain open 24 hours a day, every day of the year;
- b. Maintain trained and competent staff on site at all times to provide safety monitoring and reAssessment to individuals receiving services; and
- c. Maintain a stable and supportive environment that provides a venue for biological, psychological, and social interventions targeted at the current Crisis while fostering community reintegration

### 5. Psychosocial programming

In accordance with 26 TAC Chapter 306, Subchapter F §306.321 (relating to Day Programs for Acute Needs), programming must be provided as clinically necessary in and focus on a range of topics that include, at a minimum:

- a. reality orientation;
- b. symptom reduction and management;
- c. appropriate social behavior;
- d. improving peer interactions;
- e. improving stress tolerance;
- f. the development of coping skills

## **D. Standards**

### 1. Services Availability

- a. This service must be available to individuals 24 hours a day, every day of the year. The availability of Crisis residential services is dependent on LMHA or LBHA funding.
- b. Admission of an individual to Crisis residential must be determined by the LMHA or LBHA and based on Medical Necessity as determined by an LPHA.
- c. When appropriate, the LPHA may use Telemedicine or Telehealth services to assess an individual for admission.

## 2. Staffing

- a. Policies and Procedures. A psychiatrist must serve as the medical director for all Crisis services and must approve all written procedures and protocols.
- b. General Staffing Pattern. A written staffing plan must be available and address clinically indicated staffing adjustments based on the acuity and number of individuals served. The staffing plan must provide the following:
  - i. An On Call roster of clinical (QMHP-CS and above) and nursing (RN and LVN) staff that is maintained and a process in place for assessing and anticipating staffing ensures clinical or nursing staff members are on-site at all times;
  - ii. Staff coverage during the first and second shifts by trained and competent professional staff (i.e. QMHP-CSs);
  - iii. Staff coverage used on third (i.e., overnight) shift may be trained and competent Crisis Support Staff (i.e. non-licensed staff with less than a bachelor's degree in a human services field);
  - iv. A sufficient number of staff trained and competent in verbal de-escalation intervention techniques available at all times;
  - v. No fewer than two staff members, trained in verbal and physical management of assaultive or aggressive behavior, must be on site and available to respond at all times to ensure a safe environment;
  - vi. A sufficient number of staff on site to provide one-on-one supervision of one or more individuals as indicated; and
  - vii. A number of staff trained and competent in the verbal and physical management of assaultive or aggressive behavior which may be increased to a sufficient level to ensure the safety of all individuals and staff in the facility.
- c. Day Programming for Acute Needs. Staffing of day programs must be provided to ensure safety and program adequacy per 26 TAC §306.321 (relating to Day Programs for Acute Needs).
- d. Training, Competency and Credentialing.
  - i. The competence of all staff must be continuously evaluated, monitored during the actual delivery of services, and continually enhanced to address the unique needs of individuals in different settings and situations.
  - ii. Competency based expectations for all staff members are outlined in 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and include, but are not limited to:
    - (1) Required competencies for all staff members;
    - (2) Critical competencies for staff members whose primary job duties are related to individual service contacts and interactions;
    - (3) Specialty competencies for staff who perform specialized services and tasks;
    - (4) Telemedicine competencies for staff whose job duties are related to assisting Telemedicine services; and
    - (5) Competencies for staff providing Crisis services.

- iii. Licensing and credentialing of all staff must be monitored and verified prior to these staff providing services. Documentation of current credentialing and recredentialing should be maintained in the staff members' personnel records.
- iv. Staff involved in Assessment or treatment must receive Crisis training that includes, but is not limited to:
  - (1) Identifying signs, symptoms, and Crisis response related to a substance use;
  - (2) Identifying signs, symptoms, and Crisis response to trauma, abuse, and neglect;
  - (3) Identifying signs, symptoms, and Crisis response to individuals with Intellectual Disability and developmental disabilities;
  - (4) Identifying specialized Assessment and intervention strategies for Children, Adolescents, and families;
  - (5) Assessing individuals and providing intervention;
  - (6) Conducting suicide Screenings and Assessments, homicide Screenings and Assessments, and risk of deterioration Screenings and Assessments;
  - (7) Applying knowledge and effective use of communication strategies such as a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, according to 25 TAC, Chapter 415, Subchapter F (relating to Interventions in Mental Health Services);
  - (8) Completing clinical interviews in behavioral health Crisis care for staff, such as a physician (preferably a psychiatrist), Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), Physician's Assistant (PA), Licensed Practitioner of the Healing Arts (LPHA), or Qualified Mental Health Professional – Community Services (QMHP-CS); and
  - (9) Using Telehealth or Telemedicine technology, if applicable. Telemedicine and Telehealth competencies must be included for positions in which a staff member's job duties are related to or involve assisting with Telemedicine or Telehealth services and include adequate and accurate knowledge of:
    - (a) operation of the Telemedicine or Telehealth equipment; and
    - (b) how to use the equipment to adequately present the individual.
- e. Availability, Duties, and Responsibilities.
  - i. Staff On Duty must remain awake and alert at all times.
  - ii. All facility staff trained and competent in verbal and physical management of assaultive/aggressive behavior must ensure the safety and wellbeing of all individuals and staff during the time a physician, PA, APRN, or RN is in route to provide needed services.
  - iii. Duties and responsibilities for all staff involved in the Assessment or treatment of individuals must be:
    - (1) defined in writing by the medical director;
    - (2) appropriate to staff training, competency, and experience; and
    - (3) in conformance with the staff member's scope of practice and state standards for privileging and credentialing.
  - iv. LPHA

- (1) An LPHA must be immediately available during the day and must be responsible for ensuring the individual is provided active treatment defined in an Individualized Crisis Treatment Plan.
- (2) At least one LPHA must be available, either in person or through Telehealth, to conduct patient interviews and initiate a full Assessment within eight hours of presentation to the unit or sooner when indicated.

v. Physician

- (1) Post admission, a physician (preferably a psychiatrist), PA, or APRN must see every individual at least once per week, or more frequently as clinically indicated and be On Call 24 hours a day to evaluate individuals as needed and to provide supervision and consultation
- (2) A process must exist to obtain medical and psychiatric medications, as needed, for the individual.
- (3) A physician, (preferably a psychiatrist), PA, APRN, or RN must be on site or readily accessible to provide face-to-face services either in person or through Telemedicine or Telehealth services. If a physician is not already on site, the physician (preferably a psychiatrist), PA, or APRN must be available to provide face-to-face services, either in person or through Telemedicine services, within one hour.

vi. Nursing staff

- (1) An RN must be On Call for emergencies, supervision, and consultation 24 hours a day, seven days a week.
- (2) If a RN is not on site, the RN must be available to provide face-to-face services as soon as possible.

f. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

### 3. Assessment and Intake

a. Full Psychiatric Assessment

- i. Individuals who present for Crisis residential services must receive a full psychiatric Assessment, either in person or through Telemedicine services, by a physician (preferably a psychiatrist) APRN or PA within 24 after presentation unless:
  - (1) such Assessment was conducted within the past 72 hours by an outpatient mental health provider, inpatient mental health facility or psychiatric emergency services provider and is available for review; and
  - (2) there are no recent changes to the individual's mental health status since the previous Assessment was completed; or
  - (3) other observable indications that another full psychiatric Assessment is warranted.

- ii. A process must be developed and implemented to ensure that any individual requiring an immediate full psychiatric Assessment due to increased risk of harm or deterioration can received such Assessment within eight hours of initial presentation.
- b. Assessment Process
  - i. The Assessment process includes an attempt to determine an individual has an active Declaration for Mental Health Treatment and a biopsychosocial Assessment which includes patient interview by QMHP-CSs, LPHAs or PAs;
  - ii. When indicated and as appropriate, Telemedicine or Telehealth services may be used to conduct Assessments.
  - iii. The Assessment process must include a review of available records of past treatment;
  - iv. The Assessment process must gather and incorporate:
    - (1) Proactive history from family and collateral sources and in keeping with laws on confidentiality;
    - (2) Contact with the current behavioral health providers whenever possible and in keeping with laws on confidentiality;
    - (3) A diagnostic Assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
    - (4) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
    - (5) Documentation of the individual's ability and willingness to cooperate with treatment, as well as any treatment wishes listed in an individual's Declaration for Mental Health Treatment as applicable;
    - (6) A history of previous treatment and the response to that treatment including a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescribing practitioner;
    - (7) Documentation of an individual's current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;
    - (8) Documentation of an individual's current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;
    - (9) A general medical history that identifies all medical conditions that an individual has, and includes:
      - (a) Medical considerations of how these conditions affect the individual's overall current condition; and
      - (b) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);
    - (10) A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition;
    - (11) A detailed Assessment of substance use conducted by an individual trained in assessing substance related disorders;

- (12) An Assessment for trauma, abuse or neglect by trained clinical staff, preferably an LPHA, with training in this Assessment; and
  - (13) A physical health Assessment as outlined below.
- v. Physical Health Assessment
- (1) Individuals must receive a physical health Assessment by a physician (preferably a psychiatrist), PA, APRN, or RN, within two hours of entering a Crisis residential unit unless:
    - (a) Such an Assessment was already conducted within the last week; and
    - (b) There are no recent changes or other indications that another Assessment may be warranted.
  - (2) Individuals not currently in services, or for whom the health status is unknown, must receive a comprehensive nursing Assessment by an RN within 1 hour of presentation.
  - (3) The initial evaluation for physical health must be performed as ordered, by a physician (preferably a psychiatrist) or a APRN or PA and includes, at a minimum:
    - (a) Vital signs;
    - (b) A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
    - (c) A Screening neurological examination that is adequate to rule out significant acute pathology;
    - (d) A medical history and review of symptoms
    - (e) A pain Assessment
    - (f) Screening for substance use and intoxication and, when indicated, Screening for symptoms and complications of substance withdrawal;
    - (g) An Assessment of medical and psychiatric stability and dangerousness to self or others; and
    - (h) An Assessment of capacity to self-administer medications.
  - (4) Access to phlebotomy, urine collection, and laboratory studies must be provided. A written policy and procedure must be developed and implemented that defines how blood and urine specimens will be sent to a laboratory and how results will be transmitted back to the facility.
  - (4) Immediate access to urgent and emergent non-psychiatric medical Assessment and treatment must be provided.
- vi. Orientation. Every individual admitted to services must receive a unit orientation no later than 24 hours after admission. In accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities). The orientation must explain orally and in writing, the individual's rights in a language and format easily understandable to the individual, and if applicable the individual's parent, LAR, or Adult Caregiver:
- (1) Facility rules and expectations;
  - (2) The rights of individuals receiving treatment;
  - (3) The grievance policy;

- (4) The schedule of program activities; and
- (5) Determine that the individual comprehends the information provided in 1) - 4).

#### 4. Interventions

- a. Policies and Procedures. A written policy must be developed and implemented in accordance with 25 TAC Chapter 415, Subchapter F (relating to Interventions in Mental Health Services) that:
  - i. Specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in service;
  - ii. Identifies a process to obtain medical and psychiatric medications for individuals as needed;
  - iii. Is reviewed and updated as needed; and
  - iv. Is approved by the medical director.
- b. Treatment Planning. Every individual admitted to services must participate in the development of a Crisis Treatment Plan that delineates the most effective and least restrictive treatment for the individual's behavioral health disorder.
  - i. This information will be shared with the individual and the individual's family, Adult Caregiver, LAR, or identified support system as appropriate.
  - ii. The Crisis Treatment Plan must be based on the provisional psychiatric diagnosis and must incorporate individual preferences.
  - iii. The Crisis Treatment Plan must incorporate individual preferences as reported or indicated in the individual's Declaration for Mental Health.
- c. Treatment Interventions.
  - i. An array of treatment interventions must exist in the Crisis residential setting in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
    - (1) A minimum of four hours per day of such programming must be available and must be provided to those who can participate at a minimal level of engagement as defined by the individual's treatment team.
    - (2) Services should be goal-oriented and focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills. Services may consist of the following components:
      - (a) Psychiatric nursing services,
      - (b) Pharmacological instruction,
      - (c) Symptom management training, and
      - (d) Functional skills training.
    - (3) The programming requirements may be fulfilled through the provision of individual Crisis intervention services or by providing group services.
    - (4) Group services may be delivered through the provision of services as specified in 26 TAC §306.321(relating to Day Programs for Acute Needs).



- (5) Individuals who have significant co-occurring substance use must receive counseling designed to motivate the individual to continue substance use treatment following discharge from the program.
- ii. Individuals must not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- iii. The program must provide a stable therapeutic environment that includes:
  - (1) Consistently assigned unit personnel;
  - (2) Consistently scheduled unit activities;
  - (3) RN supervision or delegated staff supervision of an individual's self-administration of medication;
  - (4) Same-day access to medications available when needed; and
  - (5) Education on the psychotropic medication provided by the RN or QMHP-CS.
- iv. In the event of a psychiatric emergency, regardless of consent, the individual may be administered emergency medication in accordance with 25 TAC Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication—Mental Health Services).

## 5. Coordination of Treatment, Continuity of Care, and Discharge

- a. A Crisis residential unit must create and implement:
  - i. A written policy to ensure the provision of Continuity of Care and successful linkage with the referral facility, agency, or provider; and
  - ii. A written procedure defining the actions that must be taken to ensure every effort is made to contact existing treatment providers during the course of the individual's Assessment and treatment in the service.
- b. Coordination of services and Continuity of Care must be provided for every individual and must include:
  - i. identifying and linking the individual with all available services necessary to ensure transition to routine care; and
  - ii. providing necessary assistance in accessing those services, including contacting and coordinating with the individual's existing or newly selected service providers in a timely manner and in conformance with applicable confidentiality requirements.
- c. Discharge planning must be initiated at the time of an individual's admission. In accordance with 26 TAC §301.201 (relating to Discharge Planning), a discharge plan must be developed for every individual, and must include:
  - i. Appropriate education relevant to the individual's condition;
  - ii. Information about the most effective treatment for the individual's behavioral health disorder;
  - iii. Identification of potential obstacles to a successful return to the community and means to address these obstacles; and

- iv. Information about follow-up care, and appropriate linkages to post discharge providers.

## 6. Physical Plant

- a. If the LMHA holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by HHSC, and any Quality Management and Compliance reviews will entail only programmatic elements.
- b. If the LMHA owns and operates a non-licensed facility under an exemption from licensure they are required to register and submit a facility exemption form in conjunction with the Consolidated Local Services Plan submission every two years.
- c. Crisis residential service units must provide a clean and safe environment.
- d. Crisis residential services must create as normalized an environment as possible.
- e. Crisis residential services units must not be designed to prevent elopement and must not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility.
- f. All medications must be securely stored.

## 7. General Facility Environment

- a. Water/Waste/Trash/Sewage.
  - i. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
  - ii. The water supply must be of safe, sanitary quality, suitable for use and adequate in quantity and pressure and must be obtained from a water supply system.
  - iii. Waste, trash, and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
- b. Windows. Operable windows must be insect screened.
- c. Pest Control. An ongoing pest control program must be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals must be used.
- d. Maintenance and Cleaning.
  - i. In kitchens and laundries, facility staff must use procedures to avoid cross-contamination between clean and soiled utensils and linens.
  - ii. The facility must be kept free of accumulations of dirt, rubbish, dust, and hazards.
  - iii. Floors must be maintained in good condition and cleaned regularly.
  - iv. Walls and ceilings must be structurally maintained, repaired, and repainted or cleaned as needed.

- v. Storage areas and cellars must be kept in an organized manner.
- vi. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
- vii. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.
- e. Telephone Access. There must be at least one telephone in the facility available to both staff and individuals for use in case of an emergency.
- f. Temperature. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in individual-use areas.
- g. Bedroom.
  - i. A bedroom must have no more than four beds.
  - ii. The facility must provide for each individual a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings.
  - iii. Furnishings provided by the facility must be maintained in good repair.
- h. Bathroom.
  - i. At least one water closet, lavatory, and bathing unit must be provided on each sleeping floor accessible to individuals of that floor.
  - ii. One water closet and one lavatory for each six occupants, or fraction thereof, must be provided.
  - iii. One tub or shower for each ten occupants, or fraction thereof, must be provided.
  - iv. Privacy partitions and all curtains must be provided in water closets and bathing units in rooms for multi-individual use.
  - v. Tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
  - vi. Individual-use hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
  - vii. Individuals must have access to towels, soap, and toilet tissue at all times.
- i. Storage.
  - i. The facility must provide sufficient and appropriate separate storage spaces or areas for the following:
    - (1) Administration and clinical records;
    - (2) Office supplies;
    - (3) Medications and medical supplies (these areas must be locked);
    - (4) Poisons and other hazardous materials (these must be kept in a locked area and must be kept separate from all food and medications);
    - (5) Food preparation (if the facility prepares food); and
    - (6) Equipment supplied by the facility for individual needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen

- equipment etc.
- ii. Storage must not be permitted in the attic spaces.
- j. Food storage.
  - i. Food storage areas must provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
  - ii. Food subject to spoilage must be dated.
- k. Laundry.
  - i. A large facility (i.e., a facility with more than 16 beds) which co-mingles and processes laundry on-site in a central location must comply with the following:
    - (1) The laundry must be separated and provided with sprinkler protection if located in the main building (separation must consist of a one-hour fire rated partition carried to the underside of the floor or roof deck above);
    - (2) Access doors to the laundry area must be from the exterior of the facility or if from within the building by way of non-individual use areas; and
    - (3) Soiled linen receiving, holding and sorting rooms must have a floor drain and forced exhaust to the exterior must operate at all times that soiled linen being held in this area.
  - ii. If laundry is processed off the site, the following must be provided on the premises: soiled linen holding room, clean linen receiving, holding, inspecting, sorting or folding, and storage room.
  - iii. Individual-use laundry, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.
- l. Smoking. Regulations must be established and if smoking is permitted, outdoor smoking areas may be designated for individuals. Ashtrays of noncombustible material and safe design must be provided in smoking areas. Staff must not provide or facilitate individual access to tobacco products.
- m. Room Space.
  - i. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms must be provided and have appropriate furniture.
  - ii. Dining areas must be provided and have appropriate furnishings.

## 8. Accessibility (ADA Compliance)

Crisis residential facilities must comply with the most recent versions of:

- a. The Americans with Disabilities Acts Accessibility Guidelines;
- b. The Texas Accessibility Standards in Texas Government Code, Chapter 469 (relating to Elimination of Architectural Barriers); and
- c. All applicable sections of the Texas Administrative Code.

## 9. Postings

- a. The facility must post in, near or within the medication room, a list of all staff members permitted to access the medication room.
- b. The facility must post 911 as the emergency contact at, or within view, of the telephone.
- c. The facility must ensure any permitted smoking areas are clearly marked as designated smoking areas.
- d. The facility must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.
- e. The facility must post an emergency evacuation floor plan.
- f. The following must be prominently displayed in areas frequented by the consumers:
  - i. Contact information for the Rights Protection Officer;
  - ii. Contact information, including a toll-free number, and instructions for reporting abuse and neglect; and
  - iii. Contact information stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
- g. The facility postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.
- h. A facility that prepares food on site must post the current food service permit from the local health department, if applicable.

## 10. Life Safety

- a. Life Safety Code. The facility must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code. Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
- b. Local Fire Code. The facility must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
- c. Code Compliance. The facility must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
- d. Emergency Evacuation Plan. The administration must have in effect, and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary.
  - i. The plan must:
    - (1) Include special staff actions, including fire protection procedures needed to ensure the safety of any resident;
    - (2) Be amended or revised when needed;
    - (3) Be readily available at all times within the facility;

- (4) Require documentation that reflects the current evacuation capabilities of the individuals; and
- (5) Include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the facility or during facility evacuation.
- ii. All employees must be periodically instructed and kept informed with respect to their duties and responsibilities under the plan.
- iii. The facility must conduct emergency evacuation drills quarterly and calculate evacuation scores in accordance with the fire code under which the facility is inspected.
- e. Disaster Plan.
  - i. The administration must have in effect and available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, per 26 TAC, Chapter 301, Subchapter G, §301.312 (relating to Environment of Care and Safety).
  - ii. The written disaster plan must address, at a minimum, eight core functions:
    - (1) Direction and control;
    - (2) Warning;
    - (3) Communication;
    - (4) Sheltering arrangements;
    - (5) Evacuation;
    - (6) Transportation;
    - (7) Health and medical needs; and
    - (8) Resource management.
  - iii. The written disaster plan must include processes for identifying and assisting individuals as stated above in d.1) e) who have mobility limitations, or other special needs, who may require specialized assistance within the residential facility or during facility evacuation.
- f. Recorded Inspections.
  - i. Facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections must be signed and dated.
  - ii. The following initial and annual inspections are required and must be kept on file:
    - (1) Local Fire safety inspections as outlined in 10.g., below;
    - (2) Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
    - (3) Annual local health authority kitchen inspection, if required;
    - (4) Fire extinguisher inspection and maintenance by personnel licensed or certified to perform the inspection; and
    - (5) Liquefied petroleum gas systems inspection by an inspector certified by the Texas Railroad Commission.

g. Fire Safety Inspections.

- i. Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal's Office.
- ii. The facility is responsible for arranging required inspections and ensuring that inspections are carried out in a timely manner.
- iii. The initial and ongoing fire safety reports must be signed by the certified inspector performing the inspection.
- iv. These reports must be kept on file and be readily available for review by the state.
- v. All fires causing damage to the Crisis residential unit or to equipment must be reported to the HHSC Contract Manager within 72 hours. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Report must be made by telephone during normal business hours and by telephone call and e-mail during other times, with a follow-up telephone call to the Contract Manager on the first business day following the event.
- vi. Open flame heating devices are prohibited. All fuel burning heating devices must be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.

h. Correction Plan. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff must take immediate corrective action to bring the facility into compliance with the applicable code.

- i. The facility must have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions.
- ii. The facility must have on file documentation by the Certified Fire Inspector that all findings have been corrected and that the facility is in full compliance with all applicable codes.
- iii. During the period of corrective action, the facility must take any steps necessary to ensure the health and safety of individuals residing in the facility during the time repairs or corrections are being completed.

i. Newly Operational Facilities. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in the State of Texas. Such certification must be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a Crisis residential facility.

j. Pre-operational facility requirements. Any newly constructed or renovated or remodeled unlicensed Crisis residential facility must receive a preoperational on-site review by HHSC QM before being open to the public to provide Crisis residential services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.

- k. Individual Safety. The LMHA or LBHA must ensure that:
  - i. All staff members are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;
  - ii. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or harm to a staff member;
  - iii. Individual bedrooms, bathrooms and other private or unsupervised areas must be free of materials that could be utilized by an individual to attempt, or to die by suicide, or to harm or kill others, such as, but are not limited to:
    - (1) Ropes;
    - (2) Cords (including window blind cords);
    - (3) Sharp objects;
    - (4) Substances that could be harmful if ingested; and
    - (5) Extended ceiling fans.
  - iv. Individual bedrooms, bathrooms and other private or unsupervised areas must contain:
    - (1) Break-away curtains; and
    - (2) Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.
- l. Vehicle Safety.
  - i. All vehicles used to transport individuals must be maintained in safe driving condition, in accordance with 37 TAC Chapter 23, Subchapter D (relating to Vehicle Inspection Items, Procedures, and Requirements)
  - ii. Any vehicle used to transport an individual must have appropriate insurance.
  - iii. Every vehicle used for individual transportation must have an easily accessible fully stocked first aid kit and an A:B:C type fire extinguisher.

## 11. Infection Control

- a. Infection Control.
  - i. Each facility must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
  - ii. The facility must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-related Facilities).
  - iii. The facility must have written policies for the control of communicable disease in employees and individuals, which includes tuberculosis (TB) Screening and provision of a safe and sanitary environment for individuals and employees.
- b. TB Reporting Requirement. The facility must maintain evidence of compliance with local and/or state health codes or ordinances regarding employee and individual health status.
  - i. Individuals. The name of any individual of a facility with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of



Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.

(1) All individuals must be screened upon admission and after exposure to TB and provided follow-up as needed.

(2) HHSC will provide TB Screening questionnaire for admission Screening:

<https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf>

ii. Employees. If employees contract a communicable disease that is transmissible to individuals through food handling or direct individual care, the employee must be excluded from providing these services as long as a period of communicability is present.

(1) The facility must screen and test all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.

(2) All persons who provide services under an outside resource contract must, upon request of the facility, provide evidence of compliance with this requirement.

c. Universal Precautions. Personnel who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.

i. Universal precautions must be used in the care of all individuals.

ii. First Aid Kits must be sufficient for the number of individuals served at the site.

(1) Gloves must be immediately accessible to all staff.

(2) One-way, CPR masks must be immediately available to all staff.

(3) Spill Kits must be immediately accessible to all staff.

iii. Sharps containers must be puncture resistant, leak proof and labeled.

(1) Sharps containers must not be overfilled.

(2) Needles in the sharps containers must not be capped or bent.

iv. Disinfectants and externals must be separated from internals and injectables.

(1) Medications requiring special climatic conditions (e.g. refrigeration, darkness, tight seal, etc.) must be stored properly.

(2) The refrigerator must have a thermometer.

(3) Recorded refrigerator temperatures must be maintained between 36 and 46 degrees Fahrenheit, in accordance with 22 TAC §291.15 (related to Storage of Drugs).

v. Running water or dry-wash disinfectant must be available to staff where sinks are not easily available.

vi. Staff must demonstrate ability to accurately describe the policy for handling a full sharps container.

(1) Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.

- (2) Staff must be able to describe the actions to take if exposed to blood or body fluids.
  - (3) Staff must be able to describe how to clean a blood or body-fluid spill.
  - (4) Staff must be able to direct QM reviewer to all protective equipment.
- vii. Poison Control phone numbers must be posted throughout the facility and information regarding Emergency Medical Treatment for Poisoning must be available to staff.
- viii. All medical materials must be properly stored on shelves or in cabinets that must be correctly labeled.
- d. Animal Safety. Animals housed at the facility or visiting the facility must be properly vaccinated and supervised.

## 12. Medication Management

- a. Medication Storage. All facilities that provide or store an individual's medication during the length of stay must implement written procedures for medication storage, administration, documentation, controlled substances, inventory, and disposal in accordance with 26 TAC Chapter 301, Subchapter G, §301.355, (relating to Medication Services). An LMHA must ensure that:
  - i. Individuals do not retain any of their personal medications while in the facility;
  - ii. Individuals receive their personal medications upon discharge from the facility;
  - iii. Medications that are kept on-site are kept locked at all times; and
  - iv. Staff are able to provide a copy of the most recent medication Stock Inspection.
- b. Climate Controlled Medications.
  - i. The facility must maintain a record indicating that staff regularly checks the temperature in the refrigerator.
  - ii. Refrigerators used to store medications must be kept neat, clean and free of non-pharmacy and non-medical items. Lab specimens must be stored separately.
- c. Labelling Medications.
  - i. The facility must ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.
  - ii. Medication labels must not be handwritten or changed.
- d. Controlled Substances.
  - i. Controlled substances must be approved by a physician employed by or contracting or subcontracting with the LMHA or LBHA that operates the facility.
  - ii. An inventory of controlled substances must include:
    - (1) Whether the inventory was taken at the beginning or close of business;
    - (2) Name of controlled of substances;
    - (3) Each finished form of the substances (e.g. 100mg tablet);
    - (4) The number of dosage units of each finished form in the

- commercial container (e.g. 100 tablet bottle);
- (5) The number of commercial containers of each finished form (e.g. four 100 tablet bottles); and
- (6) Controlled substances must be stored under double locks.
- e. Facility Management.
  - i. The facility management must:
    - (1) Ensure that only licensed medical staff members have access to medications administered to individuals;
    - (2) Maintain in the medication room a current list of all LMHA, LBHA or subcontracted practitioners who are authorized to prescribe the medications that are administered from the residential facility medication room;
    - (3) Maintain a current list in the medication room of all staff allowed to administer medications to individuals;
    - (4) Maintain a current list in the medication room of all non-licensed, trained staff allowed to observe self-administration of medications; and
    - (5) Ensure that staff does not transfer medications from one container to another; individuals may independently transfer their own medications from a bottle to a daily medication reminder.
  - ii. The facility must ensure that staff members have readily available access to a hardcopy or digital format of a medication guide (such as the Physician's Desk Reference or similar publication) in a version that is no more than two years old.
  - iii. The facility must maintain an Emergency Medication Kit.
    - (1) The medications in the emergency medication kit must be monitored with a perpetual inventory and make use of breakaway seals.
    - (2) The medication kit must contain medications and other equipment as specified by the facility medical director. This generally includes, but is not limited to, short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications.
  - iv. There must be evidence in the clinical records that individuals are educated about their medications whenever medications are prescribed or changed.

### 13. Food Preparation and Food Service

- a. Inspections. If the facility prepares meals in a centralized kitchen on site, it must pass an annual kitchen health inspection as required by the local health department, as applicable. The facility must:
  - i. Immediately address any deficiencies found during any health inspection.
  - ii. Post the current food service permit from the local health department.
- b. Kitchen Standards.
  - i. If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the individuals.

- ii. It must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.
  - iii. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.
  - iv. All facilities must provide a means for washing and sanitizing dishes and cooking utensils must be provided.
  - v. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.
  - vi. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.
- c. Meal Preparation.
- i. In facilities that prepare meals for individuals, at least three meals or their equivalent must:
    - (1) Be served daily;
    - (2) At regular times;
    - (3) With no more than a 16-hour span between a substantial evening meal; and
    - (4) Breakfast the following morning.
  - ii. In facilities where individuals prepare their own food:
    - (1) The facility must ensure that a variety of foods are available for each meal to allow individuals to have a choice of foods for to prepare for each meal;
    - (2) The facility must ensure that the foods available are nutritious and well balanced, such as those recommended by the United States Department of Agriculture and must accommodate individual kosher dietary needs or other related dietary practice;
    - (3) Food for at least three meals must be provided daily for individuals to prepare;
    - (4) If individuals require special dietary items, the facility must ensure that such items are provided to the individual; and
    - (5) Regular food preparation and mealtimes must be established by the facility.
- d. Nutrition and Diets.
- i. Therapeutic diets must be provided to individuals when ordered by a physician.
  - ii. In facilities that prepare food for the individuals, the menus must be prepared to provide a balanced and nutritious diet, such as those recommended by the United States Department of Agriculture, and must accommodate individual Kosher dietary needs or other related dietary practice.
- e. Availability. In all facilities, food and beverage must be available to accommodate individuals who enter the facility after established meal times.
- f. Food Storage. In all facilities, supplies of staple foods for a minimum of a

four-day period and perishable foods for a minimum of a one-day period must be maintained on premises. Food subject to spoilage must be dated.

g. Food Service.

i. When meals are provided by a food service, a written contract must require the food service to:

- (1) Comply with the rules referenced in Form N, Section V. Crisis Residential Services. 13. Food Preparation and Food Service; and
- (2) Pass an annual kitchen health inspection as required by law.

ii. The facility must ensure the meals are transported to the facility in temperature-controlled containers to ensure the food remains at the temperature at which it was prepared.

iii. The facility must ensure that at least one facility staff, at minimum, maintains a current food handler's permit.

## **VI. Crisis Respite Services**

### **A. Definition**

Crisis respite services provide short-term, community-based residential, Crisis treatment to individuals who have low risk of harm to self or others and may have some presence functional impairment, and who require direct supervision and care, but do not require hospitalization. The primary objective of Crisis respite services is stabilization and resolution of a Crisis situation for the individual and/or the individual's caregiver(s). All Crisis respite services must be delivered in accordance with Title 26 Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and 26 TAC Chapter 306, Subchapter D (relating to Mental Health Services—Admission, Continuity, and Discharge).

These services can occur in houses, apartments, group and foster homes, the individual's own home, or other community living situations. Crisis respite services may serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the individual for whom they care to help that individual avoid a mental health Crisis. Utilization of these services is managed by the LMHA or LBHA based on Medical Necessity. The availability of facility-based respite units is dependent on LMHA or LBHA funding.

### **B. Goals**

- Provide immediate Crisis stabilization
- Restore sufficient functioning to allow the individual to transition to the least restrictive level of care
- Provide the individual with critical coping skills to support resilience and recovery
- Engage the individual with family, caregivers, and LARs or identified support system and community resources and support
- Provide the individual with coordination of care and continuity of appropriate recovery support services.
- Reduce inpatient and law enforcement intervention through stabilization in the least restrictive environment.

### **C. Description**

#### **1. Length of Stay**

The length of stay may vary depending on the clinical needs of an individual with the average length of stay being between a few hours to ten days.

#### **2. Admission Criteria.**

Individuals considered for admission into Crisis respite services:

- a. Must be at risk of psychiatric crises due to severe stressors in their

- environment but are at low risk of harm to self or others;
- b. Must have the ability to perform their own activities of daily living with staff support;
- c. May have mild functional impairment but must be able to cooperate with staff support;
- d. Must be capable of self-administering medications with staff support;
- e. Must have enough medications upon arrival to ensure psychiatric and medical stabilization for the expected length of stay;
- f. May have mild medical co-occurring diagnoses, as specified and approved by the facility medical director, if the medical condition is stable with prescribed and available medications;
- g. May have co-occurring psychiatric and Substance Use Disorders (COPSD) that result in no more than mild impairment; and
- h. Must have low risk for elopement if the individual is a Child or Adolescent.

### 3. Egress.

Crisis respite services must be provided in an unlocked facility that provides individual residents restricted entrance and unrestricted exit. Facilities may utilize exits with delayed egress.

### 4. Facility Standards.

Crisis respite facilities must:

- a. Separate Children and Adolescents from adults and further separate Children from Adolescents according to age and developmental needs, unless there is documented clinical or developmental justification;
- b. Create a stable and supportive environment with limited supervision provided by trained and competent staff;
- c. Create and implement procedures to obtain medications for individuals when needed.
- d. Ensure compliance with the minimum standards in 26 TAC Chapter 748 (relating to Minimum Standards for General Residential Operations), except for those minimum standards identified for specific types of services that the operation does not offer when Child and Adolescent Crisis respite services are provided in a General Residential Operations environment.

### 5. Psychosocial Programming.

This stable and supportive environment provides a venue for biological, psychological, and social interventions targeted at the current Crisis while fostering community reintegration.

- a. During facility-based respite, individual and group skills training are provided and are based on the needs of the individual and the goals of their Individualized Crisis Treatment Plans. Individuals may be provided support from peer specialists and connection to recovery support services.

- b. When Child and Adolescent Crisis respite services are provided in a free- standing facility operated by a LMHA or LBHA, facility standards are the same as those listed in Form N, Section VI. Crisis Respite Services 5. Psychosocial Programming
- c. When Child and Adolescent Crisis respite services are provided in a General Residential Operations environment, the respite provider must ensure programming includes:
  - i. Provision of educational services as recommended by the clinical team and in accordance with 26 TAC Chapter 748, Subchapter I, Division 3 (relating to Educational Services);
  - ii. Ensure that the use of television, online videos, computers, or video game systems as an activity for Children and Adolescents:
    - (1) Are age-appropriate;
    - (2) Do not exceed two hours per day; and
    - (3) Are not used to replace the psychosocial programming activities
  - iii. Provision of opportunities for recreational activities and physical fitness in accordance with general requirements listed in 26 TAC, Chapter 748, Subchapter Q, Division 1 (relating to General Requirements).

## **D. Standards**

### **1. Services Availability**

- a. When offered, this service must be available 24 hours a day, every day of the year and respite services must be made available to individuals throughout the local service area.
- b. Admission to Crisis respite must be determined by the LMHA or LBHA and must be based on a Medical Necessity determination by an LPHA.

### **2. Staffing for Facility-based Crisis Respite**

- a. Policies and Procedures. A psychiatrist must serve as the medical director for all Crisis services and must approve all written procedures and protocols.
- b. General Staffing Pattern.
  - i. The Crisis Support Staff must be trained, competent, and on site 24 hours a day.
  - ii. The respite program must develop and implement a process for assessing and anticipating staffing needs.
  - iii. The Crisis Support Staff must be scheduled in sufficient numbers to ensure individual and staff safety during the provision of needed services.
- c. Training, Competency and Credentialing. The LMHA or LBHA must:
  - i. Ensure that services are provided by staff members who are operating within the scope of their license, credentialing, job description, or contract specification;
  - ii. Define competency-based expectations for each respite facility staff position;



- iii. Ensure each staff member receives initial training before the staff member assumes Crisis respite responsibilities and annually throughout the staff member's employment with the respite facility;
  - iv. Require all staff members to demonstrate:
    - (1) required competencies in accordance with 26 TAC §301.331(a)(3)(A) (relating to Required Competencies); and
    - (2) critical competencies for topics delineated in 26 TAC §301.331(a)(3)(B) (relating to Critical Competencies).
  - v. Ensure that Crisis Support Staff members providing in-home Crisis respite services receive the additional training and display the additional competencies required to provide Crisis services to Children and Adolescents.
- d. Availability, Duties, and Responsibilities.
- i. Staff members On Duty must remain awake and alert at all times.
  - ii. The facility must develop and implement policies and procedures allowing on-site staff members to obtain 24-hour access to supervision, consultation, and evaluation when needed from:
    - (1) A physician (preferably a psychiatrist), a PA, an APRN, or an RN for medical emergencies; and
    - (2) An RN or LPHA for clinical emergencies.
  - iii. Duties and responsibilities for all staff involved in the Assessment or treatment of individuals must be:
    - (1) Defined in writing by the medical director;
    - (2) Appropriate to staff training, competency, and experience; and
    - (3) In conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- e. When Child and Adolescent Crisis respite services are provided in a General Residential Operations environment, Crisis respite providers must adhere to:
- i. Facility staff standards listed in 26 TAC Chapter 748, Subchapter G (relating to Child/Caregiver Ratios); and
  - ii. Staff training and professional development 26 TAC Chapter 748,
  - iii. Subchapter F (relating to Training and Professional Development).
- f. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

### 3. Assessment and Intake

- a. Individuals must receive a full Crisis Assessment by a physician (preferably a psychiatrist) or a PA, APRN, LPHA, RN, or QMHP-CS, prior to admission to Crisis respite services and must include an attempt to determine an individual has an active Declaration for Mental Health Treatment
- b. Individuals in respite services must be provided immediate access to urgent and emergent non-psychiatric medical Assessment and treatment when needed.

- c. Every Child, Adolescent, and adult admitted to Crisis respite services, as well as the individual's parent, LAR, or Adult Caregiver, as applicable, receives a unit orientation from an appropriately trained staff member no later than 24 hours after admission.
- d. The respite unit or service provider must ensure that the staff member providing intake and orientation:
  - i. Explains orally, and provides in writing, in a language and format easily understandable to the individual, and their parent, LAR, or Adult Caregiver, as applicable;
    - (1) The individual rights, as addressed in 25 TAC, §404.161 (relating to Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers);
    - (2) The Child or Adolescent's special rights, in accordance with 26 TAC Chapter 748, Subchapter H (relating to Child Rights);
    - (3) The facility's or operation's grievance policy;
    - (4) The facility's or operation's rules and expectations;
    - (5) The facility's or operation's schedule of programs; and
  - ii. Determines that the individual, and their parent, LAR, or Adult Caregiver, as applicable, comprehends the information provided in item a).
- e. When Child and Adolescent Crisis respite services are provided in General Residential Operations, Crisis respite providers must adhere to the following additional Assessment and intake standards:
  - i. Complete a placement agreement with a Child or Adolescent, and their parent, LAR, or Adult Caregiver, as applicable, that defines the service provider's roles and responsibilities, and authorizes the provision of services for the Child or Adolescent. The placement agreement must include:
    - (1) Authorization permitting the service provider to care for the Child or Adolescent;
    - (2) A medical consent form signed by a person legally authorized by the Texas Family Code to provide consent; and
    - (3) c) The reason for placement and anticipated length of time in care.
  - ii. Staff members gathering preadmission information must adhere to standards in 26 TAC Chapter 748, Subchapter S, (relating to Respite Child-Care Services), including obtaining pre-admission Continuity of Care information listed in §748.4265 (relating to What information regarding a Child must I receive prior to providing respite Child-care services to that Child?);
  - iii. Staff members conducting admission Assessments for Children and Adolescents needing Emergency Care Services, including respite Child-care services, must adhere to standards in 26 TAC §748.4231 (relating to What information must an admission Assessment include for a Child needing Emergency Care Services, including respite Child-care services?).

#### 4. Interventions for Facility-based Crisis Respite

- a. Behavioral Health Emergencies. A written policy must be developed and implemented in accordance with 25 TAC Chapter 415, Subchapter F (relating to Interventions in Mental Health Services) that:
  - i. Is approved by the medical director;
  - ii. Specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the service;
  - iii. Outlines ways to access appropriate immediate care to stabilize a behavioral health emergency (e.g., to prevent harm to the individual or to others); and
  - iv. Is reviewed and updated as needed.
- b. Treatment Planning. An individual Crisis Treatment Plan must be followed for everyone. The Crisis Treatment Plan must incorporate individual preferences as reported or indicated in the individual's Declaration for Mental Health. This information must be shared with the individual and the individual's parent, LAR, Adult Caregiver, or identified support system as appropriate. The facility must develop and implement a written procedure that Crisis Support Staff members:
  - i. Provide daily documentation on an individual's progress on treatment goals;
  - ii. Document progress on the format approved by facility administrator; and
  - iii. Communicate daily documentation to the credentialed staff member, at minimum as a QMHP-CS, responsible for making updates to the individual Crisis Treatment Plan and making recommendations to continue services, change current services, or discharge from services. The credentialed staff member may be located or work from a location outside of the Crisis respite facility.
- c. Treatment Interventions. An array of treatment interventions must be provided in the Crisis respite setting to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
  - i. Services should be goal-oriented and based on the individual's needs and Individualized Crisis Treatment Plan. Services should focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills; and may consist of the following component services:
    - (1) Psychiatric nursing services,
    - (2) Pharmacological instruction,
    - (3) Symptom management training, and
    - (4) Functional skills training.
  - ii. The programming requirements may be fulfilled through the provision of individual Crisis intervention services or by providing group services.
  - iii. Group services may be delivered by level of care assignment or through the provision of Day Programs for Acute Needs as specified in 26 TAC Chapter 306, Subchapter F (relating to Mental Health Rehabilitative Services).

- iv. Individuals who have significant co-occurring Substance Use Disorder must receive counseling designed to motivate the individual to continue with Substance Use Disorder treatment following discharge from the program.
- d. Individuals must not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- e. Facility-based Crisis respite units must maintain a stable therapeutic environment that includes assigned personnel and scheduled activities.
- f. When Child and Adolescent Crisis respite services are provided in General Residential Operations, Crisis respite providers must adhere to the following additional standards for:
  - i. Child and Adolescent Assessments, in 26 TAC Chapter 748, Subchapter T (Additional Requirements for Operations That Provide an Assessment Services Program), when the service provider conducts Assessment services;
  - ii. Child and Adolescent Crisis respite services provided to pregnant and parenting Children and Adolescents, in 26 TAC Chapter 748, Subchapter J, Division 10 (relating to Additional Requirements for Pregnant and Parenting Children); and
  - iii. Child and Adolescent Crisis respite services provided to individuals with COPSD issues, in accordance with 26 TAC §448.906 (relating to Access to Services for Co-Occurring Psychiatric and Substance Use Disorders (COPSD) Clients).

## 5. Coordination and Continuity of Care

- a. A Crisis respite unit must create and implement:
  - i. Written policy to ensure the provision of Continuity of Care and successful linkage with the referral facility, agency or provider; and
  - ii. Written procedure defining the actions that must be taken to ensure every effort is made to contact existing treatment providers during the individual's Assessment and treatment in the service.
- b. Coordination of services and Continuity of Care must be provided for every individual and must include:
  - i. Identifying and linking the individual with all available services necessary to ensure transition to routine care; and
  - ii. Providing necessary assistance in accessing those services, including contacting and coordinating with the individual's existing or newly selected service providers in a timely manner and in conformance with applicable confidentiality requirements.
- c. Discharge planning must be initiated at the time of an individual's admission. In accordance with 26 TAC §306.201 (relating to Discharge Planning), a discharge plan must be developed for every individual, and must include:
  - i. Appropriate education relevant to the individual's condition;
  - ii. Information about the most effective treatment for the individual's behavioral health disorder;

- iii. Identification of potential obstacles to a successful return to the living situation of the individual's choice and means to address these obstacles; and
  - iv. Information about follow-up care, and appropriate linkages to post discharge providers.
- d. When Child and Adolescent Crisis respite services are provided in General Residential Operations, Crisis respite providers must adhere to 26 TAC Chapter 748, Subchapter I (relating to Admission, Service Planning, and Discharge) standards related to emergency and non-emergency:
  - i. Admission;
  - ii. Service Planning;
  - iii. Discharge and transfer planning; and
  - iv. Release of a Child or Adolescent.

## 6. Physical Plant

- a. The physical plant must have written policies and procedures for monitoring environmental safety, in accordance with 26 TAC §301.312 (relating to Environment of Care and Safety).
- b. Any new Crisis respite unit must receive a preoperational, on site Quality Management (QM) review before being open to the public to provide services.
- c. The Crisis respite unit is subject to HHSC QM reviews. Any changes in programming, construction or facility must be reported to the HHSC Contracts Management department immediately. For facility-based Crisis respite, if the LMHA or LBHA holds an Assisted Living
- d. A Type A licensed facility will be accepted as "deemed status" by HHSC, meaning:
  - i. Any Quality Management and Compliance reviews will entail only programmatic elements; and
  - ii. Any Regulatory Compliance inspection and survey will occur in accordance with assisted living licensing standards located in 26 TAC §301.312 (relating to Environment of Care and Safety).
- e. If the LMHA owns and operates a non-licensed facility under an exemption from licensure they are required to register and submit a facility exemption form in conjunction with the Consolidated Local Services Plan submission every two years.
- f. The facility must provide a clean and safe environment.
- g. The facility must create a stable and supportive environment.
- h. Crisis respite units are not designed to prevent elopement and must not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility. Crisis respite units may use exits with delayed egress.
- i. All medications must be securely stored.
- j. Contracted residential treatment centers or foster care homes that serve

Children and are used for Crisis respite are subject to licensing regulations of the Department of Family and Protective Services.

## 7. General Facility Environment

When Crisis respite services are provided at a residential or Crisis triage facility, or at a stand-alone facility, the facility must meet the following standards:

- a. Water/Waste/Trash/Sewage.
  - i. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
  - ii. The water supply must be of safe, sanitary quality, suitable for use and adequate in quantity and pressure and must be obtained from a water supply system.
  - iii. Waste, trash, and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
- b. Windows. Operable windows must be insect screened.
- c. Pest Control. An ongoing pest control program must be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals must be used.
- d. Maintenance and Cleaning.
  - i. In kitchens and laundries, facility staff must use procedures to avoid cross-contamination between clean and soiled utensils and linens.
  - ii. The facility must be kept free of accumulations of dirt, rubbish, dust, and hazards.
  - iii. Floors must be maintained in good condition and cleaned regularly.
  - iv. Walls and ceilings must be structurally maintained, repaired, and repainted or cleaned as needed.
  - v. Storage areas and cellars must be kept in an organized manner.
  - vi. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
  - vii. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.
- e. Telephone Access. There must be at least one telephone in the facility available to both staff and individuals for use in case of an emergency.
- f. Temperature. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in individual-use areas.
- g. Bedroom.

- i. A bedroom must have no more than four beds.
  - ii. The facility must provide for each individual a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings.
  - iii. Furnishings provided by the facility must be maintained in good repair.
- h. Bathroom.
  - i. At least one water closet, lavatory, and bathing unit must be provided on each sleeping floor accessible to individuals of that floor. One water closet and one lavatory for each six occupants, or fraction thereof, must be provided. One tub or shower for each ten occupants, or fraction thereof, must be provided.
  - ii. Privacy partitions and all curtains must be provided in water closets and bathing units in rooms for multi-individual use.
  - iii. Tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
  - iv. Individual-use hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
  - v. Individuals must have access to towels, soap, and toilet tissue at all times.
- i. Storage.
  - i. The facility must provide sufficient and appropriate separate storage spaces or areas for the following:
    - (1) Administration and clinical records;
    - (2) Office supplies;
    - (3) Medications and medical supplies (these areas must be locked);
    - (4) Poisons and other hazardous materials (these must be kept in a locked area and must be kept separate from all food and medications);
    - (5) Food preparation (if the facility prepares food); and
    - (6) Equipment supplied by the facility for individual needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment etc.
  - ii. Storage must not be permitted in the attic spaces.
- j. Food storage.
  - i. Food storage areas must provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
  - ii. Food subject to spoilage must be dated.
- k. Laundry.
  - i. A large facility (i.e., a facility with more than 16 beds) which co-mingles and processes laundry on-site in a central location must comply with the following:
    - (1) The laundry must be separated and provided with sprinkler protection if located in the main building (separation must consist of a one-hour fire rated partition carried to the underside of the floor or roof deck above);

- (2) Access doors to the laundry area must be from the exterior of the facility or if from within the building by, way of non-individual use areas; and
- (3) Soiled linen receiving, holding and sorting rooms must have a floor drain and forced exhaust to the exterior must operate at all times that soiled linen being held in this area.
- ii. If laundry is processed off the site, the following must be provided on the premises: soiled linen holding room, clean linen receiving, holding, inspecting, sorting or folding, and storage room.
- iii. Individual-use laundry, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.
- l. Smoking. Regulations must be established and if smoking is permitted, outdoor smoking areas may be designated for individuals. Ashtrays of noncombustible material and safe design must be provided in smoking areas. Staff must not provide or facilitate individual access to tobacco products.
- m. Room Space.
  - i. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms must be provided and have appropriate furniture.
  - ii. Dining areas must be provided and have appropriate furnishings.
- n. The respite services providers must meet physical site minimum standards listed in 26 TAC Chapter 748, Subchapter P (relating to Physical Site) when Child and Adolescent Crisis respite services are provided in General Residential Operations.

## 8. Accessibility (ADA Compliance)

Crisis respite facilities must comply with the most recent versions of:

- a. The Americans With Disabilities Acts Accessibility Guidelines;
- b. The Texas Accessibility Standards in Texas Government Code, Chapter 469, (relating to Elimination of Architectural Barriers); and
- c. All applicable sections of the TAC.

## 9. Postings

- a. The facility must post near, or within the medication room, a list naming all staff members permitted access to the medication room.
- b. The facility must post 911 as the emergency contact at, or within view, of the telephone.
- c. The facility must ensure that designated smoking areas are clearly marked.
- d. The facility must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.
- e. The facility must post an emergency evacuation floor plan.



- f. The following must be prominently displayed in areas frequented by individuals:
  - i. Contact information for the Rights Protection Officer,
  - ii. Contact information, including a toll-free number, and instructions for reporting abuse and neglect;
  - iii. Contact information stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
- g. A facility that prepares food must post the current food service permit from the local health department, if applicable.
- h. The facility postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area; and
- i. The respite provider must ensure the additional posting requirements listed in 26 TAC §748.191 (relating to What items must I post at my operation?) when Child and Adolescent Crisis respite services are provided in a General Residential Operations environment. The following items must be posted in a prominent and public place that is accessible for staff members, Children, parents, and others to view at all times:
  - i. The operation's permit, posted at the main office location;
  - ii. The HHSC Licensing notice, Keeping Children Safe; and
  - iii. Emergency and evacuation relocation plans posted in each building and living quarters used by Children and Adolescents.

## 10. Life Safety

- j. Life Safety Code. The facility must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code. Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
- k. Local Fire Code. The facility must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
- l. Code Compliance. The facility must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
- m. Emergency Evacuation Plan. The LMHA or LBHA must develop, implement and make available to all supervisory personnel, written copies of a plan for the protection of all individuals in the event of fire.
  - i. The plan must:
    - (1) Include details on safely evacuating individuals from the building to areas of refuge;
    - (2) Include details on sheltering in place when appropriate;
    - (3) Include special staff actions including fire protection procedures needed to ensure the safety of any individual;
    - (4) Be amended or revised when needed;

- (5) Be readily available at all times within the facility; and
  - (6) Require documentation that reflects the current evacuation capabilities of the individuals
- ii. All employees must be periodically instructed and kept informed with respect to their duties and responsibilities under the plan.
- iii. The facility must conduct emergency evacuation drills quarterly and calculate evacuation scores in accordance with the fire code under which the facility is inspected.
- n. Disaster Plan.
  - i. The LMHA or LBHA must have in effect and available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, per 26 TAC, Chapter 301, Subchapter G, §301.312 (relating to Environment of Care and Safety).
  - ii. The written disaster plan must address, at a minimum, eight core functions:
    - (1) Direction and control;
    - (2) Warning;
    - (3) Communication;
    - (4) Sheltering arrangements;
    - (5) Evacuation;
    - (6) Transportation;
    - (7) Health and medical needs; and
    - (8) Resource management.
  - iii. The written disaster plan must include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the respite facility or during facility evacuation.
- o. Recorded Inspections.
  - i. Facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections must be signed and dated.
  - ii. The following initial and annual inspections are required and must be kept on file:
    - (1) Local Fire safety inspections as outlined in 10.g., below;
    - (2) Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
    - (3) Annual kitchen inspection by the local health authority, if applicable;
    - (4) Fire extinguisher inspection and maintenance by personnel licensed or certified to perform the inspection; and
    - (5) Liquefied petroleum gas systems inspection by an inspector certified by the Texas Railroad Commission.
- p. Fire Safety Inspections.

- i. Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal's Office.
- ii. The facility is responsible for arranging required inspections and ensuring that inspections are carried out in a timely manner.
- iii. The initial and ongoing fire safety reports must be signed by the certified inspector performing the inspection.
- iv. These reports must be kept on file and be readily available for review by the state.
- v. All fires causing damage to the Crisis residential unit or to equipment must be reported to the HHSC Contract Manager within 72 hours. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Report must be made by telephone during normal business hours and by telephone call and e-mail during other times, with a follow-up telephone call to the Contract Manager on the first business day following the event.
- vi. Open flame heating devices are prohibited. All fuel burning heating devices must be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.
- q. Correction Plan. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff must take immediate corrective action to bring the facility into compliance with the applicable code.
  - i. The facility must have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions.
  - ii. The facility must have on file documentation by the Certified Fire Inspector that all findings have been corrected and that the facility is in full compliance with all applicable codes.
  - iii. During the period of corrective action, the facility must take any steps necessary to ensure the health and safety of individuals residing in the facility during the time repairs or corrections are being completed.
- r. Newly Operational Facilities. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in Texas. Such certification must be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a Crisis residential facility.
- s. Pre-operational facility requirements. Any newly constructed or renovated or remodeled unlicensed Crisis residential facility must receive a preoperational on-site review by HHSC QM before being open to the public to provide Crisis residential services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.
- t. Evacuation Plan. All facilities must post emergency evacuation floor plans.

- u. Individual Safety. The administrator of each facility must ensure that:
  - i. All staff members are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;
  - ii. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or harm to a staff member;
  - iii. Individual bedrooms, bathrooms and other private or unsupervised areas must be free of materials that could be utilized by an individual to attempt, or to die by suicide, or to harm or kill others, such as, but are not limited to:
    - (1) Ropes;
    - (2) Cords (including window blind cords);
    - (3) Sharp objects;
    - (4) Substances that could be harmful if ingested; and
    - (5) Extended ceiling fans.
  - iv. Individual bedrooms, bathrooms and other private or unsupervised areas must contain:
    - (1) Break-away curtains; and
    - (2) Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.
- v. Vehicle Safety.
  - i. All vehicles used to transport individuals must be maintained in safe driving condition, in accordance with 37 TAC Chapter 23, Subchapter D (relating to Vehicle Inspection Items, Procedures, and Requirements)
  - ii. Any vehicle used to transport an individual must have appropriate insurance.
  - iii. Every vehicle used for individual transportation must have an easily accessible fully stocked first aid kit and an A:B:C type fire extinguisher.
- w. Additional Safety Standards for Children and Adolescents. Respite services providers must adhere to additional safety standards listed in 26 TAC Chapter 748, Subchapter O (relating to Safety and Emergency Practices) and transportation safety standards listed in 26 TAC Chapter 748, Subchapter R, Division 2 (relating to Safety Restraints) when Child and Adolescent Crisis respite services provided in General Residential Operations.

## 11. Infection Control

- a. Infection Control.
  - i. Each facility must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
  - ii. The facility must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-related Facilities).

- iii. The facility must have written policies for the control of communicable disease in employees and individuals, which includes tuberculosis (TB) Screening and provision of a safe and sanitary environment for individuals and employees.
- b. TB Reporting Requirement. The facility must maintain evidence of compliance with local and/or state health codes or ordinances regarding employee and individual health status.
  - i. Individuals. The name of any individual of a facility with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.
    - (1) All individuals must be screened upon admission and after exposure to TB and provided follow-up as needed.
    - (2) HHSC will provide TB Screening questionnaire for admission Screening:  
<https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf>
  - ii. Employees. If employees contract a communicable disease that is transmissible to individuals through food handling or direct individual care, the employee must be excluded from providing these services as long as a period of communicability is present.
    - (1) The facility must screen and test all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.
    - (2) All persons who provide services under an outside resource contract must, upon request of the facility, provide evidence of compliance with this requirement.
- c. Universal Precautions. Personnel who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.
  - i. Universal precautions must be used in the care of all individuals.
  - ii. First Aid Kits must be sufficient for the number of individuals served at the site.
    - (1) Gloves must be immediately accessible to all staff.
    - (2) One-way, CPR masks must be immediately available to all staff.
    - (3) Spill Kits must be immediately accessible to all staff.
  - iii. Sharps containers must be puncture resistant, leak proof and labeled.
    - (1) Sharps containers must not be overfilled.
    - (2) Needles in the sharps containers must not be capped or bent.
  - iv. Disinfectants and externals must be separated from internals and injectables.
    - (1) Medications requiring special climatic conditions (e.g. refrigeration, darkness, tight seal, etc.) must be stored properly.
    - (2) The refrigerator must have a thermometer.

- (3) Recorded refrigerator temperatures must be maintained between 36 and 46 degrees Fahrenheit, in accordance with 22 TAC §291.15 (related to Storage of Drugs).
- v. Running water or dry-wash disinfectant must be available to staff where sinks are not easily available.
- vi. Staff must demonstrate ability to accurately describe the policy for handling a full sharps container.
  - (1) Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.
  - (2) Staff must be able to describe the actions to take if exposed to blood or body fluids.
  - (3) Staff must be able to describe how to clean a blood or body-fluid spill.
  - (4) Staff must be able to direct QM reviewer to all protective equipment.
- vii. Poison Control phone numbers must be posted throughout the facility and information regarding Emergency Medical Treatment for Poisoning must be available to staff.
- viii. All medical materials must be properly stored on shelves or in cabinets that must be correctly labeled.
- d. Animal Safety. Animals housed at the facility or visiting the facility must be properly vaccinated and supervised.

## 12. Medication Management

An Emergency Medication Kit should be maintained if the facility contains the staff qualified to handle such medications.

- a. Medication Storage. All facilities that provide or store an individual's medication during the length of stay must implement written procedures for medication storage, administration, documentation, controlled substances, inventory, and disposal in accordance with 26 TAC §301.355 (relating to Medication Services). An LMHA must ensure that:
  - i. Individuals do not retain their personal medications while in the facility;
  - ii. Individuals receive their personal medications upon discharge from the facility;
  - iii. Medications that are kept on-site be kept locked at all times; and
  - iv. Staff are able to provide a copy of the most recent medication Stock Inspection.
- b. Climate Controlled Medications.
  - i. The facility must maintain a record indicating that staff regularly checks the temperature in the refrigerator.
  - ii. Refrigerators used to store medications must be kept neat, clean, and free of non-pharmacy and non-medical items. Lab specimens must be stored separately.
- c. Labelling Medications.
  - i. The facility must ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.

- ii. Medication labels must not be handwritten or changed.
- d. Controlled Substances.
  - i. Controlled substances must be approved by a physician employed by or contracting or subcontracting with the LMHA or LBHA that operates the facility.
  - ii. An inventory of controlled substances must include:
    - (1) Whether the inventory was taken at the beginning or close of business;
    - (2) Name of controlled of substances;
    - (3) Each finished form of the substances (e.g. 100mg tablet);
    - (4) The number of dosage units of each finished form in the commercial container (e.g. 100 tablet bottle);
    - (5) The number of commercial containers of each finished form (e.g. four 100 tablet bottles); and
    - (6) Controlled substances must be stored under double locks.
- e. Facility Management.
  - i. The facility management must:
    - (1) ensure that only licensed medical staff members have access to medications administered to individuals;
    - (2) maintain a current list in the medication room of all practitioners who are allowed to prescribe medications that are administered from the medication room;
    - (3) maintain a current list in the medication room of all staff allowed to administer medications to individuals;
    - (4) maintain a current list in the medication room of all non-licensed, trained staff allowed to observe self-administration of medications; and
    - (5) ensure that staff does not transfer medications from one container to another. Individuals may independently transfer their own medications from a bottle to a daily medication reminder.
  - ii. The facility must ensure that staff members have readily available access to a hardcopy or digital format of a medication guide (such as the Physician's Desk Reference or similar publication) in a version that is no more than two years old.
  - iii. The facility must maintain an Emergency Medication Kit.
    - (1) The medications in the emergency medication kit must be monitored with a perpetual inventory and make use of breakaway seals.
    - (2) The medication kit must contain medications and other equipment as specified by the facility medical director. This generally includes, but is not limited to, short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications.
  - iv. There must be evidence in the clinical records that individuals are educated about their medications whenever medications are prescribed or changed.
  - v. Child and Adolescent Crisis respite services provided in General Residential Operations settings must also adhere to additional Child and

### 13. Food Preparation and Food Service

When Crisis respite services are provided in a private home or in free-standing Crisis respite facility of the LMHA or LBHA, the private home or facility is exempt from meeting the Standards as described in Form N, Section D. Crisis Respite Services, Subsection 13. Food Preparation and Food Service, a. Inspections.

- a. Inspections. If the facility prepares meals in a centralized kitchen on site, it must pass an annual kitchen health inspection as required by the local health department. The facility must:
  - i. immediately address any deficiencies found during any health inspection; and
  - ii. post the current food service permit from the local health department.
- b. Kitchen Standards.
  - i. If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the individuals.
  - ii. Kitchen or dietary area must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.
  - iii. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.
  - iv. All facilities must provide a means for washing and sanitizing dishes and cooking utensils must be provided.
  - v. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans, cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.
  - vi. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.
- c. Meal Preparation.
  - i. In facilities that prepare meals for individuals, at least three meals or their equivalent must:
    - (1) be served daily;
    - (2) at regular times; and
    - (3) with no more than a 16-hour span between a substantial evening meal and breakfast the following morning.
  - ii. In facilities where individuals prepare their own food:
    - (1) The facility must ensure that a variety of foods are available for each meal to allow individuals to have a choice of foods to prepare for each meal;
    - (2) The facility must ensure that the foods available are nutritious and well balanced, in accordance with the most recent version of the United States



- Department of Agriculture's guidelines, and accommodate individual kosher dietary needs or other related dietary practice;
- (3) Food must be provided for individuals to prepare at least three meals daily;
- (4) The facility must ensure that such items are provided to individuals that require special dietary items; and
- (5) Regular food preparation and mealtimes must be established
- (6) by the facility.
- d. Nutrition and Diets.
  - i. The facility must provide therapeutic diets when ordered for an individual.
  - ii. In facilities that prepare food for the individuals, the menus must be prepared to provide a balanced and nutritious diet, in accordance with the most recent version of the United State Department of Agriculture's guidelines and must accommodate individual kosher dietary needs or other related dietary practice.
- di. Availability. Food and beverage must be available to accommodate individuals who enter the facility after established meal times.
- dii. Food Storage. In all facilities, supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period must be maintained on premises. Food subject to spoilage must be dated.
- diii. Food Service.
  - i. When meals are provided by a food service, a written contract must require the food service to:
    - (1) comply with the rules referenced in Form N, Section VI. Crisis Respite Services. 13. Food Preparation and Food Service; and
    - (2) pass an annual kitchen health inspection as required by law.
  - ii. The facility must ensure the meals are transported to the facility in temperature-controlled containers to ensure the food remains at the temperature at which it was prepared.
  - iii. The facility must ensure that at least one facility staff, at minimum, maintains a current food handler's permit.
- div. When Child and Adolescent Crisis respite services are provided in a General Residential Operations environment, Crisis respite providers must adhere to:
  - i. Facility food preparation, storage, and equipment standards listed in 26 TAC §748.3441 (relating to What general requirements apply to food service and preparation?); and
  - ii. Child nutrition and hydration standards listed in Division 7 of 26 TAC Chapter 748, Subchapter J (relating to Child Care).

## **VII. Peer Run Crisis Respite Services**

### **A. Definitions**

A Peer-Run Crisis Respite (PRCR) program provides short-term, community-based residential Crisis respite services to adult individuals (“Guests”) who are experiencing, or are at risk of experiencing, a behavioral health Crisis but do not require hospitalization or higher levels of behavioral health clinical care. PRCR services are provided in a safe and home-like environment, usually in a house within a residential neighborhood, for a period of a few hours up to several days. PRCR programs provide non-clinical provision of peer specialist services through the evidence-based Peer Support model of care.

PRCRs are operated and staffed by a Peer Specialist Care Team consisting of Certified Peer Specialists (CPS), who use lived experience, in addition to skills learned in formal training, to deliver voluntary, recovery-oriented, person-centered, relationship-focused, and trauma-informed services to promote a Guest’s recovery and resiliency. Peer Specialists provide services for an LMHA or LBHA, in accordance with Texas Administrative Code (TAC), Title 1, Chapter 354, Subchapter N (relating to Peer Specialist Services). PRCR program availability varies by region and is dependent on LMHA or LBHA funding. Unlike traditional Crisis respite facility programs, utilization of PRCR services are not based on Medical Necessity determined through clinical Assessment.

### **B. Goals**

- Reduce inpatient and law enforcement interventions through Crisis stabilization in the least restrictive environment
- Provide an opportunity to address the underlying cause of a Crisis before the need for traditional Crisis services arises
- Reduce hospitalization by building mutual, trusting relationships between Peer Staff members
- Reduce possible trauma that can occur to individuals during emergency room visits, inpatient psychiatric hospitalizations, and contact with law enforcement
- Provide Guests with critical coping skills to support resilience, recovery and personal growth
- Engage Guests with community resources and support recovery-related outcomes

### **C. Description**

#### **1. Length of Stay**

PRCR programs provide short-term hourly or 24-hour care. The average length of stay is 4-5 days, with a maximum length of stay determined by the Guest in coordination with the Peer Specialist Care Team.

#### **2. Admission Criteria**

Admission to a PRCR does not require a clinical Assessment or enrollment into the LMHA/LBHA utilization management level of care. Each PRCR must develop and implement

admission guidelines that reflect an individualized approach to admission criteria, with acknowledgement that a non-clinical level of care cannot accommodate every individual requesting admission. Admission to a PRCR program must be determined through an intake interview and a collaborative decision made between the potential Guest and the Peer Specialist Care Team.

- a. An individual requesting admission must meet the following criteria:
  - i. must have a low risk for potential of violence towards self or others;
  - ii. must have the ability to independently perform activities of daily living;
  - iii. must have the ability to self-administer medications without Peer Staff support;
  - iv. must bring no more than a one-month supply of any prescription medication to the PRCR;
  - v. may have mild medical conditions that are stable with prescribed and available medications; and
  - vi. may have co-occurring psychiatric and Substance Use Disorders (COPSD) resulting in no more than mild impairment.
- b. The PRCR must not admit an individual who requires a level of care that cannot be provided through PRCR services. Individuals that require a greater level of care must be referred to a more appropriate service.

### 3. Egress.

Crisis respite services must be provided in an unlocked facility that provides individual residents restricted entrance and unrestricted exit.

### 4. PRCR Standards.

A PRCR Program director must:

- a. Create a stable and supportive environment with limited supervision provided by trained and competent Peer Staff;
- b. Develop and implement operational procedures to assist Guests with obtaining physical and psychiatric medications when they are unable to access these resources independently;
- c. Develop and implement operational procedures to provide Guests with immediate access to urgent and emergent non-psychiatric medical Assessment and treatment when Guests are unable to access these services independently;

### 5. PRCR Programming.

PRCRs use self-help strategies, self-determination, and peer-support to address the needs of Guests with the goal of enhancing participation in their life and community. Guest participation is completely voluntary, and all programs and services are elective. The choice of services includes the Guest's right to choose no services. Guests define and address their own recovery goals and maintain the ability to choose the PRCR Care Team or the professional services that best suit their recovery goals. The PRCR must ensure that programming responds flexibly to the needs of Guests and supports individual and group

participation as fully as possible for Guests with varying physical, psychiatric, intellectual, and sensory processing conditions.

## **D. Standards**

### **1. Availability**

When offered, this service must be available to individuals in Crisis 24 hours a day, every day of the year throughout the local service area.

### **2. Staffing**

#### **a. Operational Guidelines.**

- i. A psychiatrist must serve as the medical director for all Crisis services provided by the contracting LMHA or LBHA. The medical director must approve all PRCR program written policies, procedures, and operational guidelines for subcontracted services provided on behalf of the contractor.
- ii. A psychiatrist must serve as the medical director for all Crisis services provided by the contracting LMHA or LBHA. The medical director must approve all PRCR program written policies, procedures, and operational guidelines for subcontracted services provided on behalf of the contractor. While the PRCR's daily operations will be managed by PRCR staff, a medical director needs to be designated for urgent clinical issues and to review incidents related to quality of care.
- iii. The PRCR Program Director must:
  - (1) Ensure that services are provided by staff members who are operating within the scope of their credentialing, job description, and contract specification, in accordance with 1 TAC §354.3055 (Ethical Responsibilities);
  - (2) Define competency-based expectations for each PRCR staff positions;
  - (3) Ensure each Peer Staff member receives initial training before the staff member assumes responsibilities providing PRCR program services and annually throughout the staff member's employment with the organization.

#### **b. Peer Specialist Certification. The LMHA or LBHA must ensure that CPSs:**

- i. complete training and display core competencies for initial certification, and certification renewal, as required by their credentialing entity, in accordance with 1 TAC Chapter 354, Subchapter N, Division 6 (relating to Peer Specialist and Peer Specialist Supervisor Certification); and
- ii. receive documented supervision in accordance with 1 TAC §354.3103 (relating to Supervision of Peer Specialists) and 1 TAC §354.3101 (relating to Requirements).

#### **c. Peer Specialist Training, Competency and Credentialing. The LMHA or LBHA must ensure that Peer Staff members providing Peer Support services adhere to competency and credentialing requirements provided in:**

- i. Required competencies delineated in 26 TAC §301.331(a)(3)(A) (relating to Competency and Credentialing);
  - ii. Critical competencies for topics delineated in 26 TAC §301.331(a)(3)(B) (relating to Competency and Credentialing), including: Individual emergency behavior interventions, in 26 TAC Chapter 748, Subchapter N, (relating to Emergency Behavior Interventions) Admission, Service Planning, and Discharge); and
  - iii. Additional requirements for credentialing as a peer provider, in accordance with 26 TAC §301.331(f) (relating to Additional requirements for credentialing as a peer provider).
- d. Peer Staffing Pattern.
- i. Trained and competent Peer Staff members must be present and available onsite 24 hours a day, every day of the year.
  - ii. The PRCR must develop and implement a process for assessing and anticipating Peer Staffing needs.
  - iii. The PRCR staff must be scheduled in sufficient numbers to ensure individual and staff safety during the provision of needed services.
- e. Availability, Duties, and Responsibilities.
- i. Duties and responsibilities for all Peer Staff providing Guest services must be:
    - (1) Defined in writing by the LMHA or LBHA;
    - (2) Appropriate to Peer Staff training, competency, and experience; and
    - (3) In conformance with the scope of Peer Staff certification and availability.
  - ii. Peer Staff members On Duty must remain awake and alert at all times.
  - iii. Peer Staff members must be willing to disclose about personal recovery.
  - iv. The LMHA or LBHA must develop and implement policies and procedures allowing on-site Peer Staff members to obtain 24-hour access to supervision, consultation, and evaluation as needed from:
    - (1) A physician (preferably a psychiatrist), a physician's assistant (PA), an advanced practice nurse practitioner (APRN), or a registered nurse (RN) for medical emergencies; and
    - (2) An RN or Licensed Practitioner of the Healing Arts (LPHA) for clinical emergencies.
  - v. The PRCR Staff Care Team must consist of a minimum of following:
    - (1) A Program Director, who supervises the Peer Staff Care Team;  
A Peer Services Team Lead, who supervises Peer Navigators and Peer Bridgers;
    - (2) A Peer Bridger, who provides peer services, such as:
      - (a) community outreach;
      - (b) assisting Guests in linkage with community resources; and

- (c) gathering Guest satisfaction data after Guests have completed their PRCR program stay; and
- (3) A Peer Navigator, who provides peer support and recovery-oriented services, such as:
  - (a) facilitating peer groups;
  - (b) mentoring Guests;
  - (c) teaching psychosocial skills;
  - (d) modeling hope for recovery;
  - (e) assisting Guests with navigating through complex social and healthcare systems; and
  - (f) assists in promoting safety in the living environment.
- f. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

### 3. Intake and Orientation

- a. The PRCR intake process is flexible and is based on an informal conversation that focuses on building a relationship with the potential Guest. The Peer Staff member interviews the individual seeking services to form a relationship, explore the individual's current situation and needs, and determines whether the individual may benefit from admission into services.
- b. Potential Guests must receive an intake interview from a Certified Peer Specialist Care Team Member prior to admission into services.
- c. An individual with capacity to consent must give written consent to receive respite services.
- d. Every Guest admitted to services must receive a unit orientation by an appropriately trained Peer Staff no later than 24 hours after admission and in accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities). The orientation must explain the Guest's individual rights both orally, and in writing, in a language and format easily understandable to the Guest. The orientation must include:
  - i. The rights of Guests receiving treatment;
  - ii. A description of the PRCR grievance policy;
  - iii. The schedule of program activities;
  - iv. A description of the menu of services offered; and
  - v. Determine that the Guest comprehends the information provided in 1) – 4).

### 4. Supports and Services

The Peer Staff Care Team provide services by engaging with individuals, demonstrating empathy, trust, and respect. Services are provided in accordance with 1 TAC, Subchapter N, §354.3013 (relating to Services Provided).

- a. The LMHA or LBHA must develop and implement written guidelines for intervention and services, which:
  - i. are reviewed and approved by the medical director and updated as needed; and
  - ii. describe the most effective and least restrictive ways to access appropriate immediate care to stabilize a behavioral health emergency in accordance with 25 TAC Chapter 415, Subchapter F (relating to Interventions in Mental Health Services).
- b. The PRCR Program must offer services to include:
  - i. Formal Peer Support Services - CPSs use recovery and wellness support, which includes providing information on and support with planning for recovery; mentoring, which includes serving as a role model and providing assistance in finding needed community resources and services; and advocacy, which includes providing support in stressful or urgent situations, and helping to ensure that the recipient's rights are respected, to support Guests and promote possibilities for change;
  - ii. Informal Peer Support – Informal, unscheduled groups and informal peer relationships that promote peer to peer self-help opportunities with other Guests;
  - iii. Informal Crisis Prevention - Informal individual or group peer support or peer counselor support, education and advocacy, provided to address Guest problems before they escalate;
  - iv. Direct Linkages – CPSs refer Guests to outside agencies and community-based services or supports;
  - v. Social Inclusion – CPSs coordinate opportunities for socialization and recreational activities that promote the learning of life skills, foster community, and create new support systems; and
  - vi. Wellness and Recovery Tools - CPSs provide Guests with opportunities to learn about, develop, and refine personalized tools for managing their mental wellness, using Evidence Based Practices, such as:
    - (1) Assisting Guests with wellness and recovery planning through:
      - (a) Discovering their own simple, safe wellness tools
      - (b) Developing a list of things to do every day to stay as well as possible;
      - (c) Identifying upsetting events, early warning signs and signs that things have gotten much worse and, using wellness tools, develop action plans for responding at these times;
      - (d) Creating a Crisis plan; and
      - (e) Creating a post-Crisis plan; and
    - (2) Declaration for Mental Health Treatment (Advanced Directive) outlining preferred mental health treatment if an individual becomes unable to provide consent.
- c. Menu of Services. The PRCR must provide a menu of services to all Guests. The provision of individual and group skills training must be based on the individual

needs and recovery goals of each Guest. Guests maintain the ability to choose the PRCR Care Team or professional services that best suit their recovery goals. Individuals may choose to be provided with peer specialists support and connection to substance use recovery support services. The PRCR must provide programming services that include:

- i. Group or individual time including:
  - (1) support groups;
  - (2) individual time with a peer specialist;
  - (3) building social supports;
  - (4) trauma-informed peer support; and
  - (5) access to mutual understanding and connection; and
- ii. Skills training, including:
  - (1) training on the creation of a wellness and recovery plan;
  - (2) educational activities; and
  - (3) learning about recovery; and
- iii. Social group activities; and
- iv. Recreational activities, which may include:
  - (1) art groups,
  - (2) exercise groups; and
  - (3) cooking and nutrition groups;
- v. Unstructured time to explore independent and communal interests;
- vi. Activities consistent with the Guest's cultural and spiritual background; and
- vii. Other activities supportive to Guests in Crisis.

## 5. Wellness and Recovery Planning

- a. The LMHA or LBHA must develop and implement a written guideline and procedures to ensure Peer Staff members:
  - i. Provide daily documentation on an individual's progress on recovery goals;
  - ii. Document progress on the format approved by PRCR Program Manager; and
  - iii. Communicate daily documentation to the Care Team Lead staff member.
- b. Linkage to services and Continuity of Care must be provided for every Guest and include:
  - i. Identifying and linking the Guests with all available community-based services necessary to ensure transition to routine care; and
  - ii. Providing necessary assistance in accessing those services, including COPSD services, in accordance with 26 TAC §448.906 (relating to Access to Services for Co-Occurring Psychiatric and Substance Use Disorders (COPSD) Clients), and contacting and coordinating with the individual's existing or newly selected service providers in a timely manner and in conformance with applicable confidentiality requirements.
- c. A PRCR program must develop and implement written guidelines and procedures to ensure Guests are provided satisfaction surveys to rate the PRCR program and have their grievances addressed.



## 6. Physical Plant

- a. A PRCR physical plant must have written policies and procedures for monitoring environmental safety, in accordance with 26 TAC §301.312 (relating to Environment of Care and Safety).
- b. Any new PRCR facility must receive a preoperational, on site Quality Management (QM) review before being open to the public to provide services.
- c. All PRCR facilities are subject to HHSC QM reviews. The operating LMHA or LBHA must immediately report to the HHSC Contracts Management department any changes in programming or construction.
- d. If the LMHA or LBHA PRCR holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by HHSC, meaning:
  - i. Any Quality Management and Compliance reviews will entail only programmatic elements; and
  - ii. Any Regulatory Compliance inspection and survey will occur in accordance with assisted living licensing standards located in 26 TAC §301.312 (relating to Environment of Care and Safety).
- e. If the LMHA owns and operates a non-licensed facility under an exemption from licensure they are required to register and submit a facility exemption form in conjunction with the Consolidated Local Services Plan submission every two years.
- f. A PRCR must provide a clean and safe environment.
- g. A PRCR must create a stable and supportive environment.
- h. A facility must not be designed to prevent Guest exit and must not use locks, mechanical restraints or other mechanical mechanisms to prevent Guest exit from the facility.

## 7. Coordination and Continuity of Care

- a. A PRCR program must utilize a strengths-based framework that emphasizes physical, psychological, and emotional safety, in accordance with the evidenced-based Peer Support Model.
- b. Water/Waste/Trash/Sewage.
  - i. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
  - ii. The water supply must be of safe, sanitary quality, suitable for use and adequate in quantity and pressure and must be obtained from a water supply system.
  - iii. Waste, trash, and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
- c. Windows. Operable windows must be insect screened.

- d. Pest Control. An ongoing pest control program must be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals must be used.
- e. Maintenance and Cleaning.
  - i. In kitchens and laundries, peer staff must use procedures to avoid cross-contamination between clean and soiled utensils and linens.
  - ii. The facility must be kept free of accumulations of dirt, rubbish, dust, and hazards.
  - iii. Floors must be maintained in good condition and cleaned regularly.
  - iv. Walls and ceilings must be structurally maintained, repaired, and repainted or cleaned as needed.
  - v. Storage areas and cellars must be kept in an organized manner.
  - vi. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
  - vii. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.
- f. Telephone Access. There must be at least one telephone in the facility available to both Peer staff and Guest for use in case of an emergency.
- g. Temperature. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in individual-use areas.
- h. Bedroom.
  - i. A bedroom must have no more than four beds.
  - ii. The facility must provide for each guest a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings.
  - iii. Furnishings provided by the facility must be maintained in good repair.
- i. Bathroom.
  - i. A PRCR must provide At least one water closet, lavatory, and bathing unit must be provided on each sleeping floor accessible to individuals of that floor.
  - ii. A PRCR must provide one water closet and one lavatory for each six occupants, or fraction thereof.
  - iii. A PRCR must provide one tub or shower for each ten occupants, or fraction thereof.
  - iv. Privacy partitions and all curtains must be provided in water closets and bathing units in rooms for multi-individual use.
  - v. A PRCR must provide tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
  - vi. A PRCR must provide individual-use hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
  - vii. A PRCR must provide individuals must have access to towels, soap, and toilet tissue at all times.

- j. Storage.
  - i. The facility must provide sufficient and appropriate separate storage spaces or areas for the following:
    - (1) Administration and Guest records;
    - (2) Office supplies;
    - (3) Medications and medical supplies (these areas must be locked);
    - (4) Poisons and other hazardous materials (these must be kept in a locked area and must be kept separate from all food and medications);
    - (5) Food preparation (if the facility prepares food); and
    - (6) Equipment supplied by the PRCR for individual needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment etc.
  - ii. Storage must not be permitted in the attic spaces.
- k. Food storage.
  - i. Food storage areas must provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
  - ii. Food subject to spoilage must be dated.
- l. Laundry. Individual-use laundry, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.
- m. Smoking. The PRCR must develop and implement regulations must be established and if smoking is permitted, outdoor smoking areas may be designated for Guests. Ashtrays of noncombustible material and safe design must be provided in smoking areas. Peer staff must not provide or facilitate individual access to tobacco products.
- n. Room Space.
  - i. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms must be provided and have appropriate furniture.
  - ii. The PRCR must provide dining areas must be provided and have appropriate furnishings.

## 8. Accessibility

- a. The PRCR must comply with the most recent versions of:
  - i. the Americans With Disabilities Acts (ADA) Accessibility Guidelines;
  - ii. the Texas Accessibility Standards in Texas Government Code Chapter 469, (relating to Elimination of Architectural Barriers); and
  - iii. all applicable sections of TAC.

## 9. Postings

- a. The PRCR must post 911 as the emergency contact at, or within view, of the telephone.
- b. The PRCR must ensure that designated smoking areas are clearly marked.
- c. The PRCR must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.
- d. The PRCR must post an emergency evacuation floor plan.
- e. The following must be prominently displayed in areas frequented by individuals:
  - i. Contact information for the Rights Protection Officer,
  - ii. Contact information, including a toll-free number, and instructions for reporting abuse and neglect; and
  - iii. Contact information stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
- f. The PRCR postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.

## 10. Life Safety

- a. Life Safety Code. A PRCR must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code. Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
- b. Local Fire Code. A PRCR must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
- c. Code Compliance. A PRCR must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
- d. Emergency Evacuation Plan. The LMHA or LBHA must have in effect, and available to all supervisory personnel, written copies of a plan for the protection of all Guests in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary.
  - i. The plan must:
    - (1) Include special Peer Staff actions including fire protection procedures needed to ensure the safety of any resident;
    - (2) Include special staff actions including fire protection procedures needed to ensure the safety of any individual;
    - (3) Be amended or revised when needed;
    - (4) Be readily available at all times within the facility; and
    - (5) Require documentation that reflects the current evacuation capabilities of the individuals
  - ii. All Peer Staff must be periodically instructed and kept informed with respect to their duties and responsibilities under the plan.

- iii. The facility must conduct emergency evacuation drills quarterly and calculate evacuation scores in accordance with the fire code under which the facility is inspected.
- e. Disaster Plan.
  - i. The LMHA or LBHA must have in effect and available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, per 26 TAC, Chapter 301, Subchapter G, §301.312 (relating to Environment of Care and Safety).
  - ii. The written disaster plan must address, at a minimum, eight core functions:
    - (1) Direction and control;
    - (2) Warning;
    - (3) Communication;
    - (4) Sheltering arrangements;
    - (5) Evacuation;
    - (6) Transportation;
    - (7) Health and medical needs; and
    - (8) Resource management.
  - iii. The written disaster plan must include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the respite facility or during facility evacuation.
- f. Recorded Inspections.
  - i. The PRCR facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections must be signed and dated.
  - ii. The following initial and annual inspections are required and must be kept on file:
    - (1) Local Fire safety inspections as outlined in 6.g., below;
    - (2) Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
    - (3) Annual kitchen inspection by the local health authority, if applicable;
    - (4) Fire extinguisher inspection and maintenance by personnel licensed or certified to perform the inspection; and
    - (5) Liquefied petroleum gas systems inspection by an inspector certified by the Texas Railroad Commission.
- g. Fire Safety Inspections.
  - i. Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal's Office.
  - ii. The PRCR is responsible for arranging required inspections and ensuring that inspections are carried out in a timely manner.

- iii. The initial and ongoing fire safety reports must be signed by the certified inspector performing the inspection.
- iv. These reports must be kept on file and be readily available for review by the HHSC.
- v. All fires causing damage to the Crisis residential unit or to equipment must be reported to the HHSC Contract Manager within 72 hours. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Report must be made by telephone during normal business hours and by telephone call and e-mail during other times, with a follow-up telephone call to the Contract Manager on the first business day following the event.
- vi. Open flame heating devices are prohibited. All fuel burning heating devices must be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.
- h. Correction Plan. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff must take immediate corrective action to bring the facility into compliance with the applicable code.
  - i. The facility must have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions.
  - ii. The facility must have on file documentation by the Certified Fire Inspector that all findings have been corrected and that the facility is in full compliance with all applicable codes.
  - iii. During the period of corrective action, the facility must take any steps necessary to ensure the health and safety of individuals residing in the facility during the time repairs or corrections are being completed.
- i. Newly Operational Facilities. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in Texas. Such certification must be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a Crisis residential facility.
- j. Pre-operational facility requirements. Any newly constructed or renovated or remodeled unlicensed Crisis residential facility must receive a preoperational on- site review by HHSC QM before being open to the public to provide Crisis residential services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.
- k. Evacuation Plan. All facilities must post emergency evacuation floor plans.
- l. Individual Safety. The administrator of each facility must ensure that:
  - i. All Peer staff are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;

- ii. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or harm to a staff member;
- iii. Individual bedrooms, bathrooms and other private or unsupervised areas must be free of materials that could be utilized by an individual to attempt, or to die by suicide, or to harm or kill others, such as, but are not limited to:
  - (1) Ropes;
  - (2) Cords (including window blind cords);
  - (3) Sharp objects;
  - (4) Substances that could be harmful if ingested; and
  - (5) Extended ceiling fans.
- iv. Individual bedrooms, bathrooms and other private or unsupervised areas must contain:
  - (1) Break-away curtains; and
  - (2) Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.
- m. Vehicle Safety.
  - i. All vehicles used to transport individuals must be maintained in safe driving condition, in accordance with 37 TAC Chapter 23, Subchapter D (relating to Vehicle Inspection Items, Procedures, and Requirements)
  - ii. Any vehicle used to transport an individual must have appropriate insurance.
  - iii. Every vehicle used for individual transportation must have an easily accessible fully stocked first aid kit and an A:B:C type fire extinguisher.
- n. Additional Safety Standards for Children and Adolescents. Respite services providers must adhere to additional safety standards listed in 26 TAC Chapter 748, Subchapter O (relating to Safety and Emergency Practices) and transportation safety standards listed in 26 TAC Chapter 748, Subchapter R, Division 2 (relating to Safety Restraints) when Child and Adolescent Crisis respite services provided in General Residential Operations.

## 11. Infection Control

- a. Infection Control.
  - i. A PRCR must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
  - ii. A PRCR must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-related Facilities).
  - iii. A PRCR must have written policies for the control of communicable disease in employees and individuals, which includes tuberculosis (TB) Screening and provision of a safe and sanitary environment for individuals and employees.
- b. TB Reporting Requirement. The PRCR must maintain evidence of

compliance with local and/or state health codes or ordinances regarding employee and individual health status.

- i. Individuals. The name of any individual of a PRCR program with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.

- (1) All individuals must be screened upon admission and after exposure to TB and provided follow-up as needed.

- (2) HHSC will provide TB Screening questionnaire for admission

Screening:

<https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf>

- ii. Peer Staff. If staff contract a communicable disease that is transmissible to individuals through food handling or direct individual care, the employee must be excluded from providing these services as long as a period of communicability is present.

- (1) The PRCR must screen and test all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.

- (2) All persons who provide services under an outside resource contract must, upon request of the PRCR, provide evidence of compliance with this requirement.

- c. Universal Precautions. Peer staff who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.

- i. Universal precautions must be used in the care of all individuals.

- ii. First Aid Kits must be sufficient for the number of Guests served at the PRCR.

- (1) Gloves must be immediately accessible to Peer staff.

- (2) One-way, CPR masks must be immediately available to all Peer staff.

- (3) Spill Kits must be immediately accessible to all Peer staff.

- iii. Sharps containers must be puncture resistant, leak proof and labeled.

- (1) Sharps containers must not be overfilled.

- (2) Needles in the sharps containers must not be capped or bent.

- iv. Disinfectants and externals must be separated from internals and injectables.

- (1) Medications requiring special climatic conditions (e.g. refrigeration, darkness, tight seal, etc.) must be stored properly.

- (2) The refrigerator must have a thermometer.

- (3) Recorded refrigerator temperatures must be maintained between 36 and 46 degrees Fahrenheit, in accordance with 22 TAC §291.15 (related to Storage of Drugs).

- v. Running water or dry-wash disinfectant must be available to staff where sinks are not easily available.

- vi. Peer staff must demonstrate ability to accurately describe the policy for handling a full sharps container.



- (1) Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.
- (2) Peer staff must be able to describe the actions to take if exposed to blood or body fluids.
- (3) Peer staff must be able to describe how to clean a blood or body-fluid spill.
- (4) Peer staff must be able to direct QM reviewer to all protective equipment.
- vii. Poison Control phone numbers must be posted throughout the facility and information regarding Emergency Medical Treatment for Poisoning must be available to staff.
- viii. All medical materials must be properly stored on shelves or in cabinets that must be correctly labeled.
- d. Animal Safety. Animals housed at the facility or visiting the facility must be properly vaccinated and supervised.

## 12. Medication Management

It is outside the scope of peer specialist services to provide medication services or to administer prescription or over-the-counter medications. The Program Manager must develop and implement written procedures for Guest medication storage, administration, documentation, controlled substances, inventory, and disposal in accordance with 26 TAC §301.355 (relating to Medication Services).

- a. Self-Administration of Medication.
  - i. If taking prescription medication(s), the Guest is responsible for taking these as prescribed, without direction or assistance. Individuals may independently transfer their own medications from a bottle to a daily medication reminder.
  - ii. The clinical service of medication management is not offered by PRCR Peer Staff, although Peer Staff can assist Guests with accessing Medication assistance in the community by referring Guests to appropriate medical personnel and services. Once an individual is a Guest at the PRCR, any new prescriptions, or refills, brought to the facility must be presented to Peer Staff to document.
- b. Medication Storage.
  - i. All Guest medications must be securely stored in a double-locked space.
  - ii. Medications that require special conditions such as refrigeration, darkness, and tight seal, must be stored appropriately.
  - iii. A separate refrigerator must be available to store medications.
- c. Climate Controlled Medications.
  - i. The PRCR must maintain a record indicating that Peer Staff regularly checks the temperature in the refrigerator.
  - ii. Refrigerators used to store medications must be kept neat, clean and free of non-pharmacy and non-medical items.
- d. Labelling Medications.

- i. A Guest's prescription medication(s) must be contained in a properly labeled, original medication container. The medication container must include a clear and legible label. Labels must contain:
  - (1) Name of pharmacy;
  - (2) Name of Guest;
  - (3) Name of prescribing physician;
  - (4) Date prescription was dispensed;
  - (5) Instructions for use of medication;
  - (6) Name of medication;
  - (7) Side effects and adverse reactions to medications;
  - (8) Use of psychotropic medication;
  - (9) Strength of medication;
  - (10) Combination medications without a brand name must list principal active ingredient; and
  - (11) Any special handling instructions for medication.
- ii. The PRCR must ensure there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.
- iii. Medication labels must not be handwritten or changed.
- iv. The PRCR must ensure that Peer Staff members have readily available access to a hardcopy or digital format of a medication guide (such as the Physician's Desk Reference (PDR) or similar publication) in a version that is no more than two years old for non-clinical reference purposes only.
- e. Controlled Substances. An inventory of controlled substances must include:
  - i. Whether the inventory was taken at the beginning or close of business;
  - ii. Name of controlled of substances;
  - iii. Each finished form of the substances;
  - iv. The number of dosage units of each finished form in the commercial container;
  - v. The number of commercial containers of each finished form; and
  - vi. Controlled substances must be stored under double locks.

### 13. Food Preparation and Food Services

When Crisis respite services are provided in a free-standing facility, the facility is exempt from the requirement to obtain Health Department inspections and certifications.

- a. Kitchen Standards.
  - i. If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the Guests.
  - ii. Kitchen or dietary area must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.
  - iii. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary

manner.

- iv. All facilities must provide a means for washing and sanitizing dishes and cooking utensils must be provided.
- v. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans, cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.
- vi. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.
- vii. All poisonous or hazardous materials such as cleaning supplies will be housed in cabinet separate from those cabinets containing food items
- b. Meal Preparation. Peer Staff must not prepare meals for Guests, in accordance with the evidence-based Peer Support model of care.
- c. Food Supplies. The PRCR must ensure:
  - i. a variety of foods are available to allow individuals to have a choice of foods to prepare for each meal;
  - ii. the foods available are nutritious and well balanced, in accordance with the most recent version of the United States Department of Agriculture's guidelines, and accommodate individual kosher dietary needs or other related dietary practice to the extent possible;  
The PRCR must encourage Guests to bring food that is part of each Guests' wellness and recovery plan.
- d. Availability. Food and beverage must be available to accommodate Guests who enter the facility after developed meal times.
- e. Food Storage.
  - i. In all facilities, supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period must be maintained on premises. Food subject to spoilage must be dated.
  - ii. Thermometers will be in all refrigerators to ensure temperature remains at settings recommended by manufacturer.