Proposal for Community Crisis Response FY 2016
Health Planning Region V

In July, 2013, Health Planning Region V (HPRV) received funding to provide the following children’s crisis and psychiatric services:

- A medically supervised 3 “bed” 23 hour crisis assessment and stabilization center that will be available to serve all HPRV Community Service Boards (CSBs) in the HPRV region. This ultimately developed into the Children’s Behavioral Health Urgent Care Center operated by the Hampton/Newport News Community Services Board. It is located at Maryview Medical Center in Portsmouth, VA, and is able to serve all children in HPRV.

- 30 hours per week of child telepsychiatry available to all HPRV CSBs to include direct clinical services and consultation/liaison services to HPRV CSBs.

- Implementation of community-based youth crisis services in four localities that offer a continuum of community-based crisis services for youth and families in need with private or no insurance.

- Quarterly regional training seminars on issues related to children’s mental health including effective crisis assessment and stabilization services.

However, one large gap continues to remain throughout the region, and that is the lack of access in every locality to community-based crisis intervention or crisis stabilization services. Currently, only 4 of the 9 CSBs in HPRV offer youth mobile crisis services, and these programs generally consist of only one or two clinicians serving an entire CSB catchment area. Therefore, it is the consensus of the CSBs in HPRV to focus solely on the expansion of youth mobile crisis services throughout the region in this application for additional funds.

Philosophical Tenants.

Our proposed services are based on the following fundamental principles:

- *Rapid, flexible responses.* A crisis occurs when there is a change for the worse in the emotions or behavior of any individual that results in their usual coping skills becoming overwhelmed. During these acute events, a rapid and flexible response focused on restoring equilibrium for the individual experiencing the crisis and for the members of their support system will be provided through an interdisciplinary team approach.

- *A full continuum of community-based crisis services.* In order to effectively reduce the number of youth with mental health issues being hospitalized, residentially placed, or put into foster care, it is important for a community to have a full continuum of community-
based services available to youth and families in crisis. This includes focusing on services that will prevent the exacerbation of symptoms over time by providing services to youth immediately when problems arise, having a single point of access, linking them with appropriate community resources, providing flexible, community-based services that meet the presenting needs in a natural setting, and having immediate psychiatric support.

- **Collaborative partnership with individuals and their families.** Periods of crisis are inherently difficult for family members and others who are supporting the individual in crisis, as well as for the individual actually experiencing the crisis. Successful crisis stabilization rarely occurs in isolation from an individual's support system. The crisis teams will work in a collaborative partnership with individuals, their families and other members of their support systems to stabilize the crisis in the least intrusive or restrictive manner possible always taking into account their unique cultural, ethnic, and personal characteristics.

- **Individual and family strengths create solutions.** The service delivery approach is strengths-based and person-centered, building the individual's and family's own strengths and resources to develop achievable solutions. By promoting a mutually respectful, collaborative partnership we empower individuals and their families are empowered to build resiliency and manage their own path to recovery.

- **Continued support for recovery.** Individuals who experience a crisis may need additional community based supports to return to their prior level of functioning. The crisis team will ensure that individuals and families access the community services that they see as most useful to achieve their stabilization goals.

**Identification of Need.**

HPRV comprises nine Community Services Boards. The nine CSBs are Chesapeake Integrated Behavioral Healthcare, Colonial Behavioral Health, Eastern Shore CSB, Hampton-Newport News CSB, Middle Peninsula-Northern Neck CSB, Norfolk CSB, Portsmouth Department of Behavioral Healthcare Services, Virginia Beach Department of Human Services, and Western Tidewater CSB.

The 5,950 square mile geographic area of HPRV spans the North Carolina border on the south, Potomac River on the north, and Maryland border in the northeast via the Eastern Shore. According to the 2010 Census, HPRV contains 1,844,250 people or about 23% of the population of Virginia, making it one of the densest regions in Virginia. Because of this, the area is considered “urban” even though the rural areas account for the majority of the land in the region. Six of the nine areas in HPRV are below the Virginia poverty rate of 10.6% making this also one of the poorest HPR’s. The Region is home to over ¼ of the active duty military service men and women in the United States and their dependents. This includes 92,962 military personnel and 51,340 federal civilian employees according to a study on *The Economic Impact of the Department of Defense in Hampton Roads* completed in 2013 by the Hampton Roads Planning
District Commission. Children of military families are 56% more likely to feel sad or hopeless and 34% more likely to have suicidal thoughts than their non-military peers according to a 11/30/13 article titled: *Teens with Deployed Family Members Face Greater Risk of Depression* by Traci Pederson and reviewed by John M. Grohol, Psy.D. Additionally, it is noted that 32% of children of military families scored “high risk” for child psychosocial mortality, 2.5 times the national average. It is also noteworthy that children of military families with 1 caregiver deployed are not only at a greater risk for depression and suicidal ideation, but the absence of a caregiver from the home further reduces the available resources to resolve the behavioral illness. Further, the symptoms are more likely to reach a high level of acuity due to delayed treatment before the family/individual seeks help due to the stigma of mental illness in military culture. The size, population, geography, and poverty rate of the region present enormous challenges to the nine Community Services Boards.

In its Final Report to the General Assembly, Item 304.M, “A Plan for Community-Based Children’s Behavioral Health Services in Virginia,” the Department of Behavioral Health and Developmental Services (DBHDS) addresses the “incomplete array of services in all communities and a lack of consistency of service availability across the state.” As a result DBHDS recommended defining and establishing a “base” or foundational set of services that every community should have to begin to meet the needs of children and families. These are defined as:

- Crisis Stabilization Unit for Children
- Emergency Respite Care
- In Home Crisis Stabilization
- Mobile Child Crisis Response
- Psychiatric Services
- Case Management
- Intensive Care Coordination
- Intensive In-Home Services

Each year the Office of Comprehensive Services conducts a critical service gaps survey to identify gaps and barriers in services needed to keep children in the local community. Crisis Intervention and Stabilization are consistently listed as a top ten critical service gap need in the Eastern Region of Virginia.

Research is clear that using a mobile, community-based approach to treating crisis is much more effective than the traditional emergency room-based intervention. Hospital-based emergency service patients were found to be more than three times as likely to be admitted to a psychiatric inpatient unit when compared with those using a mobile community-based crisis service, regardless of their clinical characteristics. Emergency psychiatric services which include a
mobile component and provide a specialized multidisciplinary team approach appear to be most effective in providing services in the least restrictive environment and avoiding hospitalization (Hugo, 2002).

In order to effectively reduce the number of youth with mental health issues being hospitalized, residentially placed, or put into foster care, it is important for a community to have a full continuum of community-based services available to youth and families in crisis. This includes focusing on services that will prevent the exacerbation of symptoms over time by providing services to youth immediately when problems arise. Having a single point of immediate community access to crisis services, linking youth and families with appropriate community resources, providing flexible community-based services that meet the presenting needs in a natural setting, and having immediate psychiatric support are all critical components of an effective crisis continuum. Other research has shown that patients referred to a community service showed greater improvement in symptoms and are more satisfied with services than those in the hospital-based service. Patients treated in the hospital-based service spent eight times as many days as psychiatric inpatients as those treated in the community-based service. Patients both prefer and seem to benefit more from community-based psychiatric care (Merson, 1992).

One community-based service that is flexible and can be provided in the home, office, and/or community setting is Crisis Intervention (CI). CI services can be provided immediately to youth who are showing an escalation in behavioral health symptoms or a decrease in their day to day functioning as a result of a mental health condition, but are not yet at the severity to require hospitalization. By having immediate access to crisis services available in the community, youth demonstrating an escalation in behavioral symptoms can often avoid a further escalation that could result in hospitalization or even longer term out of home care. Crisis services are short term in nature, with CI lasting only up to 30 days. Often with effective crisis services, the stressors prompting the crisis can be reduced and an ongoing level of intensive service can be avoided. It becomes more cost effective for the community as a whole and better serves the needs of the youth and family. Research has shown that a consumer using a traditional hospital intervention such as going to the emergency department when in crisis was more than half again more likely to be hospitalized than one using community-based mobile crisis services to be hospitalized within the 30 days after the crisis (Guo, 2001). Results indicate that community-based mobile crisis services resulted in a lower rate of hospitalization than hospital-based interventions.

In addition to CI services, another service needed to build the crisis continuum of care is short term case management. Recent research has shown that many suicidal patients treated and released from emergency departments fail to follow through with subsequent outpatient psychiatric appointments, often presenting back for repeat hospital services (Currier, 2010). Youth who are deemed at-risk or diagnosed with serious emotional disturbance qualify for case management services that allow the youth and family to have quick access to the mental health
field for assessment and evaluation of needs. Having a mobile crisis response for youth coming out of the hospital setting is often imperative for continuity of care. Simply referring a youth and family in crisis for service is often not good enough. Successful first clinical contact after a hospital discharge increased by 40% when using a mobile crisis approach for patients that had been suicidal (Currier, 2010). This is especially important for youth and families that move in and out of crisis. “Crisis” case management services can quickly be available to link the youth and family to needed mental health services, monitor the service delivery for effectiveness, and constantly reassess to determine if the level of need is being met. It provides quicker access to services and a consistent contact to youth and families when problems arise. While youth who receive Medicaid already have this service funded, funds are limited for those without Medicaid. Youth and families experiencing a crisis can have a crisis case manager assigned to aid them for 1-3 months to aid in navigating treatment options and to refer for ongoing services when the crisis has subsided. It provides a consistent point of contact for youth and families that may move in and out of crisis rapidly, shortening the response time if subsequent crises occur.

It is also imperative that youth and families experiencing a current crisis receive immediate access to mental health services and psychiatric care to prevent further escalation. A single point of access in the community for crisis services allows families to receive more rapid response when crises occur. Many youth and families may be experiencing a crisis for the first time, and have no history of mental health treatment. While emergency prescreening is available in all localities, this does not guarantee immediate access to other mental health services except for hospitalization. Other research showed that using a community-based mobile crisis approach resulted in a highly significant immediate decrease in both the number of admissions and the duration of hospital stay. Re-hospitalization was also rare. Results support the development of ambulatory crisis intervention services. The prevention of hospitalization must be based as much on a possible alternative at the time of the crisis as on subsequent access to ambulatory care. (Robin, 2008) Having immediate access to less restrictive services and psychiatric care aids in reducing hospitalizations. Therefore, having dedicated access and intake staff available for assessment and referral for youth and families in crisis is essential to providing a full continuum of crisis services to the community. Having available psychiatric time for youth and families in crisis is also imperative to a successful continuum.

Therefore, HPRV is in agreement that this application for funding will focus entirely on making youth mobile crisis services available to every youth in the region. Crisis intervention and case management as described above are services that are funded by Medicaid. However, no other insurance plan covers these services. Approval of the funds requested for HPRV will ensure that each child in the region, regardless of insurance coverage or lack thereof, will be able to access timely, community-based crisis services.

Specifically, HPRV is proposing to add 3 additional mobile crisis teams within the region in areas where these services do not currently exist, and having existing mobile crisis teams expand
to offer coverage to the two remaining CSBs that will not be providing this service themselves at this time. In addition, existing programs will be able to expand to provide better overall crisis coverage for their respective catchment areas.

With approval of this funding application, the following CSBs in the Hampton Roads area will be able to begin new community-based youth crisis service programs:

- Hampton-Newport News CSB
- Norfolk CSB
- Portsmouth Department of Behavioral Healthcare Services.

In addition, Chesapeake Integrated Behavioral Healthcare and Eastern Shore CSB will be provided funding to contract with another CSB in the region to provide mobile crisis coverage as needed (See Attachment “A”: Sample MOU). Also, Colonial Behavioral Healthcare, Middle Peninsula/Northern Neck CSB, Virginia Beach Department of Human Services, and Western Tidewater CSB will all be able to expand existing crisis services to better serve their respective catchment areas.

**Needs and Implementation Plans by Locality.**

The following demonstrates the local need and each CSB’s respective plan to begin or expand youth mobile crisis services:

**Hampton-Newport News Community Services Board:**

The Hampton-Newport News Community Services Board (HNNCSB) proposes to provide mobile crisis services to the citizens of Hampton and Newport News to augment the continuum of behavioral health crisis intervention services. Children’s mobile crisis services will provide an alternative to facility-based intervention and inpatient care, when clinically appropriate. Services shall be performed by one full-time licensed therapist (or license eligible therapist) who shall provide home, office or community-based crisis intervention services for children and adolescents who experience a mental health crisis. Services shall be administered to children and adolescents in need, regardless of their insurance status.

The H-NNCSB has a comprehensive array of child, adolescent and family behavioral health services specifically designed to serve and support children and their families in the community in the least restrictive, clinically appropriate level of care. The HNNCSB and its local CPMTs work in close partnership to serve children in their family homes in their community without of the use of expensive, higher levels of care such as group homes or residential treatment.
The HNNCSB offers comprehensive outpatient services including four Outpatient Clinics, Two Board Certified Child Psychiatrists, 14 Psychiatrists across four clinics and regional hospitals that provide attending, consultation, and treatment, Children’s Behavioral Health Urgent Care Center, licensed clinicians who perform individual, group and family counseling, VICAP Assessments, Psychiatric Evaluations, Tele-Psychiatry, Psychopharmacological Management and Psychological Assessments.

The HNNCSB offers a full continuum of community based programs including Case Management, Emergency Services, Prevention Services, Intensive Care Coordination, Community Care Coordination, Intensive In-home Therapy, Therapeutic Mentoring, Mental Health Skill Building Services for Young Adults, Therapeutic Day Treatment, Juvenile Detention-based services, Mental Health Screening Initiative in the City of Hampton, and the Newport News Juvenile Drug Court.

Please see below for current children’s program utilization data:

- 654 children – Case Management – Serious Emotional Disturbance
- 301 children – Case Management – Intellectual/Developmental Disability
- 34 children – Intensive Care Coordination/Community Care Coordination
- 85 families – Healthy Families Case Management, a partnership between HNNCSB and NN Department of Human Services
- 30 families – Medicaid or CSA funded intensive in-home therapy
- 812 children – Psychiatry services at our C&A clinic
- 360 children – C&A outpatient therapy
- 635 children – TDT at 69 schools
- 149 children – Therapeutic Mentoring
- 13 children – NN Juvenile Drug Treatment Court

While the HNNCSB offers immediate access to Emergency Services, Regional Children’s Urgent Care, Adult Crisis Stabilization, Adult Mobile Crisis Services and a full continuum of youth, family and adult clinical services, a critical service area that is missing from the continuum is Children’s Mobile Crisis Services. This service is needed to enhance our emergency response to families at critical times to prevent exacerbation of symptoms that may lead to hospitalization or higher, more expensive levels of care. Over the past calendar year, HNNCSB Emergency Services personnel completed 237 crisis assessments for individuals under the age of 18 years old. Over the past 18 months, the Child and Adolescent Case Management Program serving individuals with a Serious Emotional Disturbance provided crisis intervention services to 19 children. Some of those children required more than one, thirty day period of crisis intervention.
The HNNCSB’s current plan for managing children’s crises is to coordinate an agency response through the Emergency Services Department. For enrolled consumers, during traditional work hours, Emergency Services coordinates with the child-serving programs to arrange for the appropriate clinical response. For callers unknown to the agency, Emergency Services completes a crisis assessment and may link the caller to other HNNCSB programs for follow-up support. The addition of a mobile crisis clinician will afford the agency the opportunity to provide an enhanced crisis response to include crisis intervention services. Qualifying crisis intervention services are funded by Medicaid, however, most commercial insurance plans do not cover these services. Funding from this proposal will allow for crisis intervention services to be provided to families who are unable to afford crisis services provided by Emergency Services.

HNNCSB Implementation Plan:
Referrals for mobile crisis services shall be accepted from all clinical programs of the HNNCSB, community stakeholder agencies as well as private behavioral health providers in the community. Emergency Services shall serve as a point of entry to access children’s mobile crisis services and will triage callers to the mobile crisis clinician who do not require a pre-screening for hospitalization. The Regional Children’s Behavioral Health Urgent Care Center may also refer callers to the HNNCSB mobile crisis clinician for initial or interim consults for individuals who require crisis intervention services.

The mobile crisis clinician shall work directly with the child and family to develop a plan of action for resolving the crisis including a safety plan. The clinician shall conduct a comprehensive clinical assessment in compliance with Medicaid guidelines and DBHDS licensure standards. Crisis intervention services shall be performed until the child’s symptoms are stabilized. The intervention shall include linkage to recommended services and outreach to any involved service providers in the community who may be able to assist in resolving the crisis. For every child who is served by the mobile crisis clinician, their safety plan will be shared with all involved service providers to insure continuity of care. The mobile crisis clinician shall coordinate with the all parties to maintain a holistic team approach.

If the mobile crisis clinician determines that a psychiatric evaluation is needed during traditional work hours, an assessment may be arranged at the Regional Children’s Behavioral Health Urgent Care Center. The HNNCSB has referred 44 youth from Hampton and Newport News to Urgent Care over the last year. The mobile crisis clinician shall coordinate with HNNCSB clinical staff as well as our numerous private partners in the community to insure that services are responsive. For those children who are screened by Emergency Services and require services from the Intellectual and Developmental Disabilities (IDDS) Children’s Mobile Crisis Team, screening data will be shared with the assigned team. The Child and Adolescent Case Management Department serving individuals with IDDS will maintain weekly contact with Emergency Services to share information about youth who have recently experienced a crisis. The details of their behavior plans or safety plans shall be shared with Emergency Services in preparation for
day and after-hours crisis management. Emergency Services clinicians shall determine the most appropriate mobile crisis response for individuals with co-occurring behavioral health and developmental disabilities. Services and supports shall be designed individually and with flexibility. Services shall be adjusted to meet the distinct needs of the consumer and family. There will be frequent, scheduled interaction between the Children’s Mental Health and IDDS Mobile Crisis Teams for the Hampton and Newport News communities.

The HNNCSB Emergency Services Department will continue to perform crisis assessments as mandated by the Code of Virginia and operate in compliance with the DBDHS Performance Contract. The mobile crisis clinician will be used as a resource for Emergency Services clinicians to provide crisis intervention in the community and as a less restrictive alternative to hospitalization, when appropriate.

The HNNCSB will maintain and report outcome statistics related to the utilization and effectiveness of children’s mobile crisis services. These statistics shall be reported quarterly to the Region and State. Utilization tracking will include the total number served by HNN per quarter, the average length of total service provision per consumer and the average wait time for the initiation of crisis services from the time of referral. Effectiveness will be measured by tracking the percent of successful discharges from crisis services, which will be defined by a youth being able to avoid hospitalization who has received crisis intervention services. Recidivism rates will be measured per locality.

**Norfolk Community Services Board:**

The City of Norfolk has a population of 245,000, of which children under the age of 18 make up over 20% of the population. Norfolk residents have a median household income of $44,747 and a poverty rate of 19.2%. Norfolk CSB’s Emergency Services Department on average receives 650 calls a year for children and adolescents with an average of 445 of those calls resulting in an admission to an acute facility. According to the Virginia Department of Health suicide data for the City of Norfolk from 2003 – 2011, young people in this age range represent over 16% of the completed suicides.

Norfolk has also seen an increase in admissions and bed days at Commonwealth Center for Children and Adolescents (CCCA). Data for FY 2015 shows that by March 2015, CCCA had served 15 youth from Norfolk with a total of 339 bed days. For the same time period in FY 2014, CCCA served 3 Norfolk youth for a total of 135 days. This illustrates a significant increase in the acuity of the youth in the City of Norfolk and a significant need for mobile crisis services available in our home community. The CCCA data also reflects an increase in the acute hospitalizations that are coming from youth placed in Norfolk Juvenile Detention Center (NJDC). Since local hospitals rarely accept youth coming out of a detention facility, most of these youth are placed in CCCA.
Immediate access to mental health services is critical in reducing hospitalization, however most community-based mental health services cannot be offered immediately upon crisis. Outpatient services typically have a waitlist of 2-4 weeks. More intensive services, such as intensive in-home require that youth first have an independent assessment through the VICAP process to determine the qualifying need prior to the initiation of the service. Mobile crisis services through the Norfolk CSB would serve as a bridge between services by offering same day access to services when a crisis occurs and assisting the youth and their families until they can be connected to longer-term services. Mobile crisis will be able to address the immediate need, thus reducing the frequency of youth needing placement in an acute facility to manage their crisis. Mobile crisis services would also serve as a liaison with the staff at the NJDC, thus allowing a better ability to manage crisis situations and reducing the need for placement at CCCA.

This proposal will allow for funding to hire one license-eligible crisis staff. This staff will be a certified prescreener, and will be able to respond and provide services to youth and families in the office, home and community. This staff would be able to provide full-time crisis intervention services to the community for youth, regardless of insurance. Short term crisis case management (1-3 months) could also be available for youth and families without Medicaid whom have experienced a crisis in order to aid them in accessing other appropriate services available in the community once the crisis has stabilized.

Services will be provided based on client need, which may include evening, weekend, and holidays when necessary. Overnight crisis evaluation will be provided by existing Emergency Services workers, with next day access to community-based crisis services funded through this proposal. Norfolk CSB will utilize current child psychiatrist or psychiatric nurse practitioner as well as community psychiatric providers to assist with medication stabilization as needed.

The mobile crisis worker will collaborate with the larger Child and Adolescent Team to ensure that children and their families are connected to any services that can assist in their stabilization. This will include SED Case Management, Intensive Care Coordination (High Fidelity Wraparound), outpatient counseling, and psychiatric services along with linkage to community providers to ensure that youth’s immediate and ongoing needs are met. While this position will be supervised by the Clinical Coordinator of Emergency Services, there will be a strong link of collaboration with the Programs Manager for Child and Adolescent Services.

Norfolk Mobile Crisis will provide the following services:

- Mobile response
- Linkage to psychiatric assessment and medication management
- Consultation and collaboration with HPR-V mobile crisis teams
- Clinical assessment
• Individual and Family Counseling utilizing trauma informed and evidenced based practices.
• Family Team Meetings
• Behavioral management services
• Substance abuse screening
• Referrals to traditional and non-traditional services for any family with a child in crisis
• Autism outreach services

All of the proposed services are anticipated to be funded through a combination of billing to the clients’ existing insurance and through use of the funding being currently requested through this proposal. Mobile Crisis services at Norfolk CSB would include accessing Medicaid funding, however those with no insurance coverage for crisis services would still receive the same level of service as those with Medicaid through this funding. This allows flexibility in capturing revenue to supplement the money received through this proposal, and adds to the longevity of the service, allowing sustainability over time.

**Portsmouth Behavioral Healthcare Services:**

The City of Portsmouth has a population of 96,000, with a median household income of $46,166, and a poverty rate of 18.4 percent. Data from Portsmouth Emergency Services indicates that on average, seven youth are admitted to local and state inpatient hospitals each month. Data from Commonwealth Center for Children and Adolescents indicates that in March of 2015, Portsmouth exceed the total number of hospitalizations for calendar year 2014. In addition, data from the Hampton Newport News Urgent Care Center for Children indicate that 21% of their referrals come from the City of Portsmouth. This Urgent Care Center reports that Portsmouth Public schools are among their highest referral sources. Based on these statistics, there is a high need for youth Mobile Crisis services in the City of Portsmouth.

With the increase focus on Crisis response, the Department of Medical Assistance Services now requires youth identified as at risk of physical injury to self or others to receive services immediately via a linkage to crisis response services. Often youth that are assessed are not able immediately able to access services. This process often takes up to two weeks or more to complete. Families and youth in crisis cannot wait 2-4 weeks to access services, and access to this service in Portsmouth would allow children to remain in the home. Mobile Crisis Services provided by Portsmouth Behavioral Health Care Services would be able to be immediately implemented, with the goal of same day access.

This proposal will allow for funding to hire one license eligible crisis staff. This staff will be a prescreener, and will be able to respond and provide services to youth and families in the office,
home and community. This staff would be able to provide full-time crisis intervention services to the community for youth, regardless of insurance. Short term crisis case management (1-3 months) will also be available for youth and families without Medicaid whom have experienced a crisis in order to aid them in accessing other appropriate services available in the community once the crisis has stabilized. Portsmouth Behavioral Healthcare has been able to partner with public and private providers to insure that services are continuous and there is a collaborative, ongoing response to provide services to youth in the City of Portsmouth.

Services will be provided based on client need, which includes evening, weekend, and holidays whenever necessary. An additional pool of existing staff will be trained in crisis service provision and be available for extended service coverage as needed. Overnight crisis evaluation will be provided by existing Emergency Services workers, with next day access to community-based crisis services funded through this proposal. Portsmouth will utilize community psychiatric providers as well at the Hampton Newport News Urgent Care Center to assist with medication stabilization as needed.

Services will be delivered via collaborative team effort. Portsmouth will utilize Target Case Management, Intensive Care Coordination (High Fidelity Wraparound) and community providers to ensure that youth’s immediate and ongoing needs are met. The program will be supervised by the Clinical Manager with frequent staffing and collaboration.

To assist with ongoing stabilization, Mobile Crisis services will focus on developing natural family support. The program will use Family Team meetings to assist the family in determining natural supports, setting realistic and important goals, recognize and encourage the family's strengths, identify needs, and find solutions that build on the family's strengths.

Similar to Norfolk, Portsmouth Mobile Crisis will provide the following services:

- Mobile response
- Linkage to psychiatric assessment and medication management
- Consultation and collaboration with HPR-V mobile crisis teams
- Clinical assessment
- Individual and Family Counseling utilizing trauma informed and evidenced based practices.
- Family Team Meetings
- Behavioral management services
- Substance abuse screening
- Referrals to traditional and non-traditional services for any family with a child in crisis
- Autism outreach services
All of the proposed services are anticipated to be funded through a combination of billing to the clients’ existing insurance which will be accessed whenever possible and through use of the funding being currently requested. Mobile Crisis services at Portsmouth Behavior Healthcare would include accessing Medicaid funding for those youth who qualify for this coverage. Those with no insurance coverage for crisis services would still receive the same level of service as those with Medicaid through this funding. This allows flexibility in capturing revenue to supplement the money received through this proposal, and adds to the longevity of the service, allowing it to become more self-sustaining over time as increased billing is captured.

**Chesapeake Integrated Behavioral Healthcare (CIBH):**

The city of Chesapeake has a population of approximately 232,977. Approximately 30% of the residents are under the age of 18. 9.7% of these children are in households living below the poverty level. This indicates that approximately 28% percent of children receive Medicaid benefits. Medicaid is the only insurance that pays for crisis intervention services. Children who are not covered by Medicaid for crisis services equal 72% of the population. Currently, no youth community-based crisis intervention services exist in Chesapeake in either the public or private sector. This proposal would allow Chesapeake to contract to provide a continuum of youth crisis services to the entire population, regardless of insurance coverage. In order to build an effective continuum of crisis services for a city growing by 15% a year, funding for those not receiving Medicaid coverage is imperative.

Community-based crisis services also serve as a bridge between services when a crisis occurs. Indicated by the data referenced above, immediate access to mental health services is critical in reducing hospitalization. Outpatient psychiatric services in Chesapeake often have a wait list of up to 4-6 weeks. Intensive services such as Intensive In-home and EPSDT behavioral services that are available in the community are not able to immediately respond to a crisis due to insurance pre-authorization requirements. Families and youth in crisis cannot wait 2-4 weeks to access services. Crisis intervention services contracted by Chesapeake Integrated Behavioral Healthcare would be able to be immediately implemented, with the goal of same day access.

This proposal will allow for funding to reduce hospitalization by contracting with Western Tidewater CSB to provide a license eligible crisis staff, to respond and provide services to youth and families in need in the office, home and community within the City of Chesapeake. This would provide crisis intervention services to the community for youth without Medicaid, in addition to a similar availability of service for youth with Medicaid that would not require additional funding from this proposal. Short-term crisis case management (1-3 months) will also be available for youth and families without Medicaid whom have experienced a crisis in order to aid them in accessing other appropriate services available in the community once the crisis has stabilized. Finally, this will allow immediate access/intake assessments for uninsured youth in crisis to be provided. This would allow crisis psychiatric care to be available immediately to
youth and families in crisis who currently have no insurance coverage, offering them psychiatric access with no delay. Services will be provided based on client need, which includes evening, weekend, and holidays whenever necessary. An additional pool of existing staff will be available in collaboration with Western Tidewater Community Services Board for crisis service provision and be available for extended service coverage as needed. Overnight crisis evaluation will be provided by existing Emergency Services workers, with next day access to community-based crisis services funded through this proposal.

Emergency Services will continue to serve the City of Chesapeake community for crisis assistance 24/7 and support Crisis Mobilization Response when needed. Protocols are in place to receive and process urgent and emergent calls at any hour. Youth crisis staff funded through the mobile crisis funds will collaborate closely with our ES department in order to:

- Ensure the Youth Crisis Clinicians serves as the primary point of contact during day-time crisis calls for children/adolescents.
- Ensure that Emergency Services staff are aware of how to access the on-call youth crisis stabilization staff during business hours, after hours, on weekends and holidays.
- Serve as a consult for the Emergency Services staff that might have questions regarding youth services (both crisis and non-crisis) through the CIBH.
- Ensure that the Emergency Services protocols already in place continue to respond to crisis calls which come in when the Youth Crisis Clinician are not available.

Services will be delivered via collaborative effort with WTCSB as well as accessing CIBH services such as: Targeted Case Management, Intensive Care Coordination (High Fidelity Wraparound) and community providers to ensure that youth’s immediate and ongoing needs are met. The program will be supervised by the Licensed Program Supervisor with frequent staffing and collaboration.

To assist with ongoing stabilization, Mobile Crisis services will focus on developing natural family support. The program will use Family Team meetings to assist the family in determining natural supports, setting realistic and important goals, recognize and encourage the family's strengths, identify needs, and find solutions that build on the family's strengths. Similar to other regional Mobile Crisis the following services will be provided:

- Mobile response
- Linkage to psychiatric assessment and medication management
- Consultation and collaboration with HPR-V mobile crisis teams
- Clinical assessment
- Individual and Family Counseling utilizing trauma-informed and evidenced-based practices.
- Family Team Meetings
- Behavioral management services
• Substance abuse screening
• Referrals to traditional and non-traditional services for any family with a child in crisis
• Autism outreach services

All of the above services are anticipated to be funded through a combination of billing to the clients’ existing insurance which will be accessed whenever possible and through use of the funding being currently requested. The proposed youth crisis continuum of care in Chesapeake would include accessing Medicaid funding for those youth who qualify for this coverage. Those with no insurance coverage for crisis services would still receive the same level of service as those with Medicaid through this funding. This allows flexibility in capturing revenue to supplement the money received through this proposal. This adds to the longevity of the service, allowing it to become more self-sustaining over time as increased billing is captured.

Colonial Behavioral Health:

Since 1971, Colonial Behavioral Health (CBH) has served as the public mental health, substance use disorder and intellectual disability service provider for the localities of James City County, the City of Poquoson, the City of Williamsburg and York County. Since 2006, CBH has been enhancing Children Services in order to provide a continuum of care that includes Prevention Services, Outpatient Services, Intensive In-Home Services, Adolescent Substance Use Disorder Services, Case Management Services, and the Greater Williamsburg Assessment Center. Of the 40 CSBs statewide, Colonial Behavioral Health ranks 13th in providing the 37 services defined in the comprehensive service array, and provides 50 percent of the “base” set of services. One critical service need that remains for children and adolescents in CBH’s and the entire HPR-V service area is crisis response services.

Currently all crisis services are handled through CBH’s Emergency Services Department. In FY10, Emergency Services documented 177 face-to-face assessments for children and adolescents. This data does not take into account the number of crisis-related telephone calls or the number of episodes diverted to Children’s Services - Outpatient Services. Since 2006, Emergency Services has experienced a 117% increase in the volume of face-to-face screenings it provides; while the number of Temporary Detention Orders has seen an increase of 50 percent during that same time. Over the past three years, CBH’s hospitalization rate for children and adolescents has increased from 19 percent to 25 percent.

CBH Children's Mobile Intervention Team’s (CMIT) is currently composed of one FTE. CBH CMIT and Emergency Services provided services to 236 children/adolescents in FY 14, and to 442 children/adolescents in FY 15.
Funding provided through this proposal will allow the hiring of a second Full Time CMIT counselor to be able to provide services to the population served by CBH that would normally not have insurance coverage for these services. In addition, a PRN pool will be established to provide after-hours, weekend, and holiday coverage as needed. These positions will provide assessment and crisis counseling services to children and serve as back-up for after hour and weekend coverage with the goal of preventing hospitalization or re-hospitalization. These positions will be master’s level and/or licensed clinicians. Through partnership with existing Emergency Services, the CMIT program will be run seven days a week, 24 hours/365 days and will provide a rapid response to children and their families in their homes, schools, hospitals, and shelters. CMIT services will link and collaborate with CBH-Emergency, Children and Medical Services Departments. The team will be able to improve access to services including psychiatric crisis consult, and provide short-term crisis intervention including counseling to stabilize the child and avert hospitalization or residential placement.

The CMIT program provides the following services:

- Mobile response
- Psychiatric assessment
- Medication consultation
- Short-term medication management
- Clinical assessment
- Behavioral management services
- Hospital discharge planning
- Referrals to traditional and non-traditional services for any family with a child in crisis

CBH Children's Mobile Intervention Team’s (CMIT) mission is to provide early intervention and stabilization services to children age 0-17 years old in order to prevent hospital and/or residential placement. The goal would be to treat the child within their home community. The team will respond to crisis situations and deliver a range of services to children, their families and caregivers, including children residing in adoptive and foster care homes. The CMIT will facilitate triage into a supervised treatment setting for children who may require a higher level of care.

For children who are currently involved in clinical treatment, the team will first assess the capability of that clinical service to handle the intervention. The CMIT team is responsible for assuring that the child and family receive appropriate care during the crisis period.

The Children Mobile Intervention Team assures a full continuum of emergency crisis services to the children and families of our community. The team provides face-to-face crisis intervention
in community settings and/or in office setting, provides in home crisis stabilization, and assists in
developing supports and crisis plans to avert future crises from recurring.

The Children Mobile Intervention Team will develop a partnership and collaborate with Western
Tidewater CSB to address crisis interventions with ID/DD children and adolescents.

**Middle Peninsula Northern Neck CSB:**

With the current funding that Middle Peninsula Northern Neck Community Services Board (MPNN) currently receives through the existing HPRV funding, a dedicated Child/Adolescent Crisis therapist provides same day access to community-based crisis services in one central location. Services are provided to both Medicaid recipients and non-Medicaid alike. In addition, an On-Call pool is funded to ensure after-hours, weekend and holiday coverage as needed. Crisis workers are therefore able to provide same-day access for crisis assessments and crisis intervention; initiate crisis stabilization when necessary, and keep cases up to one month or until the child/adolescent is connected to an appropriate level of service within the continuum available in the community to manage his or her needs. In addition, this funding allows for the provision of Intensive Care Coordination (ICC) for up to one month for youth in crisis. ICC is a service at this time that is funded only through the Office of Comprehensive Services through approval by the local Family Assessment and Planning Team (FAPT). Unfortunately, there is often a delay of several weeks in obtaining FAPT approval and funding, making it difficult to access for youth and families in crisis. Utilizing this funding, ICC is able to be provided to youth who are Medicaid funded, privately insured, and uninsured immediately at the time of crisis. ICC provides up to 5 hours per week of in-home support and coordinates the services in the community necessary to prevent hospitalization and/or out of home placement. If ICC is needed for more than one month, the Intensive Care Coordinator has time during the initial month of service provision to assist the family in navigating the FAPT process to access continued funding.

This new funding proposal would allow for MPNN to hire a second full time licensed or licenseeligible clinician to provide same-day access to crisis intervention five days a week. With the addition of a second crisis worker, one would be based in the southern part of the MPNN catchment area to serve the lower five counties, and the other would be based in our Warsaw Clinic and serve the upper five counties. These clinicians would also serve as the lead clinician and coordinate all of the staff providing direct crisis stabilization (on-call for telephone consult 24/7). In addition, the overnight and weekend stipends to secure on-call crisis stabilization staff would be able to double in capacity; one roster to cover the lower five counties, and one roster to cover the upper five counties.

The 2 FTE Crisis Clinicians will be cross trained regarding issues and challenges related to responding effectively to the needs of ID/DD individuals in crisis. Our program currently already
serves individuals who have a mild or moderate ID/DD diagnosis when MH issues are primary. There will be ongoing collaboration with the regional ID/DD youth crisis project, with both teams potentially being able to offer support on a case by case basis.

Emergency Services remains a portal well-known to the MPNN community for crisis assistance. They also have mechanisms in place to receive and process calls at any hour. Youth crisis staff funded through the mobile crisis money collaborate closely with our ES department in order to:

- Make sure the Youth Crisis Clinicians serve as the primary point of contact during daytime calls for children/adolescents.
- Assure that Emergency Services staff are aware of how to access the on-call youth crisis stabilization staff after hours and on weekends.
- Serve as a consult for the Emergency Services staff whom might have questions regarding youth services (both crisis and non-crisis) through the CSB.
- Assure that the Emergency Services mechanisms already in place continue to catch crisis calls which come in when the Youth Crisis Counselors are not available.

**Virginia Beach Department of Human Services:**

Virginia Beach Department of Human Services serves the largest population catchment area in HPRV, with the City of Virginia Beach having a population of 450,980. The City of Virginia Beach covers a geographic area of 250 square miles, with a population density of 1,759 people per square mile. Fewer than 10% of the city’s population had Medicaid benefits when researched in 2013. In order to build an effective continuum of crisis services in a heavily populated area such as Virginia Beach, funding for those not receiving Medicaid coverage is imperative.

Community-based crisis services serve as a bridge between services when a crisis occurs. As indicated by the research mentioned previously, immediate access to mental health services is critical in reducing hospitalization. Outpatient therapy in Virginia Beach often has a waitlist of up to 4 weeks. More intensive services that are available in the community are not able to immediately respond to a crisis due to insurance pre-authorization requirements. For example, in order to access intensive in-home services (a service that is available via private providers to youth in the city whom have Medicaid coverage), youth are required to first have an independent assessment that shows there is a qualifying need for the service before being referred and scheduled for an assessment with a private provider. This process often takes up to two weeks or more to complete. Crisis intervention services provided by the Virginia Beach CSB are able to be immediately implemented, with the goal of same day access.

Currently, two crisis staff, whom are licensed or licensed-eligible and certified pre-screeners respond and provide crisis services to youth and families in need in the office, home and community within the City of Virginia Beach. In addition, crisis service workers are able to provide immediate access/intake assessments for youth in crisis as needed. This allows child
psychiatric care to often be available within one week to youth and families identified to be in crisis. For those children needing same day psychiatric evaluation, Virginia Beach crisis workers work collaboratively with the HNN CSB’s Behavioral Urgent Care Center to coordinate evaluation and follow up crisis care. This has produced very positive results to date. Crisis services are provided based on client need, which includes evening, weekend, and holidays whenever necessary. An additional pool of existing staff have been trained in crisis service provision and are available for additional service coverage during periods of high demand. Overnight crisis evaluation is provided by existing Emergency Services workers, with the goal of next day access to community-based crisis services as needed.

With the additional funding being requested in this proposal, Virginia Beach will be able to expand the current crisis services to better serve the large population of the city. An additional FT licensed or licensed-eligible staff member that is a certified prescreener would be added to the team, allowing same day access to crisis services as needed. This will allow more focus to be placed on ensuring a rapid response to new referrals for crisis services, with the goal of a two hour response being provided by crisis service staff during working hours. Emergency Services would continue to provide after-hours crisis coverage. Currently, due to the high volume of referrals and the necessary triaging of these individual’s needs, crisis assessments are on average offered within one business day. Expanding the staffing of this program would greatly improve the ability to rapidly respond to individuals’ needs as they are occurring.

All of the above services are anticipated to be funded through a combination of billing to the clients’ existing insurance which will be accessed whenever possible and through use of the funding being currently requested. The proposed youth crisis continuum in Virginia Beach would include accessing Medicaid funding for those youth who qualify for this coverage. Those with no insurance coverage for crisis services would still receive the same level of service as those with Medicaid through this funding. This allows flexibility in capturing revenue to supplement the money received through this proposal. This adds to the longevity of the service, allowing it to become more self-sustaining over time as increased billing is captured.

**Western Tidewater CSB:**

Western Tidewater is geographically composed of the cities of Franklin and Suffolk and the counties of Isle of Wight and Southampton. The four localities comprise 1,358 square miles, including Virginia’s largest geographic city, Suffolk (430 square miles). There is a total population in the service area of 139,277 individuals. During the last fiscal year, WTCSB provided mental health services to 1,195 children under the age of 18. A marked increase in demand has been observed for crisis intervention and assessment of students in the 4 local school districts has significantly increased demand on the Emergency Services department.
Currently, a FT Master’s level counselor with pre-screening certification has been added to the Screening, Intake and Care Coordination team of clinicians that currently operate with the WTCSB’s Child and Family Services department. Additionally, a PRN pool of counselors with similar capabilities to the full time clinician has been established to increase after hours and peak demand coverage availability. Functionally, this would enhance the team’s capability to effectively intervene in emerging crises and, as needed, to provide ready access to pre-admission screening services for the Southside area. These services are partially funded through the regional funding with additional costs offset through billing of appropriate services to the individual’s receiving services. This increases access to crisis intervention services within the southwestern portion of the Region and provides critically needed supports to an underserved, high traffic corridor.

As a mobile crisis response, the clinicians provide crisis intervention, short term crisis case management and service linkage to children’s psychiatry, ICC, Children’s targeted case management, and/or additional programming as appropriate. Under the purview of a supervising LCSW and Child Psychiatrist, crisis needs are effectively triaged in a clinically sound and rapid manner, thereby limiting delays in providing services through more traditional intake services. This rapid community based response modality results in decreased response time to individuals experiencing acute crises, a decrease in hospitalization and sub-acute care services, and ensures the delivery of appropriate community based supports to youngsters and their families at high risk of hospitalization and unnecessary removal from the home.

With the use of additional funding, Western Tidewater CSB will be able to expand current crisis services to their catchment area by offering an additional 60 hours per month of Crisis Intervention services to children without Medicaid, and 5 additional units of short term (1-3 months/child) crisis case management to assist families without Medicaid in linking to stabilization resources when need for assistance continues to be demonstrated, but they no longer meet Crisis Intervention or Crisis Stabilization medical necessity criteria.

**Regional Collaboration:**

Two localities within HPRV (Chesapeake Integrated Behavioral Healthcare and Eastern Shore CSB) under funding from this proposal will be able to contract with existing CSB youth mobile crisis teams in the region to ensure that all children within the region have access to timely, crisis services within a community setting. In addition, expansion of regional support from the planned Children’s ID/DD Regional Mobile Crisis Response Team will occur to offer services from this team to any locality within the region needing crisis services. Western Tidewater CSB, as the regional fiscal agent of the regional ID/DD crisis project, will be able to provide crisis services to children that currently are out of the scope of service of the targeted ID/DD population when a need occurs throughout the region. These services will be rendered as a regional back up to board specific mobile crisis services when the local crisis responders are at capacity or a crisis
occurs outside of their targeted service hours for mobile crisis responders. Additional funds will be provided to Western Tidewater CSB from this proposal to provide 30 hours per month of Crisis Intervention services to the entire region as needed.

In addition, to ensure regional collaboration and standardization across the Region V children’s crisis continuum of care, Western Tidewater CSB will offer the Region V Children’s ID/DD Crisis Navigator to provide clinical and procedural guidance to all DBHDS funded regional crisis programs. The Navigator will accommodate regional needs by hosting a quarterly meeting of all CSB Children’s Crisis providers and a variety of stakeholders to include representation from the MH, ID, and ES council. Additionally, the Navigator will be responsible for coordinating staff development efforts throughout the region by arranging for training to meet the needs of local providers and assisting MH Crisis responders with adhering to established training standards for the ID/DD Children’s Crisis Project. HPRV feels that this is the most effective way to maintain autonomy of local service needs while ensuring equal access to care throughout the Region’s geographically and economically diverse catchment area that includes varying rates of rural, urban, military, affluent, and impoverished populations. The Navigator is best suited for this collective clinical oversight based on their existing responsibilities to ensure 24/7/365 response within 2 hours throughout the region for their select population and their ability to re-direct staff to collaborate with existing crisis programs to meet the needs across the disability areas. The Region will provide this support “in kind” from The Navigator as funding is already supporting the position through the ID/DD Children’s Crisis Project and the task is consistent with the Navigator’s tasks of ensuring equal access to care, training opportunities, and promoting collaboration throughout the region.

All localities implementing mobile crisis services will maintain and report outcome statistics related to the utilization and effectiveness of the mobile crisis services. These statistics will be reported as required to the regional and state level. Utilization tracking will include the total number of youth served by locality per quarter. Effectiveness will be measured by tracking the percent of “successful discharges” from crisis services, which will be defined by a youth upon discharge being able to avoid hospitalization during crisis service provision and being maintained successfully in their home environment at the time of discharge.
## Budget:

<table>
<thead>
<tr>
<th>Category</th>
<th>Explanation</th>
<th>Amount</th>
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<tbody>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personnel, Colonial Behavioral Health (CBH):</strong></td>
<td>CMIT Crisis Counselor (1 FTE) for CBH in order to provide assessment and crisis counseling services to children; serve as back-up for after hour and weekend coverage. Position is master level, licensed or license-eligible. Annual personnel costs: Salary:  $51,000 Fringe benefits: $15,300</td>
<td>$66,300</td>
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<tr>
<td><strong>Miscellaneous Expenses for CBH Personnel</strong></td>
<td>Cost associated for computer ($1650), mileage reimbursement ($2,000), cell phone ($720), training of CMIT staff in required pre-screening, orientations and policy &amp; procedures at local hospital &amp; police stations, and other administrative costs ($2,000).</td>
<td>$4,370</td>
</tr>
<tr>
<td><strong>CMIT PRN Pool/Shift Differentiation Salary for CBH</strong></td>
<td>CMIT Crisis Counselor(s): (PRN or Shift Differentiation) Provides PRN coverage/shift differentiation due to holiday/weekend time and/or leave of CMIT Crisis Counselor as well as additional support for after hour assessment and crisis counseling services to children. Position is master level, licensed or license-eligible. ($4,330)</td>
<td>$4,330</td>
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<td><strong>Personnel, Portsmouth Behavioral Healthcare (PBH):</strong></td>
<td>Crisis Counselor (1 FTE) for PBH in order to provide assessment and crisis counseling services to youth; serve as back-up for after hour and weekend coverage. Position is licensed or licensed eligible pre-screener. Annual personnel costs: Salary: 55,775 Fringe benefits:  $13,422</td>
<td>$69,297</td>
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<td>Expense Type</td>
<td>Description</td>
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<tr>
<td>Miscellaneous Expenses for PBH Personnel</td>
<td>Computer: $1000; Phone: (52 month x 12 months) = $624; Training: $454; Mileage: $1000 at .555 per mile; PRN Coverage: 150 hours @ $17.50 = $2625</td>
<td>$5703</td>
</tr>
<tr>
<td>Personnel, Norfolk Community Services Board (NCSB):</td>
<td>Crisis Counselor (1 FTE) for NCSB in order to provide assessment and crisis counseling services to youth; Position is licensed or licensed eligible pre-screener. Annual personnel costs: Salary: $55,000 Fringe benefits: $12,390</td>
<td>$67,390</td>
</tr>
<tr>
<td>Miscellaneous Expenses for NCSB Personnel</td>
<td>Computer: $2200; Phone: (42 month x 12 months) = $508; Meetings and Training: $902; Transportation: $3500 (mileage $2500 at .565 per mile, $1,000 taxi for transport of families, if needed); Supplies: $500</td>
<td>$7,610</td>
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<tr>
<td>Personnel, Virginia Beach Department of Human Services (VBDHS):</td>
<td>Crisis Counselor (1 FTE) for VBDHS in order to provide assessment and crisis counseling services to youth; Position is licensed or licensed eligible pre-screener. Annual personnel costs: Salary: $55,000 Fringe benefits: $16,500</td>
<td>$71,500</td>
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<tr>
<td>Miscellaneous Expenses for VBDHS Personnel</td>
<td>Mileage: $3500 @ $0.56/mile</td>
<td>$3,500</td>
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<tr>
<td>Contracted Services, Chesapeake Integrated Behavioral Healthcare (CIBH)</td>
<td>$75,000 @ $74.44/hour for crisis intervention service &amp; $326.50 per unit of crisis case management service</td>
<td>$75,000</td>
</tr>
<tr>
<td>Contracted Services, Eastern Shore CSB (ESCSB)</td>
<td>$50,000 @ $74.44/hour for crisis intervention service &amp; $326.50 per unit of crisis case management service</td>
<td>$50,000</td>
</tr>
<tr>
<td>Personnel, Hampton-Newport News CSB (NCSB):</td>
<td>Therapist II Licensed (1 FTE) for HNNCSB in order to provide assessment and crisis intervention services to children; serve as back-up</td>
<td>$66,923</td>
</tr>
</tbody>
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for after hour and weekend coverage. Position is licensed, or license eligible or pre-screener. Annual personnel costs:
Salary: $52,282.65
Fringe benefits: $14,640.00

| Miscellaneous Expenses for HNNCSB Personnel | Cost associated for computer $1,800; mileage $825 @0.555/mile; cell phone $1,200 ($100/mo x 12 months); training of CMIT staff in required pre-screening $4000; other administrative costs $252 | $8,077 |
| Personnel, Middle Peninsula Northern Neck CSB | FT Therapist (Licensed or License-eligible) to serve upper five county region of catchment area: Annual personnel costs: Salary: 43,000 Fringe Benefits: 15,360 | $58,360 |
| Crisis intervention/Crisis stabilization On Call Stipend: Middle Peninsula Northern Neck CSB | On-call stipend to assure after-hours/weekend/holiday crisis intervention/crisis stabilization service delivery: $320/week x 52 weeks | $16,640 |
| Crisis Service Provision, Western Tidewater CSB | Crisis Intervention services: 60 hours/per month @ $74 hour = $53,280; Crisis Case Management: 5 units/month @$326.50 = $19,590 | $72,870 |
| Program Operating Costs, Western Tidewater | Mileage costs are estimated at $.55 per mile and 223 miles per month. Mobile Phone and Data costs for the additional staff are $55/month. | $2,130 |
| PRN Pool, Western Tidewater | 30 hours per month of Regional Coverage for Crisis Intervention at a rate $74 hour; Mileage costs are estimated at $.55 per mile and 150 miles per month. | $27,630 |
| Total Youth Mobile Crisis Team Regional Request | | $677,630 |
Implementation Timeline.

HPRV anticipates that all programs listed above will be able to either begin immediately upon receipt of funding, or within a 90 day time frame due to recruitment and hiring of new positions.

References:


Attachment A

Proposed Memorandum of Agreement

Parties: The Parties to this agreement are Chesapeake Integrated Behavioral Health and Western Tidewater Community Services Board.

Chesapeake Integrated Behavioral Health,  Western Tidewater Community Services Board
224 Great Bridge Blvd.  5268 Godwin Blvd.
Chesapeake, VA 23320  Suffolk, VA 23434

Term: This agreement shall be in effect for a period of 12 months commencing on July 1, 2015 and ending on June 30, 2016.

Purpose: Chesapeake Integrated Behavioral Healthcare (CIBH) has interest in providing access to Mobile Crisis Services to children in the City of Chesapeake. CIBH has been provided funding for one (1) full time equivalent employee by The Department of Behavioral Health and Developmental Disabilities to deliver Crisis Services. The volume child and adolescent crisis care needs in The City of Chesapeake exceed the volume of care that can be provided by one (1) full time equivalent employee. Western Tidewater Community Services Board (WTCSB) has existing child crisis services that are able to provide a higher volume of care as well as extended service hours.

Population to be Served: Children and Adolescents up to the age of 18 experiencing acute behavioral health crisis in the City of Chesapeake

Geographic Service Area: The City of Chesapeake, Virginia

The parties understand and agree to perform the following roles and activities throughout the term of this agreement:

Chesapeake Integrated Behavioral Healthcare Agrees To:

1. Provide Payment of $75,000 each fiscal year as received through warrants furnished by the Department of Behavioral Health and Developmental Services Children’s Mental Health Crisis Funding.

2. Provide information regarding the WTCSB Children’s Mobile Crisis Program and make referrals to WTCSB for children and adolescents up to age 18 experiencing acute behavioral health crises.

3. Ensure that clients requesting services at WTCSB sign the Authorization for Disclosing and/or Requesting Health Information form and fully understand what information will be shared to coordinate care.

4. Coordinate intake to long term services with CIBH as needed to support individuals qualifying for such services in order to remain stable in the community.

5. Meet, at minimum, quarterly with WTCSB to discuss the efficacy of the partnership and address any issues that may have arisen in relation to the delivery of services to the clients.
6. Abide by all applicable confidentiality standards, ensuring that information is only shared with a signed client consent for coordination of care except in the instance of mandated reporting of homicidal or suicidal ideation to the appropriate authorities.

**WTCSB Agrees to:**
1. Recruit, hire, and train mobile crisis staff available to respond to children and adolescents up to age 18 in the City of Chesapeake between the hours of 8:00AM and 10:00PM Monday through Sunday.
2. As appropriate, link any child and adolescent meeting the medical necessity criteria for ongoing behavioral health services to the CIBH Access Department.
3. Provide the following documentation to CIBH:
   a. Consent to Release Information to CIBH
   b. Crisis Assessment
   c. Crisis Plan
4. Meet, at minimum, quarterly with CIBH to discuss the efficacy of the partnership and address any issues that may have arisen in relation to the delivery of services to the clients.
5. Abide by all applicable confidentiality standards, ensuring that information is only shared with a signed client consent for coordination of care except in the instance of mandated reporting of homicidal or suicidal ideation to the appropriate authorities.

Both parties agree this Agreement may be terminated at any time with written notice. If the parties agree to terminate this Agreement, all efforts will be made to ensure continuity of service for the clients.

This agreement will be valid for a period twelve (12) months from the date of execution. At that time, the parties will assess the partnership and determine if any changes need to be made to the Agreement.

Both parties agree to share any and all data or information required by funders, within the boundaries and limits of confidentiality and only with the proper written consent in the client’s file.

Both parties agree to maintain appropriate insurance during the term of this Agreement.

All changes to this Memorandum of Agreement must be reduced to writing and agreed to by both parties.

In witness whereof, the Parties hereto have executed this MOU as of the day and year written below.

**Chesapeake Integrated Behavioral Health**
Signature: ________________________________
Date: ________________________________
Printed Name and Title: ________________________________
Western Tidewater Community Services Board
Signature: ______________________________
Date: _________________________________
Printed Name and Title: ___________________