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**5122-29-14 Mobile response and stabilization service.**

(A) Mobile response and stabilization service (MRSS) is a structured intervention and support service provided by a mobile response and stabilization service team that is designed to promptly address a crisis situation; with young people who are experiencing emotional symptoms, behaviors, or traumatic circumstances that have compromised or impacted their ability to function within their family, living situation, school, or community.

(B) MRSS is provided to people who are under the age of twenty-one.

(C) The initial mobile response occurs within sixty minutes, with a de-escalation period up to seventy-two hours and a stabilization period for up to six weeks.

If the initital mobile response is requested to occur longer than sixty minutes from point of contact, the dispatcher will provide the MRSS team with the requested contact time. The de-esclation period begins when the initial mobile response occurs.

~~(B)~~ (D) In order to be certified for the MRSS service, a community mental health services or addiction services provider must also hold and maintain certification from the Ohio Department of Mental Health and Addiction Services (OhioMHAS) for all the following:

(1) General services as defined in rule 5122-29-03 of the Ohio Administrative Code.

(2) SUD case management services as defined in rule 5122-29-13 of the Ohio Administrative Code.

(3) Peer recovery services as defined in rule 5122-29-15 of the Ohio Administrative Code.

(4) Community psychiatric supportive treatment as defined in rule 5122-29-17 of the Ohio Administrative Code.

(5) Therapeutic behavioral services and psychosocial rehabilitation as defined in rule 5122-29-18 of the Ohio Administrative Code.

~~(C)~~ (E) The community mental health services or addiction services provider must be able to provide all allowable services by telehealth as defined in rule 5122-29-31 of the Ohio Administrative Code.

~~(D)~~ (F) Definitions:

(1) Crisis means a situation defined by the person or their family that is causing stress or discordance to the person or their family or the community.

(2) Family means any individual or caregiver related by blood or affinity whose close association with the person is the equivalent of a family relationship as identified by the person including kinship and foster care.

(3) Young person means a child, youth or young adult under the age of twenty-one.

~~(E)~~ (G) MRSS team staff.

(1) A MRSS team must consist of at least:

(a) A clinician identified in rule 5122-29-30 of the Ohio Administrative Code who can either

independently diagnose behavioral health disorders or who can diagnose behavioral health disorders under supervision and who holds a valid and unrestricted certification or license, or a practitioner who is a bachelor level clinician working under the supervision of an independently licensed individual who can independently diagnose. A qualified behavioral health specialist (QBHS) as defined in rule 5122-29-30 of the Administrative Code does not meet the requirement of this paragraph. This provider must also demonstrate and maintain competency in the under twenty-one years of age population; and

(b) One of the following:

(i) A peer recovery supporter who holds a valid and unrestricted certification from OhioMHAS issued in accordance with rule 5122-29-15.1 of the Ohio Administrative Code. After November 1, 2021 the peer recovery supporter must be a parent peer or young adult peer in accordance with rules 5122-29-15.1 and 5122-29-15.2 of the Administrative Code. Peer recovery supporter will also demonstrate competency in the care and services of individuals in the under twenty-one years of age population and has scope of practice for persons age twenty-one and under with mental health disorders and substance use disorders.

(ii) A QBHS as defined in rule 5122-29-30 of the Administrative Code. This QBHS must also demonstrate competency in the care and services of individuals in the under twenty-one years of age population and has scope of practice for persons age twenty-one and under with mental health disorders and substance use disorders.

(c) (2) The MRSS team must have ready access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes as needed, and this person is not necessarily a member of the MRSS team. The psychiatrist or certified nurse practitioner or clinical nurse specialist must hold a valid and unrestricted license to practice in Ohio. The psychiatrist or certified nurse practitioner or clinical nurse specialist must also demonstrate competency in the under twenty-one years of age population.

~~(F)~~ (H) Providers must provide MRSS in accordance with the OhioMHAS "Practice Standards for Mobile Response and Stabilization Services" in effect at the time certification is requested and achieve and maintain fidelity as determined by OhioMHAS for the duration of the certification period on the OhioMHAS MRSS Fidelity Scale.

~~(G)~~ (I) Providers of MRSS must assure the service meets the following:

(1) Available twenty-four hours a day, seven days a week.

(2) Provided on a mobile basis. MRSS is provided where the young person is experiencing the crisis or where the family requests services, not at a static location where the person must present themselves.

(3) The initial mobile response occurs within sixty minutes where the young person is experiencing the crisis.

(4) Provided by eligible providers and supervisors identified in rule 5122-29-30 of the Ohio Administrative Code and paraprofessionals as defined in this rule.

~~(H)~~ (J) MRSS provides immediate de-escalation, delivers rapid community-based assessment, and stabilization services to help the young person remain in their home and community. MRSS consists of three activities: screening/triage, mobile response, and stabilization. Some young people may not require all three MRSS activities but are still considered MRSS participants.

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MRSS must be initiated through screening/triage and progress in the order listed in this paragraph.

(1) Screening/Triage

The MRSS service may be initiated through direct connection with the MRSS provider. When the service is initiated through direct connection with the provider:

(a) An initial triage screening is done to gather information on the crisis or crises, identify the parties involved, and determine an appropriate response or responses. The initial triage screening is performed remotely, usually by telephone.

~~(c)~~ (b) All calls with a young person or family in crisis where 911 is not indicated, are responded to with a mobile response.

~~(d)~~ (c) If a young person or family is already involved with an intensive home-based service (i.e. IHBT, wraparound) the mobile response team is dispatched to de-escalate the presenting crisis. Once the family is stabilized, the family is re-connected with the existing service.

(2) Mobile Response

(a) The mobile response team will mobilize to arrive at the location of the crisis or a location specified by the young person or family within the required response time, as determined by the end of the triage assessment. If the initial response is done by a single team member, that team member must meet the requirements of paragraph (G)(1)(a) of this rule.

(b) The MRSS mobile response team will provide de-esclation services for up to seventy-two hours until the young person and family are stable including:

(i) An urgent evaluation of the following elements for de-escalation: Understanding what happened to initiate the crisis and the young person’s and their family’s response or responses to it; risk assessment of lethality, propensity for violence, and medical/physical condition including alcohol or drug use, mental status, and information about the young person’s and family's strengths, coping skills, and social support network.

(ii) Crisis counseling and intervention with the young person or family.

(iii) Solution-focused therapeutic response including teaching of coping and behavior management skills, mediation, parent support and psychoeducation.

(iv) Care coordination including coordination with primary care physician, coordination with other care coordination programs as applicable, coordination with existing behavioral health providers, referrals, linkages to services and natural supports.

(v) Telephonic psychiatric consultation initiated when indicated.

~~(c)~~ (vi) Complete the MRSS Intake tool.

~~(d)~~ (vii) Administer the Ohio Brief Child and Adolescent Needs and Strengths (CANS) tool including an assessment of young person and community safety, caregiver capability, and clinical risk, social and natural supports. This must be performed by a provider who is a qualified CANS assessor.

~~(e)~~ (viii) Consult with the young person or family to define goals for preventing future crisis and the need for ongoing stabilization.

~~(f)~~ (ix) Develop or update an individualized MRSS plan, including safety precautions.

(3) Stabilization

(a) Stabilization services are provided by the MRSS team as documented in the individualized MRSS plan. The six weeks of stabilization services immediately follows the 72 hours of mobile response.

(b) Continued monitoring, coordination, and implementation of the individualized MRSS plan.

(c) The MRSS team provides stabilization services that are defined in the individualized MRSS plan to achieve goals as articulated by the young person or family. Stabilization services are to build skills of the young person and family, to strengthen capacity to prevent future crisis, facilitate an ongoing safe environment, link the young person and family to natural and culturally relevant supports and build or facilitate building the young person and family's resilience. Stabilization activities include but are not limited to:

(i) Psychoeducation: Young person or family individual coping skills; behavior management skills, problem solving and effective communication skills;

(ii) Referral for psychiatric consultation and medication management if indicated;

(iii) Advocacy and networking by the provider to establish linkages and referrals to appropriate community-based services and natural supports;

(iv) Coordination of services to address the needs of the young person or family.

(d) Linkage to the natural and clinical supports and services to maintain engagement and sustain the young person's or their family's stabilization post MRSS involvement.

(e) Convene or participate in planning meeting(s) with the young person, family, and cross system partners for the purpose of developing and coordinating linkages to ongoing services and supports when family need indicates.

(f) Service Transition

(i) The MRSS team and the young person or their family will work on moving from stabilization to ongoing support through identified supports, resources, and services, which are consistent with their unique needs and documented in the individualized MRSS plan.

(ii) With the young person's or family's permission, the MRSS team will share the most recent individualized MRSS plan and supporting information with other service providers in person, including by video or telephone, and with the young person or family present when possible.

(iii) Review with the young person or their family newly formed coping skills and how future crisis can be managed; emphasizing the role of the young person and the family.

(iv) Prepare and finalize a transition plan with the young person and their family. The transition plan must include the most recent version of the individualized MRSS plan with safety precautions.

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**5122-29-28 Intensive home based treatment (IHBT) service.**

(A) In addition to the definitions in rule 5122-24-01 of the Administrative Code, the following definitions apply to this rule:

(1) "Caseload" means the individual cases open or assigned to each full-time equivalent IHBT staff.

(2) "Continued stay review" means a review of a child/adolescent's functioning to determine the need for further services to achieve or maintain service goals and objectives.

(3) "Crisis response" means the immediate access and availability, ~~by phone and face-to-face,~~ as clinically indicated, to the child/adolescent and family, which may include crisis stabilization services in accordance with rule 5122-29-10 of the administrative code, safety planning, and the alleviation of the presenting crisis.

(4) ~~(4) "Face-to-face contacts" means in-person IHBT provided in the home, school, and community working directly with the person served and his or her family, or on the child/adolescent 's behalf.~~

(5) (4) “Family” means any individual or caregiver related by blood or affinity whose close association with the person is the equivalent of a family relationship as identified by the person; including kinship and foster care.

(5) "Home" means any ~~long-term~~ family living arrangement including but not limited to biological, kinship, adoptive, foster home, and non-custodial families who have made a ~~long-term~~ commitment to the child/adolescent.

(6) "Out-of-home placement" means any removal of the child/adolescent from his or her home. Planned respite, where the child's main residence remains his or her home, is not considered out-of-home placement.

(B) Intensive home based treatment (IHBT) service is a comprehensive behavioral health service provided to a child/adolescent ~~and his or her family that provides coordination and support for persons with serious emotional disturbance for a person enrolled in the service and integrates~~with serious emotional disturbance (SED) and their family for the purpose of preventing out of home placement or facilitating a successful transition back home. IHBT integrates trauma-informed and resilience-focused assessment, crisis response, individual and family psychotherapy, service and resource coordination, and rehabilitative skill development with the goal of either preventing the out-of-home placement or facilitating a successful transition back to home. These intensive, time-limited behavioral health services are provided in the child/adolescent's natural environment with the purpose of stabilizing and improving ~~his/her~~ their behavioral health functioning as documented using the Ohio specific child and adolescent needs and strengths (CANS) tool.

The purpose of IHBT is to enable a child/adolescent with ~~serious emotional disturbance (SED)~~ SED to function successfully in the least restrictive, most normative environment. IHBT services are culturally, ethnically, racially, developmentally and linguistically appropriate, and respect and build on the strengths of the child/adolescent and family's race, culture, and ethnicity.

(C) The following describes the activities and components of IHBT:

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(1) IHBT is an intensive service that consists of multiple in person ~~face-to-face~~ contacts per week with the child/adolescent and family, which includes collateral contacts related to the behavioral health needs of the child/adolescent as documented in the individual client record (ICR) as required by Chapter 5122-27 of the Administrative Code~~ICR~~. IHBT can be provided via telehealth in accordance with rule 5122-29-31 of the Administrative Code. ~~The frequency of contacts may fluctuate based on the assessed needs and unique circumstances of the child, adolescent, and family.~~

(2) IHBT is provided in the home, school, and community where the child/adolescent lives and functions;

(3) The frequency and modality of contacts may fluctuate based on the assessed needs and unique circumstances of the child, adolescent, and family.

~~(2)~~ (4) IHBT is strength-based and family-driven, with both the child/adolescent and family regarded as equal partners with the IHBT staff in all aspects of developing the service plan and service delivery;

~~(3)~~ (3) ~~IHBT is provided in the home, school, and community where the child/adolescent lives and functions;~~

~~(4)~~ (5) Provided by staff with a caseload that averages over any six month period and per full time equivalent staff:

(a) ~~Fourteen~~ Twelve or less when provided by a team of two, or

(b) ~~Seven~~ Six or less when provided by an individual staff;

~~(5)~~ (6) ~~Crisis response is available twenty-four hours a day, seven days a week.~~ Immediate crisis response is available twenty-four hours a day seven days a week by the lead IHBT team member with back-up coverage available from other IHBT team members or the IHBT team supervisor. ~~Crisis response, at a minimum, may be provided by the provider's on-call system after business hours and weekends, as long as at least one IHBT staff is accessible to the on-call staff, and is available to the client and family as needed;~~

~~(6)~~ (7) Each child/adolescent and family receiving IHBT is assessed for risk and safety issues. ~~When clinically indicated, a~~A jointly written crisis and safety plan shall be developed that is provided to the child/adolescent and family;

~~(7)~~ (8) Collaboration ~~occurs~~ is required to be performed with other child-serving agencies or systems, e.g., school, court, developmental disabilities, ~~job and family services~~child welfare, and health care providers that are providing services to the child/adolescent and family, as well as family and community supports identified by the child/adolescent and family;

~~(8)~~ (9) The service activities and components are ~~is flexible and~~ individually tailored to meet the needs of the child/adolescent and family. Appointments are made at a time that is convenient to the child/adolescent and family, including evenings and weekends if necessary;

~~(9)~~ (10) The service is time-limited, with length of stay matched to the presenting ~~mental~~ behavioral health needs of the child/adolescent and the family~~.~~ ~~IHBT certified providers must have clearly written~~

guidelines for granting extensions and procedures for continued stay of each individual. A continued stay review must be documented for each child/adolescent receiving IHBT beyond six months, and every forty-five days thereafter. The continued stay review must include the criteria in paragraph (F) of this rule; and; and,

(10) (11) The IHBT team will collaboratively develop a plan to transition with each youth and family. The plan will include a focus on transition to other services, supports and providers for services and supports based on the individualized needs of the youth and family.

(10) (10) The child/adolescent and family's IHBT aftercare service needs are addressed. Continuing care planning shall be collaborative between the child/adolescent, family and IHBT staff.

(D) (D) Practitioner(s) on an IHBT team that provides services to a youth with a co-occurring substance use disorder shall have appropriate credentials from the state licensing board(s) to provide both mental health and substance use treatment.

(E) (D) The provider shall determine who is eligible to receive the service and must document how the child/adolescent meets the following criteria necessary to receive IHBT services:Eligibility for IHBT will be determined by the IHBT team in collaboration with the youth and family and other cross systems partners by documenting the following criteria:

(1) Is clinically determined to meet the "person with serious emotional disturbance" (SED) criteria in rule 5122-24-01 of the Administrative Code and the child/adolescent;

(a) Is under twenty-one years of age;

(b) Has an Ohio specific CANS assessment that indicates:

(i) Marked to severe behavioral/emotional impairment; and

(ii) Impairment that seriously disrupts family or interpersonal functioning; and,

(d) (c) Would benefit from the services of another youth-serving system (e.g., education, child protective services, juvenile court, health, intellectual disabilities, youth services, and others).

(2) Meets one or more of the following criteria as documented in the ICR:

(a) Is at risk for out-of-home placement due to his/her their behavioral health/mental health conditions;

(b) Has returned within the previous thirty days from an out-of-home placement or is transitioning back to their home within thirty days; or

(c) Requires a high intensity of mental behavioral health interventions to safely remain in or return home; and,

(3) (3) IHBT may also be provided to transitional age youth between the ages of eighteen and twenty-one who have had an onset of serious emotional and mental disorders at an age younger than eighteen.

(F) (E) The community mental health services or addiction services provider must demonstrate that the following

staff requirements and qualifications are met:

(1) A minimum of two full-time equivalent staff provide the service. Services may be provided by a single person, or team of staff clearly sharing various responsibilities for the same child/adolescent and family. Each child/adolescent shall have a staff assigned with lead responsibility. ~~IHBT direct care staff must be fully dedicated to the IHBT program and cannot have mixed service caseloads.~~

(2) The provider must have a documented plan for clinical supervision of each team member.~~, which includes:~~

(a) ~~(a) The IHBT supervisor shall have a designated responsibility to IHBT;~~

(b) ~~(b) Each staff person shall receive clinical supervision that is appropriate for the staff person's expertise and caseload complexity; and~~

(c) ~~(c) Consideration of the staff person's assessed training needs.~~

(3) The IHBT supervisor shall have primary responsibility for providing supervision to the IHBT staff twenty-four hours a day, seven days a week. If the IHBT supervisor is unavailable, then supervision must be provided by staff qualified according to rule 5122-29-30 of the Administrative Code.

~~(G)~~ (F) The provider must demonstrate that each IHBT staff has an individualized training plan based on an assessment of his/her specific training needs. The following professional training and development criteria must be met:

(1) Each staff receives an assessment of initial training needs based on the skills and competencies necessary to provide IHBT service prior to providing IHBT service; and

(2) The agency shall have a written description of the skills and competencies required to provide IHBT service, which include, at a minimum, the following:

(a) Family systems;

(b) Risk assessment, ~~and~~ crisis stabilization, and safety planning;

(c) Parenting skills and supports for children/adolescents with SED;

(d) Cultural competency;

(e) Intersystem collaboration with a focus on schools, courts, and child welfare:

(i) Knowledge of other systems;

(ii) System advocacy; and

(iii) Roles, responsibilities, and mandates of other child/adolescent-serving entities;

(f) Trauma-informed and resiliency-focused care;

(g) Educational and vocational functioning:

(i) Assessment and intervention strategies for resolving barriers to successful educational and

vocational functioning;

(ii) Knowledge of special education laws; and

(iii) Strategies for developing positive home-school partnerships and connections;

(h) IHBT philosophy, including strength-based assessment and treatment planning; and

(i) Differential diagnosis with special needs children/adolescents, including co-occurring substance use disorders and developmental disabilities, for staff credentialed to diagnose.

(H) (G) The provider's training plan must include provisions for ongoing training specific to the identified training needs of the staff as it relates to the population served, including attention to cultural competency, changing demographics, new knowledge or research, and other areas identified by the agency.

(I) (H) The provider must demonstrate that each IHBT supervisor receives training specific to the clinical and administrative supervision of the service.

(J) (I) ~~The provider shall obtain at least one fidelity review of the provider's entire IHBT service~~ The provider shall obtain satisfactory fidelity reviews based on the provider's specific program modality every twelve months by an individual or organization external to the provider and designated by the Ohio department of mental health and addiction services (OhioMHAS), utilizing the IHBT fidelity rating tool (dated September 23, 2016) ~~avaialbe~~available at www.medicaid.ohio.gov. The provider shall incorporate the results of the fidelity review into the provider's performance improvement program, if indicated.

(K) (J) Intensive home based treatment service shall be ~~provided and~~ supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

(L) (K) IHBT shall be provided by at least one of the following:

(1) At least one licensed practitioner and at least one other licensed or license-eligible practitioner who is authorized to provide services pursuant to rule 5122-29-30 of the Administrative Code and who are providing an evidence-based practice approved by OhioMHAS and are licensed by a national accreditation body or their delegate. Each practitioner must have their own caseload of clients.

For those providers who are delivering functional family therapy, the services may be delivered by an individual who is licensed to provide services pursuant to rule 5122-29-30.;

(2) At least two or more licensed or licensed-eligible practitioners who are eligible to provide services pursuant to rule 5122-29-30 of the Administrative Code and who are providing an evidence-supported practice approved by OhioMHAS. Each practitioner must have their own caseload of clients.; or,

(3) At least two practitioners eligible to provide services pursuant to rule 5122-29-30 of the Administrative Code. One of the practitioners must be licensed and the other either a qualified behavioral health specialist as defined in rule 5122-29-30 of the Administrative Code or a certified peer recovery supporter as defined in rule 5122-29-15.1 of the Administrative Code. These practitioners must share a caseload of clients.