Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	STABILIZATION, ASSESSMENT, AND INTERVENTION FACILITY	POLICY 4.25

Authority:	Title 71A RCW	*Developmental Disabilities*
	Chapter 388-847 WAC	*Stabilization, assessment, and intervention facility*
	Chapter 388-825 WAC	*DDA Service Rules*
	WAC 388-845-1100	*What are stabilization services – crisis diversion bed?*
	WAC 246-840-930	*Nurse Delegation*
Reference:	DDA Policy 5.14	*Positive Behavior Support Principles*
	DDA Policy 5.15	*Restrictive Procedures: Community*
	DDA Policy 5.16	*Psychotropic Medications*
	DDA Policy 5.17	*Physical Intervention Techniques*
	DDA Policy 5.18	*Cross-System Crisis Plans*
	DDA Policy 5.21	*Functional Assessments and Positive Behavior Support Plans*
	DDA Policy 6.12	*Incident Management and Reporting Requirements for Residential Service Providers*
	DDA Policy 6.15	*Nurse Delegation Services*
	DDA Policy 6.19	*Residential Medication Management*

BACKGROUND

The Stabilization, Assessment, and Intervention Facility (SAIF) provides short-term residential habilitative supports focused on supporting a client to reach their goals safely by reducing the client's target behaviors. SAIF staff apply positive behavior support principles, de-escalation, and trauma-informed techniques as they work with clients to reduce the severity, frequency, and duration of identified target behaviors and to increase skills so that their goals can be met. SAIF will collaborate with the client's residential service provider in providing opportunities for them to learn these techniques and supports.

PURPOSE

This policy establishes eligibility, referral, admission, service delivery, discharge, and quality assurance requirements for SAIF.

SCOPE

This policy applies to SAIF employees and DDA field services and headquarters quality assurance staff.

DEFINITIONS

Acute care setting means a hospital, an evaluation and treatment facility, or a residential habilitation center.

Behavior support plan means a residential habilitation plan written by SAIF addressing target behaviors that do not meet the level of medical necessity as defined in WAC 182-500-0070, based on lack of diagnosis, or impact severity affecting a medical or behavioral health condition, for which the client receives professional treatment and is not eligible for state plan services. A behavior support plan is designed to:

- Strengthen or improve a client's existing adaptive behaviors and skills;
- Expand the client's existing adaptive behaviors and skills to new tasks or settings;
- Teach the client new adaptive behaviors and skills;
- Provide supports to the client;
- Modify, reduce, and eliminate situations in the environment known to reinforce, setup, or cause target behaviors; and
- Reduce or eliminate the use of target behaviors.

Cross-system crisis plan means a guide for service providers across systems of care to deliver a coordinated and collaborative response to a client experiencing, or at risk of experiencing, a crisis as defined in DDA Policy 5.18, *Cross-System Crisis Plans*. Examples of systems of care include Behavioral Health Organizations (BHOs), Managed Care Organization (MCOs), Accountable Communities of Health (ACHs), state hospitals, law enforcement, probation or parole staff, local behavioral health agencies, etc.

Individualized team means the group of people who work together to provide formal and informal supports to a client. A typical team includes the client, the client's family and legal representative, SAIF staff, the client's case resource manager, care coordinators, the client's residential service provider, and other community providers.

Information-gathering meeting means a meeting where SAIF staff review documents, ask questions, and request additional information to make an admission decision.

Legal representative means a parent of a client if the client is under age 18, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act for the client.

Point person means a designated person who can discuss the client's support needs in depth, current efforts being made to support the client, and the transition plan from SAIF to the community. This person should attend all Individualized team meetings and is responsible for any follow-up information SAIF requests. There should be an identified point person for the region, residential service provider, SAIF, and family.

Residential service provider means an entity that will support the client after discharge from SAIF, such as a supported living provider or a facility-based community residential service provider. This may also include the client's family home.

Target behavior means a specific, observable, and measurable behavior that requires modification or replacement. The client's individualized team identifies target behaviors.

Transition framework means the process to facilitate a client's timely and stable transition from one setting to another.

POLICY

A. ELIGIBILITY

A person is eligible for admission to SAIF if the person meets eligibility requirements under WAC 388-847-0030.

B. SERVICE DELIVERY

1. SAIF provides short-term, intensive, residential habilitative services by applying positive behavior support principles and techniques to decrease the client's target behaviors to reach up to three identified short-term goals.

2. SAIF teaches new skills to improve the client's quality of life through behavioral, social, and educational services.

3. SAIF addresses support needs for clients who are:

   a. Experiencing a crisis that risks disruption to their residential services; or

   b. Exhibiting persistent behaviors that prevent continued access to residential service providers.

4. SAIF must use behavioral tracking to assess the effectiveness of each intervention strategy used.

5. SAIF must collaborate with the individualized team to:

   a. Support the client to reduce target behaviors related to their goals so they can return to their home and be supported by their chosen residential service provider;

   b. Develop and implement a behavior support plan to address the client's short-term goals and desired outcomes; and

   c. Develop a transition plan that ensures techniques the client has learned are communicated to the individualized team.

6. SAIF must partner with the client's current community providers to ensure continuity of care between support plans and treatment plans by:

   a. Assisting the client in maintaining their community supports (e.g., employment, healthcare provider, school); and

   b. Coordinating with the client's care coordinator or fee-for-service behavioral health provider.

7. Stabilization services provided by SAIF are available for up to 90 consecutive days.

PROCEDURES

A. REFERRAL PROCESS PART 1 – Regional Case Managers

1. For a client to be considered for SAIF, the case resource manager (CRM) must:

a. Consult with the identified regional contact or designee, the client, and the client's legal representative on the appropriateness of a referral to SAIF; and

b. Confirm the client meets eligibility for admission criteria under WAC 388-847-0030.

2. If the client does not meet eligibility for admission criteria, the CRM must complete a planned action notice.

3. If the client meets eligibility for admission criteria, the CRM must:

a. Complete DSHS 13-936, *SAIF Eligibility and Referral*;

b. Collaborate with the client's support team to identify up to three target behaviors for stabilization and related goals;

c. Document in a service episode record (SER) that the residential service provider agrees to serve the client upon discharge from SAIF; and

d. Document in a SER whether the residential service provider agrees to collaborate and attend team meetings and observations with the client while at SAIF.

4. If the residential service provider does not agree to utilize SAIF, or support the client after discharge from SAIF, the client is not eligible for SAIF.

5. The CRM must include the following current and relevant documents in the referral application:

a. DSHS 13-936;

b. DSHS 14-012, *Consent*;

c. DSHS 10-574A, *Transition Preparation*;

d. Guardianship documents;

e. The client's current medication list;

f. An outline of the client's transition plan to residential service provider after discharging from SAIF;

g. The client's person-centered service plan and assessment details;

h. The client's risk assessment and quarterly community protection plan, if the client is participating in the community protection program; and

i. Other client-related documents, such as a functional assessment and positive behavior support plan, a cross-systems crisis plan, a risk assessment, incident reports, evaluations, hospital records, clinical notes, and rate assessment.

6. If the client is assigned to the transitional caseload, the transitional case manager must follow the procedures outlined in the Transition Framework Procedural Manual on supporting a client transitioning into and out of SAIF.

7. The CRM must send the referral to their supervisor or designee to review.

B. REFERRAL PROCESS PART 2 - Regional Approval

1. The supervisor or designee must review DSHS 13-936 and supporting documents for completeness and accuracy and then forward the referral to the Regional Administrator and the Regional Clinical Team (RCT) or designee.

2. The Regional Administrator or designee must review DSHS 13-936 and supporting documents for completeness and accuracy and then forward to the SAIF referral Inbox and RCT.

3. The Adult State-Operated Community Residential (SOCR) Program Manager must review DSHS 13-936 and supporting documents for completeness and accuracy and then forward to SAIF.

C. REFERRAL PROCESS PART 3 –SAIF review

1. When determining if a client will be admitted, the SAIF Program Administrator or designee must:

a. Review DSHS 13-936;

b. Review all supporting documents;

c. Schedule an information gathering meeting;

d. Discuss the client's support needs with the residential service provider and the legal guardian if the client has a legal guardian;

e. Meet the client virtually or in person;

f. Verify vacancy and staffing are available to meet the client's support needs; and

g. Contact the Adult SOCR Program Manager to communicate an admission decision or request additional information.

2. The SAIF Program Administrator or designee considers the following when determining whether to admit a client, and determining the order of admission (if multiple clients are being considered):

a. Individual client needs;

b. Program capacity; and

c. Whether the client poses a risk to the health or safety of SAIF staff and other clients supported by SAIF.

3. The CRM must invite all identified point persons on DSHS 10-574B, *Active Coordinator of Transition*, to any information gathering meetings related to the admission decision.

4. The SAIF Program Administrator or designee must notify the CRM and regional leadership of the SAIF admission decision.

5. No more than five days after receiving SAIF's decision, the DDA CRM must document the decision and date in a SER in CARE.

6. The Adult SOCR Program Manager must notify via email the CRM and provide direction related to the planned action notice and client's person-centered service plan before admission.

D. PRE-ADMISSION

SAIF must hold a pre-admission meeting, at least 10 days before admission, with the client, and the client's CRM, legal representative, and residential service provider to:

1. Identify primary contacts for communication, e.g., CRM, family, and Residential Service provider;

2. Ensure the client and legal representative sign a release of information before SAIF shares information with others;

3. Provide the expectations for the client and residential service provider's participation in the program;

4. Establish a plan for the residential service provider or medical provider to send a supply of the client's medication to SAIF;

5. Establish a plan for contact between the client and the client's family or legal representative (e.g., in-person or video chat);

6. Determine if the client requires nurse delegation;

7. Review the client's short-term goals and begin developing strategies to reduce target behaviors;

8. Review and inventory the client's personal items (e.g., clothes, shoes, sensory items, and hygiene items) and determine if additional items need to be requested;

9. Review the client's transition plan for exiting SAIF and receiving support from the residential service provider; and

10. Establish the client's admission and discharge date (these may change).

E. PLANNED ACTION NOTICE (PAN)

1. The CRM must send a services PAN:

   a. When stabilization services—crisis diversion bed are approved, denied, withdrawn, or terminated;

   b. If the client does not meet eligibility for stabilization services—crisis diversion bed; or

   c. When the client is discharged from SAIF.

2. If the client does not meet eligibility for admission criteria for SAIF, the CRM must work with the QCC Unit to send appropriate PAN.

3. The CRM must update the Temporary Residence Screen on date of admission.

F. PERSON-CENTERED SERVICE PLAN

The CRM or transitional case manager must add stabilization services – crisis diversion bed to the person-centered service plan when approved for the service.

G. CRM INVOLVEMENT

The CRM must collaborate on the transition process by:

1. Attending all individualized team meetings and using the Transition Framework Procedural Manual for all relevant transition steps and ensuring DSHS 10-574A is updated for any outstanding items not included in the initial referral packet.

2. Documenting the individualized team meeting in a SER.

3. Working with the client's residential service provider and SAIF to:

   a. Reinforce the importance of the residential service provider regularly observing the client while receiving services from SAIF;

   b. Follow up on recommendations identified by the individualized team before the client's discharge and ensure plans are updated accordingly; and

   c. Coordinate the client's transition to the residential service provider.

4. Recording in an SER a copy of the SAIF meeting notes and any documentation;

5. Updating the client's person-centered service plan, as needed;

6. Updating the DDA assessment in CARE, as needed;

7. Coordinating with the resource manager to identify any barriers to returning to the community or reducing target behaviors; and

8. Collaborating with the regional clinical team and individualized team to assist in developing the client's functional assessment, behavior support plan, and cross-systems crisis plan.

G. DISCHARGE PLANNING - SAIF

1. The SAIF team must review the discharge plan at all information gathering meetings and individual team meetings.

2. SAIF must inform the individualized team of any changes to the client's predicted discharge date. The client's discharge date may change depending on client's progress, but the client's admission must not exceed 90 days.

3. SAIF must provide opportunities for the residential service provider to participate in individualized team meetings, observe the client in the program, discuss effective environmental strategies, and collaborate on techniques for implementing the client's behavior support plan.

4. SAIF must provide a discharge report to the point people on date of discharge.

H. DISCHARGE PLANNING - CRM or Transitional Care Unit

1. The CRM or Transitional Care Unit must:

   a. Partner with SAIF around discharge planning at first individualized team meeting.

   b. Track the case to ensure that there are no barriers to discharging.

   c. Identify any prescriber or community provider who should attend individualized team meetings and participate in transition planning.

   d. Identify and schedule all DDA assessments that need to be completed before discharge.

2. For a client assigned to a transitional caseload, the transitional case manager must document the transition process on DSHS 10-574B and DSHS 10-574C, *Post-Move and Stabilization.*

3. The CRM must invite SAIF to attend the post-move and stabilization meetings for the first 30 days after discharge.

I. POST-DISCHARGE

1. Up to 30 days after discharges, SAIF will provide technical assistance to a residential provider to support the care of a client through:

a. Consultation with the client's support team;
b. Behavior support plan review; and
c. Habilitative goal review.

2. If the residential service provider requests technical assistance, the CRM must contact the SAIF Program Administrator to request and coordinate contact between SAIF and the residential service provider.

J. CERTIFICATION EVALUATIONS

DDA certifies SAIF according to WAC 388-847-0260.

K. QUALITY ASSURANCE

1. The HQ Quality Assurance Unit must send each client and the client's legal representative a satisfaction survey upon the client's discharge from SAIF.

2. The HQ Quality Assurance Unit must monitor the feedback provided in the survey responses and inform the Adult SOCR Program Manager of any concerns.

3. The Adult SOCR Program Manager must evaluate potential program improvements based on the survey responses.

EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESSION

4.25, *Stabilization, Assessment, and Intervention Facility*
Issued July 15, 2022

Approved: _____ Date: February 1, 2024
Deputy Assistant Secretary
Developmental Disabilities Administration