What is DAS/APH?

The Diversion and Acute Stabilization (DAS) and Acute Partial Hospitalization (APH) programs are Voluntary collaborative programs working to meet the Residential and Mental health needs for adults 18 years and older diagnosed with a mental health disorder in acute crisis. The DAS program is a 24/7 supportive program focusing on the residential needs for the individual such as medication management, self-care, providing 3 meals per day and monitoring/improving ADLs. The APH program utilizes a combination of Group and Individual therapy to address the mental health concerns of the consumer. The purpose of the APH/DAS program is to provide an alternative residential and mental health program to inpatient hospitalization or a transitional program from hospitalization back to the community.

What the Consumer can expect from DAS/APH?

**Diversion and Acute Stabilization (DAS)**

The DAS program is a voluntary 24/7 residential environment licensed under 5310 Regulations. There are 3 single rooms and 6 shared rooms. The rooms are designated by availability and single rooms are based on the medical/safety needs of the program. The program provides organized group activities, psych-social assessments, and medication management to assist individuals in preparing to return to the community. The DAS program provides 3 meals per day with meal plans based on the medical/dietary needs of the consumers, community areas to socialize, and opportunities to improve independent skills and ADLs.

**Acute Partial Hospitalization (APH)**

The APH program is also voluntary, but participation is mandatory as consumers admitted to DAS must also attend the APH program. The APH program consists of Individual and Group Therapy.

**Individual Service Planning**

During the admission process, the consumer and staff will work together to develop an Individualized Service Plan that will include goals customized to meet the consumer’s needs and address all mental health symptoms and concerns.

**Therapeutic Groups**

Monday to Friday 9:00am to 4:25pm. The program provides 6 1-hour group sessions per day/5 days per week. Therapeutic groups are conducted to work on:

* Coping and self-care skills
* Handling stress and emotions
* Daily Living skills
* Improving communication
* Self-esteem
* Mental Health Education
* Anger Management
* Medication Education and More!

What is expected from Supports?

All Service coordinators/CTT/ECSC teams are expected to:

* Meet with their consumers weekly,
* Attend and participate in all treatment team meetings
* Complete referrals/housing applications as needed and report status of applications to the Treatment Team.
* Provide any appointments with the consumer to the APH program with a minimum of 24 hours’ notice.

**Admission Process for APH/DAS**

**If you have a Client/Consumer who is in need of APH/DAS, to refer to the program:**

1. Fax the following mandatory paperwork under the 5310 regulations to

(412) 462-4901 or you may email the paperwork to DASReferrals@tcv.net:

* + **APH/DAS admission referral form—see below**
  + **Most recent psych eval (within the last year)**
  + **Medication list (must be signed by a doctor) or Scripts**
  + **PHI information re: medical concerns (i.e., Diabetes, Seizures, IBS etc.)**
  + **Legal issues (i.e., current charges, on probation, Megan’s Law etc.)**
  + **Documentation noting medical stability signed by CRNP or MD**
  + **Substance Abuse history (needs to contain last use or any MAT currently used)**
  + **Any additional information such as recent progress notes reporting progress**

1. After sending paperwork call the APH/DAS supervisor phone (412-228-7702 or Director at 412-770-5642) to confirm we have received the referral or email DASReferrals@tcv.net.
2. **Once all required documentation is received**, the APH supervisor and DAS supervisor will review for program appropriateness. The following will be assessed- lethality risk, drug and alcohol history, dangerous or aggressive behaviors, willingness to adhere to medication management, willingness to engage in treatment and APH group participation.
3. The APH supervisor, DAS supervisor or on call clinician will contact you with a decision after review is completed.

**Important Contact Names:**

APH supervisor: Brian Rach

DAS supervisor: Terri Lynn Smith

DAS therapist: Vacant

DAS nurse: Rosa Davis

APH therapist: Cathy Laus, Andrew Roberts

**DAS/APH ADMISSION REFERRAL FORM**

**Referring for (check all that apply): DAS  APH**

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| **Demographics** | **Name:** | |  | | | | | | | | | | | | | **DOB:** | |  | | | | | | **SSN:** | | |  | | | | |
| **Legal Address:** | | |  | | | | | | | | | | | | | | | | | | | | | | **Is Consumer Homeless?** | | | | |  **Yes**  **No** |
| **Phone #:** | | |  | | | | | | | | | | | | | **Services with TCV? Qualifacts ID:** | | | | | | | | | | | | |  | |
| **Does consumer live with Natural support? (Skip if N/A)** | | | | | | | | | | | | |  **Yes**  **No** | | | | | | **Able to return home?** | | | | | | | |  **Yes**  **No** | | | |
| **Insurance:** | | | | | **1.** | | | | | | | | | | | | | | **2.** | | | | | | | | | | | | |
| **CCBHO (yes or no)** | | | | | | |  **Yes**   **No** | | | | | | | | **If no: Compass application completed?**  **Yes**  **No** | | | | | | | | | | | | | | | | |
| **Diagnosis** | **Admitting Psychiatric Diagnosis (DSM V):** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Medical Diagnosis:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **D&A Diagnosis:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Do any above Dx/medical needs interfere with Treatment or Safety?** | | | | | | | | | | | | | | | | | | | | | | |  **Yes**  **No (medically stable)** | | | | | | | |
| **Current Acute Psychiatric Symptoms:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **SI/HI:** | | **Current:** | | | | | |  **Yes**  **No** | | | | | | | | | | | | | | **History of:** | | | |  **Yes**  **No** | | | | | |
| **Hx of Aggression/ Violence:** | | | | | | | | | | | |  **Yes**  **No** | | | **If Yes, explain:** | | | | | | | | | | | | | | | | |
| **Legal** | **Sexually Inappropriate Behaviors or Registered Sex Offender?** | | | | | | | | | | | | | | | | | | | | | | **Yes**  **No** | | | | | | | | |
| **Active Legal/ Probation/Parole:**  **Yes**  **No** | | | | | | | | | | | | | | | | | | | **Reason:** | | | | | | | | | | | |
| **PO Officer/JRS Worker Name:** | | | | | | | | | |  | | | | **Phone number:** | | | | | | |  | | | | | | | | | |
| **Supports** | **Referred by:** | | | | |  | | | | | | | | | | | | | | | **Phone #:** | | | |  | | | | | | |
| **Agency/Hospital:** | | | | | | | |  | | | | | | | | | | | | **Email:** | | | |  | | | | | | |
| **Service Coordination:** | | | | | | | | | | |  | | | | | | | | | **Phone #:** | | | |  | | | | | | |
| **Agency:** | | |  | | | | | | | | | | | | | | | | | **Email:** | | | |  | | | | | | |
| **Family involved/ Natural Support:** | | | | | | | |  | | | | | | | | | | | | **Phone #:** | | | |  | | | | | | |
| **PCP:** | | |  | | | | | | | | | | | | | | | | | **Phone #:** | | | |  | | | | | | |
| **Housing Status:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Disposition Plan:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Need Handicap Accessible?** | | | | | | | | | | |  **Yes**  **No** | | | | **Complete ADLs Independently?** | | | | | | | | | | | | | |  **Yes**  **No** | | |
| **Projected Admission date needed:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature of Staff Completing Referral:** | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | |