Report on Project Planning Workgroup #2 – Short-term Crisis Residential Services and Behavioral Respite (residential)
June 10, 2014 Conference Call
Linda Mabile, Lead

Small Group Task: Gather information, including the list of deliverables below, with recommendations to be determined by the larger workgroup

Deliverables: List and describe the services needed for short term housing for residential crisis stabilization and behavioral respite, as follows:

a. Specific list of services needed
b. Type of provider(s)
c. Time frames for the services and/or service limitations
d. Qualifications of providers (If there is to be a new designation, list criteria)
e. Statute changes required in order to implement the service
f. How the service differs from current services being provided
g. Review and complete the Project Planning Worksheet

A conference call was held on June 10, 2014 to discuss the services assigned and make recommendations on deliverables. The conference call focused on deliverables a – d.

Attendance:
Sharon Boyd, Parents in Action; Mark Swain, Sunrise ARC; John Riehm, Sunrise ARC; Kim Reidel, Devereaux; Patty Houghland, Disability Rights, FCC; Clint Bower, Mactown; Ken Wynn, Quest; Jennifer Cannon, Adams Acres, Inc., Linda Mabile, Florida ARF

Summary of Discussion on Deliverables

Eligibility for Services	Suggested eligibility criteria for Short-term Crisis Residential services and/or Behavior Respite Services has been defined below. Eligibility criteria should be further refined, as determined necessary. Data is needed to identify those individuals eligible for this level of service, what the capacity needs may be for specific areas of the state and to plan for the type of services that would benefit individuals' needs. Ideally, these services would be available in all APD Areas.
Eligibility Criteria	1. Definitions for the populations needing Short-term Crisis Residential services and/or Behavior Respite Services include: • Individuals meeting the eligibility criteria for Intensive Behavior and/or Behavior Focus Residential Habilitation Services, regardless of whether they reside in a residential facility authorized to provide this level of intervention. • Individuals having a mental health diagnosis as well as being diagnosed with a developmental disability and eligible for services from APD.
Data Collection	2. Gather data on the eligible population to determine: • How many people fall into categories defined as being "Dually Diagnosed" and/or having "Intensive Behaviors". • Where these individuals are living and located around the state. • What services the individuals are currently receiving and/or needing.

Regulation Change	3. Possible data resources include: • Level of Behavior Analysis, Behavior Assistant, and/or Residential Habilitation services being received by the individual per the individual's iBudget cost plan. • Data from DCF on individual's who have been "Baker Acted" within the past 2 years who are also receiving APD services, and how often. • Data from AHCA on individual's receiving state plan mental health/behavioral health services who are also receiving, or are eligible to receive, services from APD. • Data from the APD Incident Reporting system. Note: Both APD's iBudget system and AHCA's Medicaid State Plan have service limits that will be barriers to meeting needs in a Short-Term Crises Residential setting and to providing Behavioral Respite services. It was noted by members on the workgroup that individual's may require more hours per day than can be authorized currently. Also noted is that services cannot be billed the same day the individual is discharged from a hospital setting, thus potentially limiting adequate funding to provide these two services. The definitions of direct and indirect services must be clarified if these types of services are initiated.
Types of Providers Service Description and Standards Bed Hold Funding	It is recommended by the workgroup that existing Residential Habilitation Service providers authorized to provide Behavior Focus and/or Intensive Behavior Services be used initially to establish the two services. The services can be implemented more quickly using the current infrastructure, even with the need to make regulatory changes and establish appropriate funding level rates for the services. The following service descriptions and standards for service delivery are recommended: • Participation in the provision of these services is voluntary. Providers may elect to provide either short-term crises residential services or behavioral respite, or both. • The service will be implemented by authorizing "slots or beds" within the residential program that will be held vacant and filled only when there is a short-term need for either crisis stabilization or behavior respite. • <u>The "slot or bed hold' must be continuously funded</u>. It is critical to successfully achieving implementation of these services that the "slot or bed hold" be funded. Crisis services must be available when there is a need. Behavior Respite services can usually be planned in advance unless there is a family emergency, but this is not always the case. • Depending on the size and configuration of the facility(s) the provider may hold one bed for these services, or more than one. The number of designated beds held and available will be prior approved by the agency. • Specific parameters should be developed that define a provider's right to refuse admission to the facility and the use of the "held" bed when the

Statewide Capacity	admission will place other residents in danger, or there are other health and welfare considerations that impact the admission decision. The inability to accept an individual needing crisis supports or behavior respite must be minimal in order for the provider to maintain certification to provide these services. (An example of when denial of admission may be warranted is if the person needing admission is a sexual predator and the provider only has a room available with a vulnerable roommate.) • The geographic need for the service must be a consideration in identifying the number of facilities and beds approved to be available for these services. It is recognized that some areas may have more resources than others to initiate the services. This should be rectified over time with a requirement and commitment by APD that all APD areas having at least a basic ability to provide for short-term crisis and behavioral respite. It is recommended that the need to travel out-of-area to receive these services be minimized and eventually eliminated.
Future Service Develop Needs In-home supports	While it is proposed by the workgroup that both the Short-Term Crises Residential service and the Behavior Respite service be initiated using the identified current residential settings, it is important to note that ultimately both a method of crisis intervention and behavioral respite services must be developed and available to eligible individuals in the family home. This in-home service may be a spin off from the residential facility that will hire and train staff capable of responding to an emergency in the home setting and providing overnight respite services in the home for family relief. Possibly a mobile crises unit will be developed and available for in-home emergency intervention that provides services in an individual's home, as well as the family home and group homes. It was recommended that in-home behavior respite be developed as a separate service under the waiver respite category with appropriate staff qualifications and funding levels to support this level of individual need in the home setting. It is recommended that further investigation on similar services in other states, such as the START (Systematic Therapeutic Assessment Respite and Treatment) system, continue to be evaluated in order to adapt applicable and appropriate procedures to the Florida system.
Provider Qualifications Meet current Waiver Qualifications	Providers must be certified by the Agency to provide Short-term Crisis Residential services and/or Behavior Respite services. Certification will include the following criteria: • Providers must meet the qualifications for, and must be currently providing Behavior Focus and/or Intensive Behavior Residential Habilitation Services. • Providers must be considered "in good standing" as evidenced by quality assurance results and Agency oversight evaluations to determine the

Collaboration for System Improvement Mental Health Supports Accessibility	provider's capability to provide these services. Criteria for defining this element must be developed. • The provider must have demonstrated experience working with the mental health system. • Required for certification will be participation in a statewide quality management/improvement group focused on improving and developing expertise and best practices for this population. There needs to be a demonstrated commitment both at the state and the provider level to improving services for people with a dual diagnosis and intensive behavioral issues. The group should focus on developing expertise to provide services to this population and problem resolution of system support issues and barriers. • In addition to meeting waiver service requirements, the provider must have a contract or agreement with a psychiatrist for psychiatric oversight. The psychiatrist may be accessed through mental health resources. Ideally, the psychiatrist will have shared values for minimizing medications used for intervention and a "team" approach to treatment modalities. It is recommended that a bundled rate be established for this services that includes the services of a psychiatrist. Access to a psychiatrist is considered a critical component for the services. • The provider must have a contract or agreement with a psychiatric/mental health counsellor to provide staff training, client specific counselling and partnership with the programs clinical director to assure adequate and appropriate intervention methods. The counsellor may be accessed through mental health resources. It is recommended that the rate established be a bundled rate that includes the services of a mental health counsellor. • The provider must provide 24-hour-a-day, 7-days-a-week timely response to the system of care in support of individuals with a dual diagnosis or intensive behavioral health needs.
Rates for Services	It is recommended that a bundled rate for these services, or an add-on to the current Residential Habilitation Rates for Behavior Focus and Intensive Behavior be established to adequately cover the cost of behavioral and mental health service intervention and the staffing required to meet this level of short-term need. Staffing must be sufficient and trained in behavioral intervention techniques as well as mental health approaches.
Duration of Service and Services	It is proposed that Short-Term Crisis Residential Services and the Behavior Respite services be limited, in general, to 30 days or less. • In order to meet crisis needs the system must be streamlined to be more responsive than it is presently. (It doesn't benefit an individual in crisis to wait weeks for approval to access appropriate supports, or to end up in a mental health facility, if there is no need.) Some systems serving this population in other states recommend that in times of crisis immediate

Identification of Alternative Placements	telephonic access and in-person assessments be available within two hours of the request, whenever possible. • Often individuals admitted for short-term crisis may not be able to return to their home or previous residential facility. There must be better coordination of information about available vacancies in group, foster and other types of facilities so that placement plans can be readily made for discharging an individual from the short-term crises or respite setting once the person is stabilized, or a need for alternative placement is identified.
Intake	• The provider must perform an intake assessment within 24 hours of admission to identify issues and follow-through. A solid plan for intervention while in the facility must be established. It is recommended that the discharge or transition plan be a required component of the intake assessment and planning process. Due to the short term nature of the placement, stabilization for discharge or transition must be the primary focus for the crisis treatment team.
Support for Day Activities	• It is recommended that "meaningful day activities" be included in the individual planning process when the person is ready to assist with stabilization and transitioning back to a less intense residential setting. Funding should be available for the day activity. This may be part of the bundled rate for the service, or a separate add-on that adequately funds the level of support needed in a day activity setting.
Positive Planning Prior to the Need for Services	• It is strongly recommended that individuals identified as eligible and having the need for these services be identified <u>prior</u> to the need for respite, or the occurrence of a crisis, whenever possible, so that up front appropriate and adequate planning can occur in advance of the placement. 1. The support planning process must include an individual assessment and development of an individual crisis prevention and intervention plan. The plan should address, at a minimum, the types of services and supports needed by the individual and other information necessary to promote a smooth and rapid transition into the facility for crisis intervention, or respite care and support. 2. Copies of record information to include medical and behavioral information, must be available to the facility. It is recommended that prior planning include the availability of important record information that can be transferred with the individual at the time of the crisis. When "unplanned" admissions do occur, appropriate and adequate record information must be available to the facility within 24 hours of admission. It was noted that the short-term nature of these services are supported by a "bed hold" approach to funding as there is no incentive to maintain someone in a facility bed beyond stabilization.