Adult BH Home & Community Based Services (HCBS)

Crisis Respite

October 26th, 2015
Agenda

- Welcome
- MCTAC Overview
- Business/Billing Rules
- Services Definition
- Service Components
- Example
What is MCTAC?

MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

MCTAC’s Goal
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
Who is MCTAC?
Adult BH HCBS Services

- Rehabilitation
  - Psychosocial Rehabilitation
  - Community Psychiatric Support and Treatment (CPST)
- Habilitation
- Crisis Respite
  - Short-Term Crisis Respite
  - Intensive Crisis Respite
- Educational Support Services

- Individual Employment Support Services
  - Prevocational
  - Transitional Employment Support
  - Intensive Employment Support
  - On-going Supported Employment
- Peer Supports
- Family Support and Training
- Non Medical Transportation
- Self Directed Services Pilot (anticipated start date July of 2016)
Crisis Respite

- Important component of HCBS package
- Does *not* require New York State Community Mental Health Assessment
- Does require individual to be enrolled in a HARP
Short Term Crisis Respite Business/Billing Rules

- Billed daily with a max unit of 1 per day.
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual).
  - If more than 7/21 days are needed, MCO can authorize additional days of service, but will need to obtain OMH or OASAS Medical Director approval.
- May only be provided in facilities dedicated solely for this purpose.
- Fee includes transportation, do not bill transportation separately.
- It is anticipated that persons may also receive other HCBS services and state plan services while in this level of care.
HCBS Utilization Thresholds

HCBS services will be subject to utilization caps at the recipient level that apply on a rolling basis (any 12 month period). These limits will fall into three categories:

1. Tier 1 HCBS services will be limited to $8,000 as a group. There will also be a 25% corridor on this threshold that will allow plans to go up to $10,000 without a disallowance.

2. There will also be an overall cap of $16,000 on HCBS services (Tier 1 and Tier 2 combined). There will also be a 25% corridor on this threshold that will allow plans to go up to $20,000 without a disallowance.

3. Both cap 1 and cap 2 are exclusive of crisis respite. The two crisis respite services are limited within their own individual caps (7 days per episode, 21 days per year).

If a Plan anticipates they will exceed any limit for clinical reasons they should contact the HARP medical director from either OMH or OASAS and get approval for a specific dollar increase above the $10,000 effective limit.
Setting

- Site-based residential settings will offer a supportive home-like environment with a maximum preferred capacity of 8-10 guests (fewer in rural areas), preferably in single rooms.
- The setting must be code compliant.
- Staffed and open 24 hours a day, seven days a week when a resident is present.
- Residents should be allowed to leave and return as needed, maintaining employment and other daily activities to the extent possible.
- To the greatest extent possible, guests will be encouraged to maintain contact with significant others, including family members, friends, and spouses. To facilitate this contact, guests may have visitors at any time that is convenient and practical for the guest as well as the operations of the CRC.
Crisis Respite Based on Residential Settings

Respite staff should coordinate with HH care coordinators and MCOs to assist with the housing process (brokering enrollment in Health Homes, identifying housing readiness skills, etc.) and should focus care and discharge planning on moving the housing process along as they are able, but will not be expected or required to find housing or to hold recipients in Respite until housing is available.

- If someone enters a Respite program from a shelter, it is appropriate to discharge them back to a shelter
- If someone enters a Respite program from the street, it is strongly recommended that client be discharged to a shelter

Providers should develop policies and procedures and recipient consent and orientation processes to address these points.
Admission Criteria/Exclusions

• Admission/Eligibility Criteria
  • Must be experiencing a crisis, and be:
  • Willing to voluntarily stay at a Crisis Respite
  • Willing to be assessed by a treating professional
  • Willing to authorize release of medical records by relevant treating providers
  • Experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others

EXCLUSIONS:
• Diagnosis of dementia, organic brain disorder or TBI
• Those with an acute medical condition requiring higher level of care
• At imminent risk to self or others that requires higher level of care
• Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive behavior
• Is not willing or able to respect and follow the guest agreement during his/her stay
• Is not willing to sign necessary registration documentation
• Is not willing to participate in the wellness process during his/her stay
Limitations/Staffing

• Limitations/Exclusions
  – No longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

• Certification/Provider Qualifications
  – Crisis Respite services may be delivered by peers or non-licensed staff.
  – The CR should have a Program Director (1 FTE) who will have 3-5 years of management experience working in a social service or related setting and will supervise CR staff and coordinate the day-to-day activities associated with managing the CR.
  – Peer Respite staff will have experience as a recipient of mental health and/or substance use disorder services with a willingness to share personal, practical experience, knowledge, and first-hand insight to benefit program enrollees.
  – Peer Respite staff will possess the competency to meet requirements outlined in the job description, and will complete any relevant trainings within 90 days of employment.
  – All Peer staff must be OMH or OASAS certified.

• Staffing ratios/case limits
  – There shall be a minimum of one staff person on-site for every four guests from 7 am to 8 pm.
  – Between the hours of 8 pm and 7 am, there shall be a minimum of two staff on-site.
  – The director or a designee shall be available at all times by cell phone.
Short Term Crisis Respite

- Short-term care and intervention strategy for individuals who are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person’s home and community environment.

- Imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others.

- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support.

- Referrals may come from:
  - Emergency room
  - Community
  - Self-referrals
  - Treatment team
  - Part of a step-down plan from an inpatient setting

- Crisis respite is provided in site-based residential settings.
Components

➢ Onsite peer support during the respite stay
➢ Health and wellness coaching
➢ Crisis Intervention Planning (such as WRAP planning)
➢ Wellness activities
➢ Family support
➢ Conflict resolution
Components Cont.

- Working with existing treatment providers
- Relaxation techniques
- Coordinating with primary care, Health Home or other BH providers
- Ongoing communication
- Crisis respite staff, together with the individual and his or her established behavioral health providers, will make a determination as to the continuation of necessary care and make recommendations for modifications to the recipients’ plan of care.
Example
Intensive Crisis Respite Business/Billing Rules

• Billed daily with a max unit of 1 per day.
• Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual).
  • If more than 7/21 days are needed, MCO can authorize additional days of service, but will need to obtain OMH or OASAS Medical Director approval
• Fee includes transportation, do not bill transportation separately.
• Because of the high level of clinical involvement associated with this service, persons receiving intensive crisis respite may not receive any other HCBS or state plan service – with the only exception being peer supports.
Setting/Admission Criteria

• **Setting**
  • Participants are encouraged to receive respite in the most integrated and cost-effective settings appropriate to meet their respite needs, preferably in a residential, community-based setting.

• **Admission/Eligibility Criteria**
  • Individuals who may be a danger to self or others and are experiencing acute escalation of mental health symptoms and/or at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others but can contract for safety.
  • Experiencing symptoms beyond what can be managed in a short term crisis respite.
  • Individual does not require inpatient admission or can be used as an alternative to inpatient admission if clinically indicated and person can contract for safety.
Limitations/Exclusions

- 7 days maximum
- Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.
- Have an acute medical condition requiring higher level of care.
- If more than 7/21 days are needed, MCO can authorize additional days of service, but will need to obtain OMH or OASAS Medical Director approval.
Provider Qualifications

- Certification/Provider Qualifications
  - Agency must possess a current license to provide crisis and/or treatment services (i.e. clinic, Comprehensive Psychiatric Emergency Programs (CPEP), Partial Hospital, PROS, Psychiatric Inpatient or have licensed professionals who have a minimum of 1 year of experience in delivering off-site crisis services including conducting psychiatric evaluations and providing treatment.
  
  - This service will be provided by a multidisciplinary team of licensed, para-professional and certified peer staff.
Staffing

- **Staffing ratios/case limits**
  - Adequate number of staff and an appropriate staff composition to carry out its goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision and treatment.
  - Every ICR shall have at least one psychiatrist as primary medical coverage. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds. Counties of less than 50,000 population may utilize a licensed physician for on-call activities and daily rounds as long as the physician has postgraduate training and experience in diagnosis and treatment of SMI and SUD.
  - At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week when there is a consumer in care.

- **Staffing ratio:**
  
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<th>Beds:</th>
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<tr>
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Intensive Crisis Respite

• Short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including
  – Individuals who are suicidal
  – Express homicidal ideation
  – Experiencing acute escalation of mental health symptoms.
  – Person must be able to agree on a suicide prevention plan
• Individuals are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care.
• The immediate goal is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.
Components

• Comprehensive assessment including screening for physical health conditions
• Comprehensive risk assessment medication management
• Individual and group counseling
• Training in de-escalation strategies
• Relaxation techniques
• Monitoring for high risk behavior
• Psychiatric evaluation for competency
Components Cont.

- Linkage to resources and referrals
- Peer support
- Crisis Intervention Planning (such as WRAP planning)
- Wellness activities
- Family support
- Engagement of Natural Supports
- Conflict resolution
- Hotline
- Ongoing communication
- Clinical staff, together with the individual, will make recommendations for modifications to the recipients’ plan of care.
Example
<table>
<thead>
<tr>
<th>HCBS/State Plan Services</th>
<th>OMH Clinic/OASAS</th>
<th>OASAS Opioid Treatment Program</th>
<th>OMH ACT</th>
<th>OMH PROS</th>
<th>OMH IPRT/CDT</th>
<th>OMH Partial Hospital*</th>
<th>OASAS Outpatient Rehab</th>
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*If a participant is admitted into a Partial Hospital program, their HCBS payments will be suspended so that their services will not be terminated.

** All HARP Members are eligible for Crisis Respite Services except for individuals residing in excluded settings. However, MCOs can choose to provide crisis respite as an in lieu of service for those individuals.

***If an individual receives OASAS state plan peer services through an OASAS clinic, then they are not eligible for HCBS peer services and vice versa

****OLP= Other Licensed Professionals
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<th>HCBS Combinations</th>
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* PSR and Habilitation may only be provided at the same time by the same agency.

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Links to OMH/OASAS Documents – Manual, Billing Manual and Fee Schedule


• Fee Schedule and Rate Codes: http://www.omh.ny.gov/omhweb/bho/phase2.html
Adult BH HCBS In Person Trainings

- 10/26 -- Crisis Respite
- 10/27 – Employment Education
- 10/28 -- Family Support
- 11/2 – Peer Supports
- 11/6 – Family Support
- 11/9 – Peer Supports
- 11/13 – Hab/Rehab/CPST
- 11/16 – Hab/Rehab/CPST
- TBD (in-person or web-based) -- Non-Medical Transport
Visit [www.mctac.org](http://www.mctac.org) to view past trainings, sign-up for updates and event announcements, and access resources.