

Residential Discharge Planning Work Group
Call Summary
June 17, 2009

Dr. Hall facilitated the discussion and provided a brief overview of the charge for the group. Karen McLeod provided additional clarifying information specific to the proposed elimination of Residential 3 and 4 within 6 months of the passage of the proposed legislation. A review of the charge of this workgroup occurred as below:

Charge of Workgroup

DMA tasked this group with determining specific elements to be addressed by treatment teams at the Residential facilities when preparing a Discharge Plan. It is anticipated that this Discharge Plan will be submitted to the ValueOptions as part of the transition out of the facility and in preparation for movement into other services when indicated. The group began discussion and noted there are key questions which must be clarified in preparation for the phase out of Residential levels of care:

Key Questions for DMA

1. Is it possible to have CS phase out in such a way that the Case Management component phases out after closure of the Residential facilities? At present the Residential Provider is not allowed to complete the PCP so how will the linkage and updates occur without CS if it ends as a service before or during the Residential closure?
2. Since rural areas lack wrap services can CS be used in an expedited manner? Could the 25% of CS designated to remain present for EPSDT be utilized for wrap supports?
3. It is possible the not enough foster homes are available. In situations where the Resident does not meet PRTF criteria but needs access to all needed services in a secure, structured setting (Level 4 Residents) what options exist for this group?

Call notes (General topics):

After reviewing the charge for the group Karen McLeod clarified questions related to timeline for closure of the Residential 2 – 4 facilities. The group also discussed the expectation that once the legislation is passed it is expected that the Residential Provider will submit a Discharge Plan to the ValueOptions with the next request for continued services (ITR and PCP update). It was noted that individuals in the Residential levels of care could receive up to 6 months of service before the service ends.

There was a brief discussion of potential numbers of individuals in the Residential levels of care, specifically 200 plus in Level 4, 1800 – 2300 (number is most likely closer to 1600) in Level 3 and 2500 plus individuals in L2 (all types). These are estimates and not an exact count

Per email from Leslie Kellenberger on 6/17 ‘there are 400 DSS custody kids in Level III and 32 in Level IV. In Level II Family Type there are 818 kids in DSS custody’.

The group also discussed plan to stop any new admissions into Residential levels of care once the Legislation is enacted. The group estimated an additional 180 or so individuals who would also need to be served by other levels of care once admissions cease.

A brief discussion was held about the impact of an “IMD” designation for a facility. It was noted that PRTF would be exempt from the IMD designation.

Items identified by group that are needed for Discharge Planning

Risk ratings/Assessment tool

Group members recommend that the treating team screen the child/adolescent to determine the level of care needed based on an assessment of risk/level of need derived using a screening instrument. Much discussion was held on this subject.

It should be noted that group members did submit suggested instruments/tools that could be used to determine level of need upon discharge from the Residential facility.

Submissions to date (Friday June 18th) are the CALOCUS scale, CALOCUS – risk assessment instrument, Risk Assessment and Crisis Triage Rating Scale

Action: Each member of the call would identify possible screening instruments/rating scales and submit via email to Dr. Hall. These would be reviewed by the group during another call on Friday, June 18th. The group would determine which instrument(s) would be recommended to DMA (time TBD and set up by K. McLeod). The group stressed the need to select instruments that would not involve a fee to use and which could be rapidly deployed.

Timeline

Residential Provider must establish measurable timeline for the transition with specific target dates

LME Involvement/Agency involvement

Per DMA discussion, LME involvement is expected during the transition out of the Residential service. The workgroup further recommends that at a minimum the LME participate for outlier cases. Specifically the LME Care Review Team should be involved with complex cases, assist with identification of resources

Additionally, the group recommends the Discharge Plan include information about service gaps and how they are being addressed at the LME and DMH level. The group suggests this information be submitted as an addendum to the PCP.

One suggestion from the workgroup is that a Hotline be set up at DMH to assist with communicating information about service gaps/needs for hard to place individuals

Workgroup members also inquired about a “Rapid response/High Priority method of accessing an authorization from the ValueOptions. Dr. Hall noted this would be passed onto ValueOptions Management as this is an operations question

PCP Planning Team and key elements for Discharge Plan

The workgroup recommends the Discharge Plan include elements reflecting all key stakeholders are involved and specific issues are addressed. For example, educational needs/plan, DJJ related issues, DSS related issues are accounted for in the Discharge Plan

It is also recommended by the workgroup that any systemic barriers to Discharge Planning be addressed in the plan. This may be related to service gaps or special needs/populations

Alternate levels of care

Submission of Discharge Plan should include identification of alternate services such as IIH and MST Group recommends that ValueOptions treat these as expedited requests and process as such. Dr. Hall will forward this suggestion to ValueOptions management given this is an operations issue

EPSDT

Discharge Plan should be inclusive of the consideration of EPSDT as it relates to exclusions and limitations of services. Specifically, the team must consider combinations of services for wrap purposes that would otherwise be excluded but are allowed under EPSDT

Example: Combining Day Treatment and IIH

Group noted that the usual exclusions and limitations do not apply for Therapeutic Foster Care. It was also noted that TFC will be replaced by a service under a different name

Planning for High Risk individuals

Any Discharge Plan must be submitted with a Safety Plan for individuals identified to be at high risk for dangerous behaviors. This includes but is not limited to those with h/o sex offense, running away, self injurious behaviors, physical aggression, fire setting etc.

The workgroup discussed whether individual in Level 4 should be prioritized for PRTF and MST