

**Residential Work Group**  
**June 29, 2008**

**Attending:** Tara Larson, Ted Lane, Michael Watson, Leslie Kellenberger, Libby Jones, Claretta Witherspoon, Tara Fields, Bob Hensely, Sherry Bradsher, Carla Roberts, Mark Upright, Bob Hedrick, Tanya Simmons, Chris Simmons, Cliff Parker, John Koppelmeyer, Karen McLeod, Rob Turner, Linda Gunn-Jones, Carolyn Wiser, Will Woodell, Dr Ranota Hall, Catharine Goldsmith, Grayce Crockett, Nancy Gleghorn, Kelly Crowley, Jim Jarrard, Martin Pharr, Deby Dihoff, Yvonne Copeland, Tyrone McRae, Christina Carter, Delwin Clark and Jim Sheehan.

**Handouts:** June 29<sup>th</sup> Agenda, Draft letter to Community Support Providers regarding residential closure, draft Level III and IV Residential notice, Additional LME Questions and Concerns, DJJDP Out of Home Placement Survey, Risk Screening Tool, Needs Checklist Subcommittee minutes, Transitional Placements Subcommittee Minutes, LME Role in the Closure of Level III and IV Group Homes Statewide, One Pager – Barrier and Solutions, Summary of Table of Statewide Capacity of Child and Adolescent MH services by Region, Draft Discharge Plan Document, NC Provider’s Council Position Paper, Sample VO risk data summary and list of services by county.

**Minutes** from the prior meeting were sent out through email prior to the meeting. Bob Hedrick asked that his name be added to the Attendees. Please review and provide any corrections to [catharine.goldsmith@dhhs.nc.gov](mailto:catharine.goldsmith@dhhs.nc.gov).

**Discussion:**

There have been modifications in the special provision by the legislature that decrease the cuts to residential services. However, issues related to CMS requirements and required approval for state plan services remain a significant factor that may impact planning and implementation.

- ◆ Timber Ridge and 3 Springs will still close as Level III providers due to CMS provisions regarding the prohibition of use of federal funds in mental health facilities over 16 beds unless the facilities are licensed as PRTFs.
- ◆ Currently will be a reduction of residential services of \$15 million the first year.
- ◆ DMA and DMH will continue to advance and support policy that promotes placing children and adolescents in family settings.
- ◆ Timelines have not changed.
- ◆ We will be submit Therapeutic Foster Care definition to CMS
- ◆ Information that was submitted by DMH/DMA for revised special provisions include:
  - Separation of case management from Community Support Services; elimination of paraprofessional level of provider within 60 days of enactment.
  - Revision of admission and continued stay criteria for Levels III and IV residential
  - Add a placement discharge plan to requirements.
  - Submission of a discharge and transition plan along with the ITR to VO
  - Length of stay will be 120 days, with provisions for medically necessary exceptions based on active treatment, parental/guardian participation, community involvement

- Must demonstration of unsuccessful treatment with MST, IIH prior to referral to residential
- State plan amendments will be sent to CMS based on current proposals in the legislature

**Committee workgroup reports/follow up:**

- ◆ **LME:** The joint memo draft letter will need to be rewritten by the LME workgroup because of modification in the special provisions. Gracye Crockett provided list of additional LME concerns regarding implementation of this process.
- ◆ **DJJDP** distributed a handout concerning data on juveniles located in out-of-home placements as of June 18, 2009. Information is gathered from Chief Court Counselors and will continue to be gathered to use in this transition.
- ◆ **The discharge planning workgroup** distributed handouts: a draft discharge plan document was proposed for providers to submit along with the ITR, updated PCP and request for specific services when possible. A significant question has not been resolved relating to how to determine level of risks for the children and adolescents being moved from Levels III and IV. The group developed a draft risk screening tool document which was handed out and discussed. Dr. Hall will continue to refine this instrument and “weight” the most critical items. There was consensus that the tool must be completed by a licensed clinician. This group also raised issue regarding how gaps in local service arrays will be addressed.

**Consolidation of case management** will include separating case management out of the community support definition. Paraprofessionals are going to be eliminated. Case management will be part of admission, discharge for any level of care.

**Steps in moving forward were discussed with these suggestions:**

- ◆ Time frames need to be clear;
- ◆ Consider a moratorium on Levels III, IV and II Program Type;
- ◆ Prioritize kids from Level IV, first priority; for review and placement
- ◆ Have the child based facility based crisis definition in place, ( requires CMS approval)
- ◆ Revise PRTF issues to facilitate building capacity.
- ◆ Create incentives for using IIH services; keep the best providers, avoid lawsuits, appeals;
- ◆ Improve endorsement policies and procedures to make more consistent, effective to promote quality providers and improved services.
- ◆ Make sure decisions/actions move us in the right direction.

**The Therapeutic Family Definition was discussed.** A need was identified for a licensed clinician with each child placing agency. The clinician would be a clinical administrator providing oversight, make sure training would take place and that kids are receiving correct “wrap” services.

The rule citations need to be upgraded. Bob Hensely will work on these edits. There will be a follow up call of TFC stakeholders to review/update/revise policy.

**Planning for Crisis Services.** The need for quality accessible crisis services remains but with the slowing of the downsizing the immediacy of need for increased crisis beds is reduced. The child facility based crisis definition has been sent back to the definition work group for more work.

**DMA/DMH went over recommendations concerning PRTF's.** The group did not support the non-medical licensed staff ordering seclusion or restraints. It was agreed a nurse can assess someone that has be secluded/restrained but this cannot be done by a non medical licensed professional. A nurses order must be signed off on by an MD in a prescribed number of hours. (24 to 48) Also, it was agreed that a LPN instead of a RN could work the night shift in a PRTF. However, there is continued discussion related to this last provision. Rule now states 24 hour nursing by a RN is required.

#### **Discussion Items.**

- ◆ Reductions in Level III and IVs may be accomplished through attrition, accreditation requirements as well as tightening endorsement processes at the LME level.
- ◆ With reduction/elimination of CSS, option was presented of having residential providers complete their own PCPs. This function could also move to the Child and Family Team.
- ◆ New requirements for requests for continued stay for both CSS and Residential must be present for requests to be processed by ValueOptions.
- ◆ Work and planning must take into consideration both a 6 and 12 month timeframe

#### **Action List**

- ◆ Rewrite letter to the field concerning special provisions by Grayce Crockett and committee; work can begin on determining if any kids can be moved now.
- ◆ The Department will develop and issue the official policy statement to the field about changes to residential services
- ◆ Moratorium on Levels III, IV, II Program Type
- ◆ Add new requirements for admission, services and discharges developed for Levels III and IV to Level II as well, including accredited facilities, preferred.
- ◆ DMH will develop a list of accredited residential providers.
- ◆ Need list of providers over 16 beds (Licensure?)
- ◆ LME workgroup continuing new letter to community stakeholders based on new provisions.
- ◆ Discharge workgroup: transition plan draft; triage checklist; risk/safety list, priority planning for capacity of work force.
- ◆ Follow up call with TFC stakeholders to review/update/revise policy.