MAY 2018

Children, Families, Health, and Human Services Interim Committee
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HJR 24 STUDY: OPTIONS FOR CRISIS RESPONSE

Background

The Children, Families, Health, and Human Services Interim Committee has reviewed crisis consultation and response services in Montana, Georgia, and New Mexico as part of its House Joint Resolution 24 study of community services for individuals with developmental disabilities. This briefing paper provides:

- further information about the crisis response offered in the three states, including the costs of those services;
- a related discussion of factors influencing a provider's ability to discharge clients from service in Montana; and
- options for committee consideration.

Crisis Response in Montana

The Department of Public Health and Human Services has a Behavior Consultation Team that can assist developmentally disabled individuals, their families, and community providers. A written description presented at the committee's March 2018 meeting says the three-member team can consult by phone or in person when a person has "challenging behaviors" that:

- are not responding to interventions and therapies that have been effective in the past; and
- have led to hospitalization, interaction with law enforcement, or the risk of losing a community placement.

Generally, the team meets by conference call with the people familiar with the individual involved in the matter, develops an action plan for the referring team, makes formal recommendations, and follows up with the referring team two weeks later to see if the recommendations have been implemented and have been effective. The formal recommendations could include staff training or in-person mentoring by a Behavior Consultation Team member, or they may be limited to resource recommendations.

The department clearly states in its materials that it is unable to provide crisis intervention services because of its limited staff resources.

Related Issues: 90-Day Exit Policy and Facility of Last Resort

During the HJR 24 study, committee members have heard concerns from providers about the so-called "90-day exit policy." This policy, established in administrative rule[1] in December 2012, governs the manner in which providers can stop serving a person.

The rule requires a provider to notify the department, the individual, and various advocates for the individual about the provider's intent to discontinue services.

[1] 37.34.2003, Administrative Rules of Montana.

DPHHS must schedule a meeting to review the basis for the request, determine if any changes to the current services or supports would allow the person to remain with the provider, and develop a plan of care that identifies the actions that must be taken to put those changes into place. If it's determined that the person must be placed with a different provider, the case manager will help seek an alternative placement.

However, the rule also states: "The provider will continue to provide services to ensure the persons' health and safety during the course of the process provided for in this rule."

Providers have said that with the 2015 Legislature's decision to close MDC, limited options exist for placing challenging clients in an alternative placement because other community providers are unwilling or unable to provide services.

At meetings in February and September of 2016, state officials outlined their plans for providing state-funded crisis alternatives when MDC closed.[2] In addition to continuing existing efforts on behavioral support services and consultations and on funding increased needs, the plans included:

- applying for a waiver that would allow higher, bundled reimbursements for up to 50 individuals with intensive needs;
- opening state-operated group homes, with at least two in place by December 2016;
- contracting for an institutional level of care with an out-of-state facility;
- creating a crisis hotline to operate around the clock;
- providing training for local officials and for providers;
- creating a mobile crisis outreach team with contracted medical and psychiatric support; and
- creating 12 crisis beds at the secure facility on the MDC campus and contracting with behavioral health facilities for four crisis beds in eastern Montana.

Passage of HB 387 in 2017 maintained the 12-bed secure facility on the MDC campus for individuals committed by a court. However, the state has not created crisis beds in eastern Montana, opened any state-run group homes, contracted for an institutional level of care in another state, established a mobile crisis team, or applied for a second waiver to serve people with intensive needs.

The Developmental Services Division has decided the additional waiver isn't needed at this time because providers have shown they're willing and able under the current waiver to serve clients who are leaving MDC. In addition, the division has not ruled out operating state-run group homes even though it has no immediate plans to do so. And it is continuing to pursue a contract for an out-of-state provider to provide an institutional level of care.[3]

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[2] "Montana Developmental Center SB411 Transition Proposal," Department of Public Health and Human Services, April 27, 2016, and "Montana's Developmental Disability Crisis Plan," Department of Public Health and Human Services, Sept. 22, 2016. Both documents were presented to the Transition Planning Committee that was created by Senate Bill 411 (2015) to advise DPHHS on planning for the closure of MDC.

[3] DPHHS response to information requests, provided by Marie Matthews, DPHHS Medicaid and Health Services Branch Manager, May 1, 2018.

Crisis Services: Georgia and New Mexico

Committee members received an overview of crisis services in Georgia and New Mexico at their March meeting. This section summarizes that information and provides additional detail about the services in those states.

Georgia

The state has contracted for a crisis response system that consists of on-call mobile crisis response teams that must respond on site within 90 minutes. The teams provide an in-person evaluation and determine the least restrictive manner in which to handle the case. Currently, the contractor providing mobile crisis response also must offer crisis support in the person's home and operate four-bed crisis respite homes for individuals who can't safely remain in their current placements. The person in crisis may receive additional supports in his or her home, such as training for family and caregivers or modeling of effective intervention. If a greater level of support is needed, the person could be placed in a crisis respite home for up to 30 days. Contractors must have two crisis homes in each of the state's six service regions, for a total of 48 crisis beds.

The crisis response system was one of many system changes required under the settlement of a complaint brought by the U.S. Department of Justice against the state in 2010, alleging violations of the Americans with Disabilities Act. The settlement agreement required the state to create six mobile crisis response teams by July 1, 2012, and to open 12 crisis respite homes over a two-year period.

The state is reconfiguring the crisis response so that a provider will no longer have to offer mobile crisis response, in-home support, and respite homes. The state has issued an RFP for a combined behavioral health and developmental disability mobile crisis response system and will be issuing separate RFPs for both in-home crisis supports and crisis respite homes. State officials say that having separate crisis response for the developmental disabilities and mental health systems has sometimes led to confusion over whether a person should be served by the DD crisis team or the behavioral health crisis team.

A March 27, 2018, report[4] by an independent reviewer for the settlement agreement noted that Georgia has had difficulty limiting stays in crisis respite homes to 30 days. Thirty of the 39 people who were in crisis respite homes at the time of the review — or 77% — had been there for more than 30 days: Of those 30 individuals:

- 22 had lived in the homes since 2017;
- 5 were admitted in 2016; and
- 3 had been there since 2014. One of them had been admitted in August 2014, one in June 2013, and one in June 2012.

The report cited "very challenging" barriers to discharge, including behavioral management issues and a lack of providers with the skills and resources to provide services in an alternative setting.

New Mexico

The state Bureau of Behavioral Support provides crisis response services at three different levels, depending on the needs of the person. Tier I services encompass training and technical assistance for providers so the provider can offer necessary supports in hopes of preventing a crisis situation. State employees provide the training. Tier II services add on-site support and mentoring for the direct-care workers who are responsible for the person. These services are usually provided by state

[4] "Notice of the Joint Filing of the Report of the Independent Reviewer," United States of America v. The State of Georgia, et. al., Civil Action No: 1:10-CV-249-CAP, March 27, 2018, p. 26.

personnel or by direct support professionals who have received specialized training and can be used when needed to help out in crisis situations. Tier III response involves services from a provider certified as a crisis provider agency. That provider offers direct crisis support services to the person, either at the person's home or in another residential setting if necessary.

Providers offering either Tier II or Tier III services are able to bill for the services. The state's *Developmental Disabilities Waiver Rate Table* indicates that crisis support in the individual's residence can be billed at the rate of $9.05 every 15 minutes, while crisis support in an alternative residential setting is billed at $345.17 a day.

Like Georgia, New Mexico's crisis response system was developed as part of a settlement of a lawsuit. The settlement required the parties to present a proposal on crisis services by Sept. 30, 2004, and to jointly develop a plan for providing Tier I, II, and III services statewide.

Cost of Crisis Services

The following information was provided by state officials about the costs of the crisis services in the three states.

Montana

Montana's Behavior Consultation Team currently consists of a supervisor in Helena, a behavior consultation specialist located in Billings, and a behavior intervention specialist located in Great Falls. Two positions are vacant. The team also can obtain additional support from contracted physicians and a licensed therapist. The current costs for the team are $359,277, with personnel costs making up all but $1,500 of that amount. The remainder is spent on travel costs.[5]

Georgia

Georgia contracts with four companies to provide crisis services in its six regions. The contracts total about $127.6 million a year. The cost covers the mobile crisis response teams that travel to a person's home as well as the in-home supports a person may need and the crisis respite homes the provider must operate as part of their contracts.[6]

Any person eligible for developmental disabilities services is eligible to receive the crisis services.

New Mexico

The New Mexico state agency providing crisis services has five regional offices and a staff of 15 full-time equivalent (FTE) employees. Each office is staffed by a regional behavioral specialist who has a master's degree in a mental health profession and a regional crisis specialist whose educational background could vary depending on the person's years of experience in the field. The administrative staff consists of a bureau chief, a statewide crisis coordinator who supervises the crisis specialists, a clinical director who supervises the behavioral specialists, and an administrative assistant. In addition, the bureau's employees staff a 24-hour crisis line, and the bureau contracts with five consultants for specific services or technical assistance.

The table on the following page summarizes the costs related to the Bureau of Behavioral Support.

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[5] DPHHS response to information requests, provided by Marie Matthews, DPHHS Medicaid and Health Services Branch Manager, May 1, 2018.

[6] Information provided by Beth Shaw, Director, Office of Transitions, Georgia Department of Behavioral Health and Developmental Disabilities, May 3, 2018.

Item	Yearly Cost
State Staff: 15 FTE	$747,650*
Consultant Contracts	$370,300
Hotline	$51,000
Total	**$1,168,950**

*Figure does not include benefit or retirement costs

The state also budgets $230,000 a year in general fund that can be used for a number of purposes, ranging from supports for people experiencing a behavioral crisis to paying housing-related costs for people in emergency situations or paying for staff support when someone is hospitalized. The state spent $97,100 of the appropriation in FY 2017.[7]

Options for Committee Consideration

If the committee decides to pursue legislation related to crisis services, members should decide the following questions to guide the drafting of a bill.

1. Should the state contract with a private provider for crisis response, as Georgia does, or provide response through a DPHHS-administered and staffed program, similar to New Mexico?
   a. If services are contracted out, what elements of crisis response should the contractor be required to provide?
   b. If services are provided by DPHHS, how many staff members and what types of specialists are needed? What services should be included?
   c. How specific does the committee want any draft legislation to be in terms of staffing and services?
   d. To what degree should any draft legislation detail the elements of a crisis response system and to what degree should it allow DPHHS discretion to identify those elements?

2. Should DPHHS continue its current model of consultation services at an increased level? If so, to what degree should services be increased?

3. Should any change to the crisis response system be implemented statewide or undertaken as a pilot project with a report back to the 2021 Legislature on recommendations for statewide implementation?

4. Should DPHHS be directed to undertake any of the crisis response activities it outlined to the MDC Transition Planning Committee, as noted on page 2? If so, which ones?

5. Should DPHHS be directed to revise the 90-day exit policy to allow a provider to stop serving an individual under certain circumstances?

6. Are there other crisis-related bills or activities the committee would like to consider?

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[7] Information provided by Cheryl L. Frazine, Chief, New Mexico Bureau of Behavioral Support, May 2, 2018.

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