Members

Sen. Ronald Grooms, Chairperson
Sen. Jean Breaux
Rep. Wes Culver
Rep. Sheila Klinker
Sally Lowery
Suda Hopkins
Betty Williams
Christopher Durcholz
Susan Ferverda Hoback
Bettye Dunham
Scott Sefton
Sharon Kooi

LSA Staff:

Kathy Norris, Fiscal Analyst for the Commission
Ann Naughton, Attorney for the Commission

Authority: IC 2-5-27.2

COMMISSION ON DEVELOPMENTAL DISABILITIES

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

MEETING MINUTES[1]

Meeting Date:	**September 24, 2013**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 233**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Sen. Ronald Grooms, Chairperson; Sen. Jean Breaux; Rep. Sheila Klinker; Christopher Durcholz; Bettye Dunham; Scott Sefton.**

Members Absent: **Rep. Wes Culver; Sally Lowery; Suda Hopkins; Betty Williams; Susan Ferverda Hoback; Sharon Kooi.**

The third meeting of the Commission on Developmental Disabilities was called to order at 10:12 A.M. by Senator Grooms, Chairperson. Members introduced themselves, and Sen. Grooms reviewed materials distributed to the members by staff. (Exhibits 1 and 2.)

Dee Quaglio, Direct Support Professionals (DSP)
Ms. Quaglio addressed the DSP Initiative, a collaborative pilot program that was designed to develop an educational and career ladder for direct support providers. (See her written remarks in Exhibit 3.)

Commission discussion and questions followed concerning wages of DSPs, the need for increased compensation, and the role that mandatory certification might play in increasing compensation and eliminating "bad actors". Commission member Bettye Dunham, discussed the costs of wages and benefits for DSPs and the struggle that agencies have in filling DSP positions. Scott Sefton discussed the idea of developing a state registry of persons who have been convicted of neglect, abuse, or exploitation of clients with developmental disabilities to prevent these persons from re-engaging in this behavior under the employment of a different

[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

agency. There was further discussion concerning the effectiveness of registries in addressing the problem of identifying persons who have been involved in neglect, abuse, or exploitation of clients and subsequently preventing them from being employed as a service provider by a different employer. The Chairperson commented that he would investigate actions that might be necessary to resume the pilot career ladder and certification initiative, the potential of a registry, and a certification program.

John Dickerson, Executive Director, The ARC of Indiana
Mr. Dickerson explained the terminology applied to individuals with developmental disabilities and mental illness. Providers that deal with the developmentally disabled refer to this as the dually diagnosed population, while mental health providers refer to co-occurring illness. He described the difficulty of providing appropriate services to the dually diagnosed client. He then introduced Dr. Joan Beasley.

Joan Beasley, M.Ed., Ph.D., Director, Center for Start Services, University of New Hampshire
Dr. Beasley showed a video and discussed the Systematic Therapeutic Assessment, Respite, and Treatment (START) program currently used in 23 locations, including Texas and Virginia. She explained that the START program is a systems change; it evaluates the services that are in place and determines what services or supports the existing system needs to better support dually diagnosed individuals. (See the slide presentation and other handouts in Exhibits 4, 5, 6, and 7.)

Commission questions and discussion followed. In response to a question from Chairman Grooms concerning how to determine if the START program would work well in Indiana, Dr. Beasley explained that the process begins with the performance of a gap analysis intended to determine what services are in place and what areas could be improved. One piece of the analysis is an examination of the most expensive clients in the system. Additional discussion topics included the role of police agencies and respite programs in crisis management and how the program is financed in other states. In response to questions about implementing a pilot program in Indiana, John Dickerson explained that introducing the START model to the Commission was the goal of this meeting. The program is concentrated on capacity building instead of building a new service/funding silo. He suggested the first step would be to investigate what resources would be required and how to do the gap analysis before proceeding with a pilot. The Commission members discussed where a pilot might be located, and Dr. Beasley explained that would have to be determined after the gap analysis was completed.

Steve Cook, Vice-president, Anthony Wayne Services (AWS)
George Harris, Director, Crisis Management, AWS
Mr. George Harris introduced himself as the Director of AWS Benchmark Program in Georgia. He described the system that AWS has established in Georgia as recommended by the Department of Justice. He explained that Georgia chose AWS services as a best practice model as demonstrated by data generated from Indiana experience. He explained that AWS had been contracted to provide crisis management services in Indiana from 2007 to 2010, but that the contract was not renewed after 2010 due to budgetary pressures. Mr. Steve Cook provided some background information on the AWS contract program that was operated in the southern and northern regions of the state prior to 2010. Mr. Cook reviewed the program statistical data collected during the term of the Indiana contract and in Georgia. (See slide presentation in Exhibit 6.)

Commission discussion and questions followed regarding the differences between the AWS program and the START program described by Dr. Beasley. Dr. Beasley commented that aspects of the two programs are similar. Chairman Grooms pointed out that the two programs would not be incompatible.

After asking for public comments or discussion, the chairman suggested that he would be asking further questions concerning how the state should address the lack of crisis management services. The meeting was adjourned at 12:50 P.M.

Developmental Disabilities Commission Follow-up

August 6, 2013

First Steps Program: Cathy Robinson

- Senator Breaux: Does the First Steps program operate with an annual deficit? If so, what is the deficit?

  Answer: For the period between July 1, 2012 and June 30, 2013, First Steps' deficit was about $600,000. This is less than in previous years. FSSA is able to utilize funds from other programs if additional funds are needed.

- Senator Breaux: Can you provide a link to the First Steps program website?

  Answer: www.firststeps.in.gov

- Senator Grooms: How do we compare to other states in regards to program population, funding and services provided?

  Answer:

  Federal Fiscal Year 2011 (July 1, 2011 – June 30, 2012)

  Percentage of Indiana's 0-3 Population Served: 3.54%
  National Average of 0-3 Population Served: 2.75%

  Federal Fiscal Year 2010 (July 1, 2010 – June 30, 2011)

  Percentage of Indiana's 0-3 Population Served: 3.92%
  National Average of 0-3 Population Served: 2.82%

  Each state has its own set of legislated eligibility criteria for Part C services (broad, moderate, and narrow). Indiana has been considered a 'moderate' eligibility state since 2007. Compared to other states with moderate eligibility criteria, Indiana's percentage is very similar.

DDRS Annual Update: Nicole Norvell

- Senator Grooms: What is the total VRS population?

  Answer: The total individuals served during SFY13 was nearly 30,000. The active caseload at the end of SFY13 was approximately 17,000 (snapshot as of 6/30/2013). Individuals apply and exit VR throughout the course of a year.

- Mr. Sefton: What is the average length of time from the moment an application is filled out to when services are delivered?

  Answer: For the VR program, the average number of days from application to Individualized Plan for Employment (IPE – the VR service plan) is currently 87 days (average for past 12 month period). The

Exhibit 1
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federal timeliness requirement is that eligibility be determined within 60 days of application, and that IPE is developed within 120 days of eligibility.

- Senator Breaux: Does FSSA have a common client system? How was/will the development of this system be funded?

  Answer: Currently, we call common client index the ECI (enterprise client ID), but it is communicated to all divisions for all clients submitted. Each month the divisions send client records through a matching process to be incorporated into each system.

Developmental Disabilities Commission Follow-up

August 27, 2013

Nicole Norvell

- Senator Grooms: What are the primary types of disabilities served by the CIH waiver?

  Answer:

Mild Intellectual Disability (IQ: 50-69)	2,378
Intellectual Disability (unspecified IQ range)	1,685
Moderate Intellectual Disability (IQ: 35-49)	853
Autism	803
Profound Intellectual Disability (IQ: 0-19)	643
Severe Intellectual Disability (IQ: 20-34)	430
Cerebral Palsy	347
Borderline Intellectual Disability (IQ: 70-84)	269
Down Syndrome	180
Development Delay NOS	106

  Gender:

  Male: 59%
  Female: 41%

- Representative Culver: What month and year are we currently targeting?

  Answer: Our next targeting date is June 5, 2008.

Commission on Developmental Disabilities
Legislative Services Agency
23-Sep-13

	Topic	Scheduled	Heard	Additional Issues Identified	Draft Legislation Requested	Drafted	Commission Recommendations
1	Services for Offenders in state prisons		8/6/2013	Services & treatment of DD offenders in Co. Jails			
2	Transitioning Prisoners to Community		8/6/2013				
3	Services for Dually DX	8/14/2013	9/24/2013				
4	Adult Guardianship	8/14/2013	8/27/2013 9/24/2013	Supreme Ct. Guardianship Registry funding			
5	Medicaid Waivers		8/6/2013	DSP reimbursement for hospitalized clients			
6	Provider Reimbursement	8/14/2013	8/27/2013	Restoration of Medicaid reimbursement cuts			
7	Money Follows the Person Federal grant		8/27/2013				
8	First Steps Program		8/6/2013				
9	Crisis Management	9/19/2013	9/24/2013				
10	After-school care for Special needs children						
11	Medication Therapy Mgmt						
12	Respite Care						
13	Career ladder & training for Direct Service Providers (DSP)		8/27/2013	Direct Service workforce development			
14	Work opportunities for DD		8/27/2013	Post-Secondary Ed. & training programs for DD			

Exhibit 2
Commission on
Developmental Disabilities
Meeting 3, 9/24/2013

Direct Support Professionals of Indiana (DSPIN)
2013 Policy Priorities

Who We Are

DSPIN is the association for Indiana's direct support professionals (DSPs), governed by and for DSPs. As a state chapter of the National Association of Direct Support Professionals (NADSP) our mission is to provide educational and professional development opportunities for Hoosier DSPs and raise awareness about the important work DSPs do every day in supporting individuals with disabilities to live and work in their chosen community.

Historical Mission

DSPIN was initially formed in connection with Indiana's efforts to develop an educational and career ladder for Indiana DSPs. Known as the DSP Initiative, this effort brought together the Division of Disability and Rehabilitative Services, the Indiana Institute on Community and Disability, Ivy Tech Community College, the Department of Workforce Development, and INARF to design and implement a pilot program that provide DSPs an opportunity to secure a Career Development Certificate. Because it was based out of Ivy Tech, the course work was available to all students and had the potential to help recruit professionals to the field.

DSP Training in Indiana

Currently, all providers are required to train their Direct Support Professionals to competency in several key areas, prior to providing hands on support to individuals served. Most providers comply with this requirement with orientation training. Agencies typically provide up to 40 hours of pre-service orientation training and then periodic in-service training as a DSPs job duties change and/or to keep current. Agencies may pick their own orientation curriculum, so long as the result is that their DSPs are trained to competency in the following areas: person-centered planning; protection against abuse, neglect and exploitation; health and wellness; medication administration; First Aid and CPR; and individual-specific interventions.

The DSP Training Initiative

Beginning in 2007 through 2009, the DSP Initiative laid the ground work to standardize this orientation training (referred to as the Foundations of Direct Support Professionals), provide an education and career ladder, and tie to the national credential offered through NADSP. After orientation, interested DSPs could achieve their national credential through either a DSP-specific human services certificate through Ivy Tech, the College of Direct Support, or the Department of Labor Apprenticeship program. Offering three pathways provided both DSPs and the agencies that employ them with options, as to what curriculum provided the best fit. The Ivy Tech certificate was the most developed pathway and as a result the most used.

inarf

The Ivy Tech pathway was based out of their Human Services Program. Four sites provided online courses: Bloomington, Muncie, South Bend and Valparaiso.

The Initiative was piloted with nine agencies across the state. The pilot provided funding to offset the direct and indirect costs to participate in the program. Direct costs included things like tuition, books, and fees, while indirect costs included the mentoring and coordination provided by the pilot agencies in supporting DSPs enrolled in the program. The pilot also provided funding to offer a wage increase to successful graduates of the certification program.

DSP Initiative: Key Outcomes

- From fall 2007 to summer 2009, 2,000 DSPs participated in the Foundations for Direct Support Professionals program.
- Of those 2,000 staff, about 25% enrolled in the DSP Certificate Program.
- By summer 2009, 126 DSPs had graduated from the Ivy Tech DSP Certificate Program and many of them have continued to work toward the Technical Certificate and Associates Degree.
- Initial results demonstrated that those DSPs who completed the program developed a deeper commitment to the individuals they served, required less supervision and direction, and were focused on creating meaningful and quality outcomes.
- Unfortunately, none of the Ivy Tech courses are offered today due to lack of funding; however, initial results indicate that the DSP Initiative was off to a strong start.

2013 Policy Recommendations

As stated during the August and September Commission meetings, we specifically recommend:

1.) The Commission considers efforts, legislative or otherwise, to study ways to revisit the DSP Training and Professional Development Initiative and make Indiana a state that works for DSPs. The study should work towards bringing actionable recommendations to the DD Commission for study during the 2014 interim period.

2.) Consideration be given to taking action to add a Direct Support Professional as named member of this Study Commission. At present, the Commission is composed of state legislators and citizen commissioners who speak on behalf of self-advocates, families, and disability service providers. DSPs are a crucial link to services and supports and persons served, yet we lack a voice on the Commission. In recognition of the crucial role that DSPs play in the service delivery system, we respectfully request that that the Commission adds one commission seat for a Direct Support Professional.

A Systems Linkage Approach START

Systemic, Therapeutic, Assessment, Resources and Treatment

Joan B. Beasley, Ph.D.
Research Associate Professor
University of New Hampshire
Institute on Disability

NC-START Movie

The Social Movement Toward Community Living for All

- Between 1967-2000, the number of people with ID in MR/DD and MH institutions reduced by 79%
- Populations decreased by 76% from 194,650 to 47,592
- By June 2000 only 12.6% of people residing outside of families lived in institutions

Exhibit 4
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Positive Outcomes for Individuals with Disabilities

- Functional skill development
- Social relationships
- Community participation
- Family satisfaction
- But not always... those who were left behind.

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Individual Rights and Equality

- The Olmstead decision (1999): restrictions that derive from the government's unwillingness to respond to established benefits of community life as assured by the Americans with Disabilities Act, constituted unlawful discrimination
- Concluded that states are required to place individuals in community settings rather than institutions when they are appropriate with reasonable accommodation
- Spoke out against unjustified segregation of people with disabilities
- But not so fast...Our mission is to prove that individuals with behavioral issues are "appropriate"

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The Importance of Community Capacity in Reducing Use of Institutions

- Adult issues continue
- Research findings indicated that people with challenging behaviors are less likely to be served in community in U.S. residential and day services
- People with co-occurring disorders fall between in cracks

Evaluate the Effectiveness of the System of Care (On an Ongoing Basis) in Addition to the Person in Need

Service System Trends

- Costly and ineffective residential services, over-reliance on high staffing patterns and single programs as remedies
- Inadequate collaboration between provider agencies, state services
- Ineffective community mental health services including crisis services
- Little to no accessible crisis or respite beds
- High case management caseloads - no special training for this population

The System Goes Into Crisis With the Person

- Homelessness
- Incarceration
- Hospitalization
- Overmedication
- Restrictive services
- "Falling between the cracks"
- Harmful care

Trend: The Crisis Plan Begins at Time of Crisis, not Comprehensive; High Use of Expensive, Emergent Services

When Inpatient Unit Becomes Temporary Housing

- No place to go, homeless
- Cannot return home yet
- No service system taking responsibility (not "enrolled")
- Hospital reluctant to take additional patients increases likelihood of State Hospital admissions

Poor Collaboration with Families

- Families not informed
- Family viewed as the problem
- Not educated about service options
- Overburdened
- Large meetings, but no dialogue
- They know their loved one best
- We rely on them as informants and caregivers
- They are not case managers!

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"The world as we created it is a process of our thinking. It cannot be changed without changing our thinking."

~ *Einstein*

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Coordination of Services Helps to Insure Effectiveness

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The Need for Effective Services:

The 3 A's

- Access
- Appropriateness
- Accountability

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Access

- Timeliness
- Array of services
- Availability
- Geographic proximity
- Resources alone should not define service use…

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"Unfortunately, you have what we call 'no insurance.'"

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Appropriateness

- Roles are clear
- Providers have expertise
- Defining the problem
- Service matches needs…

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Accountability

- There is consensus with regard to roles and responsibilities on the part of providers
- Services are cost effective
- Recipient is satisfied with services
- Services meet objectively established goals
- Services change with the changing needs of the service user
- Listening and mutual respect in the system is required...

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A Brief History of START

- Massachusetts in 1988

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The "START" model: Systems Linkage Approach

- KEY: Enrich the system (avoid strain)
- Resources allocated to promote linkages (i.e. the use of a linkage "team")
- Resources allocated to fill in service gaps
- Services provided across systems
- Outreach is key
- Develop a common language

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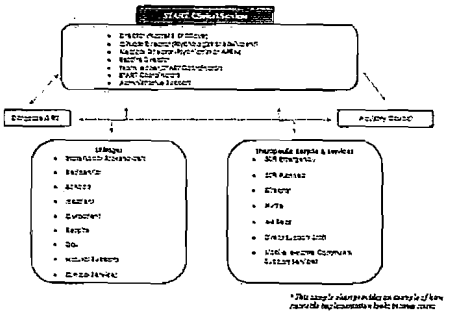
SAMPLE START ORGANIZATIONAL CHART*



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The Benefits of Linkages

Synergy: 1. Mutually comparable combined action or operation. 2. The interaction of elements that when combined produce a total effect where the sum is greater than its parts.

Video Link

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Essential Components

- Linkages
- Expertise (in some places this needs to be developed)
- Family support and education
- Planned and emergency therapeutic resources (respite services)
- Cross systems crisis prevention and intervention planning
- Employs evidence-informed practices and outcome measures (advisory council, clinical team, data analysis)

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Core START Elements

- Trained Linkage Coordinators
- Direct support training (Emotional intelligence)
- Linkages (local, statewide, national)
- Consultation, service evaluations
- Training, forums for collaboration
- Crisis support 24 hours/7 days a week
- Planned therapeutic resources (respite; in-home and program-based)
- Emergency therapeutic resources (respite, mostly program based)
- Expertise as members of core team
- Data-driven, evidence-informed practices

Community-Based Crisis Response

- Must be: available and accessible, integrated into the overall system, use a multidisciplinary team approach, and be able to communicate effectively
- Crisis Evaluation, Prevention, Intervention, and Stabilization
- The referent is usually not the person "in crisis" and may be in more of a crisis than the person they are calling about!

START Service Development

- First peer-reviewed article describing the model published in 1990
- Beginning in 1990, many other locations in North America developed some services based on START (see map), i.e., Minnesota, with promising results
- Some of the protocols adapted with mixed success; needed technical support, a more comprehensive approach, patience, funding
- Research funded through Merck II Scholars program first published in 2000 on original START program
- Washington State Collaborative Work Plan (2001)
- Cited as a National Model in the US Surgeon General's report (2002)

START Service Development (23 regional teams)

- TNSTART (2003-2007); new services (2014)
- NC START first statewide implementation (2009),
- NH (2010) statewide and lifespan (2013)
- Virginia statewide (2011)
- Ohio: First START local program developed for children and transitional youth (2009)
- Ark: First START program developed by a private provider network (2011); expansion statewide(2013)
- Noted as a best practice by NASDDS (2012)
- Move toward lifespan services NH and Ohio (2012)
- NY: Pilot with two regions (2013)
- Texas programs Tarrant County, Travis County, El Paso Community (2013)

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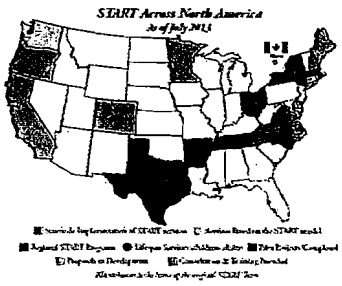

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START Funding Table

State	Medicaid Funds: Medicaid Healthcare Transformation Waiver (1115)	Medicaid Funds: Balancing Incentive Program (BIP) Grant	Medicaid Funds: Other Medicaid Waiver Services (1915)	Medicaid Funds: Medicaid (Fee for Service)	State Funds	County Levy Funds	Number of teams/type	Date
Massachusetts					X (50% match through Medicaid waiver admin.)		1 regional	1983
North Carolina			x (very limited)		x		3 statewide regional	2007
Ohio				x		x	1 County Board	2009
New Hampshire		x	x		x		3 statewide regional	2009
Arkansas			x		x		3 statewide regional	2010
Virginia				x	x		5 statewide regional	2011
New York		x	x				2 regional pilot for statewide	2012
Texas	x						3: 2 regional, 1 county	2013

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The Role of the Center for START Services

1. Training by national experts, identifying local experts
2. Technical support to START teams
3. Measures of fidelity
4. Evidence-based practices
5. Linkages between START teams
6. Research and publishing
7. Development of leaders to improve systems of care throughout the U.S.

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START Information Reporting System (SIRS)

Purpose: web-based data collection system for managing START services.

- Provides service outcome feedback to project managers and administrators to assess the effectiveness and efficiency of START services
- Captures de-identified information about START clients and has the ability to provide reporting by case load, by region and by state
- Supports a continuous quality improvement approach

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What We Learned from the Original START Program

- It takes time: In year three, there was a significant drop in emergency service use
- Expertise developed, now part of community
- Families remained intact with support
- Traditional MH providers were more willing to serve
- Cross systems crisis planning core service element
- As the system became more efficient could serve many more people for the same dollars

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Comparison of Average Emergency Service Usage (and Associated Costs) of Clients with and Clients without TN-START Services (N=20)

Emergency Service	TN-START Clients	Average Cost	Non-TN-START Clients	Average Cost
Emergency Room Visits	0.47	$39.34*	5.2	$435.24
# of Psychiatric Hospitalizations	0.67		2.6	
Hospital Days	7.3	$4,403.21	19.93	$12,021.38
Crisis Contact	(TN-START Crisis) 2.7		(Community-Based Mobile Crisis) 2.7	
# of Police Contacts	0.67		4.13	
# of Arrests**	0.27		0.2	
Respite Days	7.6	$3,274.00	32.2	$15,778.00

Cost Per Individual - First Year of Implementation of NC START

- Average annual cost per individual supported by NC START - **$6,674**
- The average cost per day of state psychiatric hospitals is $1,200, but the first 3 to 5 days are more expensive due to assessments and evaluations that are conducted. A conservative cost estimate of a **7** day stay - **$10,000.**

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Regional Data SFY0910 – Estimated Cost Savings

- *If NC-START prevented only one hospitalization for each of those diverted during 2009:*

Diversions (120 x $10,000) = $1,200,000

NC-START (120 x $6,674) = $800,880/year

Savings *$ 399,120*

Key Goals and Outcomes (from Washington State)

- Provide hope
- Form an alliance
- Decrease immediate involvement of police, fire, criminal justice system, ERs and hospitals
- Increase linkages

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"You never fail until you stop trying."

~ Einstein

Systemic Therapeutic Assessment, Respite and Treatment

START Program Overview

REV 4.25.13

Exhibit 5
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The contents of this manual and related companion guides for the implementation of the START program are approved by the Center for START Services, University of New Hampshire, Institute on Disability (UNH/IOD) for application of the START model. This Overview and its Companion Guides intend to provide a detailed description of the elements of the START program and guidelines for promoting fidelity to the model.

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START Mobile In-Home Community Support Services ..... Page 40

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Introduction to START

START (Systematic, Therapeutic, Assessment, Respite and Treatment) is a linkage model to promote a system of care in the provision of community services, natural supports and mental health treatment to people with intellectual and developmental disability and mental health issues (IDD/MH).

This model, first developed in 1988, and cited by the Surgeon General's Report (U.S. Public Health Service, 2002), has been used as a basis for the development of services throughout the United States. The goal of START is to enhance the existing system of care, provide technical support and assistance, and fill in service gaps. Emergency and planned therapeutic respite programs and supports are included in the services provided to meet this important goal.

Fidelity to the model is essential for success. While START promotes the development of services in the context of the local system of care, essential mechanisms must be in place for effective service delivery.

Mission Statement

The Mission of START is to enhance local capacity and provide collaborative cost-effective support to individuals and their families through exemplary clinical services, education and training, with close attention to service outcomes.

In meeting this mission, START aims to:

1. Promote the development of least-restrictive, life-enhancing services and supports to the people referred.
2. Provide 24-hour-a-day, 7-days-a-week timely response to the system of care in support of individuals with IDD and behavioral health care needs. In times of crisis this means immediate telephonic access and in-person assessments within two hours of the request whenever possible.
3. Provide clinical treatment, assessment, and stabilization services in the context of short-term therapeutic respite – both emergency (hospital prevention, transition to community, and acute assessment and treatment) and planned (ongoing support for the individual and care provider for individuals who primarily live with family members or other natural/unpaid supports).
4. Facilitate the development and implementation of individual, Cross-Systems Crisis Prevention and Intervention Plans.
5. Provide support and technical assistance to partners in the community including but not limited to: Individuals and their families, Mobile MH Crisis

Teams, residential and day providers, and outpatient and inpatient MH providers.

6. Provide state-of-the-art assistance through Certified START Coordinators along with a highly trained work force, access to experts in the field, linkages with local and national resources, and the commitment to ongoing consultation and training for both the START programs and their partners.
7. Create and maintain affiliation and linkage agreements with community partners in order to clarify roles and responsibilities, overcome existing barriers in the system, and enhance the capacity of the system as a whole.
8. Provide systemic consultation to work with teams to improve: opportunities for mutual engagement; understanding and a team approach that fosters clarity of roles and responsibilities; and cooperation and collaboration in the context of a comprehensive understanding of the people we serve.
9. Assess the needs of the population locally, statewide, nationally, and internationally, and work with stakeholders to insure that effective service delivery takes place.
10. Collect data, measure outcomes, and modify strategies to meet the aforementioned goals.

Service Effectiveness

A primary goal of all START programs is to promote effective supports and services for persons with IDD and behavioral health needs. Service elements aim to accomplish goals to improve access, appropriateness, and accountability – the three cornerstones of the START model.

Access to Care and Supports: Care must be inclusive, timely, and community-based. We provide a systemic approach to link systems and improve access to all services including those of our affiliates and partners.

Appropriateness of Care: Appropriateness of care is reflected in the ability of service providers to meet the specific needs of an individual. This requires linkages to a number of services and service providers, as individual service needs range and change over time. It also requires expertise to serve the population.

Accountability: The third essential element for effective service provision is accountability. There must be specified outcome measures to care. Service systems must be accountable to everyone involved in the provision of care and this includes funding sources. Outcome measures must be clearly defined, and

review of data must be frequent and ongoing. The service delivery system must be accountable first and foremost to the persons receiving care. Therefore, outcome measures need to account for whether an individual's service/treatment plan is effective over time. Service recipient satisfaction with services is an important outcome measure as well. Accountability measures should also pay attention to cost. Services must be cost effective, and when insuring access and appropriateness, they can also be treatment effective. The three only conflict with each other when attention to appropriateness of care and the need for access are lacking.

Finally, accountability is a measure of the ability of a system to adapt to changes in individual service needs. Systems must have a structure that can readily adapt to changes in the demands which are placed upon them. In order to provide an effective service delivery system and continue to assess progress in meeting our goals, the Center for START Services, the University of New Hampshire, and participating projects developed a START Information Reporting System (SIRS). Utilizing unique ID numbers, the SIRS database captures de-identified health information about individuals receiving START services and has the ability to provide reporting by case load, by region, and by state. Analysis of service outcomes will provide valuable information on service effectiveness over time and be used as a management tool for decision-

makers. Analysis of data must be used as a barometer to determine where a service delivery system has succeeded and where it must now go. Data is multi-dimensional and includes both qualitative as well as quantitative measures.

The START model emphasizes that appropriate services are to be both readily accessible and provided in a timely fashion. Data collection and review determines the need for modification of resources to comply with this requirement. The program is designed to evolve over time to meet the needs of the population and the system of care.

Who is Eligible for START?

All individuals eligible for START services must have a developmental disability and significant behavioral or mental health needs that have not been adequately addressed with typically available supports. Individuals with a developmental disability (eligible for START) meet the following criteria.

"Developmental disability" means a severe, chronic disability of a person which:

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
b. Is manifested before the person is 18 years old
c. Is likely to continue indefinitely;

d. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction, and economic self-sufficiency; and
e. Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or
f. When applied to children from birth through four years of age, may be evidenced as a developmental delay.

START Clinical Team

The START clinical teams offer both the linkage/clinical and respite services that will be described in greater detail in the pages that follow.

The START Clinical team consists of the following personnel:

1. A Director who supervises the Respite Director, Clinical Director, Medical Director, and the START Team Leader, and oversees the operations of the program.

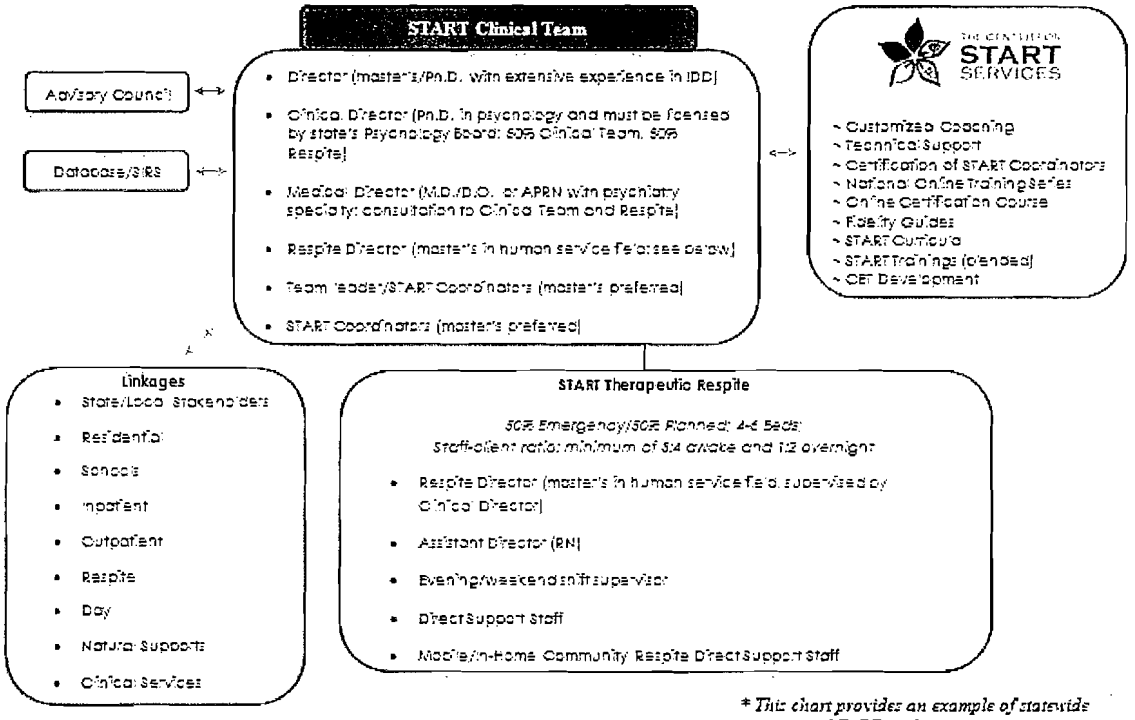
2. The START Coordinator Team Leader who oversees START Coordinator services and carries a halftime caseload.
3. START Coordinators who provide 24-hour crisis support, linkages, outreach, and consultation services.
4. Consulting psychiatrist who serves as the Medical Director.
5. Fulltime psychologist who serves as the Clinical Director.

The START Respite personnel consist of the

1. Respite Director
2. Assistant Director/ Nurse
3. Qualified direct support professionals

Prior experience in the field and a proven track record of high standards of performance are emphasized in the selection of all START personnel. Each START team includes local experts to enhance the ability to meet the program's goals.

START ORGANIZATIONAL CHART*



** This chart provides an example of statewide START implementation*

START Team Personnel Descriptions

DIRECTOR of START Team (1 FTE)

The Director facilitates all linkage agreements, is the primary contact with stakeholders, and provides reports to the Advisory Council. The Director participates in all trainings required to become a Certified START Coordinator. The Director supervises the Clinical Director, Medical Director, Respite Director, and the Coordinator Team leader.

Required Qualifications: Must have a Master's degree or Ph.D. with extensive experience in Intellectual and Developmental Disabilities (IDD), specifically with individuals that have challenging behavior and/or mental health needs. Four years of supervisory experience in the IDD and/or mental health field is also required. Knowledge of the state system of Mental Health/Developmental Disabilities/Substance Abuse Services is critical.

Primary Responsibilities:

- Supervise/oversee Clinical Team and Respite facility
- Establish community linkages and serve as liaison to community partners
- Based on feedback of Clinical Teams, identify training/support needs of the community
- Coordinate trainings utilizing expertise of psychologists and psychiatrists, Team Leaders, and specialists within the community
- Identify and coordinate necessary trainings for team members
- Maintain communication with other regional START Directors
- Ensure the collection of required data and documentation on consumer access and utilization of START services
- Provide support as needed to clinical team and respite 24/7/365

CLINICAL DIRECTOR (1 FTE)

The Clinical Director serves as senior clinician on the team. Half-time is spent at the respite facility and half-time is spent with the clinical team, supervising and training the START Coordinators and community partners.

Required Qualifications: Ph.D. in Psychology and currently licensed by the state's Psychology Board as a Licensed Psychologist with extensive experience in Intellectual and Developmental Disabilities (IDD), specifically with individuals who have challenging behavior and/or mental health needs. Experience developing and implementing behavior support plans is preferred.
(Note: In some programs this responsibility may be shared between a fulltime masters' level clinician and a part time licensed psychologist.)

Primary Responsibilities:

- Provide oversight and consultation on behavioral supports
- Provide training and consultation to staff, families and providers
- Participate in recurring team meetings as necessary
- Develop behavior support plans as necessary for guests at respite that require more extensive safety measures
- Participate in discussion regarding potential respite admissions

- Provide on-site consultation as needed for guests receiving respite services, including assessments for guests at respite
- Assist with the development and implementation of all Cross-Systems Crisis Prevention and Intervention Plans and Comprehensive Service Evaluations as needed
- Provide ongoing clinical supervision to START Coordinators
- Coordinate and lead monthly Clinical Education Team meetings

MEDICAL DIRECTOR (.25 FTE)

The Medical Director is a psychiatrist or nurse practitioner who has expertise in the mental health aspects of IDD. The Medical Director serves on the Clinical Education Team, and provides expert consultation at START Respite and to the Clinical Teams as needed. The START Medical Director provides consultation and training to psychiatrists in the community.

Required Qualifications: M.D./D.O. or APRN with specialty in psychiatry or developmental pediatrics and currently licensed to practice medicine in the START project state. Extensive experience treating individuals with Intellectual and Developmental Disabilities (IDD) and challenging behavior or dual diagnosis (mental illness and IDD).

Primary Responsibilities:

- Provide consultation and training to staff
- Provide consultation to primary treating physicians of individuals supported by START
- Provide consultation to psychiatric hospitals regarding treatment of individuals with I/DD and/or dual diagnosis
- Participate in recurring team meetings as necessary
- Provide on-site consultation and treatment as needed for guests receiving respite services

RESPITE DIRECTOR (1FTE)

The Respite Director is responsible for supervising all respite activities, both facility-based and in-home services.

Required Qualifications: Master's degree in a human service related field and no less than one year of supervisory experience in a residential care setting.

Primary Responsibilities:

- Provide clinical and administrative support/supervision of respite counselors

- Coordinate with START Clinical Teams on admissions to and discharges from respite
- Plan and implement structured day programming for all guests
- Develop discharge/transition plans for all guests utilizing emergency respite services
- Maintain contact with families and/or providers upon admission to respite services
- In collaboration with START Clinical Teams, identify ongoing support and training needs of families and providers who utilize START respite
- Maintain linkages and relationships with community partners
- Attend all required meetings with START Leadership, Clinical Team, etc.
- Convene and facilitate recurring START Respite staff meetings
- Identify and coordinate necessary training for respite staff
- Ensure the collection of required data and documentation on guest access and utilization of START respite services

NURSE (1 FTE)

The Nurse works out of the respite program and serves as the Assistant Respite Director. The Nurse provides clinical consultation at the respite facility and in the community through the START clinical teams as needed.

Required Qualifications: It is preferred that the nurse be an RN. Expertise in working with individuals with IDD for a minimum of five years is required.

Primary responsibilities:

- Provide medical oversight of START respite/ assistant director of respite is preferred but not required
- Provide consultation to START clinical teams
- Provide training to START team and community as needed

START Coordinator TEAM LEADER (1 FTE)

Supervises all START Coordinators and works in close collaboration with the Respite Director and Senior Clinicians, fulfills all duties of a START Coordinator. Must have all skills of a certified START Coordinator, and participate in the certification program.

Required Qualifications: Master's degree in human service field preferred and experience in programming for individuals with challenging behavior and/or mental health needs.

Primary Responsibilities:

- Supervise START Coordinators
- Maintain linkages and relationships with community partners
- Ensure the coordination of support meetings and crisis plans for individuals served through START
- Share on-call responsibilities to ensure 24/7 response to crisis situations within one hour of crisis call telephonically and within 2 hours of crisis call face-to-face
- Participate in recurring meetings with START leadership, clinical team, and respite program
- Develop Cross-Systems Crisis Prevention and Intervention Plans, intake/assessments, intervention and outcomes, and any other applicable documentation of services provided
- Maintain active half-time caseload (variability may occur depending on activity level of cases)

START COORDINATOR (Minimum of 4.0 FTEs per team; depends on size of region and ability to respond within one hour of crisis contact)

The START Coordinator is the first point of contact for clients and the community. Coordinators link service providers with those needing them and work to improve the functioning of existing service elements in the community.

Required Qualifications: Master's degree in social work or human service field preferred. IDD and/or mental health experience and experience in programming for individuals with challenging behavior and/or mental health needs. Must be certified within one year of engagement in program.

Primary Responsibilities:

- Maintain linkages and relationships with community partners
- Ensure the coordination of support meetings and crisis plans for individuals served through START
- Share on-call responsibilities to ensure 24/7 response to crisis situations within one hour of call telephonically and within 24 hours of call face-to-face
- Participate in recurring meetings with START leadership, clinical team, and respite program
- Develop cross systems crisis plans, intake/assessments, intervention and outcomes and any other applicable documentation of services provided
- Maintain active caseload of approximately 30 individuals (variability may occur depending on activity level of cases and project goals)

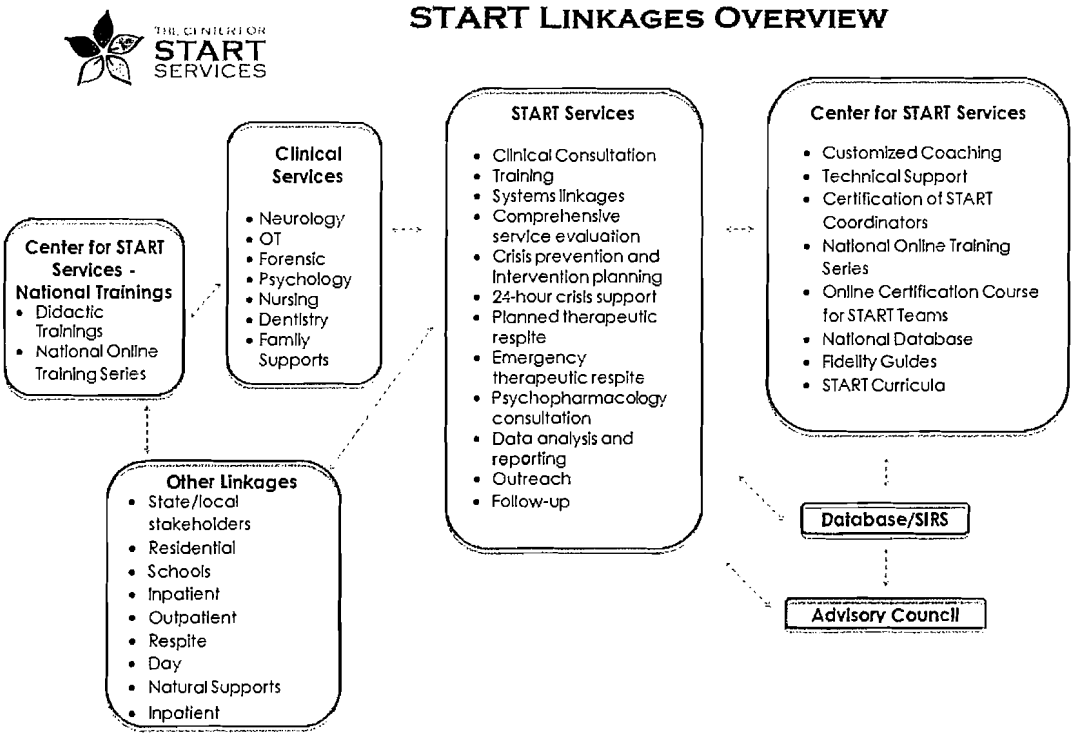
START Service Elements

In order to promote effective services and supports the START Program service elements include:

- An ongoing team approach
- Affiliations/linkages/outreach and follow-up
- Systemic and Clinical consultation
- Training/Clinical Education Teams
- Cross-Systems Crisis Prevention and Intervention Planning
- Emergency assessment and response
- Clinical assessments and service evaluations
- Emergency and planned respite
- Advisory Council and ongoing assessment of service outcomes (data, documentation)

START Services & Linkage Elements

The START systems linkage program is presented in the diagram that follows:



The START Team Approach

Active communication and collaboration begin with the START team itself. There are various methods used that, in spite of the fact that START team members operate in the field independently, require that the entire team works together to support individuals and the system. Following are some of the protocols that are required for START programs:

Morning Triage Calls

Members of the team participate in a Triage call every weekday morning. Triage calls provide a time for START Coordinators to review any calls they may have received since the previous day. The Respite Director or designee provides updates on the guests at respite and reviews respite admissions/discharges as necessary. This is also a time to discuss crisis/emergency needs of individuals referred or already part of the START program and receive direction/support from supervisory staff. Follow-up for crisis contacts is also determined at this meeting along with dissemination of intake assignments for emergency referrals.

Staff Meetings

Each START team conducts weekly staff meetings to review systems related issues, respite, and other service elements. Recurring Team Meetings are intended to ensure all necessary information is communicated to the entire START Team and to provide meaningful dialogue regarding the care and treatment of individuals supported by START through coordination and support of their respective systems. In doing this the following agenda items should be included in all START Recurring Team Meetings:

- Review of any individuals on the active caseload who are experiencing difficulties, crises, significant events and/or are experiencing circumstances and situations that may lead to crisis events. This includes individuals whose early stage(s) of crisis intervention may have occurred.
- Review status of guests at respite and any upcoming plans for discharge.
- Review the planned respite schedule for the week and any openings.
- Review any new administrative/operations procedures, policies, etc. and/or problems/issues with current processes that may warrant further discussion and/or changes to current operational processes.
- Review individuals on waitlist (if applicable) as well as recent referrals.
- Review any significant administrative or procedural problems, changes, etc.

Peer-Review

Peer-review is an essential component of the program's internal process for quality assurance. In addition to external audits and reviews, START completes internal peer-reviews to improve the development of Cross-Systems Crisis Prevention and Intervention Plans, respite discharge summaries, and maintenance of medical records. START Coordinators and the Team Leader, Regional Director, Clinical Director, and/or Respite Director participate in peer-reviews as deemed appropriate by the Regional Director. Peer-reviews should occur a minimum of quarterly.

Live Supervision

Live supervision techniques are part of the core training and supervision protocol for all START respite personnel and includes review of videotaped meetings and activities to improve the skills and effectiveness of the respite team.

Linkages, Outreach, and Follow-up

START develops relationships with community partners in order to bridge service gaps and improve service outcomes. Formal affiliation/linkage agreements are a key to defining those partnerships and key to the START program. These agreements link the START program with mental health and medical providers,

inpatient mental health units, developmental disabilities providers, residential providers, vocational and day services providers, state agencies, dentists, neurologists, experts in the field, etc. Affiliates are partners with signed linkage agreements whom START maintains frequent and ongoing collaboration with as part of the infrastructure. This includes an affiliation with the National Center for START Services at the UNH/IOD through our work with Center for START Services Director Dr. Joan Beasley, which allows the program to offer trainings and linkages with other START teams nationally.

Further, START has numerous partners providing services in the community; partners are defined as those agencies with whom START does not have a formal affiliation agreement, but with whom they work in collaboration. In adhering to the goal of systems accountability, the approach is adaptable to the changing needs of the people and systems supported.

One of the most critical affiliation/linkage agreements is to develop a crisis support continuum. This includes development of affiliation agreements and collaboration with Mobile Crisis Management and First Responders for increased diversion, collaboration with hospitals regarding admittance and discharge planning and transition, as well as Crisis Plan Development and Emergency Respite.

Outreach serves to support the systems of care. START personnel are in frequent contact with service providers and individuals to insure that they continue to receive effective services. This includes home visits and phone contact to remain in-touch so that needs are responded to in a timely fashion.

Follow-up is another important element of the START approach to service linkages. The project follows any individual referred to START for up to a year (or more as needed). Individuals placed on the inactive status will remain part of the system and be reactivated should the need arise.

Another important service provided by START is planned outreach. We learned from prior research from the START program in Massachusetts that the most overwhelmed systems are the least likely to contact the START team, increasing the likelihood of eventual emergency service use. As a result, all active cases receive at least monthly phone contact to check in and insure that the individual continues to do well.

START Coordinators maintain ongoing contact with family members and other caregivers. Follow-up meetings are scheduled to evaluate the effects of treatment strategies, update crisis prevention plans, and foster active

communication among providers and with direct caregivers. One critical way the important information that is gathered at meetings is shared is through minutes from meetings. Minutes from all meetings are taken by START team members (usually the START Coordinator but may also be other team members as needed) as part of their contribution to the linkage approach to care. This includes goals and objectives of the meeting and the plan of action and follow-up. Notes from each meeting are disseminated by the START team within 24 hours or the next business day after the meeting occurred to all who attended the meeting.

START Coordinators and other members of the clinical team provide outreach support through:

- Home visits
- Assistance in attending appointments with mental health providers
- Attendance at admission and discharge planning meetings for psychiatric inpatient stays and emergency and planned START respite stays
- Visits to residential and day providers to provide consultation and training
- Other community-based contact as needed and available

Systemic and Clinical Consultation and Training

Systemic Consultation is a core service element for the START model, and was first developed by the program's founder, Dr. Beasley. All START Coordinators are trained to provide a systems approach to team consultation. Based on the work of Salvador Minuchin, START staff members incorporate an understanding of the context/structure in which the system makes decisions and implements action to assist a team in problem solving and service planning. START Coordinators receive ongoing supervision in order to improve their own skills to provide a systemic approach that encourages engaging all members of the team, the use of functional analysis techniques, and fostering active communication and collaboration of all team members.

Clinical Consultations/service evaluations: Members of the START Clinical team include experts in the field of psychiatry and psychology working with individuals with IDD and behavioral health needs. START-approved instruments are used to collect data. START respite staff are trained and supervised in data collection methods. In addition, START Coordinators provide an analysis of individual records and service outcomes through the development of comprehensive service evaluations.

Clinical Education Team Meetings

The START Clinical Education Teams (CETs) meet monthly. This is a forum designed to improve the capacity of the local community to provide supports to individuals with IDD and behavioral health needs through clinical teaching.

The team consists of START Coordinators and members of Treatment/Service Community. Members from the local community of service providers are invited and included in the process. These partners include, but are not limited to, local mental health centers, emergency services and inpatient, residential, day program providers. The goal of the CET is to help service system providers learn how to best support people while improving the capacity of the system as a whole through information sharing, learning, and collaboration among team members.

Because this is an educational forum, each individual presented will have his or her identity hidden to protect confidentiality. The training is less about the person presented than it is the descriptions of the problems faced, strengths and resources, as well as diagnosis and treatment information so that the individual serves as an example for discussion and further examination. However, it is expected that the discussion will generate ideas about possible remedies to improving services and clinical outcomes to explore for the individual presented.

Each month, up to two people are reviewed. START Coordinators will initially select individuals but later reviews may come from community partners. The meetings take two hours to complete each month. START Coordinators receive a summary of recommendations and provide follow-up information to the team at subsequent meetings so that all can learn from the process.

These education teams do not involve natural supports or the individual. This is training rather than consultation.

Training for Providers/Families

All members of START provide training to providers and/or families when requested. Training for the Cross-Systems Crisis Prevention and Intervention Plan (CSCPIP) or respite recommendations are common topics of trainings completed. However, other specialty trainings are completed by the Clinical or Medical Directors, or Program Director, depending on the request or topics involved. Training network providers helps build education and capacity within communities. Offering training is essential in the framework to support community capacity in working with individuals with IDD.

Cross-Systems Crisis Prevention and Intervention Planning

Another essential element of START services is the Cross System Crisis Prevention and Intervention Plan (CSCPIP). The CSCPIP is an individualized, client-specific written plan of response that provides a concise, clear, concrete, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist a client who may be experiencing a behavioral health crisis. The goal of the CSCPIP is to identify problems that have or may arise and map out a strategy that offers the tools for the circle of support to assist the individual to address problems and prevent crises from occurring.

START Coordinators facilitate individual Cross-Systems Crisis Prevention and Intervention Planning meetings. Whenever possible, the START Coordinator, the individual, members of the mental health service team (which could include an outpatient therapist, a representative from the clinical home provider, psychosocial rehabilitation provider, etc.), members of the developmental disabilities service team (which could include the targeted case manager, residential and day program providers), and the individual's natural supports (family members, friends, and other interested parties) meet to develop a plan to assist the individual and his or her caregivers during times of difficulty.

A full and comprehensive CSCPIP should be written within 60 days of initiating the process. The CSCPIP is modified as needed and should be reviewed frequently and revised as needed. Once it has been used successfully over a significant period of time, it will be reviewed and revised at least annually.

The first and perhaps most important way to handle a crisis is to avoid its occurrence whenever possible. The use of crisis services most often follows severe maladaptive behaviors on the part of the individual, e.g., assault or property destruction. Crisis prevention planning can provide a strategy to assist an individual and the people who provide support to better cope in times of difficulty.

There are five goals of the CSCPIP process to accomplish this task:

1. Reaching an understanding regarding communication of needs through challenging behaviors: A primary goal of the collaborative planning process is for all concerned parties to reach consensus regarding what an individual may be communicating through their challenging behaviors. Family caregivers and other people providing support and assistance can better introduce alternative strategies to help an individual get their needs and wishes met when they understand the "meaning" of a given challenging behavior. When effective, this strategy helps to prevent a crisis from occurring.

2. Developing/improving upon coping strategies for the individual and caregiver: The CSCPIP outlines options for individuals and their caregivers to cope with feelings or difficulties that may increase the likelihood of challenging behavior(s) if not addressed. For example, the plan may delineate "early warning signs" that may indicate an individual is experiencing anxiety. The plan outlines relaxation techniques to assist in reducing the person's anxiety, based on what is known about the individual.

3. Preventing the system from going into crisis: The roles and responsibilities for specific professionals and service providers are delineated in the plan. The CSCPIP helps service providers respond more effectively in times of crisis. It is helpful when the plan is as specific as possible in defining who should be contacted, when, and what they will do. The plan may also include important facts about the individual to help the service providers contacted better assist the caregivers. To ensure that the plan is taken seriously, each plan is signed and approved by all involved parties.

4. Identifying signs/ behaviors that may also indicate symptoms of acute mental health symptoms: These are carefully monitored with recommended interventions and often involve mental health treaters in the planning process.

5. Simplifying access to services: It is important that access to emergency services be as easy as possible. For example, we provide a list of

services and important contacts to families and caregivers. Families and other direct support providers have ready access to this list as part of the CSCPIP.

Comprehensive Service Evaluations

Comprehensive Service Evaluations (CSEs) provide an in-depth overview of an individual's service history in order to identify opportunities to strengthen service outcomes for individuals with intellectual/developmental disabilities and their families in the community.

The CSE takes about 30 days to complete and is an important tool to assist teams in improving their understanding of the client and of his or her service needs.

CSE Guidelines

- It is important to review all available records, and when records are not readily available to seek them out whenever possible (remember we do not want to "strain the system by assigning this to case manager or others; our job is to assist in attaining records so that the team remains engaged in the process).

- Draft reports are reviewed with the START Clinical Director prior to sending them to the person's team.
- Draft reports are sent to the team for review and discussion, and a final report, written after meeting with person's team, must include an action plan.
- Summaries include "reported" information along with interpretation from the START team. Do not just copy what you find in records; explore their meaning.
- Test scores must be reviewed with the Clinical Director, and interpretation of implication of the scores should be included in the report.
- Recommendations often include other assessments that are needed. Please include who you would recommend conduct these assessments whenever possible.
- The START team assists the team in follow-up with recommendations from the CSE.

Crisis/Emergency Assessment and Intervention

Emergency Meetings

It is often necessary to participate in emergency team meetings when someone is experiencing an acute psychiatric emergency or behavioral challenge.

Emergency meetings are often facilitated by START Coordinators to ensure all team members are informed of and involved in the issues surrounding the emergency in order to better support the individual.

Another important service provided by START teams is to assist during times of difficulty. In order for our community partners to be able to reach START, there is always at least one designated START Coordinator on-call for each respective region 24 hours a day, 7 days a week. The Program Director or Clinical Director serves as the back-up for the on-call system. Typically the on-call responsibilities rotate between START Coordinators. The Team Leader maintains the schedule for the on-call system and ensures the region is always covered.

If assistance is requested from START there are several things that must occur. The START Coordinator will:

- Identify the problem or reason for the call.
- Consult with all parties involved if necessary to determine nature of the problem and what assistance will be provided.
- Assist the person with developing a safety plan to ensure the safety of all involved.
- Determine what assistance can be provided: i.e., face-to-face consultation, making phone calls to alert individuals of the situation, or to

initiate other services such as Mobile crisis management, review crisis plan if involved in START services to determine if interventions can be effective, or continuing phone consultation throughout situation until resolved.

- Present information to START clinical team during triage calls.
- Follow up to determine if other assistance is necessary.
- It is important to *never* communicate the concept that there is nothing that can be done to help. Even if we must link to a more appropriate resource, that is a success.
- Emergency calls come from a variety of sources. START may receive emergency calls for assistance from the following, but not limited to: hospital emergency departments, mobile crisis teams, clinical homes, community providers, families, law enforcement, and the individuals needing assistance or experiencing the emergent situation.

START is expected to respond to a crisis call in a timely fashion, and to assess emergency service needs through face-to-face evaluations whenever possible. Adherence to the model requires immediate telephonic response and for onsite evaluations to occur within two hours of the initial contact. Review of outcomes helps determine if there are obstacles to this important goal being met. It is the role of the funding sources, Advisory Council and START program to assess the

ability of a timely response and to propose and implement remedies when needed.

All instances of crises for individuals supported by START should include next-day follow-up by the START coordinator assigned to the individual who experienced the crisis to learn about the resolution of the crisis and, if not already known, the effective strategies for stabilization and resolution. If the crisis outcome included placement in a higher level of care such as a mental health inpatient unit, the next business day follow-up should include a face-to-face meeting at the hospital or facility to discuss goals of the admission and discharge planning. START will assist in the engagement of all stakeholders, caregivers, and providers in the treatment and service planning process.

In all circumstances of crises for individuals eligible and/or currently supported by START, the information obtained from the response to the crisis should be included and/or considered when developing/revising the individual's CSCPIP. Each person involved with START will have a CSCPIP that should be reviewed with the service team and revised as needed, especially after an emergent situation has occurred.

In most situations, when a crisis (emergency) call is received a START

representative will seek to complete a face-to-face assessment/consultation within two hours of the request whenever possible. There will be situations when this will not occur, such as when the person experiencing an emergent situation is placed in a different setting such as another respite facility or hospital bed, or when the person is deemed to not be an appropriate START service recipient. All calls and interventions will be documented. It is our goal to assist all callers and provide response/intervention as necessary for each person.

Prescreening for Emergency Respite

START Coordinators prescreen for emergency respite at START and co-evaluate for a full array of crisis and emergency services with first responders.

Should other potential guests present with urgent needs for crisis respite without available beds in the respective region, the START Director will inquire and collaborate with other START Directors about emergency respite availability and potential out-of-region admission, if in-home supports is not adequate.

START Mobile In-Home Community Support Services

START in-home supports are designed to assess and stabilize an individual in his or her natural setting. This service is part of the mobile crisis capacity of START,

and the START Coordinator determines the need for supports. In most cases the provision of in-home supports is planned with the full knowledge about the individual and the setting. However, the provision of supports may occur in response to an emergency or crisis seven days a week, and will depend on the person's crisis plan and his or her need for services.

Once contacted, the team will be expected to have in-home supports in place within two hours of the plan to provide services. This means that the mobile in-home supports team will be located throughout the region so that they can provide timely support.

The goal of the in-home support is to assist the person's current support provider or family in implementing successful strategies to prevent the exacerbation of a problem, implement crisis intervention strategies, and provide observational assessment of the person and their circumstances. In-home support does not replace existing services or staff. The in-home supports will be provided by qualified, trained personnel who will be part of the local mobile crisis network which is made up of START Coordinators and on-call clinicians who will provide assistance and support as needed. It is expected that services will be provided for up to 72 hours per intervention period. Prior to the end of this period the individual will be reassessed by a START Coordinator and the team will

determine the follow-up services and supports needed, including planned or emergency respite at the START Therapeutic Respite facility.

START Respite Services

When determining clinical appropriateness for eligible potential guests for START Therapeutic Respite, START Coordinators confer with the START Director, START Respite Director, and START Clinical Director (as appropriate) regarding the current clinical presentation and needs of the potential guest(s). START programs do all that they can to accommodate those in need.

In adherence to the expectation of effective service delivery, START Therapeutic Respite programs provide a proactive clinical service approach along with the ability for those in need to access services with regard to proximity of the facility and design of the program space. Therefore, START Respite programs should allow for enough space to provide a therapeutic environment for all guests. This requires enough community space for programming, meeting space for staff and community partners, and individual bedrooms for guests. The surroundings should be home-like but clinically appropriate to support individuals who may need limited access to daily items, such as sharps, for safety. The staffing pattern allows for individualized programming and personnel must be trained to support potentially volatile individuals.

The mission of the program also requires that the respite facility be geographically accessible to those in need so that the location should not

exceed a one-hour travel time under ordinary travel conditions for most eligible guests. This may not be possible for all START service users, but should be a target for locating respite so that most of the time travel time and distance is not an obstacle to access. *Evaluation of the respite programs will include the adherence to these guidelines and remedies should be requested if not in place.*

START Respite is a community-based therapeutic program that provides assessment and supports in a highly structured setting. The START Respite program requires clear emergency back-up policies and procedures and a highly trained staff to provide the needed supports and service to guests at respite. It is closely linked with the START Clinical team and includes evaluations by the START Medical and Clinical Directors in addition to ongoing collaboration with START Coordinators.

The START Respite program provides community-based, short-term respite exclusively for potential guests eligible for and enrolled in the START program experiencing acute, chaotic and/or other needs that may also be identified as a "crisis." The intent of this respite with the START program is crisis prevention, stabilization, assessment, treatment and tracking via providing a change in environment and a structured, therapeutic community-based home-like setting.

All guests of the START Respite home are visiting the home because they were recently or are currently experiencing a crisis or have demonstrated a high propensity for crisis situations. Therefore the home is designed to create a safe environment for assessment and stabilization. Each START respite home has private bedrooms, space for programming and meeting, a fenced-in yard to allow for people to leave the home without injury, and a sensory room which can offer a quiet area when needed. The space must allow for both integrated programming and individual support as needed. The program should be located in a neighborhood with access to ordinary community activities.

The individuals served at the program are considered to be guests, and do not have unsupervised access to sharps, flammable materials, cleaning supplies, medications, hygiene products, or food to insure safety. Unless approved, they do not have unsupervised community access. This is a therapeutic setting and is not intended to replicate a home environment.

Planned Respite

Half of the beds in the four tosix bed respite facility are designated as "planned respite beds." Planned respite beds at START are intended to serve people who have not been able to use respite in more traditional settings due to ongoing

mental health or behavioral issues. Families and others participating in the program must be approved as eligible for these services, but once approved they schedule visits as needed (and when available).

The goals of planned respite are to: provide a break from the daily life experiences of both the caregiver and guest, monitor the effects of treatment, conduct coping skills training, work on crisis prevention, provide positive experiences to look forward to, offer training to providers and caregivers, and increase recreational opportunities for individuals who often lack the ability to access these supports in the community.

Potential guests scheduled for START planned respite services are required to have confirmed transportation from their permanent residential setting to the respite home prior to admission, and at discharge. In limited circumstances the START team may provide transportation, although this shall not be a regular occurrence. The START Director and/or Respite Director (as applicable) must approve any transportation provided by the START Team.

Length of Stay

START planned respite services are designed to be very short-term and generally will not exceed five consecutive calendar days. As START planned respite

services are limited, guests may receive no more than 36 days of planned respite per calendar year with the recommendation of no more than one visit per month. The START Director may grant exceptions to these limits with the agreement of the Respite Director and Clinical Director. Length of stay is determined prior to admission.

Planned Respite Visits

Planned respite visits do not include an overnight stay. Planned respite visits are provided to any START service recipient and are not restricted to people living with their family. An individual can visit respite for dinner, a recreational activity, or to just "check in" for a few hours. Some families visit respite with the guest to become familiar with the facility and the staff prior to scheduling an overnight visit.

Scheduling

The first planned respite admission is facilitated by the START Coordinator in collaboration with the Respite Director or designee. Following the first admission to planned respite, all subsequent admissions to respite are scheduled between the families and the START Director and communicated to the START Coordinator.

Activities, services, assessments and data collection for guests in the START respite home are driven by information provided in the respite admissions summary, Cross-Systems Crisis Prevention and Intervention Plan, and any and all other supporting documentation or dialogue provided prior to or at admission. All activities, services, assessments, and data collection are individualized and dictate much of the daily activities schedule.

Although there are certain activities that take place as part of regularly scheduled programming, the needs of the guests guide the specifics of these activities. All activities are based on an individual's goals/objectives and tailored to the individual's needs. The program policy and procedures guide will also document assessments and the protocols for implementing them while at respite.

At the conclusion of a guest's stay, staff will meet with the guest and their caregiver about the visit to discuss what was learned, and answer any questions the guest and/or caregiver may have. Guests are also encouraged to complete an anonymous survey about their experience while at respite.

Planned respite discharge summaries are written by the Respite Director or designee quarterly and will be sent to the START Coordinator for distribution to the guest's team within one week of their most recent stay.

Emergency Respite

Emergency respite services are provided at the START respite facility located in each region. Half of the 4-6 -bed respite facility operated by START are designated for emergency respite purposes. Unlike planned respite, which is offered primarily to families, all START service recipients can access emergency respite as needed. Emergency respite is designed to provide out-of-home housing and services for people who, for a short period of time (30 days or less), cannot be managed at home or in their residential program.

The goals of emergency respite include: clinical assessment, hospital diversion, stabilization, reunification with home and community settings, training caregivers and providers, initiating collaborative contacts/consultation with treatment teams, step down from mental health inpatient services, positive social experiences, behavioral support and planning, assessment and refinement of treatment approaches, coping skills development and enhancement, and family support and education.

A list of forms and protocols is documented in the policies and procedures companion guide.

Prescreening and Coordinating Potential Admissions

Crises occur at all hours of the day and all days of the year. As such, scheduling emergency admissions to the START respite home may necessitate a significant amount of planning take place within a very limited timeframe. Planning and troubleshooting for emergency admissions occur within one hour of the request through direct contact between the START Coordinator and the Respite Director/designee. In many cases, potential guests for START emergency respite are new to the program. When coordinating guests' emergency admissions the assigned/on-call START Coordinator will contact Respite to discuss the clinical needs of the potential guest, bed availability, and expected length of stay (not to exceed 30 consecutive days per admission).

It is the responsibility of the START Coordinator to collaborate with the Respite Director throughout the admissions process. The final decision about admissions occurs between the Respite Director/designee and START Coordinator under the supervision of the Director of START Services. If needed, consultation with the START Clinical or Medical Directors will occur to make the final determination with regard to the appropriateness of the admission.

General Rules for times/dates on admissions:

- Admissions for crisis respite generally occur between the hours of 8:00 AM and 7:00 PM Monday through Friday
- Previous guests of the START respite home in need of emergency respite services may be admitted outside of the designated admissions hours
- Admissions after hours and on weekends will be considered on a case-by-case basis

Potential guests scheduled for START emergency respite services are required to have confirmed transportation from their permanent residential setting to the respite home prior to admission and at discharge. In limited circumstances the START team may provide transportation, although this shall not be a regular occurrence. The START Director or Respite Director (as applicable) must approve any transportation provided by the START team.

Admissions Meeting

Upon or prior to arrival at START respite, the guests' care provider and a START Coordinator participate in a brief meeting to review a brief history, issues or concerns, and identify goals/objectives for respite services, assessments and

data to be collected during the guest's stay or in home supports. The START respite team facilitates this meeting. Other participants in the respite admissions meeting may include the Respite Director, Nurse, Respite Counselors, Clinical Home provider, Residential Provider, family, etc.

A designated START Coordinator participates in all START respite admission meetings. START Coordinator will also visit the individual while at respite to help evaluate progress and service needs, and maintain contact and exchange of information with families or support providers.

Documentation

START Respite staff members complete relevant and appropriate documentation for all guests in care. Many of the forms selected are specifically designed to meet the needs of the program, while some more generalized forms are agency or state-required forms. Each form selected for documentation with START has been carefully reviewed and approved by the Respite Director and START Team. **It is imperative that all documentation identified be completed prior to the end of each Respite Counselor staff's assigned work shift.

The forms designed for use with START program are identified in the companion guide.

Guests of START Emergency Respite will have an approximate discharge date identified upon admission. This date will be determined by goals and objectives established with the team at intake. This date may require adjustment based on the individual's progress.

All guests receiving START Emergency respite will have weekly discharge planning meetings facilitated by the respite team and the respective START Coordinator. These meetings will provide a forum for dialogue to assess significant events, progress toward goals as well as discuss the potential discharge date, transition to home environment, and any necessary follow-up care.

Weekly collaborative meetings are required and full team participation is needed in order to maximize the effectiveness of the respite stay and prevent the need for future crisis services whenever possible. Meetings will include participation by the clinical home provider, the home case manager or care coordinator, residential provider (if applicable), family member/legal guardian, and any other applicable team member. Meetings may occur face-to-face,

via teleconference, or a mixture of the two. The START Coordinator will attend all meetings. The START Coordinators must be present for face-to-face meetings whenever possible.

Guidelines for assessment of target behaviors: Because people are admitted to START after incidents have occurred, there may be an absence in the occurrence of target behavior while at respite. This should not preclude assessment of what may have resulted in difficulties, the provision of clinical and psychological supports and dialogue and discussion with the guest's home setting assist in preventing future difficulties once the person returns home. In order for this to occur it is essential that ongoing collaboration between respite staff, START Coordinators, and home providers occur on an ongoing basis in order to get a better understanding of the conditions that precipitated the emergency respite admission.

At the conclusion of a guest's stay at the START respite home, respite staff in conjunction with the assigned START Coordinator will meet in person with the guest, their caregiver, and clinical home provider during a discharge meeting about service delivery and process what occurred, what was learned, and answer any questions the guest, clinical home provider, and/or

caregiver/transport may have. Guests are also encouraged to complete an anonymous survey about their experience at the respite home.

Following discharge, the Respite Director will collaborate with Respite Counselors, START Clinical Director, and the assigned START Coordinator to develop a Discharge Summary of the guest's stay to be completed and disseminated no later than one week after discharge. The Discharge Summary is then forwarded to the START Coordinator along with relevant data collected on behavior tracking, etc., for distribution and dialogue with the individual's clinical home and relevant care providers.

START emergency respite services are designed to be short-term and generally will not exceed 30 consecutive calendar days. However, a measure of success in improving service outcomes is the reduction of readmissions over time. As such, a guest's length of stay for crisis respite may be extended to ensure adequate data and maximum therapeutic benefit. Any decision to exceed the above-identified maximum length of stay will be determined by the START Director and Respite Director.

START Advisory Council

The Advisory Council is critical to ensure effective service delivery in the context of the START program. It consists of stakeholders, experts, and personnel from START. The Advisory Council meets quarterly to provide support and review progress and discuss future directions. The Advisory Council enhances our capacity to remain accountable to everyone involved.

Data Collection/Reporting

It is essential that all START programs continue to evaluate service needs and outcomes through the ongoing process of data collection and evaluation both for reporting purposes and to improve service effectiveness over time. This is a core element of the START philosophy – you must continuously measure what you are doing and for whom you are doing it. The protocols for data collection are found in the policies and procedures companion guide.

The Center for START Services, the University of New Hampshire, and participating projects developed a START Information Reporting System (SIRS). Utilizing unique ID numbers, the SIRS database captures de-identified health information about individuals receiving START services and has the ability to provide reporting by case load, by region, and by state. START collects data at

a variety of levels including, but not limited to, individual demographics, service event/encounters, respite services and outcomes, and administrative activities.

Quarterly Reports

The START program reports select data on a quarterly basis to the contracting and oversight entities. The START Program Director is responsible for aggregating the required data and submitting the reports to their respective stakeholders and funding sources.

Annual Reports

All START programs compile an annual report to review with their Advisory Council and other stakeholders. From analysis and discussion of the outcomes documented in the report, the team develops goals and objectives for the project in the coming year.

Setting/services	Residential (non ICF)	Typical Community In-patient psychiatric hospital	START Center
Criteria	Must meet eligibility criteria and be able to benefit from program, including setting, staffing and services. Must be able to be safely supported in the setting. Can support very severely impaired individuals based on the program design Requires collaboration with other providers and treaters Goals are established through service planning and can take several months to achieve.	Must have an acute mental health condition that can benefit from a brief stay. Must leave when ready for discharge, can be transitioned through START Center when needed. Must be manageable on a traditional mental health unit. This often requires START assistance. Goals for assessment and treatment must be established upon admission. Typical MH units are not designed for persons with severe/profound impairment	Must meet the criteria for START services and have a place to return to upon discharge. Must have active collaboration with providers and treaters to assist the individual and the system of support. Goals for assessment and treatment must be established upon admission Designed for individual ranging from mildly IDD to profoundly IDD. Can meet a range of criteria. Do not have to be diagnosed with ID or MI to be admitted.
Locked	No	Yes	No
Long term care	Yes	No (brief care usually 7-10 days)	No (up to 30 days)
Planned admissions	Yes	No	Yes (up to 5 days)

Exhibit 6
Commission on
Developmental Disabilities
Meeting 3, 9/24/2013

Acute care admissions	Not typical	Yes usually through ER	Yes, requires medical clearance
Voluntary only	Yes	No	Yes
Service recipient is known as	Resident /client	Patient	Guest
Independent community access	Yes	No	No
Ongoing collaboration with community treaters, family, etc	Yes	In general No, in an ideal situation yes.	Yes
Single bedrooms	Sometimes	Sometimes	Yes
Access to household items, sharps	Yes	No	Supervised and limited only
Community activities	Yes	No	Yes
Access to snacks and food outside of planned menu	Yes	No	Limited
Television, personal cell phone, electronic devises	Yes	limited	No
Therapeutic structure	No	Yes	Yes
Crisis supports in house	limited	Yes	Yes

Mechanical and chemical restraint options	No	Yes	No
Management of aggression and acute conditions	No	Yes	Yes
Management of chronic medical conditions	When designed to do so	Yes	With additional supports
Treatment/service plan required	Yes	Yes	Yes
Access to bed and bedroom during the day	limited	limited	No (unless prescribed by MD)
Day program provided	NO	Treatment groups	Yes, therapeutic day
Supervision required	variable	Line of sight atypical 30 minute checks	Line of sight with night checks
Setting designed to support people with autism	When designed to do so	No	Yes, low sensory room, sensory integration
Caregiver training provided	Somewhat	Not typical	Ongoing
Formal assessments provided	No	MH only	Yes (ABC, MEDS, Functional analysis, ADL, IADL, CSPIP,
Treatment focus	Community living, skill development. Person centered approach, sometimes implement PBSPs. Collaboration with	Diagnosis and treatment of acute mental health conditions. Identification and treatment of acute medical conditions may	Person Centered, Positive psychology, expressive therapies, health and exercise, assessment of communication, PBS and

	the system of support is key	also occur. Follow up service and treatment recommendations also provided	coping skill development. Consultation and collaboration with system of support is key
24 hour awake staffing	variable	Yes	Yes
Nursing 24 hours	no	Yes	No access to 24 hour supports arranged as needed
MD prescribes on site	No, Community prescriber	Yes	No, Community prescriber MD consultant
Comprehensive discharge summary and follow-up	No	Limited summary some follow-up	Yes
Supported by START team	Yes	Yes	Yes
Satisfaction surveyed	Sometimes	Sometimes	Yes
Transitional in home supports at discharge	No	No	Yes as needed

START Funding Table

	Medicaid Funds							
State	Medicaid Healthcare Transformation Waiver (1115)	Balancing Incentive Program (BIP) Grant	Other Medicaid Waiver Services (1915)	Medicaid (Fee for Service)	State Funds	County Levy Funds	Number of teams/type	Date
Massachusetts					X (50% match through Medicaid waiver admin.)		1 regional	1988
North Carolina			x (very limited)		x		3 statewide regional	2007
Ohio				x		x	1 County Board	2009
New Hampshire		x	x		x		3 statewide regional	2009
Arkansas			x		x		5 statewide regional	2010
Virginia				x	x		5 statewide regional	2011
New York		x	x				2 regional pilot for statewide	2012
Texas	x						3: 2 regional, 1 county	2013

Exhibit 7
Commission on
Developmental Disabilities
Meeting 3, 9/24/2013

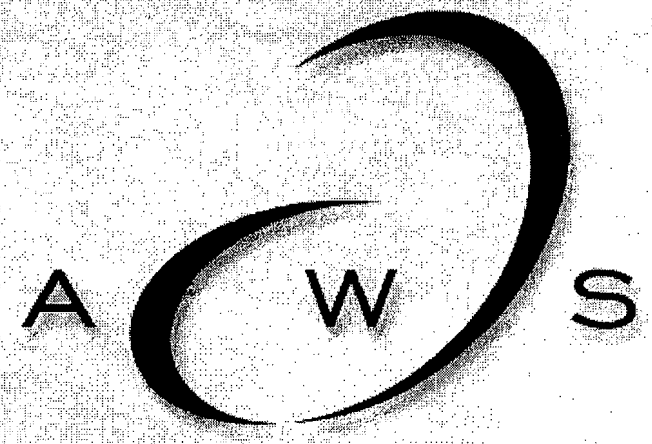


Exhibit 8
Commission on
Developmental Disabilities
Meeting 3, 9/24/2013

Indiana Crisis Management Services

- 2007, Indiana Closed its last State Institution for People with ID, and Crisis Services were Initiated
  - January: Contract Award after Competitive RFP Process
  - February & March: Contract Negotiations
  - July: 3-Tier Crisis Services Fully Implemented
- 2009, Positive Outcomes led to Contract Renewal
- 2010, State Revenue Shortfall from Financial Crisis resulted in Crisis Contract being Discontinued

Three Main Components of Indiana Crisis

1. 24/7/365 Hotline
   - Toll-Free
   - Live Person answers the phone for Initial Triage
   - Clinician Phone Contact within 30 minutes
2. In-Home Services
   - Within 24 hours – usually much sooner
3. Out-of-Home Placement
   - Guaranteed Availability to Anyone in Need

Program Outreach & Collaboration

Getting the Word Out – Vendors & State Executives

- Started prior to Rollout; Continued throughout Contract
- Regional Provider Meetings sponsored by State
- ARC
- Indiana Association of Behavior Consultants (IN-ABC)
- INARF (Indiana's Provider Association)
- Mental Health Center Provider Association
- Hospitals & Acute-Care Centers

Key Operational Partnerships

- State Contract Managers
  - Weekly Meetings with Case Report Updates
  - Monthly Outcomes & Invoice Withhold Reports
  - Approval of all Out-of-Home Placements
- Out-of-Home Partners
  - Acute-Care Hospitals throughout State
  - ASPIN: Organization of Mental Health Centers
  - Damar: Acute Children's Placements

AWS/Benchmark Crisis Service Roles

- Regional Directors - Licensed Psychologists
  - Operational & Clinical Direction; Reporting to State
- Psychiatrists
  - Med. Review/Collaboration with Community Psychiatrists; Emergency Appointments; Out-of-Home Follow-up
- Behavior Clinicians
  - In-Home Service & Case Management; Assessments & Clinical Reports; Collaboration with IDT & Families
- *Also:* Nurses (medical issues) & QDDPs (hotline)

State Required Reporting

- Weekly Report on Referrals, Out-of-Home Placements, & Crisis Case Closures
- Monthly Outcome Reports
  - Prevention Outcomes (e.g., hospitalizations prevented)
  - Downward Trends (e.g., reduction in aggression)
- Monthly Invoice Withholds & Performance Metrics
- Qtrly. Provider Trends – Utilization by Company
- Qtrly. Recommendations for System Improvement

"Typical" Crisis Case Example

All Cases are Unique, but a Common Pattern is:

- Individual being Aggressive toward Provider Staff
- Call placed to Crisis Hotline, often requesting *immediate* hospitalization
- Behavior Clinician goes to home, meets client & coaches staff; Reviews Data & BSP; works with IDT
- Medication review by Psychiatrist; collaborates with comm. Psy., & minor adjustments made to regimen
- Client Stable so Case Closure; No Police, No Hospital

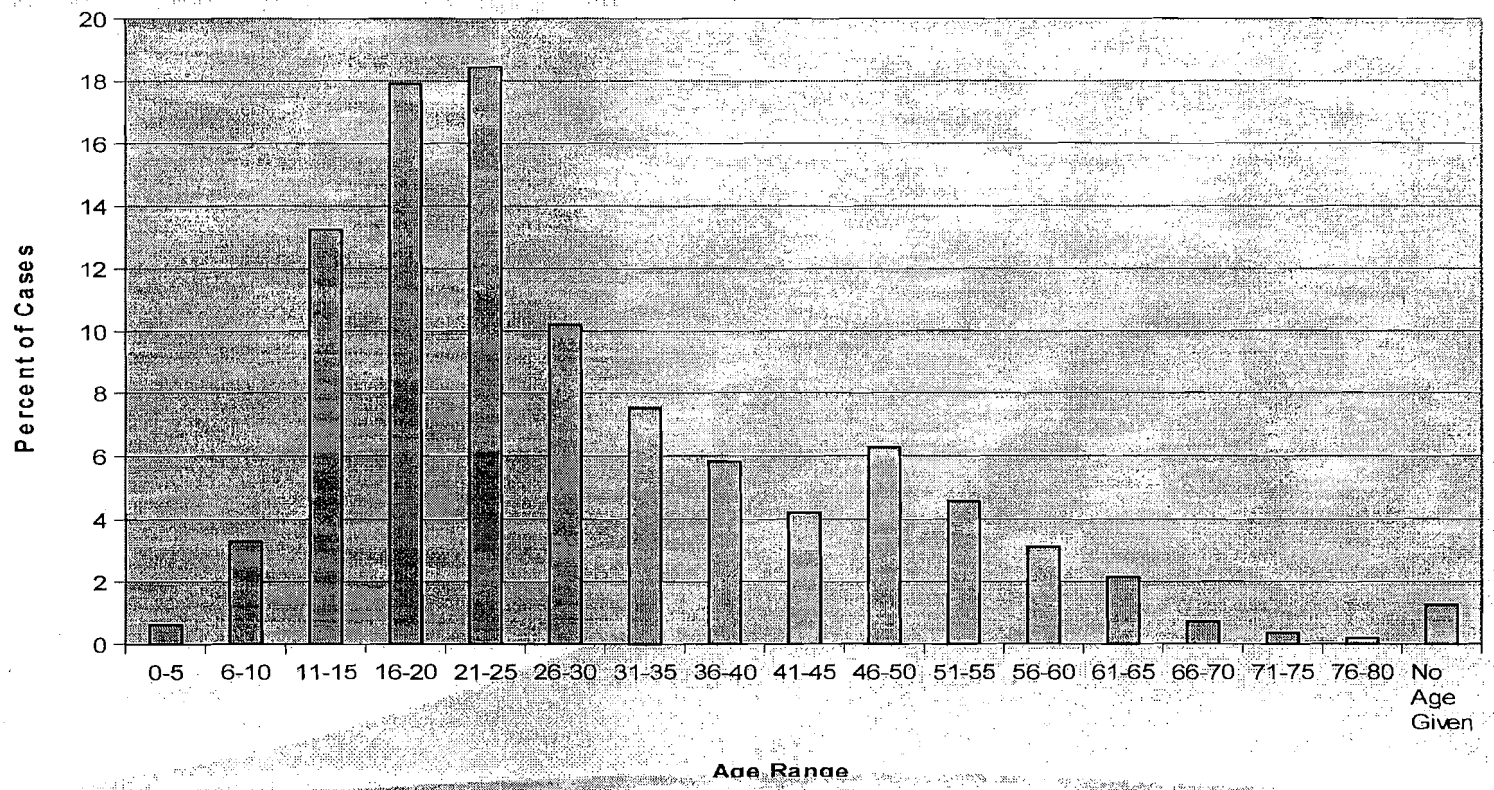
Other Types of Crisis Calls

- Crisis Call Placed by Overwhelmed Parent
  - Help connect to community resources
  - Behavioral Coaching & Behavior Support Plan Implementation
  - May assist with interim psychiatry appointment
- Crisis Call Placed after Incarceration
  - Facilitate transfer to Out-of-Home Placement for Treatment instead of Jail
  - Work with Providers or Families for Discharge back Home

A Snapshot of Accomplishments

- AWS/Benchmark initiated Services within months of Contract Award – Fully Operational on First Day
- Maintained approximately 95% Consumer Satisfaction
- Worked Collaboratively with over 100 Providers
- Every Hotline Call had Response
- Recidivism Below 5% (State Goal was to keep under 25%)
- Over 95% Discharge back to Original Community Home for all Out-of-Home Placements
- *More Data on Indiana's Crisis Program →*

AWS/Benchmark Crisis - Serving All Ages



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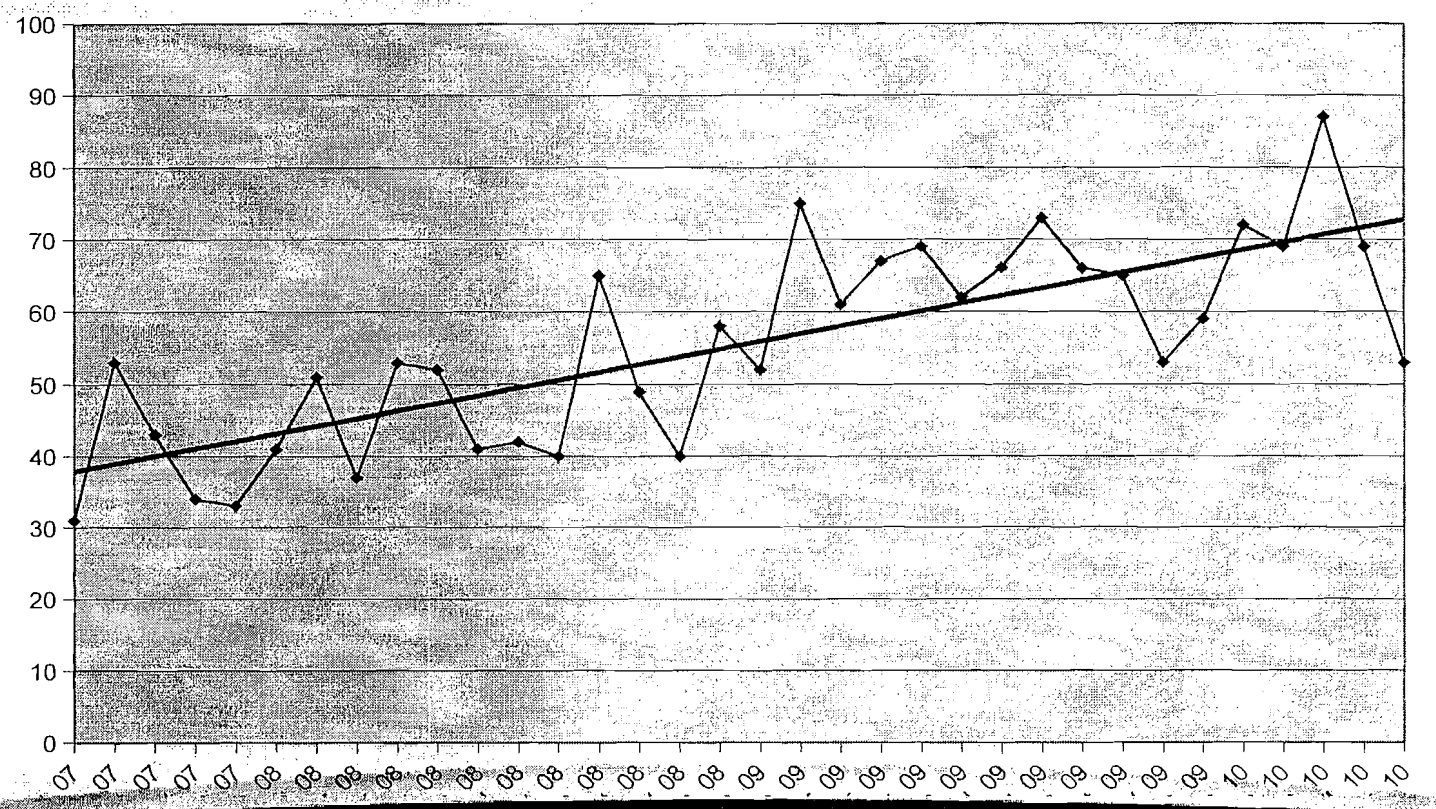
New Referrals Across Indiana by Month



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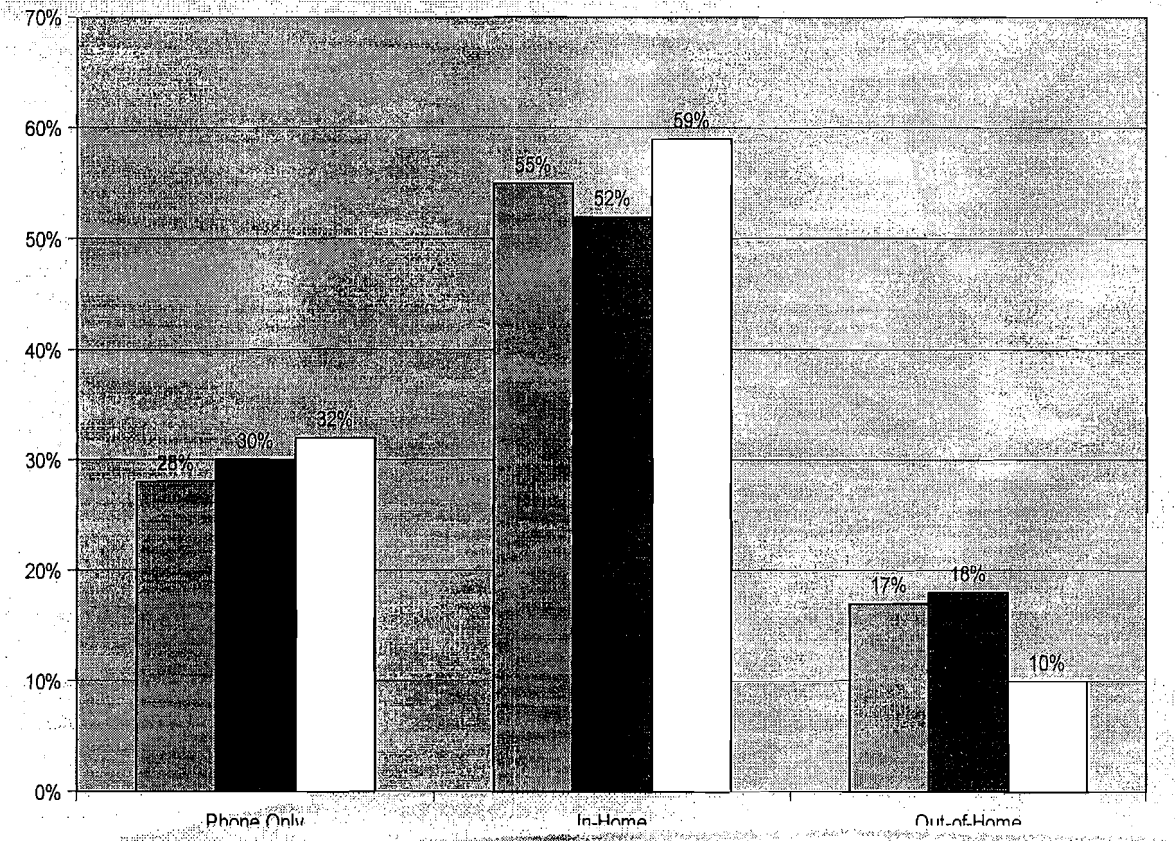
Most Crisis Clients Served in Their Homes



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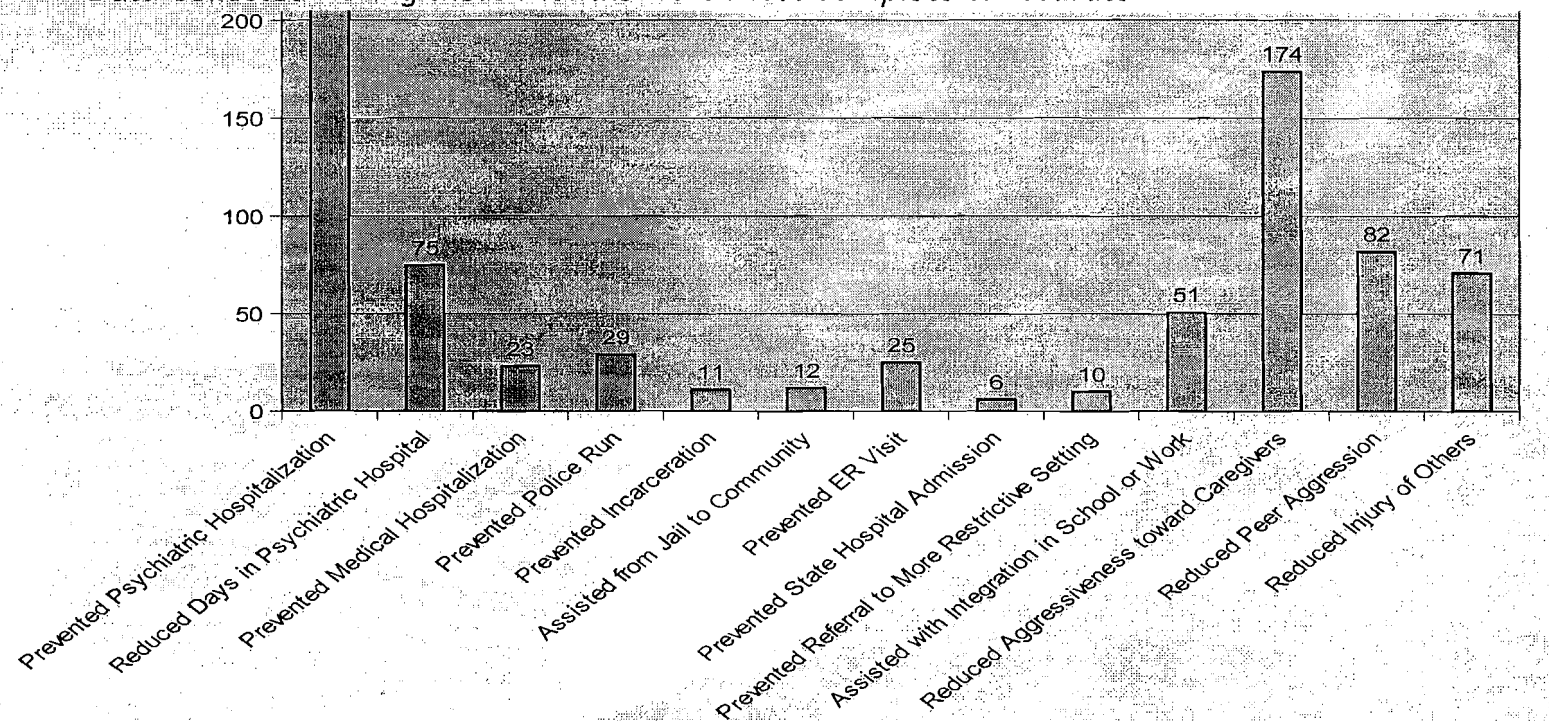
Our Crisis Outcomes July'09 – May'10

Data Collected During these Months were Most Complete & Accurate



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Origin and Scope
GA's DD Mobile Crisis Intervention Model

- DOJ Settlement on October 17, 2010
- Cease admissions of persons with DD to State Hospitals (6) effective July1, 2011
- Move 150 persons from State Hospitals each year through 2015—complete transition to community

DOJ Settlement Continued . . .

- Establish 12 4-bed crisis respite homes by July 1, 2014
- Implement 6 mobile crisis teams for persons with DD by July 1, 2012
- GA chose to achieve full compliance in 2011 for mobile crisis teams and developed 9 crisis respite homes

Georgia Crisis System Scope

- Population of 9.8 million; 5.25 million in 25 county metro Atlanta region
- 159 counties: rural south GA on FL line to coastal border and N. GA mountains
- FY 2009: 9,233 DD Medicaid consumers; 6.4 K in community waiver, 1.1 K in State Hospitals, and 1.8 K in ICF/nursing facilities
- Total state funding at $14 million annually

Implementation Continued . . .

- Crisis teams in all 6 DBHDD regions by July 1, 2011
- Crisis support (respite homes) operational in all regions by September, 2011
- Benchmark hired/trained 120+ staff, secured property and renovated six crisis support homes in 120 days

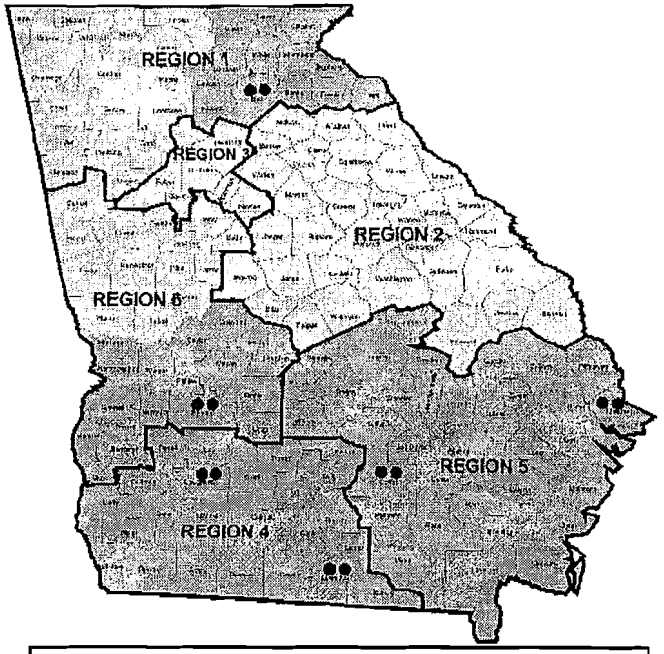
Composition of Mobile Crisis Teams/Support

- *Licensed Clinical Social Worker (LCSW)—Team Leader*
- *Board Certified Behavior Analyst*
- *Specially trained Direct Support Professional*
- Consulting Psychiatrist (via telemedicine)
- Consulting Psychologist and RN
- EMS Psychiatric Transport

Standards for Crisis Support Homes

- 4 person homes, sprinkled w/ anti-suicide and passive features (scatter proof glass, etc.) to support high behaviors, fully accessible; accessible vans w/partitions
- Certified by State of GA in lieu of licensure
- LPN home supervisor required
- Staffed and open for admissions 24/7; 7 day stay without regional office approval

Location of Homes and Teams



- Home
- Mobile Crisis Team
- Counties served by Benchmark Human Services
- Counties served by other providers

Cities where homes and mobile teams are located:

Region 1: Gainesville
Region 4: Valdosta, Albany
Region 5: Savannah, Douglas
Region 6: Americus

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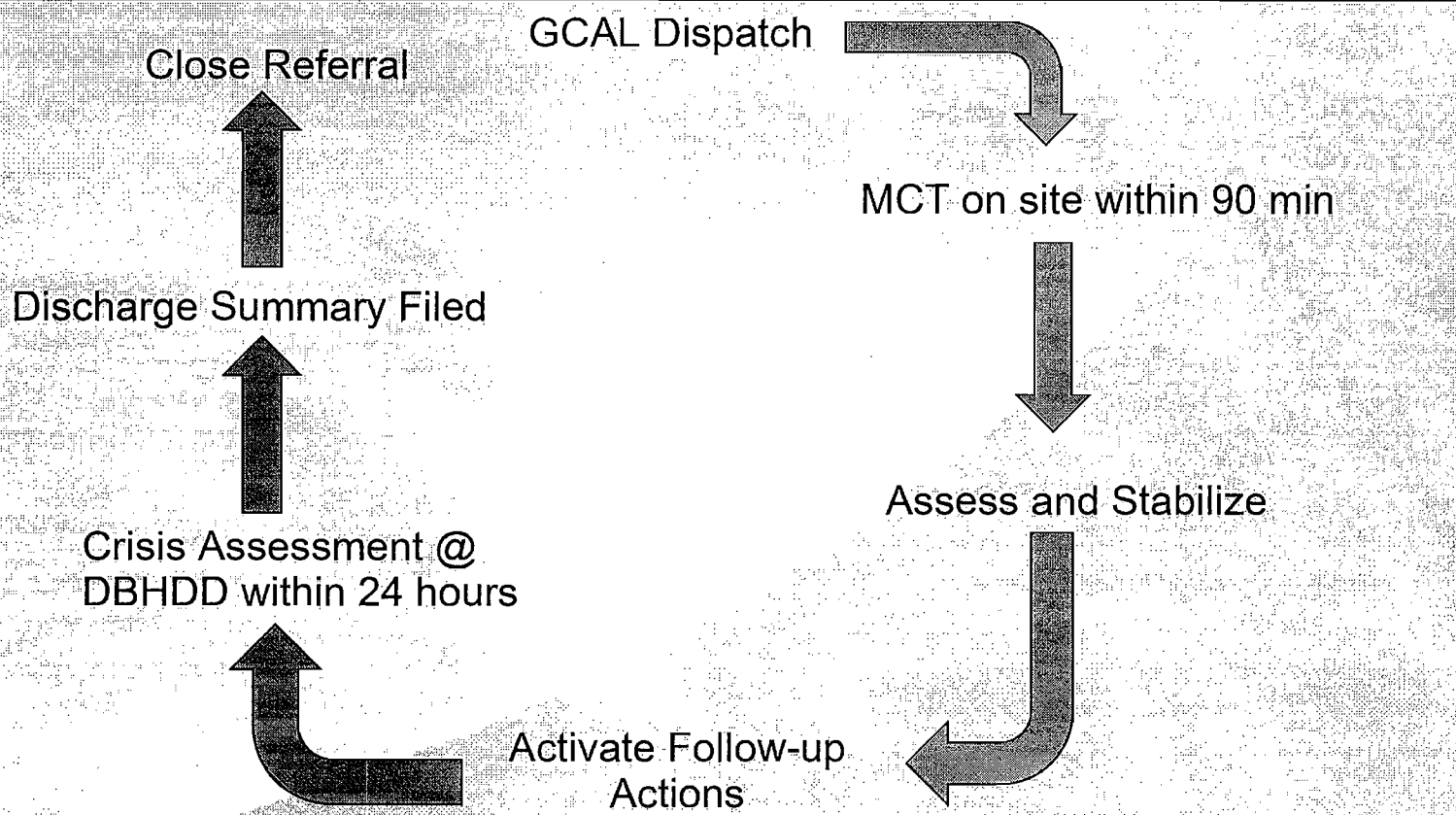
Dispatch System and Eligibility for Services

- State-wide 24/7 1-800 access

- Any one can call—individual, providers, law enforcement, hospitals, DD agencies
- Individual does not have to be in service
- Hot line clinician does phone triage and determines DD/MH involvement—dispatches a crisis team to respond on-site within 90 minutes

Mobile Crisis Team (MCT) Response Cycle



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Sequence of Benchmark Crisis Team Response

1. GCAL contacts on-call Benchmark LCSW team leader; sends electronic record if available
2. Team (LCSW, BCBA and DSP) communicates and arrives in unison at crisis site (Team members live in the region and work from home; no offices—company vehicle used for remote calls)

Crisis Team Response Continued . . .

3. Team arrives on-site (home, ER, community, provider site, State Hospital, etc.) within 90 minutes—"Special Ops" style response with no boundaries
4. Assess and act—stabilize crisis, living environment, safety issues, determine need for out of home placement (crisis home or acute hospital placement)

Crisis Team Response Continued . . .

5. Team determines action/discharge plan: including in-home DSP staffing, safety plans, response to commitment orders (1013s) assistance/intervention with family, or arrange for out of home placement

6. Crisis Assessment form is completed within 24 hours and submitted to Regional State DBHDD Office, plus discharge plan required to close each referral (to DBHDD Reg. Office)

Georgia Crisis Response System
Call Data: June 1, 2011 to June 30, 2012

- 3076 total calls (system wide)
- Conversion rate to dispatch in range of 45-50%
- 1,749 calls or 57% from persons not in Medicaid waiver or on planning lists

Crisis Data Summary Continued . . .

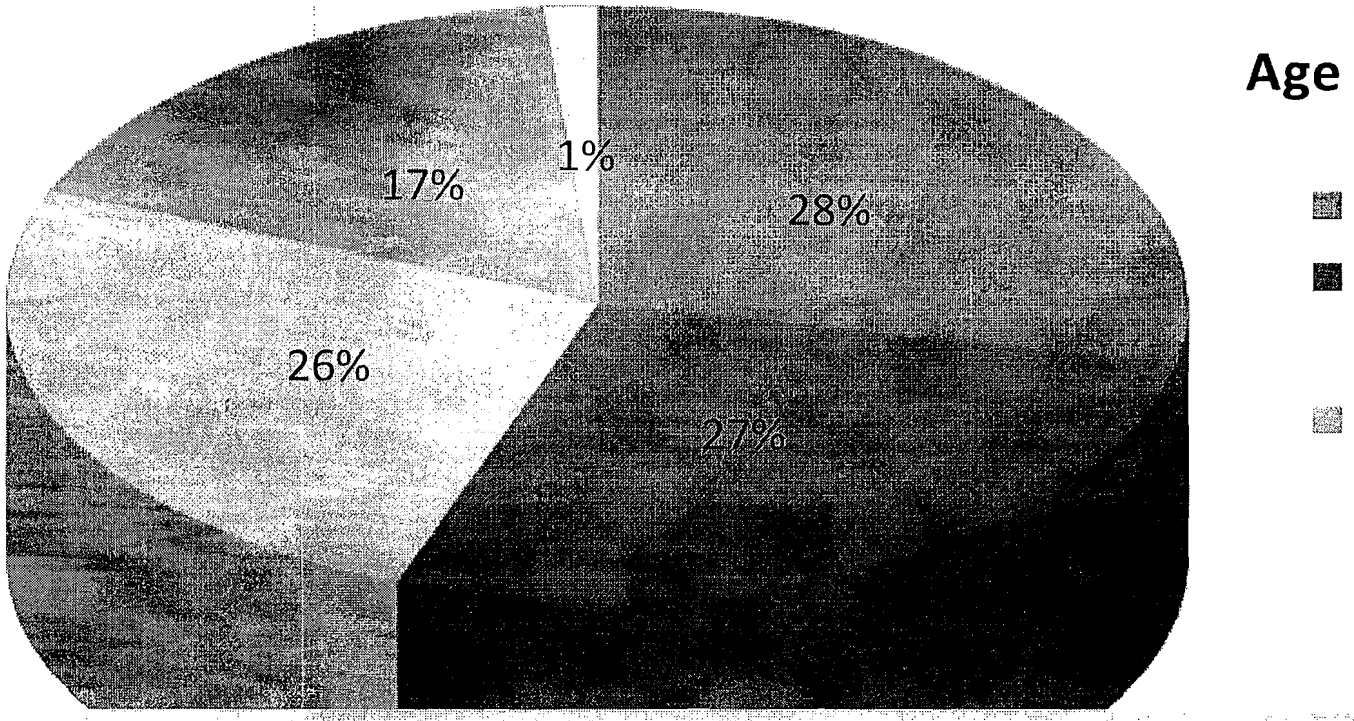
- 470 calls or 15% under age 18 (children age 5 and older eligible)
- Approximately 22% of calls MH presenting
- 747 calls or 24% from ER's

Source: DBHDD Presentation, 7/17/12, Crisis Intervention Consortium

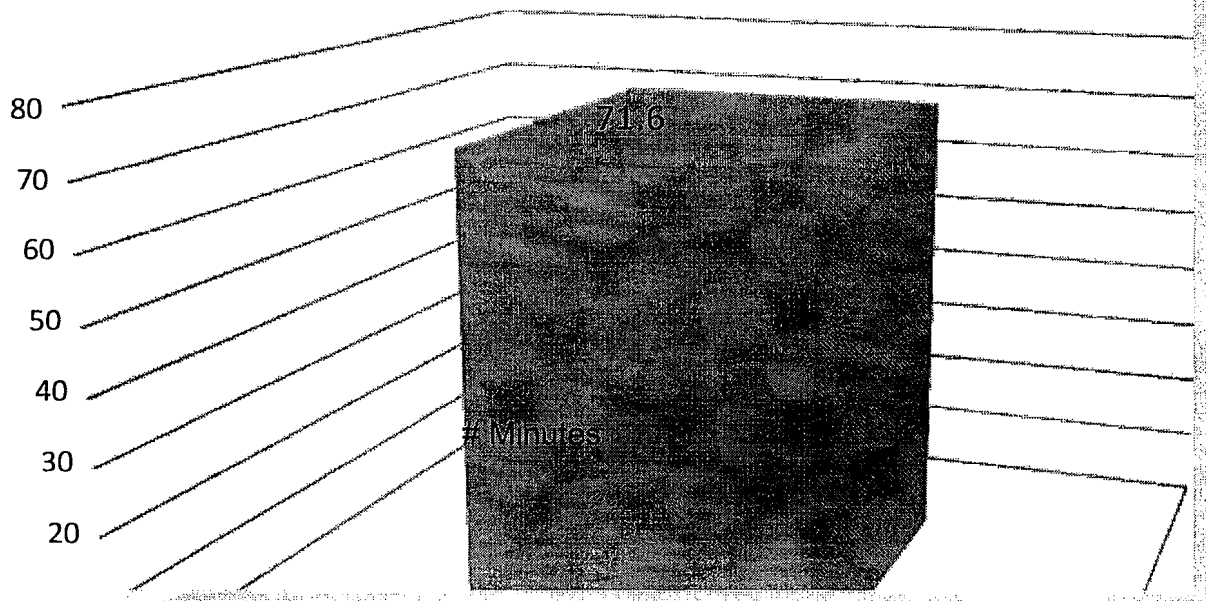
Benchmark Referrals by Age Group

Percent by Age

July 2011 - July 2013



Average Response Time
Contract Required Time = 90 minutes
July 2011 – June 2013



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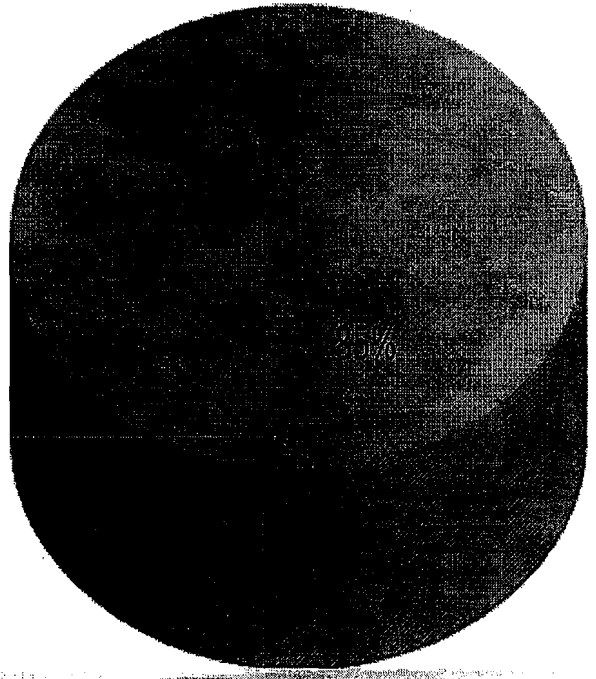
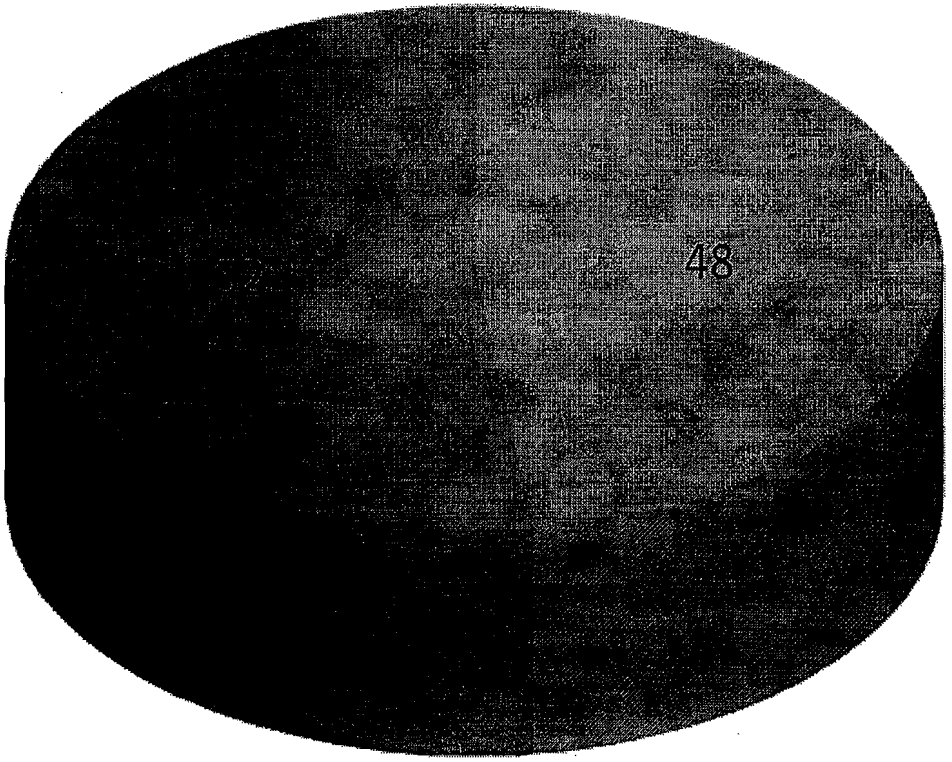
% Referrals Served in Community vs Needing Inpatient Care

July 2011 - June 2013



% 1013s Diverted from ER & Inpatient Facility
July 2011 - July 2013



Diverted Not Diverted

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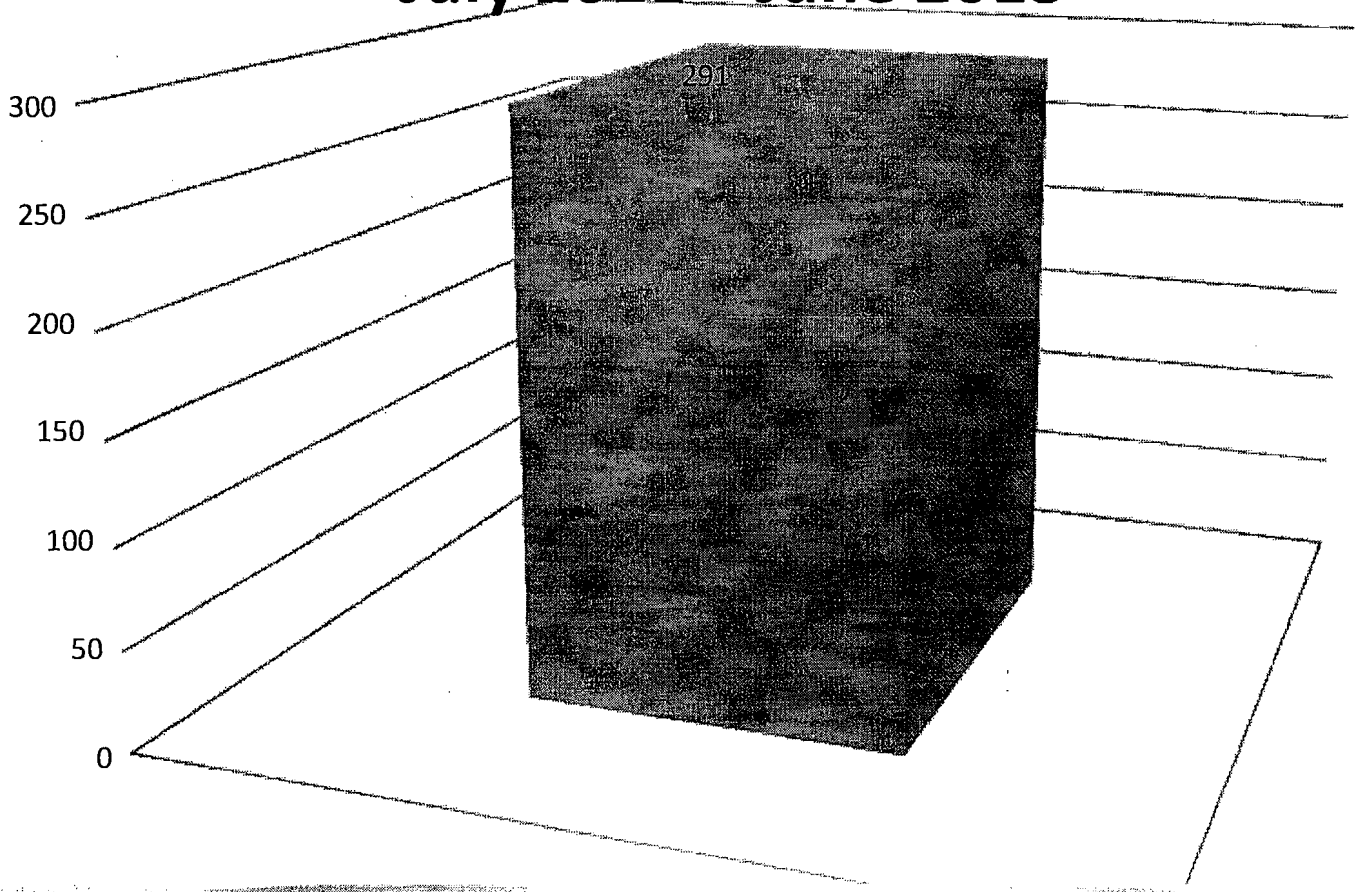
Individuals Served – Crisis Group Home
July 2011 – June 2013



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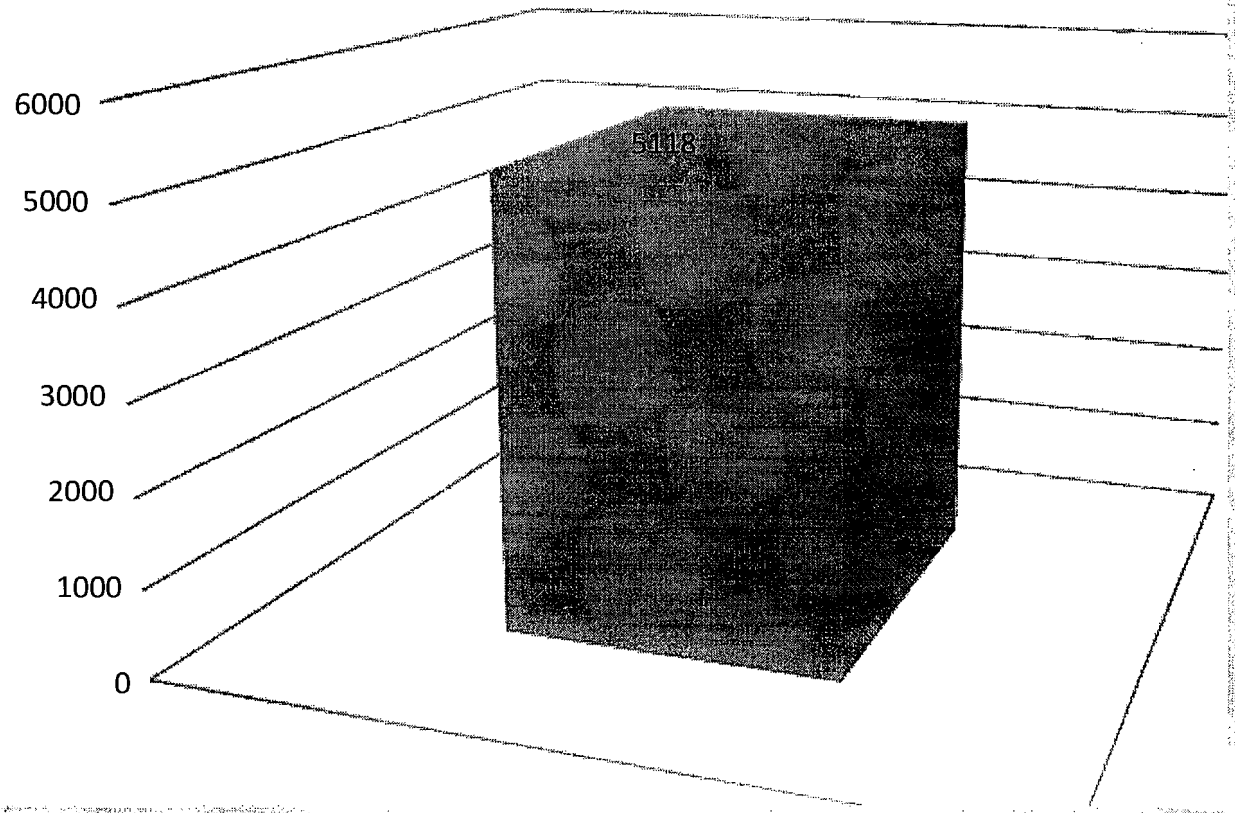
Occupied Bed Days – Crisis Group Home
July 2011 – June 2013



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How Many Crisis Cases Might You Expect Where You Live?

U.S. State:	Population*	Annual Crisis Cases (est.**)	U.S. State:	Population*	Annual Crisis Cases (est.**)
Alabama	4,661,900	512	Nebraska	1,783,432	196
Alaska	[illegible]	75	Nevada	2,600,167	285
Arizona	[illegible]	714	New Hampshire	1,315,809	[illegible]
Arkansas	[illegible]	313	New Jersey	8,682,661	953
California	[illegible]	4035	New Mexico	1,984,356	218
Colorado	[illegible]	542	New York	19,490,297	2140
Connecticut	[illegible]	384	North Carolina	9,222,414	1012
Delaware	[illegible]	96	North Dakota	641,481	70
Florida	[illegible]	2012	Ohio	11,485,910	1261
Georgia	[illegible]	1063	Oklahoma	[illegible]	400
Hawaii	[illegible]	141	Oregon	[illegible]	416
Idaho	[illegible]	167	Pennsylvania	[illegible]	1366
Illinois	[illegible]	1416	Rhode Island	[illegible]	115
Iowa	[illegible]	[illegible]	South Carolina	[illegible]	492
Kansas	[illegible]	[illegible]	South Dakota	[illegible]	88
Kentucky	[illegible]	[illegible]	Tennessee	[illegible]	682
Louisiana	[illegible]	[illegible]	[illegible]	[illegible]	2670
Maine	[illegible]	[illegible]	[illegible]	[illegible]	300
Maryland	[illegible]	[illegible]	[illegible]	[illegible]	68
Massachusetts	6,497,967	[illegible]	[illegible]	[illegible]	853
Michigan	10,003,422	[illegible]	[illegible]	[illegible]	719
Minnesota	5,220,393	[illegible]	West Virginia	1,814,[illegible]	199
Mississippi	2,938,618	[illegible]	Wisconsin	5,627,[illegible]	618
Missouri	5,911,605	[illegible]	Wyoming	532,66[illegible]	58
Montana	967,440	[illegible]	Washington DC	591,833	65

* *2008 Es[illegible] from U.S. Census Bureau (at http://www.census.gov/popest/states/NST-ann-est.html)*

** *Based on Indiana's experiences after providing nearly two years of service; This represents a "best initial guess," and we recognize that results would vary depending on many factors, including services already available in a state.*

Observations/Recommendations

1. **Determine scope and intent of crisis program—match to target need, budget, demographics and geographic area:**

- Crisis programs can be modular—set up for defined populations or geographic areas. Consider the 20% factor high need users
- Determine desired outcomes first—hospital diversions, stabilization of community placement, etc.

Observations/Recommendations . . .

2. High impact crisis system features:

- Advance arrangements/protocols for limited acute psychiatric placement
- Provider engagement, accountability and training (behavior support is paramount)
- Aggressive case coordination for high need referrals (prevent high cost of "cycling")

Observations/Recommendations . . .

- Outreach to ER's and Law Enforcement
- Availability of psychiatric support; evaluate efficacy of telemedicine solutions
- Quality, qualifications and training of response teams impact outcomes—determine level of support intensity
- Intensive data analysis and performance mgt. essential for high outcomes

Observations/Recommendations . . .

3. Crisis System Primary Cost Drivers:

- Type of dispatch system
- Crisis team qualifications
- Response time
- Scope of service areas and populations
- Emergency respite options (homes, etc.)
- Acute psychiatric support/stabilization options
- Level of provider support/engagement

Potential Medicaid Funding Options for Mobile Crisis Services

Medicaid Funding Match (Can Single Source)

Indiana Crisis Funding Sample

Total State Spend for the month	$300,000.00
Total Consumer Served for the month	100
# of total consumers served who were Medicaid eligible for the month	75
% of consumers served who were Medicaid eligible	75.00%
% of total spend eligible for Medicaid match	75.00%
Amount of total spend eligible for Medicaid match Billing	$225,000.00
Medicaid Administration Match Rate	50.00%
Federal Match Billing Amount	$112,500.00
% of total State spend reimbursed	37.50%

Funding Options Continued . . .

Crisis as Defined Medicaid Service

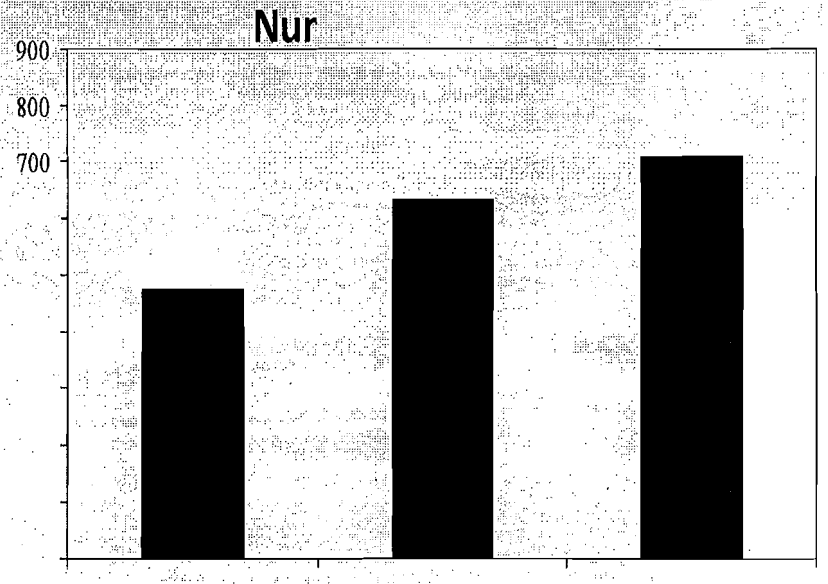
- Modify HCBS waiver to include crisis support as a defined service: "crisis support or intervention"
- Can define very specifically (prescriptive need criteria/risk factors) to limit cost exposure (i.e. for individuals at risk for incarceration, hospitalization, co-existing diagnosis, etc.); mandate approval process by treatment team, physician, etc.
- Must be open to all qualified providers; unit of service

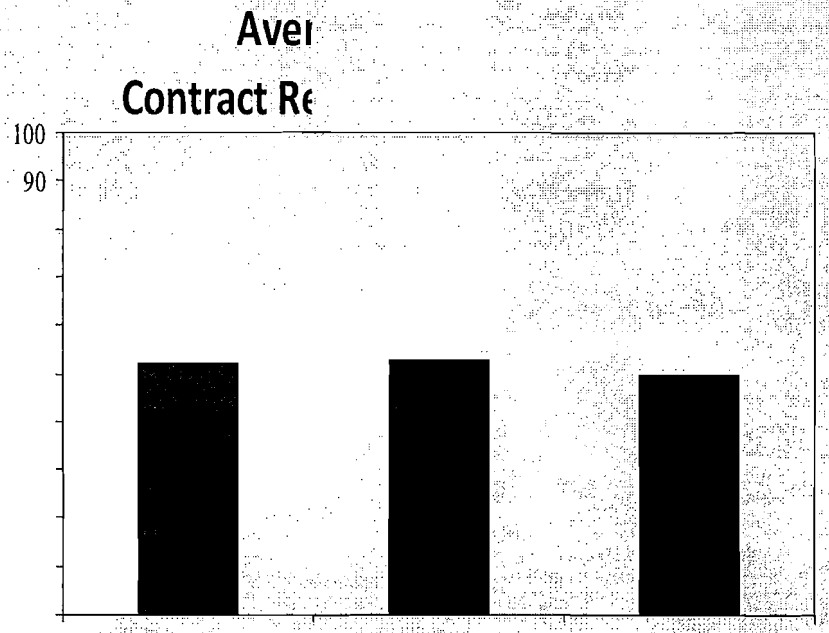
Funding Options Continued . . .

DD Provider Assessment to Fund Crisis

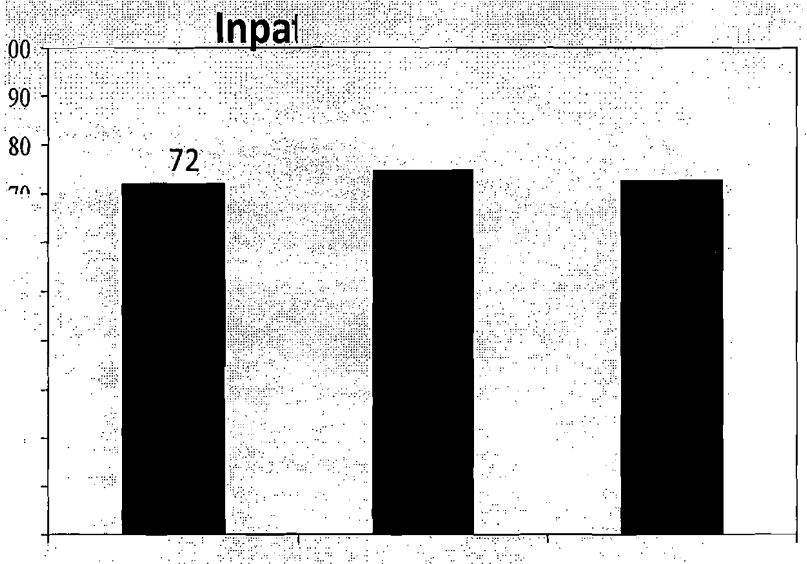
- DD providers are assessed a fee for the funding of a crisis intervention system; regardless if utilized or not
- Vermont is an example. State's program is a highly effective 3 tier model including residential crisis placement
- Contact Dr. Pat Frawley, Director, Phone: 802-496-7830, and pfrawley@uvs-vt.org

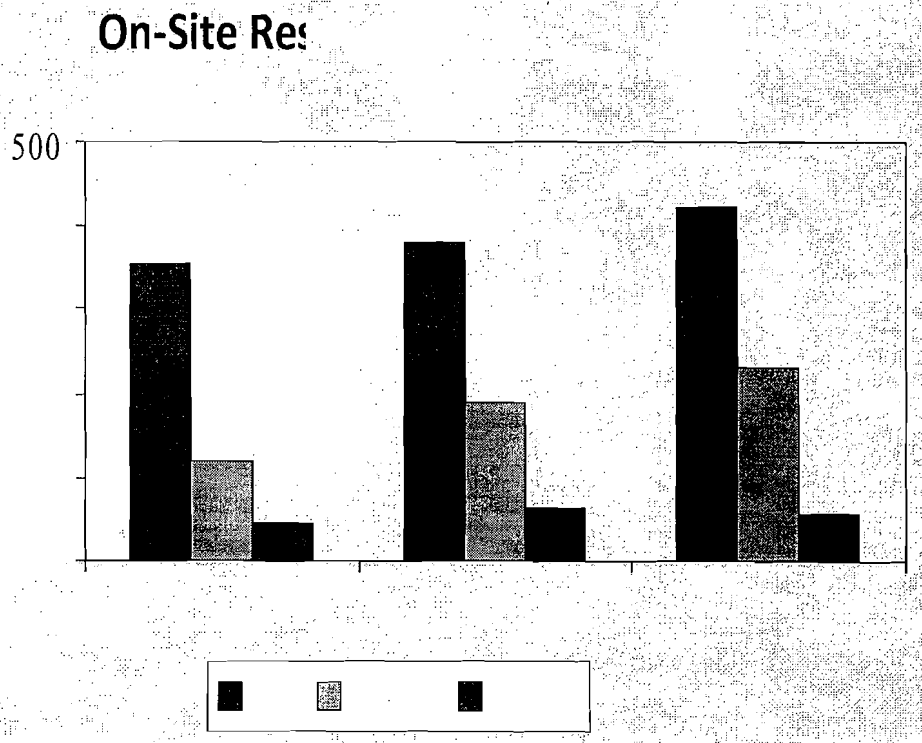
Mental Health Mobile Crisis





Mental Health Mobile Crisis Continued . . .





Future Considerations

- Combine ID and MH mobile crisis functions for efficiency
- Use system savings to increase peer driven wellness programs
- Consider alternative funding streams such as Medicaid
- Development of 24/7 open access emergency crisis services

Thank You!

Contacts:

Steve Cook, Vice President
AWS/Benchmark Human Services
scook@awsusa.com
317-514-8265

George Harris, GA Crisis Director
Benchmark Human Services
grharris@benchmark-hs.com
404-938-1553

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