

Alternative or “in Lieu of” Service Description
Alliance Health

1. Service Name and Description: Rapid Response Crisis Services for Children and Youth

Service Name: Rapid Response

Procedure Code: S5145 22 Z3

License: 131D Licensed Therapeutic Foster Homes

Description: Rapid Response Homes are licensed therapeutic foster homes with a North Carolina Licensed Child Placing Agency that provides emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This emergency service is intended to support family stability, prevent abuse and neglect, provide short term treatment and prevent or minimize the need for out-of-home placements.

This service includes the following activities:

- Individualized and intensive supervision and structure of daily living designed to minimize the occurrence of disruptive behaviors related to family and psychosocial stressors and to help restore at a minimum to the previous level of functioning.
- Psychoeducation to impart information about the beneficiary’s diagnosis, condition, and treatment to the beneficiary, family, caregivers, or other individuals involved with the beneficiary’s care.
- Specific and individualized interventions including identifying triggers that lead to crises, including, interventions to assist in anger management, relearning relevant social skills, family and/or caregiver communication skills, stress management, relationship support, and intensive crisis or crisis prevention and management including de-escalation interventions exclusive of physical restraints.
- Ensure linkage to community services and resources, including connecting with schools, vocational programs, and other service and physical health providers.
- Direct and active intervention in assisting children and youth to remain involved in naturally occurring community support systems and supporting the development of personal resources (assets, protective factors, etc.). This includes licensed clinical staff work with the family and/or natural supports.
- 24/7 availability of provider agency staff and therapeutic parents for immediate response and placement.
- 24/7 emergency/crisis support from provider QP staff for Rapid Response therapeutic parents to avoid burn out of families serving high needs youth.
- 24/7 availability of licensed clinical staff for clinical assessment and consultation.
- The Rapid Response Provider is the First Responder while the youth are in a Rapid Response home.

2. Information About Population to be Served:

Population	Age Ranges	Projected Numbers	Characteristics
Child MH/SU and I/DD, not functionally eligible for the NC Innovations Waiver program but are in crisis due to their diagnosis.	5-20	<i>See Projected Numbers below</i>	Youth are presenting in crisis, however do not meet the imminent danger to self or others threshold and can be diverted short term while a sound long term plan is formulated and executed. Crisis is characterized as serious conflict in current environment, adding to emotional dysregulation, requiring removal to allow de-escalation and re-evaluation/assessment and further development of the crisis plan as needed.
Projected Numbers Alliance BHC		Alliance BHC expects to serve approximately 265 youth with Rapid Response. This is based on 2015-16 Rapid Response data, and a 15% reduction in utilization of inpatient, PRTF and residential group homes (all levels) and/or a reduction in LOS. Total served for 2015 for Inpatient and PRTF alone=1799.	

Eligibility Criteria:

- Medically stable, but may need short term stabilization assistance to comply with medical treatment (Medical stability is defined as: youth who may refuse non-life threatening or function altering medication, managed through re-teaching and psychoeducation, and disruptive behavior not dangerous to self and others in a therapeutic family setting). If a youth requires 24 hour eyes on monitoring/awake night staff for safety reasons, they are not eligible for Rapid Response and must be referred to an alternate level of care **AND**
- A physical has been completed within the past year (per 131D licensing rule). If not, a physical must be completed within 14 days by the beneficiary’s Primary Care Physician or a physician that has a formal agreement with the provider agency to perform consumer physicals when needed **AND**
- The beneficiary is experiencing A or B below (may be related to the presence of moderate affective, cognitive or behavioral problems or intellectual/developmental delays/disabilities):
 - a) Difficulty maintaining in the naturally available family or lower level treatment setting as evidenced by, but not limited to:

- 1) Frequent and acute conflict in the setting, **OR**
 - 2) Frequently limited acceptance of the behavioral expectations and other structure, **OR**
 - 3) Difficulty in engaging in available natural supports and community based services resulting in an increase risk or use of crisis services.
- b) Frequent verbal aggression or infrequent, moderate intensity physical aggression, which may be directed toward property or occasionally to self or others.
- 1) Frequent difficulty in maintaining appropriate conduct in community settings, **OR**
 - 2) Acute difficulties accepting age appropriate direction and supervision in significant areas from caretakers or family members.

AND

- There is an immediate need for structured treatment and reduction of environmental stress, and without, youth would likely be in a higher level of care or present to the hospital, **AND**
- Youth must have a clinical assessment face to face by a licensed clinician prior to admission to a Rapid Response home that determines this level of care will meet the needs of the youth, **AND**
- Youth needing 24 hour active “eyes on” monitoring shall be excluded from Rapid Response and referred for evaluation for a higher level of care.

Priority population for this service includes youth who can be diverted from crisis facilities and EDs, and those youth stepping down from a crisis facility, inpatient, or ED. These are youth who present with acute mental health and/or behavioral issues but do not require inpatient hospitalization. All youth appropriate for step down will be referred by crisis facility staff in consultation with the crisis facility psychologist and/or psychiatrist.

3. Treatment Program Philosophy, Goals and Objectives:

Rapid Response is a crisis service that is person-centered, resiliency and recovery focused, with an aim of not only helping individuals and families maintain stability in areas of functioning and wellness valued by the child/family, but also helping individuals and families continue on their own path of recovery through person-centered planning and service delivery. It is expected that the service will be consistent with the LME/MCO clinical guidelines and best practices. It is expected that the Rapid Response provider will have a Therapeutic Foster Care evidence-based practice implemented.

Rapid Response will not only serve to diffuse crises, it will also serve as a time to complete a more comprehensive assessment, and/or specialized assessments, completed by either the pre-existing treating clinical staff, and/or the provider agency licensed clinical staff, or arranged by the provider agency staff. This is in addition to, or an evolution of, the assessment and initial crisis plan completed prior to placement. The result of the assessment will be to identify the appropriate level of care and treatment plan that will prevent future crises, including a thorough review of the crisis plan and safety plan as applicable with revisions as needed occurring throughout the Rapid Response course of treatment.

Rapid Response provider agencies should clearly articulate a philosophy consistent with the System of Care/Wraparound model from the provider leaders, senior staff, QPs, and therapeutic parents. This philosophy will be apparent in all written materials.

4. Expected Outcomes:

Home Stability:

It is expected that youth served will return to their natural family setting, with a goal of increasing the percent of youth returning home over time. If alternate placement is needed, then the least restrictive most appropriate level will be chosen. CFT's should plan around crisis, transition or residential placement. Barriers to returning to original setting shall be documented and an action plan shall be created to address the barriers.

- At least 50% of youth served shall be diverted from out of home placement after receiving the service.
- If a return home is not the CFT recommendation, at 100% of youth will be connected with the identified appropriate level of care.

Decreased hospital admissions:

- Monitor the % of youth who are diverted from crisis or inpatient services due to entering the Rapid Response beds, with a goal of increasing the percent over time (FY 15 will serve as baseline).

Response to placement requests will be handled in a prompt manner:

- 100% of requests for the service by local crisis or inpatient services are answered within one (1) hour of request;
- 90% of requests for the service by other entities (Care Coordination, other providers) are answered within one (1) hour;
- 80% of youth meeting criteria for service are placed in Rapid Response home within 12 hours of the initial request.

5. Staffing Qualifications, Credentialing Process, and Levels of Supervision Administrative and Clinical) Required:

This treatment may be provided in a North Carolina licensed therapeutic foster family setting with one or two surrogate family members providing services to no more than one consumer per home. Given the high risk nature of some consumers accessing Rapid Response every attempt should be made to have a diverse pool of parents available including one stay at home parent, single occupancy homes, etc. Identified homes shall be a Rapid Response Only designated home. The designated home shall have a separate bedroom for Rapid Response youth, not shared space with any other individual person. Therapeutic Foster Homes identified for Rapid Response shall not provide Family Foster Care while serving as a Rapid Response provider.

Rapid Response Families shall have competency in working with high needs youth. This is measured by experience as a treatment or foster family for a minimum of two years. Exceptions to this may be approved by the MCO.

Provider staff supervising Rapid Response homes will assist the LME/MCO in arranging appropriate ongoing services such as mental health services, substance use treatment, other specialized assessments, and medical services.

Treatment is provided in a structured setting with qualified and trained provider staff support and therapeutic parents who are present and or available at all times of the day. A minimum of one provider staff (QP) is required to supervise no more than six total homes at all times, regardless of home level of treatment. If the provider QP is supervising IAFT or E-TFC homes, they may supervise no more than a maximum of 2 Rapid Response homes that count toward the total number of homes. The QP has a minimum two years of experience working directly with youth and families.

The provider agency shall have licensed clinical staff to provide clinical assessment prior to the service if not completed by referring provider prior to service entry. Licensed clinical staff also oversee all clinical interventions, provide outpatient therapy (inclusive of family therapy) as needed, and consultation 24 hours per day. Licensed clinical staff are North Carolina Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, or Licensed Professional Counselor. Associate licenses may be utilized with two years of experience with the population.

Agency shall have a North Carolina Licensed Psychiatrist available for medical and psychiatric oversight and consultation. The Licensed Psychiatrist will provide psychiatric evaluation as needed.

The provider agency must follow minimum requirements in 131D and 122C rules, including:

- Skills and competencies of this service provider must be at a level that offers psycho-educational and relational support, behavioral modeling of interventions, and supervision.
- These preplanned, structured interventions occur as required and outlined in the consumer's service plan.

Along with the standard Therapeutic Foster Care MAPP training curriculum (or other NCDSS approved curricula), Rapid Response providers QPs and therapeutic parents will receive an additional 30 hours minimum of advanced pre-service training to include:

- Strategies to address safety, intensive supervision, and intensive therapeutic interventions
- System of Care/Wraparound model
- Trauma Informed Care
- Crisis de-escalation
- Specialty training, based on the youth being placed, to address sexually reactive behaviors, dually diagnosed youth, and other specialty populations
- Provider QPs training will include strategies to provide supervision and support for all of the above to Rapid Response therapeutic parents.

It is expected that the pre-service training curricula for staff and therapeutic foster parents will be delivered utilizing a mixture of in-person classroom settings and other forms of formal instruction.

Specific training curricula must be approved by the MCO.

Provider QP staff shall provide individual face-to-face supervision with the therapeutic parents at least twice weekly, in the Rapid Response home during the placement. The Provider also has daily contact with the Rapid Response family. This supervision will address the complicated, and often stressful, situations that providing crisis response can create.

All new provider QP staff providing Rapid Response support shall receive all training prior to a Rapid Response placement being made and existing staff will receive annual refresher training.

6. **Unit of Service:** 1 day = 1 unit
7. **Anticipated Units of Service per Person:** 7-14 consecutive days with a maximum of 21 days; any recurring crisis event would trigger a clinical team review to determine the repeated need for this service.

Utilization Management

There is no prior authorization (PA) required for the first 7 days per episode. An authorization request must be submitted if placement is needed beyond 7 days. The maximum length of service is 21 days per episode. If an imminent transition is scheduled to the appropriate service level, and cannot be completed in the 21 day timeframe, an authorization request may be submitted, but must have a specific plan in order to be authorized beyond 21 days.

EPSDT Special Provision

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age *42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]*

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay

the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

- 1) That is unsafe, ineffective, or experimental or investigational.
- 2) That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

- 1) If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- 2) IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problem

Entrance Process

The process for a beneficiary to enter this service includes completion of a face to face clinical assessment including a crisis assessment (risk assessment that includes health and safety). This assessment shall be completed prior to admission to the Rapid Resource home, and will include the identification of eligibility criteria for this service.

8. **Targeted Length of Service:** 14 days

9. **Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.**

Rapid Response Homes are 131D licensed therapeutic foster homes that provide emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis. This emergency service is intended to support family stability, prevent

abuse and neglect, provide short term treatment and prevent or minimize the need for out-of-home placements.

Crisis services for youth and families include Mobile Crisis and children's Facility Based Crisis, however there are many times a youth is hospitalized, when the youth and family could have been separated to decrease conflict intensity for a period of time. In a Rapid Response Home, interventions are delivered that give the family and youth the skills needed to reunite and continue living as a family. Rapid Response allows for a structured therapeutic family for a short period of time to allow for stabilization, additional assessment, and planning by the Child and Family Team, and agency licensed clinical staff.

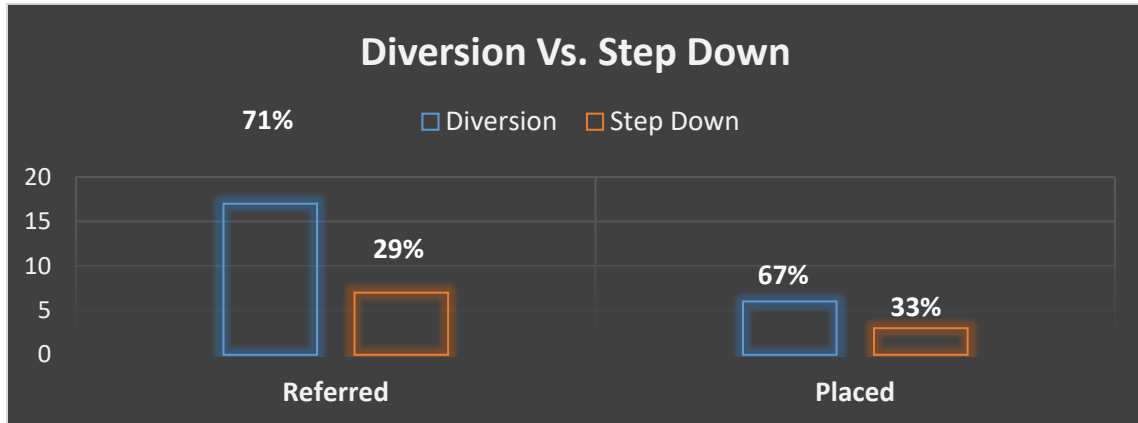
Rapid Response has been a successful service provided in our catchment area using non-Medicaid funds.

Data from previous use of Rapid Response in Alliance's catchment area has been monitored and results include the following:

The service has been implemented in NC as a county funded service with the following outcomes in the first half of the FY:

- 1) At least 50 % of the youth served shall be diverted from out of home placement after receiving the service:
 - 8/14 (**57%**) of consumers post-service were returned home.
 - 6/14 (**43%**) were discharged to:
 - 2) Level III Group Home 3) Therapeutic Foster Care and 1) Inpatient Facility.

Provider is expected to monitor the percentage of consumers who are diverted from crisis or inpatient services as a result of placement in the Rapid Response Beds, with a goal of increasing this percentage over time. This is broadly categorized each referral as either "Step-Down" or "Diversion." As reported in the original data, of those referred, 17 were categorized as "Diversion" and 7 as "Step-Down." For referrals resulting in placement, 6 were "Diversion" and 3 were "Step-Down." Percentages are demonstrated in the graph (see below). Updated data did not include this but will be captured moving forward. Therefore, the graph includes only the original 24 referrals/placements. Clarification on the Diversion versus Step Down will need be more clearly defined moving forward. It was difficult to capture based on way the reporting sheet was originally designed.



- 2) 100% of requests for service by local crisis or inpatient services are answered within one (1) hour of the request:
 - Of the 7 “step-down” referrals originating from an inpatient/crisis facility or Alliance embedded care coordination services, all 7 were responded to within the one hour time frame (7/7; 100%).
- 3) 90% of requests from other entities will be answered within one (1) hour (Original Reporting - Revised Report did not capture this element):
 - Out of the remaining referrals, 15/16 (94%) were responded to within one hour. The provider cited the reason for the one delay as “the referral was emailed after hours and was not called into the ‘after hours’ response line.”
 - One referral had to be removed from the analysis due to an error with referral/response time on the reporting sheet.
 - With the remaining 23 referrals, the overall average response time was 39 minutes.
- 4) 80% of youth meeting criteria for placement are placed in Rapid Response homes within 12 hours of the initial request :
 - For the 9 consumers who met the criteria for placement, (22%) were placed within 12 hours of the initial request.
 - The remaining 7 placement times ranged from 18:05 hrs. /min. to 140:33 hrs. /min.
- 5) Youth should ideally not remain in Rapid Response Homes longer than 14 calendar days:
 - All consumers were discharged from the Rapid Response Homes in 14 nights or less. The 14 consumers stayed an average of 9.28 nights (Longest length of stay 14 nights; shortest length of stay 1 night) and they stayed an accumulative total of 130 nights.
 - As there are 30 Days/April, 31 Days/May and 30 Days/June with a total of 3 Rapid Response Beds available, this would equate to 273 total bed days available during this reporting period.
 - Rapid Response Beds were utilized 47.62% of the total bed nights available (130/273)
 - (89%) of placed consumers participated in a Child/Family/Team (CFT) Meeting during placement. The one consumer who did not stayed only one night.

10) Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.

Crisis services for children and adolescents has been identified as a significant need in our Gaps and Needs assessment. The plan is to use Rapid Response in order to prevent ED visits, reduce inpatient stays and the need for higher levels of care for children and adolescents in crisis. The desired outcomes is to divert children/adolescents from other crisis services and out of home placements.

Previous data noted above shows successful use of Rapid Response with non-Medicaid funds. Expanding this service to the Medicaid population will also prove to be cost effective based on our previous data and the comparison data below.

Description of comparable State Plan Service Payment Arrangements (include type, amount, frequency, etc.)

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
ED/Crisis visits	Facility Charge	Varies	1400 Youth presenting at ED's and/or Crisis Facilities in 2015.	\$468,000 Average cost per youth: \$334
Inpatient Bed Days	Facility Charge	Per Diem	Rates Range from 500-990 per day	1561 served, total cost=11,205,019 \$7,178 per individual
PRTF	Facility Charge	Per Diem	Rates Range from 342/day to 965/day	239 served, total cost=11,601,392 \$48,541 per individual

Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.)

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
Rapid Response		Per diem	14 units per stay maximum (no more than 30 if given extension)	\$200.00 <u>Projected Cost:</u> \$2800 individual cost per 14 day stay. \$ 742,000 total cost for 265 youth@ 14 days

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)

Claims data will reflect fee for service billing. Data will be uploaded to DMA by the MCO.

Encounter Data will be recorded by providers with the minimum standard of a daily service note to include all significant contacts, service events, or interventions.

Providers will collect and report/provide access through sharing of the health record to all encounter data. At a minimum, this would include time spent on family based sessions, individual sessions, and indirect contacts, as well as all supervision notes for the Provider QP staff, licensed clinical staff, and the Therapeutic Parents.

Description of Monitoring Activities:

The MCO will review claims monthly to monitor patterns and trends in utilization of this service.

The MCO will monitor service utilization through prior authorizations after first seven day period, utilization management, and post payment reviews. In addition, MCO will maintain a real-time dashboard to monitor placements throughout the catchment.

The MCO will measure outcomes minimally through an initial crisis assessment (risk assessment that includes health and safety), CALOCUS scores, ASAM Levels (for individuals with substance use disorders), CANS and ECSII (for 3-6 year olds).

Documentation Requirements

Refer to the DMH/DD/SAS *Records Management and Documentation Manual* for a complete listing of documentation requirements.

The minimum standard is a daily service note to include all significant contacts, service events, or interventions.

A completed LME-MCO Consumer Admission and Discharge Form shall be submitted to the LME-MCO.

A documented discharge plan shall be discussed with the child, family, and other providers and included in the service record.