Continuum of Care CSP Service System (CSP Perspective)

The following information outlines several ideas from the CSP perspective of what is needed in a continuum of care for people receiving services under the CHOICES Waiver program. It is important to emphasize that these are only ideas and the information below is intended to be presented broadly.

Placement and Service Initiation	Behavior Plans & Support	Crisis Services	Service Jeopardization
• Reimbursement rates that support high needs populations. • Supporting 100% of methodology ensuring that staff wages are paid at full benchmark wages indicated in the methodology. • 30-day evaluation period for SDDC transitions to CSP with option for the person to return if service needs cannot be met by the CSP. • Ongoing monitoring and additional support system for SDDC transitions following the 30-day monitoring period.	• Invest in HCBS system so CSPs have greater access to Board Certified Behavior Analyst (BCBA) level experts. • Invest in comprehensive behavior modification training systems for all CSPs. • Possible ARSD rule modifications that better support people with rights restrictions and psychotropic medications. • SDDC consultation in situations of potential crisis. These situations would require an expedited request process. • Development of triggering/reporting mechanisms that support quick action.	• Facility-based option for full crisis care to include medication assessment, behavioral assessment, & 30-90 day stays with expectation that the person returns to the CSP. This could be SDDC or other HCBS waiver established facility-based provider. • 1115 Demonstration Waiver option developing a crisis service that utilizes local or regional hospital resources in conjunction with CSP staff. This would be for short-term hospitalization. • Requires immediate action upon notification. Requests would require an expedited process.	• Last resort to include additional stay at crisis care facility-based provider. This could be SDDC or other HCBS Waiver established facility-based provider. • Include option of out-of-state placement. The state could potentially contract with out-of-state providers to perform this service. • Provider initiated termination of services.

***Table 1*:** General continuum description.

Placement & Service Initiation

Any continuum of care must start at the beginning with placement and service initiation. This includes a reimbursement methodology that not only covers standard services included in the waiver, but also the staffing and service delivery needs for intensive servcies. Supporting 100% of the methodolgy is the best way to accomplish this need. It ensures that benchmark wages indicated in the methodology and

services included in the waiver (e.g. behavioral support specialists) are met. Staff are the backbone of providers and stabilizing the workforce with highly competetive wages ensures continuity of staff, appropriate staffing ratios, and better prepares providers in serving high needs populations that are more likely to experience crisis.

SDDC outplacement has been an important part of the IDD system for many decades. CSPs act as the community-based option for people transitioning out of SDDC. All CSPs support people who once received institutional services at SDDC and this continues today. One of the practices that used to occur was a 30-day evaluation period for a person transitioning to a CSP. This transition period allowed the CSP provider to evaluate if the person would be a fit to their organization, fine tune behavioral and environmental supports, and other aspects of the person's life. If the CSP was not able to meet their needs, the person had the option of returning to SDDC. This activity was important because it focused on the transition needs of the person and the CSP provider. It is also preventative in the sense that it established a foundation of support for the person both short and long-term. **CSP providers propose the following ideas:**

- ***SDDC transition periods –*** Revive this practice for all SDDC transitions to CSP services.
- ***Transition period expansion –*** Expand the transitions to include at least a minimum follow up period conducted by SDDC (e.g. 30-60 days) after the 30-day transition period is complete. This would act as an additonal support to the provide to fine tune behavior and environmental plans et cetera. This would also benefit SDDC in the sense that the transition would be more comprehensive improving success.

<u>Behavior Plans & Support</u>

This column has several proposed ideas focused on preventative activities and support that CSPs need to avert crisis situations ranging from ARSD rule modification to improved access to expert consultation. **CSPs propose the following ideas:**

- ***BCBA Access –*** Invest in the HCBS system to improve access to BCBA level experts. The state is now producing these professionals at a much higher rate through the BCBA program at the University of South Dakota. BCBA certification is the gold standard for behavioral analysis and CSPs only minimally have access to this level of expertise. Investing in this resource so each CSP has access to these professionals either internally or regionally could greatly improve the CSPs capacity in preventing crisis.
- ***Comprehensive behavior modification training –*** CSPs already have standard training and participate in supplemental training as opportunities arise. This idea focuses on how to enhance current CSP training practices with gold standard behavior modification training and crisis response training.
- ***ARSD Rule changes –*** There are some ARSD changes that could potentially help in a preventative sense. These include rules regarding use of psychotropic medications, rights restrictions, and termination of services. In recent discussions with DHS on the crisis services topic, they asked CSP providers what changes to rule could be made to help in the immediate. This resulted in a letter to DHS with our findings, concerns, and recommendations (see attached letter for more information).

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- ***SDDC Consultation –*** This idea is not new and is currently active to an extent. Essentially, this activity centers on situations where a person is either entering a crisis stage or in crisis, but not at the point where the CSP feels the need to terminate services. In other words, it is likened to an emergency consultation of sorts. What we propose is to streamline this process so that's it's easy to access immediately. It would include the possibility of onsite evaluation and observation by SDDC staff and coordinated planning.
- ***Development of triggering mechanisms –*** This is more of a coordinating activity so that CSP service teams have seamless coordination with case managers, DDD, and SDDC et cetera. This would help keep all those involved in care on the same page and activate more intensive supports when needed.

Crisis Services

This column proposes several ideas for how to approach the most serious crisis situations. These are situations where the person's safety, safety of others, and continued services are in serious jeopardy. They are situations where previous interventions and preventative measures have failed, and more intensive settings and services are needed to stabilize the person. **CSP proposed ideas include the following:**

- ***Reliable short-term crisis respite care –*** One of the issues that many CSPs contend with is the lack of access to psychiatric hospitals for people who need immediate crisis support in that type of environment. It's a hit and miss situation, where sometimes the hospital will admit our population and other times they will not. The primary reason many of these hospital settings do not admit our population is that they not set up environmentally or training wise to work with our population. CSPs often hear from these facilities that SDDC is the proper place for our population to go in crisis situations, much like HSC is available for those experiencing mental health crisis. Having access to this type of service either locally or regionally would be ideal for those situations where the person might need short-term crisis care and stabilization.
- ***Facility based respite crisis care –*** This type of service would be more geared toward intermediate-term stays (e.g. 30-90 days). This would be the most intensive option reserved for the most serious crisis situations that require longer-term stabilization to include full medication assessment and behavioral analysis.
- ***1115 Demonstration Waiver –*** Section 1115 of the Social Security Act gives the U.S. Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs. This type of waiver could potentially include both crisis service options above (facility based and short-term) and states could receive the FMAP share. This could potentially be a great option for those short-term hospital type of services needed. It could allow the both the hospital and CSP to receive funding and the CSP could have staff present in the hospital for personal care and other supports as necessary.

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Service Jeopardization

This is the last resort type of scenario and would again include crisis services but may require long-term placement in a more restrictive environment and potentially include termination of services from the community-based provider. **Ideas include:**

- ***Long-term facility-based placement –*** Placement in this situation could potentially be longer than 90 days and is geared towards very extreme crisis situations. In these cases, SDDC has the facilities, expertise, and capability to serve these individuals. It could also include a private HCBS waiver provider.
- ***Out-of-state placement –*** Another option if SDDC or other HCBS provider is not available is out-of-state placement. The state could contract with providers that have this type of expertise and capability. It is not the most family friendly type of service, but it's an option that has been used before and can work for people in these kinds of situations. In this case, we propose that it be more formally designed.

Continuum Illustration

Below is an illustration of how the continuum could possibly work in a cycle type fashion.

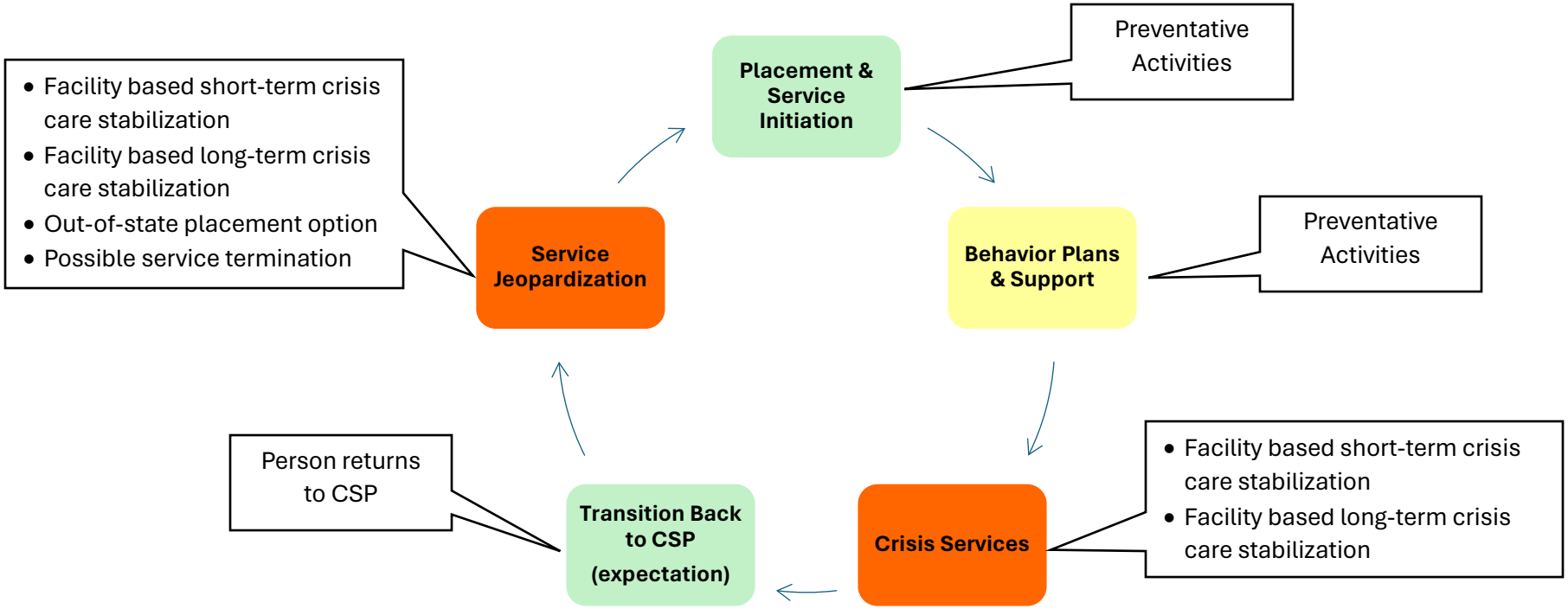

***Figure 1*:** Continuum illustration cycle fashion. **Note.** Crisis services and services jeopardization are similar. The idea is that if a person receives crisis services once and then again, alternative long-term placement should be considered by service teams. This could include the options noted, but also could include returning to the CSP system. The main point is that if a person reaches this stage in the cycle, placement is not working and consideration of alternatives is appropriate.

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Again, it is important to note that the above are ideas with potential and require further development and exploration to determine viability, barriers, and fiscal impact. There are also other state models that deserve exploration for a fit in South Dakota's service system. DHS is also working with Alverez and Marsal on possible crisis care models that would fit our system needs as well. Following the meeting with legislators, DHS, DSS, SDDC, Governor's office, and CSP representatives on February 12, 2024, CSP representatives have met with Sec. Rechtenbaugh and Senior Policy Advisor Laura Ringling on 2/20/24, 3/5/2024, and 4/5/2024. These meetings discussed the above options with the understanding that there will be long-term and short-term solutions to further explore.