STATE OF TENNESSEE

DEPARTMENT OF FINANCE AND ADMINISTRATION

Division of Health Care Finance and Administration

Bureau of TennCare

REQUEST FOR RECOMMENDATIONS AND MCO CONTRACTING INFORMATION

June 15, 2015

Request for Recommendations
and MCO Contracting Information:

Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with Intellectual and Developmental Disabilities

Date Issued: June 15, 2015

TennCare, in partnership with Amerigroup, BlueCare Tennessee and United Health Community Plan Managed Care Organizations (MCO), seeks to gather information and to identify potential providers of Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with Intellectual and Developmental Disabilities (I/DD) who experience challenging behaviors that place themselves and others at risk of harm, under a newly designed I/DD Stabilization Model of Support. A description of the proposed services and model of support is attached. Providers selected to provide this service will be contracted with TennCare MCOs to deliver the service.

The information gathered through this request for recommendations and MCO contracting information will be used both to finalize certain aspects of the service and model of support requirements, and to identify potential providers of the service for contracting with the MCOs.

Response to this request does not obligate you to contract for the provision of these services. However, we anticipate that only providers who respond to this request will be selected for initial contracting with an MCO to provide these services. Providers will be selected based on the experience, expertise and capacity they will bring in delivering the new service and implementing the Model of Support (MOS).

Experience in delivering mental health—in particular crisis services—and/or in serving individuals with intellectual and/or developmental disabilities who have challenging behaviors is required.

Please submit responses to each of the questions listed below no later than COB July 31, 2015. Responses should be addressed to TennCare Behavioral Health Operations (Mary Shelton, Director) and submitted via e-mail to Debbie Bresee, Administrative Assistant, debbie.bresee@tn.gov. Please ensure that you have read and understand the proposed service and model of support description attached prior to responding. Responses should clearly address each of the questions and all aspects of the proposed service and model of support. Responses to each item will be reviewed and scored.

Please limit your total response to no more than 50 pages, including attachments.

If there are questions that you believe are *critical* to your ability to respond to this request for recommendations, you may submit those questions in writing by COB June 22, 2015 via email to debbie.bresee@tn.gov. Please limit your questions to information that is *critical* to your ability to respond to this request, as the service and model of support requirements will not be finalized until the conclusion of this process.

Future opportunities for elaboration/clarification will be made available.

On behalf of TennCare and the Managed Care Organizations, we look forward to the review of your responses and your potential participation as a provider of these services.

Should you have any questions, please do not hesitate to contact me.

Respectfully,

Mary C. Shelton
Director, Behavioral Health Operations
Bureau of TennCare

Summary of Events

EVENT	TIME/DATE
RFR Released	**June 15, 2015**
Critical questions *only* submitted in writing*	**COB June 22, 2015**
RFR Response Due Date	**COB July 31, 2015**

**Please see paragraph at the top of this page regarding questions.*

Provider Information

Please provide the name under which your organization is licensed to conduct business.

Are you licensed to provide services in Tennessee?

If so, please list the license(s):

Provide your organization's:

- Name
- Address
- E-mail address
- Primary Contact Person(s)
- Primary contact telephone number and email address

Capacity

Describe your experience providing behavioral crisis prevention, intervention and/or stabilization services. Include the specific type of behavioral crisis services you provide(d), the populations served, the timeframe, the entity with whom you contracted to provide these services, and the primary payer source. Include the name, email address and phone number of a person with that entity that we can contact regarding the services you provide. What were the qualifications of staff that provided these services? Please describe any data you have regarding service outcomes. Were there any lessons learned?

Describe your experience providing other behavioral health services. Include the specific type(s) of service(s) you provide(d), the populations served, the timeframe, the entity with whom you contracted to provide these services, and the primary payer source. Include the name, email address and phone number of a person with that entity that we can contact regarding the services you provide. If this has already been described in the response to item #1, please reference and do not repeat.

Describe your experience working with individuals with intellectual and/or developmental disabilities (I/DD). Include the specific type(s) of service(s) you provide(d), the populations served, the timeframe, the entity with whom you contracted to provide these services, and the primary payer source. Include the name, email address and phone number of a person with that entity that we can contact regarding the services you provide. If this has already been described in the response to items #1 and/or #2, please reference and do not repeat.

Describe any existing relationships/partnerships you have with organizations or groups that could be engaged in providing natural supports to individuals in the model of support.

Describe your experience and capacity in utilizing Telehealth in the delivery of services and supports. Identify any potential barriers to the provision of Telehealth.
Describe, if applicable, your solution to overcome identified barriers.

What are the greatest strengths you would bring to the delivery of these services in Tennessee?

In which of the grand regions of the state (east, middle, and west) would your organization be able to provide these services? (Note you must agree to serve members in all counties of that region.) List all regions that apply.

Approach

How would you go about planning/preparation to deliver behavioral health crisis prevention, intervention and stabilization services as described in Tennessee?

How would you go about implementation of these services in Tennessee?

Describe your operational model.

Describe your proposed staffing model. Explain how you would ensure 24/7 availability of crisis intervention and stabilization services, including back-up and supervision.

How would you go about engaging MOS Team members in all aspects of the proposed MOS?

Describe your formal and informal assessment approach specifically designed to address behavioral health crisis prevention and intervention for the I/DD population.

Describe your approach for working with existing Circles of Support (for people enrolled in existing 1915(c) waivers) in the planning process.

Implementation

What kind of training would you need in order to begin providing these services?

Can you be prepared to begin providing services on October 1, 2015? Provide a list of activities that you will undertake to prepare for implementation and the date by which each activity will be completed.

Describe your vision of this model's success.

Recommendations

What do you think should be included in the qualifications of providers contracted to provide these services? What do you think should be the qualifications of staff who actually deliver the services and provide supervision?

These services will be reimbursed on a case rate methodology, inclusive of all of the crisis prevention (including assessment, planning and training), intervention and/or stabilization services needed by a member participating in the model of support. Please describe what you think would be a fair and reasonable case rate. Include justification for each component of the proposed case rate.

Once sufficient data has been gathered, the payment approach will also include outcome-based incentives and/or shared savings. Please share any thoughts regarding such incentive or shared savings approach, including key indicators of performance that you think should be part of the payment model.

What are the concerns, barriers, or challenges you foresee in implementing these services and the MOS? Please describe any proposed solutions.

Do you have recommendations that you think would strengthen the proposed behavioral health crisis prevention, intervention and stabilization services and model of support?

ATTACHMENT:

Description of Proposed Behavioral Health Crisis Prevention, Intervention and Stabilization Services and Model of Support for Individuals with Intellectual and Developmental Disabilities

Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD: Proposed I/DD Stabilization Model of Support

This proposed I/DD Behavioral Health Stabilization Model of Support (MOS) is a comprehensive, person-centered approach to the delivery of behavioral health crisis prevention, intervention and stabilization services for individuals with intellectual and developmental disabilities (I/DD) who experience challenging behaviors that place themselves and others at risk of harm. The model is designed to provide a full array of necessary behavioral services and supports for individuals with I/DD and co-occurring mental health and/or behavior disorders including behavioral health crisis prevention, intervention, stabilization and when necessary, referral to out-of-home respite or inpatient services, with coordinated transition back to community living.

This proactive MOS is designed to improve quality of life by promoting behavioral crisis planning and prevention. Behavioral health crisis prevention includes person-centered assessment and planning, and training on the MOS as well as the needs of the individual in order to avoid potential triggers and to provide positive behavior supports so that individuals have the opportunity to experience greater independence and an improved quality of life, free of challenging behavior. The model will further support sustained integrated community living by equipping families and providers supporting individuals with I/DD to quickly identify and address potential behavioral crisis situations, intervening immediately to de-escalate a potential behavioral crisis situation whenever possible.

When necessary, the MOS includes the availability of an in-home behavioral health crisis intervention and stabilization response to assist and support the person or agency primarily responsible for supporting an individual with I/DD who is experiencing a behavioral crisis that presents a threat to the individual's health and safety or community living arrangement, or the health and safety of others. If it is determined that short-term placement (i.e., respite) out of the current living arrangement is needed in order to stabilize the crisis or that inpatient treatment is appropriate, the model will include preparation and planning for transition back to the appropriate community living arrangement as soon as appropriate, and with review and revision as needed of the Crisis Prevention and Intervention Plan prior to such transition.

Participation in the model is expected to be time-limited, based on the needs of each member. The goal of the model is to empower the person and those who provide support to effectively manage day-to-day situations and environments in positive ways that do not result in behavioral crises. This will be accomplished in part by developing capacity and expertise within MOS Team Members who will continue to be engaged in planning and providing supports once participation in the MOS has concluded. Ongoing supports could include referral and transition to Behavior Services available under an HCBS waiver, as applicable, and the development/enhancement of a Behavior Support Plan, when needed to help maintain outcomes that have been achieved and to ensure sustained community living.

Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD: Proposed I/DD Stabilization Model of Support

Model:

Assessment/Planning/Prevention:

- Person-centered assessment
- Development of individualized Crisis Prevention and Intervention Plan (WRAP®-like concept)—ongoing process
- MOS Champion (the individual's "subject matter expert")
- MOS Team
- MOS Liaison (MCO Expert)
- MOS and individualized CPIP training

Crisis Intervention and Stabilization Response:

- Specialized I/DD Crisis Team/MOS Champion/MCO Liaison
- Team Focused Stabilization (HBT/MHCC Two Tier Model)
- Facilitation of Behavioral Respite/Inpatient treatment, when appropriate; including transition back to community placement

Enhance System Capacity:

- I/DD and MOS training for existing Crisis Teams
- First response de-escalation training
- Hospital-based Dual Diagnosis Specialist Crisis Screener
- Tele-health/tele-supervision
- EHR

Components:

Planning/Prevention:

- "General" Model of Support (MOS) training will be delivered first to providers, including direct support workers, families providing support, and as the model evolves, to any systems that will be impacting the treatment and support of individuals with I/DD. Existing training materials, including the IDD Toolkit, will be reviewed and leveraged whenever possible in the development of the MOS training.
- Comprehensive face-to-face person-centered assessment conducted by MOS provider, with MOS Champion and Liaison, if possible. Discussions with caregivers (paid or unpaid), family members/conservators, etc., who may help inform the planning process.
    - Include comprehensive review of health care issues/needs including physical and mental health diagnoses and emotional concerns that could trigger need for behavior intervention
    - Identification of medications which could impact behaviors and/or prescribed to address behavioral needs
- MOS Team Meeting
- Development of individualized Crisis Prevention and Intervention Plan (CPIP)

- Modeled from a WRAP®-like action plan[1] (a proactive approach to crisis prevention)
- Plan must be easily understood by person supported, family members, and direct support staff (person-centered and practical)
- This plan will be individualized and speak specifically to potential triggers and the most effective calming/de-escalation techniques
- Plan should be updated on an ongoing basis, and following any behavioral crisis requiring intervention and/or stabilization services
- For individuals enrolled in an HCBS waiver or ECF CHOICES,[2] will be integrated into the ISP in order to ensure integration/coordination of behavior support needs across services and settings

- MOS Champion (expert on the individual): This person will be identified as the member's advocate and an expert on the person's needs and preferences. This could be a family member, Independent Support Coordinator (ISC), direct support professional, or other person most knowledgeable about the individual's needs and preferences and available to engage in crisis planning, prevention and stabilization activities. The MOS Champion would sign a MOS Agreement, confirming his or her agreement to function as the person's MOS Champion and to fulfill the responsibilities of the MOS Champion on the person's behalf.
- MOS Team: Includes the Champion, Liaison, MOS Provider and other individuals important and instrumental in planning and implementing behavior supports,(family members, friends, service providers, etc.). For individuals enrolled in an ID waiver, builds on the Circle of Support[3] and brings behavioral expertise to the planning process. For individuals enrolled in ECF CHOICES, builds on the person-centered planning team. For individuals not receiving HCBS, would be convened by the MCO Liaison. For individuals requiring mental health treatment services (including medication management), would include the Psychiatrist (or prescribing practitioner,

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[1] **Wellness Recovery Action Plan®**, and WRAP®, are the registered trademarks for a recovery model authored and designed by Mary Ellen Copeland. It is an evidence-based practice, consisting of a personalized wellness and crisis plan development program, and is included on the SAMHSA National Registry for Evidence-Based Programs and Practices. For more information, see http://www.mentalhealthrecovery.com/.

[2] **ECF CHOICES** or Employment and Community First CHOICES is a new Managed Long Term Services and Supports Program for individuals with intellectual and developmental disabilities that is expected to be implemented in 2016. For more information, see http://tn.gov/tenncare/forms/ConceptPaper.pdf.

[3] The **Circle of Support** (COS) is a group of individuals who meet or otherwise share information on a regular basis to help a person who is enrolled in one of the State's HCBS programs for individuals with intellectual disabilities accomplish personal life goals and become an active member in the community. Members of the COS may engage in social activities with the service recipient; however, the primary purpose of the COS is to advise the person and legal representative regarding the planning of services and supports.

e.g., Physician Assistant or Nurse Practitioner) and/or the Primary Care Provider (PCP), who may consult with MOS Psychiatric Consultants, as needed. If the PCP or Psychiatrist (or prescribing practitioner, e.g., Physician Assistant or Nurse Practitioner), as applicable, is unable or unwilling to participate in the MOS Team meetings, the MOS Liaison will be responsible for communication and coordination with the PCP and/or other prescribing practitioner. One of the primary responsibilities of the PCP or Psychiatrist (or prescribing practitioner), as applicable, will be to assist the team in reviewing the appropriateness of currently prescribed psychotropic medications and to explore other potential non-pharmaceutical behavioral interventions.

- MOS Liaison
  - MOS and MCO expert
  - Modeled after the system of care concept
  - Able to facilitate access to needed behavioral services and supports
- MOS Psychiatric Consultant
  - Psychiatrists with expertise in serving individuals with intellectual disabilities who 1) have received training on the MOS; 2) are committed to the identification and implementation of non-pharmaceutical behavioral interventions, when appropriate, and a preventative approach to managing behavior crises; and 3) agree to provide expert consultation and recommended strategies for optimal integration of medication treatments with other treatment modalities to PCPs of individuals with a Crisis Prevention and Intervention Plan, as needed.
- More in-depth MOS training and training on the person's individualized Crisis Prevention and Intervention Plan will be provided to paid and unpaid caregivers.

Crisis Intervention and Stabilization Response:

- Families and providers are equipped (i.e., with training and planning) to quickly identify and address potential crisis situations on behalf of individuals with I/DD they support, intervening immediately to de-escalate a potential crisis situation whenever possible.
- Specialized I/DD Crisis Intervention Team /MOS Champion/MOS Liaison
  - Specialized "I/DD crisis intervention response team" to focus on people with I/DD; these will be I/DD professionals who are trained in the delivery of crisis response (not vice versa)
  - Immediate engagement of MOS Champion

- In-home crisis intervention and stabilization response as needed to assist and support the person or agency who is primarily responsible for supporting an individual with I/DD who is experiencing a behavioral crisis that presents a threat to the individual's health and safety or community living arrangement, or the health and safety of others
- Goal is to stabilize in place, divert from inpatient, and support sustained integrated community living whenever possible and appropriate
- Critical for a MOS Liaison to be part of this team to help assist in navigating through the managed care system when a crisis arises for the person
- Referral to behavioral respite and inpatient treatment, when appropriate
- Plan for and facilitate transition back to appropriate community placement, including review/revisions to the Behavior Prevention and Intervention Plan, any training needed for direct support staff or family members providing support, and working with the PCP or Psychiatrist (or other prescribing practitioner) to reconcile psychotropic and other medications upon discharge
- For individuals with a Crisis Prevention and Intervention Plan (and provider), crisis calls would go directly to the person's MOS provider; if referred inappropriately to the existing Crisis Team, the crisis specialist answering the call would transfer the call to the MOS Provider for specialized I/DD crisis response
- For individuals without a Crisis Prevention and Intervention Plan (or other calls directed through the existing crisis system), provide specialized training to support the existing Crisis Teams pending full implementation of the MOS
- Once fully implemented, individuals not previously identified for Crisis Prevention and Intervention could enter the MOS in crisis—planning and prevention services could be initiated once the crisis is stabilized; re-evaluate existing Crisis Teams' role in managing new referrals upon full implementation
- Training/instruction will advise all callers to dial 911 if there is an immediate likelihood of serious harm to the member or others.

- Team Focused Stabilization (HBT/MHCC Two Tier Model)
  - Provide two stabilization options
  - Team trained in the model to know which tier of the model most appropriate to the individual's presentation

Reporting of benchmarks

- Look at provider engagement and opportunities for performance-based incentives with focus being on supporting/sustaining community tenure
- Examples of focus areas would be increased supported employment, increased supported living, decrease in the PRN use of anti-psychotic medications, decrease in crisis events and inpatient admissions
- Introduce the utilization of some form of the Personal Outcome Measures®.[4]

Provider Network:

- Enhancement and development of a provider network equipped to provide specialized services in addressing the needs of this population
- Conduct an RFI-type process to outline expectations for the MOS. Potential MOS providers will explain their proposed solutions/expertise in key areas.
- Would be equipped to provide treatment options supporting community tenure, develop crisis prevention and intervention plan with supporters (paid or unpaid) and provide training as needed
- The same providers must support Crisis Planning and Prevention, Intervention, and Stabilization, including referral to behavioral respite and inpatient treatment, when appropriate.
- To avoid potential conflict of interest, the MOS Provider would not deliver residential services, behavioral respite, or inpatient treatment services to a person supported by that provider in the MOS, but would be responsible for helping to plan for and facilitate transition back to appropriate community placement, including review/revisions to the Behavior Prevention and Intervention Plan and any training needed for direct support staff or family members providing support
- Case rate reimbursement model for MOS providers with incentive payments or shared savings component to be developed and implemented once sufficient data/experience is available to establish appropriate benchmarks and payment approach based on key performance indicators, including reduced incidence of crises and in-place stabilization/reduced inpatient days; providers must

[4] ***Personal Outcome Measures®*** are a data set for the valid and reliable measurement of individual quality of life for persons receiving long-term services and supports, i.e., whether the services and supports are having the desired results or outcomes that matter to the person. For more information, see http://www.c-q-l.org/the-cql-difference/personal-outcome-measures.

participate in the MOS for 12 months before becoming eligible for incentive payments

- Case rate will include all crisis prevention (i.e., planning, coordination and training), in-home crisis intervention response, in-home crisis stabilization (i.e., HBT or MHCC)[5], and all cost-effective alternative services (e.g., in-home crisis respite) delivered as part of the MOS
- Case rate will exclude PCP incentive payments, Psychiatric consultation, Behavioral Respite (provided out of the home) and inpatient hospitalization
- MOS providers will be required to report service "encounters," e.g., planning, coordination, training, in-home crisis intervention response, in home- crisis stabilization (one for HBT, the other for MHCC), referral for behavioral respite, referral for inpatient, discharge planning, etc. Data will be used for purposes of incentive payments/shared savings and to analyze and improve the efficacy of the model.

Implementation Phases:

Phase I

- Provider network development, beginning with potential providers
- Identification/contracting with MOS Implementation Consultant to develop and deliver specialized MOS training
- Training of potential providers, including competency evaluation
- Credentialing/contracting with qualified providers

[5] **Home Based Treatment (HBT)** and **Mental Health Care Coordination (MHCC)** are two levels of care modeled after the System of Care model, a SAMHSA Evidenced Based Practice, that are part of a TennCare pilot program for children/youth with behavioral needs. HBT provides time-limited comprehensive and coordinated in-home treatment interventions as a community-based alternative for children/youth at immediate risk of out-of-home placements due to severe and high risk mental health symptoms. HBT provides in-home individual and family psychotherapy and counseling using evidenced based treatment modalities in addition to care coordination focused on improving child/youth and family linkage and engagement to providers and community resources. MHCC identifies and coordinates the multiple systems and community stakeholders that serve the child/youth; facilitates access to services, resources, and treatment providers; and ensures ongoing coordination and collaboration in order to meet the mental health needs of the child/youth. MHCC empowers the parents/caregivers to manage the child/youth's needs post discharge.

Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD: Proposed I/DD Stabilization Model of Support

- I/DD and MOS training for current crisis teams pending full implementation of MOS
- Stakeholder education/engagement, including individuals, families, I/DD providers, PCPs, and psychiatrists
- Identification of individuals with I/DD encountering a crisis event requiring inpatient treatment over the previous three months and referrals identified by DIDD and approved by TennCare for persons enrolled in the Statewide Waiver who require such services in order to be safely served in the community within the individual cost neutrality cap.
- Identification of the MOS Champion and MOS Liaison
- Development of the MOS Team
- Comprehensive face-to-face person-centered assessment
- MOS Team Meeting
- Development of Individualized Crisis Prevention and Intervention Plan of Care for each individual with I/DD encountering a crisis event requiring inpatient treatment over the previous three months and referrals identified by DIDD and approved by TennCare for persons enrolled in the Statewide Waiver who require such services in order to be safely served in the community within the individual cost neutrality cap.
- Implementation of the I/DD in-home crisis intervention and stabilization response Availability of cost-effective alternative services to avoid inpatient treatment and maintain community tenure when appropriate and not counter-productive that could be layered in during the crisis period to support the person or agency primarily responsible for supporting the person (e.g. In-home crisis respite);
- Tele-consultation opportunities

Phase II

- Reporting capabilities
- Individualized Crisis Prevention and Intervention Plan (wrap-around model) developed for additional members of the I/DD population experiencing a crisis requiring inpatient treatment in the previous 3 months

Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD: Proposed I/DD Stabilization Model of Support

Phase III

- Individualized Crisis Prevention and Intervention Plan (wrap-around model) developed for additional members of the I/DD population (continuing in 3 month increments based on a crisis event requiring inpatient admission and/or other prioritization protocols in order to achieve a proactive approach to crisis planning and prevention for the population, as applicable)
- First response de-escalation training (Police, Fire Department, and EMT);moving the first responders' crisis response from being focused on de-escalating behaviors to understanding how to address the symptoms presented with this population during a crisis (similar to current Crisis Intervention Team for the SMI population)
- Expand tele-health/tele-supervision capabilities to allow for more robust technological opportunities (enhance tele-health availability, development of apps, etc.)
- Development of information repository
    - Comprehensive information regarding the individual and his/her needs and updated as each person "touches" the member
    - This repository would be a "snapshot" of this member beyond clinical information.
    - Include but not limited to member care plans, medical history, identified crisis triggers, individualized calming/de-escalation techniques, etc.)

Potential Future Enhancement Opportunities to Consider

- Hospital-based Dual Diagnosis Specialist Crisis Screener
    - Stabilization of individual when they present for hospitalization (physical or mental health)
    - "No wrong door"
    - Focus will be to prevent the additional trauma that can occur when this population is admitted and to provide an I/DD specialist to assist when any member of the I/DD population is admitted to the hospital (including members that do not have an individualized plan of care)
- Certified Peer Recovery Specialist
- Family Support Specialist

Behavioral Health Crisis Prevention, Intervention and Stabilization Services for Individuals with I/DD: Proposed I/DD Stabilization Model of Support

Interface with Existing Waiver Behavior Services

- Behavior Services will continue to be offered through the existing waivers.
- A person who experiences a behavioral crisis requiring inpatient treatment will be referred for MOS (see description of phases), along with persons identified by DIDD and approved by TennCare who are enrolled in the Statewide Waiver who require such services in order to be safely served in the community within the individual cost neutrality cap.
- A person will not receive waiver Behavior Services and Behavioral Crisis Prevention, Intervention and Stabilization Services at the same time. Once a person is referred for participation in the MOS, waiver Behavior Services will stop. However, the MOS provider will be responsible for facilitating seamless transition back to the waiver Behavior Services provider when determined by the MOS Team (inclusive of Circle of Support when a person is enrolled in a waiver) to be necessary upon discharge from the MOS.