MENTAL HEALTH RECOMMENDATIONS

Assisted Living Facility Work Group	
Workgroup Recommendations **Mental Health Issues**	**Status**
Phase I 1. Increase training for LMH facility staff, provided by mental health professionals and including an emphasis on aggression management and de-escalation techniques. *Originally Recommendation 1 under "Limited Mental Health Training" for Phase I*	DCF DCF will be adding behavior management and de-escalation has been included in new training. DOEA **ALF Negotiated Rulemaking Committee Rule Change:** Change to Rule 58A-5.0191 to add topics for administrators receiving Core Training for aggression control, de-escalation techniques, and behavior management; and the proper use of the Baker Act. DCF has increased training hours to 8 and has revised training materials in both English and Spanish, and has included behavior management topics. Proposed in SB 2074
Phase I 2. Require all staff members who have contact with residents with mental health issues to complete the mental health training. *Originally Recommendation 2 under "Limited Mental Health Training" for Phase I*	DOEA **ALF Negotiated Rulemaking Committee Recommendation for Statutory Change:** Change to 429.075 (1) Omit "within 6 months after" and substitute "**prior to**". This provision should not go into effect before July 1, 2013, and must be contingent on the course being provided online by DCF. 429.075 Limited mental health license.—An assisted living facility that serves three or more mental health residents must obtain a limited mental health license. (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected deficiencies or violations, and must ensure that, prior to ~~within 6 months after~~ receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. Such designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. Proposed in SB 2074

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Phase I 3. Establish a panel of mental health experts to develop a comprehensive, standardized training curriculum for mental health training for assisted living facility staff members. *Originally Recommendation 3 under "Limited Mental Health Training" for Phase I*	<u>DCF</u> DCF conducted focus groups in Tampa and Miami in March to review curriculum and revise based upon feedback given. Curriculum completed July 2012. Training will be offered on-line by July, 2013.
Phase I 4. Increase the training hours for staff members working in facilities with an LMH license from 6 hours of limited mental health training to 8. *Originally Recommendation 4 under "Limited Mental Health Training" for Phase I*	<u>DCF</u> DCF increased curriculum to 8 hours. Statute/Rule state that training has to be a minimum of 6 hours.
Phase I 5. Require staff members to complete a test following their training in mental health and score a minimum of 80%. *Originally Recommendation 5 under "Limited Mental Health Training" for Phase I*	<u>DCF</u> DCF included a quiz in new materials which is given after each module. As part of the revised training package, a score of 75% is required to be consistent with core training requirement. Proposed in SB 2074
Phase I 6. Allow the Department of Elder Affairs to monitor and sanction trainers providing the mental health training course. *Originally Recommendation 6 under "Limited Mental Health Training" for Phase I*	<u>DCF</u> Requiring trainers to be certified Core Trainers could be the avenue to allow for this. DCF would like to partner with DOEA in this effort. <u>DOEA</u> **ALF Negotiated Rulemaking Committee Recommendation for Statutory Change:** Change to 429.52 (12) Propose to add statutory authority for DOEA to work in consultation with DCF in establishing trainer credentials and requirements for limited mental health

	training as follows: The department in consultation with the Department of Children and Families may adopt rules to establish limited mental health trainer credentials, trainer registration procedures, training curriculum, reporting requirements, and fees.
Phase I 7. Collaborate with NAMI (National Alliance on Mental Illness) in each community with an active chapter to provide free training of residents (Peer-to-Peer), caregivers (Family-to-Family), and Provider Education, as well increased oversight when NAMI members are present in the facilities *Originally Recommendation 7 under "Limited Mental Health Training" for Phase I*	<u>DCF</u> ALFs can contact their local NAMI and ask for assistance. As funding is available, the training is free.
Phase I 8. Require a Limited Mental Health (LMH) license for ALFs with any mental health residents. The current definition of LMH license is an ALF that serves three or more mentally ill or disabled residents must obtain a limited mental health (LMH) specialty license. Change the definition to require an ALF that serves one or more mental health residents as defined in statute to obtain a limited mental health specialty license. For the	<u>DCF</u> Regardless of designation, an ALF can refer an individual with a mental illness for case management services at any time. Proposed in SB 2074

purposes of assisted living licensure, a mental health resident is defined as an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS). This definition is limited as there may be other assisted living facility residents with severe and persistent mental illness who have a case manger but do not meet this specific definition. *Originally Recommendation 1 under "Mental Health" for Phase I*	

PHASE II	
Phase II 1. Improve case management services and advocacy for residents by offering residents choice of case managers and living arrangements.	DCF DCF supports choice. Individuals receiving or seeking case management services who have Medicaid or another means of payment can obtain those services from any provider who offers those services. Most individuals in ALFs have, or are eligible for, Medicaid. Those who have no third-party payer must get services from a mental health provider who has a contract with DCF (or its Managing Entity). Sometimes choice of providers is limited in rural geographic areas. Whenever possible (contingent upon resources), individuals are offered choice of living environments, such as supportive housing settings, independent living, family, residential treatment facilities, and Adult Family Care facilities. AHCA Medicaid's managed care contracts currently require recipient choice in direct care provider for behavior health services. Enrollee handbooks inform enrollees of their right to choose their providers. According to the Medicaid Provider General Handbook: Per Title 42 of the Federal Code of Regulations Part 431.51, recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. AHCA has developed an ALF Behavioral Health Subgroup of the Statewide Behavioral Health Workgroup. The Workgroup identified the need to address behavioral health services to ALF residents. The purpose of the ALF Behavioral Health Subgroup is to provide an opportunity for the managed care organizations behavioral health providers, ALF representatives, and other interested parties to discuss any concerns related to the provision of behavioral health services to residents of ALFs. Proposed in SB 2074

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Phase II 2. Require DCF/Managing Entity verify that each mental health resident is assigned a case management and that face-to-face contact has been documented as required by law and rule. *Originally Recommendation 12 under "Mental Health" for Phase II*	DCF DCF concurs with this recommendation and has already incorporated contract language that directs the ME to provide services to residents in ALFs, to follow provisions of the law, and to review samples of case management record to assure services are offered. DOEA **ALF Negotiated Rulemaking Committee Rule Change:** Edit Rule 58A-5.029 FAC to state that every facility with a LMH license is required to ensure that mental health residents are referred for case management and other mental health services. Residents may be referred to public or private agencies for assistance. In the event that a resident refuses such services the refusal must be documented by the facility and the facility must request that the refusal be submitted in writing. Proposed in SB 2074
Phase II 3. Maintain the Mental Health Targeted Case Management service in the community mental health centers to provide the extensive psychiatric oversight and linkage only available in a clinical setting; and retain role of the designated mental health providers to manage mental health clinical issues and do not shift this role of the ALF. While close working relationships between the ALF and the mental health providers are essential, it is equally essential that no inducements or other devices limit the choice of residents as to where or from whom they receive their mental health services. *Originally Recommendation 6,7,and 8 under "Mental Health" for Phase II*	DCF DCF concurs with the recommendation. AHCA If the ALF were to provide these mental health services, they would effectively be creating an institution for mental diseases (IMD). An IMD is a facility of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with behavioral diseases (Title 42 CFR Part 441.13 and 435.1008). According to the *Medicaid Behavioral Health Community Behavioral Health Services Coverage and Limitations Handbook*, services rendered to residents of institutions for mental diseases are not covered under the Medicaid community behavioral health services. The community living support plan must clearly address the resident's behavioral health concerns and needs. Ultimately, there has to be a collaborative relationship between the ALF staff and mental health providers. AHCA has language in our contracts with managed care organizations ensuring that recipients have choice in their behavior health provider. The Medicaid managed care core contract language has been revised to strengthen the responsibility of the managed care organizations to ensure the community living support plan is developed and implemented by the ALF and the designated behavior health care provider for recipients residing in long

	term care facilities.
Phase II—Revised Recommendation 4. Retain continuity of care for ALF residents by prohibiting DCF from contracting with specialized community mental health centers to provide case management and other mental health services which could limit choice. *Originally Recommendation 9 under "Mental Health" for Phase II*	DCF It is not clear what is meant by "specialized community mental health centers." DCF is directed by s. 394.4573 F.S. to provide a continuity of care management system which includes case management. This system is funded through contracts with DCF Managing Entities based upon available funding. Generally, there are multiple providers within each region and a person receiving services can choose their service provider if that is the case.
Phase II 5. Increase the monitoring of case managers and increase services for mental health residents in assisted living facilities. *Originally Recommendation 4 and 13 under "Mental Health" for Phase II*	DCF DCF concurs with this recommendation and has contract language that directs the ME to provide services to residents in ALFs, to follow provisions of the law, and to review samples of case management record to assure services are offered. AHCA AHCA monitors case management services provided to mental health residents in ALFs who participate in the behavioral health managed care program. We are working to improve and expand this process. Currently the policies and procedures of each managed care plan related to the provision of case management services to mental health recipient's in ALFs are reviewed during monitoring. As a part of managed care organizations (MCO) compliance audits the following is reviewed: 1. A sample of clinical and TCM records of residents who live in an ALF 2. A copy of the cooperative agreement between the MCO and the ALF Administrator 3. A Copy of the resident's community living support plan, and procedures for the ALF to follow should an emergent condition arise with an enrollee that resides at the ALF Proposed in SB 2074

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Phase II 6. Require DCF/Managing Entity evaluate the cooperative agreement and community living support plans in place to ensure that they are sufficient to meet the mental health needs of ALF/LMH facility residents. *Originally Recommendation 11 under "Mental Health" for Phase II*	DCF The role of DCF/ME is to monitor the contracted public community mental health providers. The DCF offices and MEs have been given templates. Language included in ME contracts. Representative sample reviewed. Template provided in packet. AHCA In addition to DCF/ME activities, Medicaid has taken steps to improve its oversight of Medicaid managed care plans in meeting their recently modified contractual responsibilities of ensuring that the community living support plan is implemented as written.
Phase II 7. Cooperative agreements should adequately address: case management services, access to consumer-operated drop-in centers, access to services during evenings, weekends, and holidays, access to emergency psychiatric care and, supervision of the clinical needs of residents. *Originally Recommendation 10 under "Mental Health" for Phase II*	DCF Representative sample is reviewed. Template provided in packet. AHCA Per Florida Statute 429.02(8), Medicaid has revised the Medicaid managed care contracts to require cooperative agreements between the mental health care providers and the ALFs. Managed care plans will ensure the cooperative agreements are in place and are implemented. AHCA will oversee the managed care organizations in meeting this requirement.
Phase II 8. Clarify oversight responsibilities of private case management and mental health treatment providers as it relates to community living support plans and cooperative agreements. Not all individuals in ALFs are served by DCF funded mental health providers, making DCF oversight of those providers difficult. *Originally Recommendation 5 under "Mental Health " for Phase II*	DOEA **ALF Negotiated Rulemaking Committee Recommendation for Statutory Change:** Change to Rule 58A-5.029 FAC to assure that every LMH ALF assure that mental health residents have the documentation from either a case manager or other mental health provider that they are a resident with a severe and persistent mental illness and that they are referred for mental health services to either a public or private provider. Furthermore, if the mental health resident refuses services, the ALF must document the refusal and request a signature from the resident.

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Phase II 9. Identify the features or characteristics of a good LMH for model of programs that best meet the needs of persons with serious mental illness and the associated behaviors. *Originally Recommendation 3 under "Mental Health" for Phase II*	DCF DCF will assist as needed. AHCA The Agency has expanded the Florida Health Finder website to include additional consumer information.
Phase II 10. Develop a process for persons with severe and persistent mental illness whose care is subsidized to allow that subsidy to follow that person in alternative residential settings. *Originally Recommendation 15 under "Mental Health" for Phase II*	DCF If rental or ALF subsidies are funded by DCF, subsidies can already follow the person. AHCA AHCA does not assign funds for behavioral health based upon the type of residential setting.
Phase II 11. Conduct a study to explore the methods of enhancing care for persons with severe and persistent mental illness in assisted living facilities. *Originally Recommendation 16 under "Mental Health" for Phase II*	DCF DCF will assist as needed. AHCA AHCA will explore ideas for research projects through our contract with Florida Mental Health Institute for next year.

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Phase II 12. Amend Chapters 429, F.S., to require that before an ALF can initiate an involuntary examination under the Baker Act that it must document a series of efforts have been attempted to prevent this action. *Originally Recommendation 14 under "Mental Health" for Phase II*	DOEA **ALF Negotiated Rulemaking Committee Rule Change:** Change to Rule 58A-5.029(3) to require a facility that initiates an involuntary mental health examination pursuant to the Florida Mental Health Act, the facility must document all actions taken to avoid the involuntary mental health examination. Additionally, best practices and behavior management/aggression control is a topic added to core training.
Phase II 13. Require facilities to utilize a best practice tool governing behavior management /aggression control and involuntary Baker Act guidelines. *Originally Recommendation 14 under "Mental Health" for Phase II*	DCF The Florida Health Care Association published a document called Best Practice Tool for Behavior Management, Aggression Control, and Baker Act Guidelines found at: http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/2011BakerActRevFINAL.pdf DOEA **ALF Negotiated Rulemaking Committee Rule Change:** Change to Rule 58A-5.029(3) to require a facility that initiates an involuntary mental health examination pursuant to the Florida Mental Health Act, the facility must document all actions taken to avoid the involuntary mental health examination.
Phase II 14. Require LMH facility administrators to have a two year degree and two years of experience or a four year degree with coursework in a mental health related field. *Originally Recommendation 1 under "Mental Health" for Phase II*	Proposed in SB 2074

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Phase II 15. Recognize the shift of placements for persons discharged from state hospitals, currently residing in ALFs. *Originally Recommendation 2 under "Mental Health" for Phase II*	<u>DCF</u> Data is not available to show a trend, but DCF recognizes that ALFs have filled a housing choice gap for individuals being discharged from state hospitals for many years. Currently, there are 20 DCF-contracted providers serving over 1600 people in Permanent Supportive Housing programs (wrap around services and rental subsidies). This is not enough to meet the need. People with serious mental illnesses are disproportionately poor and cannot afford even modestly priced rental housing without government housing assistance. Federal housing subsidies are extremely scarce, and housing waiting lists can be five-ten years long.