

LME: Smoky Mountain Center
Title: DD Diversion Emergency Respite Service

Service Definition:

Community Respite is a 24-hour service which provides periodic relief for a family or family substitute for adult (eighteen (18) years and older) DD consumers on a temporary basis and in cases where a DD consumer is at risk for loss of placement or has no placement in which to return from an inpatient setting. This is an emergency respite service for adult consumers with a developmental disability diagnosis, or reasonable suspicion of such, who are in crisis, at risk of losing or have lost placement and do not meet medical necessity for psychiatric hospitalization. The consumer may receive supportive counseling, crisis stabilization counseling, and de-escalation activities. Receipt of this service does not preclude receiving Developmental Therapy or other services if deemed medically necessary. This service may be approved up to a maximum of 30 days in cases where a consumer is unable to return to prior residence. In cases where a consumer can return to prior residence this service may be approved up to a maximum of 15 days.

If the consumer has an existing Clinical Home, the Clinical Home is responsible for coordinating and linking services. The Clinical Home is responsible for ensuring the following items to accompany the consumer to the respite site:

1. A copy of the Person Centered Plan (PCP) and Crisis Plan;
2. All medications as well as doctor's orders for both prescription drugs and over the counter medications (if applicable).

The Clinical Home will provide the following services to the consumer while placed in the respite service:

1. Coordination and linkage to medication appointments or other necessary medical or habilitative service needs;
2. A team meeting within ten (10) business days or sooner as defined by the PCP and/or Crisis Plan
3. Updating/Reviewing the PCP and Crisis Plan as appropriate
4. Planning and coordinating a return to original placement or new placement.

If the consumer does not have an existing Clinical Home, LME Care Coordination staff will link the consumer to the appropriate services.

The respite site shall provide the following services:

1. Assistance with personal care, activities of daily living, leisure and vocational activities;
2. Room/board, food and provisions;
3. Transportation in accordance with medical and psychiatric needs;
4. Medication and behavioral management as directed by a physician;

5. Monitoring for continuing stabilization of the consumer to transition back to his or her home community.

All services delivered by a paraprofessional must be under the supervision of a Qualified Professional (QP) and a QP must be available 24/7 for consultation or support for the site. Supportive counseling, crisis stabilization and de-escalation shall be provided by a Qualified Professional as appropriate. Emergency services (911) should only be utilized in the event of a medical emergency or in instances where the consumer's behavior presents immediate risk for injury to self or others and the Clinical Home and site have exhausted all other clinical resources including first response, implementation of the Crisis Plan and Mobile Crisis. In cases where the Crisis Plan was not effective, the Clinical Home will revise the Plan.

Developmental Therapy may be provided as an adjunct by a paraprofessional under the supervision of a QP if deemed clinically appropriate by the LME. A separate authorization process is necessary for Developmental Therapy.

Service Delivery Setting

This is a residential service provided in a licensed or unlicensed AFL setting. Service to more than two individuals served concurrently requires licensure and no more than two (2) individuals should be receiving service in the home.

Medical Necessity

Consumer's placement is at risk.

Service Order Requirement

This service does not require a service order but does require initial preauthorization from LME or LME contracted licensed clinical staff.

Continuation/Utilization Review Criteria

Service approval is based upon medical necessity criteria. Medical necessity is determined based upon North Carolina community practice standards, criteria established by the NC Department of Health and Human Services and as determined by the appropriate LME licensed clinician. The Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

The Local Management Entity will determine the initial authorization period. The request for service approval and supporting documentation reflecting the appropriate level of care and service must be submitted to the Local Management Entity.

If continued DD Diversion Community Respite services are needed at the end of the initial approval period, a new request for the service must be submitted to the Local Management Entity. This must occur prior to the expiration of the current approval. Failure to request re-approval prior to the expiration date will result in a

denial and will be considered an initial request for purposes of determining eligibility of maintenance of service.

Maximum utilization is 30 days per consumer per event.

Discharge Criteria

N/A

Service Maintenance Criteria

N/A

Provider Requirement and Supervision

AFL staff must follow all Core Rules including certification for medication administration if the consumer requires medication. Paraprofessional level person who meets the requirements specified for paraprofessional status according to 10 NCAC 14V. Supervision of paraprofessionals is also to be carried out according to 10 NCAC 14V. Licensed facilities must meet the requirements as cited in 10 NCAC 27G.5100.

Documentation Requirements

Documentation in the client record is required.