MIDD Briefing Paper

#59 Medically Fragile Short Term Shelter

Type of Concept: New Concept

SUMMARY: trained staff, including 24-hour a day registered nurses and nurses' aides to provide medical care and oversight, and social workers who will look for long-term residential placements and resources. The proposal predicts older adults will be stabilized within 72 hours and then helped to either return to their former residence or locate a place to live after that time. Based on expert consultation, this paper proposes to change the model to a stay of up to 90 days, as it is unrealistic to expect individuals to transition within 72 hours, as described in sections below. This means that fewer people would be served, but the service would be appropriate for filling a current service gap.

Collaborators:

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Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This concept proposes the development of a specialized Adult Family Home (6 beds or fewer) with trained staff, including 24-hour a day registered nurses and nurses' aides to provide medical care and oversight, and social workers who will look for long-term residential placements and resources. The proposal predicts older adults will be stabilized within 72 hours and then helped to either return to their former residence or locate a place to live after that time. Based on expert consultation, this paper proposes to change the model to a stay of up to 90 days, as it is unrealistic to expect individuals to transition within 72 hours, as described in sections below. This means that fewer people would be served, but the service would be appropriate for filling a current service gap.

This concept would develop an alternative to hospital beds, including inpatient psychiatric beds specifically for older adults with psychiatric diagnoses, behavioral and functional issues, and limitations performing activities of daily living (ADLs). The proposal states there is a lack of resources currently available in King County for older adults with behavioral or cognitive issues that may prevent them from remaining in their current residences. (Note: These residences include private homes, adult family homes, and assisted living facilities.) In addition, the services proposed for funding would be available for older adults who have no permanent residence and are experiencing psychiatric issues.

Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area (Select all that apply):

- ☒ **Crisis Diversion**
- ☐ **Prevention and Early Intervention**
- ☒ **Recovery and Re-entry**
- ☒ **System Improvements**

Please describe the basis for the determination(s).

This concept fits best under the recovery and re-entry strategy. The proposed concept is consistent with the recovery model, in that it focuses on helping older adults in crisis situations receive assistance so that they can live as independently as possible.

It also fits under the crisis diversion and system improvements by providing services and treatment for older adults with psychiatric diagnoses, behavioral and functional issues.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for**

whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

Approximately 18 percent of King County's population is 60 years or older (368,000 residents). Seventy-eight percent of the older adults in King County are estimated to have one or more chronic conditions, and an estimated 38 percent are believed to have a disability. It is estimated that 20percent of older adults (55 years or older) experience a mental health issue; the most common are anxiety, severe cognitive impairment, and mood disorders such as depression or bipolar disorder. (The State of Mental Health in Aging America, Issue Brief One: What Do the Data Tell Us?, www.cdc.gov/aging/pdf/mental_health.pdf). An estimated one half of older adults who admit that they have mental health problems receive treatment from any health care provider, and only three percent of those receive specialty mental health services, which is the lowest rate of any adult group. (Source: MHCADSD website.)

If an older person living with a serious psychological issue reaches a crisis point in which their behavior or symptoms prevent them from safely remaining in their current residence, they may be referred to an emergency room for evaluation and treatment. If the person's immediate medical issues are resolved, but the person's psychological, behavioral or functional symptoms continue and the person is assessed as not being able to return to their prior living situation, the hospital must try to find a place for them to go. If a place is not quickly found, the hospital may have no other option than to admit them.

If the patient is admitted to a hospital bed due to no other places being found for them, the resulting length of stay may be significant. One care manager at an Eastside hospital stated that a percentage of older adults for whom there is no appropriate placement may stay in the hospital beds for a month to several months. The result may be that these hospital beds are not available to patients with more acute needs.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

The concept paper proposes that a specialized Adult Family Home may provide a short-term solution for freeing up hospital beds once the patient's medical issues are stabilized. The specialized Adult Family Home or similar facility could provide the patients with a short term place to stay while they are evaluated and referred to an appropriate, long term placement. During the time of the short stay, the patient would be cared for by staff trained to address ongoing medical, psychiatric, behavioral, functional, and ADL limitation issues.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

There is little evidence that simply providing a temporary, safe, therapeutic place to live leads to positive, long-term outcomes for those served. However, as a part of a full service continuum, use of an AFH setting is one means to promote long term improvements.

A thorough analysis of the service continuum available to older adults with behavioral health disorders was completed by a BHRD work group in 2015. A literature review led to the following assessment:

> The Surgeon General's 1999 report on Mental Health and the President's 2003 New Freedom Commission on Mental Health have been especially influential in identifying the behavioral health concerns of older adults. While recognizing that the majority of older adults do not suffer from behavioral health conditions, the Surgeon General's report forecasted that senior disabilities as a result of mental illness would "become a major public health problem in the near future" due to the growth of this age cohort. It went on to review the available treatments and advocated for a national effort to increase prevention and education efforts, and for accessible, coordinated, evidence-based treatments[1]. Similar to the Surgeon General's paper, the New Freedom Commission identified the growing need for older adult behavioral health services and the impact of mental health on life quality and longevity. Its recommendations included early health screenings as well as accessible, consumer-driven, evidence-based treatments provided by trained geriatric professionals[2,3]. The subsequent 2005 White House Conference on Aging mirrored many of the recommendations[4]. These reports coincide with more than 20 years of research that explored older adult treatment interventions and identified evidence supported practices. A 2003 literature review and resource guide compiled by Washington Institute for Mental Health Research and Training (WIMHRT) lists nearly three dozen best and promising behavioral health practices for older adults and caregivers[5]. Likewise, the Substance Abuse and Mental Health Services Administration (SAMHSA) toolkit on the treatment of older adult depression describes nine evidence supported interventions, including Cognitive Behavioral Therapy, Reminiscence Therapy, Cognitive Bibliotherapy, PEARLS (Program to Encourage Active, Rewarding Lives for Seniors) and IMPACT (Improving Mood: Promoting Access to Collaborative Treatment)[6].
>
> MHCADSD's efforts to provide geriatric-specific treatment strategies have aligned with, and in some cases preceded, the information and insights provided by these reports and research. During the past 30 years, MHCADSD has been a leader in developing a

[1] U.S. Dept. of Health and Human Services. Older Adults and Mental Health. In: Mental Health: A Report of the Surgeon General, 1999, pp 330 - 381. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS
[2] The President's New Freedom Commission on Mental Health, 2003 http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf
[3] Bartels, Stephen J., Improving the Systems of Care for Older Adults with Mental Illness in the United States, Findings and Recommendation for the President's New Freedom Commission on Mental Health, Am J. Geriatr Psychiatry 1:5, September – October, 2003, pp 486-497
[4] 2005 White House Conference on Aging, The Booming Dynamics of Aging: From Awareness to Action, Report to the President and the Congress, http://nicoa.org/wp-content/uploads/2012/04/2005-WHCOA-Final-Report.pdf
[5] Washington State Dept. of Social and Health Service, Mental Health Division, The Washington Institute for Mental Health Research and Training, A Literature Review and Resource Guide for Evidence Based Best and Promising Mental Health Practices, pages 302 – 392. http://www.dshs.wa.gov/pdf/dbhr/mh/resourceguide/Bestpracreport.pdf
[6] U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Selecting Evidence-Based Practices For Treatment of Depression in Older Adults http://store.samhsa.gov/shin/content/SMA11-4631CD-DVD/SMA11-4631CD-DVD-Selecting.pdf

knowledgeable workforce and providing specialized screening and treatment services. A brief historical scan reveals the following highlights.

- Working with the State of Washington to develop the credentials and required training for Geriatric Mental Health Specialist
- Development of guideline for Older Adults to Community Support Services
- Development and funding of the Geriatric Regional Assessment Team (GRAT) in the 1980s and 1990s
- Development of residential programing for older adults requiring intensive support
- Priority allocation of non-Medicaid funding to assist low income older adults in the 1990s
- Priority allocation of non-Medicaid MIDD funding for GRAT and Screening, Brief Intervention and Referral to Treatment (SBIRT) services initiated in 2008 and 2009, respectively.
- 2012 addition of funding for GRAT that supports individuals' need for Substance Use Disorder (SUD) services
- Increased emphasis on coordination of service with medical providers and other publicly funded agencies
- Merging of mental health and substance use disorder services to form MHCADSD, and the HIPAA and privacy rules that allow mental health (MH) and SUD to work more closely.
- Housing options and services for high needs older adults (age 55 and older)
- Development of specific older adult recovery incentives as part of the Recovery and Resiliency Plan recovery incentive system

The BHRD analysis resulted in a number of recommendations to improve the service continuum in King County, one of which mirrors this proposal:

- Develop step-down transition projects with or without allied providers for older adults discharged from inpatient treatment (i.e., residential, use AFH bed with behavioral health support).

4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Best Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

This proposed concept is not a Best Practice, but could be described as an Emerging Practice.

5. What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?

An investment of MIDD funds for the Specialized Adult Family Home likely would serve at minimum 18 older adults (six per quarter). (This is significantly lower than the estimated number of 208 older adults that was stated in the concept proposal.) The result would be that a similar number of hospital beds could be available for people in more acute situations.

A related outcome would be the reduction in expenses to house the 18 or more older adults in the Adult Family Home.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply): Older Adults, regardless of diversity issue

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☒ **Black/African-American**
☐ **Children 6-12**	☒ **Hispanic/Latino**
☐ **Teens 13-18**	☒ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**
☐ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☒ **Families who are caregivers of older adults**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☐ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

   A range of collaborations will be needed, both in the planning and development stage of this concept, as well as later on, once the Adult Family Home is licensed, fully staffed, and residents are in place.

   Collaborations with hospitals that specialize in serving older adults such as Northwest Hospital, Highline Hospital, Evergreen Health, and Overlake Hospital would be valuable. The discharge planners, social workers, and treatment providers would be helpful in identifying ways to stabilize the older adult with psychiatric diagnoses and on-going medical issues. In addition, these experts in helping older adults could help develop strategies that prevent the older adults from reaching a crisis point that results in re-admission to the emergency room.

Collaborations with RSN-supported community mental health agencies, such as Navos or DESC. For example, Navos has a team of geriatric mental health specialists.

Collaboration with Aging and Disability Services, the designated Area Agency on Aging for King County, to identify older adults living in their own residences in the community who are experiencing psychiatric issues that may prevent them from remaining independent without help.

Collaborations with Washington State Department of Social and Human Services (DSHS) Home and Community Services Division to identify older adults living in assisted living or adult family homes who are experiencing psychiatric issues that may prevent them from remaining in their current residence without help such as stabilization.

Collaborations with Adult Protective Services to identify older adults who were referred that need help with psychiatric issues that are creating barriers to them living in their current residence.

Collaboration with RSN supportive housing providers to determine if housing/treatment options currently operated by such agencies can be used as models for the specialized Adult Family Home proposed by this concept paper.

Collaborations with the Geriatric Regional Assessment Team (GRAT) to identify referrals to them that require assistance in stabilizing the psychiatric issues that are hindering the older adult from remaining in their own home, or finding more appropriate residential options.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

The current Medicare funding restrictions that only pay for Skilled Nursing Facilities and not for Adult Family Homes may affect the ability of low-income older adults who are not Medicaid eligible to be housed in the Adult Family Home.

Currently, Washington State Department of Social and Human Services' Home and Community Service Division (HCS) determines the rates it will pay for long term residences such as Adult Family Homes and Skilled Nursing Homes. The rates charged by King County Adult Family Homes are often higher than what is paid for by HCS. The result would be that the older adult likely would be charged the difference, and if that older adult does not have the ability to pay, then their family might be asked to pay.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

a. **What is the focus of the specialized Adult Family Home?**

The model needs to be developed and implemented with guidance and input from several key partners. A determination would need to be made if the Adult Family Home would house only those with a psychiatric need, or those who also have co-occurring medical or dementia-related

needs as well. Each person could need help from a combination of experts including mental health professionals and a geriatric medical professional. In addition, all residents likely will need help from a housing professional to help them find an appropriate place to live once they leave the Adult Family Home.

b. **Financial Resources**:
Older Adults who would benefit from this resource may live on low incomes, some of whom would be Medicaid eligible. . Not all Adult Family Homes or Assisted Living facilities accept Medicaid. Also, finding longer term residential options that accept Medicaid may also be a barrier.

A related issue is those older adults whose only income is Social Security may not be able to pay for rent, living expenses and the supports they need. This is particularly relevant for those seeking residences in the greater Seattle and Bellevue areas.

Older Adults who may be deemed stable enough to return to living in the community independently after the crisis may need supportive services. The older adult would need to have the financial resources or authorization through a program such as COPES to have access to those services.

c. **There may not be an immediately available place in which to move, which can result in a log jam at the specialized Adult Family Home**:

The concept paper proposes that 72 hours is the estimated average length of stay for older adults in the specialized Adult Family Home. Most of the experts who were consulted for this briefing paper said that will not be long enough to find a long term residence for older adults. In fact most of the experts consulted for this briefing paper stated that, on average, older adults need significantly longer to find long term housing/treatment, especially if they need a place that accepts Medicaid. In addition, the process to be evaluated by HCS to determine the person's financial eligibility for support takes between 45 days to two months. The process of moving to a new residence can be delayed even further if the person is not willing to go, or if the person is judged not competent to make decisions and a guardian needs to be assigned.

If the older adult has had behavioral issues in the past that resulted in them being asked/forced to move, it may take even longer for a place to be found that will accept them.

Most of the people who were consulted said that keeping in mind the big picture of stabilization, and referral to long term housing is crucial. The expected short-term turnaround in the specialized Adult Family Home is realistic only when there are long term beds/residences to which the older adult can move, the older adult is in relatively good physical health, and the financial situation for the older adult is stable. If long-term residences are not readily available, the possibility is that far fewer older adults will be served in the specialized Adult Family Home than anticipated in the original proposal. One estimate from an expert consulted for this briefing paper was that it could take several months to find a place for the older adult. Therefore, it is proposed that the temporary Adult Family Home stay be authorized for up to 90 days.

d. **72 hours will not be enough time** to assess, stabilize, and find a supportive long term place for most older adults referred to the specialized Adult Family Home. One key expert

stated that stabilizing someone who is older and in frail health can take a longer period of time. In addition, staff will need to work with the older adult to develop a care plan, determine what resources are needed to implement the elements on that plan, and to work with HCS to determine if the older adult qualifies for Medicaid/COPES. The expert predicted this process (i.e., stabilizing, care plan, and determination) could take between two to three months.

c. **Developing a licensed Adult Family Home takes time in general. And, since this is a new concept, there will need to be time at the beginning to design and develop the components of the specialized Adult Family Home.** This might realistically require up to six months to bring together the funders, policy makers, and experts needed to plan a model that ensures that what is put in place will meet the needs of the older adults, and fill a currently unfilled gap in the care continuum.

d. In addition, resolving any community or neighborhood concerns, and recruitment of a full range of appropriately credentialed behavioral health professionals may be barriers to implementation whether in rural, unincorporated, or urban areas of the County.

e. **Identifying an existing adult family home willing to transform into a specialized facility** with the level of staff training and expertise in working with clients with multiple chronic conditions and mental health disorders may be challenging.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

   If the "log jam" predicted by the expert consultants is realistic (i.e., older adults remain far past the expected 72 hours due to lack of available beds/housing or needing more time to become stabilized enough to be moved), then rather than 208 older adults being served, far fewer may be served.

   The worst case scenario is that the short-term alternative ends up serving as an Adult Family Home for older adults with behavioral and medical needs, with a highly trained staff which may be more costly to operate and maintain than typical Adult Family Homes. On the plus side, however, such a specialized Adult Family Home could serve as a pilot to test if this is an effective model to serve older adults with acute psychiatric, behavioral, and functional needs.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

   Access to appropriate short term assessment and care for older adults with psychiatric diagnoses, behavioral health issues, and functional issues will continue to be a challenge, resulting in continued use of more costly hospital settings .

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of**

cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

An alternative approach was developed by the state Department of Social and Health Services in 2014, primarily to facilitate state hospital discharge for this population of elders. The state obtained a waiver from the federal government to pay an enhanced rate to selected AFHs in order to provide appropriate behavioral health services to such individuals.
The state's model involves specialized training and 24 hour crisis support for AFH operators, as well as additional staffing to promote a therapeutic and safe environment.

Although this model is available in King County and other parts of the state, implementation has been sorely challenged by a lack of appropriate AFH settings, and a lack of willing providers. It is possible that MIDD 2 funding for the AFH proposed in this new concept paper would leverage existing state resources and result in full implementation of the model.

An alternative model to address this need would be to expand capacity in the current residential and intensive supportive housing facilities under contract with BHRD (e.g., Long Term Rehabilitation programs (LTRs), Expanded Community Services (ECS), and/or Program for Assertive Community Treatment (PACT).

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

   This concept points out a need that if addressed, will help free hospital beds for patients with more acute needs.

   It also would allow individual older adults the chance to be assessed, stabilized, and referred to appropriate long term residential options. This latter result fits within the Health and Human Services Transformation Plan's Communities of Opportunity by helping to shape the health and well-being of residents.

   This concept also fits within the goal of physical and behavioral health integration by strengthening the continuum of care for older adults by helping avoid long term or frequent use of the emergency system. Once the older adult is assessed, stabilized and referred to the appropriate housing setting (back home, adult family home, assisted living) and provided with the supports needed, the need for additional emergency system usage could be significantly reduced.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

   This concept is focused on helping older adults receive the care and support they need to recover from the crisis situation that was present when they were first assessed at the

emergency room. With appropriate residential treatment options, their level of resiliency may be improved.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

   This concept directly addresses a key determinant of equity identified as part of the County's equity and social justice (ESJ) work. It would improve access to health and human services for older adults, particularly those who may have psychiatric and/or health conditions, live on low incomes and those receiving Medicaid. These older adults may delay seeking help until they end up needing emergency care due to a crisis.

   The May, 2015 updated Behavioral Health in King County, Washington Data Watch states that King County adults living on incomes less than 200 percent of the federal poverty levels are four times more likely to have higher psychological distress than adults with higher incomes. (Page 10).

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

   a. Physical space: at least one Adult Family Home (up to six beds)
   b. Staff: 24-hour onsite presence of a registered nurse with appropriate knowledge and training in working with older adults with psychiatric and functional issues
   c. Staff: 24-hour onsite trained nursing aides
   d. Staff: Social worker to provide referrals to available housing options
   e. Licensure/ credentialing appropriate to the level of needs presented by the older adults
   f. Funding to pay for salaries, physical space, food, utilities, etc.
   g. Resources for consultations with medical staff such as psychiatrist

2. **Estimated ANNUAL COST.** $450,000 per service delivery option. **Provide unit or other specific costs if known.**

   The concept paper estimates that $450,000 a year is needed to pilot this model, with the goal of serving 208 older adults. However, as noted earlier under the Barriers section, most expert consultants agreed that 72 hours may not be long enough to assess, stabilize and refer an older adults with psychiatric issues. In addition, the lack of available residential options for older adults with these issues, especially those who rely on Medicaid, may pose problems in quickly finding them a place. It is more likely that a stay of up to 90 days, serving approximately 18 individuals annually is more realistic.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**
   In addition, this concept might be appropriate for funding from the Veterans and Human Services Levy -3 renewal. In particular, the concept of a low-stimuli and well- staffed environment might be helpful for older veterans experiencing long term Post Traumatic Stress Disorder and related issues.

It is possible that the state Home and Community Services Division may be interested in a shared funding approach to develop this specialized AFH. See Section C. 5.

4. **TIME to implementation:** 6 months to a year from award

What are the factors in the time to implementation assessment?

Convening a work group to determine the focus of the specialized Adult Family Home,

Locating a facility that can be used as an Adult Family Home (one month to four months)

Hiring the staff (6 weeks to 2 months)

Establishing referrals from hospitals, APS staff, GRAT staff, etc. (Ongoing)

Determine if a public/neighborhood meeting is needed to alert the neighbors

Becoming licensed

a. What are the steps needed for implementation?

Identifying a provider
Becoming licensed
Training the staff on an ongoing basis
Developing an effective referral system that can identify available housing options and move the older adults quickly to a safe, long-term environment

b. Does this need an RFP?

Yes

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

The proposed concept may fit under a broader approach The large majority of the consultants who helped contribute to this briefing paper acknowledged the need for short term alternatives for older adults who need assessment, stabilization and referrals to appropriate housing options. There may be other proposed concepts that can be combined to create or strengthen a network of services/supports for older adults with psychiatric/behavioral issues.

This concept links to BP 12 & 105, hospital step up/down program. The “step-up” program would divert individuals who are experiencing an escalation in symptoms from a hospital stay and preserve the individual’s ability to remain in his/her housing despite experiencing a crisis. The “step-down” program would enhance and improve the system of care by discharging individuals who no longer meet medical necessity for a hospital level of care to a less intensive yet supportive model, thereby opening access to hospital beds for those individuals whose psychiatric needs are most acute. It would assist individuals with transitioning from the psychiatric hospital back to the community.

The need for the resource proposed in this concept paper was confirmed by every expert consulted. However, more research is needed by experts in BHRD to fully analyze the following:

1. Are there other residential/treatment models in King County that can be used to compare and inform whether this approach is both feasible and needed, i.e., Community Psychiatric Clinic (CPC)?
2. What are the licensure and credentialing requirements for developing an alternative to inpatient psychiatric beds or for places that serve frail older adults with psychiatric, behavioral and functional needs?
3. Is there a different funding source(s) that has the responsibility for developing and sustaining the model being proposed?

#59 Working Title of Concept: Medically fragile Short Term Shelter

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1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

We are proposing a short term shelter for medically and functionally impaired adults with the following characteristics: a. clinical staff with the expertise to continue basic medical and ADL care needs as well as mental health expertise to stabilize impaired indviduals in crisis once medically evaluated (at an ER likely) ; b. hours that allow for people to stay 24-72 hours if needed; c. able to accommodate short term stays when adult family home placements "blow up"; d. beds versus floors to sleep on.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

When adults in adult family homes (AFHs), assisted living (AL) or living in the community independently reach a crisis point due to increasing care needs, behavioral disturbances, or a safety risk of living alone and requiring 24 hour supervision, they often end up in emergency rooms. They are not appropriate to admit to the hospital because they aren't in medical crisis, but they are unable to return to their prior residence for whatever reasons (often not allowed back/refused to return). They need an adult family home (AFH) or skilled nursing placement, but that cannot be arranged for a couple days. These individuals will often be deemed unable to care for themselves due to mental and physical conditions. The hospital has no choice, but to keep them and this takes up scarce and costly treatment beds. Even worse, they may be discharged with little planning and end up homeless. This leads to a pattern of them returning back to the emergency room setting. Or, patients that are deemed no longer requiring hospitalization in an acute care setting but cannot live independently in a shelter setting need housing arranged, and are hence taking up needed hospital beds while their disposition/discharge plan is being arranged.

3. How would your concept address the need?
Please be specific.

The shelter can be setup as a short-stay AFH. It would be staffed 24 hrs a day with an RN to administer medical care (medications) as well as ongoing assessment, and nursing assistants to provide ADL assistance. It would have shared bedrooms that have 2 residents per room, and provide meals, hygiene and opportunity to be in a low-stimuli environment. It would also have a social worker 8 hours daily to

actively work on finding solutions to housing/disposition/coordination of care needs. Clients would be referred to this shelter by ERs or hospitals once individuals are medically cleared/safe to be discharged and needed medical care is given. Ideally clients would not be staying beyone 72 hours before they are transferred to an appropriate longer term housing solution, likely an AFH.

4. Who would benefit? Please describe potential program participants.

The medically fragile individual first and foremost would benefit.
Other less appropriate diversion programs such as crisis diverson centers, which are geared towards more independent adults would benefit from not being taxed with more functionally impaired individuals.
The county would benefit from not having to pay for uncessary hospitlaizations, as well as decreasing the use of the CDMHPs for involuntary treatments for grave disability.
The licensed adult family homes in the county would benefit from having this respite option for quick client stablizaiton, as well as more time to evaluate and accept potential new admissions to their homes. .

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

a.Reduction of stays in shelters by medically fragile adults: this information is collected by the database used by shelter programs in King County; b. reduction of emergency room admissions for individuals that have been suddenly discharged from adult family homes: hospitals collect information about inappropriate use of ER; c. Continuity of Adult Family Home Placements: COPES collects data on the stability of AFH placements. Reduction in adults involuntarily hospitalized for grave disability, data collected from CDMHPs, King county.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

This concept would address the challenge posed by indivdiuals who have mental health and or substance use disorders and medical comormidity .

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

We envisioned a partnership with an organization like NAVOS, an adult family home providerwilling to do shot term respite, possibly with Roads to Community Living or Full Life Care , which addresses crisis/behavioral issues within the COPES/AFH settings. Alternately a partnership with DESC could work if the medical/geriatric expertise were available.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$ 450,000 per year, serving 208 people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.