“Building Capacity through State and Provider Collaboration to Support People with Challenging Behaviors”

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Presenters:
• Bernard Simons, Deputy Secretary, Maryland DD Administration
• Jeff Cross, President, Public Solutions, Benchmark Human Services
Overview

I. Understanding the Capacity Challenge

II. Action Steps for States: Defining Scope and Capacity

III. Example of State and Provider Collaboration

IV. “Provider Wrap Around” Concept: Increasing Provider Capacity w/Competency Building and Shared Services
The Big 5 Lack of Capacity Drivers

1. “Complex” sub-population is growing with significant cost, quality, and policy implications, limited data available or in use

2. Medicaid funding not always sufficient or flexible enough to meet this challenge; limits coordination of supports vs. fee for service, and is compliance vs. outcome driven

3. Undiagnosed mental health conditions that traditional IDD programs/behavior support don’t address, overdependence on staffing as an intervention; limited access to behavioral health support
The Big 5 Lack of Capacity Drivers

4. Varying effectiveness of behavior supports, many without “integrated lifestyle” focus and insufficient to address high acuity on a sustained basis

5. Can’t recruit enough new providers, must build capacity of existing agencies/systems and adopt different strategies
What’s Driving Demand

• 35% of people with IDD with co-existing psychiatric diagnoses (NCI)

• 64% of people with IDD in the community use at least one psychotropic medication (NCI), often limited access to psychiatrists (creates related poly pharmacy/health issues)

• Residual populations leaving state facilities, predictably greater than 35% with co-existing conditions and highly challenging behaviors (Lakin 2007)
What’s Driving Demand

• Persons with autism transitioning to adulthood
• Middle age adults at home losing elderly care givers and family support
• Environmental “Boredom Factor,” lack of work/meaningful activity/integrated lifestyle increases reliance on staffing as behavior support (Puts stress on capacity/expensive)
Potential Demand at 10%/35% Factors:

* Assuming 600,000 people supported: 60,000+ People w/Most Intensive Behavioral Challenges

* Estimated 210,000 People with Co-Existing Conditions
Annualized Cost of 1-on-1 Staffing as Primary Behavior Support

*Assumes $12 per hour wage, 25% benefits, and 5% overtime.*
Deeper Data Dive

- The Cost of Serving Individuals with Developmental Disabilities and Mental Health Challenges: Initial Survey of People with Dual Diagnosis Across the Commonwealth, 2011, Funded by the PA Developmental Disabilities Council

- Retrospective Study of Civil Admissions of Adults with Developmental Disabilities to State Hospitals Operated by the Department of Behavioral Health and Developmental Services FY 2015 (July 1, 2014 thru June 30, 2015), VA Department of Behavioral Health and Developmental Services, Mark Diorio, PhD
Characteristics of Persons Supported

1. 60% male, 40% female
2. Estimated 70% are age 20-40; majority are 21-30 and spikes again at 51-60
3. Estimated over 60% with mild intellectual disabilities
4. Estimated at least 20% with autism diagnosis
5. Co-existing diagnoses, using one or more psychotropic meds and/or history of PRN usage
6. Psychiatric hospitalization history
7. Multiple placement failures, law enforcement involvement, extensive trauma – reputation in the service system

(Estimates drawn from multiple data sources: NCI, referenced VA and PA reports, Benchmark GA crisis data)
Impact of Co-Existing Conditions Varying Intensity/Sub-Populations

• In FY15, 200 individuals w/IDD were admitted to Virginia state-operated MH hospitals including 42 individuals (21%) who were admitted more than once.

• These 42 individuals accounted for 102/38% of the total 269 state MH hospital admissions by individuals with ID/DD.

Virginia DBHDS Retrospective Study of Civil Admissions of Adults with ID/DD in FY15, Author: Mark Diorio, PhD
Age Range

Risk Profile

1. Forensic background/adjudicated placement
2. Sexual assault/predatory behavior/arson
3. Physical/verbal aggression (threat to self or others)
4. Severe property damage
5. Elopement
6. Self-injurious behavior
Reason for Crisis Calls (January 2016-March 2017)

Benchmark GA IDD Crisis Data, 2016 Annual Report/Current

- Refusals/Noncompliance: 5%
- Place self in harmful situation: 4%
- Suicidal Ideation/Attempt: 16%
- Self Harm/Abuse: 10%
- Elopement: 8%
- Verbal Threats/Verbal aggression: 32%
- Property Destruction: 19%
- Phy Aggress toward caregiver: 31%
- Other: 62%

Total calls-526  Calls may have multiple presenting reasons for crisis
January 2016 – March 2017
Potential Consequences
Benchmark GA IDD Crisis Data, 2016 Annual Report/Current

- Law Enforcement involved: 48%
- Emergency Dept/BHCC Access: 50%
- Inpatient Hospitalization: 40%
- Loss of placement: 30%
- Jail: 23%
Getting to Solutions

1. Traditional IDD approach (behavior support/staffing) alone is not sufficient, must be addressed as a discrete service population w/behavioral health needs

2. Create access to psychiatric support/medication management/stabilization, crisis response

3. Requires a coordinated and systemic approach/data based system – real time data, acuity projections, monitoring outcomes of individuals with complex needs – intensive case management
Getting to Solutions

4. Coordination with mental health agencies, health care, and law enforcement; the non-IDD stakeholders

5. Building capacity within the existing provider system is essential, credentialed agencies/training, shared clinical services, telehealth, remote monitoring, virtual support/technology, emphasis on work, and primary care coordination
Capacity Building Continuum

$ Analysis and Strategy
- Data Based Analysis
- Scope
- Stakeholder Engagement
- Coordination with Behavioral Health
- Strategy

$$$$ Intensive Support
- Supervised/Residential
- Behavior Support
- Staffing
- Behavioral Health
- Lifestyle Focus
- Crisis Response

$ Lifestyle Integration
- Work
- Behavioral Health
- Housing
- Monitoring/Case Management
- Prevention

Benchmark Human Services
What Support Looks Like
“A sustained life in the community vs. mitigating behavior”

Interview with Dungarvin, supports 300 people with challenging behaviors:

- Modified homes/technology (as appropriate) with 1-4 persons with intensive staffing
- Person centered behavior support plans, person specific staff training
- Licensed psychologist or BCBA on team, also included in staff training
- Medication management coordinated by psychiatrist and nurse; wellness focus and uses behavior data
- Structured activity/schedules/work/meaningful day with high levels of personal decision making
What Support Looks Like

• Specialized/repetitive staff training – rapport building, problem solving, listening skills, de-escalation, crisis intervention, and consistency

• Trained staff working in a team environment – practiced decision making and scenario based support and crisis intervention skills

• Higher staffing ratios and regular management presence/mentoring on site

• Data based – correlations with meds, staff changes, environmental, medical/health and aggression

• Contingency/crisis plans and pre-crisis collaboration with law enforcement, community
Life Style Focus and Capacity

- *The Importance of Environment: From Toxic to Healing*, Smull and Bourne
- Easier (cheaper) to change the environment than mitigate behavior (w/power struggles, control, staffing)
- Doing things I enjoy, work and community life are far more reinforcing than any behavior support plan
  - Basic needs met
  - Feel secure/can trust
  - Self development
    - I am safe, I am happy, and I can build relationships/contribute with family, community, etc.
    - “4 months to trust”
- Major implications for persons living at home and with limited funding (e.g. Community of Practice LifeCourse Tools, ”Integrated Long Term Supports”)
Efficiency of Lifestyle Driven Support

- Goal is a sustained life in the community with typical waiver funding, local resources, and case management
- Matches demographics (30 and younger, higher intellectual functioning, motivation to work, intense desire for community participation/validation)
- Promotes transition from structured (contained) behavior support to a community based lifestyle = significant $ savings
I. Define Scope – Data Profile

- Use available data to determine a state specific profile of need – who and where? How many?
- Heightened Risk Subpopulations: Sex offending behavior, arson, severe assault, forensic, high recidivism, etc.
- Number of psychiatric hospitalizations
- Persons with IDD admitted to state facilities due to no community alternative
- Law enforcement involvement/incarceration
- Crisis response data
- Case management/support coordination data
II. Map Existing System

- Placements by type and location
  Where do these people live?
- Regional psychiatric stabilization options
- Crisis response capacity
- Estimate provider capacity – rank by capacity and ability to support people with challenging behaviors, how many people can the system currently support vs. estimated annual demand? Create capacity baseline*
III. Engage Providers and Stakeholders

• Working sessions with provider associations and individual providers on capacity solutions

• Share Scope and System Map findings

• Engage non-IDD focused stakeholders: hospital emergency departments, law enforcement, mental health centers

• “What can be done with available resources – funding, providers, and community specific assets?”
State and Provider Collaboration in MD

• Goal was to provide community residential options for people with forensic backgrounds and court ordered placements. Histories of assault, arson, predatory sexual behavior, and elopement.

• State provided two capital grants toward securing affordable modified housing, three 4-person homes in Carroll County, MD

• Benchmark secured and renovated homes. Established a Medicaid funded “Enhanced Supervision” based model with targeted 2 to 2.5 year transition out of program
State and Provider Collaboration in MD

• Combines intensive behavior support with emphasis on integrated lifestyles including structured active schedules, work/job apps, community engagement, and tapered staffing

• First home opened in August, 2016 with total of three now open; two more planned

• Challenges: One person arrested and returned to secure facility; will ask court for re-admission

• Success: One person entered home with extreme property destruction/aggression. Now employed at McDaniel College, Westminster, MD
Wrap Around Provider Directed Support Network

System Support
- Credentialing Standards
- Data/Outcomes Measurement
- Acuity Tracking
- EHR
- Training Curricula
- Technology
- Best Practices

Shared Services
- Director
- Psychiatrist
- RN
- Licensed Social Worker
- Behavior Specialist
- Psychologist
- Trainer
- Psych stabilization
- Crisis Response
- 24/7 Clinical Access

Provider Agency Group
Provider “Wrap Around” Concept: Building Provider Capacity through Clinical Support/Credentialing/Shared Services

• Draws features from the evidence based Assertive Community Treatment (ACT) model in behavioral health and shared services concepts in education, etc.

• Providers are partners in a coordinated network or “Wrap Around System” (can be scaled from pilot stage and up) to support people with intensive challenges

• Establish credentialing standards for providers of residential and crisis respite services

• Competitive provider application process for limited placements; focus on 50-100 people w/5-10 providers

• Standard core training and staff competencies; implementation of best practices
Provider Wrap Around System
High Impact Service Design

• Clinical services team shared by all providers in the program: psychiatrist, psychologist/BCBAs, licensed social workers, nurses/primary care practitioner, master trainers, etc. Providers pay allocated % of support network cost

• Shared Electronic Health Record w/data collection and analysis capability

• Negotiated access to psychiatric stabilization; potential stabilization unit reserve day purchase (e.g. 100 days per year)
Provider Wrap Around System
High Impact Service Design

• Shared contracts for telehealth and monitoring technology
• Population specific crisis response capability with 24/7 clinical support
• Intensive case management pre/post placement
• Regional collaboration/formal engagement with law enforcement, mental health agencies, health care, and housing resources
• Weekly acuity analysis, outcomes measurement. Focus on transition success
## Provider Wrap Around Budget

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<tr>
<th>Staffing and Expense</th>
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<th>Annual Costs ($)</th>
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<td>Contract Psychiatrist</td>
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<td>Benefits/Travel</td>
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<tr>
<td><strong>Total</strong></td>
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Cost of Using Staffing vs. Provider Wrap Around

• *1-on-1 staffing for 16 hrs. per day x 365 @ $12/hr. plus benefits, 5% overtime factor = $89,790 per person/year

• *1-on-1 staffing for 24 hours, same assumptions = $134,685 per person/year

• Provider Wrap Around cost $22,583 (est. 10% of existing reimbursement) per person/year, based on 60 people and 6 providers

• PA DD Council Survey: $239K spent annually (2011) per person with co-existing diagnoses; $14,340,000 for 60 people
THANK YOU