

Supporting Individuals with Co-Occurring Mental Health Support Needs and Intellectual/Developmental Disabilities

Themes, Trends, and a Synthesis of Promising Activities

Introduction

State agencies serving individuals with intellectual and developmental disabilities (I/DD) routinely identify supporting people with co-occurring mental health issues as one of the largest challenges in their service delivery system. In addition, in August 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA) convened an expert panel to discuss an array of issues pertaining to individuals with I/DD and mental health support needs. This panel's discussion surfaced many of the issues impeding the ability of individuals with I/DD to gain access to effective mental health treatment. One significant issue identified by state I/DD agencies, and reinforced during the SAMHSA expert panel discussion, is the varying levels of collaboration at the state level between agencies overseeing I/DD supports and agencies providing mental health treatment.

An estimated 7.37 million people in the United States had an intellectual or developmental disability in 2016.¹ It is further estimated that 30 to 70 percent of individuals with I/DD have a mental health condition.^{2,3} Despite this high prevalence level, even on the lowest estimates, there is a chronic lack of a whole-person approach in most states to supporting individuals with co-occurring I/DD and mental health issues, taking into account both the clinical supports necessary to treat the mental health (MH) condition while providing the needed, well-trained and supportive services for the individual to live and thrive in their communities. These challenges often prevent individuals with complex support needs from getting a coordinated approach to clinical services and community-based supports.

While these issues are sometimes attributable to rigid state infrastructure and financing parameters, there are notable examples of states that have overcome these issues through strong relationship building and collaboration and through innovative service design strategies. To spotlight effective strategies, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), the National Association of State Mental Health Program Directors (NASMHPD), and NADD, an international association for persons with intellectual/developmental disabilities and mental health needs, joined in partnership.

Each organization identified members who have succeeded in supporting individuals with co-occurring I/DD and MH support needs, hoping to identify themes and strategies that can be replicated across the country.

1-Sheryl A. Larson, Heidi Eschenbacher, Lynda L. Lahti Anderson, Brittany Taylor, Sandra L. Pettingell, Amy S. Hewitt, Mary P. Sowers, and Mary Lou Bourne, *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and Trends Through 2016* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 2018).

2-Ludwik Szymanski, M.D. and Bryan H. King, M.D., "Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults With Mental Retardation and Comorbid Mental Disorders," *Journal of the American Academy of Child and Adolescent Psychiatry*, (1999): 38 (12 Suppl):5S-31S.

3-Sally-Ann Cooper, Elita Smiley, Jillian Morrison, Andrew Williamson, and Linda Allan, "Mental Ill-Health in Adults with Intellectual Disabilities: Prevalence and Associated Factors," *The British Journal of Psychiatry* 190, no. 1 (2007): 27–35. doi:10.1192/bjp.bp.106.022483.

This partnership resulted in a three-part roundtable series focusing on the following three topical areas:

- State organizational structure, financing, payment approaches, and policies:
Opportunities to Transcend Structural Stovepipes and/or Misaligned Incentives
- Access to skilled clinical capacity and specialized support/training for direct support workforce:
Clinical Capacity Building and DSP Workforce Development Efforts
- Identification and design of effective service modalities:
Service Design Innovation Opportunities within State Medicaid Programs

This report features summaries of the roundtable discussions on these three topic areas. Each of the discussions surfaced specific replicable strategies as enumerated within each of the summaries. However, larger themes also emerged that transcend the specific topic areas. States that have made inroads into devising effective strategies to support people with co-occurring I/DD and mental illness generally engaged in the following practices:

- Reflective systemic analysis to identify areas of needs and strengths upon which to build;
- Collaboration and problem-solving across and within program agencies;
- Identification of multi-level system interventions to enhance overall capacity; and
- Commitment to person-centered practices to provide support and treatment to individuals in a manner that meets their specific needs.

Partner State Participants

We extend heartfelt gratitude to the states participating in this roundtable effort: **Delaware, Maryland, Michigan, New Mexico, and Ohio**. We especially wish to thank the state directors of developmental disabilities services and the state directors of mental health services and their team members who devoted both the time and their extensive wisdom to share those efforts afoot and in development in their states to effectively support individuals with I/DD and MH conditions.

Specifically, we appreciate the following individuals who contributed their vast knowledge and expertise:

State	Participants
Delaware	Dorothy Pryor, Kamin Giglio, Danielle Gumbs, Marie Nonnenmacher, Terrence Macy, Deanna Pedicone, Elizabeth Romero, Alexia Wolf, and Gary Meeks
Maryland	Bernard Simons and Lisa Hovermale
Michigan	Debra Pinals
New Mexico	Wayne Lindstrom, Cheryl Frazine, and Chris Heimerl
Ohio	John Martin, Mark Hurst, Kathleen Coate-Ortiz, and Tina Evans

Association Staff Participants

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The National Association of Developmental Disabilities (NADD): Jeanne Farr
National Association of State Mental Health Program Directors (NASMHPD): Brian Hepburn, Genna Bloomer, & Tim Tunner

Background on Participating States

The states participating in the roundtable each have their own unique state agency infrastructure, financing mechanisms, and service delivery systems. Provided below is a high-level description of these individual state structures, demonstrating the variation among our participating state partners. Notably, the themes that emerged as helping the states to overcome any organizational impediments transcend the nature of the stovepipe or challenge, providing strong practices for emulation in any state financing and structural ecosystem.

Delaware

In Delaware, within the Department of Health and Social Services, there are independent divisions for developmental disabilities services, mental health services, and Medicaid. Primarily, the Division of Developmental Disabilities Services delivers services through a fee-for-service 1915(c) home and community-based services waiver, along with state plan services for targeted case management and the health home benefit. The Division of Substance Abuse and Mental Health (DSAMH) delivers an array of services through a program called the PROMISE program, delivering an variety of HCBS through an 1115 demonstration program. The division also coordinates an array of other services and works closely with the state's managed care entities who are responsible for delivering most of the mental health state plan benefits through their networks. Delaware also has a separate children's bureau that manages children's mental health benefits.

Maryland

In Maryland, the Developmental Disabilities Administration (DDA) and the Behavioral Services Administration (BHA) both are located, along with Medicaid, within the Department of Health. DDA primarily delivers services through three 1915(c) HCBS waivers. BHA provides a wide array of supports and services for individuals with mental health needs, many of which are authorized and managed through an administrative services organization (ASO).

Michigan

Within Michigan, the Behavioral Health and Developmental Disabilities Administration (BHDDA) is located within the Michigan Department of Health and Human Services (MDHHS). BHDDA administers Medicaid waivers for people with intellectual/developmental disabilities (I/DD), mental health, and serious emotional disturbance, and it administers prevention and treatment services for substance use disorders. Services and supports are delivered within a carved out managed care authority.

New Mexico

In New Mexico, the Developmental Disabilities Support Division (DDSD) is located within the New Mexico Department of Health. The DDSD oversees three home and community-based Medicaid waiver programs. The Behavioral Health Services Division (BHSD), however, is located within the New Mexico Human Services Department. BHSD managed the adult portion of the state's mental health support system and is a member of the New Mexico Behavioral Health Collaborative.

Ohio

Within Ohio, the Department of Developmental Disabilities (DODD) and the Department of Mental Health and Addiction Services (OhioMHAS) are standalone cabinet departments, as is the Department of Medicaid. DODD operates multiple 1915(c) HCBS waivers in partnership with county boards throughout the state. OhioMHAS oversees a wide array of services, including the Community Behavioral Health System consisting of 51 alcohol, drug addiction, and mental health boards and approximately 600 provider agencies providing prevention and treatment services for mental health, drug, and other addiction services.

Round Table I

State Organizational Structure, Financing, Payment Approaches and Policies: *Opportunities to Transcend Structural Stovepipes and/or Misaligned Incentives*

January 10, 2019

Topical Introduction

The first of the three state roundtables focused on the strategies in use in states to remove or to overcome structural or financial obstacles to effective collaboration.

The participating states in this roundtable, as noted above, included Delaware, Maryland, Michigan, New Mexico, and Ohio. These states differ in the manner in which I/DD services and mental health services are arranged and delivered within the state, providing a unique vantage point into strategies that can transcend organizational and financial appropriations structures.

Specific Questions Posed to the Group

In order to ascertain mechanisms used in these states to overcome stovepipe financing and/or organizational structure, the roundtable facilitators posed these three questions:

- How are your state agencies that are supporting individuals with I/DD and individuals with mental health structured within your state? Same agency? Separate agency, same department? Separate department? Others?
- In consideration of your specific state structure, what strategies have you employed to overcome potential system silos? Which strategies have proven most effective?
- Have you established joint regulations, operating policies, or memoranda of understanding that govern your collective work together?

Identified Themes from Roundtable Discussion I

Through this facilitated discussion with these states that have discovered strategies to overcome structural impediments, the following themes emerged as essential to creating an atmosphere that creates *Opportunities to Transcend Structural Stovepipes and/or Misaligned Incentives*:

- Leadership and Commitment to Collaboration
- Consistent Communication and Mutual Education
- Tenacity and Creative Solution Identification

Effective Strategies for Partnership Described in Roundtable I

As noted above, despite the various infrastructure constructs in use across the states, a number of themes emerged as fundamental in all of the strategies described below: leadership and commitment to collaboration; consistent communication and mutual education; and tenacity and creative solution identification.

Delaware

Delaware identified the need to fill a gap between their systems for individuals with mental health support needs and I/DD. Within Delaware, different parts of the system were responsible for different fragments of care. Medicaid managed care organizations are at risk for state plan mental health services for most Delawareans except, until very recently, individuals with I/DD enrolled in the state's 1915(c) waiver for individuals with developmental disabilities. These individuals were to receive their state plan benefits through fee-for-service. In addition, the state's mental health division provides a comprehensive community-based continuum of support through its PROMISE program. This program does not include individuals who are enrolled in other HCBS programs. As the mapping of the service delivery system revealed these gap areas for individuals with I/DD, DDS devised a strategy to develop — first with state-only dollars — a program based on the Team ACT model of support adapted for individuals with I/DD. This program, referred to as the Assertive Community Integration and Support Team (ACIST — pronounced, "assist"), works as a coalescing team to coordinate the full continuum of supports for individuals with co-occurring I/DD and mental health diagnosis.

ACIST provided a unique opportunity for partnership between the DD division and the MH division, as ACIST models its eligibility and referral processes on those of the PROMISE program, enabling seamless handoffs as needed between the two programs. It also emulates the existing interface(s) between the team and the other key partners in service delivery, the managed care organizations, and those providers rendering long-term services and supports.

Delaware recently gained approval from the Centers for Medicare & Medicaid Services (CMS) to use the Health Home authority for the continuation of the ACIST program. This authority, which brings a 90 percent federal financial participation for the first eight quarters of operation, reinforces the whole-person approach to supports and sets key expectations for quality outcomes.

As Delaware described their success with this effort, it was apparent that strong vision and leadership was a key component. This coupled with an intentional approach to build and maintain personal, effective working relationships greatly impacted the process and enabled the building of sustainable structural approaches. While Delaware notes that its size is an advantage in the development and maintenance of key relationships for collaboration, the models they employ are replicable in even the largest of jurisdictions.

In this example, Delaware leveraged knowledge and processes from existing mental health and Medicaid programs, while devising a tailored strategy specifically for individuals with I/DD. Delaware noted that cultivating and maintaining personal relationships has been an essential component to their agencies' partnerships.

Delaware has also begun working more closely with family services and behavioral health peers working on cases together. This collaboration has been essential to solving individual solutions and provides strong insights into key components for memoranda of understanding.

Maryland

As previously noted, Maryland's Department of Health serves as an umbrella agency that includes the Developmental Disabilities Administration, the Behavioral Health Administration, and Medicaid. Maryland continues to identify supporting individuals with co-occurring I/DD and MH support needs as a critical issue and has undertaken a number of key efforts to bridge existing system gaps. In recognition of the importance that relationships play in the establishment of effective strategies for collaboration, DDA and BHA have a key position that serves as a liaison between the two

administrations, effectively negotiating person-centered solutions for individuals requiring supports from both agencies. This liaison plays a pivotal role in intervening to ensure individuals do not become "stuck" in emergency rooms or hospitals, helps anticipate individuals who may be emerging from the child welfare system with I/DD and MH support needs, and has been instrumental in the establishment and partnership with two clinics within the state supporting individuals with co-occurring I/DD and MH diagnosis. These clinics include an adult autism/special needs clinic connected with Johns Hopkins Bayview aimed at supporting individuals while bolstering the in-state clinical capacity. This is a rate-regulated clinic, meaning that they receive a higher rate than other mental health clinics. In addition, a neuropsychology unit at Sheppard Pratt has been developed with dedicated clinical staff at one of the state's largest mental health system.

In addition, collaboration is key. For example, there is a call with behavioral health every Monday morning for individuals who are in state mental health placements, reducing the number of individuals from 45 to 13.

In addition, Maryland is making sizable investments in other efforts to round out the ability to support individuals with co-occurring I/DD and MH needs. Maryland has retooled and bolstered its ability to provide positive behavioral supports to individuals with I/DD receiving DDA services and has also engaged heavily in augmenting access to trauma-informed care. In addition to contracting with nationally recognized experts on positive behavioral supports, DDA has also selected the MANDT framework for behavior supports, as it is more current with the administration's philosophy which focuses on building healthy relationships, providing a more person-centered, values-based process that encourages positive interactions.

DDA has also joined NADD to build capacity within the I/DD system. In addition, DDA has also begun a pilot of the START program which will include its hallmark elements of:

- Comprehensive Evaluation of Services & Systems of Care (local and state)
- A systems linkage approach to service provision
- Expert Assessment & Clinical Support
- Outcomes-Based Research & Evaluation
- Short-Term Therapeutic Resources and Opportunities
- Cross Systems Crisis Prevention & Intervention Planning
- Family Support, Education & Outreach
- Interdisciplinary Collaboration

While these service delivery advancements are occurring within the DDA infrastructure, the BH/DD liaison contributes to the ongoing collaboration between the two agencies.

In addition, DDA continues work with the Department of Human Services within the state to support and plan for children who are in the custody of child welfare, many of whom have support needs that will span the DD and MH systems. There were many children in out-of-state placements. BHA and DDA worked to create in-state capacity, both within the state DD provider network and within the Regional Institutes for Children and Adolescents (RICA).

Finally, the state has made recent enhancements to the 1915(c) home and community-based waiver to better complement and coordinate the services provided therein with the other Medicaid/mental health services to which individuals are entitled.

Michigan

Michigan is structured to have unified services for persons with I/DD and MH needs, currently operationalized through its Behavioral Health and Developmental Disabilities Administration (BHDDA) and its State Hospitals Administration (SHA), under the direction of the Department of Health and Human Services. There are no ICFs, but there is one hospital, Kalamazoo, that is designated to support individuals with I/DD as needed. The state uses this hospital to learn about strong practices.

The administration is devoted to addressing the needs of individuals with autism spectrum disorder (ASD). Michigan has bolstered the workforce of board certified Applied Behavior Analysts and has begun to embed some of these skills within a variety of settings including state hospitals.

When the ICFs closed, the state tracked all discharges to assure community placement was stabilized and continues to monitor related to emergency department visits or psychiatric hospitalizations. Through the licensing/certificate of need process, the state tried to expand acute care setting bed capacity to meet needs and has been working hard to improve staff capacity. The state hosted a large conference in February (2019), bringing together a variety of stakeholders and raising the bar for staff capacity to support individuals with I/DD.

In addition, the state is working to collect data on individuals who are forensically involved. Michigan also conducts National Core Indicator surveys each year through a contract with a University Center for Excellence in Disability – Wayne State University.

New Mexico

The Developmental Disabilities Supports Division (DDSD) is within the Department of Health. This agency partners with the Human Services Department which includes the Behavioral Health Services Division (BHSD). Most mental health services come through the Human Services Department. However, there is a community-based Developmental Disabilities Waiver (DDW) program, and the DDSD provides a variety of supports through the DDW, including behavioral support consultation, which works in tandem with behavioral health services supplied through Human Services and the NM Behavioral Health collaborative.

The Department of Health and the Human Services Department are the major departments, collaborating with others as needed (for example, Children, Youth and Families). In addition to Medicaid waiver services (DDW), they also offer other support services and clinics primarily through the University of New Mexico, such as Center for Development & Disability (CDD -- it is a center for excellence), the Transdisciplinary Evaluation and Support Clinic (TEASC) that offers in-home and clinic-based consultation to adults with I/DD having complex medical, mental health, and support system needs, and a DDMI clinic, which offers consultation to local practitioners providing medical/psychiatric and mental health care to people with I/DD throughout the state. The DDMI clinic is currently supported mainly through telehealth. The University of New Mexico offers many educational opportunities for new psychiatrists, other mental health and medical professionals, as well as those professionals in training. Through the collaboration and the use of contracts, there are many individual consultations and trainings conducted in a variety of settings.

Other state-wide strategies used to overcome silos are the Behavioral Health Collaborative and crafting legislation designed to study specific issues. Some of the things DDSD has done in the past are: 1) being persistently involved in other agency's programs that have a potential impact on individuals with I/DD, 2) offering technical assistance and training to any entity desiring it, and 3)

taking joint operations conducted on smaller scales – such as the Taos clinic that developed a hybrid psychosocial day program for psychiatric recovery of people with I/DD -- and expanding and replicating successful aspects of the project in other locations around New Mexico (DDMI clinic).

New Mexico notes the importance of relationships in these successful collaborations. In many instances, this is the key, and systematizing these can be difficult, but ultimately profitable.

The Director the BHS Division notes that the state has had some major challenges around timely assessments at the University of New Mexico and a waiting list for families waiting for services on the DD waiver. There is an opportunity given new administration and budget surplus at the time to make some strides. The DDMI collaborative was seen as an opportunity to jointly plan and fund behavioral health. While these have not fully realized their potential, the collaborative has launched a children's behavioral health initiative and anticipates a working group around these issues. There is planning around an ABA benefit within Medicaid, and they have made strides in creating that capacity.

Representatives from DDSD provided some historical perspective. The state has invested significantly in person-centered planning and bringing wrap-around supports in this context. At the heart of the complications facing those with co-occurring support needs, one of the most overwhelming issues is trauma; consequently, the state has begun investing in trauma-informed care, shifting emphasis away from behavior and toward emotional needs and mental health supports. New Mexico has been successful teaching Direct Support Professionals (DSPs) what contributes to extreme emotional, trauma, and mental health distress (rather than focusing exclusively on behavior). The state has spent significant resources to identify information about successful DSPs and how we should support them in their work. New Mexico has a huge geography and few people. The state developed a profile for DSPs and the skills that they needed to provide to them. This work was an important aspect of the development of community-based crisis capacity as most individuals could not rely on psychiatric hospitals except in limited circumstances. The state began training around trauma, co-occurring disorders and psychotropic medications. New Mexico also began talking about the wellness of DSPs (both ongoing and post-crisis event) so that the DSPs can understand their emotional and pragmatic response – continuing the focus on the individual, while providing essential learning for the staff. The focus on wellness and emotional well-being is fundamental in New Mexico's approach.

Ohio

Though the Departments of Developmental Disabilities (DODD) and Mental Health and Addiction Services (MHAS) are separate cabinet-level state agencies, there is constant collaboration. The agencies partner on a host of initiatives across the lifespan. DODD operates services through 88 counties and numerous developmental centers, with two units for children. MHAS funds also flow to the county boards — 51 mental health and addictions boards. Those boards then work with providers in the communities. Ohio also expanded Medicaid and carved-in behavioral health services into Medicaid managed care. The only services that are provided directly by the department are inpatient services, with a majority of the individuals served who are forensic. MHAS also oversees the providers. Many treatment providers are dually certified for mental health and addictions. While there are no formal agreements, there is a strong collaboration around person-centered, trauma-informed care.

Mental Illness/Intellectual Disabilities Coordinating Center of Excellence (MI/ID CCOE) is a pillar of collaboration across the I/DD and MHAS infrastructures. The agencies have partnered for many years around this effort. Wright State University and Dr. Julie Gentile provide a team of professionals

to support local teams on second opinions, psychiatric assessments, etc. The teams also work throughout the state to encourage the partnerships between providers, DODD, MHA, and MI/ID CCOE. CCOE do significant training on best practice. This is a hugely successful joint project. This started in 2001, with the departments solidifying the center.

The other important program is around telepsychiatry. Through this work, the team at Wright State are covering most of the 88 counties. Dr. Gentile and Wright State have consulted with the state psychiatric hospitals including training on behavioral and therapeutic approaches and have provided a wide array of consultation. The state has contracted with this group for an online curriculum. This is an ongoing effort to increase sustainability.

The other partnership with Wright State is a MI/ID psychiatric residency program aimed at increasing the clinical capacity within the state.

Ohio does a joint NADD conference, and this is a partnership between DODD and MHA. There is a joint website with MHA, CCOE, and DODD to highlight these effective initiatives.

Roundtable I Resources and Strategies: Replicability and Scalability

This first of three roundtables highlighted the pivotal importance of leadership and relationships in transcending structural and financial silos within state government.

Numerous examples in the state profiles provided above could be easily replicated in other states if the necessary partnerships, resource braiding, and ongoing communication and commitment are present. In each of these states, appropriations and structures are generally situated by diagnosis, and it has only been through vision, leadership, communication, commitment, and relationship building and maintenance that these approaches have thrived.

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Medicaid is an important element in the success of many of these strategies, providing a funding infrastructure for services as well as for the proper and efficient administration of the state plan. While the state general revenue comprising some of the approaches included above may originate from separate state agencies, the resources can be threaded together to provide a cohesive structure to support individuals within a Medicaid framework. Furthermore, the efforts to improve and maintain the clinical capacity in the states can also benefit from Medicaid, through administrative dollars, including those potentially above the typical 50 percent match rate.

Round Table II

Access to Skilled Clinical Capacity, Specialized Support, and Training for Direct Support Workforce

March 14, 2019

Topical Introduction

On March 14, 2019, representatives from Delaware, Maryland, Michigan, New Mexico, and Ohio participated in Part II of an invitational roundtable on "Effective State Practices Supporting Individuals with I/DD and Mental Health Support Needs" that focused on access to skilled clinical capacity and specialized support/training for the direct care workforce.

Roundtable II considered access to skilled clinical capacity and specialized support/training for the direct support work force. It is estimated that more than a third of Americans with intellectual/developmental disabilities have a behavioral health need and can be diagnosed and treated for the full range of mental health conditions. One significant issue that has been identified by state I/DD agencies is the varying availability of clinicians to provide mental health treatment to individuals with intellectual and developmental disabilities. Another issue that has been identified concerns the lack of sufficient training for direct support professionals.

Specific Questions Posed to the Group

To identify how the states were meeting the challenges concerning the needs for skilled clinical capacity and specialized support and training for the direct support work force, the roundtable facilitators posed the five following questions to each of the participating states:

- How would you describe the clinical capacity within your state to meet the needs of individuals with I/DD and mental health support needs?
- What strategies have you used to bolster the availability of clinicians? Which strategies have proven most effective? How are you measuring success?
- Have you established joint regulations, operating policies or memoranda of understanding or other efforts to work across the mental health and I/DD agencies?
- Have you undertaken any efforts to improve the skillset or knowledge base of direct support professionals in the field? If so, please describe.
- Have these proven effective? How are you measuring success?

Identified Themes from Roundtable Discussion II

Through this facilitated discussion with the states, the following four themes emerged:

- There are significant limits in clinical capacity and mental health services are scarce
- Service delivery systems are still siloed and fragmented
- Measuring success is difficult
- Training the DSP workforce is a critical area of concern and focus

Most of the states participating in the roundtable noted limits in their state's clinical capacity, some noting that mental health services are scarce in many areas of the state for everybody, not just for individuals with I/DD and mental health needs. Most states also called out in the discussion how service delivery systems are still siloed and fragmented.

All states concurred that measuring success is difficult. It was noted that to some extent, success could be judged by the number of individuals able to stay in their homes, versus the number of out-of-home placements. A reduction in the number of emergency room visits and hospital admissions are other indicator of success. Person-centered planning and behavioral intervention successes are ways to measure, as are individual service planning goals measurements which could include skill building or community engagement. Additionally, the success of these programs can be measured, in part, through job satisfaction and level of turnover.

Effective Strategies for Partnership and Measurement from Roundtable II

Following are specific insights and ideas of effective strategies for partnership and measurement from each state related to the identified themes.

Ohio

Although there are still gaps, clinical capacity is getting better. NADD and the state of Ohio Developmental Disability and Mental Health divisions have been in partnership for 17 years in the hosting of an annual conference that highlights treatment and support approaches in working with people with I/DD and mental illness. The Center for Excellence also offers training and support. Capacity is greatly enhanced through a telepsychiatry project being run by Dr. Julie Gentile and her Wright State team, who have enrolled 1,500 people including 200 youth. The capacity to serve individuals with I/DD is being enhanced through a residency program in MI/DD. Over the years, 40 individuals have passed through the residency program. The success of Ohio's various programs is measured, in part, through the number of individuals who are able to remain in their homes vs. out-of-home placement. Reductions in emergency room visits and hospital admissions provide further measures of success.

New Mexico

The challenge of enhancing clinical capacity is important because mental health services in New Mexico are scarce in many areas of the state for everybody, not just for individuals with I/DD and mental illness. Services are still siloed and fragmented. Few psychiatrists have expertise or comfort treating those with co-occurring disorders. The scarcity of prescribers is being addressed by allowing non-medical practitioners to become prescribers. Training is being offered at university for PhD or PsyD psychologists to learn and become qualified to prescribe. The Center for Excellence and university centers provide expert consultation training. Expert consultation is also available through the 5 regional offices. Telehealth training is provided. Success is measured through person-centered planning and behavior effectiveness. Benchmarks include skill building, opportunities to be out in community, reduction of destructive behavior, ecological approach, and whether they function well together.

Michigan

Although there are training and supports needed, there are pockets of people who are well-equipped to work with this population. One approach to the challenges of clinical capacity has been co-housing, with I/DD and MH in the same unit. There is one state hospital designated as the hospital of choice for individuals with I/DD. Michigan has built an ABA-certified workforce. Wayne State

University - MI DDI - offers Direct Support Professionals and provider trainings on PCP, independent facilitation, self-determination, emergency preparedness, and the HCBS rule in partnership/ collaboration with BHDDA and the DD council.

Maryland

Maryland is developing a pilot program with assistance of the Center for START Services. To bolster availability of clinicians, in 2018 Maryland changed from contracting for one agency in each region to do behavior supports to allowing provider agencies to develop behavior plans and do assessments. As a result, there are more clinicians available to do this work. An area of relative weakness is working with other agencies. It is hoped that the project with START will open communication with other agencies.

Delaware

Clinical capacity is limited. There is a dearth of psychiatrists with adequate abilities — especially pharmacology. A challenge in bridging the gaps between systems is that the structures are so disparate that there are barriers to bringing tools together, and the I/DD system uses terminology differently than the MH system does. They are trying to develop a more common language. They are working on increasing trauma-informed care. The ACIST program is designed specifically for individuals with co-occurring I/DD and severe and persistent MI. There is a behavior support plan using a mental health model. The ACIST program utilizes an RN monitoring health; case manager monitoring progress; and a mental health clinician (at this time the mental health clinician is an advanced practice RN). Telepsychiatry is also utilized.

Efforts to Improve the Skillset or Knowledge Base of Direct Support Professionals

DSP workforce development efforts were a major focus of the conversation. It was noted that many direct care staff are there because they want to make a difference, but they need the tools to do that. People serving those with co-occurring disorders need additional training in:

- I/DD-MI Dual Diagnosis core competencies
- Neurobehavioral issues
- Trauma-informed care
- Pharmacology
- Crisis response
- Positive treatment approaches

Ohio

In partnership with Dr. Gentile and Wright State University, trainings for DSPs are available online. When there is staff turnover, new staff can see the trainings. A combination of regional and virtual trainings for direct care staff and providers has been developed around autism spectrum disorder, youth transition, emotional regulation, and sensory challenges. An eBook for specialized trainings is being developed.

New Mexico

The DSP workforce comes without a great deal of skills learned in the classroom. Most end their education with a high school diplomas or GEDs. Some have been DSPs for over twenty-five years. DSPs serving people with co-occurring disorders need additional knowledge about neurobehavioral and other mental health issues; trauma-informed care; pharmacology; crisis (there is a two-day training available); and positive approaches. An important part of training DSPs is not in teaching

them information but in teaching them how to recognize what they already know, and how to communicate what they know about the person.

Michigan

Training quality is reviewed with feedback from participants. Michigan's BHDDA has also developed trainings for first responders to help address issues that arise in the community with individuals with ASD. More recently the Mental Health Diversion Council has developed first responder training to address the needs of individuals with I/DD more broadly.

Maryland

Maryland is starting a pilot on positive behavior supports working with the University of Minnesota's UCET. Three hundred and fifty trainers have been trained in trauma-informed care and in positive behavior supports. A work force development group is looking into the different competencies that are needed for starting DSPs as well as at various levels of experience. Maryland is developing a DSP credential. Outcome or success will be measured by job satisfaction and by reduction in turnover.

Delaware

Delaware is supplementing their DSP education efforts with trainings from private agencies, especially in trauma-informed care and positive behavior support. They also provide consulting for particularly challenging cases. They have developed learning communities that bring behavior analysts together with DSPs to talk to each other.

Round Table III

Identification and Design of Effective Service Modalities: *Service Design Innovation Opportunities within State Medicaid Programs*

May 3, 2019

The third invitational roundtable with representatives from the five states (Delaware, Maryland, Michigan, New Mexico, and Ohio) discussed successes and promising practices in working with individuals who have dually occurring intellectual/developmental disabilities (I/DD) and mental health (MH) support needs, with a focus on opportunities for service design innovation within state Medicaid programs.

Each of the first two questions below have summaries of common themes raised by state representatives, which are followed by notes from each state. The third question asked about service capacity priorities and needed tools, and these responses are in a bulleted list.

Question #1

Has your state identified any specific effective service modalities to support individuals with co-occurring I/DD and MH support needs? Include clinical services and/or community-based support services and what Medicaid authorities, if applicable, you used.

Meeting participants discussed the importance of having a trauma-informed approach and incorporating its tenets throughout a person's care. Traumas that an individual experiences can often manifest later in life in the person's health and behaviors, and understanding this effect can help to understand how people should be served by the I/DD and mental health systems. Having support for implementing trauma-informed care should ideally be at the highest level of government possible. With support from the governor, for example, it becomes possible to work towards having everyone in the system be aware of and work through the lens of trauma. Using positive behavioral supports can work well in tandem with trauma-informed care.

Several states underscored the importance of a support team and teamwork for those served. This support team could be a formal model such as Assertive Community Treatment (ACT) or WRAPAROUND, a collaboration of team members with different areas of expertise. Participants emphasized the importance of ongoing training and support for direct care staff, whether through a university, consultation with experts, and others who collaborate and share responsibility for the clients.

Both the Charting the Life Course approach/initiative and the Project ECHO in Ohio were raised as models that may demonstrate some positive results worth replicating in other areas and other states. Participants emphasized having a local and individualized approach to providing care. Telepsychiatry was also mentioned as an effective adjunct for care.

Several different Medicaid authorities were cited as options to pay for services, including a habilitation supports waiver, a children's waiver (both possibly through managed care), and billing for ACT under a bundled rate. One state also discussed using the health home option under the Affordable Care Act. The health homes can have more flexibility, as they operate independently of a waiver, which can sometimes exclude some services.

Michigan

Representatives from Michigan reported they have been working with their home and community-based services (HCBS) rule and compliance team to guide how to consult with teams to improve support to individuals with I/DD.

They noted the following efforts to improve services:

- In an effort to ensure good community services, one person reflected that when they first came to work for the agency they were conducting home visits and compliance audits to ensure adherence to rules. The person recommended that there is a need to provide both audit and consultation functions for home and community-based services (i.e. tracking people who were previously in intermediate care facilities (ICFs) who moved into the community).
- The agency is reviewing transition support planning for currently institutionalized individuals who they believe can move into the community. To do so they are considering models used for children with substance-use-disorders (SUD) that incorporate transitional support teams.
- The Michigan Developmental Disabilities (DD) Institute provides guidance to community providers.
- The agency is looking to residential treatment facilities for youth that might have applicability for adults with I/DD with special needs.
- Michigan has a DD council and participates in a cohort of states for a Charting the Life Course Initiative to help develop policies, supports, and services for people with I/DD, including innovations in Medicaid policy.
- In 2018, using Medicaid, Michigan developed a policy for certified peer mentoring, which established the ability to have peer mentoring re-infused via Medicaid.
- The agency has been looking to the Center for Medicare & Medicaid Services (CMS) to see if the habilitation supports waiver and children's waiver program can be moved into managed care to augment and expand services provided.
- In general, they have a lot going on with Medicaid clinically, in policy, and programmatically.

*Note from the roundtable facilitator: NASDDDS is very involved in the Charting the Life Course program. This program may be helpful for other states to learn about at www.nasddds.org

New Mexico

New Mexico is a large state, and they are looking for local and individual solutions to problems. Representatives from New Mexico noted the following initiatives:

- New Mexico provides training for clinical behavioral health support staff (called behavior support consultants--BSCs) and teams that support individuals with I/DD. Core training requirements for BSCs include positive approaches and behavioral supports, supporting sexuality, people with co-occurring disorders, psychotropic medications and others foundational medical issues that people with I/DD commonly experience such as polypharmacy and aspiration risk management. Giving BSCs a firmer foundation in concerns that come up for those with I/DD is very important; this then translates to others who work with directly with the person (DSPs).
- Through the University of New Mexico (UNM), the agency has specialty clinics such as TEASC and DDMI that have specialty providers and can make referrals for consultation, either in person or using videoconferencing or other remote technology.
- There is a project at UNM where physicians and others are involved in clinics for

cerebral palsy, seating clinics, and safe assessment and feeding evaluation (SAFE) both for pediatrics and adults. The adult clinics are run by the New Mexico Developmental Disabilities Supports Division (DDSD) with consultants.

- There is a lot of consultation with entities that have shared responsibility for behavioral health for the I/DD community. Currently, the interactions are around crisis treatment or problem-solving when supports being provided appear not to be effective—i.e. someone is going to the hospital for multiple, short-term stays, or through monitoring and outreach, it appears that someone is getting multiple medications changed quickly, based on rapid behavioral changes.
- The agency would like to see more interaction around the well-being of the persons served with I/DD, as the current approach tends to be more problem-focused.
- Community integration is a long-term part of the process for evaluating how behavioral support is being used. They are working to use community integration as a part of the evaluation process for everyone now.

Ohio

Ohio is working to identify more effective practices for individuals with a dual diagnosis and to ensure clinical and support staff have training, such as in Dialectical Behavioral Therapy, especially for individuals with borderline personality disorder or similar characteristics. This approach is designed to help staff become more skilled and better manage challenging behaviors.

- The Ohio agency is focusing on assessing for histories of trauma and how experiences of trauma may manifest in behaviors.
- Ohio offers special consultation for individuals who have a dual diagnosis, including pharmacological approaches and treatment planning.
- The agency has worked to coordinate a local approach to avoid duplication of efforts. There are county-based teams with representatives from both MI and I/DD systems to blend the resources, support individuals and their families, and create comprehensive plans.
- These teams often come together with other partners to identify training needs (i.e. for their upcoming forensic conference). Last year the forensics conference had a specific track regarding individuals with I/DD involved in the court system, which was highly attended and well received. This year the focus will continue to be on I/DD. Ohio noted that bringing people together seems to improve collaboration and learning.
- Medicaid in Ohio has not yet been able to be fully utilized, but the agency is exploring the idea of having an Assertive Community Treatment (ACT) team for individuals who are dually diagnosed, as they can now bill Medicaid for ACT at a bundled rate. They are excited about exploring a new option.
- Ohio has been reviewing Medicaid claims data for information such as the frequency that individuals who have dual diagnosis go to the emergency room (ER) or are admitted to the hospital. They have been using this data to develop training, both in-person and virtually, around such topics as the frequency of diagnoses for which people are presenting such as bipolar disorder, anxiety, and depression. In the last two years, they have increased this training in addition to trauma-informed care (TIC) trainings.
- Ohio echoed the importance of Charting the Life Course. This model was originally rolled out to families. Families are getting it in the hands of professionals so they can have better conversations with people with complex needs, particularly related to planning.

- Ohio has identified telepsychiatry as an effective service for this population for both children and adults. Ohio has approximately 1200 individuals utilizing the service. OH keeps data on emergency room visits and out-of-home residential placements.
- The agency has received positive feedback for Project ECHO (Project Extension for Community Healthcare Outcomes), which started in January 2019 for youth who have a dual diagnosis and are involved in multiple systems. The project has been very helpful for those working directly with individuals to build their capacity. This project involves an expert panel made up of physicians, pharmacists, child psychiatrists, pediatricians, adult psychiatrist, an autism expert, transition-age youth expert, parents, trauma-informed care specialist, and other professionals. Challenging cases are presented and the panel, in addition to about 30-35 virtual learners, have a 15 minute didactic related to the topic.

Delaware

Delaware is focused on incorporating the principles of trauma-informed care throughout their behavioral supports.

- In Delaware, the ACIST team (Assertive Community Integration Support Team) program is built off of the ACT model and layers in typical services such as ABA for those with I/DD, using behavioral analysis, regular therapy, case management, and psychiatry for medication management. The program became Medicaid funded under the Health Home option, which allows a bundled rate for an ACT team, as well as fluidity of the wraparound model, and covers both individuals living in the community and in residential facilities. The program uses telepsychiatry to ensure it remains community-based. There were barriers to using Medicaid, so they researched several Medicaid authorities before landing on the Health Home authority put in place by the Affordable Care Act (ACA) in 2010, which allows a bundled rate for an ACT team, as well as fluidity of the wraparound model. There are about six components. The state plan amendment was approved in January 2019, and it is diverse enough to cover things as basic as high blood pressure to covering people in our program. One "beauty" of the Health Home is it operates independently of their waiver and the CSAM waiver. Sometimes with a waiver, it excludes some things, and this health home waiver allows individuals living at home and in the community and individuals in residential homes and individuals who might be receiving services through CSAM. Again, they do not duplicate services, but it does allow fluidity between the two.
- Delaware leadership all the way to the top recognizes the importance of trauma-informed care and the impact that trauma can have. Delaware participated in the ACES study, and the governor declared Delaware a trauma-informed state and is gearing up everyone in their services — not just those with a mental illness — to be aware of and work through the lens of trauma.
- Comprehensive services are also available for those who do not reach the acuity threshold for individuals in the ACIST program. There is a strong focus on positive behavioral supports, trauma-informed care, and proactive supports to help individuals live one's life in the best way possible. If an individual's acuity increases, they can then also be referred to the ACIST program.

Maryland

Maryland representatives began by stating that, from a clinical side, everything mentioned in other states people have talked about has also worked at some level in Maryland:

- The Maryland agency is in a "building" phase in working toward implementing the START program.
- Maryland re-emphasized what other states had previously shared regarding the importance of positive behavioral support and values of trauma-informed care.

- There has been discussion in Maryland of how to best track individuals as they transition into the community.
- A special needs clinic was established through Johns Hopkins University. Dr. Wise entered into a collaboration with the University of New Hampshire and the START project, and they are hoping to see some synergy.
- Most services, aside from those at Johns Hopkins, have been provided only through the state's Medicaid waiver. There has been conversation within the agency regarding Health Homes, because not everyone is able to be covered under the DD waiver. Maryland staff referenced Nancy Cane in New York, who used to have an ACT team and did some writing about it. Maryland would be interested in learning more about this approach.
- Maryland has expert teams, but they are mostly based in facilities. It is difficult in Maryland to get a child psychologist and psychiatrist in the same place together because of workforce issues.

General Discussion Following Question 1 Presentations

Following information presented by representatives of each of the five states, the floor was opened for questions, including either general questions or those for specific presenters. The following questions were posed:

Has anyone used in their DD waiver the extended state plan services as referenced in the TA guide?

Mary Sowers from the NASDDDS provided some background for this question, noting that for Medicaid in general there are both mandatory and optional state plan benefits. Within the HCBS waiver states can go above the basic benefits and a number of states have extended them to include such things as providing services that go beyond a unit limitation for a particular type of service or to expand their provider pool more targeted to the audience served. Ms. Sowers asked for any experiences among those on the call. No specific experiences were mentioned as examples, but Ms. Sowers noted there are a number of interesting services that can be done in the waiver, and she could pull some information together to share with the group and others.

How is Project ECHO Funded?

The response was that it is funded through state general revenue.

Is Project ECHO related to general child psychiatry access for which you have some specialists? We have a consultation service, our MC3 project modeled after Massachusetts and we partnered with them and have behavioral pediatricians and autism experts but embedded in general child psychiatrist access and wondering if it is embedded in Ohio?

Ohio representatives responded that it is not embedded, but rather a standalone model, similar to one out of New Mexico. Ohio has a couple of specific ECHO projects. This one was designed specifically for youth with co-occurring issues and involved in multiple systems. However, Ohio also has an ECHO project on medication-assisted treatment—one done by a pediatric hospital (not the state) on autism. The I/DD Project ECHO is conducted jointly between the Department of Developmental Disabilities and the Department of Mental Health and Addiction partially funded by general revenue funds. A former governor also allocated a significant amount of funding to do similar work approximately five years ago. The project is also funded through opioid funding, set-aside funds for individuals with first episode psychosis (FEP) or early mental illness, and with other block grant dollars. They are currently piloting this project to see if it is something they want to continue.

Is there a timeline for the transition support teams in Michigan to get them deployed?

This is still in the exploratory phase and they are having conversations to figure out the mechanics

and funding first. They do already have one effective program for children coming out of state psychiatric hospitals and many have ASD- or I/DD-related challenges. Therefore, there is discussion of capturing this model for the adult population with serious mental illness (SMI) and I/DD, or at least for those with just I/DD. Some individuals are also forensically involved and some are not. They have been having discussions about copying that for a different population. There is currently no timeframe as they have funding for the children's work, but are still thinking about policy developments and funding for the infrastructure for the adult side.

Question #2

What are your next frontiers for service delivery improvements?

A common theme that was first brought up by Michigan and reiterated by several others is the knowledge gaps among those delivering services in the field. They stated that they could not find a lot of practitioners who are well versed in individuals with I/DD and serious mental illness, including psychiatrists, child psychiatrists, etc., and so they have to do a lot of work on multi-disciplinary training to get future professionals to understand what it takes to work with individuals with I/DD. It does not matter what is in a waiver if they do not have providers who can serve these populations. Thus, there needs to be an emphasis on specialized training. Professionals and other direct care staff really need proper tools and education. They hear from direct support staff that these resources help immensely to provide quality care and that the tools and time provided are helpful, whether those are provided in a formal didactic training or if the learning happens during the process of providing care. New Mexico does regional consultation in the community with the intellectual disability teams (IDTs) when needed, and the agency insists that direct care staff be at the table for discussions, as it really is correct that much of the quality of life is a result of the quality of direct care and that direct care staff need to be heard and given tools.

Training and workforce development is an even more pertinent issue when working with certain particularly challenging populations, such as those with traumatic brain injury, individuals involved in the forensics system, or those with sexual behavior concerns. In many cases a person might exhibit inappropriate sexual behaviors that are not intended to be predatory, but they are a problem because the person does not understand and ends up violating social norms and boundaries, which can subsequently also then lead to increased stigmatization. Sexuality services can be included within a DD waiver, and it can be useful to develop contracts around risk, screening, consultation, and supports for working with them. Having the proper specialized supports and training (psychiatric, behavioral analyst, etc.) for staff is again invaluable for working with these populations.

One priority reiterated by several states was community integration and community-based care. An important focus for this is increasing supports, including those for families, so that children and others can remain in their homes. Using a person-centered approach to care is an important tandem to serving people in the community.

Michigan

A challenge in Michigan is that there continues to be knowledge gaps among those delivering services in the field. They could not find a lot of practitioners who are well versed in individuals with I/DD and serious mental illness, including psychiatrists, child psychiatrists, etc., and so they are doing a lot of work on multi-disciplinary training to get future professionals to understand what it takes to work with individuals with I/DD.

A recent statewide conference on I/DD was held in Michigan, which 200-250 people attended. The agency received a lot of great feedback on the conference. They are now thinking about how to take this forward as well as implement other training opportunities.

- A great job has been done building the ABA workforce in the state, but the agency sees a need to expand the pool to get other types of professionals who have knowledge and skills in supporting individuals with I/DD.
- The agency has also identified a gap in community services for individuals whose behaviors are challenging and providers' ability to determine appropriate placements so they are not placed in hospitals by default. This is an even bigger challenge when there is justice system involvement. For example, a person might exhibit inappropriate sexual behaviors that are not predatory but rather they are a problem because the person does not understand and so violates social norms and boundaries, leading to stigmatization.
- There is discussion in the Michigan agency about challenges with fidelity to home and community-based services. The agency is moving towards person-centered care and community-based care, when there is a long history of institutional thinking even in community-based settings. They are trying to balance rules and laws with practicality.

New Mexico

The New Mexico agency would like closer collaboration with local behavioral health providers to work on shared initiatives such as better access to outpatient and inpatient behavioral health treatment when needed. Regarding integration, the agency has discussed this in the context of their DD waiver system, and it is a big part of how they've envisioned DD support in New Mexico. However, it has not been fully embraced on the behavioral health side. New Mexico has a multidisciplinary telehealth approach called their DDMI project, though they would like it to have closer ties to the New Mexico ECHO project.

- New Mexico has been working with managed care organizations who do state plan services to collaborate and coordinate better. They have been working on partnerships among leadership, particularly with Project ECHO to get this going.
- There are sexuality services within the DD waiver, and the agency has contracts around that. These contracts have been in development with preliminary risk, screening, and consultation around individuals who exhibit risky or sexually offending behavior in the community, and they have developed good supports around this. Within DDS there is also education around sexuality programs to promote working together with the behavioral health community for strategic planning that includes those with IDD. New Mexico is also working to ensure people with IDD have access to sexuality education to decrease their likelihood of sexual abuse or inappropriate sexual behaviors and also as a part of person-centered planning to increase the quality of their relationships and lives.

Ohio

In Ohio, they are still trying to identify strengths and gaps but are focused on local capacity. Some counties and providers are doing a really good job with the training of direct care staff, but the goal is to identify gaps and offer more training, support, and tools.

- Some individuals with a more mild I/DD challenge with traumatic brain injury can pose a challenge to work with, as are people with borderline personality disorder.
- Generally, Ohio echoed what Michigan said about the service capacity of working with individuals with complicated histories, involved with the court. Maybe they have been charged or have some form of sexual and other problem behaviors, and such behaviors continue to be challenging to address in the community. It is most difficult to get teams to come together to find the right system, program, and support for these individuals.

- Ohio also echoed what Michigan said about gaps related to workforce, training, and trying to improve the knowledge of providers. The workforce is needed to support what is in the waiver. As a result, they have emphasized specialized training. Specifically for children, the governor has invested millions of dollars in funding for improving services. However, it is important to figure out how to do better for children in home settings before looking at out-of-home options. Provider capacity should be built for in-home and then for out-of-home care when needed. This approach is on the horizon for the next year for Ohio and would be a pressing priority.

Delaware

Delaware also underscored Michigan's message on the resource issue, which is a fundamental need in Delaware. They are trying to address this with the expansion of the ACIST project, looking to recruit a second provider and build better skill sets. Likewise, their providers have the same deficits as Michigan in terms of psychiatric supports and behavioral analyst supports.

- Delaware is hoping to create a new resource pool for families regarding access to more psychiatric supports. The agency has done a lot of work with behavior analysis in communities, and they have really matured in terms of their ability to address the issues they are facing every day with their caseloads.
- Delaware is looking to build on some of the work they have done collaborating with other state agencies.
- In the past, the mindset was that people with I/DD could not have MH issues, so the Delaware agency is trying to change that mindset. Over the last four to five years, they have helped change this mindset, and this has created more opportunities and conversations about what complex needs are about. The Delaware agency continues to have conversations around this, and it has garnered their ability to have more partnerships, be more involved with communities of practice, and to work with families and people at younger ages to have a positive impact for people before they become middle-aged adults.

Maryland

Maryland's focus has been on community integration and supporting families. They are being very proactive on this front.

- Maryland underscored the workforce issue — both in the professional and direct-care domain. Eighty-five to ninety percent of the quality of life of individuals receiving care is directly related to the quality of care provided by direct care staff, so Maryland is trying to integrate these staff into medication reviews, spend time educating them, including them in conversations, and ensuring that they understand why things are done the way they are done. This is a challenge though, as it is difficult to provide real education in real time so it makes a difference in people's lives. Much of this issue has to do with training, but also with logistics and implementation strategies, as well as strategies to get the professional staff more in tune and interested in working with this population. Implementation strategies are a key factor in whether professionals want to work with this population. They need to have the information to make informed decisions.
- In forensics, Maryland seems to have the same individuals coming into contact with the system over and over, indicating a gap in services for these individuals. Most of these individuals have had terrible trauma. Skilled treatment provision and care is required to keep these individuals in the community.

General Discussion Following Question 2 Presentations

Following the individual state presentations, New Mexico echoed what Maryland said about the need to support and educate professionals and direct care staff, and that this has a great impact on the quality of care. New Mexico hears from direct support staff that these resources help immensely to provide quality care, and that the tools and time provided are helpful whether those are provided in a formal didactic training or if the learning happens during the process of providing care. New Mexico does regional consultation in the community with the IDTs when needed. The New Mexico agency insists that direct care staff be at the table for discussions, as it really is correct that much of the quality of life is a result of the quality of direct care and that direct care staff need to have input and be provided tools.

Question #3

What service capacity areas are your most pressing priorities and what tools/support would be helpful to you in these pursuits?

Rather than each state taking turns presenting their priorities, the floor was opened for panel representatives to make suggestions and give ideas of what would be helpful.

- All states agreed it would be helpful to create a resource library of dual diagnosis best practices, research, and articles (especially those that were mentioned on this call), so that people do not have to struggle to track down the information that they can use for reference. It was noted that NADD is in the process of developing that resource.
- There was agreement that it would be helpful to have ways to learn about new resources and programs existing in other places that might be implemented in their state — for example, the START initiative from the University of New Hampshire.
- States are interested in learning more about creative use of Medicaid and how to connect with managed care organizations (MCOs). They would be interested in the sustainability of Medicaid strategies and other programs that are working well that they might consider doing.
- Staff are interested in learning about successes states have had in collaboratively working with MCOs to meet the needs of individuals. It might be helpful to identify gaps in existing resources for working with those entities to meet the needs for individuals with I/DD.
- There is an existing gap in training for those general practitioners who see individuals with I/DD among those with typical intellectual abilities. Sometimes there is a feeling they need specialized training, and so training and access to resources for individuals outside the I/DD community could be helpful for understanding how to increase their confidence to work with this population. They had an individual who went into a 24-hour crisis facility; he used assistive technology to speak, and they were at a complete loss of how to treat him. Training on I/DD and assistive technology is needed.

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