Public Meeting Notice

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Anything said during this meeting may be part of the public record

Increasing Access and Expanding Organizational Capacity for Individuals with Co-Occurring Disabilities

Presenters: Boyd Brown, HMA; Victoria Laskey, BHA; Kathleen Homan, MPA, HCPF; Meredith Davis, HCPF; AJ Beyrer, Ph.D. LCSW, BCBA-D; Charles Burd, MS, BCBA

June 27, 2024

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

HMA
Health Management Associates

Learning Objectives

After completing this training, participants will be able to:

1. Identify how state policy changes are aimed at supporting providers in building capacity and improving access to deliver robust behavioral health services for individuals with co-occurring disabilities including intellectual and developmental disabilities and identify needed organizational changes to minimize barriers to access.

2. Identify the key principles, lessons learned and fundamental components of building effective behavioral health services for co-occurring disabilities including intellectual and developmental disabilities within a behavioral health organization.

3. Summarize how a national provider is delivering effective behavioral healthcare including evidence-based services for individuals with co-occurring disabilities including intellectual and developmental disabilities and begin to apply the steps needed to build readiness and capacity within their own organizations to improve the quality of care for co-occurring disabilities.

4. Gain awareness of evidence-based practice and potential innovations for behavioral health providers providing behavioral health services for members with co-occurring disabilities including intellectual and developmental disabilities.

Level Setting on Terminology and Training Focus

Definition of Co-occurring Disabilities

Co-occurring disabilities include, but are not limited to, intellectual or developmental disabilities (I/DD), Autism, cognitive impairments, fetal alcohol syndrome disorder, are neurodiverse, have a brain injury, physical disabilities, people who are deaf, blind, deaf/blind, hard of hearing, and/or other disabilities.

Today's presentation will focus primarily on behavioral health providers serving individuals with intellectual and developmental disabilities, however, many of the concepts shared would enhance behavioral health service delivery for individuals with other co-occurring disabilities.

State Efforts to Enhance Access

Presenters:
Kathleen Homan, HCPF
Victoria Laskey, BHA

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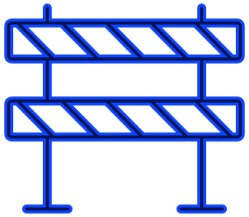
Behavioral Health Access and Common Barriers

- Prevalence of co-occurring mental illness and I/DD or other disabilities in Colorado.
  - In a sample of 3,177 individuals with I/DD and 3,522 individuals in non-HCBS Medicaid, we found the count of Behavioral Health diagnoses for the I/DD population was twice (40%) the Medicaid sample (20%). This aligns with national research.

- Behavioral health service utilization by persons with co-occurring mental illness and I/DD or other disabilities.
  - Both populations have an average of 6 claims per person
  - Claims showed an $100 higher cost per member for BH services in I/DD group
  - I/DD group had 13.8% higher expenditures because of inpatient hospitalization and emergency room visits

Behavioral Health Access and Common Barriers



- Failure to accurately diagnose mental illness in persons with an I/DD
- Lack of training related to adapted mental/behavioral health services to person with an I/DD.
- Insufficient stabilization options for person with an I/DD who have mental/behavioral health needs.
- Limited planned respite options for persons with I/DD in advance of a mental/behavioral health crisis.
- Limited mobile supports for person with I/DD who are experiencing mental/behavioral health needs.
- Lack of intensive wraparound supports.
- Limited or inconsistent collaboration between agencies, providers, and health professionals

Behavioral Health Access and Common Barriers

POLL: Have you experienced any of these common barriers when supporting individuals with co-occurring behavioral health and I/DD or other disabilities? Check all that apply.

Improving Access to Behavioral Health Services

- Diagnostic and Training: Disability Cultural Competency for Behavioral Health Providers (DCCBH) Training currently under development
- Crisis Response Training specific to supporting individuals with disabilities mandated and provided by BHA OwnPath Learning Hub
- BHA and HCPF collaboration on standardized Mobile Crisis Response delivered in community
- Behavioral Health Secure Transportation to decrease law enforcement interaction
- Denver START program pilot to improve intensive wraparound supports for individuals with an I/DD.
- Improved collaboration between RAEs, CMAs and HCPF to support complex cases including CDHS' Regional Center/Community Support Teams
- Behavioral Health Safety Net prioritizing care coordination

Improving Access to Behavioral Health Services

- Diagnostic and Training: Disability Cultural Competency for Behavioral Health
- Crisis Stabilization: According to report, still a barrier (any updates?)
- Respite Options for persons with I/DD:
  - CHRP respite limits were updated to match CES respite limits and allow for much more flexibility and overage requests when more respite as needed
  - Developed additional respite service delivery options that support exceptional medical and/or behavioral needs for members on the CES or CHRP waivers. The additional service delivery options for both CES and CHRP are: Skilled Certified Nursing Assistant (CNA) Respite (unit and day), Skilled Registered Nurse (RN)/Licensed Practical Nurse (LPN) Respite (unit and day), and Therapeutic Respite (unit and day). 1 unit means: 1 15-minute increment. Day means: more than 4 hours in a 24-hour period.

Improving Access to Behavioral Health Services

Accountable Care Collaborative Phase III (ACC 3.0)

Updates to MCE Contracts for ACC Phase III

- Contractor shall ensure that Members who have co-occurring disabilities have access to necessary Behavioral Health services that are clinically and culturally appropriate.
- Contractor shall make Medical Necessity determinations based on the presence of a covered diagnosis and Contractor's determination that the issues requiring treatment are related to that covered diagnosis.
- Contractor shall not deny services for a covered diagnosis on the basis that a co-occurring disability is present and there is confusion in determining the etiology of Behavioral Health symptoms.
- Contractor shall be financially responsible for a Member's treatment when the Member is presenting with Behavioral Health symptoms for the purposes of acute stabilization, safety, and assessment to determine whether or not the Primary Diagnosis occasioning the Member's treatment is a Behavioral Health disorder or a co-occurring disability.

Updates to MCE Contracts for ACC Phase III Cont.

- Any decision to deny services or authorize a service in an amount, duration, or scope that is less than requested to a member with an intellectual/developmental disability must be reviewed by an individual competent in the use of the DM-ID-2 as an adaptive diagnostic tool that satisfies DSM-5 criteria.
- Contractor shall ensure that practitioners use current best practices when assessing for, screening for, and/or diagnosing Behavioral Health conditions in Members who have co- occurring disabilities. A co-occurring disability must be present to explain variances from DSM-5 criteria.
- Contractor shall ensure Members with a co-occurring disability have access to the full spectrum of appeal rights for Adverse Benefit Determinations rendered with regard to clinical services for the treatment of covered Behavioral Health diagnosis.

Improving Access to Behavioral Health Services

- Safety Net System creation by July 1, 2024 pursuant to 27-50-301, C.R.S.
- Partnership between Behavioral Health Administration and Health Care Policy & Financing
- Incentivizing high quality, inclusive care using Alternative Payment Models (APMs)
- Standards for “Safety Net Providers” and when standards are followed, eligible for APMs including a higher fee schedule or prospective payment system (PPS)

Improving Access to Behavioral Health Services (continued)

Essential Behavioral Health Safety Net Provider

Provides care coordination and **one or more** of the following:

- Emergency/Crisis
- Outpatient
- Intensive Outpatient
- Residential
- Withdrawal Management
- Inpatient
- Integrated Care
- Hospital Alternatives
- Other services determined by the BHA

Comprehensive Community Behavioral Health Provider

Provides care coordination and **all** of the following either directly or through contract:

- Emergency/Crisis
- Outpatient
- Intensive Outpatient
- Recovery Supports
- Care Management
- Outreach, Engagement, Education
- Outpatient Competency Restoration

No Refusal for Essential and Comprehensive Providers

Unless needs fall outside scope and capacity of the provider, no refusal to treat based on individual's:

- Insurance coverage, lack of insurance coverage, or ability to pay;
- Clinical acuity level related to the individual's behavioral health condition or conditions;
- Readiness to transition out of inpatient care;
- Involvement in the criminal or juvenile justice system;
- Current involvement in the child welfare system;
- **Co-occurring mental health and substance use disorders, physical disability, or intellectual or developmental disability, irrespective of primary diagnosis, co-occurring conditions, or if an individual requires assistance with activities of daily living or instrumental activities of daily living, as defined in Section 12-270-104(6), C.R.S.;**
- Displays of aggressive behavior, or history of aggressive behavior, as a symptom of a diagnosed mental health disorder or substance use disorder;
- Clinical presentation or behavioral presentation in any previous interaction with a provider;
- Place of residence; or
- Disability, age, race, creed, color, sex, sexual orientation, gender identity, gender expression, marital status, national origin, ancestry, or tribal affiliation.

Providing Person-Centered Care for Individuals with Complex Needs

BENCHMARK
HUMAN SERVICES

WHO WE ARE

Benchmark Human Services' history is rooted in developing customized solutions to meet the needs of individuals with intellectual and developmental disabilities (IDD) in our community.

OUR TEAM

- 3,100+ employees
- 23,000+ children and adults served annually

OUR MISSION

To help people live as independently as possible, be included in the community, and reach their full potential

SERVICES

- Active Consulting
- Autism Services
- Case Management
- Crisis Respite Homes
- Day Services
- Early Intervention
- Family Preservation
- Group Homes
- Intensive Care Coordination
- Mobile Crisis Response
- Pediatric In-Home Healthcare
- Specialized Residential
- Supported Living

BENCHMARK HUMAN SERVICES

CONNECTING PEOPLE AND POTENTIAL

COLORADO Department of Health Care Policy & Financing

COLORADO Behavioral Health Administration

HMA Health Management Associates

Overview of Service Delivery

- Co-Occurring Behavior Health and IDD/DD/ASD
  - Often operating exclusively
  - Silo-ed service models

- Definition and Significance of Team-based Care

Effective Strategies and Behavioral Interventions

- **Core principles of co-occurring care**
  - Holistic/Wrap Around Support
  - Team Work
  - Person-Centered Practice

- **Foundational strategies for effective intervention**
  - Person-Centered Care
  - Consistent and Active Scheduling
  - Enriching Environment
  - Data-Driven Decision Making

Effective Strategies and Behavioral Interventions (continued)

- **Use of evidence-based practices**
  - Trauma-informed treatment modalities
  - Individualized behavior planning
  - Least to most restrictive intervention modalities
  - Wrap-around support (i.e., PT, OT, SLT)
  - Tailoring therapy based on individual needs
  - Addition of caregiver/family supports
  - Always assessing efficacy

Building Staff Capacity and Readiness

- Internal training programs
  - Positive Behavior Supports
  - Person-centered training
  - Competency-Based Training Models
- Continuous professional development initiatives
- Staff Resources:
  - Performance Diagnostic Checklist
  - Working with Staff to Overcome Challenging Behavior among People who have Severe Disabilities

Building Staff Capacity and Readiness (continued)

- In the moment performance feedback
- Debriefing
- Accountability for team members
- Regular modeling, practice, and feedback
- Mission-Driven Approaches
- Creating a positive work culture
- Not asking staff to do what we would not…

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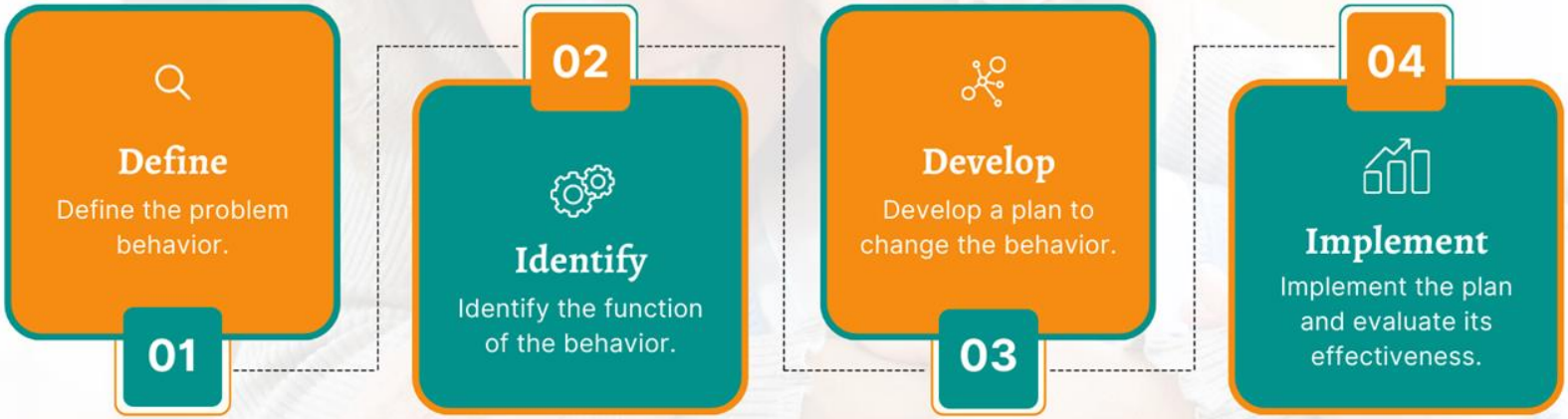
Basics of Positive Behavior Support



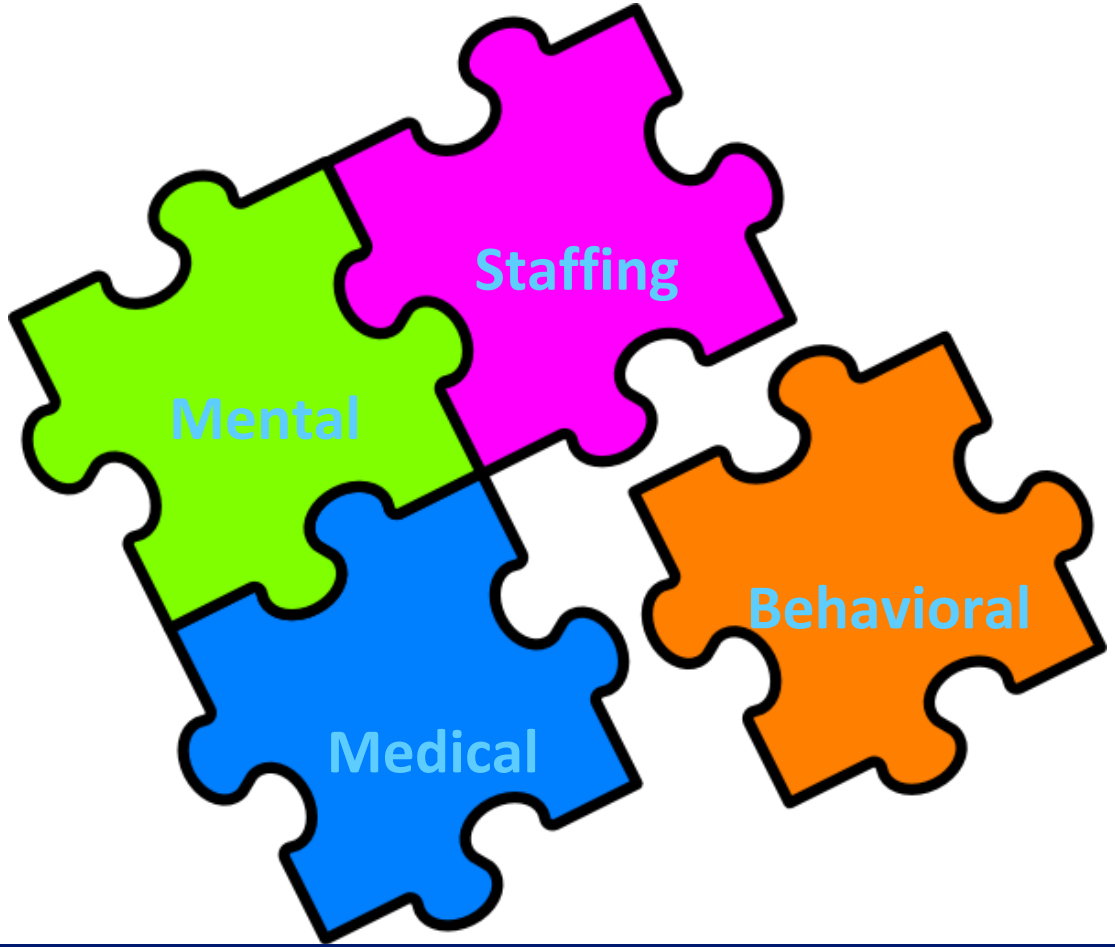
Interactive Exercise 1

Discussion Question

How do your current practices align with co-occurring care principles?

Multidisciplinary Methodologies

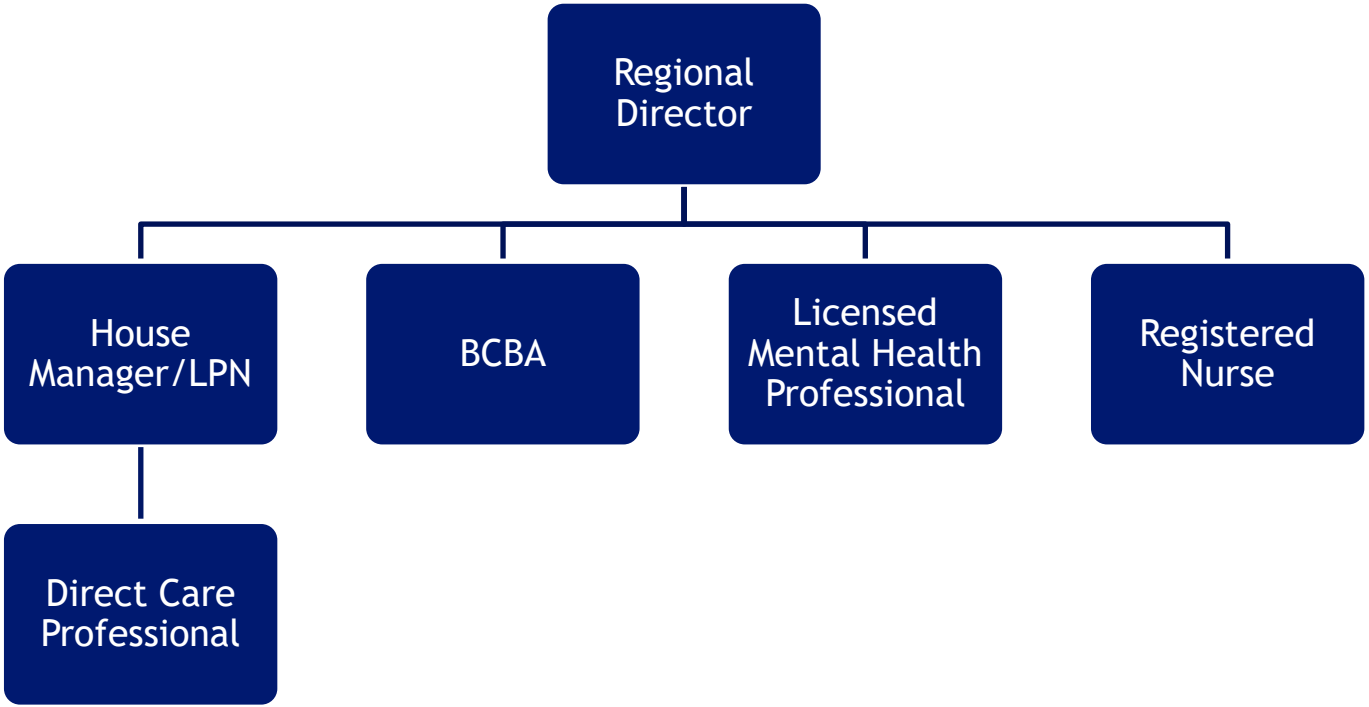
- Importance of multidisciplinary collaboration
  - Complex needs often require integrated care
  - Focus on the INDIVIDUAL's needs
  - Open-minded collaboration (egos aside)
  - Honest conversations: "Is this working?"
- Examples of team approach in programs
  - School based care
  - Healthcare


Staffing
Mental
Behavioral
Medical

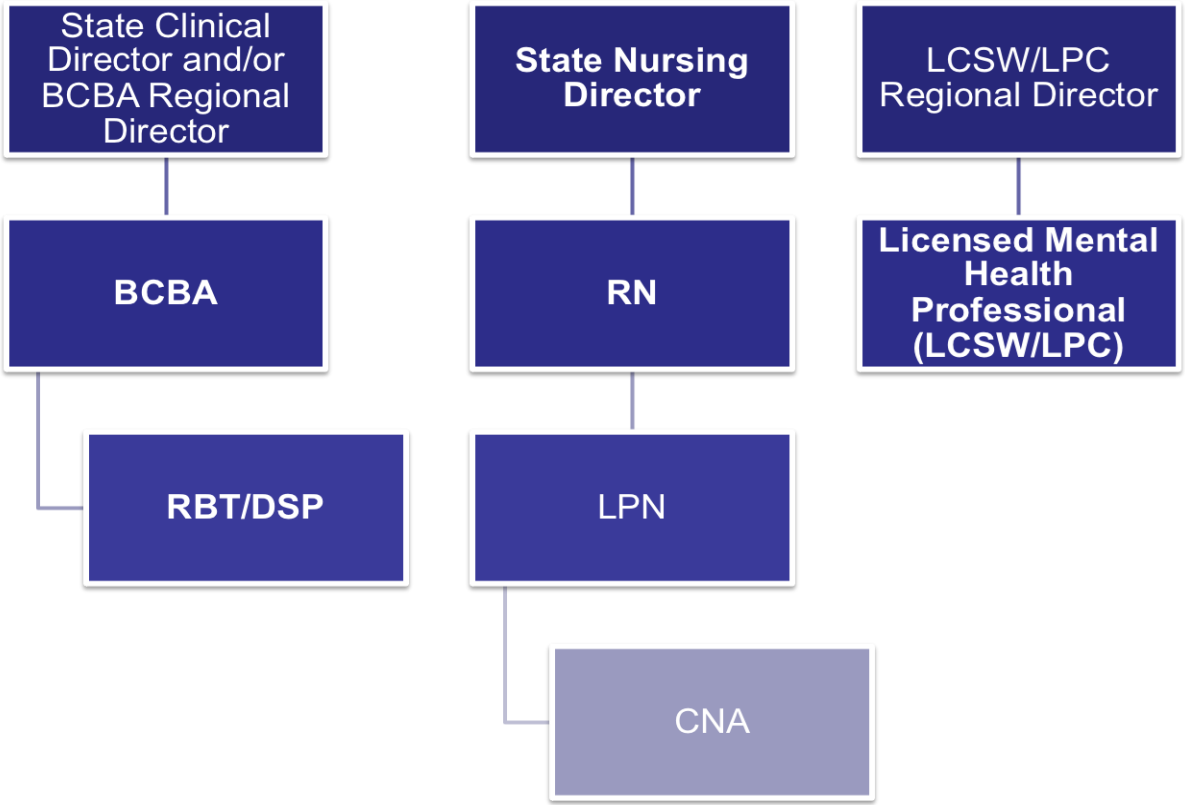
Team Approach

- Ensuring effective intervention strategies
    - Data collection – ESSENTIAL!
    - Graphing
- Enhancing outcomes through team-based approach
    - Team meetings
    - Person-centered qualifiers

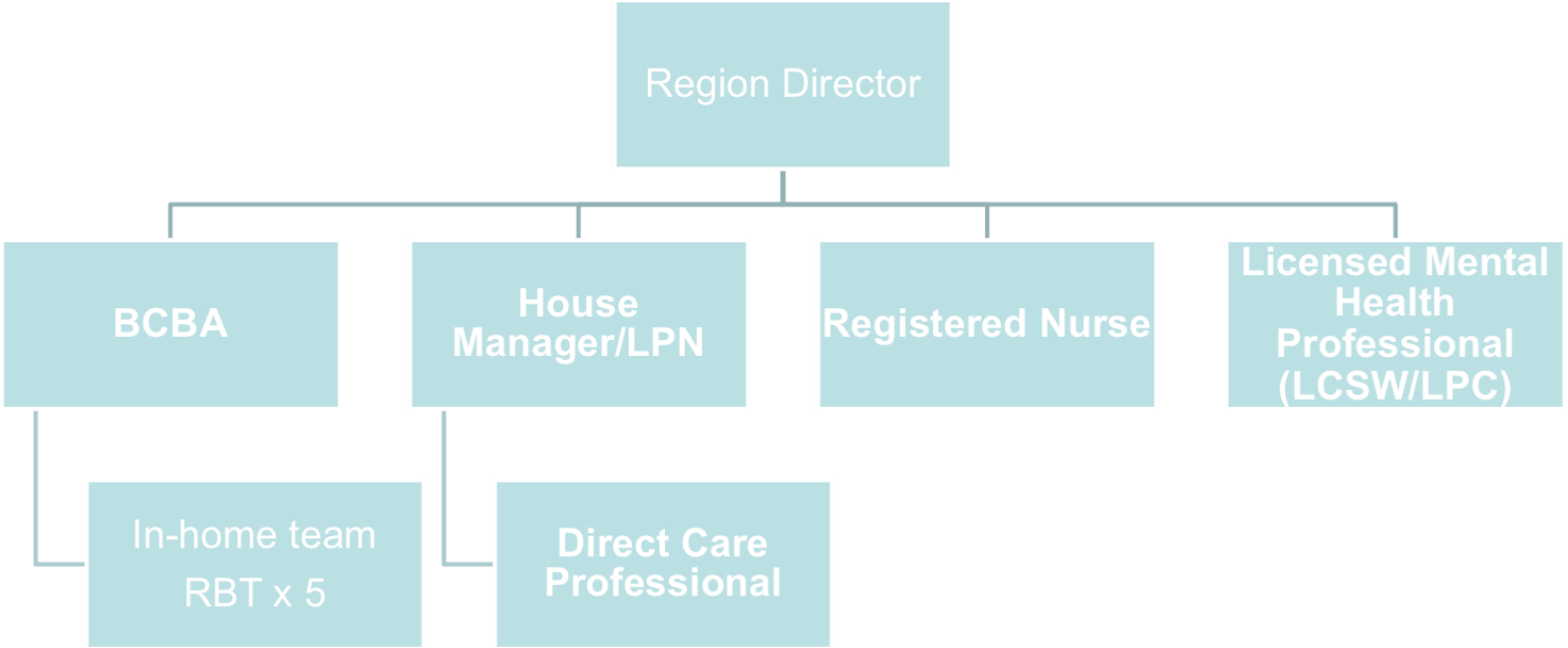
Administrative Staffing Example



Clinical Staffing Example

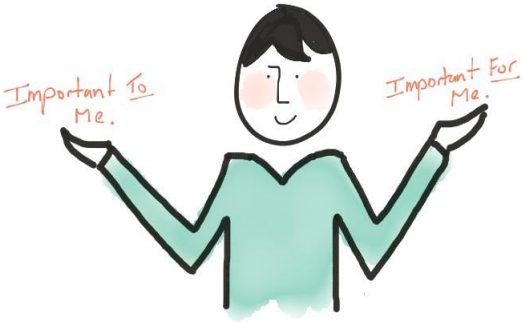


Behavior Program Set-Up



Engagement and Decision-Making

- Involving individuals in their care
- Building person-centered decision-making processes
    - Using person-centered training and tools



Framework for 4 + 1 Questions

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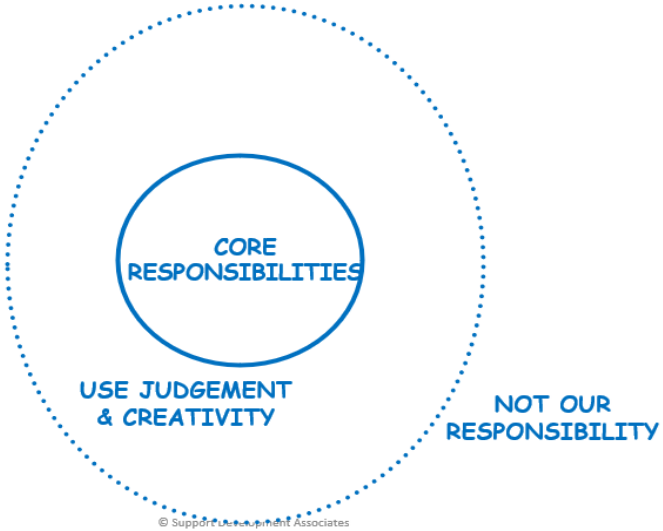
What did you try? 1	What did you learn? 2	What are you pleased about? 3	What are you concerned about? 4
• Bullet point format • Should list all things that have been done • If nothing has been tried, write that here as well	• Be specific • Often can be 'unexpected things' • This is often the 'new' question. Leads into different thinking….	• What aspects really worked well • What gave you/other energy and satisfaction • Would like to see continue	• Did not bring intended results • Didn't 'feel' right… • Should not be continued • On right track, but needs adjusting

1) Look at ALL the information written
2) Thoughtfully consider it all
3) Identify specific actions to take
+1 - Given your learning,
what will you do next?

Challenges and Strategies

- Effective collaboration techniques
  - Clarifying Roles
    - Donut Sort
- Advantages of cross-training
  - Consistency in services
  - Quality of care
  - Happiness of caregivers
  - Happiness of staff



Things To Consider

- Activity Scheduling
- Staff and caregiver training
- PCP and asking GEM?
- Incorporating natural motivators
- Focus on one thing at a time

What does research say?

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Pyramid training Model

- **Clinical Director > BCBA > RBT/DSP**

Direct care staff will not typically do behavior programming without direct supervision and extra reinforcement

Burnout is an organizational issue relating to your culture.

- **“Group home” mentality will strain your behavior programming.**

STRUCTURE AND ROUTINE IS THE KEY

Interactive Exercise 2

Role-play Scenario:

Demonstrating multidisciplinary teamwork

- Discussion Prompts
- Agendas

Implementing Person-Centered Care

- **Definition and importance**
- **Practical steps for implementation**
    - **Person-Centered Tools**

Person-Centered Thinking

CARE FOR thinking

- Places focus on the person's need or disability first
- Promotes doing *for* the person
- Encourages dependence on staff

PERSON-CENTERED thinking

- Places focus on the person first
- Promotes doing *with* the person
- Encourages independence

Person-Centered Practices[2,3]

BENCHMARK HUMAN SERVICES

Important *TO*

- Things that the individual values
- Give a sense of purpose and meaning

Important *FOR*

- Things that others value for the individual
- Promotes issues of safety and well-being

Case Studies and Success Stories

- Real-world examples of person-centered care
- Impact on outcomes

Building Cultural Competence

- Addressing bias in care
- Preventing institutionalized mindset
- Strategies to improve cultural competence

Interactive Exercise 3

Case Study Analysis:

- Developing person-centered care plans
- 4 plus one questions

References and Resources- Websites

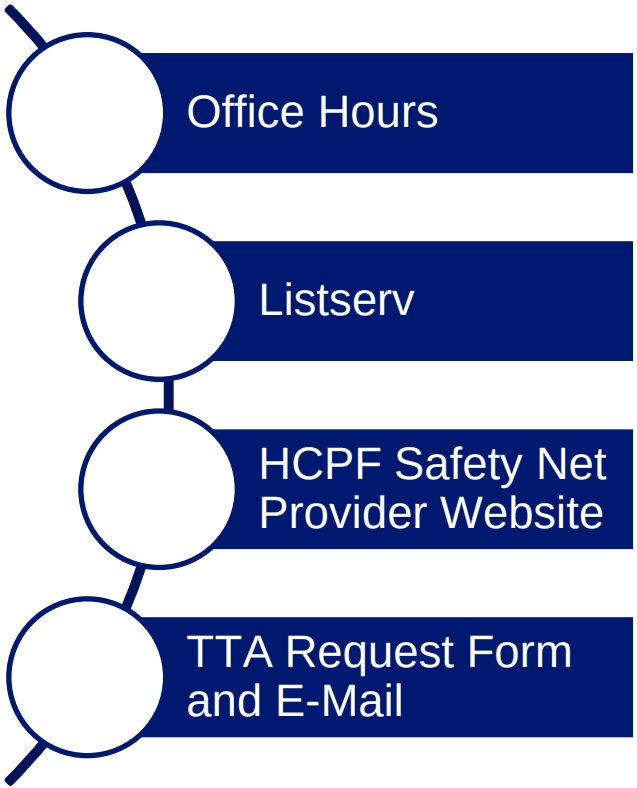
AAIDD: aaidd.org

National Leadership Consortium: natleadership.org

NADD: thenadd.org

MHDD Center: mhddcenter.org

Appendix A: Additional Resources



Office Hours are offered on the last Friday of every month (through September 2024) at noon MT! Please visit the HCPF Safety Net Website for details & registration information.

Join the Listserv to receive notifications of trainings, technical assistance, and other stakeholder engagement opportunities: Register Here

Visit the website for details on upcoming training topics and announcements, training recordings and presentation decks, FAQs and more: https://hcpf.colorado.gov/safetynetproviders

Request TTA support or share your ideas, questions and concerns about this effort using the TTA Request Form or e-mail questions and comments to: info@safetynetproviders.com

Appendix B: References

Blackman, et al. (2022). *Effects of a Systems-Level Intervention to Improve Trainer Integrity in a Behavioral Healthcare Organization*

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