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DEVELOPMENTAL DISABILITY HEALTH SUPPORTS NETWORK PROPOSAL

A WHITE PAPER ON TRANSITIONING REGIONAL COMMUNITY SUPPORT HEALTH SERVICES FROM VIRGINIA'S TRAINING CENTERS : " Creating The Developmental Disability Health Support Network"

INTRODUCTION

This document reviews the history of the Training Centers providing access to individuals living in the community to access gaps in health services, such as dental care. The Department of Behavioral Health acknowledges that as a conceptual model, that additional changes, amendments and issues may occur with implementing this model as the five regional catchment areas. This document provides a launching point or starting point for the provision of health related supports. Through the process of developing a model or variation of the model, enhancements should occur prior to the last network moving off the training center grounds.

The process of creating health support networks in a changing health care environment will be a dynamic, evolving process. This paper addresses some of the factors and processes required to transition Regional Community Support Center (RCSC) supports currently provided through the five Intellectual Disability Training Centers operated by the Department of Behavioral Health and Developmental Disabilities to a community based network of medical, dental and allied health supports.

The white paper proposal was the result of several months of research, interviews, surveys and discussion as to whether RCSC type supports would be needed in a fully integrated service system and if so what could be the structure for such a system of support for individuals. The resulting Developmental Disabilities Health Support Network (DDNSNs) model is somewhat different than the current RCSC models. Each Training Center RCSC developed a different menu of health services available to the community. The draft proposal lays out the current thinking and strategies to transition to a fully intergraded service system envisions a clinical team approach for each of the five Health Care Planning Regions (HPRs) in the Commonwealth.

The intent is to create a network of five clinical teams made up of talented clinicians experienced in supporting individuals with Developmental and Intellectual Disabilities. Inherent in the proposal is the recognition that each region of the Commonwealth has somewhat different support needs. Each of the five DDHSNs would employ the basic model described in the proposal with alterations made depending on regional needs. Significantly different aspects of the proposed DDHSN model from current RCSC practices include the use of teleconferencing to maximize clinical resources and expansion of efforts to assist community based professionals in their understanding and comfort in serving individuals with disabilities.

BACKGROUND

The Department of Behavioral Health and Developmental Services (DBHDS) (formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services) created Regional Community Support Centers (RCSCs) at the behest of the General Assembly in 2004.

The General Assembly appropriated continuous funding of $350,000 for the previously operating RCSC at Northern Virginia Training Center and $200,000 for each of the other four Training Centers in the Commonwealth to implement the RCSC concept throughout the state.

The RCSCs have provided a wide range of medical, dental, behavioral and allied health services to citizens with intellectual disability living in the community since 2005 (1996 in Northern Virginia). The Commonwealth is undergoing a transformation from residential services provided in large state operated Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IDD) to small community based residential options. One important aspect of this transformational process is assurance that the supports provided by the RCSCs be continued as the training centers currently providing these services are closed during the next several years.

A former facility director familiar with the RCSC service and an advisory group were charged to develop a proposal for how such a transformation could be accomplished. The result of the work of that group is described below. Of note is that the Advisory Group recommended changing the title of the facility based RCSC programs to the more inclusive Developmental Disabilities Health Support Network (DDHNS). It was thought that this new title would better describe the DDHNs as five regional offices with a common mission and procedures designed to support individual citizens and to help in building and supporting health related infrastructure serving persons living in the community. This new title will be used in the rest of this proposal except in cases historical reference to RCSCs is required.

RESULTS OF PAST RCSC USAGE, NEEDS SURVEY, MEETINGS, INDIVIDUAL DISCUSSIONS

The DBHDS completed an analysis of recent usage of the five RCSCs. To date more than sixty stakeholders have been interviewed regarding needed clinical supports for individuals currently living in integrated community settings and those individuals moving to such settings from state operated Training Centers. In addition, a needs assessment survey developed by the Virginia Network of Private Providers and the DBHDS was sent to members of the Virginia Network of Private Providers and the Developmental Services of all Community Service Boards (CSBs) in the Commonwealth.

Results of this information gathering process indicated a wide range of needed supports with a fairly consistent consensus regarding the most needed and used services as detailed below:

> Dental Services: Medicaid does not provide reimbursement for dental services of adults in Virginia except in medically related cases. This lack of reimbursement is the main cause for dental services consistently being the most utilized RCSC service
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> Medical: The most frequently mentioned physician services needs were Neurology, Psychiatry, General Medical (especially differential diagnosis), and Podiatry
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> Laboratory: Individualized supports may be needed for individuals who resist the drawing of blood

Nursing Consultation: Particularly mentioned was the need for consultation with residential and medical providers regarding medical support issues unique to some individuals with Intellectual and Developmental Disabilities (I/DD).

Behavioral Consultation: Behavioral consultation should include licensed therapists willing to provide continued services through the Medicaid Waiver: Surveys and interviews with stakeholders indicate that there is a pent up need for behavioral assessments, consultation and interventions for individuals leaving residence in the training centers as well as persons already living in the community. The START program has positively impacted this issue but it continues as a major concern for stakeholders.

Physical Therapy/Wheelchair Adaptations: While not frequently noted in the usage or needs survey, interviews with stakeholders indicate a gap in services designed to provide individualized seating systems as well as environmental modifications for residences

Speech and Language Pathology: Important for communication development. Especially effecting in developing social/behavioral supports and in assessment/treatment for eating/swallowing disorders

Occupational Therapy: Attention is needed for professionally developed programs for individuals with eating/swallowing disorders, OTs and SLPs typically work together with this type of problem

Other: Development/enhancement of community supports through staff/family/provider training and expansion of and support for community clinical providers

ISSUES AND OBSERVATIONS

As indicated in the usage study done by the DBHDS, dental services have been the most used service. The state operated Training Centers have chosen to provide this service utilizing three models.

- One facility provides dental services with state employee dental professionals at the onsite dental suite.
- Three facilities provide dentals services with community contract dentists at the onsite dental suites.
- One facility contracts with community dentists to provide services at the dentist's office.

Interviews with DBHDS and CSB employees indicate that there are community dentists who might be willing to serve more individuals with ID if individualized behavioral supports and financial payments were provided. A number of private providers have identified community dentists who are able and willing to provide services for these individuals; however they are not available in all areas and, as mentioned above, funding for the services is a challenge. The DDHSN Project Coordinator is currently working with the Executive Director of The Dental Association of Virginia Foundation to execute a Memorandum of Understanding for receipt of some dental services from members of the Dental Association with concurrent behavioral and logistical supports from the regional DDHSNs.

Dentistry is the most utilized and requested DDHSN service. However other medical and allied health services are also used and continue to be requested for persons currently living in community settings. In addition, persons moving from training centers as a result of Virginia's commitment to a more integrated approach to supports for individuals with I/DD are also continuing to access services.

There is a cadre of dedicated, experienced medical and other allied health professionals working as members of interdisciplinary teams supporting residents of training centers. Some of these professionals

may be interested in continuing to support persons with I/DD as those persons live in more integrated settings. Expansion of the services that have been provided in the RCSCs to involve those professionals in the creation of a new model of comprehensive community based supports is a logical outgrowth of the original RCSC concept envisioned by the General Assembly and the DBHDS.

In addition to services provided there are several decisions that will need to be made about the DDHSNs including future offices for the program. DDHSN office locations will need to be accessible for individuals, integrated into the larger community and hopefully close to medical specialty providers. Possible opportunities to co-locate include Community Service Board offices, local hospitals, regional universities or community colleges with nursing and/or other allied health programs, or stand alone office spaces leased by the Commonwealth. Co-locating would reduce the need to lease offices or other spaces—allowing the services to be delivered across a wider catchment area.

Technology, especially telemedicine technologies, has not been utilized heavily by the facility based RCSCs. With new emerging technologies there is an opportunity to expand clinical services throughout the Commonwealth at costs that are much less than earlier telemedicine systems used in Virginia. DDHSNs could house regional hubs for such technology and should utilize telemedical technology for more efficient use of clinicians' time and more timely responses to emerging individual needs. In addition, DDHSN could integrate with other telemedicine initiatives such as the one for behavioral health needs in Health Care Planning Region I.

The development and expansion of networks of community based clinical providers should be a natural outgrowth of the closure of the Training Centers. As indicated above, a large number of clinical providers are and have been employed in the Training Centers. This group of skilled professionals could become a part of such networks if given incentives to participate in an expanded community based system of clinical supports.

PROPOSAL

Implementation of changes in the DDHSN support system should be completed in stages with initial implementation in Health Care Planning Region (HPR) 4 due to the closure of SVTC within the next year. Implementation in other HPR's would be based on planned availability of current staff, closure dates for the remaining three Training Centers and lessons learned from the Region 4 model. Initially the DDHSN program would be a hybrid model of state operated and private operated services. After testing and refinement of the new model, operation could be transferred to the regional CSB structure which exists now to manage other programs such as START or other community programs. In each region, a working advisory/planning committee made up of representatives of the DBHDS, the CSBs, the provider community and a self-advocate representative should guide the development, implementation and ongoing operations of the community based DDHSN. Individuals to be served by the DDHSNs would include those children under the age of six who are at developmental risk and those persons over the age of six who have either a developmental disability or intellectual disability diagnosis.

Though a more detailed structure for the new DDHSN model needs to be developed, we have basic skill and clinical expectations for the program. Initial staffing for the program is envisioned to be a clinical team made up of current Training Center professionals. Core team makeup would include a Coordinator/Team Leader, a Certified Nurse Practitioner or Registered Nurse, a Physical Therapist, a

Speech and Language Pathologist, an Occupational Therapist, a behavior specialist, a Developmental Support Professional and an Office Manager responsible for scheduling and reimbursement activities. It is anticipated that several current Training Center employees would be interested in such assignments. There may also be clinicians working in community programs who have interest in employment with the DDHSN. In the Region 4 startup of the new DDHSN program, persons assigned to the DDHSN team would transition to their new duties as quickly as the SVTC Director determined that this could be done without undue disruption of supports for individuals remaining in residence at SVTC. John Randolph Hospital in Hopewell was identified as a possible office resource by the Region 4 CSB Intellectual Disability Directors. The hospital has indicated a willingness to provide a community based work space for a DDHSN a team. Once the workgroup is in place, there may be additional recommendations for the location of the community RCSC program for Region 4.

The remaining Training Centers would begin to transition to the new DDHSN model after the initial Region 4 program is operational and as the Training Centers have downsized to the point that some or all current team members could be freed up from Training Center duties without unduly impacting day to day Training Center operations. Movement toward the transition model should not be based on anticipated closure dates only, but on availability of Training Center professionals interested and capable of implementing the model in their respective regions.

This core team of professionals would have several interconnected responsibilities. The focus of team members should be interdisciplinary in nature with each team member required to be knowledgeable of all aspects of habilitation not just the specific tenets of their clinical specialty. Duties would include the provision of direct services for persons needing supports not available to them in their home communities; behavioral and other supports needed for individuals receiving dental, medical and laboratory services provided by local professionals; assistance in the development of an expanded network of clinical providers in the region; assistance with individuals in obtaining needed specialized equipment; adaptation of specialized equipment for individuals; and provision of large group training programs for individuals, families and providers. Additionally, this expanded DDHSN concept could provide opportunities for internships and clinical rotations for students in medical and allied health training programs. The NVTC RCSC currently provides training for community clinical providers including CEU credits paid for by the facility as an inducement for clinicians to participate. Each regional DDHSN should include such a practice moving forward.

The regional DDHSN and REACH Crisis program should develop close working relationships and institute cross-training processes, as it is anticipated that each program will be supporting some of the same individuals. This sharing of information should assist each program in achieving their respective missions and, most importantly, provide enhanced supports for citizens with I/DD living in Virginia.

As in current practice, the CSB's would serve as the single point of entry for DDHSN supports and screen individuals to ensure that supports are needed and not available in their home communities. This screening process could also serve as an on-going needs assessment for the CSB and the region. As the new DDHSN model is established in each region, the DDHSN teams should provide informational training sessions describing available services through the DDHNSs for individuals, CSB Support Coordinators, residential providers and community medical and allied health clinicians. Regional lines should be blurred if an individual is in need of a service not provided in one region but provided in

another region. Utilization of telemedicine technology will be helpful in such circumstances. Standard policies, procedures, forms, etc. should be utilized by all regional RCSCs. One of the initial duties of the Region 4 Team should be to assist the RCSC Coordinator in development of these processes.

Dental and primary medical services not provided by the core team described above would be provided by local dental and medical providers. For dental services a "voucher system" would be established to provide financial support for individuals without dental insurance or who were otherwise unable to afford dental care. A sliding scale based on ability to pay including a co-pay amount would also be utilized to assure that individuals provide some financial contribution to their dental care. Such a sliding payment scale could also be used for medical services in the rare circumstance that an individual did not have any form of health insurance.

In addition to the regional core team of professionals, a senior group of medical professionals made up of a primary care physician, a neurologist, and a psychiatrist with experience working with persons with I/DD would be employed under contract or as part time employees to provide telemedical consultation for community medical professionals on an as needed basis.

The DBHDS should assign primary oversight and coordination of the regional DDHSNs to a DDHSN Coordinator. This person would work the core clinical team and core team leader to assure that the guiding principles and common procedures of the DDHSNs are implemented consistently throughout the Commonwealth regardless of the community based entity operating the DDHSN for a given region.

NOTE: Of the five HPR Regions, Region 4 is in the best position to begin the approach to dental and primary medical services as described in the paragraph immediately above. SVTC RCSC dental services are currently provided by a local dentist in the dentist's own office. In addition the Virginia Dental Association Foundation mentioned earlier is already well established in the Southside area. There are primary medical providers in the region and Hiram Davis Hospital is equipped to provide backup dental and lab services if an individual could not be supported using this community based model due to especially challenging behaviors. If such a case were to arise, the core team would be responsible for designing a treatment approach to assist the individual to the point that the use of the backup system was no longer needed.

Two part time technicians (possibility half-time positions, this would need to be determined after a few months of operations of the Region 4 transitional DDHSN program) would be hired to provide wheelchair modifications and other personalized adaptive equipment. One technician would be assigned to the East Central area of the state and one to the Southwest/Central area. Each would work under supervision of the DDHSN core teams as individuals' needs for their work are identified by the teams. Ideally, each of the part time technicians would have a van assigned for outreach efforts.

The core team described above would occasionally see an individual at their office location but much of their work would be done on an outreach basis with visits to home, day activity and dental/medical appointments. Team members would have access to teleconference technology to maximize efficient use of their time and expertise. An emphasis for the team should be the expansion of current training activities including the use of traditional (large and small group training sessions, information booths/presentations at state and regional conventions, office open houses, etc.), and non-traditional (web sites, use of social

media, web based question and answer forums, etc.) to enhance the knowledge of individuals, their families as well as residential and clinical providers.

BUDGET

A very rough estimate of staff costs for the clinical team would be $600,000 per year. This is based on a review of the average salary and benefits for persons in such positions currently employed by DBHDS. Estimated annual cost for the three senior consultants would be $180,000. Community medical providers, other than dentists, can be and are reimbursed through Medicaid, Medicare and private insurers. Estimated cost for two part time rehabilitation engineer technicians and their required support is $80,000.

SVTC is expected to spend approximately $120,000 of its $200,000 RCSC funds this Fiscal Year for their dental contract. With movement of the remaining less than one hundred individuals currently residing there it is safe to assume that much of the remaining $80,000 will need to be utilized for dental services utilizing a "voucher system" to provide financial support for those individuals unable to afford dental care. Initial start up costs would include computers and teleconferencing cameras for each team member (CISCO has developed a HIPPA compliant system at a very low start up and monthly user cost) and access to at least three vehicles. John Randolph Hospital has estimated office rental of $37,750 per year for 2,000 square feet of office space. As there are probably other costs not yet identified, an optimal RCSC service as described above would cost roughly $1,300,000 per year per region.

Current funding for RCSC services is $200,000 per year ($350,000 for NVTC). This funding should continue with additional continuing funding of $1,100,000 ($950,000 in additional funding for the Northern Virginia region) for each regional RCSC. Physician consultation, Psychiatry, Physical Therapy, Speech and Language Therapy, Occupational Therapy, Psychology/Behavior Consultation, and some Nursing consultation will be reimbursable by Medicaid State Plan, Medicaid Waiver, Medicare or private insurers. In addition, some environmental modifications including wheelchair repairs/modifications may be reimbursable by Medicaid State Plan, Medicaid Waiver or possibly the Individual and Family Support Program for persons on the wait list for Medicaid Waiver services. Additionally a minimal payment sliding scale based on ability to pay should be developed for those persons receiving services who do not have any insurance and a small co-pay plan developed for individuals with insurance.

OTHER ISSUES

The DBHDS should consider providing incentives in the form of time off and tuition reimbursement for currently employed Psychology Associates identified as the most appropriate group who would be able to obtain to obtain certification as Applied Behavior Analysts or endorsement as Behavior Support Facilitators prior to the closing of respective Training Centers. Presently, there is a pent up need for the expertise of such professionals in the community.

Consideration should also be given to designing a plan to allow current Training Center clinical professionals who might be interested in becoming members of the clinical core team described in this proposal to maintain their status as members of the Virginia Retirement System regardless of which

community entity operated the DDHSN for a particular region. Such a plan should serve as an extra inducement to encourage the most talented Training Center clinicians to continue to serve individuals with development disabilities in the Commonwealth.

Some aspects of the model described above may not be effective in some regions of the Commonwealth. As an example, shortages of dentists exist in Southwest Virginia. There are alternatives for this concern that will be explored and should be in place prior to the closure of the Training Center serving this area.

The DBHDS and Training Centers other than SVTC can begin to implement parts of the DDHSN model years before closure as the census of the Centers become smaller. The issues described above including identifying training center staff assigned to the new DDHSN model, identification of community based locations for the service, identification and remediation of regional gaps in available community providers and alterations to the model based on lessons learned from the initial implementation in Region 4 will need to be addressed on an on-going basis until full transition to a community based DDHSN program occurs.