New Mexico Best Practice Model for Serving Individuals with Developmental Disabilities and Mental Illness

Individuals with co-occurring developmental disabilities and mental illness are a particularly vulnerable population, usually poorly understood and underserved by social service organizations. Their unique challenges create formidable obstacles to funding and delivery of services. Most individuals comprising the population require a coordinated array of support and treatment options only partially found in either the developmental disability or mental health systems. Services are organized to address either one condition or the other, but usually not both. Out of this reality a need was seen for development of a service delivery model that utilizes and promotes best practice concepts from the fields of developmental disabilities (DD) and mental illness (MI).

Benefits of the model include:

- Accurately diagnose and provide enhanced treatment for individuals with co-occurring conditions of mental illness and developmental disability
- Train existing staff to work effectively with these individuals
- Become a best practice site, both clinically and administratively
- Obtain consultation and technical assistance on issues of concern
- Access additional resources and enhance care coordination
- Maximize revenue opportunities through technical assistance on billing for services
- Obtain assistance to work effectively across systems
- Maximize resources from all systems
- Identify and utilize seed money to implement the pilot

The values surrounding medication use and program models are different in the two systems. Those involved in both planning and implementation of the new system need to be aware of the core values driving services in each field, as values from both fields are relevant in addressing different circumstances or periods of an individual’s life.

Core Values

<table>
<thead>
<tr>
<th>Developmental Disabilities</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the field of developmental disabilities, essential services include community involvement and employment.</td>
<td>In the mental health field people need to have a safe place where they can feel welcome and secure. The community is not always that place.</td>
</tr>
<tr>
<td>Staff are the community connectors for the individual and must believe that with proper supports success is possible. Staff must also be able to operate “out of the box” when it is the right thing to do for an individual.</td>
<td>The specific methods for helping a person with a mental illness to be stable must be appropriate to the diagnosis and symptoms</td>
</tr>
<tr>
<td>Medication use is often viewed very cautiously due to misuse in the past.</td>
<td>Medication can sometimes be the primary method of helping a person with mental illness stabilize enough in order to perform normal everyday functions.</td>
</tr>
</tbody>
</table>
Critical Clinic Roles and Responsibilities Identified

Key members of the Adult DD/MI Taskforce, who represented the agencies below, were involved with the development of the model.

<table>
<thead>
<tr>
<th>DD Provider Agency Administrator &amp; Program Coordinator</th>
<th>DDSD Regional Office &amp; Office of Behavioral Services</th>
<th>TEASC Project Coordinator &amp; Clinic Facilitator</th>
<th>COC Co-coordinator RN MD Regional Medical Champion</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSD Medical Assistance Division staff</td>
<td>TCCS Psychiatrist &amp; Clinic Coordinator</td>
<td>MCO Behavioral Health Directors</td>
<td>DHI Medical Director</td>
</tr>
</tbody>
</table>

On a quarterly basis, the psychiatrist from the local mental health center identifies clinic participants from their caseload. Identified individuals come in person to meet with the group, which sometimes includes members of their individual service planning team. At times it is more comfortable for some individuals and/or families for a smaller team to meet and evaluate the person in his/her home, review records, and then provide findings to the clinic team. The full clinic team then comes up with recommendations to improve services to meet the needs of the individual.

The position critical to keeping the team organized and focused is the clinic coordinator. It became clear that the clinic itself and the coordinator position need to become embedded in the normal activity and responsibility of the Mental Health agency, with ongoing technical assistance as requested. The responsibilities of the clinic coordinator are as follows:

**Before clinic**
1. Triage referrals to assure individual meets criteria
2. Collect all relevant information from the individual’s medical and behavioral health history
3. Notify the PCP that the individual was referred to the clinic and extend an invitation to attend or provide input
4. Collect intake information from case managers at the MHC and DD provider agency
5. Coordinate scheduling of all clinic participants, as far in advance as possible, in respect of busy schedules

**During clinic**
1. Present intake information including medication and latest evaluations
2. Keep the team focused
3. Assure all paperwork is completed, including necessary consent forms and clinic summary form

**After clinic**
1. Assure that clinic summary form is distributed to relevant parties
2. Follow-up on implementation of recommendations
Clinics occur at the local provider agency and are scheduled for a half-day, depending on the reasons for the individuals' visits. A typical clinic session for a new individual usually runs about two hours and begins with a visit from the local mental health center and University psychiatrists; other professionals may be included in the visit when appropriate. This "intake" team then presents relevant issues and findings to the full clinic interdisciplinary team in order to identify appropriate medical, psychiatric and programmatic treatment. This procedure has been found to be more comfortable for most individuals. When appropriate, an individual may return to the clinic for a follow-up session; these sessions may or may not include the individual, and typically run about an hour in length. Accurate scheduling is critical for clinics to be time and cost effective.

The clinic has standardized forms for clinic coordination and uses a formal protocol for evaluation. The purpose of each clinic is twofold:

1. Review situations of individuals with a co-existing condition and determine if there are unmet medical or treatment needs and/or possible resources to support them.
2. Review individuals' situations to identify the impact of the initial recommendations. This may include a review of additional needs or changes in the individual’s situation.

The range of topics discussed during the clinic generally includes medication reviews, treatment evaluation, and brainstorming to find resources; the results vary widely from one individual to another and are summarized in a set of formal recommendations. Because the team is composed of such a wide range of members, the collaborative problem solving has been very effective in recommending services that start with the person. Participants are experiencing a better quality of life overall; lives have changed dramatically in some instances.

**Replication and Expansion into a Unique Psycho-social Rehabilitation Program**

When it was decided that a day service was needed to support the recommendations of the clinic and the needs and interests of individuals with DD/MI who were not thriving in the Taos ARC day services program, TCCS and Taos County ARC agencies once again merged resources and expertise to develop supportive service options. The participants named the program Tempo.

Tempo is a psychosocial rehab (PSR) program for selected individuals. Each person participates for the length of time they need. Some only drop in for an hour or two, others stay the entire six hours, and others work part time. This program focuses on the enhancement of skills related to successful social interactions within the community and education on related skills (i.e. hygiene, personal space, reciprocity, communication, awareness of others and respect for personal space). The program includes feedback, practice, and building maturity and community. The process is not quick; time and patience are necessary. Tempo has been successful in creating an environment where participants feel welcome and safe. People are receiving the services they need and enjoy.

Skills are taught within the context of typical adult activities. Many of the participants are demonstrating true artistic capacity. Another favorite activity is preparing a lunch meal together (the enchiladas are becoming legendary!). The direct line staff are from the Taos County ARC, the building site and program coordinator are provided through TCCS, and oversight and problem solving is a joint function of both agencies.
There have been some differences in focus between the PSR and current best practice in services for individuals with developmental disabilities. Services in the DD field have stressed community inclusion and integrated work settings. Although these are important at Tempo, the main focus has been more on creating an educational and therapeutic environment fostering positive self-image, acceptance and group interaction skills. The two services have been learning from one another and the process continues. The Collaborative Arts program is bridging the differences.

Tempo opened a community-based art gallery that features exhibitions of artists in the Tempo program, TCCS clients and the general community. While this provides an entrepreneurial opportunity for Tempo artists, emphasis is placed on supporting the recovery process through regular social and business interactions in a typical community business venture. The focus on enhancing employment skills and supporting creativity while increasing opportunities for self-advocacy is moving the collaborative and all its participants forward.

Training for clinic and agency staff was critical to develop their expertise with the complex support needs of participants. Behavior therapists and case managers, funded through the DD Waiver, were trained to support individuals with developmental disabilities, but did not have in-depth training on treatment protocols and resources for individuals with mental health issues. Taos County ARC staff were trained to provide general supports to individuals with developmental disabilities, but needed training on how to support mental health issues. TCCS staff were skilled in mental health treatment, but were unaware of best practices in service provision to individuals with developmental disabilities.

General topics for training sessions
- Overview of mental health and developmental disability diagnoses
- What behaviors are likely to be observed
- Various learning styles
- Medications and particular drug interactions/side effects
- Functioning as a team
- How to monitor and effectively address challenging behavior
- How to determine what skills, knowledge and activities are meaningful for participants
- How to teach skill acquisition
- How to understand and support human sexuality

Replication of Clinic

NM Developmental Disabilities Planning Council awarded a grant to the DD/MI Committee to replicate this model in two rural sites of Shiprock and Roswell New Mexico. Input from the community providers is critical in development of this project. The long-term goals are to enhance the care of individuals (with developmental disabilities and mental illness) and assist with the improvement of other local systems of care issues.

Site Criteria
The criteria for the replication sites are as follows:
Community Mental Health Center (CMHC) or other community-based entity in a rural area (excluding the Albuquerque and Santa Fe areas)
An entity that provides core mental health services, including psychiatric services
An entity that currently includes and/or has access to a primary care physician as part of the treatment team
An entity that serves the DD/MI population in its current caseload
An entity willing to assign a small team to partner with the state and other resources
An entity willing to serve an additional 5-10 individuals with both MI and DD
An entity with access to telemedicine would be helpful

Benefits of participation
Benefits of participation included support from multiple resources to:
Train existing staff to work effectively with the DD/MI population
Become a best practice site, both clinically and administratively
Obtain consultation and technical assistance (TA) on issues of concern
Access additional resources including seed money
Enhance care coordination
Maximize revenue opportunities through TA with billing for services provided
Assist in working effectively and partnering with DD Waiver providers
Accurately diagnose individuals with DD/MI
Resolve ongoing issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Assistance to Replication Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinical complexity/etiology of the presenting problem</td>
<td>1. At no additional cost, clinical consultation from UNM transdisciplinary teams* with expertise on the DD/MI population through on-site joint evaluation, telemedicine, or by phone.</td>
</tr>
<tr>
<td>2. High cost population (time and resources)</td>
<td>2. Assistance/training in methods of more effective and efficient care, with methods to maximize revenues and billing.</td>
</tr>
<tr>
<td>3. Difficulty with coordination of resources across systems</td>
<td>3. Assigned point person to assist in coordination with Waivers, Salud! (Medicaid Managed Care), Medicaid Fee for Service, Value Options (Managed Behavioral Health Single Entity), Primary Care Practitioners, etc.</td>
</tr>
<tr>
<td>4. Confusion regarding roles of the various state agencies and when/how to interface.</td>
<td>4. Facilitator assigned to assist in developing local interagency agreements and/or protocols.</td>
</tr>
</tbody>
</table>

*TEASC and COC

Entry criteria for all individuals:
Referrals are made through the Clinical Coordinator, and will be accepted for any individual who:
1. is 18 years of age or older;
2. who has the dual diagnoses of developmental disabilities and mental illness (DD/MI); or who has a mental illness and is suspected of having a developmental disability;
3. lives within the geographical area served by the replication site, and
4. would benefit from the services of the DD/MI clinic.

The individual can be seen regardless of whether or not they currently have a funding source. Referrals to the pilot clinic can come from the individual, their family, their support team/agencies (for those individuals who have a support team), community agencies, and local/state agencies.

**Exit criteria for Individuals being served through the DD Waiver:**

1. Clinical Coordinator for the Pilot Project Clinic will coordinate with DD Waiver case manager for issues directly related to their appointment(s) with the Pilot Project Clinic team. The DD Waiver case manager will be strongly encouraged to attend all pilot clinic appointments.
2. Following an appointment with the pilot clinic, the Clinical Coordinator will confirm that the DD Waiver case manager received a copy of the recommendations and understands the need to convene an IDT to discuss those recommendations. The Clinical Coordinator will request that the DD Waiver case manager send a copy of the IDT minutes for the Pilot Project Clinic file for the individual.
3. The Clinical Coordinator will make one additional follow-up call—according to the timeline set out in the recommendations from the Pilot Project Clinic (2-8 weeks depending upon circumstances) to determine status of follow-up. Findings will be reported at the next clinic.
4. If the Clinical Coordinator determines that follow-up by the DD Waiver case manager and/or IDT has been insufficient, or the IDT is experiencing significant barriers, the Clinical Coordinator will immediately report the need for technical assistance (TA) to the NE Regional Office of the Developmental Disabilities Supports Division (DDSD).
5. The Clinical Coordinator will briefly summarize the case at the next Pilot Project Clinic and close the case.

**Exit criteria for Individuals currently not being served through the DD Waiver:**

1. Clinical Coordinator will provide targeted case management services, including implementation of recommendations, until such time as the stated goals and/or recommendations from the Pilot Project Clinic appointment(s) have been completed.
2. Once recommendations are met, the Clinical Coordinator will deliver a proposed “exit” report at the next Pilot Project Clinic—including proposed referral to alternative source for ongoing case management. Alternative sources of ongoing case management include:
   a. Taos/Colfax Community “regular” case manager
   b. Salud Medical case manager
   c. Other available Behavioral health case management services
3. If Pilot Project Clinic team agrees that case closure is appropriate, Clinical Coordinator will arrange transfer to another source of ongoing case management and then close the case.

**NOTE:** After case closure, regardless of whether the individual is served through the DD Waiver, or is still waiting to be served through the Waiver, if the individual or their family/team believe that circumstances have deteriorated to the point of again needing to be seen in the Pilot Project Clinic, a referral can be made to the Clinical Coordinator, and if warranted, the case can be re-opened.
Ongoing Support Resources

TEASC
(505) 272-2579  PBeery@salud.unm.edu
Continuum of Care
(505) 925-2350  areeve@unm.edu; pennye@unm.edu
DDSD/NM Department of Health
(505) 841-6546 Chris Heimerl  chris.heimerl@state.nm.us
(505) 841-2983 Jill Ryan  jill.ryan@state.nm.us
(505) 222-6693 Jennifer Lehman  Jennifer.Thorne-Lehman@state.nm.us
Human Services Department
Karan Northfield  karan.northfield@state.nm.us
Taos County ARC
(505) 758-4274  joser@taoscountyarc.org
Taos/Colfax Community Services
(505) 758-1125 x 219
Mary Thomas, Kim Hamstra

www.unmcoc.org
www.health.state.nm.us/ddsd

NM Developmental Disabilities Planning Council 505-476-7331