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

HISTORY OF THE TAOS PILOT CLINIC

The DD/MI Taskforce was developed to identify problems and solutions for the DD/MI population. The taskforce is made up of representatives from the Medicaid state agency (HSD/MAD), the Department of Health (DOH) Developmental Disabilities Supports Division (DDSD), The University of New Mexico (UNM) School of Medicine Continuum of Care Project (COC) and Transdisciplinary Evaluation and Support Clinic (TEASC), the Behavioral Health Services Division (BHSD), and representatives from the Medicaid Managed Care Organizations. The taskforce:

- Examined philosophies of each agency and discussed the differences and similarities;
- Identified ways to foster authentic collaboration with lasting effects;
- Reviewed and clarified regulations, guidelines and billing procedures;
- Identified outcomes and criteria for upcoming pilots;
- Brainstormed ways to braid funding sources in a manner respectful of the regulations;
- Identified seed money; and
- Developed the clinic model.
As issues were identified, the DD/MI Taskforce developed preliminary outcomes. It was hoped that from these outcomes a solid collaboration would be developed and sustained as the taskforce supported other areas of New Mexico.

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<th>Issue</th>
<th>Outcome</th>
<th>Support Provided</th>
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<td>Clinical complexity and etiology of the presenting problems</td>
<td>Skilled diagnosis and treatment</td>
<td>Consultation with experts from TEASC, DDSD and COC</td>
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<td>High cost population in relation to time and resources</td>
<td>More cost and time effective delivery of quality services</td>
<td>Technical assistance in use of both resource-sharing and best practice techniques</td>
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<td>Difficulty in coordinating and utilizing the resources across systems</td>
<td>More efficient use of resources and ease of billing</td>
<td>Review and clarification of regulations and procedures for billing procedures for Waivers, Salud! Medicaid Managed Care, Medicaid Fee for Service and PCPs in order to maximize existing resources</td>
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<tr>
<td>Lack of collaboration between state agencies</td>
<td>Effective collaboration</td>
<td>Assistance in development of local interagency agreements and/or protocols.</td>
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Since many rural settings throughout New Mexico lack available professionals and/or resources, the pilot focused on a project for small rural communities. A unique situation was identified in Taos, New Mexico. An agency that served people with a primary diagnosis of developmental disability identified several complex individuals who had obvious mental health needs. At the same time a psychiatrist at the Taos Colfax Community Services (TCCS), the local mental health center, was interested in learning more about individuals with a diagnosis of developmental disability. Thus Taos became the site for the first pilot combining DD and MH services in New Mexico.

What was learned from the pilot clinic

- Thinking in creative and collaborative ways was essential to resolve long-term issues.
- It was possible to clarify funding and billing in order to build bridges across systems.
- The effort of the taskforce was worth the outcome to individuals.
- Knowledgeable people from Medicaid and the Managed Care Organizations needed to address funding issues; therefore the taskforce identified and added MCO representatives.
- A skilled facilitator was necessary for planning to be effective.
- Clear-cut outcomes and criteria had to be identified at the onset of planning.

Planning process for pilot

The DD/MI Taskforce developed the following criteria for the initial pilot:

- Commitment from a community mental health center and a community based service agency for individuals with developmental disabilities
- Capacity to provide core mental health services, including psychiatric services
- Access to medical consultation by pilot participants
- Target population is part of current caseload of both agencies
Willingness to commit agency staff and resources
- Willingness to serve at least 5-10 individuals with co-occurring conditions
- Access to telemedicine was preferable, but not required

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

**Core Values**

**Developmental Disabilities**
In the field of developmental disabilities, essential services include community involvement and employment.

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.

Medication use is often viewed very cautiously due to misuse in the past.

**Mental Health**
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.

The specific methods for helping a person with a mental illness to be stable must be appropriate to the diagnosis and symptoms.

Medication can sometimes be the primary method of helping a person with mental illness stabilize enough in order to perform normal everyday functions.

**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 clinic pilot.

- **DD Provider Agency**
  - Administrator & Program Coordinator
- **DDSD Regional Office & Office of Behavioral Services**
- **TEASC Project Coordinator & Clinic Facilitator**
- **COC Co-coordinator RN MD Regional Medical Champion**
- **HSD Medical Assistance Division staff**
- **TCCS Psychiatrist & Clinic Coordinator**
- **MCO Behavioral Health Directors**
- **DHI Medical Director**
Once the clinic team was identified, criteria met, and resources established, the clinic was started. Initially, the clinic met quarterly. The psychiatrist from the local mental health center identified clinic participants from his caseload. A form was developed to capture issues and recommendations. 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

**Agency collaboration and funding**

The initial work by the DD/MI Taskforce was especially helpful in interpretation of billing guidelines and code changes to make billing for clinic time more flexible. Physicians and psychiatrists are familiar with billing in 15-minute intervals. The billing coordinator for their offices needed to be well informed on the new and existing procedures to submit requests for compensation for the extended time spent at the clinic (e.g. clarification of billing guidelines and codes permitted compensation for seeing a person in their home or program, the same as in the office, which supported the needs of both the people receiving services and the professional clinic staff). These systemic changes can now be utilized by future projects. Continued technical assistance from Continuum of Care Project and Medicaid help pilot agencies learn how to bill for services more effectively.

**What was learned from the pilot clinic**

- Barriers were seen as problems to be solved, rather than reasons not to proceed.
- Funding issues had to be resolved up front.
- People with dual diagnosis struggle with psychiatric symptoms, regardless of their IQ level.
Values, philosophies and agendas of all agencies had to be explored and differences resolved.

The fact that everyone was at the table together made it possible to assess and address several aspects of the individual’s life at once, (i.e. educational needs, medical needs, medication needs, treatment programs and settings needed by the person receiving services).

Clear roles/responsibilities for all clinic members needed to be established.

The reporting and documentation procedures had to be worked out.

To be effective, clinic coordination needed to be a separate position held by someone local.

The individual’s interdisciplinary team (if they have DD waiver funding) and behavior therapists should be routinely included in all clinics to make sure the recommendations are integrated into the person’s overall plan for services.

Someone on the team served as a liaison to the primary care physician (PCP) to ensure that medical services were identified and provided in a timely manner; planning to support active participation of the PCP should have been identified at an earlier stage.

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

As the pilot has evolved, the benefits have grown. Clinicians on the team feel support from one another, agency representatives feel heard and respected, and the individuals participating have made strides. As the word got out, other groups expressed interest in starting a second pilot. The
NMDDPC awarded start-up funds to the DD/MI committee to provide funding to two replication sites.

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 have named the program Tempo. Although the inception of the Tempo Program and the new Community Arts coalition were not formal outcomes of the pilot, the following information may be of interest to others beginning the planning process. More information on these programs is available from the Taos County ARC. These programs were made possible with flexibility in Medicaid funding, support from the business community and a grant from the Behavioral Health Planning Council (BHPC).

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 to support clinic recommendations

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.

Staff from both systems, were invited to receive intensive training provided by the DDSD Office of Behavioral Services, in conjunction with TEASC and COC. The training was funded and coordinated through DDSD. Tempo staff received 25 training sessions as part of an intensive month-long training starting in February of 2005 and continuing through March of 2005.

Since pilot staff completed this training their expertise and dedication contributed greatly to the success of these innovative programs. Both service recipients and the staff have improved quality of life; people are having fun! The service agency is planning to provide the same training to all agency staff in the hopes that the quality of service and work satisfaction spreads. Once the pilot (clinic and optional programs) has strengthened ties with the existing service planning teams, similar training should be considered to ensure true consistency across all support systems. General topics for the training are included below.

### 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

The pilot contracted for an independent evaluation for the Tempo program. The evaluation protocol was a success-based evaluation, versus traditional evaluation procedures that focus on finding what is wrong. This new evaluation process is becoming a more widely accepted and preferred evaluation strategy, as the information provided prioritizes energy and resources to expand successful aspects of the program, rather than on “band-aiding” perceived deficits. The evaluation strategy is a good match for a project that is founded on collaboration and potential.

Major findings:

- Participants, staff, administrators, and family members appear to be satisfied with the program.
- Participants take part in a variety of activities that they enjoy and have made noticeable improvements since entering the program.
- The intensive training was essential to the success of the program.
- The differences in required reporting and documentation between agencies were underestimated (e.g. what is a reportable incident to DHI).
- Although collaboration among agencies has been successful to date, there is no long-term plan to ensure that collaboration is maintained.
The evaluation includes the following recommendations:

- Identify strategies to enhance involvement of the participants in ongoing program planning.
- Identify strategies that ensure new staff receive the same intensive quality of training.
- Include the issues of required reporting and documentation that satisfy all oversight and funding agencies in the initial and ongoing staff training.
- Develop a plan to ensure ongoing collaboration among all relevant agencies.
- Assure opportunity for ongoing training for all staff.

**Replication**

As mentioned previously, the NM Developmental Disabilities Planning Council has awarded a grant to the DD/MI Committee to replicate this model in addition rural New Mexico sites of Shiprock and Roswell. 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.

**Purpose**

To 1) design and implement a model of delivering behavioral health services to individuals with developmental disabilities in a rural setting which utilizes and promotes best practice concepts, timely access and seamless coordination with medical and habilitative services and 2) provide opportunities for community providers to enhance their skills and expertise in serving this population, thus providing services with more efficiency and effectiveness.

**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>
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<tr>
<th>Issue</th>
<th>Assistance to Replication Sites</th>
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</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>
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<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>
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<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>
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<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>
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*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
References


