Supporting Persons with Co-Occurring I/DD and Behavioral Health Needs: Spotlight on Partners Health Plan New York

Individuals who are dually eligible for Medicare and Medicaid are more likely than other Medicare beneficiaries to have a mental health diagnosis as well as other complex and chronic conditions.[1] Approximately 50 percent of dually eligible adults aged 18 to 64 report experiencing symptoms of a behavioral health condition in the past year, compared to only 14 percent of adults aged 18 to 64 who are not dually eligible.[2] Additionally, it is estimated that 30-35% of individuals with intellectual and developmental disabilities (I/DD) have a psychiatric disorder. [3]

It is critical to coordinate supports for individuals with co-occurring behavioral or physical conditions and I/DD.[4] Integrating mental health, substance use, and primary care services is an effective approach for supporting people with complex behavioral and physical health care needs.[5] Providers and health plans, such as Partners Health Plan New York, are increasingly using individualized and integrated approaches to support individuals with co-occurring needs in achieving their personal goals.

Partners Health Plan New York (PHP) – a not-for-profit managed care organization focused solely on services and supports for individuals with I/DD – serves over 1500 members in nine counties surrounding New York City through a (MMP)Fully Integrated Duals Advantage Plan (FIDA). PHP is the only FIDA nationwide that exclusively serves this population. The providers who founded PHP brought together their decades of experience serving and advocating for individuals with I/DD with the mission of supporting members to live the life they choose and achieve their personal goals. PHP's vision ensures that they address the whole person, integrating care and supports in ways that support the unique needs and preferences of each member. Dually eligible beneficiaries in the service area who are age 21 and over can enroll in PHP if they meet specific eligibility requirements.[6] PHP uses a person-centered approach to planning and delivery of services for dually eligible beneficiaries with I/DD, including the integration of behavioral health. PHP has developed a strong network through sustained

[1] Medicare-Medicaid Coordination Office. (2018). [Fact Sheet] People Enrolled in Medicare and Medicaid. Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

[2] Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. The CBHSQ Report July 15 2014. https://www.samhsa.gov/data/sites/default/files/SR180/sr180-dual-eligibles-2014.pdf.

[3] National Association for the Dually Diagnosed. *Information on Dual Diagnosis.* Retrieved from: http://thenadd.org/resources/information-on-dual-diagnosis-2/.

[4] National Association for the Dually Diagnosed. *Information on Dual Diagnosis.* Retrieved from: http://thenadd.org/resources/information-on-dual-diagnosis-2/.

[5] SAMHSA-HRSA Center for Integrated Health Solutions. What is Integrated Care? Retrieved from: http://www.integration.samhsa.gov/resource/what-is-integrated-care.

[6] Eligibility requirements for enrollment in the PHP MMP require that a member: be at least 21 years old and a US Citizen or lawfully admitted entrant; be entitled to benefits under Medicare Part A and enrolled in Part B, eligible to enroll in Part D, and eligible for full Medicaid benefits; be eligible for New York's Office for People with Developmental Disabilities (OPWDD) services under the New York State Mental Hygiene Law 1.03(22); be eligible require for an intermediate care facility (ICF-IID) level of care, and live in New York City, Long Island, Rockland or Westchester County.

partnerships with local agencies and providers that support seamless integration of medical and behavioral health services.

Assessment and Care Planning for Individuals with I/DD

The PHP approach to assessing and planning care for members with co-occurring I/DD and behavioral health needs aims to understand the participant's goals for their care and to support the care team in getting to know the participant as a whole person. This approach is the basis for PHP's mission and ability to deliver person-centered care to their population. Assessment and planning activities incorporate two major components: Personal Safeguards and Valued Outcomes. Personal Safeguards include all actions needed to keep the participant safe and healthy, including health care, nutrition, fire safety, and personal supports.. Valued Outcomes represent important personal goals that participants want to work towards achieving. These may include goals to gain independence in a variety of areas, including where the person lives and works. All of these goals are identified during the initial interview and assessment process, using PHP's comprehensive *"It's All About Me"* assessment, and on-going face-to-face meetings with the participant's care team. Each member, when they enroll with PHP, becomes part of a care team that is co-led by a clinically licensed care manager (an RN, LCSW, Licensed Psychologist, or Licensed Mental Health practitioner), and a Qualified Intellectual Disability Specialist (QIDP). The care team completes an initial assessment with the member within 30 days (and then annually), which enables the care team to develop a care plan with the member. This assessment approach supports the ability to delve into the person's needs across the full continuum of care as well as their unique preferences and life goals. The assessment process also determines long-term supports and services as well as any referrals to community-based supportive services, habilitation and employment programs, transportation assistance, and other services the participant may be interested in.

PHP Member Story

Julia enrolled with PHP in spring of 2018. She is a 50-year old woman with I/DD as well as schizoaffective disorder, Asperger's syndrome, and anxiety who lives in a subsidized apartment with formal supports and informal assistance from her mother. Julia was hospitalized several times during the summer and fall of 2018 due to challenges managing her symptoms and medications. Julia's care team met to revisit her *Life Plan* with a focus on understanding the precursors to these hospitalizations and, more broadly, how she might take steps toward the goals she had set, including having more friends, being more involved in the community, and obtaining integrated work. Through this process, they recognized that Julia could benefit from more intensive support and connected her to a local Assertive Community Treatment (ACT) program with whom they had developed a partnership.

ACT, an evidence-based practice for individuals with severe mental illness who are at risk for psychiatric crisis and hospitalization, was able to provide intensive support Julia needed to stabilize her symptoms, avoid hospitalization, and work towards her goals. The interdisciplinary ACT team provided Julia with psychiatric, rehabilitation, and support services – supported by careful planning, frequent communication, and a person-centered approach**.** Julia was able to reduce her anxiety and better manage her symptoms through medication management and rehabilitative psychiatry services. She has not been hospitalized since October 2018. With her anxiety better managed, she is able to continue to work towards her goals. She is socializing more and learning to go grocery shopping and to cook with her Personal Care Aide. Her Care Management team also recently linked her with Community Habilitation and Supported Employment services, with the goal of further increasing her independence and work skills.

The resulting care plan, the member's *Life Plan*, integrates preventive and wellness services, medical and behavioral healthcare, personal safeguards and habilitation to support each participant's personal

goals in a robust and easy to navigate documentation system. Once finalized and approved by the participant, all services and supports included in the *Life Plan* are documented in PHP's electronic care management system and distributed to the professionals responsible for delivering the services. This personalized *Life Plan* then drives the care management process for the individual. To put this plan into action, PHP relies on their partnerships with diverse community providers to ensure that participants receive the essential medical, behavioral, LTSS, and other services needed to support health, safety, personal preferences, and valued outcomes. Based on the understanding of each member's needs and values, PHP staff are able to work closely with local providers and community groups to provide those services. For instance, one PHP member's assessment revealed that she wished to more fully engage in her community by participating in classes to learn American Sign Language (ASL). However, she was unable to locate any classes she could afford. PHP's PAL Program[7], which is designed to connect members to community groups according to interests, connected her with a group of individuals with varying levels of skill in ASL. Community connections are important in the life of any individual, and her PAL Program ASL group meets weekly near her home, allowing her to meet friends in her community with similar interests and while learning a new skill.

Partnering to Integrate Behavioral Health Services

PHP's *"It's All About Me"* assessment focuses on understanding behavioral health needs as a central component of each member's overall health and wellness. In addition to a review of symptoms and diagnoses, the assessment asks participants to share "things in the way of happiness" as a jumping off point for a discussion of barriers they can work to

PHP Community Behavioral Health Partnerships in Action

New York State Article 16 Clinics:
https://opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living/article_16_clinics
To ensure access to integrated services (including behavioral health), PHP works closely with Article 16 clinics that are certified by New York State's Office for People with Developmental Disabilities. Article 16 clinics provide clinical services to individuals with developmental disabilities that allow them to remain in a residential setting and are a critical access point for many PHP members. In addition to medical, dental, and rehabilitation / habilitation services, PHP members with behavioral health needs can receive social work, counseling, psychiatry services, and other services through PHP's connections to these clinics and their provider partners.

Personalized Recovery Oriented Services (PROS)
https://www.omh.ny.gov/omhweb/pros/
For members whose behavioral health needs require more intensive services than are available through Article 16 clinics, PHP staff add services and supports to the care plan that are available through the Personalized Recovery Oriented Services (PROS) model for individuals with serious mental illness, such as Assertive Community Treatment (ACT), that are administered by New York State's Office of Mental Health. PROS services are also included directly in the member's benefits package to promote integration of services. These services offer a comprehensive approach that integrates rehabilitation, treatment, and support services and are essential tools for providing intensive support to individuals at high risk of psychiatric crisis or hospitalization (*see Julia's story above*).

New York Systemic, Therapeutic, Assessment, Resources and Treatment (NY START)
https://opwdd.ny.gov/ny-start/home
When there is a significant behavioral health need, PHP members can also access crisis prevention and response services through PHP's connection to the NY START program (a community-based program targeted to individuals with I/DD as well as complex behavioral and mental health needs).

[7] PHP PAL Program. Retrieved from: https://www.phpcares.org/pal-program/

overcome as well as any potential behavioral health services that might provide support. PHP care teams then work to align and coordinate the best combination of services, including behavioral health, to support the individual.

Relationships and integration with appropriate providers are essential for the deployment of this care plan as some providers are not well equipped to meet complex needs of individuals with both I/DD and BH. PHP leadership strategically builds strong relationships to ensure access to a comprehensive network of providers and community organizations for integrated access to behavioral health services. This approach allows care coordination staff to create integrated care plans that take into account all available benefits and services for their members. For examples of key partnerships with community services that allow PHP to integrate behavioral health services, see the *PHP Community Partnerships in Action* section.

Training Staff

To ensure their ability to provide an enhanced level of support for members, PHP offers a dedicated clinical trainer and a training curricula that emphasizes holistic person-centered planning and supports the growth of staff in effectively understanding member needs and preferences. Intensive training is required for all care coordination staff on person-centered planning, care coordination processes, PHP's "It's All About Me'' assessment tool, practices for developing and managing the *Life Plan*, as well as how to utilize PHP's full array of benefits to support the individual to achieve their goals and meet their health and safety needs. This extensive training supports the successful design and use of a plan of services that enables individuals to live their best life.

PHP's training enables their staff to improve their ability to understand the member as a whole person, working with them to determine which services best fit their needs. Staff are trained on ways to assess personal preferences and goals, including situations where the individual is nonverbal or has difficulty verbalizing preferences. For example, care managers are trained to gauge the responses of members to questions to as best as possible determine preferences that can't be verbalized. Staff are also trained to work with individuals that are important in the member's life to learn about any communication styles that the member prefers, if they are unable to communicate these themselves.

Key Takeaways for Health Plans

Leadership	Ensure that leadership team members share a commitment to whole person understanding and planning. Ensure that leadership team members have experience working in the field of I/DD; an understanding of the experience of individuals with I/DD is important for success.
Assessment and care planning	Design care teams with leadership from skilled nurses, social workers, and Qualified Intellectual Disability Specialists to efficiently and effectively integrate services. Having a team that can collectively consider the interrelationships of conditions, medications, services, and care transitions is critical. Equip care teams with the tools and resources to assess and plan using person-centered principles that acknowledge needs and builds upon strengths, preferences, and goals.

	Create a care plan reflective of the individual's goals and encompassing services from all providers, including those from behavioral health partners, in one easy to find and navigate place.
Strategic partnerships with providers	**Partnerships are critical to put planning into action in an integrated way. Take time to understand the available benefits within your state and the available services across local providers; reach out to build relationships with key providers and** community partners. Prioritize partnerships for members experiencing an escalation of symptoms or more severe forms of illness. This will enable care coordination staff to act quickly when needed.
Training staff	**Provide ongoing training opportunities for care coordination staff.** **Invest in the development of a training curricula that addresses assessment and care planning processes, including for those with serious behavioral health needs or who experience challenges with verbal expression.** Train care teams to understand benefits and how to effectively draw on plan partnerships to arrange appropriate services for members.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This spotlight is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com/.