Residential and Day Supports for Adults with Autism and Intensive Medical and Behavioral Needs: Proposal for Wrap Around Model of Care

This proposal outlines a pilot residential and day model of care to provide critical medical, behavioral, and case coordination supports for individuals with severe autism and its associated comorbidities. Supports would also include clinical and staffing wrap-around sufficient to allow this population to access appropriate day services. This proposal focuses on providing medical, behavioral, and care coordination supports for the most complex vulnerable individuals transitioning from the ESU at the Hogan Regional Center back to their community-based residences, or who are at risk of placement at the Hogan Regional Center.

Target Population:

- Individuals with Autism and ID aged 22+ with comorbid medical conditions that may manifest behaviorally, and/or whose behaviors may result in medical conditions.
- Diagnoses may include variations of pica, self-injurious behavior, gastrointestinal dysfunction, mitochondrial disease, and seizure disorder.
- Adults who are transitioning from the ESU at Hogan Regional Center to community-based residential homes; or who have turned 22 and been turned down by multiple community residences due to behavioral/medical complexity but who do not require skilled nursing at least 20% of the time; or who are at risk of placement in the ESU at Hogan Regional Center due to medical/behavioral decompensation in the family home, a community-based residence, or shared living arrangement.

Service Gaps:

- There is a small subset of individuals whose baseline medical, behavioral and clinical needs exceed the capacity of the typical community-based residence.
- Failure to meet these needs can and often does lead to decompensation and puts the individual at risk of emergency department (ED) visits, medical hospitalization and need for behavioral stabilization.
- The lack of appropriate care in the community results in higher costs to the state (including to MassHealth and Accountable Care Organizations, as well as to the Department of Developmental Services).
- Within hospital settings security staff are often called in to assist with stabilization and in most cases their presence can further escalate a situation. Visits to the ED are often very traumatic for the individual, and their guardians, and can put the individual and their staff at additional risk for injury.

Service Recommendations:

- The availability of additional supports to these individuals as a proactive measure to prevent decompensation and need for higher levels of care is recommended.
- These supports would be in the form of wrap-around stabilization teams to include medical support, behavioral support, nursing support, speech and language (SLP) including augmentative alternative communication (AAC), and occupational therapy (OT) consultation.

- The goal of this service would be to reduce the rate of readmission to the ESU, and of readmission to a medical or psychiatric hospital for stabilization.

Details include:

- A total of 16 participants reside in four-person Chapter 257 Medical/Clinical residences. Each residence is no more than half a mile from two of the other residences. Alternate configurations are two duplexes, each with four residences in each half, which are no more than half a mile apart; or a combination of a duplex residence and two 4-person residences, each no more than half a mile apart.
- Direct support staff must possess a credential as either a Registered Behavior Technician (RBT) or as a Certified Nursing Assistant (CNA). In a community-based residence, at least one staff member on each shift must be an RBT, and at least one must be a CNA. In a day habilitation program, direct support staff working individually with a participant must be an RBT (if more than one staff person is working with an individual at a given moment, one must be an RBT).
- Staffing patterns in both residential and day settings must be adequate for a second staff person to be pulled in as needed.
- All trainings will be completed prior to the initiation of this pilot program.
- Development of two on-call specialty teams:
    1. **A Behavioral De-escalation Team** comprised of members with the following trainings:
        - Safety Care Trainer Training, Safety Care High Severity Behavior 1 and High Severity Behavior 2 (4 days in total)
        - The Autism Certification Center's online trainings "Many Faces of Autism" and "Foundations of Evidence Based Strategies" (12 hours in total)
    2. **A Medical Team** capable of physical assessment and care coordination and who have completed the above trainings as well as an online module designed for training of medical professionals http://www.umassmedcwm.org/autism/. (3 hour training)
        - A medical team able to provide basic treatment on site (such as blood draws), physical exam including taking vital signs, and care coordination.
        - These teams would be available to provide both on-site and remote intervention (including telemedicine) in an effort to reduce the likelihood of a visit to the ED and or subsequent hospitalization. The care coordination component is crucial in that this will allow for communication with community-based medical providers in an effort to reduce the need for an ED visit.
- Behavioral Supports and Consultation through the HCBS Waiver of up to 10 hours per week are available to an individual at day programs during the hours of 9 AM and 3 PM.
- Immediate Goals/Timing:
    1. Select 8 initial participants in the Metro North/Northeast regions (8 additional residents will be identified later).
    2. Identify a provider agency with experience with ASD-ID, medical homes, and mobile crisis team services, and which is (or is affiliated with) an ACO community partner to

oversee the pilot and provide the residential and mobile crisis services. This may include:
    a. Working with the Hogan Regional Center and the Metro North/Northeast regions to identify potential participants.
    b. Identifying existing community-based residences that might be designated for the pilot, and/or gaining site control of properties that might be used for this purpose.
    c. Hiring and training staff.
3. Identify an ACO and affiliated medical practice or practices to coordinate with the provider agency on provision of the medical specialty team services.
4. Initial funding to be provided by individual DDS allocations via Chapter 257 rates for Medical/Clinical Level 1 and ACO allocations for social determinants of health.
5. Ideally team members should have familiarity with the residents that they may possibly serve through orientation and sharing of medical and behavioral profiles for each individual.

- Mid-Term Goals/Timing:
  1. Initial participants move into residences.
- Long-Term Goals/Timing:
  1. 8 initial residents receive community-based services.
  2. Select additional 8 residents to receive community-based services.
- Expected Outcomes at the end of the pilot:
  1. DDS will compile data on hospitalizations, ED visits, restraints, aggression, self-injurious behavior, pica incidents, and whatever other markers are deemed appropriate.
  2. Data collected from the pilot can be used to inform provision of services for the target population statewide.
  3. All information will be shared with MassHealth.