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1500 Union Ave., Suite 2000, Baltimore, MD 21211

Phone: 410-727-6352 | Fax: 410-727-6389

www.DisabilityRightsMD.org

DDA Behavior Supports

A Report by Disability Rights Maryland

September 2, 2016

Nancy Pineles

Managing Attorney

Introduction and Call for Change

Disability Rights Maryland (DRM) concludes, through our experience representing clients, discussions with family members and provider agencies, and data and document reviews, that the Developmental Disability Administration (DDA) Behavior Support Service (BSS) needs comprehensive reform. DDA's proposed changes to the BSS do not provide an adequate array of services nor meet known needs.

DDA's current Transformation effort is an opportunity to take a fresh look at BSS to ensure this service complements and supports the fundamental principles of supporting each person's hopes and desires, helping them to be healthy and safe, creating supportive environments, and avoiding unnecessary restrictions. Person-centered planning and positive behavior supports have deep roots in Maryland. DDA and many provider agencies have nurtured a system of supports to respect individual rights, encourage person-centered planning, and prevent the need for unwanted structure or other restraint of personal freedom in peoples' lives. In 2008, DDA and the Maryland Association of Community Services (MACS) co-sponsored a broad stakeholder study of behavior support services in the context of eliminating the use of restraints. Eight workgroups were created: advocacy, behavioral health, data, human resources, implementation strategies, leadership, quality and training. The resulting 2010 report set forth comprehensive recommendations to reform behavior support services in eight areas: Organizational Change, Trauma Informed Care, Positive Behavior Supports, Staff Support, Funding, Advocacy, Community Supports and Project Testing.¹ This effort did not result in any significant systems change or heavily inform subsequent DDA changes to BSS. DRM urges DDA to resurrect that report and call on the extensive expertise within DDA, the provider community, individuals and family members to consider whether the recommendations are still valid or can be improved, and re-design the BSS.

¹ *Eliminating Restraints in Maryland: Trauma Informed Care Task Force Recommendations*, DDA, Maryland Association of Community Services and Trauma Informed Care Restraint Elimination Task Force, 2010.

Summaries from Recent DRM Client Experiences (All are DDA Medicaid waiver participants.)

“Adam,” who is usually sweet and smiling, has severe intellectual disability and does not communicate effectively with language. Adam was kept in four point restraints almost continuously for nine months after developing behaviors following abuse. Staff at Adam’s provider agency were caught abusing him. Subsequently, Adam’s arm was discovered broken, which the provider was unable to adequately explain. The following month, the otherwise healthy Adam was hospitalized for hypothermia and spent months recovering in the hospital. When he was ready for discharge, Adam moved to a new provider, but his behaviors had become very aggressive and he was hospitalized again, this time for his behaviors. Since sedatives did not work to calm Adam, the hospital placed him in mechanical restraints. No provider would agree to serve him. It took months before DDA and its behavior supports providers could agree on a plan for Adam. After a difficult transition, Adam is now receiving the supports he needs and is recovering his formerly pleasant demeanor.

“Justin” has an intellectual disability, is nonverbal and requires 2:1 staff support. Staff beat Justin, breaking his ribs and foot. Now, he refuses to leave his room, and his service and behavior supports providers are unable to work together to help him. Justin’s team cannot find another provider willing to serve him.

No DDA provider agency was willing to serve “Jackson” when he transitioned from school because he needs intensive staffing. Jackson has severe intellectual disability, neurological damage from seizures and visual impairment. His mother had to stop working to stay home with her adult son whose behavior she could not independently manage. Although Jackson would prefer to walk outside and listen to music, he is assembling bubbles at the only day program that would serve him. His behavior plan helps the provider gain his compliance.

“Mia” has severe intellectual disability and no verbal communication. Mia’s behaviors improve when she is able to be physically active. Only one provider agency agreed to serve her. Mia’s staffing was reduced, requiring her to be confined within a segregated day program that limits her activity.

At age 21, “Lucas,” who has autism and intellectual disability, could not leave his residential school because no provider would him. When his family said they would try bringing him home if they could hire staff, DDA denied the request for staff support, despite it having been advised by DDA’s BSS and Lucas’ team.

Consider the crisis behavior as a **symptom** and not a **disorder**. Behavioral change is often the only way people with intellectual and developmental disabilities (IDD) can express that something is wrong and communicate a need. Very frequently, the “something wrong” is not a psychiatric problem. It may be a signal that the person has a physical health problem causing pain or discomfort or that his/her environment is not meeting his/her needs.

Vanderbilt Kennedy Center, Health Care for Adults With Intellectual and Developmental Disabilities: Toolkit for Primary Care Providers, <http://vkc.mc.vanderbilt.edu/etoolkit/mental-and-behavioral-health/initial-management-of-behavioral-crises/>

“Ava,” who has intellectual and psychiatric disabilities and health issues, was hospitalized for a psychiatric medication adjustment. Without her medications or notice to her family or provider, she was committed to a psychiatric hospital in the District of Columbia.

DRM Study of Behavior Support Services

For many years, DRM has represented clients who exhibit behaviors due to dental pain, problems with roommates, unnecessary restrictions and/or disabilities that impair functioning. Recent clients developed new maladaptive behaviors after experiencing abuse. We have worked extensively with clients and their families, Coordinators of Community Services (CCS), providers, and DDA’s Behavior Support Services (BSS). On a systemic level, DRM was a member of the 2010 Trauma Informed Care Task Force. With the DD Coalition, we sponsored a Symposium on support services for people with court involvement, visited Minnesota and New York facilities for people with court involvement, identified and met with experts in other states who presented to DDA on behavior support alternatives to institutional care for people who are incompetent to stand trial and deemed to be at risk of re-offending, and have met with DDA’s clinical director to discuss BSS. As the 2013 BSS contract was ending, DRM began asking questions about the future of BSS. We obtained data from DDA through a Public Information Act request on the performance of the BSS contract over the past three years and met with provider agencies that both deliver and use BSS in all four regions served by DDA. **We are deeply concerned that DDA did not obtain adequate stakeholder input prior to developing the 2013 contract or the proposed BSS services for the waiver amendment. The proposed changes do not address the concerns of DRM or the broader DDA stakeholder community.**

ENVIRONMENT AND BEHAVIOR

“People with significant behaviors are more likely to learn, to mature and to succeed in safe and supportive home environments that meet their needs and accommodate their individual wants. Modifications to the home can often reduce the cost of supports, and avoid the need for more help and more costly interventions. Creating an environment that works for the individual should be more than a crisis measure or a one-time-only response to a problem. It should be an integral part of a person-centered plan.”

George Braddock and John Rowell, *Making Homes that Work A Resource Guide for Families Living with Autism Spectrum Disorder + Co-occurring Behaviors*, 2011, p. 6, http://www.nasdds.org/uploads/documents/Making_Homes_That_Work_A_Resource_Guide_%282%29.pdf

Problems with DDA’s Behavior Support Services

DRM has identified the following problems for people who need BSS:

- Many BSS behavior plans appear to lack a holistic view of the person’s health, environment, and trauma history as required by best practices.
- DDA policy changes have resulted in a critical lack of capacity by experienced provider agencies for services for people with intensive behavior support needs.
- Contractual BSS do not integrate well with provider agencies that support people with intensive behaviors.
- People with intellectual and developmental disabilities (I/DD) who have experienced abuse or neglect have little access to trauma care.
- People with I/DD have inadequate access to crisis stabilization services that ensure they can remain in their homes.
- Increased demand for BSS has caused capacity problems including an inability of BSS staff to spend adequate time with individuals to adequately assess their interactions with their environment and other factors that result in behaviors.
- BSS is not timely or responsive to changing needs: it takes 90 days to develop or update a behavior plan.
- Providers are struggling to provide mandatory Behavioral Principles and Strategies trainings since DDA stopped training BPS trainers.
- People with I/DD have difficulty accessing and using Maryland’s Public Mental Health System.
- High quality psychiatry support services for people with I/DD can be difficult to obtain through Medical Assistance.
- People receiving services have inadequate monitoring of the quality of their psychiatric care and effects of complex pharmaceuticals.

People with I/DD and Psychiatric Hospitals

When an individual has a behavior crisis and the family or provider calls 911, the person leaves the protections of the DDA system and enters systems where chemical and mechanical restraint and seclusion are normal. Staff at hospital emergency departments and jails lack information about often complex patients and use their own judgement, typically with little or no communication with the person’s psychiatrist or behavior support staff.

People may be treated and released with little long-term benefit.

DDA Provider-Reported Psychiatric Admissions from PCISII

Time period	6/1/2013 to 5/31/2014	6/1/2014 to 5/31/2015	6/1/2015 to 5/31/2016
Psychiatric admissions	314	351	403
Annual increase		11.7%	14.8%

There are few specialized psychiatric beds for people with I/DD in Maryland. Admission to a general psychiatric ward may require a person to spend several days in an emergency department. DRM does not receive data for emergency department visits, but since psychiatric hospital admissions for people in DDA services are increasing (see chart, below), it is likely they are spending more time in emergency departments as well, where the extent of restraint and seclusion is not tracked in the DDA system. People with I/DD can get stuck or harmed in facilities that lack staff who understand the needs of people with I/DD: Adam was subjected to months of restraint, Ava was medically neglected and transferred to a hospital outside of the state without her medications, and Justin's mother is afraid to take him to the emergency department because he was previously traumatized by a hospital experience. People with I/DD need other, better alternatives.

“It can be very difficult for people to be admitted to the psychiatric ward. Direct psych admits are difficult these days because, by law, ER patients (regardless of which hospital) have to be admitted first to any available bed in the geographic region. At least 2 patients are currently waiting in EDs in this area and would be first-up for any open bed. Waiting in an ED would be fastest, but we cannot guarantee what hospital he would go to.

I'm afraid I don't have any way around these rules. Again, this is mandated by law, and all doctors, hospitals and EDs have to comply. Also, there is a shortage of psych beds overall.

If he is a danger to self or others, take him to an ED. But, expect to wait.”

Recent email from a psychiatrist who was trying to help a DDA waiver recipient get a psychiatric admission so he could be safe while his medications are adjusted.

Medications and BSS

Many people who have DDA behavior plans take complex combinations of medications. Some DRM clients take an alarming number and combination of psychotropic and other medications. Many of them are unable to provide informed consent to the use of such medications and some have no legal guardian or family member willing or able to consent. Neither the Coordinators of Community Services nor the psychologists who develop behavior plans for these individuals question whether the client should consult a pharmacist for advice or seek a second medical opinion.

For example, “Antoine's” behavior plan lists his 12 daily psychotropic and other medications, but one month later, his individual plan lists 13 entirely different medications, most of which were prescribed before the behavior plan was written. The National Library of Medicine's Medline website cautions that many of Antoine's medications need careful monitoring for dangerous reactions and other side effects. For example, some of his medications can cause ulcers, bleeding, or holes in the stomach or intestine. Antoine takes medication to treat ulcers. Another medication merits a warning that it can cause the

patient's mental health to change in unexpected ways. At least one medication can cause constipation. Antoine takes another medication to relieve constipation. One of his medications relieves tremors caused by other medications. Two medications can cause rash, hives and itching. Antoine developed a very serious skin rash for which his doctor prescribed yet another new medication. None of the medication side effects are listed in Antoine's individual or behavior plans, and there is no explicit plan for monitoring for the numerous side effects, so it is unclear how these medications are affecting Antoine's life and behavior.

SUPPORT PEOPLE TO "GET A LIFE"

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) recommends: "To build a system that effectively supports people with the co-occurring conditions of I/DD and mental illness, it is necessary to go beyond treatment strategies and attend to the total environment including relationships, activity and routines, communication, personal autonomy and empowerment, and program models."

<http://www.nasddds.org/resource-library/behavioral-challenges/program-design/>

New DDA Practices Affecting BSS

In recent years, changes in DDA policies have made it far more difficult for people to obtain BSS from experienced, qualified provider agencies. These changes include the following:

- Several years ago, DDA began to limit approvals of intensive staff support to fixed time periods. Without an assurance of ongoing, stable funding for people with intensive needs, providers are reluctant to serve such individuals.
- DDA also began requiring providers to document each individual's need for additional funding for intensive support services, but has no transparent, specific, and consistent criteria for such documentation. Providers and Coordinators of Community Services complain that efforts to comply with this requirement are extremely time consuming. Some providers fail to collect documentation, which puts individuals at risk of harm when DDA refuses to continue services.
- DDA eliminated "temporary augmentation of staff" (TAS) as part of the BSS continuum. TAS is perceived by some as a flexible, cost-effective means of ensuring the availability of intensive, well-trained, staff support for short time periods.
- Although Behavioral Principles and Strategies (BPS) is a mandatory staff training, DDA reportedly stopped training BPS trainers. Providers are increasingly concerned that, without adequate numbers of trainers, they will not be able to secure timely training for their staff.

Behavior Support Principles and Individual Planning

DDA's principle of Person Centered Tiered Supports requires person-centered individual planning to ensure staff are knowledgeable regarding what is important to and for the

person and to actively assist the person to achieve their individualized goals.² BSS should also support people in achieving individualized goals. Currently, a DDA work group is addressing the need for stronger, more person-centered individual planning, but BSS must also be changed to become person-centered and complement the individual planning process to help individual contentment in all three tiers.

DDA's vision seems consistent with the recommendations of Charles Moseley of NASDDDS for behavior supports for people with I/DD who said, "Perhaps most of all people need support to *get a life*"³ that includes:

- Stable home and home environment
- Consistent and predictable staffing
- Support for new friendships and relationships
- Compatibility between the person and staff
- Employment
- Meaningful community participation and engagement
- Trained clinicians
- Small settings
- Flexible funding

DDA regulations for behavior planning were last revised in 1989 and while they probably reflect best practices at the time, behavior supports principles have now evolved to take a more holistic view of the person and consider all aspects of a person's life, to better support a person who is communicating via behavior. Many of the behavior plans we have seen treat the behavior as a problem to be solved rather than communication that expresses a need that deserves attention by the person's entire team.

Reportedly, DDA's BSS has recently adopted changes that remove flexibility from the behavior assessment process rather than encouraging a more holistic, person-centered approach. DDA requires all BSS staff to have Applied Behavior Analysis (ABA) certification. Data has taken on a heightened role in analyzing behavior. Behavior plans must follow a lengthy template that is difficult for direct care staff to understand and use. Most BSS providers were not consulted about these changes.

BSS staff do not spend adequate time with the individual to become familiar with the person's interaction with others in his or her daily environment, medical and dental condition, or environmental factors that may contribute to the person's behaviors. Behavior plans do not recommend health care screenings, changes to a person's services to reflect a person's wants or goals, or changes to their environment that could alleviate the person's

² See, e.g., *Tiered Supports 101*, Missouri Department of Developmental Disabilities, 2016, p. 10.
<https://dmh.mo.gov/dd/docs/brrtiered101.pdf>

³ *Population Based Strategies for Supporting People with Co-occurring Mental Illness and Intellectual/Developmental Disabilities*, Olmstead Policy Academy September 20, 2012 Charles Moseley Ed.D. National Association of State Directors of Developmental Disabilities Services. p. 32.
http://www.nasddds.org/uploads/documents/Support_Strategies_for_People_with_IDD-MI_2012.pdf

discomfort without further analysis and data collection. BSS providers say the demand for BSS is too great and caseloads too high to allow staff to spend significant observation time with an individual. Instead, they rely heavily on data provided by provider agencies. Data is not only collected by untrained direct care staff, but also measures only selected behaviors. Data cannot substitute for a subjective understanding of a person's situation.

For example, "Aiden" is articulate about his desire to live on his own and his passion for animals. Neither his individual plan nor his behavior plan for behavior outbursts and refusing to bathe are person-centered. While acknowledging Aiden's desire to find a job working with animals, the behavior plan does not consider approaches to helping Aiden get a better life such as helping him find a way to have more contact with animals. In addressing his reluctance to bathe, rather than help Aiden grow an interest in personal hygiene by helping him develop relationships, friendships, and self-confidence, the plan merely suggests rewarding him for compliance with his provider's bathing demands. Data collection and analysis will not help Aiden get the life he wants and needs.

DDA's Proposed Waiver Amendment

DDA has proposed changes to its Medicaid Waiver BSS that omit two necessary BSS services required by COMAR 10.22.10.03: temporary augmentation of staff, and behavioral respite services. DDA has been providing behavioral respite services through the current waiver and 2013 BSS contract. DDA did not include temporary augmentation of staff in the 2013 BSS contract, but the waiver included a variety of other services that may have been used in a similar way.

BSS services in the proposed waiver amendment are limited to:

- (1) Behavioral assessments
- (2) Behavioral consultation
- (3) Brief support implementation services

DRM RECOMMENDATIONS TO IMPROVE BSS

SHORT TERM RECOMMENDATIONS: IMPROVE BSS SERVICES IN THE PROPOSED WAIVER AMENDMENT

If DDA intends to submit a waiver amendment before it conducts a thorough review of the BSS service, it should: (1) ensure children will not lose services, (2) enlarge the continuum of BSS, (3) make revisions to ensure providers use person-centered best practices that help people "get a life," (4) work with providers to address capacity issues to ensure individuals have a choice of qualified and capable provider agencies.

- 1. Services to children:** The proposed waiver amendment is presuming that children with I/DD in Maryland have access to all entitlement EPSDT services through the State Medicaid Plan, and therefore, DDA can carve these services out of its waiver. **We caution that this is not the case.** For example, although CMS requires states to

deliver certain services to children with autism, Maryland's Medical Assistance program has just issued proposed regulations to add applied behavior analysis (ABA) to its EPSDT services. These services are not currently available, nor do the proposed services fulfill the requirements for EPSDT in Maryland.⁴ Another example is that neuropsychologists are finding that they cannot bill Medical Assistance for children who do not have a mental health diagnosis even though children with I/DD are entitled to receive full diagnostic services through EPSDT. We recommend that DDA fully discuss this issue with providers of services to children, Medicaid and DRM before carving these services out of the waiver.

2. **Enlarge the continuum of BSS:** We strongly recommend adding behavioral respite, mobile crisis intervention and temporary staff support, although we also believe these services need to be improved through a comprehensive review of DDA's BSS. These services are needed to help support people in their homes, prevent calls to 911, and avoid hospitalization.
3. **Reflect best practices:** We recommend that the proposed services should more effectively describe assessment practices that are similar to person-centered best practice models that "go beyond treatment strategies and attend to the total environment including relationships, activity and routines, communication, personal autonomy and empowerment, and program models." These best practices should require consultation with a pharmacist or physician for advice when the person is prescribed complex medication combinations, especially when the person cannot consent or has inadequate support to understand their medications.
4. **Provider capacity issues:** States "may not limit a group of waiver participants to receiving a pre-defined package of waiver benefits by preventing members of the group from accessing other services offered under the waiver."⁵ Adam, Justin, Jackson, Mia, Lucas and others like them experience long waits to find any provider at all to serve them. Then they are forced to remain with that providers even if they do not receive adequate support or are seriously harmed. They and others have spent long periods of time living in institutions or at risk of institutionalization because they cannot find providers willing to serve them. DDA practices are limiting access to services or, at least, are not ensuring adequate provider capacity for people who need intensive support. To help people in services remain safe from harm, avoid institutions and find providers that meet their needs, DDA needs to resolve the issues that are causing providers to turn away from serving people with greater support needs.

⁴ DRM will share its finalized comments on the proposed regulations with DDA.

⁵ CMS Technical Guide, Instructions: Version 3.5 HCBS Waiver Application, 2015, p. 48 and Olmstead Letter to State Medicaid Directors #4.

LONG TERM RECOMMENDATIONS:

- 1. Review the BSS system:** Similar to DDA’s effort to create a strategic plan for employment, DDA should engage stakeholders to develop a comprehensive proposal for a continuum of behavior supports in Maryland, and consider how to affect change in the wider service delivery system, such as psychiatric and pharmacological support for people with I/DD and the Public Mental Health System.

“To help shift the stigma and assumptions that have become connected to ‘behaviors’ and to foster a new way of thinking about the supports provided, it is recommended that the term ‘behavior plan’ be changed to the term ‘support strategy plan.’”

Trauma Informed Care Task Force
Report, p. 11.

- 2. Person-centered BSS:** BSS should complement and support person-centered planning and adhere to best practices that look at the person in the context of their personal desires, health and environment, rather than looking at the behavior as an isolated problem. BSS staff should support the Coordinators of Community Services to identify and address a person’s outstanding needs to ensure the person has services that address their goals; medical, psychiatric, dental, and pharmaceutical attention; and a supportive environment.

- 3. Build or re-build capacity at provider agencies that specialize in services to people with intensive behavior support needs:** In each region, DDA has provider agencies that specialize in supporting people with intensive behavior support needs. DDA’s reimbursement rates need to ensure that these provider agencies have the funding necessary to hire professionals who are qualified to work with people with I/DD. People with intensive behavior and psychiatric support needs due to complex disabilities should not be restricted to psychiatrists who are willing to accept Medical Assistance rates if the available Medical Assistance providers are unable to meet their needs. In addition, these agencies must be carefully monitored for the quality and outcomes of their behavioral services.
- 4. Establish an oversight system to ensure the quality of behavior plans and BSS, whether provided by agencies described in #3 above or otherwise:** BSS need to be timely, responsive to a person’s changing needs, support person-centered services, and adhere to regulations and professional standards. People receiving services are vulnerable to abuse and neglect if agencies do not adhere to quality standards.
- 5. Commit BSS services to ending or reducing 911 calls by provider agencies for behavioral crises.**
- 6. Improve the statewide capacity for psychiatric services for people with intellectual and developmental disabilities:** It may be helpful to secure psychiatric nurse practitioners and pharmacists who are specialized or can be trained to specialize in working with people with I/DD.

Appendix: From DRM Conversations with Providers and BSS Providers

Behavior Plans
DDA required a new template a year or so ago, is harder to use and harder to train staff, uses complex language that staff will not understand such as “appetitive”
Takes 90 days for BSS to develop behavior a plan, 90 days to update an existing plan
BSS provider needs 90 days to renew a behavior plan
BSS staff are reluctant to help recommend staff ratios
Provider staff need to collect good data for BSS provider
Western and Eastern regions: BSS spends more time with people, staff, families, fuller participation in meetings
Behavior Plan Implementation
The new template requires a lot more staff training, is too hard for direct care staff to understand, is too long, includes too many steps
It is difficult to teach staff how to collect data
Intensive Behavioral Needs/Respite
Many people still follow their protocols to call 911 instead of Mobile Crisis Intervention
Mobile Crisis is not working as intended
Need police to work more closely with providers and DDA to help in a behavioral crisis
Clarification on eligibility requirements for those who apply for respite services; how is this determined by DDA?
Need something in between residential care and hospitalization; hospital should not be fall back when provider does not have capacity to handle individuals
Hospital psychiatric care is not working well, e.g. multiple admissions to community hospitals where the person is discharged without addressing the problem
Availability of neuropsychological assessment by BSS is helpful
Cost of behavioral respite is \$1300-1400 per day
If providers had more alternatives when a person goes into crisis, they would be more willing to serve people with more intensive support needs
Regional office tells provider not available
Used to be able to send trained staff to provide temporary support, was a good service, can no longer do this
Psychiatric Care
Create a small community psychiatric unit that are trained on working with those with more intensive needs
Psychiatrists in the community are in need of training on how to work with the DD population
Some providers have contracted with psychiatrists, which has been very helpful
Providers are seeing more people with complex conditions, the needs for stronger psychiatric support is growing
Having access to trusted psychiatric services for people with DD is very helpful and successful but unsure what will happen when this provider is no longer available
Need more in-home psychiatry
People are experiencing repeated hospitalizations because of poor psychiatry support
People are overmedicated and undermedicated, there is no good review of medications, no

consistent psychiatry support
Recommendations for Improving BSS
DDA should make a decision about the BPS/PBS curriculum and begin training master trainer
Form a BSS systematic workgroup, which includes providers, to get their input on how the system should be structured
Consult with providers about accreditation/qualifications for BSS staff
Convene a workgroup of providers to discuss structure of new BSS contract
Unsure about the benefit of changing structure of BSS contract again, just adjusted and became comfortable with existing contract and wouldn't want to have to start from scratch
Need funding for psychologists to provide more intensive followup/training on behavior plans they write; psych associate needs more time with client
Allow individual providers to employ private or in-house consultants which are more cost effective, have a higher competence level and are willing to work with providers on making improvements to BSS plans
BSS contract should be able to make recommendations about care and identify what supports look like
Develop more support alternatives in the community for those with intense behavioral needs
Include temporary augmentation of staff using staff with intensive training by BSS providers, this can help keep people out of hospitals
Temporary augmentation of staff is flexible, can be quickly mobilized, e.g. when a person is released from prison or to follow a person temporarily as they leave behavioral respite
Because it is not facility based like expensive behavioral respite, temporary augmentation of staff is less costly
Revise behavior plan template to make it more user friendly for support staff
Give providers the capacity to maintain in house BSS services
Create a behavior plan template that has more structure, easier for support staff to understand, and more practical for staff to implement
Improve process for requesting more intensive services in behavior plan from DDA; Dr. Bluestone reviews all of these behavior plans; additional assessments are now required for these types of services which delays completion of plan; no recommendations are provided for services during lag time
Consider regional teams to address individuals with challenging behavior
Go back to a regional structure
Develop 2 RFPs, one for respite/mobile crisis, the other for behavioral services
Subcontractors do not have easy access to DDA to get/give information; need to go through Humanim
More consistency is needed in terms of standard operating procedures across regions
Improve Mobile Crisis
There needs to be better evaluation of services provided to clients, as required in the contract
Integrate behavior support services into service funding plan
Train support staff on trauma informed behavior support services

Hospital staff need to be more educated about working with the DD population
A more effective working relationship needs to be established between DDA and DHMH
Look at ways to maintain support staff; support staff need more education/training and better compensation
Need a better organized training system for providers and professionals in the community