Behavioral Health System for Future Generations Commission

Recommendation for Consideration

The Behavioral Health System for Future Generations (BHSFG) Commission proposes the following recommendation for consideration: **Investment in Direct Care Workforce Stabilization and Healthcare Capacity for People with Developmental Disabilities.**

Problem Statement

Individuals with intellectual and developmental disabilities (IDD) often need life-long supports and services to ensure health and safety while also promoting access to and participation within their local communities. These supports and services are provided on a day-to-day basis by Direct Support Professionals (DSPs) and secondarily through the broader healthcare system – particularly in times of acute or behavioral health crisis.

The role of DSPs is complex, encompassing a multitude of functions including but not limited to medical supports (i.e., medication administration, managing special diets, monitoring health and wellness) and supporting community inclusion (i.e., providing supports in individualized settings, developing and coaching employment opportunities, and teaching transportation and other community living skills)[1]. DSPs have historically been expected to complete these critical functions while often earning low wages and with notably few to no opportunities for career growth other than stopping direct support and moving into management roles. Further, DSPs have historically lacked the formalized professionalism and recognition enjoyed by analogous providers in the system given that they do not hold a Standard Occupational Classification designated by the Bureau of Labor Statistics (BLS).

This dichotomy of a complex role and lack of professionalization has led to compounding issues in DSP turnover and vacancy, placing growing pressure on the IDD service delivery system to provide adequate service capacity and service quality. In fact, according to the National Core Indicators (NCI)[2], in a survey of 29 states, average DSP wages were $14.50/hour and weighted average turnover was 43.3% with an average vacancy rate of 16.5% for full-time DSPs.

The “churn” in the DSP workforce has led to several systemic issues for the service delivery system. First, it is estimated that the cost to replace a DSP who leaves the field

[1] Smith, D., Macbeth, J., and Bailey, C. Moving From Crisis to Stabilization: The case for professionalizing the direct support workforce through credentialing. (2019).

[2] State of the Workforce Survey Report. National Core Indicators. (2021). https://idd.nationalcoreindicators.org/wp-content/uploads/2023/02/2021StateoftheWorkforceReport-20230209.pdf

ranges from $2,700 - $5,200 per exit[3]. This expense is most directly borne by the service providers tasked with rendering services to people with IDD and is not directly reimbursed. This has a cascading impact on the system, pulling away resources to enhance workforce training, develop new innovative service models and/or increase capacity to meet growing demand. Second, and perhaps even more critically, in research conducted by the Council on Quality and Leadership[4] (CQL), continuity of care and services is critical in supporting individuals with IDD to achieve quality of life outcomes. In fact, "continuity and security not only significantly increased overall quality of life, it also positively impacted two-thirds of the different outcomes, ranging from health to relationships to rights." Additionally, another study conducted by CQL found that "regardless of people with IDD's support needs, people with IDD who experienced (workforce) turnover had more emergency department visits, instances of abuse and neglect, and injuries than people with IDD who did not experience turnover."[5]

Stabilizing the DSP workforce is critical to system stability, sustainability, and quality. Supporting the DSP workforce requires a multifaceted approach, however. While supporting workforce wage growth is important, a survey conducted by Medisked[6] found that nearly 50% of DSP separations were due to a lack of advancement opportunities within the field. It is imperative to support continued provision of high quality supports and services to individuals with IDD in Montana to support the workforce and encourage career growth for DSPs to support higher continuity of care.

Further, while most services provided to people with IDD in Montana are through the day-to-day direct supports from DSPs or family members, equally as important is the support system for those experiencing crisis acute care and/or behavioral support needs. While one of the goals of the service delivery system is always to prevent crisis, given the nature and complexity of all lives, crisis is sometimes unavoidable. In these instances, it is imperative that we have a robust support system of other professionals (including but not limited to doctors, nurses, hospital staff, crisis intervention teams, and/or behavioral health professionals) who have the training and tools needed to

[3] The President's Committee for People with Intellectual Disabilities. Report to the President 2017: America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy. Final Report. Washington D.C., 2017.

[4] Friedman, C. (2022). The Impact of Continuity and Security on Quality of Life. Intellectual and Developmental Disabilities, 60(2), 101-112. https://doi.org/10.1352/1934-9556-60.2.101

[5] Friedman, C. (2021). DSP Turnover Negatively Impacts the Leath and Safety of People with IDD. https://www.c-q-l.org/resources/articles/dsp-turnover-negatively-impacts-the-health-and-safety-of-people-with-idd/

[6] Medisked. (2016). The Staffing Struggle In Real: New Statistics on IDD Agencies' Most Common Personnel Challenges. http://medisked.com/wp-content/uploads/2018/06/The-Staffing-Struggle-is-Real.pdf

support the needs of people with IDD appropriately and effectively. Investing in training for these professions can help reduce the time and/or impact that a crisis situation may have on an individual. Numerous studies[7] have identified that a significant barrier to healthcare access for individuals with IDD is negative healthcare experiences, often attributed to providers who do not understand the unique needs of people with IDD. This lack of understanding can lead people with IDD to feel less comfortable and less confident when seeking healthcare access; it can also lead to higher levels of fear of stigmatization and less preventative care treatment.

Taken together, there is a significant need and in turn value to investing in DSP workforce stabilization and promoting stronger capacity across the healthcare continuum to support people with IDD. Specifically, this initiative calls for piloting a DSP credentialing structure to test best practice approaches to DSP stabilization through career ladders as well as enhanced training opportunities for healthcare professionals to support individuals with IDD seeking medical and behavioral healthcare.

Data and Information Sources

Both workforce stabilization and increased capacity within the broader healthcare delivery system to support people with IDD are critical to the long-term sustainability and quality of care for Montanans with IDD. As described above, data indicates the impacts on not only the financial sustainability of IDD programs but also the impact on individual health, safety, and quality of life when adequate and consistent supports are in place. Establishing structures to support DSP workforce stabilization provides a critical opportunity to enhance the quality of care in Montana. Equipping our broader healthcare delivery system with the right tools and training needed to support people with IDD will also help ensure the system comprehensively supports individuals.

DSP Workforce Capacity:

- Montana participated in the CY2021 NCI staff stability survey (referenced previously). Data was collected through a sample of providers (n = 15) in the State. the following was documented in comparison to the NCI state average:

[7] Shady, K., Phillips, S., and Newman, S. Barriers and Facilitators to Healthcare Access in Adults with Intellectual and Developmental Disorders and Communication Difficulties: an Integrative Review. Journal of Autism and Developmental Disorders. (May 2022). 1-13. Accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9148936/#

National Core Indicators – Staff Stability Survey[8] *Data as of December 31, 2021*		
Domain	**MT %**	**NCI Average %**
Agencies that turned away or stopped accepting new service referrals due to DSP staffing issues	**87%**	52%
Turnover Ratios for DSPs	**88%**	43%
Proportion of DSPs with Tenure >6 months	**28%**	18%
Proportion of separations of DSPs with Tenure >6 months	**43%**	35%
Average full-time DSP vacancy rate	**29%**	17%

- Supporting the NCI data, in a separate data collection process completed by the Montana Association of Community Disability Services (MACDS) association of its members[9], found during FY2023 that the average DSP turnover rate was 42% with the highest agency rate at 75% and the lowest agency rate at 24%.
- Data collected by the National Alliance for Direct Support Professionals, in a small sample of provider agencies from across the country (n =3), found that turnover for certified/credentialed DSPs fell between 77-90%.

Healthcare Workforce Training:

- From 2022-2023 there were 2,564 incident reports in Montana filed for individuals with IDD receiving DDP funded services that may have required hospitalization, medical attention and/or behavioral health intervention. Of those, 70% led to the person going to the hospital or were due to serious illness requiring medical attention.
- In a survey of participants who received training through a pilot of the Curriculum in IDD Healthcare eLearn course, respondents noted the following post-training:

Survey Responses Post Curriculum in IDD Healthcare eLearn Course Pilot	
Question	**Response**
I would recommend this training program to others.	**4.75/5**
The presentation will improve my practice and patient care.	**4.75/5**
On a scale from 1-100, rate your ability to deliver effective medical care to people with IDD **BEFORE** this training	**48.75**

[8] It should be noted that the State of Montana elected to exclude findings from the national NCI staff stability report for 2021 due to a high documented margin of error. The presented data should be used cautiously.

[9] Please note, the MACDS is not inclusive of all IDD service providers in the state. The presented data only accounts for respondent agencies that are members of the association.

On a scale from 1-100, rate your ability to deliver effective medical care to people with IDD **AFTER** this training	**84.37**

Recommendation

Provide one-time grants to five (1 per DDP region) service providers for, on average, 25 DSPs to become certified and sponsor access to training for healthcare professionals and/or behavioral health staff in working with people with IDD. The funding will be used to pilot an innovative workforce initiative that improves workforce stabilization and enhances capacity development across Montana's healthcare delivery system to better support people with IDD.

DSP Workforce Capacity:

Provide grants to five (5) service provider organizations, 1 per DDP region, which include pre-purchased credentialing access to the National Alliance for Direct Support Professionals (NADSP) web-based credentialing platform for, on average, 25 DSPs each. Funds will cover staff time for DSPs participating in the credentialing program as well as "backfilled" staff to cover the shift time of staff enrolled in the credentialing program; payroll processing, grant reporting and tracking and other administrative costs incurred by selected provider agencies; technical support provided by NADSP to support providers in implementation; and one-time incentive bonuses to DSPs once they reach credentialing tiers, as modeled below:

Tier 1 –$1,000

Tier 2 – $1,500

Tier 3 – $2,000

Healthcare Workforce Training:

Purchase and make available 500 "seats" to the Curriculum in IDD Healthcare eLearn course which was designed, created, and delivered by a physician, for physicians and other clinicians. This eLearn course teaches the fundamentals of IDD healthcare, providing participants with pertinent, practical information regarding people with disabilities that can improve outcomes, reduce suffering, and prevent unnecessary death. Expanding access to this training would help promote better healthcare outcomes, including acute care services for individuals with IDD. The course could be accessed by physicians, nurse practitioners, nurses, physician assistants, behavioral health clinicians, crisis response teams or students in post-secondary education programs.

Place in Continuum	BHSFG Priority Alignment	Projected Cost
DD – Early Intervention, Youth to Transition and Adult DD – Crisis	DD System Capacity and Quality	$600,000

Impact	
Outcomes and Outputs	**Implementation Activities and Milestones**
Target **outputs** include: 1. DSP turnover is reduced in credentialed DSPs when compared to non-credentialed DSPs. 2. DSP turnover is reduced by 10% or more to consider statewide implementation. 3. Healthcare professionals identify that their ability to deliver effective medical care to people with IDD increases by 25% after taking the IDD in healthcare course. Target **outcomes** include: 1. Improved quality of life through continuity of care for people with IDD. 2. Reduced financial impact of DSP turnover to improve systemic capacity. 3. Improved access to qualified healthcare professionals to support	**DSP Workforce Capacity** 1. Funding issued through applicable procurement vehicle. a. Direct procurement of platform b. Provider grants 2. Pilot providers selected. 3. Grants issued. 4. Pilot funding issued to existing providers. 5. Credentialing seats procured. 6. Initial and recurring data collection from provider organizations to demonstrate service stability, turnover, capacity growth, utilization, and satisfaction. **Healthcare Workforce Training** 1. Execute contract with IDD in healthcare training vendor.

health and crisis response outcomes for people with IDD.	2. Release IDD in healthcare training seats. 3. Data collection from participants to demonstrate impact and satisfaction with training.

Supporting Material: ***Example*** *Program Budget**

	Number of Grantees	Average Grant per Program	Funding Distribution	Total
Grants to providers for DSP workforce credentialing	5 (125 DSPs)	$66,500	One-Time	$332,500
DDP program credentialing costs (i.e., procure credentialing "seats" and TA)	n/a	n/a	One-Time	$22,250
DDP program costs for healthcare training	500 seats	n/a	One-Time	200,000

*For **example** purposes only.

Supporting Material: ***Example*** *Grant/Access Criteria**

DSP Workforce Capacity Grants:

To be eligible for this grant, programs must ensure the following:

- Actively enrolled as a type 82 provider with Medicaid;
- Actively listed on at least one prior authorization for a 0208 wavier service;
- Be in good standing with DDP and the Office of Inspector General, including no unresolved Quality Assurance Observation Sheets;
- Must be able to attest that the organization has the administrative support infrastructure to meet the grant criteria and that selected DSPs will be provided the time needed to complete credentialing activities; and
- Only one provider per DDP region will be selected to participate in the grant pilot.

Healthcare Workforce Training:

To be eligible to participate in this training, participants must:

- Be a licensed healthcare professional, licensed behavioral health professional or a college or university student enrolled in a healthcare field; and
- DDP will prioritize access to this training to licensed healthcare and behavioral health professionals. Access to college or university students will be limited to 100 seats.

*For **example** purposes only.

Oversight and Grant Management
BHDD staff will oversee the grant management and monitoring of grant deliverables. DPHHS will verify that each grantee meets Medicaid program and service requirements. DPHHS will monitor grant usage to ensure the provider organization only expends the funds for allowable uses. Provider organizations will be required to provide data on program work plan details, service delivery metrics, and additional ad hoc reporting (including reporting related to outcomes and outputs) as identified.