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Enhanced Support Coordination

Comprehensive care coordination for individuals with Intellectual and Developmental Disabilities in the State of Tennessee

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Enhanced Support Coordination

Maladaptive behaviors can be pervasive in individuals with Intellectual and Developmental Disabilities (I/DD), spanning multiple settings and impacting an individual's ability to fully integrate into their community and achieve their personal goals.

Comprehensive care coordination, including effective behavior support that is both proactive and appropriate, can help manage these behaviors. The community-based Employment and Community First CHOICES program in Tennessee embraces and utilizes an integrated approach to care coordination. In order to provide comprehensive care coordination to individuals within the Employment and Community First CHOICES program, the UnitedHealthcare Community Plan of Tennessee utilizes an Enhanced Support Coordination model that combines care coordination services with clinical support (Behavior Supports) in order to effectively support the management of challenging behaviors. The primary goals of the Enhanced Support Coordination model are the preservation of community supports, placements, and tenure; encouragement of the full inclusion of individuals with I/DD in their communities; support for individuals to achieve their personal goals; and assistance to prevent individuals with I/DD from experiencing unnecessary psychiatric admissions or institutional placements. The clinical support utilized in the Enhanced Support Coordination model is provided by behavior analysts and includes several core features, including sound clinical assessment, comprehensive and ongoing staff and caregiver training, and emergent behavior intervention and support.

Behavior Support Needs for Individuals with Intellectual and Developmental Disabilities

Individuals with intellectual disabilities and/or developmental disabilities (I/DD) are initially identified based on cognitive functioning and/or deficits in adaptive functioning. However, this population frequently also presents a range of inappropriate and maladaptive behaviors. Common maladaptive behaviors exhibited by individuals with I/DD include physical aggression, verbal aggression, self-injurious behavior, elopement, socially unacceptable behavior, and disruptive behavior. It is estimated that approximately 30 percent of adults with I/DD exhibit challenging behavior, though some estimates of specific behavior, such as aggression, are as high as 45 percent.[1] Many of these behaviors become barriers to an individual's access to opportunities such as employment, and to their full inclusion in their communities.

The underlying causes of maladaptive behavior exhibited by an individual with I/DD are generally difficult to pinpoint, as challenging behavior can be caused or exacerbated by a combination of factors, including medical conditions (e.g. constipation, an earache), environmental factors (e.g., boredom, social isolation), and/or a mental health condition. Individuals with I/DD, who often have impaired expressive language skills, frequently use behavior to communicate a need or want. It is widely accepted that if an individual exhibiting a challenging behavior continues to engage in the behavior of concern, then they are getting a need met through the behavior; in other words, the behavior is functional for the person.

[1]Treating Individuals with Intellectual Disabilities and Challenging Behavior with Adapted Dialectical Behavior Therapy; Julie F. Brown, Milton Z. Brown, and Paige Dibiaso; July 2013; Journal of Mental Health Research in Intellectual Disabilities

According to Positive Behavior Supports Guidelines published by NASDDDS[2] , "it must be understood that all human behavior is purposeful and goal-oriented, although the purposes or goals of each behavior may not be readily perceived".[3] Individuals with I/DD use behavior to access things or activities they want, to gain attention from their loved ones and/or caregivers, to stop engaging in a task or activity that has become boring or uncomfortable, and/or to avoid a situation or activity that they do not like or that causes them anxiety or discomfort. Therefore, it is not enough to simply "get rid of" a behavior. It is also important to teach an individual a new behavior, one that is more appropriate and also helps them get their needs/wants fulfilled. It is not ethical to remove a behavior that is functioning for an individual without teaching them a replacement, or alternative, behavior that functions in the same manner.

Oftentimes, individuals with I/DD have exhibited and practiced maladaptive behavior for lengthy amounts of time across environments, and as noted above, the behavior works for them. Perhaps the behavior is not dangerous, but is instead socially unacceptable, annoying, and/or irritable to those around the person. Less intense behaviors can also be barriers to the individual accessing their community, making friends, and/or getting a job. In order for behavior change to be meaningful and effective, thereby allowing the individual more opportunities for full participation in their community and/or preventing the need for a more restrictive environment (e.g., psychiatric hospital), behavior intervention and support should be proactive, timely, and comprehensive. Many times, behavior intervention is reactive—services are sought only after an individual's behavior has become dangerous to themselves or others—and there have likely been numerous opportunities to intervene prior the behavior reaching this level. Those who support individuals with I/DD, including family caregivers as well as paid staff, have opportunities each day to positively and proactively support behavior management. Oftentimes, however, these staff and caregivers are not equipped with the most effective strategies or they have not had enough practice using the strategies that are most effective with the individuals they support.

Emergent ABA Support can be necessary when

Individual is at risk for losing their placement	**Individual is discharging from a higher level of care and there are no ABA providers available upon discharge**	**There are no providers with capacity to treat the individual in a timely manner**	**The behaviors do not meet the threshold for traditional ABA services**

Emergent ABA Support can include

Individual specific staff/caregiver training	**Written individual strategies and/or procedures**	**Interim Behavior Support Plan**	**Interim Crisis Plan**

Applied Behavior Analysis

Applied Behavior Analysis (ABA) is a widely accepted and research-based intervention used to manage and change maladaptive behavior exhibited by those with I/DD. According to the national organization Autism Speaks, ABA is a "therapy based on the science of learning and behavior" with the primary goal to "increase behaviors that are helpful and decrease behaviors that are harmful or affect learning."[4] ABA is a covered Medicaid Behavioral Health benefit for individuals with I/DD in Tennessee, as well as most other states in the country. While ABA has proven to be very effective at decreasing maladaptive behavior and increasing appropriate behavior, the intervention is not always accessed proactively or in a timely fashion. Furthermore, ABA is an intervention provided by a Board Certified Behavior Analyst (BCBA), of which there is currently a nationwide shortage as well as an uneven distribution.[5] Some ABA services can be provided by a Registered Behavior Technician (RBT); however, the service provision

[2]NASDDDS is the National Association of State Directors of Developmental Disabilities
[3]Division of Mental Retardation and Developmental Disabilities, Positive Behavior Supports Guideline, revised March 2008, p. 5.
[4]https://www.autismspeaks.org/applied-behavior-analysis-aba-0

of RBTs is supervised by a BCBA. Today there are fewer than 600 active BCBAs in the State of Tennessee.[6] More BCBAs are located in urban areas, which results in even less coverage and longer waiting lists for individuals residing in rural areas. ABA services for adults are even harder to obtain due to the majority of BCBAs providing services only to children.

In addition to the shortage of BCBAs, the process of assessment for and the initiation of ABA services can be a barrier when immediate support is needed. When an individual accesses ABA through their Behavioral Health benefit, the ABA provider must first speak with the individual and caregivers to determine if their level of behaviors will qualify that person for services. Once the provider deems that services are appropriate, they will send an authorization request to the Managed Care Organization (MCO) for an assessment. After the authorization has been approved, the ABA provider requires up to 30 days to complete the assessment, including a Functional Behavior Analysis (FBA) and a Behavior Support Plan (BSP). At that time, the provider can schedule services to begin with the individual. This process does not generally facilitate the opportunity to intervene in a timely and/or emergent manner.

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Matthew (not member's real name)

Matthew is a teenage boy with Autism and severe problem behaviors, including property destruction, physical aggression toward others and self, verbal aggression, and non-compliance. Matthew's additional diagnoses include Intermittent Explosive Disorder and Moderate Intellectual Disability, and his history is significant for numerous inpatient psychiatric admissions. Compounding Matthew's behavior challenges is his size, which enables him to easily intimidate any person who attempts to intervene or manage his behavior. At the time of Matthew's enrollment in the Employment and Community First CHOICES program, he weighed nearly 300 pounds and was six feet tall. Matthew's history is also significant for an in-home ABA intervention, but due to the lack of support in the home to assist his mother with consistent follow-through on recommended strategies and moderate progress after two years, the intervention was discontinued.

In the two years between the discontinuation of Matthew's in-home ABA intervention and his enrollment into the Employment and Community First CHOICES program, Matthew's behavior continued to escalate and become more complex. Upon Matthew's enrollment in Employment and Community First CHOICES, the long-term services and supports (LTSS) BA contacted the ABA provider who had previously worked with Matthew in his home, and the provider agreed to complete an assessment in order to consider the re-engagement of services. The ABA provider completed an assessment, and the response was, "Due to his physical size, his violent history when our agency served him previously, and his violent aggression he continues to exhibit with more intensity and frequency, outpatient ABA services are not recommended in his home or in our clinical office setting that is not equipped for his aggressive behavior, jeopardizing the safety of staff and other clients being served." Though Matthew had previously benefited from home health services, there were no agencies able to support him due to his prior behavior, some of which had resulted in injuries to home health staff.

Due to the severity of Matthew's behavior upon enrollment in the Employment and Community First CHOICES program, the LTSS BA developed an Interim Behavior Support Plan. When Matthew enrolled in Employment and Community First CHOICES, a Personal Assistant (PA) was identified and approved to provide 17 hours of in-home services each week. It was critical that the worker had strategies in order to prevent herself from being harmed, as well as to preserve the services in the home, which were important to maintain Matthew with his family. The Interim Behavior Support Plan primarily focused on prevention strategies to attempt to divert crisis-level behavior and episodes. The plan also included activities that had been determined to be preferred by Matthew and were recommended to be used in order to reinforce his appropriate behavior. After developing the plan, the LTSS BA trained Matthew's in-home worker and primary caregiver on the strategies identified to prevent Matthew's behavior from escalating to dangerous levels.

[5]Open Minds, July 2019
[6]Behavior Analyst Certification Board, bacb.com

Even though the Interim Behavior Support Plan was meant to be a temporary intervention until an ABA provider could be identified that would be receptive to providing services to Matthew, the strategies outlined in the plan facilitated Matthew's in-home services for nearly a year. Matthew's PA did not stop supporting Matthew due to his behavior, like numerous other services had in the past, as she effectively utilized the strategies in the Interim Behavior Support Plan to keep Matthew's behavior manageable and to prevent herself from being harmed by Matthew.

Evolving Models of Services and Supports for Individuals with I/DD

The long-term services and supports (LTSS) delivery model that exists today for people with I/DD has evolved over the last five decades. As late as the 1960's, much of the supports for people with I/DD were provided in large institutions.

In 1971, the federal government authorized federal funding for the first time to support long-term care models for people with I/DD. States could now draw down federal dollars when making available a new optional Medicaid service, Intermediate Care Facilities for Mental Retardation (ICFs/MR). While this signified the transition from the long-standing congregate placements, many of the same services that could be accessed at the large institutions were also available in the smaller institutional settings, such as medical and ancillary supports that those in the facilities needed on an ongoing basis. This new service option was a catalyst for states to begin looking at alternative ways to support people with I/DD.

Support for ICFs/MR's grew quickly, and by the late 1970's, over 40 states had either public and/or private ICFs/MR facilities. This growth of ICFs/MR facilities was the impetus for I/DD advocates to shift their advocacy efforts to more community-based options for people with I/DD. Though the ICFs/MR's were smaller settings, they were still viewed as institutional and other options were sought that were more community-focused. In the early 1980's, Congress passed the Omnibus Budget Reconciliation Act that gave the federal Medicaid agency the authority to 'waive' certain requirements in order for states to provide non-institutional services. With the creation of the Section 1915(c) Medicaid waiver option in the Social Security Act, states could now use this waiver to provide home and community-based services (HCBS) as an alternative to institutional care. Currently, Washington DC and 47 states are operating at least one 1915(c) HCBS waiver.[7] Other notable contributions of the HCBS movement include the passage of the Olmstead decision in 1999, the inclusion of HCBS as a formal Medicaid state plan option in the early 2000's, and the HCBS settings rule.[8]

Today, the majority of individuals are served in their communities with the support of their families and/or community-based providers who specialize in supporting people with I/DD. This shift from institutional care to community-based support largely occurred because of legislative changes driven by a strong advocacy effort by people with I/DD and their families to secure opportunities to live in the community.

State of Tennessee's Employment and Community First CHOICES Program

In Tennessee, there are three Section 1915(c) HCBS waiver programs in addition to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IDDs), formally known as ICFs/MR's. These three waivers [Statewide Waiver Program, Comprehensive Aggregate Cap Waiver Program, and Self Determination Waiver Program] are administered by the Department of Intellectual and Developmental Disability Services (DIDD), which is contracted by TennCare, the state's Medicaid agency, to administer the waivers. These three waiver programs have been closed to new enrollments since July 1, 2016, despite a small exception in the Comprehensive Aggregate Cap Waiver. In 2016, TennCare gained approval to administer a new Medicaid waiver, the Employment and Community First CHOICES Waiver, which is operating under the state's long-standing 1115 Demonstration Waiver. Through this waiver, the state is using private MCOs to provide long-term services and supports to individuals with I/DD. Employment and Community First CHOICES is the first of its kind and is currently only being implemented in Tennessee.

[7]www.medicaid.gov
[8]www.medicaid.gov

The Employment and Community First CHOICES program provides an array of services and supports to individuals of all ages and abilities who have an intellectual or developmental disability. These services include employment, housing, community integration, and other services that focus on helping individuals gain as much independence as possible and fully integrate into their communities. One of the advantages of the use of MCOs in the management of the Employment and Community First CHOICES program is the ability to coordinate care for the whole person, including medical, behavioral, and LTSS within one system.

Direct Support Professionals (DSP): Frontline Staff Supporting Individuals with I/DD in Community-Based Settings

The "backbone" of the LTSS system for those with I/DD is the direct support professionals (DSPs) who work to support individuals with I/DD in various settings.[9] The role of the DSP is vital to the provision of quality services to those accessing home and community-based services. Though the need for DSPs continues to increase, agencies providing LTSS to the I/DD population continue to struggle with recruiting and retaining staff. The demand for DSPs continues to outpace the supply of this important workforce.

Direct Support Professionals (DSPs) can be defined in many ways. At their core, these are the staff members who work side-by-side with aging and disabled individuals to assist them in achieving their goals. The support provided by DSPs ranges from assisting with activities of daily living (ADLs) to providing support within an individual's place of employment to helping an individual manage and regulate emotions and behaviors during difficult periods. DSPs are referred to by various titles, including personal care attendants, direct care workers, job coaches, and employment developers. While the core responsibilities of the DSP may seem basic, DSPs are also expected to possess many of the skills associated with other professions such as nurses, job recruiters, physical therapists, and psychologists.[10] DSPs who work with people who have challenging behaviors need additional skills that enable them to effectively manage the various emotional and behavior challenges they exhibit, while also keeping themselves safe from harm.

There is a growing need for DSPs to provide high-quality care for individuals with I/DD in community-based settings. One barrier to the recruitment and retention of DSPs is related to the training they are provided. While most states mandate courses that require DSPs to spend numerous hours completing prescribed trainings, these trainings are inadequate in preparing staff to provide the day-to-day supports expected of the DSP role. The inadequacy of the DSP training curriculum has an impact on those served by DSPs, and this impact can be even greater for individuals with I/DD who also have challenging behaviors. Ongoing, adequate DSP training is important and necessary for these critical frontline staff because the care they provide impacts the health and safety of those they serve. An additional benefit of a well-trained workforce is the confidence and high job satisfaction experienced by DSPs who receive needed, adequate training.[11] Notably, offering more relevant trainings, which include trainings specifically geared toward supporting those with challenging behaviors, not only improves the skills and confidence of the DSPs, but leads to an overall reduction in DSP turnover.[12]

[9]Bogenschutz, Hewitt, Nord, & Hepperlen, 2014. "The direct support and frontline supervision workforce supporting community living for individuals with IDD: Current wages, benefits, and stability". Intellectual and Developmental Disabilities, 52(5), p. 317.
[10]Bogenschutz, Hewitt, Nord, & Hepperlen, 2014
[11]Ejaz, Noelker, and Menne, 2008
[12]Britton Laws et al., 2014

UnitedHealthcare Community Plan of Tennessee's Enhanced Support Coordination Model

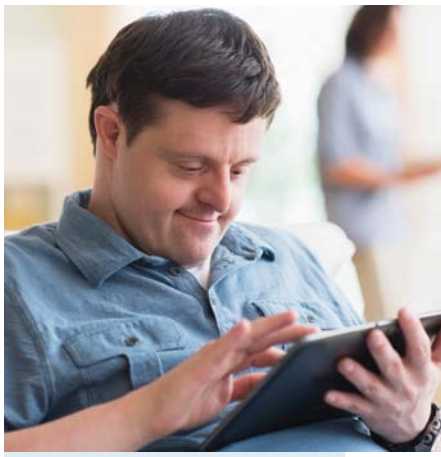
Through our UnitedHealthcare Community Plan of Tennessee, we provide an enhanced model of support coordination for the state's Employment and Community First CHOICES program that includes the addition of statewide behavior supports put in place to support the contractually required Support Coordinators. Key players in the Enhanced Support Coordination Model include the Support Coordinator (SC) and an LTSS Behavior Analyst (LTSS BA), along with family caregivers and Direct Support staff in community-based settings. Each grand region of the state has at least one BCBA, referred to as an LTSS BA. This individual provides clinical support to the SC as they coordinate the care of individuals with I/DD who are referred to the Employment and Community First CHOICES program, many of whom present with maladaptive behaviors. This clinical support is provided in a variety of ways, including through assessments, family caregiver and Direct Support staff training, interim or immediate behavior support, and linkages to appropriate behavioral health clinicians, such as ABA providers.

Support Team for an Individual in Employment and Community First CHOICES

Initial Assessment

From the outset of a referral to the Employment and Community First CHOICES program, information is gathered about maladaptive behaviors. If there is any indication of a history of, or the presence of current maladaptive behaviors, the SC invites the LTSS BA to join the first face-to-face visit with the individual and their caregivers. Even if it is evident that the individual will not qualify for Employment and Community First CHOICES due to insufficient evidence or documentation regarding intellectual or developmental disabilities, the LTSS BA is available to provide information about other resources and benefits that are available to meet the individual's needs. This proactive approach is one of the hallmarks of the UnitedHealthcare Enhanced Support Coordination Model.

The LTSS BA is responsible for completing the initial behavior assessment for individuals referred to the Employment and Community First CHOICES program. This initial assessment



UnitedHealthcare's Enhanced Support Coordination model, through its combination of care coordination and clinical support, provides a level of support necessary to meet the goals established by the Tennessee Employment and Community First CHOICES program, namely full integration of people with I/DD in their communities.

is required by TennCare and it is useful to have a clinician, such as the LTSS BA, available to complete the behavior assessment as soon as possible in order for the appropriate behavior supports to be identified, such as ABA, and implemented proactively. By doing so, a quick and seamless transition into services can be facilitated, whether those services are provided in the individual's home or in a community-based residential setting.

During the initial behavior assessment, if it is evident that the individual needs a long-term behavior intervention, such as ABA services, the LTSS BA begins the process of locating a permanent provider to provide these services. This is another great benefit of the LTSS BA role as this task can be arduous and time-consuming. Because the LTSS BA has formed relationships with ABA providers throughout the state, their knowledge and relationships help facilitate timelier identification of this needed support. When an ABA provider cannot be immediately engaged, and if the individual is not in danger of being placed into a higher level of care due to current behaviors determined by the assessment, the LTSS BA will provide general training to caregivers and/or the DSPs supporting the individuals on basic ABA strategies. The LTSS BA maintains communication with the DSPs and caregivers to ensure that the individual is responding to these strategies and that their behaviors are not escalating to the point of needing more support. The LTSS BA is also prepared and able to provide individualized, direct training to caregivers and DSPs, as warranted.

There are even times when an initial assessment completed by the LTSS BA provides evidence that, though an individual does not meet criteria for traditional ABA services, they exhibit some level of behavior that needs to be addressed. In these instances, the LTSS BA is able to provide individualized training for families and DSPs as well as work in a limited capacity with the individual to address their behaviors. This proactive support can prevent the individual's behavior from escalating to a point where greater intervention, such as an in-home ABA program, is warranted. It can also facilitate a greater opportunity for the individual to obtain a job or more fully integrate into their community.

Training Support

When training is provided in a natural setting, whether in an individual's home or a community setting, these in-the-moment training sessions are particularly helpful because the LTSS BA can work directly with the individual while also explaining and modeling strategies for caregivers and/or the DSPs. Our experience with the LTSS BA providing timely training indicates that the more engaged and knowledgeable family caregivers and staff are, the faster individuals can learn to manage their maladaptive behaviors and move closer toward independence at home and in the community. The LTSS BAs have also observed that when DSPs correctly follow behavior management protocols, behaviors can be significantly reduced. **In just over two years of having the LTSS BA team in place, we have documented that in some instances by the time a permanent ABA provider is engaged, the individual's level of behaviors has diminished to the point that he or she no longer qualifies for ABA services**.

Given the flexible nature of the LTSS BA role, training support can also be provided in other settings in order to support all who interact with the individual. For example, in cases where the individual is a minor, the LTSS BA can attend Individualized Education Program (IEP) meetings and provide training to school personnel at the same time, when permitted. Collaboration between school and home settings can be integral to behavior change. Although many schools do not allow Behavior Analysts into their classrooms, the LTSS BAs can reach out to develop a relationship with the school serving the individual. If in-school trainings are not permissible, the LTSS BA can work in partnership with school behavior personnel to discuss strategies that can be used both at school and at home. Another example of this level of important collaboration occurs when an individual prepares to enter a job placement. For these individuals, an LTSS BA can support their job coaches with training as well. The LTSS BA is able to train employment staff in basic ABA strategies as well as strategies individualized to the employee. This synergy can allow for consistent interventions to be used across settings, increasing the likelihood of positive behavior change.

Behavior Support Plan

Completion of the behavior assessment and training are two types of support that are provided by the LTSS BA. However, as noted earlier, there is currently a shortage of BCBAs to provide in-home ABA interventions for individuals with I/DD. The LTSS BA is critical to providing needed support in real time, including the development of an Interim Behavior Support Plan.

An Interim Behavior Support Plan can prevent an individual's disruption from their current placement, can divert an individual from a higher level of care, or can facilitate a successful transition from one setting to another. When the initial assessment provides evidence that an individual is in critical need of behavior services prior to the time when a permanent ABA provider can begin services, the LTSS BA's ability to initiate an Interim Behavior Support Plan is critical to maintaining and preventing their behavior from escalating. LTSS BAs begin training caregivers and DSPs on the Interim Behavior Support Plan as soon as possible so that strategies and interventions can be implemented quickly to maintain an individual's stability. The LTSS BA also will regularly monitor and provide ongoing support and training related to the Interim Behavior Support Plan until a permanent ABA provider is in place.

Discharge Planning and Transition

The LTSS BA is generally also involved in discharge planning, including training staff or family caregivers on strategies to support an individual with I/DD as they leave a highly structured setting to transition back home or to a new community-based placement such as a Community Living Support (CLS) housing option. Transitions, especially from a higher level of care to a community placement, can be a particularly challenging experience for individuals with I/DD. Given the flexible nature of the LTSS BA position, they are able to support facilities, the receiving provider agency and their staff, and/or family members on both sides of the transition process. Because transitions can be especially difficult for individuals with I/DD, planning proactively to address behavior challenges is vital to their successful transition.

Alicia (not member's real name)

Alicia, a young adult with Autism, was living at home with her parents in a rural county in Tennessee at the time of her Employment and Community First CHOICES referral. Shortly after her enrollment in the Employment and Community First CHOICES program, she was admitted to the psychiatric unit of a local hospital and her parents asked the Employment and Community First CHOICES Support Coordinator to begin looking for Community Living Supports (CLS), a community-based, residential placement for Alicia. Due to her recent maladaptive behavior, the LTSS BA completed an initial behavior assessment in order to help establish the level of support Alicia would need in the CLS setting. Once Alicia transitioned from her home setting to CLS, her challenging behavior intensified, and the LTSS BA completed an additional assessment, observed Alicia in her CLS setting, and regularly reviewed staff daily notes. Alicia's behavior history and behavior in the CLS setting was significant for self-injurious behavior, extreme temper tantrums, and verbal and physical aggression toward others. Alicia also had a history of telling fabrications that sometimes led to criminal investigations of family members and caregivers, and immediately after transitioning to the CLS, it was also discovered that she engaged in other unsafe behavior, such as sending nude photos of herself to strangers (including minors).

The initial assessment completed by the LTSS BA indicated a need for ABA services, and the process of locating an ABA provider for Alicia began. Unfortunately, the county in which she lived is an underserved area for ABA providers. Due to the immediate needs with which Alicia presented, the LTSS BA began the process of completing a Functional Behavior Assessment and drafted an Interim Behavior Support Plan. The goal of this plan was to put strategies and interventions immediately in place to support Alicia and her staff and to preserve her community placement until a permanent ABA provider was located. The DSPs in the home as well as the home manager were trained on the Interim Behavior Support Plan, and additional training was completed as staff members practiced the strategies set forth in the plan as well as when new staff members started working in the home.

Baseline data collected prior to the intervention indicated that Alicia engaged in maladaptive behaviors an average of four times per day. A data collection plan was put into place and showed within a month that Alicia's maladaptive behaviors had reduced to an average of two per day. Within just a few months, Alicia's inappropriate behaviors had reduced to less than one per day. Due to the success of the interventions and Alicia's hard work, she was able to join her family for a vacation, which she had not done in numerous years. Additionally, Alicia began spending one to two weekends per month in her family home, where she spent time with her family, including the family dogs. These were activities that she talked about often with her support staff but that had not been possible when she was exhibiting a significant level of challenging behavior.

The LTSS BA was able to locate a permanent ABA provider in less than a year. The BCBA conducted a Functional Behavior Assessment over the course of a thirty day period. During that time period, Alicia's maladaptive behaviors showed a rate of zero. The BCBA was unable to serve Alicia as she did not meet criteria for ABA services as she was not exhibiting any maladaptive behavior during the assessment period. In essence, the opportunity to implement an Interim Behavior Support Plan, which allowed Alicia's behavior to be addressed immediately, not only preserved Alicia's community placement and prevented the need for multiple inpatient admissions, but the need for a long-term behavior intervention was also averted.

Conclusion

The UnitedHealthcare Community Plan of Tennessee's Enhanced Support Coordination model was developed to facilitate the success of the goals of the Employment and Community First CHOICES program. By maintaining community tenure and preventing inappropriate inpatient admissions for people with I/DD, the model provides individuals with I/DD opportunities to fully access their communities. However, unintended additional positive consequences of the model have been realized on many levels, ranging from more confident and better trained caregivers and staff to a reduction in the need for long-term interventions to greater provider satisfaction. According to data obtained via telephonic surveys with Employment and Community First CHOICES providers and ABA providers, the support available from the LTSS BA contributed to marked differences in the effectiveness of behavior supports and decreases in maladaptive behavior. Providers reported higher levels of engagement with DSPs and their implementation of behavior strategies when they were provided with the additional support of the LTSS BA.

Though the Enhanced Support Coordination model was only implemented two years ago in Tennessee, the impact of the model has been significant and is suggestive of a more effective means of supporting people with I/DD, including those with the most complex and challenging behavior support needs.

For more information about UnitedHealthcare Community Plan of Tennessee's Enhanced Support Coordination model, please contact Jovanna Emerson, Ph.D., Tonya Copeland, MBA, and Wendy Sullivan, BCBA.

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