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Treating Mental Illness & Co-Morbidity Development Disability—The Merakey Model

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Some of the best-practices for delivering home- and community-based services include the need to create interdisciplinary teams to deliver consumer-centric, personalized services across "flexible" service locations. For more on what a "best-practice" program looks like, we had a chance to sit down with Merakey Clinical Lead Specialist Kristin Cline, and Merakey Clinical Director Kevin Kumpf, Ph.D. about Merakey's dual diagnosis treatment services: Dual Diagnosis Treatment Teams (DDTT), which operates in Pennsylvania, and Intensive Transition Services (ITS) in California.

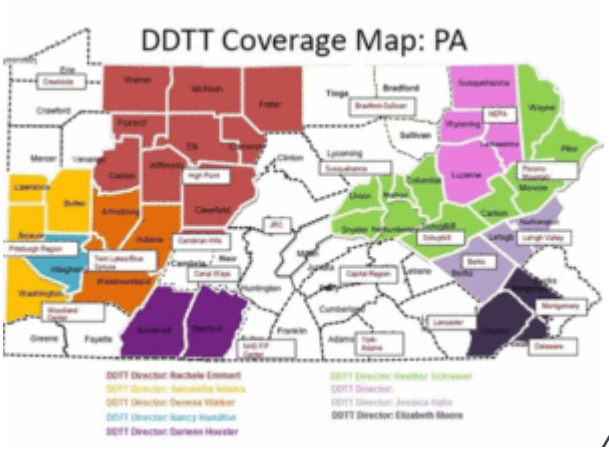
Kristin Cline, Merakey

Kevin Kumpf, Ph.D., Merakey

Merakey is a national non-profit organization that provides developmental (4,015 consumers), behavioral health (35,944 consumers), and education (1,468 consumers) services through 1,194 different programs at 779 sites and employs almost 10,000 staff. In 2018, Merakey reported $549,751,844 in revenue that included $206 million for behavioral health services, $280 million in intellectual and development disability services, and $32 million in education and autism services (see Merakey 2018 Annual Report). Merakey also assumed a rebranding initiative last year, moving from the name NHS, to Merakey. Founded in 1969 as the Northwest Center, Merakey was also recognized previously as Northwestern, NHS Human Services, and NHS. All former and affiliate sites were renamed to Merakey, while its corporate headquarters remain in Lafayette Hill, Pennsylvania (for our coverage of Merakey's rebranding effort, check out From NHS To Merakey—Rebranding In Action: An Interview With Leah Pason & Trish Pisauro Of Merakey).

One of the primary programs focused on home- and community-based services at Merakey is the Dual Diagnosis Treatment Team (DDTT). DDTT provides treatment, support, and education for individuals in the community diagnosed with a mental illness and a co-morbid developmental disability. Individuals referred to DDTT are in crisis, at risk of losing community tenure, and/or are transitioning from acute care hospitalization (see NHS Dual Diagnosis Treatment Team Receives Full Accreditation from NADD). Services are provided an average of three times per week for each consumer, over a 12 to 18-month period that progresses through three phases: assessment (initial phase and ongoing); treatment (evidence based and data driven); transition (individualized fade plans) (see Innovative Community-Based Care Models For Consumers With Complex Conditions). Ms. Cline explained:

We have a long history of community-based services. DDTT is that integrated model for mental health as well as I/DD diagnosis support. We have a similar service in our Intensive Transition Services (ITS) team, in California, that we started this past summer.



As far as DDTT is concerned, each team serves between 16 and 30 consumers, depending on geographic area, population density, and things of that nature. So, it's a small team. The California team each cover up to 20 consumers. They are still in startup so one team has 11, and the other team is working on their fifth referral. That just started in August, but the referrals are coming through quickly. The regional centers out there manage the referrals, so as they have individuals that need to transition out of their institutions, or IMDs as they call them, they refer them to our teams.

Over 90% of the contacts are done in the community. What we mean by the community, we mean typically the person's home. Sometimes they may go inpatient for whatever needs. Let's say someone needs surgery, or someone needs to go to rehab, we meet them there. Each person is seen three times a week, not including crisis. We do offer 24/7 support. So, wherever they are that's where we go. If they live in a group home that is where we go, if they live with family, that's where we go. Some of our individuals live independently. Some of them in more urban areas are homeless, and our staff go to the homeless camps and we work to find them state affordable housing. It really is an on the road treatment. The only time they come to office is for the psych evaluation which starts on admission, and then usually every six months while they are in the programs.

Funding

Consumers in the program have both Medicare and Medicaid. Ms. Cline expanded:

Our folks in Pennsylvania are all what we call HealthChoices funded. So, they are paid by the managed care organizations. In California, it's kind of the same deal but we are paid directly by the regional center. It's the same type of population, Medicare and Medicaid in California.

Staffing

DDTT is comprised of a specialized mobile team of professionals including psychiatrists, behavioral specialists, recovery coordinators, nurses, and a pharmacist consultant. In Pennsylvania there are nine teams and these teams have 60 or 70 staff total, depending on the individual team. In California there are two teams with a total of 12 staff members. Mr. Kumpf explained the importance of finding and retaining the right staff members:

A big part is that the positions are advertised appropriately and that candidates understand the nature of this service. Part of that is the education piece when people interview and making sure they know what they are signing up for. And there is also making sure that you are wrapping enough support around the staff. If the staff feels supported, and there is an internal team that provides enough support to each team so that any clinical concerns that might arise, that clinical team would be available on a regular basis to intervene and provide guidance to the staff. As you know, this population has a great degree of clinical complexity attached to it, and you need the support mechanisms in place.

The turnover is consistent with what you would see with any other community-based program. I think we do a pretty good job of retaining staff and that support piece is important. We constantly use feedback from the team members for what we can do to improve the service for the consumes as well as for the staff experience. We are

constantly updating our model, policies and procedures to make the program more efficient and more effective.

Also key to proper staffing for the DDTT teams is training, which Ms. Cline explained:

Everyone that comes in to DDTT, no matter what the level, everyone gets at least 45 hours of training for specific dual diagnoses and Merakey as a whole. When they come in, we teach them everything they need to know to get them up and running. Obviously, we are particular when we hire about the skillset people need to have. There are specific recommendations, some of our contracts require certain things.

So, there is that off the bat, and then there are training in the things they are going to have to utilize. For example, we have a motivational interviewing training, we have aspects of serving the recently diagnosed. We have trainings on the treatment plan, on the safety plan, on Merakey as a whole, policies and procedures, whether they are corporate or specific to the programs. And from there, each staff must receive at least 24 of training of training every year. We make sure they have the training they need to complete their job.

Performance

While DDTT doesn't have value-based contracting, Ms. Cline and Mr. Kumpf noted that some Merakey service lines do have VBR contracts and the organizational as a whole has a metrics-based approach that DDTT also pursues. Ms. Cline explained:

We are aware of that VBR is an emerging thing that many managed care organizations are doing. Some of our other service lines have a value-based or pay for performance contract. We do not at this time, however we do monitor the same types of things that those teams would. So, looking to get people involved in educational and vocational services. Making sure that we are offering high quality and high value care, working to get people to be as independent as possible. While we aren't directly influenced by that, we are still trying to make sure we are promoting that for our individuals.

We have two main key performance indicators (KPI). Our main KPIs are a reduction in inpatient psychiatric hospitalizations by 20% for each consumer. So that's looking at the number of inpatient psychiatric hospitalizations or acute care institutional stays pre-admission, and we go 18 months if we can. We look at intervals of six months—we go 18 months, 12 months, and six months pre-service. Then they come to DDTT, then we are looking at six months, 12 months, 18 months in treatment. We are trying to collect those metrics to post discharge.

Our other KPI is psychiatric hospitalization inpatient readmission reduction. So that's looking at the number of folks that are admitted into a hospital at any given moment in time and then at any readmission within 30 days of discharge from that first admission. Same timeframes of 18, 12, and 6 months pre; and 6, 12, 18-month post DDTT.

Advice

Ms. Cline and Mr. Kumpf recommended that provider organizations that are looking to build a similar program pay close attention to both their resources, and the motivations for the program in the first place. Mr. Kumpf addressed the need for "considerable resources" and the upfront costs necessary to start the program. He noted:

Often there are considerable costs to start up, and there is an intricate team comprised of a diverse set of treatment professionals, some of which are licensed that require psychiatric care and oversight. And there is the clinician expertise as well. You need all those things. Over time, you need resources as well to establish relationships in the community with stakeholders. There are several things in play that you need to make this a success.

Ms. Cline's advice? There is a big difference between a program designed to provide services and one designed to care for people. She noted:

I can't tell you how many times that administrators or us from a clinical perspective have gone out in the evening if someone needs something. I still get calls sometimes at 2 in the morning. I'm never going to say don't call me if you need something. If you need something, call. You don't see that everywhere and that really makes the difference. That's the heart of it. Our staff genuinely care about the people they work with. This person is our focus, they matter, they need advocacy and care and us to wrap around them to make sure we're supporting them, so they are living their best life.

If you don't truly care about the individual, this won't be successful. The answer isn't always from a book or some deeper clinical theory. The answer sometimes is that this person is lonely, and that's why they are calling 911 every night.