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To Whom It May Concern:

Please accept the following as the official response from Autism New Jersey's Applied Behavior Analysis (ABA) Advisory Committee for the **Request for Information Regarding Contract Deliverables for Out of Home Treatment Services for Youth and Young Adults with Intellectual and Developmental Disabilities and Severe Behavioral Challenges.**

Autism New Jersey's ABA Advisory Committee has worked closely with the Children's System of Care over the last three years to provide technical assistance and policy recommendations for the Intensive In-Home service line, and we are pleased to provide input into this RFP.

Question:

*1. What do you consider an ideal setting for the delivery of services to youth with Intensive I/DD? More specifically, CSOC is considering a requirement that these services be provided in a campus setting instead of in a single five-bed home or a hub. What would you define as an acceptable campus style setting? For example, would this be separate structures on the same property, or could this be a larger structure housing more than five youth simultaneously?*

Response:

- A campus setting with multiple, 4- to 5-person, single-level homes would be the most ideal setting for this program\*. Larger structures that can serve more than 5 youth typically tend to have a more institutional feel but if the structure could allow for customization based on gender or need (e.g., rehabilitation center), then it may be appropriate for this program. The homes or cluster of homes should also incorporate safety measures that allow for youth who elope or wander to be safely served. Examples of such safety measures are video cameras, delayed egress door locking systems, magnetic window locks or restrictors, and secure perimeter fencing.
- \*Although this type of setting is ideal for this population and their acute and continuous needs, we recognize that a provider may struggle to find an existing suitable location and how expensive it would be to build or renovate.

Question:

*2. The non-cost related, fixed per diem rate per youth for OOH contracts is based partly on the costs of the credentialed staff required to provide the services. Providers bill for this rate via the fiscal intermediary for Medicaid. Considering that the target population for this program is youth and young adults with a variety of I-IDD needs (See Section 1, pages 4 – 5), including, but not limited to Autism Spectrum Disorder, should the credentialed staff configuration required for this IOS and the corresponding rate be reconsidered for the delivery of appropriate services to these youth? (In Attachment A, see Exhibit E for reference) More specifically:*

Response:

- Before responding to the questions about staffing patterns, we would like to make a recommendation about the overall design of the program. From our understanding of the admissions to the two existing Intensive I/DD programs, there are two categories of youth being referred to these programs:
  - youth in need of assessment and treatment
  - youth who have recently participated in effective treatment and now require consistent implementation of their treatment plans so that their behavioral gains can be maintained over time and generalized to lesser restrictive settings and their normal routines.

We recommend establishing two phases within this program: 1) Assessment and Treatment, and 2) Generalization.

- **Phase 1 - Assessment and Treatment** – This phase would typically be the first 4-5 months of the program. Given the acute safety and behavioral needs that often preclude successful school participation, the sole focus of this phase would be the assessment and treatment of the challenging behavior, beginning with a Functional Analysis of the problem behavior(s). In lieu of school, the youth would receive two hours of homebound tutoring a day. The remainder of daytime hours would be focused on the assessment and treatment of the challenging behavior.
- **Phase 2 - Generalization** – This phase would begin once the treatment is officially written into IHP and is implemented consistently throughout the day. Tutoring hours would begin to increase along with transition planning to build back to a full day of school. Clinical staff would continue to assess the efficacy of the treatment in different settings and train the school's staff to ensure consistency across settings. Discharge planning to a less restrictive setting would also begin during this phase.

a. *Should DCF change the type and number of the professionals? If so, how?*

- **Add:**

- i. Special Education Teacher – (3-4 FTE's) these teachers would provide the 2 hours of homebound tutoring for the youth who are not in school full-time. Important to note that these positions would be funded by revenue from the youths' school districts and should not factor into the formula of determining the program's per diem rate.

- **Change:**

- i. Change Behavior Specialist to Board Certified Behavior Analyst (BCBA) (3 FTE's, 1 per home)
- ii. Behavior Technicians (6 FTE's, 2 per home) – responsibilities should be changed to assist the BCBAs in the assessment and treatment functions of the program along with overseeing the treatment plan and training the milieu staff on proper implementation
- iii. Psychiatrist – this does not need to be a full-time position. With the support of the nursing staff, 5 to 10 hours per week would be sufficient. Also, allow the flexibility for this position to be licensed psychiatric nurse practitioner.
- iv. Speech Therapist – does not need to be a full-time position. Provides intake assessment and consultative services, if needed. Additional consideration should be given to a speech therapist with experience working with feeding and swallowing disorders (10 to 15 hours a week)

- **Remove\*:**

- i. Psychologist
- ii. Allied Therapist
- iii. Occupational Therapist

\*Our recommendation to remove these positions is not to suggest that these professionals do not provide valuable services, but rather keeping the focus of this program on stabilizing the youth by reducing challenging behavior. Once stabilized and back in school, the youth can most likely access these services via their IEP, if they are needed.

*b. Should DCF change the credentials for each of the professionals required? If so, how?*

- Program Director – strong consideration should be given to requiring this position to be a BCBA or BCBA-D with program and supervision experience. The Program Director should supervise the BCBAs and could act in their capacity if there is a vacancy or if assistance is needed with assessment and treatment.
- Milieu staff – these are entry level positions for direct support professionals. The current qualifications would make it difficult to keep this program properly staffed. Change qualifications to a bachelor's degree/no experience or high school diploma with one-year experience.

*c. Should DCF increase or decrease the number of professionals required? If so, how?*

- See response to Question 2a. above

*d. To what extent should a Psychiatrist and Psychiatric APN be involved?*

- Primarily available for weekly rounds and medication monitoring, recommendations, and changes.

*e. How would you defend the use of tele-psychiatry as acceptable in meeting minimum requirements of psychiatry?*

- Initial assessments should be face to face but on an ongoing basis it would be useful for participation in rounds, discussions with nursing staff, or other ongoing monitoring that may be necessary. Given the small pool of available psychiatrists with expertise in this sub-population of youth with I/DD, tele-psychiatry can be a cost-efficient and effective means to ensure psychiatrist availability and communication with the treatment team.

*f. Should DCF consider minimum specialized experience and/or education for direct care staff?*

- Given the unique nature of this program, most potential direct care staff will not have had any similar opportunities to obtain relevant experience. The program should have detailed hiring and selection guidelines that focus on a strong desire to work with this population of

youth, interest in Applied Behavior Analysis (ABA), and physical requirements that match the strenuous nature of the work. The program should have a strong ABA-based initial training and ongoing education opportunities that allow the direct care staff opportunities for professional development.

*g. Is the ratio of 1 staff per 2 youth adequate to meet the intensive and varying needs of this population? Are there particular shifts or circumstances that would require additional staff support?*

- No. The day and evening shifts should be closer to a 1:1 ratio. A 1:2 ratio on the overnights is typically sufficient. There could be times where it may be 3:4 or 4:5 given the make-up of the youth residing in the program. Ratios should be determined by the clinical needs of the youth residing in that home but in general, it would be difficult at best and unsafe at worst to provide the type of programming that these youth need at levels less than 1:1.

*h. Is a full-time dedicated program director for up to 15 youth appropriate?*

- Yes

*i. Is a full-time dedicated house manager for each dwelling on the campus appropriate?*

- Yes

Question:

*3. Can DCF leave more to the discretion of the provider, such as the configuration and time of the delivery of services that best serves each youth within a period, while still requiring a minimum level of services for each youth, in the interests of promoting more individualized treatment?*

Response:

- Yes

Question:

*For example,*

*a. Should the minimum number of hours of specific services be provided to a youth over a longer period, such as monthly instead of weekly? (In Attachment A, see Exhibit E for reference)*

Response:

- Yes. This would allow the clinical team to adjust their allocation of time depending on the needs of youth throughout the program. These minimum hour requirements should also vary depending on the phase of the program.

Question:

*b. Should the costs of the services of certain types of professionals, such as a speech therapist or a psychologist who may not be needed by all youth in a program, be counted as overhead rather than in the cost per youth? If so, which professionals? Who should be involved in determining whether the services of some professionals are needed to inform the youth's care?*

Response:

- Our recommendations in response to question 2a. along with the other positions listed in Exhibit E provide a proven framework for this type of program. We are recommending removing the positions that would possibly be included as overhead costs due to the infrequency of use. The interdisciplinary team which would consist of the behavior analyst, psychiatrist, nursing staff, speech therapist, program director, and parent/guardian and should be the group that determines which services the youth needs.

Question:

*4. Are the potential medical care needs of these youth adequately addressed by the deliverables in the attachment? Is it sufficient that youth access any additional medical care they may need through community resources, or should more medical care be available on site?*

Response:

- The around-the-clock nursing model listed in Exhibit E should be adequate in most situations. When selecting an organization to develop this program, preference should be given to organizations that have a physician as Medical Director or Chief Medical Officer and can be available as needed and/or to sit in as a member of the interdisciplinary team. Community resources can and will be used but can be challenging with these youth, especially for smaller issues that could be easily handled by an on-site physician.

Question:

*5. Are there changes to the requirements that will reduce the administrative burdens on providers, while freeing more resources and time for direct service delivery? For example, are the contractual requirements for documenting the duration and topics of sessions reasonable and consistent with best practices?*

Response:

- The requirement for the clinical team to document duration and types of session seems reasonable. We would just suggest that if the program/organization has an established way of currently doing this, that they are not forced to duplicate this process into another system for this program. Also, graphical representation of data from a session should be an acceptable way of meeting the contractual requirements.

Thank you for these thoughtful questions and the opportunity to offer our recommendations to better serve children and adolescents with intellectual disability and severe challenging behavior. We remain ready, willing, and able to provide additional details and consultation regarding program models that best meet the treatment needs of youth with ID and severe challenging behavior.

Sincerely,

Autism New Jersey's ABA Advisory Committee

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