Dual Diagnosis Treatment Team (DDTT)

One Individual at a Time
Objectives

To gain an overall understanding of:

- The structure of the DDTT model
- The dynamics of the team approach
- The effectiveness of this model and review recent outcomes
- The use of care coordination in facilitating high quality care
- How to create and evaluate a care coordination plan
What is a Dual Diagnosis Treatment Team?
What is DDTT?

• Dual Diagnosis Treatment Team (DDTT) is recovery oriented:
  ▫ Diagnosis of mental illness and IDD
  ▫ Team approach to service coordination and treatment
  ▫ Person-centered, holistic approach
  ▫ Community-based
  ▫ Focus is on skill transfer
  ▫ Providers of care coordination for consumers, supports and treatment entities
$357,000 — 164 Referrals

DDTT Director: Rebecca Dempsey
DDTT Director: Michelle Hetrick,
DDTT Director: Samantha Stitzel
DDTT Director: Maria Kohan

DDTT Director: Nancy Hamilton
DDTT Director: Gerardo Grasso
DDTT Director: Elizabeth Moore
DDTT Director: Alison Berger
NHS DDTT Service

- Divisional (Service Line) Structure supports integrated approach
- Collaboration between Clinical and Operational leadership across the Behavioral Health and Intellectual and Developmental Disabilities divisions
- Intensive development phase
- Ongoing monitoring and review of service delivery
DDTT Staff

- Psychiatrist
- Psychiatric Consultants
- Certified Registered Nurse Practitioner
- Registered Nurse
- Pharmacist Consultant
- Director
- Behavior Specialist
- Recovery Coordinators
- Administrative Assistant
Dual Diagnosis Treatment

Focuses on:
- Continuity of care
- Hospital diversion
- Service and care coordination
- Specialized staff education and training
- Enhancing the individual’s support network

Concepts based on:
- Assertive Outreach
- Mobile Treatment Teams
- Continuous Treatment Teams
- Person Centered Orientation
- Holistic Approach
Characterization of DDTT

- A team approach
- Services in natural environment
- A small caseload of 14-22 individuals
  * Extended team 30 DDTT of Allegheny
- Time-limited services (12-18 months)
- A shared caseload
- Flexible service delivery
- Fixed point of responsibility
- Crisis management available 24 hours a day, 7 days a week
- Care coordination with individuals and their supports (personal and professional)
Attention to Individuals’ Needs

• DDTT staff work closely with individuals to develop plans to help facilitate their recovery

• An average of three face-to-face contacts per week

• Maintain open availability for updates and ongoing collaboration for coordination of care

• Communication through morning meeting structure

• As individuals’ needs change, the team adapts immediately
Innovative Treatment Strategies: Pharmacogenomics & DDTT

- NHS DDTT is partnering with Assurex Health Inc. to provide GeneSight testing
  - Analyzes genes within an individual’s DNA to evaluate metabolism and responses to medications
  - Provides the prescriber with valuable information when considering psychiatric medications
Short-Term Service

• Services will be provided for an individual over a 12-18 month period in various phases:

  Assessment ...

  Stabilization...

  Treatment ...

  Transition ...

• Discharge planning begins on day one

• Brief service period
Admission Criteria

• 18 years of age or older

• Major psychiatric disorder

• Intellectual Developmental Disability (IDD)

• Frequent crisis services and at least one psychiatric hospitalization within the last year

• At risk of losing current community housing/support

• At risk of placement in a criminal detention setting

• Requires transitional services back to the community from a higher level of care
# Supervision

## Clinical Supervision

<table>
<thead>
<tr>
<th>Person Receiving</th>
<th>Person Able to Provide</th>
<th>Minimum Frequency</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDTT Behavior Specialist</td>
<td>DDTT Program Director</td>
<td>1 x monthly</td>
<td>Clinical (Individual)</td>
</tr>
<tr>
<td>DDTT Recovery Coordinator</td>
<td>DDTT Program Director and/or DDTT Behavior Specialist</td>
<td>1 x monthly</td>
<td>Clinical (Individual)</td>
</tr>
<tr>
<td>DDTT Nurse</td>
<td>DDTT Program Director and/or DDTT Psychiatrist</td>
<td>Monthly</td>
<td>Clinical (Individual)</td>
</tr>
<tr>
<td>DDTT CRNP</td>
<td>DDTT Psychiatrist</td>
<td>Monthly</td>
<td>Clinical (Individual)</td>
</tr>
<tr>
<td>All DDTT Staff</td>
<td>Regional Service Line</td>
<td>Monthly</td>
<td>Group Supervision available, not mandatory</td>
</tr>
</tbody>
</table>

## Administrative Supervision

<table>
<thead>
<tr>
<th>Person Receiving</th>
<th>Person Able to Provide</th>
<th>Minimum Frequency</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDTT Program Director</td>
<td>Regional BH Director or DDTT Lead Specialist</td>
<td>1 x monthly</td>
<td>Individual or Group</td>
</tr>
<tr>
<td>DDTT Staff (RN, BSP, Recovery Coordinator)</td>
<td>DDTT Program Director</td>
<td>1 x monthly</td>
<td>Individual or Group</td>
</tr>
</tbody>
</table>

## Morning Meeting

<table>
<thead>
<tr>
<th>Person Receiving</th>
<th>Person Able to Provide</th>
<th>Minimum Frequency</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>All DDTT Staff</td>
<td>DDTT Program Director</td>
<td>3 x Weekly</td>
<td>Group</td>
</tr>
</tbody>
</table>

## Clinical Consultation

<table>
<thead>
<tr>
<th>Person Involved</th>
<th>Person Able to Provide</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDTT Staff (RN, BSP, Recovery Coordinator)</td>
<td>IDD Clinical Specialist, ABH Clinical Specialist &amp; BCBA</td>
<td>As needed</td>
</tr>
<tr>
<td>DDTT Psychiatrist</td>
<td>DDTT Pharmacist Consultant, Program Director &amp; Peer Consultation</td>
<td>As needed</td>
</tr>
<tr>
<td>DDTT Program Director</td>
<td>DDTT Psychiatrist, IDD Clinical Specialist, ABH Clinical Specialist, Peer Program Director through DD Peer Consultation Group</td>
<td>As needed</td>
</tr>
<tr>
<td>DDTT Nurse/CRNP</td>
<td>DDTT Psychiatrist</td>
<td>As needed</td>
</tr>
</tbody>
</table>
DDTT: A Recap

• Explicit admission criteria
• Small caseload of 14 to 22* individuals
• 24-hour coverage
• Responsible for coordination of care with existing and new providers
• Delivery of direct treatment services
• Time-limited services: 12 to 18 months

*Allegheny team has an enhanced staffing compliment to accommodate a larger caseload
DDTT
Cycle of Care
DDTT Lifecycle

1. Assessment
2. Stabilization
3. Treatment
4. Transition
Referral

- Referral criteria
- Interagency Meeting
Admission Responsibilities and Documentation

• Complete intake the day of interagency meeting
• Complete initial Treatment Plan
• Complete Personal Safety Plan
• Develop communication strategy
Comprehensive Assessment

- Multimodal in design
  - Bio-psychosocial

- Typically includes
  - Functional Behavior Assessment
  - Medical Assessment
  - Sensory Evaluation
  - Trauma Screening
  - Social Assessment and Timeline
  - Psychiatric Evaluation
  - Adaptive Functioning
Integrated Recovery Treatment Plan

- Person centered outcomes
- Long-term and short-term objectives
- Actions steps
- Addresses specific aspects and complexities of individual
- Includes the Personal Safety Plan
- Resource Guide
Continuous Treatment Planning

Evaluates the individual’s needs and effectiveness of treatment

- Morning meetings - three times per week
- Treatment team/planning meetings every 30 days
- Update Treatment Plan every 120 days
- Update psychiatric evaluation every 6 months
Discharge

- Short-term service is 12 to 18 months
- Discharge Summary
- Timeline
Brief Service Period

• Available within 1 year of discharge
• If relapse of original behaviors
  ▫ Life event
    • Trauma
    • Change of supports
• Four weeks
• Review of original assessment and Integrated Recovery Treatment Plan
DDTT
Quality Assessment and Outcomes
Challenges

• Large geographic area
  □ Travel time

• Level of trauma with this population
  □ Lack of specialized treatment providers throughout PA

• Lack of stabilization options/unique need of this population

• Co-morbidity issues that effect this group

• Building dual diagnosis capacity in the community
Outcome Expectations

Key Performance Indicators

- **Reduction in:**
  - ER visits for behavioral health needs
  - Inpatient hospitalizations
  - Readmissions (inpatient stays within 30 days of prior stay)
  - Number of ER presentations and inpatient hospitalizations
  - Number of incarcerations and days incarcerated
  - Number of calls to crisis services and law enforcement

- **Increase in:**
  - Length of time an individual maintains housing
  - Acquisition of independent living skills
  - Number of individuals engaged in meaningful day activities
  - Connections to and support from natural supports
  - Evidence of satisfaction with program delivery
Outcomes

Individuals Served through July 31st, 2016

- Total Individuals Served: 245
- Currently in Care: 116
- Discharged from Care: 129
Outcomes

Discharge Disposition

- Successful: Met all Highest Prioritized Treatment Goals: 64%
- Individual Admitted to a Higher Level of Care at Discharge: 4%
- Individual Disengaged from Treatment / Refused further care: 10%
- Team Disengaged from Treatment: Family: 5%
- Team Disengaged from Treatment: Residential Provider: 2%
- Team Disengaged from Treatment: Other Provider: 2%
- Individual Relocated out of the DDTT Coverage Area: 5%
- Case Transfer to Another DDTT: 2%
- Incarcerated at Discharge: 1%
- Loss of Insurance Coverage: 3%
- Death: 1%
- Medically Unstable: 1%
Outcomes - Decreased Hospitalizations

Pre Admission vs. Post Admission
Acute Care Hospitalizations

- 18 Months Pre Admit
- 12 Months Pre Admit
- 6 Months Pre Admit
- Month 1-6
- Month 7-12
- Month 13-18

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Inpatient Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Months Pre Admit</td>
<td>64</td>
</tr>
<tr>
<td>12 Months Pre Admit</td>
<td>102</td>
</tr>
<tr>
<td>6 Months Pre Admit</td>
<td>224</td>
</tr>
<tr>
<td>Month 1-6</td>
<td>78</td>
</tr>
<tr>
<td>Month 7-12</td>
<td>29</td>
</tr>
<tr>
<td>Month 13-18</td>
<td>8</td>
</tr>
</tbody>
</table>

- Data Includes Residential Treatment Facility stays in pre-admission
- Sample size differences
- Pre-admission data may not be all inclusive
Outcomes - Decreased Days Spent in Acute Care

Length of Stay -- Pre and Post Admission to DDTT

- 18 Months Pre Admit
- 12 Months Pre Admit
- 6 Months Pre Admit
- Month 1-6
- Month 7-12
- Month 13-18

Data Includes Residential Treatment Facility stays in pre-admission
Sample size differences
Pre-admission data may not be all inclusive

Inpatient Days

Month 1-6
Month 7-12
Month 13-18

538
2399
3822
1472
564
294
Care Coordination
What is Care Coordination?

• Is an ongoing process
• Helps ensure that an individual’s needs and preferences for health services
• Ensures that information sharing occurs across various domains (people, functions, and sites)
• Determines points of care and accountability between providers to support an individual through the system in the most efficient way possible
Failure of Care Coordination

When systems working with individuals do not do care coordination well, results can be devastating

- Individuals may end up in a system that cannot meet their needs.
- When treatment entities don’t communicate, individuals may be improperly treated for physical, mental, social and emotional needs.
- Gaps in treatment or failed transition to appropriate care may occur.
Failure of Care Coordination

Misinformation can lead to a host of issues, including:

- Inadequate support during transitions
- Duplication of services or failure to follow through with recommendations
- Clinically significant “mishaps”
Care coordination should always involve consumers and their supports, but should be managed by the professionals providing support.
Care Coordination

• The level of care coordination need will increase with:
  ▫ greater system fragmentation (e.g., wider gaps between circles)
  ▫ greater clinical complexity (e.g., greater number of circles on ring)
  ▫ decreased consumer capacity for participating effectively in coordinating one's own care, as illustrated by the following scenarios
What is the Central Goal of Care Coordination?

Meet the consumer’s needs and preferences of high quality, high-value care
DDTT Provides Care Coordination

- Activities of daily living
- Housing
- Family life
- Employment
- Benefits
- Behavioral Supports

- Health care
- Medications
- Co-Occurring disorders integrated treatment (IDD/MH)
- Counseling
- Evidence Based/Best Practice Treatment
Key Components to writing a Quality Care Coordination Plan

• DDTT imbeds it into the design of the model

• Processes are standardized for every case
DDTT Imbeds Care Coordination into the Design of the Model

Examples:

• Inter-agency meeting format at time of admission
• Proactive releases of information
• Primary care collaboration letters
• Attendance at medical/dental appointments to develop 1:1 relationship and expectations
• Structured meetings every 30 days
• Scheduled meetings at the convenience of the individual, team and family to ensure participation
• Distributed meeting minutes
• Transparent communication with the whole team
• Getting creative!
  • Using distribution lists
  • Obtaining PCP and specialists’ direct email addresses
High quality care coordination leads to high quality treatment outcomes: case study examples
Case #1
Case #2
DDTT -- East

Molly Brown-Steranko
Lead Specialist

• Schuylkill/North Central Contract East Team
• Lehigh/Northampton/Berks Team
• Montgomery/Delaware County Team
• Luzerne/Wyoming/Susquehanna/Lackawanna County Team

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DDTT - East Program Directors

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• Lehigh/Northampton/Berks Team

Elizabeth Moore  Elizabeth.Moore01@nhsonline.org
• Montgomery/Delaware County Team

Alison Berger  Alison.Berger@nhsonline.org
• Luzerne / Wyoming / Lackawanna / Susquehanna
DDTT -- West

Kristin Cline

Lead Specialist

- North Central West Team
- Allegheny County Team
- Westmoreland/Armstrong/Indiana County Team
- Washington/Beaver/Butler/Lawrence County Team

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DDTT - West Program Directors

Michelle Hetrick  MHetrick@nhsonline.org
• North Central West Team

Nancy Hamilton  Nancy.Hamilton@nhsonline.org
• Allegheny Team

Deonna Walker  Deonna.Walker@nhsonline.org
• Westmoreland /Armstrong/Indiana

Samantha Adams  SSStitzel@nhsonline.org
• Washington/ Butler/Beaver/Lawrence Team
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Tsnyder@nhsonline.org
Questions?