WABAN
Making a Difference

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Testimony in RE: Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Healthcare Workers

September 13, 2022

Good morning, my name is Jennifer Putnam. I am the Executive Director of Waban Projects, a 56-year-old organization in Southern Maine. We provide a wide range of services to children and adults with intellectual and developmental disabilities (IDD), including case management and group home services. I also serve as a member of the Maine Association for Community Service Providers (MACSP) board of directors and on the Maine Developmental Services and Oversight Board (MDSOAB).

Historically in the IDD field in Maine, violence toward direct care workers has been viewed as a result of an individual's inability to communicate, an expression of their frustration or need, or as a result of physical or emotional pain. As such, providers rarely view injuries to staff as workplace violence per se. Staff are trained in behavior de-escalation techniques and in the adaptive communication needed on an individual basis. An individual's person-centered plan identifies specific behavioral triggers, and frequently includes ways to address the individual's needs that might not be readily apparent.

Direct care workers, or DSP's (Direct Support Professionals), are required to report an injury by or to a resident to the State's Reportable Event electronic system. Behavior Support plans are sometimes put into place to mitigate a resident's injurious (either to self or others) behavior. Reportable events are monitored both at the state level as well as by the assigned case manager and by the resident's care team, which includes the resident, the family and guardian and other service provides.

Should an individual's behavior rise to the level of compromised health or safety in the residence, IDD crisis services may be called and / or emergency services. Anecdotally, due to the staffing challenges of providers and of crisis services, emergency services may be required for transportation to a medical facility for treatment and stabilization more frequently than in prior years. Typically, when a resident's behaviors require either a behavior plan or other emergency interventions, OADS crisis staff and the team are fully aware of the challenges and concerns that a provider is facing in an effort to keep the resident and others in the group home safe.

Here are responses to the questions brought forward (italicized for the reader):
"What are the requirements for group homes and ICF-IIDs for keeping residents with difficult behaviors, especially violent behaviors, in their homes especially when an individual has a medical event that requires a hospital stay or ER visit but no longer needs a hospital level of care?"

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Providers keep members in their residence as long as they are able to safely manage to do so. Providers would be in contact with state entities regarding the needs and struggles of the member long before even a 30-day notice is given. If a member is in the emergency room due to behavioral safety concerns, generally they have been in and out of the hospital over weeks or months and all available supports and options have been exhausted. Providers must consider their ability to keep the member safe as well as other vulnerable residents in the setting.

"How are these requirements enforced?"

There are no requirements that dictate to a provider when a resident must return to a group home. Disability Rights Maine (DRM) may investigate, or Adult Protective Services (APS). Providers often must weigh liability risks should they continue to try and care for a member they know they cannot safely support.

"What services are available to help group homes and facilities manage residents with behavioral issues that are dangerous to staff or other residents, e.g. crisis teams or crisis beds, or other programs?"

There are limited state supported resources or services available. Crisis beds are few and generally full for many months. Crisis workers are rarely able to go into the homes to assist with training or give providers real time support. This is due to lack of staffing as well as lack of a robust crisis program. State supports lean on the IST (Individual Support Team) process, led by the case manager, which generally tracks behaviors and attempted solutions. Providers are required to go through an authorization process which may allow them access to increased staffing ratios but not access to specialized training or support. Many agencies do not have access to specialized clinical support, essential for the ongoing oversight of complex needs. Clinicians often lack access to training for people with IDD. Even if they do have expertise, they often do not accept the established Maine Care rate. Maine lacks specialized homes designed to support members with high behavioral needs. These members are generally sent to out of state placements.

"If a provider refuses to take a resident back after a hospital stay, on what grounds does the provider do that?"

Providers are required to give a 30-day notice. Providers give notice when they no longer have staff who can work with a member, and they can longer assure the safety of the member. If a provider cannot safely staff a member, they are not able to take them back to the group home setting. As a reminder, group homes are small, residential settings, typically 2-6 beds, and provide 24/7 support for people with IDD. Following the closure of Pineland, group homes were developed to help ensure that people with intellectual disabilities were able to live in their communities instead of being institutionalized. The needs of all members in the group home setting need to be considered. In addition, provider homes are frequently not designed or equipped to support

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members with high behavioral needs and there are no resources to create “safe” home settings under the current system.

The current system is not equipped to support members with both ID/DD and acute behavioral health needs. IDD waiver homes are designed to support members with activities of daily living and community and social needs, as well as some medical complexity. The system structure – current rates, not having a true per diem, lack of resources for home modifications and safety features and inadequate clinical support result in a dearth of residential options for individuals with IDD and high behavioral needs. Traditional behavioral health providers will not admit an individual with IDD.

We have highlighted the need for specialized rates and supports for individuals with high behavioral needs before the last two legislatures. Most recently we supported LD 1574 Resolve, To Ensure Support for Adults with Intellectual Disabilities or Autism with High Behavioral Need which passed the house but did not make it to the Senate before the end of the session.

Thank you. Please contact me if you have additional questions.

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