Alliance for the Betterment of Citizens with Disabilities

Empowering People: Providers Shaping Policies

CLINICAL SERVICES AND DAY HABILITATION

Background

The term "habilitation" is defined as the "the process aimed at helping individuals with disabilities attain, keep, or improve skills and functioning for daily living."[1] According to the 2010 US Census Bureau, almost four million individuals living in the United States are diagnosed with a developmental disability.[2] For most of these individuals, services to address difficulties related to their diagnosis are identified and provided by their school district until the age of 21 and are often supplemented by outside providers. Common difficulties include communication, motor skills, activities of daily living, and ambulating within or between environments. In 2021-2022, the State of New Jersey Department of Education was budgeted to spend $3,032 per pupil on Total Support Services and $2,524 per pupil on Student Support Services Salaries. A portion of this funding was utilized to provide occupational therapy, physical therapy, and speech-language pathology services.

Total Cost for NJ Student Support Services Per Pupil [3]:

Indicator 6	Total Support Services	2019–20 Actual	2,662	2,589
Indicator 6	Total Support Services	2020–21 Actual	2,727	2,657
Indicator 6	Total Support Services	2021–22 Budgetary	3,032	3,022

Total Cost for NJ Student Support Services Salaries Per Pupil [3]:

Indicator 7	Support Services Sals & Benefits	2019–20 Actual	2,298	2,156
Indicator 7	Support Services Sals & Benefits	2020–21 Actual	2,365	2,234
Indicator 7	Support Services Sals & Benefits	2021–22 Budgetary	2,524	2,376

[1] Murphy OTD, OTR/L, SWC, L. (2018, November 14). The Difference Between Habilitation and Rehabilitation. *The Difference Between Habilitation and Rehabilitation*. https://napacenter.org/difference-between-habilitation-and-rehabilitation/#:~:text=Habilitation%20refers%20to%20a%20process,they%20have%20yet%20to%20accomplish

[2] U.S. Census Bureau. (2010). *Americans with disabilities: 2010.* Retrieved from http://www.census.gov/content/dam/Census/library/publications/2012/demo/p70-131.pdf

[3] https://www.nj.gov/education/guide/2022/

127 Route 206, Suite 26, Hamilton, New Jersey 08610 Phone: 609-581-8375 Fax: 609-581-8512
Email: Admin@abcdnj.org Web: www.abcdnj.org

By providing services within the school-day setting, clinicians utilize individuals' naturalistic environments and interactions to work on skill acquisition, maintenance, and monitoring. Clinicians in schools are also afforded the opportunity to communicate directly with other professionals, caregivers, and stakeholders to assist with generalization of skills to other settings (home and community). Services are typically provided utilizing two methods of service delivery: the "Pull-out" method of services delivery, during which individuals are removed from their classroom space to receive services or the "Push-in" model of service delivery, during which services are conducted within the classroom setting. While some research indicates that no one model is superior to the other, the consensus is that collaboration with other professionals in the classroom setting results in increased gains in speech-language skills as compared to services that were provided independently of each other.[4]

When individuals graduate from and/or leave the school system, access to these critical services decreases significantly. Pre-graduation services are provided during the day, presenting opportunities for communication with peers, participation in the occupation of living, and ambulation between different environments. Post-graduation, services are provided in settings that do not allow for tangible practice with actual activities and settings, nor do they allow for increased collaboration between staff and caregivers. As participants increase in age, skill regression becomes apparent. As such, "adults with complex communication needs may have a history of failure or learned helplessness that may require longer interventions to learn new skills."[5]

Research has shown that, "interventions can be effective when implemented by everyday communication partners in naturally occurring environments over relatively short periods. Instruction for parents, school employees, and other communication partners should result in improved outcomes for individuals who use AAC." [4]

Guardians and family members of adults with intellectual and developmental disabilities are unable to practice the beneficial "Push-In" model of clinical services themselves. Guardians face barriers when seeking "Pull-Out" services from outside providers. Outside providers likely do not have the standard Division of Developmental Disabilities (DDD) required training and may be unwilling to treat adults, especially those with complex behavioral concerns.

1,600 New Jersey Speech-Language Pathologists are currently listed on the American Speech-Language-Hearing Association's ProFind search tool for SLPs currently accepting referrals. This number decreases to 600 for those aged 18-75[6]

[4] Thorneburg, Rebecca A., et al. "A Comparison of Service Delivery Models: Effects on Curricular Vocabulary Skills in the School Setting." *American Journal of Speech-Language Pathology, vol. 9, no. 1*, 1 Feb. 2000, pp. 10-20, https://doi.org/10.1044/1058-0360.0901.10. https://doi.org/10.1044/1058-0360.0901.10

[5] O'Neill, T, et al. (2018). "Effects of interventions that include aided augmentative and alternative communication input on the communication of individuals with complex communication needs: A meta-analysis." *Journal of Speech, Language, and Hearing Research*, *61*(7), 1743–1765. https://doi.org/10.1044/2018_jslhr-l-17-0132

[6] https://www.asha.org/profind/

Each clinical discipline (Speech-Language Therapy, Occupational Therapy, and Physical Therapy) supporting individuals with intellectual and developmental disabilities has their own scope of practice:

According to the American Occupational Therapy Association,

"The tasks of daily living may be threatened or impaired by physical injury or illness, developmental disability, sensorimotor disability, psychological and social disability, the aging process, poverty, or cultural deprivation. Occupational therapy utilizes task-oriented activities adapted to prevent or correct physical or emotional disabilities as well as to minimize the disabling effects of those disabilities on the life of the individual." [6]

According to the American Physical Therapy Association,

"The professional scope of practice consists of patient and client management, which includes diagnosis and prognosis, to optimize physical function, movement, performance, health, quality of life, and well-being across the lifespan. In addition, the professional scope of practice includes contributions to public health services aimed at improving population health and the human experience." [7]

And,

"Physical therapists foster and encourage lifelong and long-term patient and client relationships. Where feasible, physical therapists, as entry-point providers, provide services within the community that are available to patients or clients over a lifetime. Efforts are made to address movement system disorders and to maintain optimal health and wellness through physical therapist intervention as needed." [8]

According to the American Speech-Language Hearing Association's (ASHA) Scope of Practice in Speech-Language Pathology (SLP):

"SLPs share responsibility with other professionals for creating a collaborative culture. Collaboration requires joint communication and shared decision making among all members of the team, including the individual and family, to accomplish improved service delivery and functional outcomes for the individuals served."[9]

"Reduce the cost of care by designing and implementing case management strategies that focus on function and by helping individuals reach their goals through a combination of direct intervention, supervision of and collaboration with other service providers, and engagement of the individual and family in self-management strategies"[9]

[6] (AOTA, 2021)
[7] (APTA HOD P06-17-08-07, 2017)
[8] (HOD S06-20- 35-29, 2020)
[9] (ASHA, 2016)

Gathering the Data:

With the assistance of the ABCD Day Program Committee, we distributed a survey to 16 Day Habilitation (DH) providers currently supporting 1,665 individuals across 53 DH programs:

- **31.25% of providers** reported they that have attempted to provide Clinical Services; of these providers, 60% are no longer providing Clinical Services due to financial concerns and only 40% continue to provide Clinical Services.

- In comparison to those providers who have been able to attempt to provide Clinical Services, **75% of those polled state that families/individuals would be interested in these services if the agency was able to offer them.**

"Why were these services **not sustainable** for your agency?" and "What are some of the barriers to offering these services?" DH Providers stated:

- "The programs were not financially sustainable when we provided them directly to our clients prior to the pandemic."
- "We lost money providing the service. Could no longer sustain."
- "These programs were not financially sustainable when we provided them prior to the pandemic because we (spent) more than we made on these services."
- "The cost of these supports (were) not financially sustainable."
- "Cost of the staff/provider too high compared to billable rate, especially since you lose DH revenue during sessions. It is hard to find providers who are willing to work part- time shifts or as-needed."
- "The three main barriers to developing these services are the rates that are paid, getting MCOs to approve applications and the recruitment of staff. We have difficulty recruiting staff for Early Intervention Services with a higher pay level than afforded for the DDD system. The reimbursement through DDD does not make us competitive with pay rates."

"Would families/program participants be **interested** in these services if you were able to offer them?" DH Providers stated:

- "Families beg for this service. It is much more convenient for them than to have to access the services independently. It disproportionately impacts low-income families who have less resources and transportation to arrange for outside therapies."
- "Our agency has quite a few families that would be interested in clinical services if offered at our facility in the future."
- "Yes, in particular I have had many referrals ask us about (Physical Therapy) and Speech."
- "We had one Support Coordinator reach out to us stating that we were the "41st agency she had contacted to find these services for her client, so we are aware that there is an absolute need for these services."

The Cost:

The current rates for Individual Clinical Services are listed in the below table:

Services	Billing Unit	Rate Effective 7/1/23 [10]
Speech, Hearing, and Language Therapy	15 Minutes	$26.84
Physical Therapy	15 Minutes	$27.48
Occupational Therapy	15 Minutes	$28.48

According to the United States Bureau of Labor Statistics:

- The current Annual Mean Wage for Speech-Language Pathologists in New Jersey is $92,790-$110,470 with a median of $101,630. [11]
- The current Annual Mean Wage for Occupational Therapists in New Jersey is $87, 670-$105, 450 with a median of $96, 560. [12]
- The current Annual Mean Wage for Physical Therapists in New Jersey is $97, 120-$114, 230 with a median of $105, 675. [13]

Proposed Solutions:

As it stands- the numbers outlined above are cost prohibitive to DH Providers attempting to establish a Clinical Services program, even though there are multiple advantages to providing these services in an existing DH setting. We propose the following:

1. DHS and DDD consider increasing the rate for all Clinical Services by **50%.**

Utilizing a Median Wage of $101, 630 with the addition of Benefits (Medical Insurance, Pension, Temporary Disability, Group Life Insurance, Payroll Taxes (FICA, Worker's Compensation, Disability, Unemployment) and facility/supply costs brings the total cost of retaining a Clinical Services Professional to approximately $150,000.

Based on a standard 40-hr work week, a feasible caseload may include approximately 30 individuals, ½ of whom would receive 2- ½ hour sessions per week and ½ of whom would receive 1- ½ hour session per week. Factoring in an 85% attendance rate, the rate per session would need to increase from approximately $27 per unit to approximately $40 per unit. This scenario is reflected in the chart below:

[10] https://www.state.nj.us/humanservices/ddd/documents/FY24_Rate_Increase.pdf
[11] https://www.bls.gov/oes/current/oes291127.htm
[12] https://www.bls.gov/oes/2019/may/oes291122.htm
[13] https://www.bls.gov/oes/current/oes291123.htm

Participant	Tier	# of Sessions Per Week	# Sessions Per Year	Proposed Rate Per 1/2 Hr. (2 Units)	Annual Revenue	Speech 85% of Attendance
#1	Da	2	94	80.52	7,568.88	6,433.55
#2	Da	2	94	80.52	7,568.88	6,433.55
#3	Da	2	94	80.52	7,568.88	6,433.55
#4	Da	2	94	80.52	7,568.88	6,433.55
#5	Da	2	94	80.52	7,568.88	6,433.55
#6	B	2	94	80.52	7,568.88	6,433.55
#7	Ea	2	94	80.52	7,568.88	6,433.55
#8	Ea	2	94	80.52	7,568.88	6,433.55
#9	Da	2	94	80.52	7,568.88	6,433.55
#10	Ea	2	94	80.52	7,568.88	6,433.55
#11	Da	2	94	80.52	7,568.88	6,433.55
#12	D	2	94	80.52	7,568.88	6,433.55
#13	Ea	2	94	80.52	7,568.88	6,433.55
#14	D	2	94	80.52	7,568.88	6,433.55
#15	D	2	94	80.52	7,568.88	6,433.55
#16	E	2	94	80.52	7,568.88	6,433.55
#17	D	2	94	80.52	7,568.88	6,433.55
#18	D	2	94	80.52	7,568.88	6,433.55
#19	B	1	47	80.52	3,784.44	3,216.77
#20	Ca	1	47	80.52	3,784.44	3,216.77
#21	D	1	47	80.52	3,784.44	3,216.77
#22	C	1	47	80.52	3,784.44	3,216.77
#23	Ea	1	47	80.52	3,784.44	3,216.77
#24	E	1	47	80.52	3,784.44	3,216.77
#25	D	1	47	80.52	3,784.44	3,216.77
#26	C	1	47	80.52	3,784.44	3,216.77
#27	E	1	47	80.52	3,784.44	3,216.77
#28	B	1	47	80.52	3,784.44	2,649.11
#29	B	1	47	80.52	3,784.44	2,649.11
#30	Ca	1	47	80.52	3,784.44	2,649.11
		48	**2256**		**181,653.12**	**152,702.15**

2. We propose that DHS and DDD consider including Clinical Services within the *Appendix K- Quick Reference Guide to Overlapping Claim for Supports Program Services under DH:*

Behavioral Supports (both Assessment and Monitoring) are included in the *Appendix K- Quick Reference Guide to Overlapping Claim for Supports Program Services under DH* with the expectation that there will be ongoing implementation of the plan and ongoing training and supervision of caregivers and behavioral aides. The ability of BCBAs and Behaviors to provide ongoing implementation and training to all staff members relies on these services being innately overlapping. Behavioral interventions and strategies are developed to be implemented for the duration of the Day Habilitative service provision (and Residential services if applicable) and not only limited to timeframe during which billable service units are provided.

Limiting Clinical Service Provision to a non-overlapping service implies that this service is only being practiced or utilized in the service setting and with the licensed practitioner. However, these interventions should be trained on and utilized across caregivers and across settings to ensure continuity and generalization of skills.

According to ASHA's Communication Bill of Rights, "All people with a disability of any extent or severity have a basic right to affect, through communication, the conditions of their existence."[14]

Specific rights include:

> "-The right to access interventions and supports that improve communication.
> -The right to access environmental contexts, interactions, and opportunities that promote participation as full communication partners with other people, including peers.
> -The right to have clear, meaningful, and culturally and linguistically appropriate communications"[14]

If clinical interventions are limited to one to two 20-30-minute sessions per week with no cross-training or generalization across settings, this becomes a human rights concern.

From a monetary standpoint, the same scenario referenced above **without** overlapping services would cost an additional $37,803.51 resulting from the loss of 2,256 DH billable units. Factoring in an 85% attendance rate, the rate per session would need to increase 55% from approximately $27 per unit to approximately $45 per unit. This is reflected in the below chart:

Participant	Tier	DH Rate (Calculated for 2 Units/1 Unit)	1/2 Hour Sessions	Number of Week 47 Per Year	Speech Tier Amount Per 1/2 Hr. (2 Units)	Speech Revenue	Speech 85% of Attendance	DH Loss
#1	Da	22.66	2	94	91.20	8,572.80	7,286.88	2,130.04
#2	Da	22.66	2	94	91.20	8,572.80	7,286.88	2,130.04
#3	Da	22.66	2	94	91.20	8,572.80	7,286.88	2,130.04
#4	Da	22.66	2	94	91.20	8,572.80	7,286.88	2,130.04
#5	Da	22.66	2	94	91.20	8,572.80	7,286.88	2,130.04
#6	B	8.78	2	94	91.20	8,572.80	7,286.88	825.32
#7	Ea	30.06	2	94	91.20	8,572.80	7,286.88	2,825.64
#8	Ea	30.06	2	94	91.20	8,572.80	7,286.88	2,825.64
#9	Da	22.66	2	94	91.20	8,572.80	7,286.88	2,130.04
#10	Ea	30.06	2	94	91.20	8,572.80	7,286.88	2,825.64
#11	Da	22.66	2	94	91.20	8,572.80	7,286.88	2,130.04
#12	D	16.12	2	94	91.20	8,572.80	7,286.88	1,515.28
#13	Ea	30.06	2	94	91.20	8,572.80	7,286.88	2,825.64
#14	D	16.12	2	94	91.20	8,572.80	7,286.88	1,515.28
#15	D	16.12	2	94	91.20	8,572.80	7,286.88	1,515.28
#16	E	10.69	1	47	91.20	4,286.40	3,643.44	502.43
#17	D	8.06	1	47	91.20	4,286.40	3,643.44	378.82
#18	D	8.06	1	47	91.20	4,286.40	3,643.44	378.82
#19	B	4.39	1	47	91.20	4,286.40	3,643.44	206.33
#20	Ca	7.64	1	47	91.20	4,286.40	3,643.44	359.08
#21	D	8.06	1	47	91.20	4,286.40	3,643.44	378.82
#22	C	5.44	1	47	91.20	4,286.40	3,643.44	255.68
#23	Ea	15.03	1	47	91.20	4,286.40	3,643.44	706.41
#24	E	10.69	1	47	91.20	4,286.40	3,643.44	502.43
#25	D	8.06	1	47	91.20	4,286.40	3,643.44	378.82
#26	C	5.44	1	47	91.20	4,286.40	3,643.44	255.68
#27	E	10.69	1	47	91.20	4,286.40	3,643.44	502.43
#28	D	8.06	1	47	91.20	4,286.40	3,643.44	378.82
#29	Da	11.33	1	47	91.20	4,286.40	3,643.44	532.51
#30	E	10.69	1	47	91.20	4,286.40	3,643.44	502.43
			48	2256		192,888.00	163,954.80	37,803.51

[14] https://www.asha.org/njc/communication-bill-of-rights

Conclusion

The proposed policy changes have a significant potential impact on the ability of DH providers to establish and sustain clinical services, resulting in benefits for both served individuals and the system.

Overlapping DH and Clinical Services have the potential to enable the utilization of individuals' naturalistic environments and interactions to work on skill acquisition, maintenance, and monitoring while increasing accessibility, slowing down skill regression, and allowing individuals to lead fuller lives in the community for longer periods of time.

These changes will alleviate the need for higher cost medical and rehabilitative services, decreasing the cost of care for both newly enrolled and aging populations.

ABCD DH Providers Clinical Services Survey

1. As a Day Services Provider, have you attempted to provide Clinical Services (i.e. Speech-Language, Physical Therapy, and/or Occupational Therapy)?
2. If yes, have these programs been financially sustainable?
3. If yes, are you still providing these services?
4. If No, please provide examples as to why these services were not sustainable for your agency:
5. If you have not provided clinical services, what are some of the barriers to offering these services:
6. Would families/program participants be interested in these services if you were able to offer them?

August 23, 2023