



Medicaid Service Coordination (MSC)

E-VISORY



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The MSC E-VISORY is an electronic publication which provides information on policies, guidance, available programs and services and training opportunities related to MSC. In order to receive an email notification when a new MSC E-Visory is posted, or to view past issues visit the following link: [MSC E-Visory Mailing List](#).

In This Issue:

Materials for the MSC Supervisors Winter Conference – December 18, 2013

The MSC Supervisors Winter Conference is being held on December 18, 2013 via videoconference and webinar. Two sessions are offered - A morning session from 9:30 am – 12:30 pm and an afternoon session from 1:00 pm – 4:00 pm. Interested parties, who have not yet registered, may do so until Sunday, December 15, 2013. To register go to the following link:

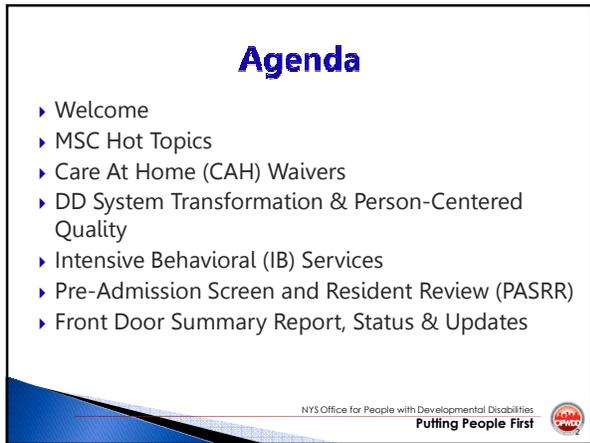
http://www3.opwdd.ny.gov/wp/wp_catalogc1310.jsp

Conference Agenda:

Care at Home Waivers
DD System Transformation & Person-Centered Quality
Intensive Behavioral (IB) Services
Pre-Admission Screen and Resident Review (PASRR)
The Front Door Summary Report, Status & Updates

NOTE: Attached to this E-Visory are the materials that will be referenced during the conference. There will be no handouts the day of the conference. An evaluation form has been attached to the conference materials; please complete and return as your input and feedback is greatly appreciated.







TRANSFORMATION AGREEMENT

www.opwdd.ny.gov keyword: transformation agreement

Three Key Areas

- Self-Direction
- Employment
- Residential Transition

• Opportunities for self-direction: **Self-Directed Community Habilitation** and CSS.

• Information on SDCH:
www.opwdd.ny.gov/node/4899

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DEPARTMENT OF HEALTH (DOH) ISP REVIEWS

- The DOH conducts ongoing reviews of ISPs and required attachments.
- Process changed from annual to ongoing.
- Key findings will be communicated regularly in an effort to remediate and improve.

➤ Recent Key Findings:

- ISP Signatures Missing
- Habilitation Plans: missing or incorrect/conflicting safeguards; missing signature dates.

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ADDITIONAL FINDINGS FROM OPWDD MEDICAID COMPLIANCE AUDITS

- Site or address listed as "Name of Provider"
- Frequency of Habilitation Services incorrect
- Valued Outcomes – no connection between ISP and Habilitation Plan

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**OPWDD's
Care At Home (CAH)
Waivers**

Lynda Baum-Jakubiak,
Statewide CAH Coordinator
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ABOUT CARE AT HOME

CAH provides services to children with severe developmental disabilities and complex medical conditions living at home with their families.

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CARE AT HOME SERVICES

- Case Management
- Respite
- Assistive Technologies/Home Adaptations including Vehicle Modifications

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CARE AT HOME ELIGIBILITY

- ❑ Under the age of 18, living at home
- ❑ Complex health care needs
- ❑ Level of Care
- ❑ Home Health Assessment
- ❑ Medicaid eligibility

For further information, refer to

http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living/Care_at_Home

DD System Transformation & Person-Centered Quality

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TOPICS

- ✓ Key Elements of the DD System Transformation and Reform
- ✓ OPWDD Person-Centered Quality Initiatives:
 - ✓ Health, Safety, & Risk for Individuals Living in Non-Certified Settings Committee
 - ✓ Council on Quality Leadership (CQL), Personal Outcome Measures, and Agency Case Studies
 - ✓ Quality Standards for Home and Community Based Services

DD System Transformation & Reform

Maryellen Moeser,
Regional Director of Continuous Quality Improvement/DQI

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DD System Transformation

- **OPWDD's "Road to Reform"**: A comprehensive review of reforms to the DD system in NYS that have been recently achieved and are underway.
- **"The OPWDD Transformation Agreement" (Appendix H of the DRAFT NYS Partnership Plan Amendment; DOH 1115 Waiver)**- Articulates clear commitments by OPWDD for achieving ambitious goals for system reform and service delivery.

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5 Specific Areas of Reform:

1. Making the system more **person-centered**
2. Restructuring to provide better, **integrated** and **holistic** support
3. Establishing **transparent and sustainable funding**
4. Measuring quality based on the **outcomes** of individuals
5. Serving people in the **most integrated settings** possible

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PRIORITY REFORMS

Expanding Options for Self-Direction

Employment—increasing opportunities and supports

Residential Transitions and Olmstead Implementation

Person Centered Service Delivery and Quality Outcomes

People First Waiver 1915 B/C

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New Ways to Measure Quality

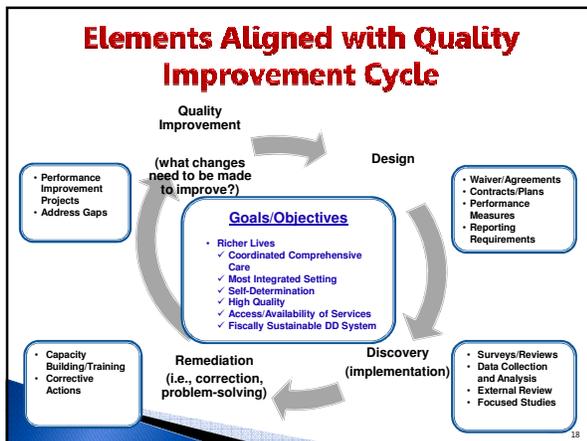
Traditional Quality

- OPWDD focus has concentrated on **required assurances** in the waiver agreement with CMS.
- Compliance of state and provider operations has been monitored with **established** regulatory processes, procedures, and deadlines.
- Traditional oversight does not gauge how well services and supports provided by OPWDD actually meet the needs of individuals.

New Ways to Measure Quality

- A key component of OPWDD's transformation is **HOW** the agency measures quality and structures process for ensuring continuous quality improvement.
- No longer will quality oversight focus solely on procedural and regulatory **compliance**.
- Quality Measures will now also begin to reflect how well individuals are being **supported** to meet their goals and achieve personal growth and satisfaction.

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Examples of DD Transformation Performance Measures:

OPWDD System Reform Measures	
Self-Direction	<ul style="list-style-type: none"> a. Provision of education on self-direction to Waiver participants b. Participants are able to make an informed choice on whether to self-direct their supports and services c. Participants who self-direct their supports and services do so with employer authority and/or budget authority
Employment	<ul style="list-style-type: none"> a. Proportion of individuals who have an integrated job in the community b. Proportion of individuals who do not have an integrated job in the community but would like one c. Proportion of individuals in Sheltered Workshops who transition to integrated community based employment
Most Integrated Settings	<ul style="list-style-type: none"> a. Proportion of Settings meeting enhanced HCBS Setting Characteristics b. New Supportive Housing Opportunities c. Transition of individuals from campus based and other institutional settings d. Money Follows the Person Quality of Life Surveys



OPWDD Person Centered Quality Initiatives

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Most-Integrated Settings and the Olmstead Decision:

- ▶ As part of the Olmstead Decision, NYS has to demonstrate that it is serving individuals in the most integrated and community-based settings.
- ▶ *More people will be moving into non-certified settings and will be living more independently.*
- ▶ How do we manage those risks that will exist while still ensuring that rights and choices are protected?

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Person Centered Quality Health, Safety and Risk for Individuals Living in Non-Certified Settings Committee

Alicia Matulewicz,
Standards Compliance Analyst, CQI



Health, Safety and Risk in Non-Certified Settings:

- ▶ A committee was formed in 2013 and represented a variety of stakeholders including provider agency leadership, family members, and OPWDD employees from various departments.
- ▶ A report of recommendations was drafted that align into **three** broad areas.

Three Broad Recommendation Areas That Need to be Addressed:

	Gaps in Systems and Supports	<ul style="list-style-type: none"> • WHO is responsible? The person or the agency? • What about lack of supports and loneliness? • Natural support networks vs paid staff
	Guiding Principles, Expectations, and Culture Shift	<ul style="list-style-type: none"> • Focus on person-centered planning with individualized quality outcomes • New expectations must infuse entire system culture
	Oversight and Monitoring	<ul style="list-style-type: none"> • Clearer expectations for MSC role in safeguard planning • DQJ culture shift towards person-centered review approaches rather than program/site based focus

Person-Centered Quality and Risk Committee – Key Concepts:

- ▶ **Thoughtful and meaningful conversations** are needed rather than risk avoidance and elimination.
- ▶ **Some** risks are more **imagined** than real: “what if---?”
- ▶ We sometimes have a tendency to **generalize** about risks from one area of a person’s life to another.
- ▶ There may be serious costs and consequences to NOT taking risks also!
- ▶ **Our approach to risk needs to adapt and evolve** if we are to transform our service system to be more focused on person-centered outcomes.

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Person-Centered Quality and Risk Committee:

- ▶ Whose risk are we talking about? Risk to the agency or risk to the person?
- ▶ **The person** is in charge of their own planning process.
- ▶ The purpose of any risk assessment is as much about the person’s **happiness** as it is their **safety!**
- ▶ Safeguards must also ensure that the person’s voice is heard as much as the voice of others.
- ▶ MSCs would benefit from further guidance on how to address safeguards for individuals living in more independent settings.

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Risk Assessment Worksheet

- ▶ The committee discussed the need for additional **tools** to help a person's team identify, discuss, and manage specific areas of risk.
- ▶ A **DRAFT** Risk Assessment Worksheet is being developed as an **OPTIONAL** tool that can help guide person-centered planning conversations.

Risk Assessment Worksheet

The worksheet is broken down into the following categories:

- autonomy, decision-making, and support network
- personal income, money management, and financial support
- housing
- physical and mental health
- safety
- appearance/hygiene

Using the Risk Assessment Worksheet

- ▶ Items on the worksheet are worded in the "first person", and **put the individual in charge** of the discussion on his/her risks ("nothing about me without me!")

Instructions:

- Worksheet should be re-visited over time as a person's needs and supports evolve and change.
- Not all risks are preventable, but it is important to demonstrate that thoughtful discussion occurred and that there is agreement on appropriate safeguards that can **mitigate** those risks.
- **LISTENING TO THE PERSON IS KEY!**
- If an area is identified on the worksheet as unmet or is an area requiring further support in order to mitigate risk, it is expected that the identified need will be further addressed in the service planning process.

Using the Risk Assessment Worksheet:

Once an area is identified by the individual and his/her circle of support as a concern or unmet need, document the following:

- ▶ Potential **barriers and factors** that impact the area of concern.
- ▶ **Short-term and long-term strategies** that can address the unmet need, such as training and education, or increased supports, services, and/or supervision.
- ▶ These elements and strategies should then be incorporated into the person's ISP.

OPWDD Case Studies and Council on Quality Leadership (CQL): Personal Outcome Measures (POMs)

Barbara VanVechten,
Director of Continuous Quality Improvement Department/DQI

How will OPWDD evolve Quality Oversight?

*"The measure of Quality is not the **delivery** of a support or service, but the **results** that services or supports provide for each person"*

A dream becomes a goal when action is taken toward achieving it...

Source: Designing Quality—Responsiveness to the Individual. CQL 1999

Shifting from site-based "bricks & mortar" inspections to reviews focused on individuals and achievement of outcomes

Council on Quality Leadership (CQL): Personal Outcome Measures

- OPWDD embraced CQL Personal Outcome Measures as a framework for Person-Centered Quality in February of 2013.
- CQL has over 40 years of experience working with Human Service Organizations and systems to measure and improve people's quality of life.
- It is a focused and tested approach to evaluation of person centered outcomes.

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CQL Measures Two Things:

- Outcomes = Quality of Life
- Supports = Quality of Services



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Personal Outcome Measures (POMs)--Measure <i>if</i> People:	
Are connected to natural support networks	Have intimate relationships
Have best possible health	Are safe
Exercise rights	Are treated fairly
Are free from abuse and neglect	Experience continuity and security
Decide when to share personal information	Choose where and with whom they live
Choose where they work	Use their environments
Live in integrated settings	Interact with other members of community
Perform different social roles	Choose services
Choose personal goals	Realize personal goals
Participate in the life of community	Have friends
Are respected	

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Understanding Personal Outcome Measures®

- Measures the **presence** of the outcome (yes or no).
- Each person is a unique sample of one ... There is **no norm or standard definition for an outcome**.
- Aggregates data on items that are **personally** defined (versus standardized measures).
- **Links outcomes to the services and supports** that facilitate – or are needed to facilitate – the outcome.
- Provides information for the design and provision of **person-centered services**.

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Personal Outcome Measures®



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CQL POMs and Provider Expectations?

Q. Is OPWDD going to **require** providers to be CQL Accredited?

A. **No**

Q. Is OPWDD going to **require** providers to use the CQL POM Methodology.

A. **No**

A. However, providers should seek to understand what matters most to each individual (i.e., their personal outcomes) and tailor support and service strategies/delivery accordingly.

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OPWDD Case Studies

- ✓ **19 agencies** were chosen to participate in the case studies: including COMPASS agencies and other agencies.
- ✓ In February 2013, case study agencies began use of POMs for individuals included in the case study focus group.
- ✓ a NEW **Person Centered Protocol is being piloted** for use with a select sample of individuals and is being piloted as part of the case studies.
- ✓ Also gives DQI exposure to **new survey methods** that are more focused on person centered supports and outcomes.

Case Studies

- ▶ Provide agencies with a preview of providing services designed to be more **individualized**
- ▶ Encourages agencies to incorporate **person-centered planning**
- ▶ First experience and overview of verifying CQL and its **impact on system-wide quality improvement** within an agency

Examples of Person Centered Review Items:

- Personal outcomes are:**
- ✓ **Identified and prioritized in the service plan**
 - ✓ based on person's **CHOICES and PREFERENCES**
 - ✓ **Supports and Services** enhance person's achievement of outcomes
 - ✓ Outcomes are **unique to the individual**
- Individuals are encouraged and supported to advocate for themselves to the best of their abilities
 - Individuals are encouraged and supported to self-direct their services to the extent possible based on their strengths, abilities, and desires
 - Services and supports are delivered in every day community settings (i.e., natural context) to the extent possible
 - Individuals are supported and afforded the opportunity to increase their social roles if they desire to

Person Centered Review

<p>Person is encouraged and supported through:</p> <p>Employment/meaningful community engagement opportunities</p> <ul style="list-style-type: none"> ◦ Does the person consider activities to be meaningful to them? ◦ Do the activities and tasks contribute to the goals of the individual and/or his/her health and well-being? 	<p>The person is supported to:</p> <ul style="list-style-type: none"> ✓ foster and maintain meaningful relationships and natural supports ✓ Exercise their rights and maintain their privacy ✓ If desired, the person's cultural identity is respected and supported
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Case Study Review Protocol

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Key Aspects of Protocol:

Is the first protocol to evaluate:

- Influence of CQL Personal Outcome Measures (POMs)
- Person-centered planning processes
- self-directed services and supports that are chosen by the individual
- Moves beyond a Met/Not Met format

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Addresses Quality of Life

- Protocol designed to be piloted and tested during the case studies.
- Moves beyond a traditional regulatory/compliance-based survey
- Will help inform development of:
 - Care Coordination Review Protocol
 - Review of DISCO's quality management plan
- **Your feedback on this protocol is important!**

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Protocol Design

Each standard has **Three** rating description options:

- 1: The standard is **not met**, absent, or is incomplete
- 2: The standard is met, but does not go beyond **bare minimum**
- 3: The "wow" factor: **best practices** and proactive approaches to person-centered planning process that go above and beyond minimum standards

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Ratings Descriptions & Guidelines

- Ratings are descriptive of the expectations
- Additional guidance re: choosing the rating is included in Guidelines if deemed necessary
- Guidance also includes activities and considerations to make a judgment
- Your feedback on whether guidance is sufficient is needed

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Two Protocols

Person Centered
&
Agency

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Person Centered

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Person Centered - 4 categories of Indicators:

- Personal Outcomes
- OPWDD Priorities
- Self Direction
- Health and Safety

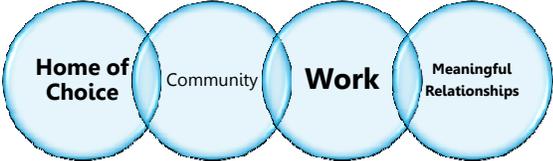
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PERSONAL OUTCOMES QIs

- ▶ Nine Quality Indicators in this area
- ▶ Purpose is not to conduct a review of the 21 POMs
- ▶ Purpose is to determine for each individual:
 - POMs interviews implemented
 - Decisions: presence of Outcomes and Supports
 - POM findings inform service planning
 - People supported to achieve outcomes
 - People are getting closer to the life they want

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OPWDD PRIORITIES & VISION QIs



Home of Choice Community Work Meaningful Relationships

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OPWDD PRIORITIES & VISION QIs



Self Advocacy Cultural Identity
Natural Supports Natural Context

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Self Directions QIs

- ▶ Option 1 Case Study Agencies
- ▶ Supports and Services designed through CSS Services

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Self Directions QIs

Self Direction Participation

Budget Authority

Employer Authority

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Health and Safety QIs

- ▶ Basic areas of health and safety reviewed
- ▶ **Individualized** considerations:
 - What are H/S concerns for that individual
 - What is best way to support
 - Informed choice balanced with risk known or suspected
- ▶ Independent and/or supports per decisions

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Health and Safety QIs

RISK AND INFORMED CHOICE

- ▶ Known Risks discussed and possible unknown Risks considered
- ▶ Focused and responsible discussion by person and team
- ▶ Decisions Explained
- ▶ Balanced approach: Safeguards proportional

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Health and Safety QIs

- ▶ ***In home health and medication routines:***
 - E.g. Medications, special diets, monitoring known conditions, equipment for health and well-being
- ▶ ***Getting to the doctor as needed/wanted:***
 - When they get sick or hurt
 - As required by their conditions
 - Routine preventative care

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Health and Safety QIs

- ▶ ***Community Safety:*** travel, communication, interactions
- ▶ ***Conscientious decisions during service planning***
- ▶ ***Outcomes for the person:*** person is safe and well per their own individualized situation

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**Case Study Protocol
Agency**

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Agency Protocol

- Staff Training and understanding of their role in supporting individuals in their Personal Outcomes
- Agency approach to self-advocacy
- Process to review for outcome attainment
- Process to aggregate outcome information
- Using information to inform agency policy and planning

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**Quality Standards for
Home and Community
Based (HCB) Services**

Maryellen Moeser,
Regional Director of Continuous Quality
Improvement/DQI

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HCBS Quality Standards

- ▶ As part of its commitment to supporting individuals in most integrated settings, OPWDD intends to adopt CMS' final regulations regarding **requirements for settings in which Home and Community Based Services (HCBS) funded under the waiver are provided.**
- ▶ (Federal Regulation Part 441.530).

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Quality Principles for HCBS Services

HCBS Waiver Service Provision is required in Integrated Community Settings

<p>In community:</p> <ul style="list-style-type: none"> • HCBS services must be integrated in and facilitate access to the greater community including: • Opportunities to seek employment, community engagement • Opportunities to control personal resources • Autonomy in deciding with whom one interacts 	<p>In provider-controlled housing:</p> <ul style="list-style-type: none"> - Privacy in living quarters - Individual choice of roommates - Access to food at any time - Ability to set one's own schedule & have visitors any time - Ability to come and go from one's own home at any time 	<p>HCBS Services cannot be provided in settings that exhibit characteristics of an institution e.g., settings in which individuals engage in the same activities at the same time regardless of choices and desires; regimented meal and sleep times; settings that restrict access to the broader community</p>
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HCBS Quality Standards & the Person-Centered Planning Process:

Excerpts from CFR 441.530:

A person-centered planning process must:

- ✓ Identify the strengths, preferences, needs, and desired outcomes for an individual
- ✓ The person must have a meaningful role in **directing** the process
- ✓ Offer informed choices regarding services and supports
- ✓ Must reflect that these services and supports have been **CHOSEN** by the individual
- ✓ Service plan should reflect **RISK** factors, and ways to minimize them, and individualized back-up plans
- ✓ Must promote service delivery in the **most integrated setting** possible (consistent with the Americans With Disabilities Act)

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What does "INSTITUTIONAL" mean?

According to C 11-491.2-10

Settings which are:

- > **Isolated** from the larger community
- > Do **not** allow individuals to **choose** whether or with whom they share a room
- > **Limit freedom of choice** on daily living experiences such as meals, visitors, activities
- > **Limit opportunities** to pursue community activities

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So what Does all This Mean?

This means that agencies should:

- > Encourage staff respect for each individual supported as a unique individual with unique preferences, interests, and goals.
- > Encourage listening, learning, and responding in ways that honor individuals and increase individual control.
- > Encourage and educate about individual rights and self-determination and how to support individuals to exercise control and choice in their own lives.
- > Engage individuals in discussion about their environment and with the people who work for them.

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HCBS Quality Standards:

*How does your agency encourage individuals to exercise **autonomy**, **choice**, and **control** in their lives?*

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Resources

TOPIC	LINKS TO WEBSITES AND RESOURCES
New OPWDD Person-Centered Planning website!	www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning
Council on Quality Leadership (CQL)	www.thecouncil.org
National Core Indicators (NCI)	www.nationalcoreindicators.org
OPWDD's Road to Reform	www.opwdd.ny.gov/transformation-agreement/OPWDD_Road_to_Reform_April2013
Appendix H Transformation Agreement with CMS	www.opwdd.ny.gov/transformation-agreement/04012013_partnership_plan_stcs_attachment
Governor Cuomo's Olmstead Report and Recommendations	www.governor.ny.gov/assets/documents/olmstead-cabinet-report101013.pdf
Federal Register: Proposed HCBS Setting Requirements	www.federalregister.gov/a/2012-10385

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Questions?

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Intensive Behavioral (IB) Services

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Background

Intensive Behavioral Services

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IB Services

Designed for individuals who live in non-certified settings or Family Care Homes, and who are presenting highly challenging behaviors that put them at imminent risk for placement into a more restrictive residential setting.

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IB Services

- Is not a crisis intervention program
- Is time-limited (180 calendar days)
- Is designed to serve individuals with severe behavioral issues
- Is provided by clinical staff that has training and experience in conducting functional behavioral assessments, developing behavior support plans, and working with people with developmental disabilities

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Goals of IB Services

- To help individuals who have a need for intensive behavioral services and have the family/caregiver strength and support necessary to implement behavior plans at home
- To effect positive change for those individuals, i.e.: a reduction in at-risk behaviors so that the individual may remain in his/her home and avoid residential placement

What an individual can expect

- ▶ Staff develop an Individualized Behavior Support Plan with the individual and family which provides direction on "what to do", "how to do", and "when to do" the specific approaches, strategies, and supports described in the plan
- ▶ Staff then work with the individual and family to implement the positive behavioral approaches, strategies and supports to establish or increase adaptive behaviors, and decrease the frequency and/or intensity of challenging behaviors that are described in the plan

What an individual can expect

- ▶ At the conclusion of the services, families and individuals are asked to complete a satisfaction survey and the needs of the individual are reassessed
- ▶ These tools are designed to help OPWDD and the provider ensure that IB Services are meeting program goals

Types of Services

- ▶ Follow up with the individual, family and/or staff as to the effectiveness of the supports, interventions and strategies
- ▶ Update the BSP to remove supports, strategies and interventions that are not effective, and/or to include new supports, strategies and interventions
- ▶ Transition plan with the individual, family, collaterals, and other agencies to refer the individual to appropriate services to maintain on a long term basis the behavior strategies specified in the BSP

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IB Services ADM

- Defines staff qualifications
- Describes individual authorization
- Identifies and describes necessary programmatic elements (FBA and BSP)
- Describes coordination and training components
- Defines service delivery and documentation requirements
- Describes billing and enrollment components

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Staff Qualifications

Intensive Behavioral Services

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Staff must be a

- Licensed Psychologist,
- Licensed Clinical Social Worker (LCSW), or
- Meet 14 NYCRR 633.16 criteria for a Behavior Intervention Specialist (BIS)

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Individual Authorization
Intensive Behavioral Services

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To be Authorized for IB Services

An individual must:

- ▶ Be enrolled in the OPWDD HCBS waiver
- ▶ Live in a non-certified residential setting or Family Care Home
- ▶ Have documentation that substantiates that the individual is at imminent risk of being placed in a more restrictive living environment due to challenging behavioral episodes (documentation may be from a variety of sources, e.g. MSC notes, letter indicating possible expulsion from school, notice indicating possible disenrollment from a day habilitation program)
- ▶ Have a clear need for the type of services provided under the Intensive Behavioral Services model
- ▶ Be able to benefit from the provision of IB Services

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To determine if an individual meets the clinical criteria:

1. The individual or a person helping the individual must complete the Individual Application
2. The individual must have a DDP2 on file that is less than 6 months old
3. The DDRO may complete a CAANS-DD (Child, Adolescent, and Adults Needs and Strengths – Developmental Disabilities Tool) to determine the service needs of an individual

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Service Delivery and Documentation
Intensive Behavioral Services

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Time Limited

- ▶ Funding is available for up to six months (180 calendar days)
- ▶ Authorization is for six months (180 calendar days)
- ▶ Reauthorization may occur with clinical justification for another six months

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Plan Fee

- ▶ Completion of the FBA & BSP
- ▶ May be billed only once every 3 years

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Plan Fee

- ▶ One-time Fee for the completion of the Functional Behavioral Assessment (FBA) and Behavioral Support Plan (BSP)
- ▶ An agency may bill again after three years for an individual if that individual has been re-authorized for IB Services and it is clinically necessary and appropriate for a new FBA & BSP

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Reimbursable Services

- ▶ Plan Fee
 - Reviewing records and evaluations
 - Conducting relevant assessments
 - Collecting data
 - Communicating with other professionals
 - Communicating with the individual, family or others
 - Writing the FBA and BSP

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Hourly Fee

- ▶ Will only be paid after Medicaid has paid for the Plan Fee
- ▶ Maximum of 25 hours of service can be reimbursed for initial authorization
- ▶ Maximum of 8 hours billed in a single day
- ▶ DDRO continues to determine need for reauthorization
- ▶ DDRO may authorize either 25 or 50* hours on a reauthorization based on an individual's demonstrated clinical needs

Hourly Fee

- ▶ For time spent implementing the BSP
- ▶ Can only be paid after the agency has been reimbursed for the Plan Fee
- ▶ An agency will only be reimbursed up to 25 hours in a six month period or for 50 hours, if authorized by DDRO, in a reauthorization

Hourly Fee

- ▶ Time at another service cannot count toward billing when the services are being delivered face-to-face with the individual
- ▶ Exceptions:
 - When the individual is receiving CH or respite or Family Care
 - When the MSC is conducting a face-to-face visit

Reimbursable Services

- ▶ Hourly Fee
 - Training of the primary caregiver, respite or CH staff on behavioral supports and interventions
 - Training the individual on behavioral supports and strategies

*Must be specified in the BSP

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Reimbursable Services

- ▶ Hourly Fee
 - Monitoring the implementation of the BSP:
 - Observing the individual, family or CH staff
 - Following up as to effectiveness of the supports and interventions
 - Updating the BSP and/or FBA
 - Transition planning

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Service Documentation Requirements

- ▶ Plan Fee
 - ISP
 - Functional Behavioral Assessment (FBA)
 - Behavior Support Plan (BSP)

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Service Documentation Requirements

- ▶ ISP
 - Category of Waiver Service: Intensive Behavioral Services
 - Identification of your agency
 - Frequency: Plan/Hourly
 - Duration: Time Limited
 - Effective Date: the date the individual was enrolled in IB Services

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Service Documentation Requirements

- ▶ Functional Behavioral Assessment
 - Individual's name
 - CIN
 - Category of Waiver Service: Intensive Behavioral Services
 - Identification of your agency
 - Date on which FBA was completed (mth/dy/yr)
 - Date Assessment was written (mth/dy/yr)
 - Name, signature, and title of staff

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Service Documentation Requirements

- ▶ Behavior Support Plan
 - Individual's name
 - CIN
 - Category of Waiver Service: Intensive Behavioral Services
 - Valued Outcomes
 - Identification of your agency
 - Date on which BSP was written (mth/dy/yr)
 - Name, signature, and title of staff completing the BSP

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Service Documentation Requirements

- ▶ Behavior Support Plan
 - Evidence of a review
 - Include name, signature and title of staff, date of the review and any changes to the BSP
 - A review is required every 60 days from the completion of the BSP
 - A review (i.e. an update) is also necessary if the individual is reauthorized to receive another six months (180 days) of IB Services or is reauthorized at a later date.

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Service Documentation Requirements

- ▶ Hourly Fee
 - ISP
 - BSP
 - Narrative Note

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Service Documentation Requirements

- ▶ Narrative Note
 - Individual's Name
 - Category of Waiver Services:
 - Intensive Behavioral Services
 - Date the service was provided
 - Primary Service Location

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Service Documentation Requirements

- ▶ Narrative Note
 - Daily description of all of the services provided for the day drawn from the individual's BSP
 - Documentation of start and stop times for each "session"
 - Individual's response to the service
 - Name, signature and title of staff documenting service
 - Date the service was documented

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Resources

- ▶ www.opwdd.ny.gov
- ▶ Administrative Memorandum #2013-03
- ▶ Individual Application

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Questions?

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Pre-Admission Screen and Resident Review (PASRR)

Martha Schunk,
OPWDD Statewide PASRR Coordinator
Martha.Schunk@opwdd.ny.gov

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Nursing Home Stays

- ▶ Try to prevent via:
 - Options at home, or
 - Alternative residential options
- ▶ PASRR through the "side door"
- ▶ When/how to follow individuals in nursing homes
- ▶ Keeping TABS data up-to date

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Questions?

Contact

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OPWDD Statewide PASRR Coordinator
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The Front Door Summary Report

Shelly Okure,
Director of Relationships and Natural Supports
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PURPOSE OF THIS SUMMARY

- ❖ To share with service coordinators valuable information individuals and families shared with DDRO Front Door (FD) Teams during preliminary discussions related to their needs, interests, desires and individual goals.
- ❖ This information can be used to augment the information gathered by service coordinators as they work with the individual and/or family in developing the ISP, PISP, or addendum to an existing ISP.

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SUMMARY COMPONENTS

Individual's Information

- ❖ Captures basic information and demographics about the individual.
 - Name, DOB, primary contact info, marital status, current residence, etc.

Initial Needs and Interests

- ❖ Indicates the individual's interest in self-direction.
- ❖ Identifies how they are currently spending their day and how they want to spend their day.
- ❖ Also identifies other interests and immediate needs **as identified by the individual/family.**

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Initial Contact Information

- ❖ Shows how the individual was referred to OPWDD.
- ❖ Indicates other non-OPWDD services the FD Team may have referred them to.
- ❖ Highlights the date they and/or their representative participated in a FD Information Session.

Priority Factors for Consideration

- ❖ Identifies the individual's level of need for immediate services based on the priorities outlined in OPWDD's HCBS Waiver.
 - There are 3 levels of priority ranging from crisis situations to need for general supports and services.

Eligibility Determination

- ❖ Shares the individual's eligibility determination and enrollment dates for:
 - ❖ OPWDD services, Medicaid; HCBS Waiver services (if applicable); Eligibility to participate in OPWDD's Money Follows the Person

Assessment Information

- ❖ Provides the date the latest assessment was conducted.
- ❖ Provides DDP2 Adaptive, Behavior, & Health scores as well as their ISPM score.

Natural and Community Supports in Place

- ❖ Identifies other family members, community organizations/associations (including houses of worship) the individual may have established connections with and/or assistance from.

Non-OPWDD Supports and Services Currently in Place

- ❖ Provides information on services the individual is presently approved for or receiving from an agency other than OPWDD.
- ❖ Also indicates whether they want to keep, change or stop receiving a service or if they want to add a non-OPWDD service.

Current OPWDD Supports and Services in Place

- ❖ Identifies any OPWDD supports already approved for or being received.
- ❖ Information as to services the individual wants to add, change or stop receiving is also provided.

Services For Consideration:

- ❖ Provides basic information on services discussed between the FD Team and the individual based on assessment, needs and interests discussed. This information should augment the discussion with the Service Coordinator and is, in no way, to be considered a pre-authorization of services.

IMPLEMENTATION

- ▶ Completed ISPs (PISPs and addendums) are submitted by the Service Coordinator (SC) to the Front Door Team with recommended services.
- ▶ Sometimes the (SC) may receive information not formerly shared with the DDRO and the service plan submitted requests supports significantly outside the initial consideration of DDRO staff.
- ▶ FD staff will work closely with SCs to ensure all relevant information is taken into consideration to ensure appropriate recommendations for services are submitted for approval.

- ▶ The Front Door Summary Report is now available to all DDROs.
- ▶ It is anticipated that Service Coordinators will begin receiving this resource, prior to service planning, by the 1st of January in email format.
- ▶ For those who use CHOICES, a procedure to share this document will be developed and implemented by February 1, 2014.

Front Door Status and Updates

James Doherty,
Statewide Front Door Quality Management Coordinator
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Statewide Front Door Productivity

For Period 06/01/2013 to 11/24/2013

- Over 10,000 individuals have made contact with Front Door teams seeking information or services.
- Over 6,000 Individuals have attended Front Door Information Sessions and determined to be eligible for OPWDD Services.
- Over 4,000 have completed assessments

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Front Door Development Activities

- Refining Policy/Standardizing across regions
- Ongoing Training
 - Information Sessions
 - OPWDD Staff Trainings
- Front Door Quality Management Team
- OPWDD Staffing and Phase 2

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Front Door Quality Improvement

Front Door Quality Management Team

- o Ongoing functions: assist in the development of standardized processes, and procedures.
- o Engage in continuous quality improvement activities.
- o Monitor Outcomes: Track metrics and performance measures related to process outcomes and customer satisfaction.

Post Assessment Correspondence Service Coordinator Packet

Individual, Family, or Advocate Letter

Identifies next steps in the process, asks that individuals work with Service Coordinator (SC) to develop PISP, ISP, or ISP Addendum. SC will get a carbon copy of this letter.

Next Steps for Service Coordinators

Guidance for the SC, including next steps and their partnership role in the FD process.

Front Door Summary Report

Correspondence sent via secure email when possible and will be addressed to the SC Supervisor.

Questions?

Contact

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Statewide Front Door Quality Management Coordinator
25 Beaver Street
New York, NY 10004
Phone: 646-766-3336
Email: james.x.doherty@opwdd.ny.gov

Dates for the 2014 MSC Supervisors Conferences

March 12, 2014
June 11, 2014
September 10, 2014
December 10, 2014

registration will open soon

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Thank You

Your feedback is greatly appreciated

An evaluation form has been provided with the conference materials.
Please share your ideas for upcoming session topics.

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MSC Front Door Service Planning Summary

Instructions for Service Coordinators: This document provides some basic information for use by the Service Coordinator as they work with the individual to develop the Preliminary Individualized Service Plan (PISP) or Individualized Service Plan (ISP). As part of the Front Door (FD) process, a FD team member and the individual/family have engaged in a preliminary discussion of needs, interests, desires, and person-centered goals as they relate to self-direction, employment/day services and housing options. Conversations also included natural and community supports, and those services currently supporting the individual. This document should be viewed as an additional resource and should not replace any service planning activities.

Individual's Information

Name	JOHNSON, BETSY D	Street Address	1313 LAKE RD
TABS ID Number	99999		LOWE NY, 55555
Date of Birth	02/22/1910	County	ALBANY
Sex	Female	Individual's Phone Number	555-867-5309
Primary Language <i>(if not English)</i>		Current Residence Type	Family care home
Medicaid Number	AF24444J	Living Arrangement	With non-relative(s)
Social Security Number	XXX - XX - 9999	Marital Status	Not Married
Is Willowbrook?	No	Individual's E-mail	LDJ123@fake.email.com
Date of Registration	12/31/1980	DDSO	CAPITAL DISTRICT DDSO
Primary Contact			
Name	Betsy Johnson	Relationship to Individual	Self
Phone Number	555-867-5309	E-mail Address	LDJ123@fake.email.com
Alternate Contact			
Name	Frankie Johnson	Relationship to Individual	Relative
Phone Number	555-555-9988	E-mail Address	test@test.email.com

Individual's Initial Needs and Interests

Are you interested in self-directing some or all of your services? **Yes: Budget Authority**
 What are you currently doing with your day? **Engaging in paid employment, Volunteering, Something Else**

Description of need

		Is this need immediate?
Where do you want to live?	On my own, With Friends or Roomate(s)	No
What do you want to do with your day?	Engage in paid employment, Volunteer, Community involvement with out paid supports	Yes
Do you need relief from caregiving (for parents/caregivers)?	No	No
Do you need help with skills to live as independently as possible in your home?	Yes	No
Do you need assistance with rent to live in a home of your choice (housing subsidy)?	No	No
Do you need an environmental modification to your home?	No	No
Do you need adaptive technology to increase communication or independence?	Yes	Yes
What else would help you?	Another need	No

Initial Participant Contact

Initial Need Identified by Individual/Family/Designee	Employment	Referred to other entity?	DOH
Date Participated in ICS Info. Session	06/01/2013		

Eligibility Determination

Is the individual eligible for OPWDD services? Yes Eligibility Date 07/30/1990
 Is the individual enrolled in Medicaid? Yes Medicaid Coverage Code Full Coverage
 Is the Individual Enrolled in HCBS Waiver? No HCBS Waiver enrollment date 03/01/1993
 Is the Individual eligible for Money Follows the Person participation? HCBS Waiver termination date 01/31/1996

Assessment Information

Has the assessment process been completed? Yes Date assessment completed 07/09/2012
 DDP Adaptive 257.88 DDP Behavior 148 DDP Health 14 ISPM Score 6

Natural and Community Supports Currently in Place

Lives with family, and will continue to live with family? No
 Lives with family, and has other family in area? No
 Does not live with family, but has family in area? Yes
 Belongs to community organizations? No
 Connected to a house of worship? Yes
 Other(Specify)

Non-OPWDD Supports and Services Currently in Place

Is the individual currently receiving Non-OPWDD services? Yes

Type of Service	Specify Other	Is the Individual currently receiving this service?	Does the Individual want to add, change or remove this service?	If change, how?	Specify other change
Vocational Services (ACCES-VR)		Yes	Change	Increase Hours	
Personal Care (DOH)		Yes			

OPWDD Supports and Services Currently in Place

Is the individual currently receiving any OPWDD services? Yes Has the individual ever received any OPWDD services? Yes

Category of Service	Type of Service	Specify	Is the Individual currently receiving this service?	Does the Individual want to add, change or remove this service?	If change, how?	Specify other change
Home	Family Care		Yes			
Coordination and Brokerage	Medicaid Service Coordination (MSC)		Yes	Change	Change Staff	

Services for Consideration

The section below reflects services that may help support the interests and goals of the individual, and can be used to *augment* the information already gathered by the Service Coordinator as a part of the established service-planning process. Please note: this section is NOT meant to be, nor should be considered, a service "pre-authorization." Ultimately it is the responsibility of the SC and the individual, family, and advocate to develop a service plan that will best meet their needs.

Category of Service	Type of Service
Community, Relationships, Meaningful Activities	Supported Employment (SEMP) - Self-Directed
Community, Relationships, Meaningful Activities	Individual Directed Goods and Services (pending waiver approval)
Health and Environmental Supports	Assistive Technology/Adaptive Devices

**Evaluation Form:
MSC Supervisors Video Conference/Webinar
December 18, 2013**

Please check a rating for each statement:

I attended the webinar ____ **I attended the video conference** ____

1. The session objectives were clearly explained.

Strongly Agree Agree Neutral Disagree Strongly Disagree

2. The session effectively met its stated objective.

Strongly Agree Agree Neutral Disagree Strongly Disagree

3. The session materials helped me to understand the subject matter.

Strongly Agree Agree Neutral Disagree Strongly Disagree

4. The session content increased my understanding of the subject matter.

Strongly Agree Agree Neutral Disagree Strongly Disagree

5. The subject matter will be useful to me in my job.

Strongly Agree Agree Neutral Disagree Strongly Disagree

6. The presenter was knowledgeable about the subject matter.

Strongly Agree Agree Neutral Disagree Strongly Disagree

7. The presentation style contributed positively to the program.

Strongly Agree Agree Neutral Disagree Strongly Disagree

8. The length of the session was appropriate.

Strongly Agree Agree Neutral Disagree Strongly Disagree

What were the positive points of this presentation?

What improvements could be made to this presentation?

Recommendations for future topics:

Name (optional) _____

Title _____

Location _____

Thank you for your feedback!

Please leave this form at the training site or return it to Angie Francis via email by December 24, 2013 to:

Angie.x.Francis@opwdd.ny.gov