



NYS Office For People With Developmental Disabilities

Putting People First



Partnering for Change

Key OPWDD Initiatives and the Road to Reform



Advance of Greater New York State (AGNY)





Welcome

Partnering for Change: Key OPWDD Initiatives and the Road to Reform

Pat Dowse

New York State Rehabilitation Association



NYS Office for People with Developmental Disabilities

Putting People First



Opening Remarks

Jerry Huber

Deputy Commissioner Person-Centered Supports



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Overview of Key OPWDD Initiatives and Objectives

**Road to Reform
Transformation Agreement
Goals of the Day**

Kate Bishop

Director of Health and Community Supports



NYS Office for People with Developmental Disabilities

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OPWDD Transformation

As OPWDD pursued development of the People First Waiver, we worked with CMS to define priority elements of system transformation:

- Expanding opportunities and supports for **EMPLOYMENT**
- Expanding **COMMUNITY SERVICE OPTIONS** – supportive housing, community-based services
- Expanding **SELF DIRECTION** options
- **OLMSTEAD PLAN** - Creating opportunities for people to move from institutions to integrated settings



Transformation Documents

“Putting People First: OPWDD’s Road to Reform”

comprehensive review of system reforms recently achieved and underway

“The OPWDD Transformation Agreement” Appendix H of the DRAFT NYS Partnership Plan Amendment (DOH 1115 Waiver)

Articulates clear commitments for achieving ambitious goals for system reform and service delivery



Putting People First: OPWDD's Road to Reform

Over the past two years with the commitment and support of agency leaders and stakeholders, OPWDD has launched a broad range of initiatives to ensure that the agency's overall culture—its attitudes, values, goals and practices—are aligned and supportive of the transformation goals.



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Reform: Working Together to Develop a New Waiver

- Initiated Stakeholder conversations with individuals, families, service providers, and CMS about needed system reforms
- Extensive and inclusive dialogue around needed reforms – design teams, Steering Committee, outside experts, Request for Information, Public Forums
- Extensive negotiation with federal CMS
- Submitted formal waiver applications April 1, 2013
 - 1915 b – to support move to managed care
 - 1915 c amendment – to continue community-based services





Focused Reform Goals

- More person-centered services
- Stronger community-based services
- Comprehensive care coordination to meet all of an individual's needs
- More meaningful ways to measure quality of care





OPWDD's Transformation

In addition to its many reform initiatives, OPWDD has worked with CMS to develop specific targets and timelines for achieving the agency's goals in support of its broad system transformation.



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OPWDD Transformation Agreement

The Agreement contains commitments for OPWDD related specifically to:

- Money Follows the Person (MFP) Demonstration
- Balancing Incentives Program (BIP)
- 1915 b/c Applications
- Residential Transitions and Supportive Housing
- Supported Employment Services and Competitive Employment
- Self-Direction



The agreement plan also includes commitments related to:

- Expanding participation in streamlined self-direction service options
- Increasing the number of individuals employed
- Expanding outreach related to these service options, in particular targeting students aging out of school
- Commitments to further de-institutionalization (beyond those participating in MFP)
- Quality oversight of the development and implementation of person-centered plans that meet people's needs in community settings



Money Follows the Person

Purpose: To help states rebalance their long-term care systems by offering people opportunities to move out of institutions into the community

Program Goals:

1. Increase use of HCBS, reduce institutional services
2. Eliminate barriers that restrict the use of Medicaid funds to provide long-term supports in settings of choice
3. Strengthen ability to provide HCBS to people who want to leave institutions
4. Put procedures in place to provide quality assurance and improvement of HCBS





OPWDD Participation

- Effective April 1, 2013 and runs through 2016.
- Will transition individuals from DCs and community-based ICF/IIDs and Skilled Nursing Facilities into community settings.
- Acceptable community settings = individual's private home, his or her family's home or a community residence that is home to four or fewer unrelated individuals.
- OPWDD will transition roughly 875 individuals into community settings.



Balancing Incentives Program (BIP)

Purpose: to provide grants & enhanced FMAP to states to increase access to non-institutional long-term supports/services

Program Goals:

- To help states develop new ways to support more people in community settings
- To support structural changes that increase institutional diversions and access to long-term supports/services

With MFP, BIP is part of CMS's strategy to redesign long-term supports/services.



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Some Specific Transformation Plan Goals

Self Direction

- Provide education to at least 1,500 beneficiaries (with designated representatives as needed) per quarter beginning on April 1, 2013.
- Increase number of individuals self directing by 1,245 by March 31, 2014.



Some Specific Transformation Plan Goals

Employment

- Increase number of individuals employed by 700 by March 31, 2014.
- End admissions to sheltered workshops on July 1, 2013.



Some Specific Transformation Plan Goals

Residential Transitions

- Transition 148 people from Finger Lakes and Taconic ICFs to community settings by January 1, 2014.
- Provide quarterly reports on how we are increasing supportive housing options, including non-traditional housing models.
- Demonstrate how we'll assure that community settings meet “home-like” standards.



Some Specific Transformation Plan Goals

People First Waiver

- Submit to CMS a request for a new rate structure for voluntary providers by July 1, 2013.
- Adopt practice guidelines for care coordinators based on CQL Personal Outcome Measures and report on progress by September 1, 2013.



Key OPWDD Initiatives

- Establishing a Valid, Consistent Needs Assessment for a better foundation for person-centered support;
- Enhancing the menu of community-based supports, clinical services, non-certified residential support options and employment supports;
- Moving toward managed care to establish comprehensive care coordination to increase coordination and efficiency;
- Transforming the fiscal platform;
- Improving and developing new ways to measure quality that looks at outcomes for individuals;
- Serving People in the Most Integrated Settings.

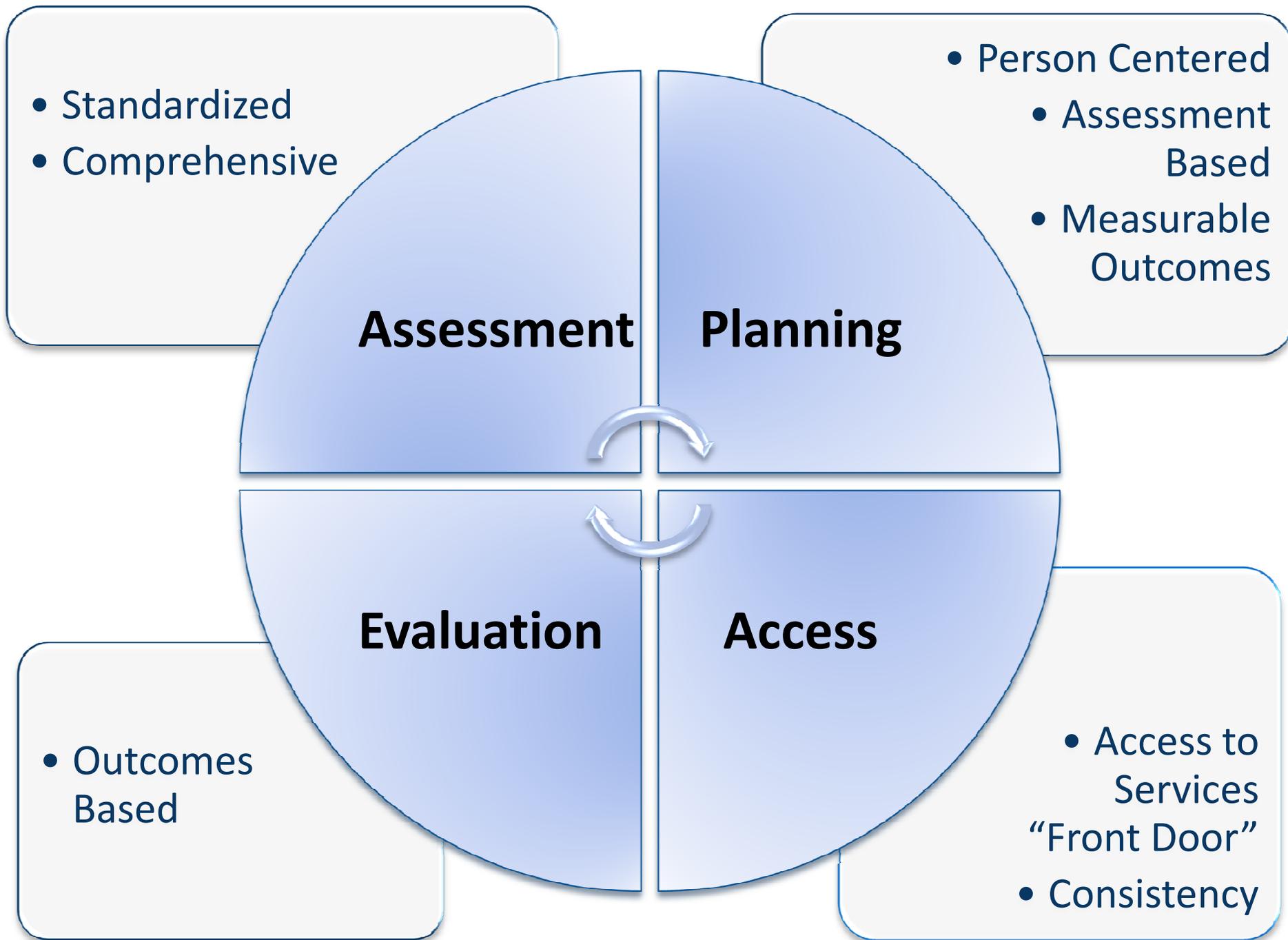




Key Initiatives

How do we get there?







Diane Woodward
State Assessment Coordinator





Development, Use and Implications of the NYS OPWDD Coordinated Assessment System

Coordinated Assessment System (CAS) Developed
from InterRAI Assessment Suite



Why Create A New Needs Assessment?

Enhance the quality of life and care of persons with DD receiving Waiver services by:

- Accurately identifying the characteristics and needs of individuals to better inform person-centered care planning.
- Discovering changes and trends in health status and their relationships to the types of supports and services utilized.
- Analyzing data across regions of the state on whether individuals with similar needs receive supports/services, regardless of where they reside.



Goals of Needs Assessment

Standardized needs assessment
that identifies individual needs
and strengths to inform
Person-centered care
planning



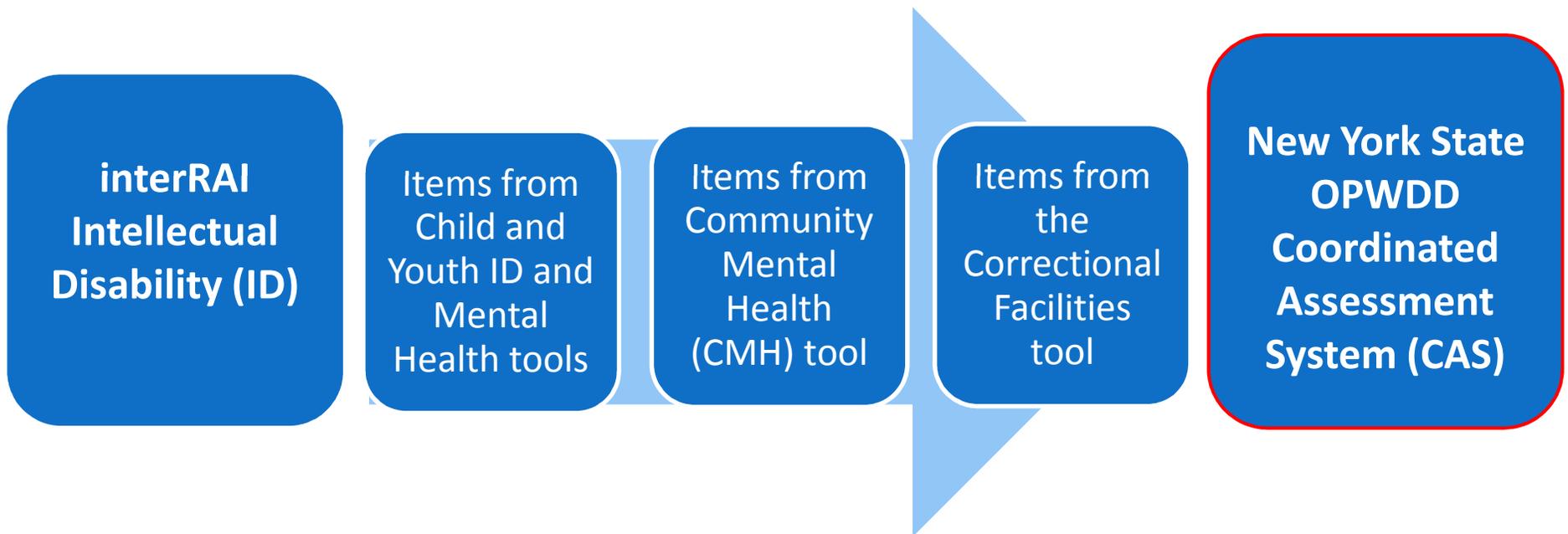
Ability to draw on individual or
aggregate level data for
quality monitoring
purposes.



An assessment tool that can
inform acuity levels for
resource allocation.



Development of OPWDD's CAS



CAS Domains

- Identification
- Intake/Initial History
- Community/Social Involvement
- Strengths/Relationships Supports
- Environment
- Communication/Vision
- Cognition
- Health Conditions
- Independence in Everyday Activities
- Oral/Nutritional Status
- Mood/Behavior
- Medications
- Service Utilizations/Interventions
- Diagnostic Information
- Assessor Information



CAS Supplements

- Specific answers to items will trigger the need to complete special supplements, on an as needed basis:
 - Child and Adolescent Supplement
 - Substance Use Supplement
 - Mental Health Supplement
 - Forensic Supplement
 - Medical Management Supplement



Collaborative Action Plans (CAPs)

- Abuse
- Communication
- Contenance
- Injurious Behavior
- Meaningful Activities
- Mental Illness
- Social Relationships

Additional 27 CHA/HC CAPs that OPWDD can draw on to aid in identifying priorities for care planning





Long-Term Vision For The Coordinated Assessment System (CAS)



Long-Term Vision

- New Coordinated Assessment System will be phased in *thoughtfully over the next several years:*
 - Beginning with year long case studies,
 - Moving next to DISCO pilot projects,
 - Next into use with all newcomers to the service system,
 - Eventually, over time, will be used with those currently receiving services.
- We will be careful not to disrupt lives, but instead identify opportunities for greater integration and independence based on needs, strengths and desires.





Long-Term Vision

- Once the CAS is standardized it will eventually replace the use of the DDP2
- In the meantime:
 - Roll-out for completion of DDP2 and provision of other life circumstance for individuals entering the Front Door
 - OPWDD will administer or verify the DDP2 for individuals new to the system





Shelly Okure

Division of Person Centered Supports





PERSON CENTERED PLANNING

- Planning from a person centered perspective seeks to listen, discover and understand the individual.
- It is a process of learning how the individual wants to live and describes what needs to be done to help them move toward that life.



- 
- The planning process capitalizes and builds on an individual's abilities and skills to form a quality lifestyle for the individual.
 - Other factors that impact the individual's life are considered, but knowing abilities and skills helps set a direction, gives guidance, provides positive motivation and increases the likelihood of success.



ESSENTIAL HALLMARKS OF PERSON CENTERED PLANNING

1. The person and people important to him or her are included in lifestyle planning, and have the opportunity to express preferences, exercise control and make informed decisions.
2. The person's routines, supports and services are based upon his or her interests, preferences, strengths, capacities and dreams.



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3. Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect.
 4. The person uses, when possible, natural and community supports.
 5. The person has meaningful choices, with decisions based on his or her experiences.



- 
6. Planning is collaborative, recurring, and involves an ongoing commitment to the person.
 7. The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.
 8. The person is satisfied with his or her activities, supports, and services.





HOW HALLMARKS RELATE TO OPWDD TRANSFORMATION AGENDA and The Road to Reform



THE FUTURE OF PERSON CENTERED PLANNING

To create a more person centered approach to every aspect of our system, OPWDD has initiated

- Development and testing of the new needs assessment methodology (CAS)
- A redesigned “Front Door” to ensure that all people coming to OPWDD have access to more comprehensive information on ALL our service options
- **Expanded options for Self Direction**
- Systemic person centered outcome measures





EXPECTATION OF THE DISCOS is to utilize characteristics essential to the successful use of a Person Centered Planning process with an individual. These characteristics will ensure that supports and services are:

1. Person-Directed
2. Person-Centered
3. Outcome-Based
4. Information, Support and Accommodations
5. Wellness and Dignity of Risk
6. Participation of those that individual selects
7. Community Integrated



- 
- The individual directs the planning process and decides when and where planning meetings are held, what is discussed, and who is invited.
 - The planning process focuses on the **individual**, not the system. The individual's goals, interests, desires, and preferences are identified with optimistic plans for a satisfying life. Services and supports are responsive to the person's needs.
 - Supports, services and necessary training needed for the individual to achieve his or her goals, plans, and desires are identified.



- **Outcomes** are also a means of measuring progress toward achievement of goals identified.
- The individual receives comprehensive and unbiased information on all OPWDD services, community resources, and available providers.
- Issues are discussed related to the individual's wellness, well-being, health and primary care coordination needs.
- Health and safety considerations are determined and plans to address them are developed.



- 
- The individual selects friends, family, and others to support him or her.
 - Supports are provided to help the individual cultivate and strengthen desired relationships.
 - The support of family, neighbors, friends, co-workers and “generic” community supports are encouraged to assist the person to live in the most integrated setting possible and to be a contributing member of the community to the extent that he/she desires.





Specific Organizational Characteristics will support Person Centered Planning



1. Individual Awareness and Knowledge

The managed care entity will provide:

- accessible and easily understood information;
- support and when necessary, training for individuals and those who assist them regarding services and supports used;
- Understanding of their rights to person centered service planning, the essential elements of the person centered planning process, and the benefits of this approach.





2. Person-Centered Culture

The managed care entity provides:

- leadership,
- policy direction,
- and activities for implementing person centered planning at all levels of the organization.

Organizational language, values, allocation of resources, and behavior will reflect a person centered orientation.





3. Training

The managed care entity will have a process to identify and train staff at all levels on the philosophy of person centered planning.

Staff who are directly involved in person centered planning are provided with additional training.



4. Roles and Responsibilities

As an individualized process, person centered planning **allows each individual to identify and work with chosen people and other supports.**

Roles and responsibilities for facilitation, planning, and developing the plan are identified.

The plan will also describe who is responsible for implementing and monitoring each component of the plan.



5. Quality Management

The managed care entity's quality management system will include a systemic approach for

- measuring the effectiveness of person centered planning and
- identifying barriers to successful person centered planning.

Best practices for supporting individuals will be identified (what is working/what is not working) and implemented.

Organizational expectations and standards will be put in place to assure that individuals are supported in directing the process and ensure that person centered planning is consistently done well.





Kate Bishop

Director of Health and Community Supports

WHAT IS THE FRONT DOOR INITIATIVE?

The Front Door Initiative is:

- ❖ A person centered approach to developing plans of support for people - not a program or a service
- ❖ Part of the fundamental process by which people access supports and services through OPWDD - providing a broader array of individualized service options to give individuals and families more flexibility and choice of supports and services that meet their needs





Why Develop A New Front Door Now?



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WHY NOW: THREE FACTORS

1. ***The sustainability factor*** - how do we sustain appropriate service provision within fiscal realities?
2. ***The relevancy factor*** - are the services we currently offer those that families and individuals coming into our service system are seeking?
3. ***The compliance factor*** - in light of Olmstead and recent federal decisions on ADA, will the menu of service options we provide allow us to meet the goals of Olmstead and federal requirements?



WHY NOW: SUPPORTING OPWDD'S DEFINED VALUES

Front Door services rest on the philosophy of *self-determination* and the principles that people with developmental disabilities have a right to:

- Enjoy meaningful relationships with friends, family and others in their lives;
- Experience personal health and growth;
- Live in the home of their choice;
- Fully participate in their communities.



WHY NOW:

SUPPORTING THE TRANSFORMATION AGENDA FRONT DOOR SERVICES WORK TO:

- Insure supports are provided in most integrated setting possible.
- Provide a person centered approach.
- Maximize control of living setting by individual receiving services.
- Increase education about and access to self direction.
- Provide increased opportunities and supports for employment.
- Measure outcomes in a meaningful way.
- Prepare for OPWDD's move into managed care.



WHAT IS THE FRONT DOOR ?

OPWDD's Front Door creates a consistent approach, designed to expand knowledge for individual choice and information to make better service authorization decisions, for people with developmental disabilities to access, continue or modify the supports and services they use.

- ❖ For new individuals, the Front Door encompasses interactions with OPWDD from the point of contact through service authorization.
- ❖ Individuals already connected to OPWDD will use Front Door services when they seek a change in service.



INTENT AND PURPOSE

The intent is to:

- Improve the way people find out about OPWDD and OPWDD service options.
- To help people connect to the services that best address their needs.
- To give people as many opportunities as possible to direct their own supports and services.
- To build consistency in statewide application of policies and practices, consumer experience and communication.



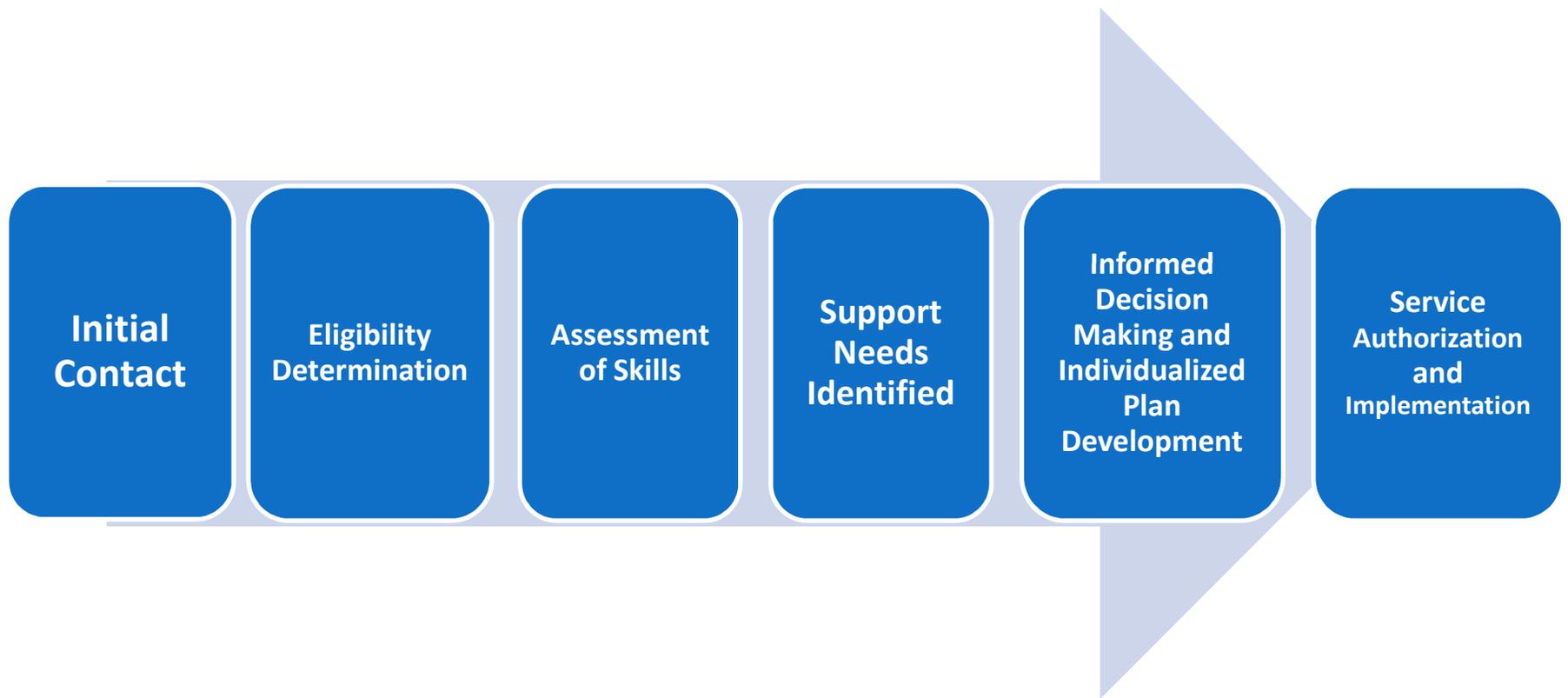
WHO COMES THROUGH THE FRONT DOOR?

The Front Door is meant to ensure that all individuals have access to the same information as they learn about supports and services through OPWDD and make choices about how those supports and services can be best utilized to help them achieve their goals. This includes individuals:

- ❖ New to OPWDD;
- ❖ People requesting a change of services due to a change in their interests or needs;
- ❖ People eligible for Specialized Template Funding and;
- ❖ People who need to access state operated settings due to legal system interfaces or other circumstances.



THE PATH TO OPWDD'S SERVICE FROM INITIAL CONTACT TO SERVICE DELIVERY





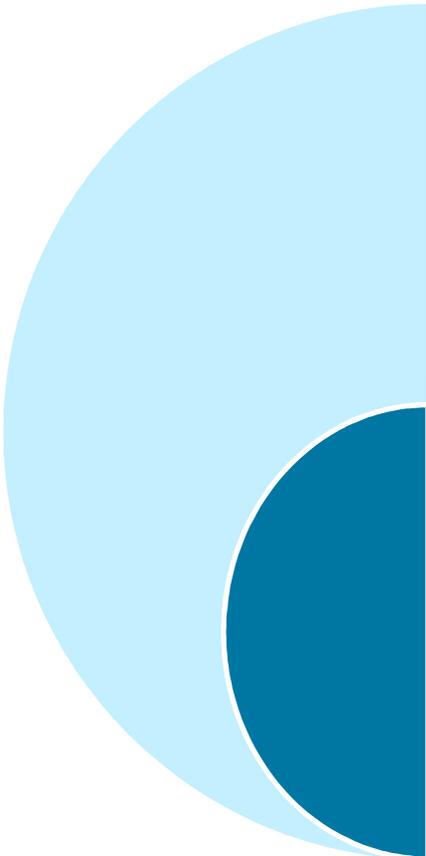
RELATIONSHIPS AND ROLES WITH PARTNERS

- Partnerships with providers will be sustained. OPWDD will continue to work with provider agencies in meeting needs.
- Providers may assist individuals and families through the eligibility and assessment processes.
- They will also be challenged to develop various service options that align with what individuals and families are seeking in order to have a life of quality and meaning.





Areas for Increased Partnership



Reinvestment Planning and Implementation
Communication in Service Planning

Reinvestment Planning and Implementation

Communication in Service Planning



Reinvestment

Reinvestment is one or more methods for individuals to maintain service dollars but change service type to be able to purchase services in a more integrated setting.



Steps to Achieve Reinvestment Models

- Review and modify existing processes, procedures and templates or develop new ones that enable providers to reinvest dollars associated with existing services that support more choice and better outcomes for people while also serving more people.
- Develop consistent policies, procedures and reports that OPWDD Regional Offices can utilize to better manage base resources.
- Create policies that can be put in place that shift management of current resources away from vacancy management and toward capacity management and more integrated settings.



Communication in Service Planning

OPWDD and partners must communicate about individual level of need and how that need impacts service planning.

Services in traditional supervised IRA and day habilitation settings will not be authorized by OPWDD simply because a program opportunity is available. An individual must have a level of need significant to require the level of support offered in these services and must choose these options as opposed to an option in a more integrated setting.

Role of the MSC in OPWDD's Front Door

The MSC acts as the conduit between OPWDD and the individual. S/he promotes OPWDD's policies of self-direction and services in the most integrated setting. The MSC helps the individual to develop and submit an individualized plan that meets needs in the most integrated setting possible and works with OPWDD staff to ensure that plan meets criteria for authorization.

Assist individuals to understand self-direction

Continue to develop service plans based on individual need

Partner with OPWDD in communicating values

Provide justification for authorization of services in plan

Regional Office Roles in the Front Door Before, During, and After Implementation of Managed Care

Front Door as currently designed	Front Door with optional enrollment in managed care	Front Door with mandatory enrollment in managed care
<p>Initial Contact</p> <p>Eligibility Determination</p> <p>Assessment</p> <p>Identification of Skills</p> <p>Plan Development</p> <p>Service Authorization & Implementation</p>	<p>Initial Contact</p> <p>Eligibility Determination</p> <p>Assessment</p> <p>Identification of Skills</p> <p><i>Choice of Enrollment in Managed Care</i></p> <p style="text-align: center;">} Fee for Service Managed Care </p> <p>Plan Development Choice of DISCO/ Enrollment Brokerage</p> <p>Service Authorization & Implementation Oversight of DISCO</p>	<p>Initial Contact</p> <p>Eligibility Determination</p> <p>Assessment</p> <p>Identification of Skills</p> <p>Choice of DISCO/ Enrollment Brokerage</p> <p>Oversight of DISCO</p>



STEPS TO THE FRONT DOOR

- The front door is opening – being piloted and tested; a soft launch in June.
- Regional Offices are concentrating on putting front door practices in place for new people coming into the OPWDD system.
- Information sessions are being conducted for individuals and families on the full scope of OPWDD services.
- Training curriculum for providers is being developed.
- We are educating our workforce on these exciting changes.





Maryellen Moeser
Bureau Director
Continuous Quality Improvement/DQI



Utilizing CQL Personal Outcome Measures (POMs) for Quality





A Key component of OPWDD's transformation agenda is to assess quality in ways that align with OPWDD's mission, vision, values, and guiding principles.





This means OPWDD needs to move beyond compliance and site based/program based monitoring to develop more meaningful ways to measure the EFFECTIVENESS of the service system in people's lives

Compliance focuses on whether programs/agencies are organized and operate in accordance with State and federal requirements such as licensure, certification, and regulations.

Quality improvement activities go beyond minimal requirements and measures the impact of programs/supports/services on the quality of life, functional independence and health of individuals.

Transformation Agreement-- Fidelity to Independent Person Centered Planning

Independent process for assuring that person centered plans meet the needs of enrollees

Process to ensure that person centered plans are implemented with fidelity to principles

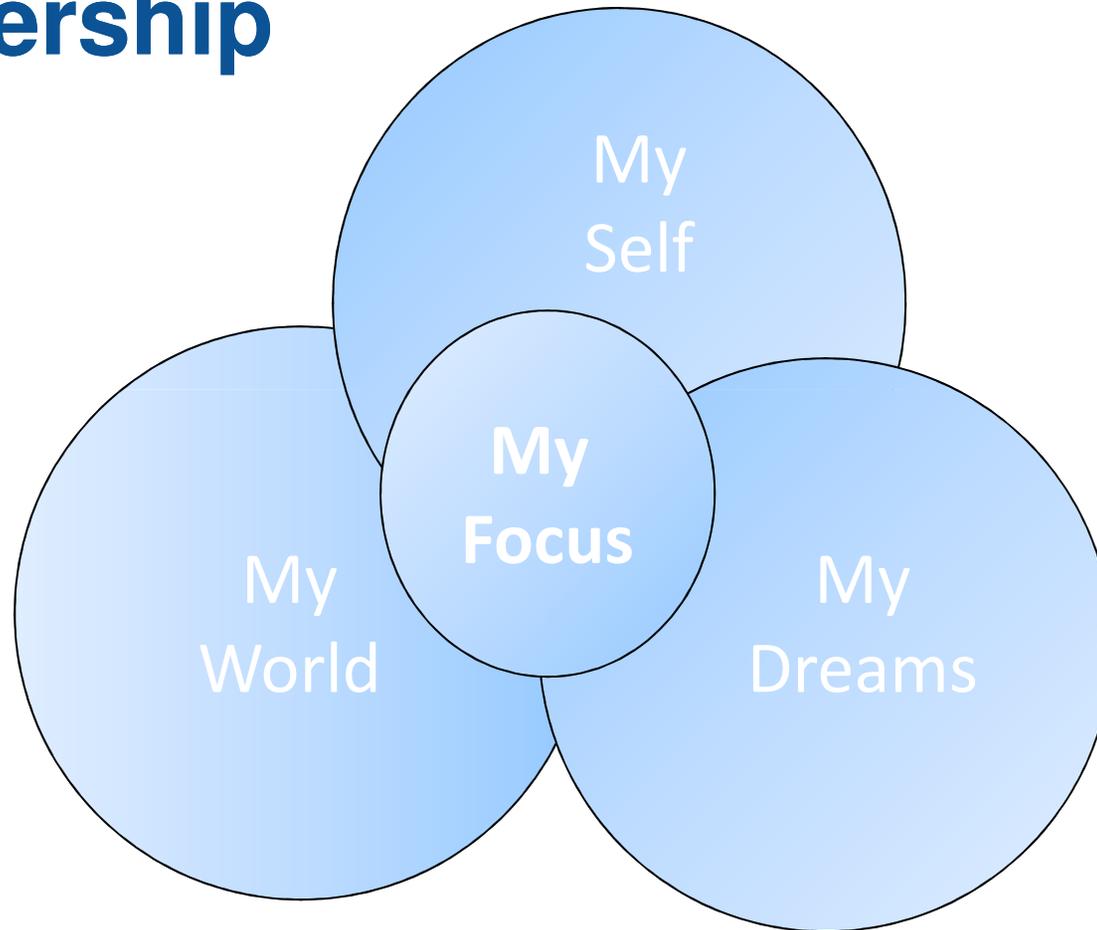
**Personal
Outcome
Measures**



What are CQL Personal Outcome Measures?

- Valid and reliable personal outcome measures that focus on what is meaningful to the person served.
- Provides a methodology to assess how well the organization's provision of supports and services facilitate outcomes that are meaningful to each individual.
- Different than National Core Indicators (NCI) which are system outcome measures.

CQL The Council on Quality and Leadership



My Focus: What is most important to me now.



CQL The Council on Quality and Leadership

My Self

1. People are connected to natural supports.
2. People have intimate relationships.
3. People are safe.
4. People have the best possible health.
5. People exercise rights.
6. People are treated fairly.
7. People are free from abuse and neglect.
8. People experience continuity and security.
9. People decide when to share personal information.



CQL The Council on Quality and Leadership

My World

1. People choose where and with whom they live.
2. People choose where they work.
3. People use their environments.
4. People live in integrated environments.
5. People interact with other members of the community.
6. People perform different social roles.
7. People choose services.



CQL The Council on Quality and Leadership

My Dreams

1. People choose personal goals.
2. People realize goals.
3. People participate in the life of the community.
4. People have friends.
5. People are respected.



® POM Uniqueness

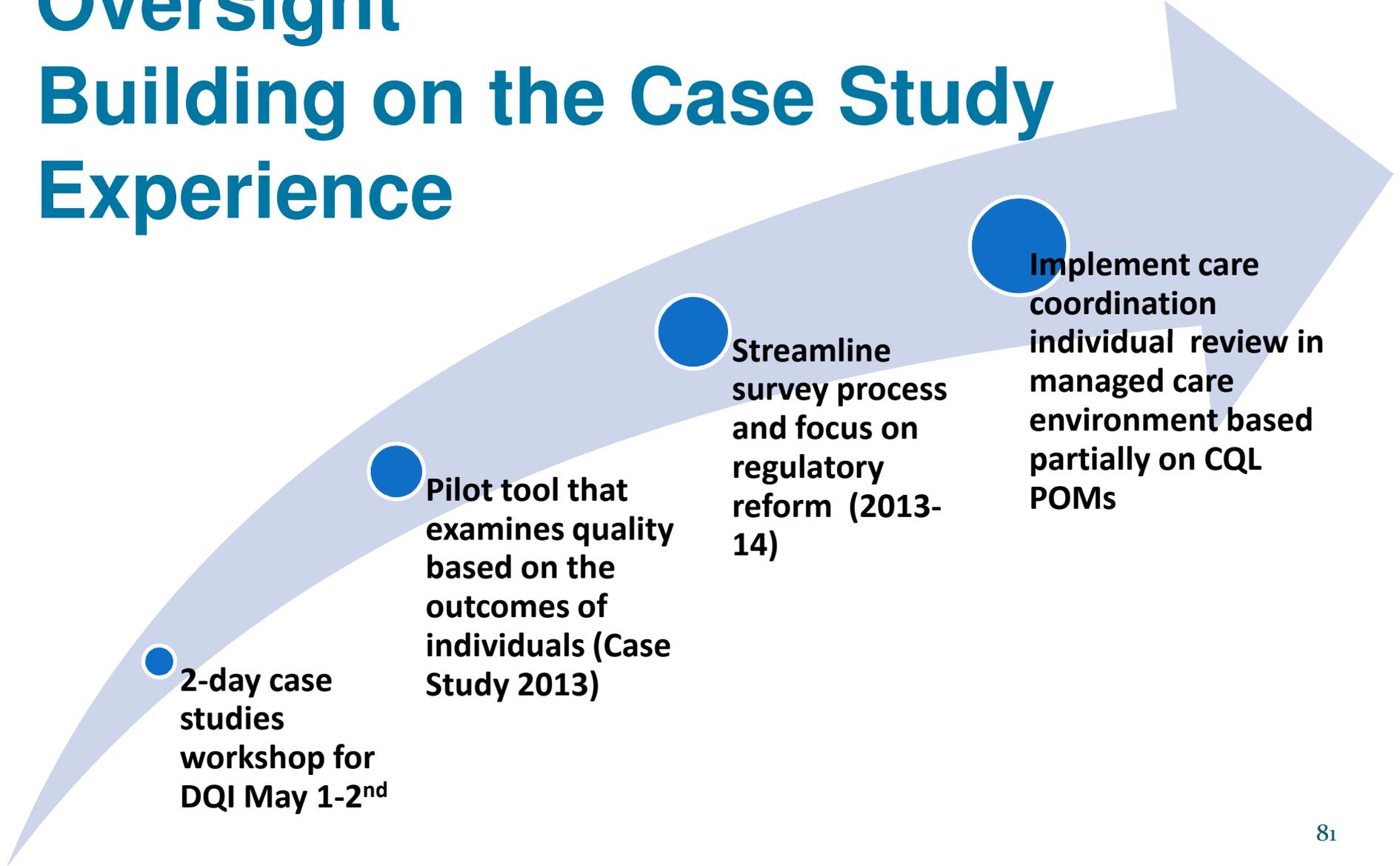
- Developed from focus groups and individual interviews with people with disabilities
- Learn about POM through a conversation, not an interview with a checklist
- The person directs the conversation
- Each individual is a unique sample of one with his or her own definition of each of the outcomes
- The POM conversation identifies the supports and services that facilitate the outcome
- The POM conversation provides the information for the individualized support plan
- The POM conversation enables the information gatherer to determine whether the outcome and support are present (+) or absent (-) and then quantify the data.

Evolving OPWDD's Quality

Oversight

Building on the Case Study

Experience



2-day case studies workshop for DQI May 1-2nd

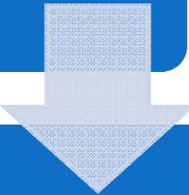
Pilot tool that examines quality based on the outcomes of individuals (Case Study 2013)

Streamline survey process and focus on regulatory reform (2013-14)

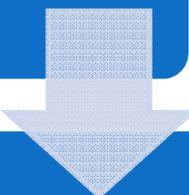
Implement care coordination individual review in managed care environment based partially on CQL POMs

Person Centered Development/Design for DISCOs

Adopt Practice Guidelines for care coordinators based upon CQL POMs



DISCO QI Plan Incorporates Use of CQL POMs



Annually assess managed care on quality of life using personal outcome information

Operationalizing POMs and DISCO Reviews

DISCOs will Need to:

- Have access to reliable/certified CQL interviewers or trainers to conduct POM interviews on a sample of members
- Report POM results to OPWDD annually
- Use POM process for continuous quality improvement and connect back to individual plans for those in the sample

DQI Will Need to:

- Validate that DISCOs are using POM measures and approach in continuous quality improvement
- Develop Care Coordination Review Tool to review effectiveness of Care Coordination in working with people on their individual outcomes (and other components of comprehensive care coordination)
- Continue MHL site visits
- Other managed care responsibilities TBD



DISCO QI Plan

Person Centered Planning Approach

- POMs
- OPWDD outcome areas
- Self-direction opt. for all who want them
- How care coordination effectiveness will be assessed by the DISCO

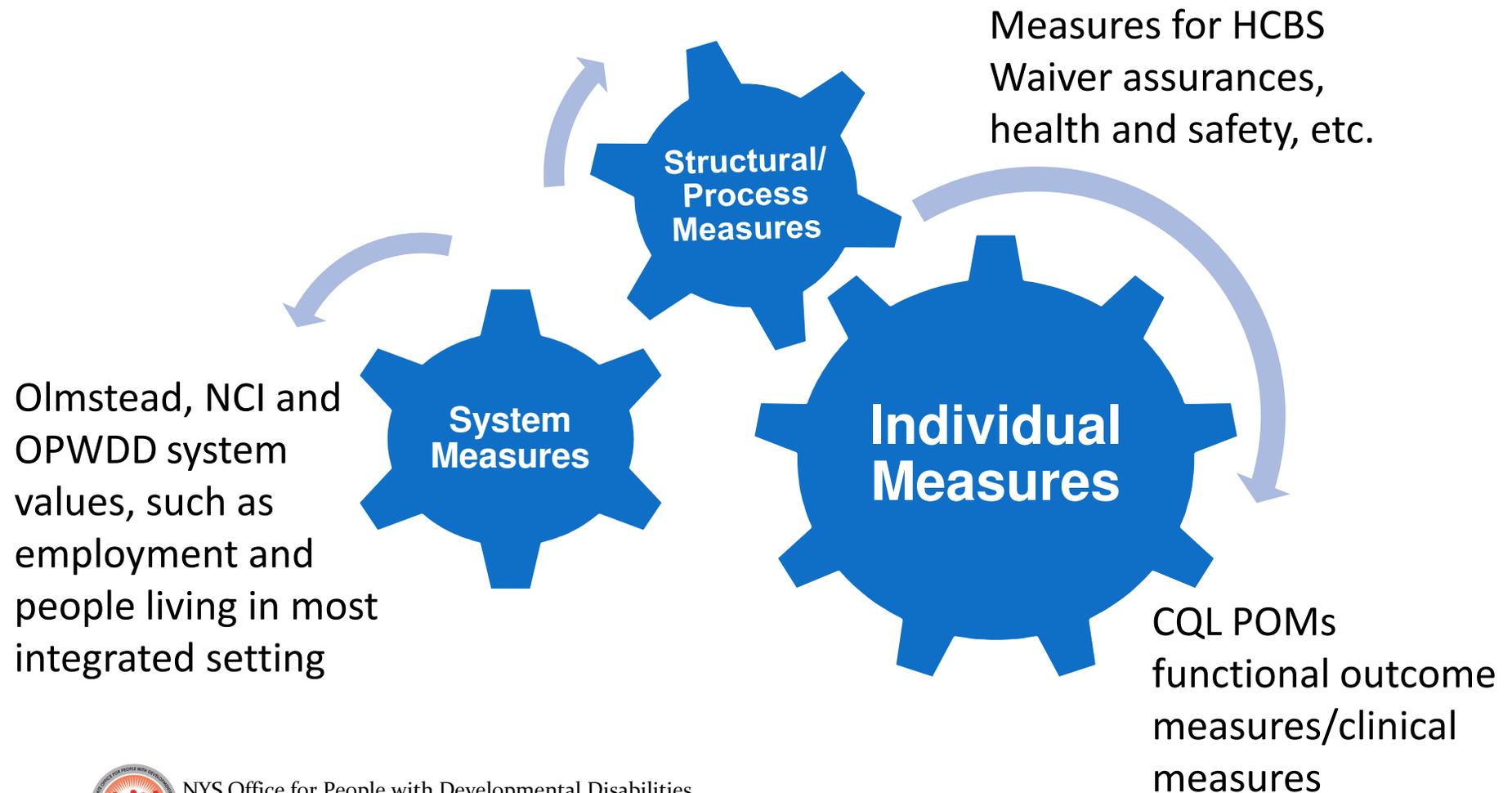
Qualifications and Capacity

- Credentialing
- How DISCO ensures network providers are qualified and meeting quality expectations
- Workforce competencies, training, etc.

Quality Improvement Processes

- Methods for review of individual needs/goals and outcomes
- How Assessments will be validated
- Roles and Responsibilities for QI
- Goals/Objectives and Measures

In Addition to CQL, Other Measures Will Still Be Needed for Managed Care





**Person Centered Quality of Life
Oversight and Outcomes**

**Health, Safety, Safeguards
Physical Plant and
Individual Incident Mgmt.**

Compliance



WHAT'S NEXT?

WE WANT TO HEAR FROM YOU

Kate Bishop

Director of Health and Community Supports



- 
1. What can you as the provider do to assist in facilitating and implementing these reforms?
 2. What has worked for those of you who have been doing this?
 3. What specific barriers and solutions do you see?
 4. What is the number one thing we must do to make it work?
 5. What would success look like to you?

