



**Office for People With
Developmental Disabilities**

Spring 2015 Division of Quality Improvement Provider Training

**Welcome
Megan O'Connor-Hebert
Deputy Commissioner**

An Introduction to the Nurse Practice Act MOU

Roger Bearden
General Counsel



Nurse Practice Act MOU and Agency Requirements

Jill Pettinger, Associate Deputy Commissioner
of Statewide Services

Vicki Schultz, Former Director of Nursing and
Health Services





**Office for People With
Developmental Disabilities**

**Registered Professional Nurse
Supervision of Unlicensed Direct
Support Professionals in Private
Homes and in the Community
ADM # 2015-03**

May 7, 2015

Background

Multiple OPWDD stakeholders worked diligently with NYS Education Department (NYSED) and the State Board of Nursing (SBON) to develop the new ADM allowing the delegation of certain nursing tasks by an RN to a DSP providing certified services in **NON-certified** sites



Outcome

OPWDD and NYSED signed the Memorandum of Understanding (MOU) and Administrative Memorandum (ADM) effective April 1, 2015. This ADM is **NOT** to be implemented by any agency until such time that a plan of implementation is communicated to the field by OPWDD.

The ADM 2003-01 remains in effect allowing the delegation of certain nursing tasks by an RN to a DSP in OPWDD certified sites.



Overview

- ADM # 2003-01 – Registered nurses supervision of unlicensed direct care staff in residential facilities **CERTIFIED** by the Office of Mental Retardation and Developmental Disabilities (now OPWDD)
- ADM # 2015-03 – Registered professional nurse supervision of unlicensed direct support professionals in programs approved by the Office for People with Developmental Disabilities (in certain **NON-certified** sites).



Purpose

ADM 2015-03 has been developed pursuant to New York State Education Law §6908(1) (a) (v), to:

- (1) identify the programs authorized to utilize direct support professionals to provide certain nursing tasks under the supervision of a registered professional nurse; and
- (2) define criteria for providing high quality, person centered, nursing services to individuals with intellectual/developmental disabilities, who participate in such programs.



Applicability

This ADM applies to providers of Home and Community Based Services (HCBS) approved or certified by OPWDD pursuant to Mental Hygiene Law section 16.03(a)(4). This ADM applies to services provided by registered professional nurses and direct support professionals to individuals with intellectual/developmental disabilities in their **private homes and while accompanying the individuals in the community**, in settings **not certified** by OPWDD.



Comparison between ADM's

Definitions in ADM 2015-03

Improved/clarified definitions in ADM 2015-03

- Individual
- Approved provider
- Registered professional nurse
- Licensed practical nurse
- Direct support professional
- Habilitation and respite care services
- Nursing tasks



Comparison between ADM's

Nursing Tasks in ADM 2015-03

For the purposes of this ADM, nursing tasks are tasks that may be delegated in writing by an RN to a DSP, and may include the following:

- bladder catheterization care (except for the insertion or removal or indwelling catheters or procedures requiring sterile technique);
- non-sterile dressing changes;
- glucose monitoring tests using medical devices approved by the FDA for over-the-counter use, if used for a single individual;
- respiratory care tasks, such as basic spirometry, oxygen administration and nebulizer treatments;
- permanent gastrostomy or jejunostomy tube feedings;
- colostomy care that does not require sterile technique.
- basic medication administration tasks (i.e., topical, eye/ear/nose drops, enemas, suppositories, and some routinely administered oral medications); and
- subcutaneous injections of diabetes-related medications and emergency injections (including, but not limited to, epinephrine, narcan, glucagon);



Comparison between ADM's

Nursing Tasks in ADM 2015-03

For the purpose of this ADM, the following activities and services shall not be delegated to a DSP and **shall not** be performed by a DSP:

- any activity that is outside the scope of practice of a licensed practical nurse;
- the administration of medications or fluids parenterally (except for subcutaneous injections of diabetes-related medications or emergency injections (including but not limited to epinephrine, narcan, glucagon, as described above));
- any services that are inconsistent with care ordered or prescribed by a physician, physician assistant, nurse practitioner, dentist, or podiatrist;
- the administration of controlled substances, except for federal Schedule IV and Schedule V controlled substances prescribed to treat seizure disorders or another developmental disability;
- any services requiring sterile technique; and,
- any nursing care that requires professional nursing judgment, including the assessment of the medication needs of an individual served by OPWDD.



Comparison between ADM's

Delegation of Nursing Tasks in ADM 2015-03

- **Initial Assessment:**

With respect to each new individual served by an approved provider, the approved provider, in collaboration with an RN employed by or under contract with the approved provider, shall review the individual's nursing needs, if any. If the RN determines that the individual requires nursing services, the RN shall complete a comprehensive assessment of the individual to determine whether nursing tasks, in whole or in part, could be delegated to DSPs with adequate training and nursing supervision.

- **Delegation Decisions:**

The same as ADM 2003-01



Comparison between ADM's

Documenting Delegation Decisions in ADM 2015-03

The RN shall develop an individualized plan of nursing services based on the comprehensive nursing assessment of the individual, which identifies the nursing services to be provided to the individual, including delegated nursing tasks. An RN who delegates the performance of nursing tasks **shall note in the individualized plan of nursing services a description of the nursing task, the name of the DSP(s) to whom the task is delegated, the date of the delegation, the RNs who will initially be assigned to supervise the DSP(s) and the RN's signature.** The RN may include specific recommendations relating to the RN supervision of the delegated tasks. An RN shall promptly document in the individualized plan of nursing services any changes or termination of a delegation along with the RN's signature.



Comparison of ADM's

Requirements of ADM 2015-03 are essentially the same as the requirements of ADM 2003-01 for the following:

- RN Supervision of DSP(s)
- Training
- Availability of RN to DSP(s)
- Plan of Nursing Services

Differences are in the following areas:

Frequency of visits by RN's

- ADM 2003-01: once per week
- ADM 2015-03: once per month

Clinical Performance Evaluations

- ADM 2003-01: include, but not limited to, medication administration
- ADM 2015-03: include, but not limited to, **annually**
 - medication administration
 - **insulin administration**
 - **tube feeding**



Comparison of ADM's

Staffing Ratios – RN to Individuals

- ADM 2003-01 – (1:50)
- ADM 2015-03 – (1:35)



Conclusion

- Training needs to remain the same for RN's, LPN's, AMAP's and DSP's who will be working in either certified or non-certified sites
- AMAP curriculum changes— training points to be added regarding restriction of controlled substances administered to allow federal class IV and V used to treat seizures and other developmental disabilities
- AMAP curriculum changes- training module to be added to address medication storage, medication administration documentation, and “meds on the go” for non-certified sites
- Agencies must develop policy and procedures related to requirements of the ADM before implementation
- Highly recommend that agencies pilot this ADM on smaller scale prior to full implementation



Conclusion

- We need to consider that we will be providing services in an individual's home – not a home operated by OPWDD or a voluntary agencies home where we don't have a level of jurisdiction
- This ADM also requires input from the individual or their representatives regarding the rendering of services by the DSP
- Remember – there is not a lot of difference compared to what we currently do, rather it is a change in where we can provide services



Person Centered Behavioral Intervention Implementation Guidance

Jill Pettinger

Associate Deputy Commissioner
Statewide Services



Supporting Individuals

Plans, Approaches & Strategies



Office for People With
Developmental Disabilities

Overview

Definitions

Components
from 633.16

Related Issues

FBA, BSPs and MPs

Interventions
& Fading Plans

Bringing it together



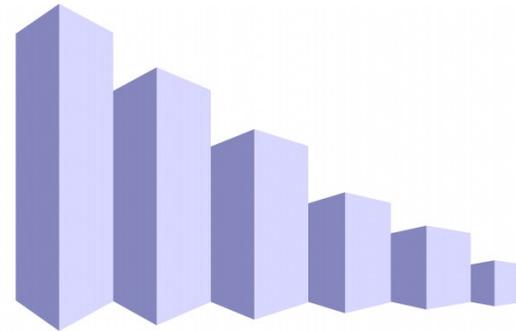
Defining our Terms

- Behavioral Data
- Challenging Behavior
- Functional Behavior Assessment (FBA)
- Behavior Support Plan (BSP)
- Monitoring Plan (MP)



- Behavioral Data

- Latency of behavior
- Frequency of behavior
- Intensity of behavior
- Duration of behavior



Challenging Behavior

- Injurious to self or others
- Interferes with the rights of others
- Interferes with the performance of everyday activities
- Disruptive of social functioning
- Undermines the potential for increased self-determination and independence



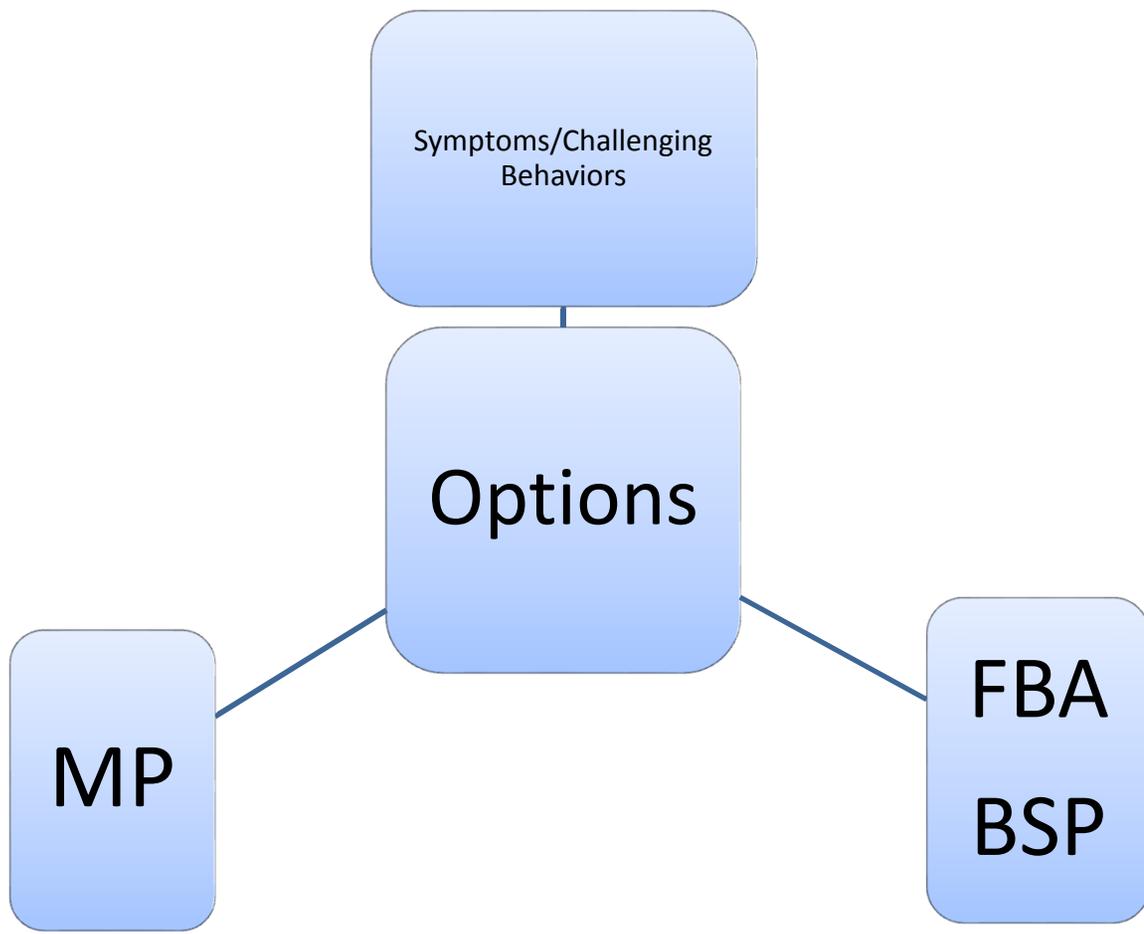
Challenging Behavior – Other Factors

- May include some **psychiatric symptoms** or overt **reactions to symptoms**:
 - Manic, aggressive, or compulsive behavior
 - Verbal threats based on paranoid beliefs or perceptions



- **Functional Behavioral Assessment (FBA)**
- A process intended to...
 - Identify and **operationally describe** challenging behavior(s);
 - Identify the **function(s)** or **purpose(s)** for challenging behavior;
 - Identify the specific environmental stimuli or conditions that:
 - Are a setting event for the challenging behavior;
 - Are a trigger for the challenging behavior;
 - Maintain the challenging behavior.





- **Monitoring Plan (MP)**

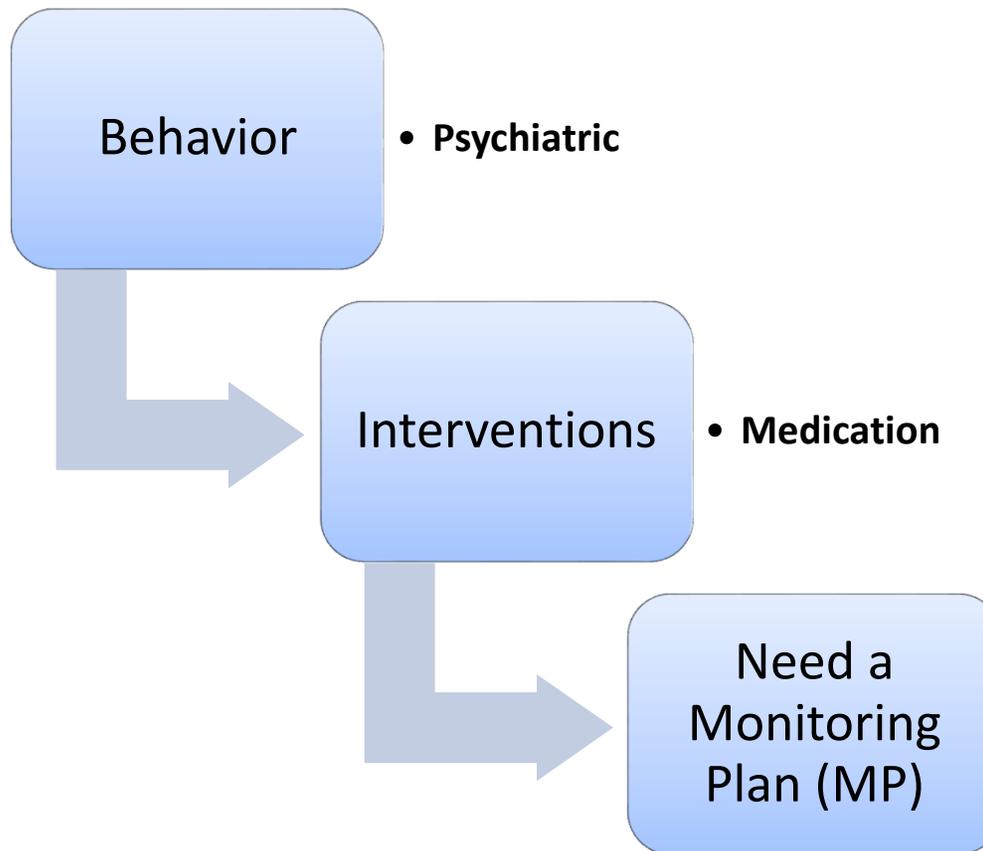
- Developed by Licensed Psychologist, LPNP, LCSW, BIS
- Requires Informed Consent

A written plan intended to...

- Identify the **target symptoms** of a co-occurring, diagnosed psychiatric disorder.
- Specify **interventions** and **methods** that will be used to address target symptoms (e.g., medications).
- Outline how progress in **symptom control** will be measured, documented, and reviewed.



Option 1: MPs



MP: Variations

1. **Routine use** of medication
2. **As-needed (PRN)** orders
 - **Criteria** for administration;
 - **Expected therapeutic effects**; and
 - If applicable, conditions under which the medications can be re-administered (and **allowable frequency**).
 - Results **documented** in person's clinical record



MP Components

Target
Symptoms

Medication
Descriptions

Administration
Conditions &
Exp. Effects

Progress
Monitoring

Other
Interventions



- **Behavior Support Plan (BSP)**
- Developed by Licensed Psychologists, LCSW, BIS

A written plan intended to...

- Identify challenging/problem behaviors
- Identify **replacement behaviors** that are incompatible with an individual's challenging behaviors.
- Outline **specific interventions** designed to support, develop or increase replacement behaviors.

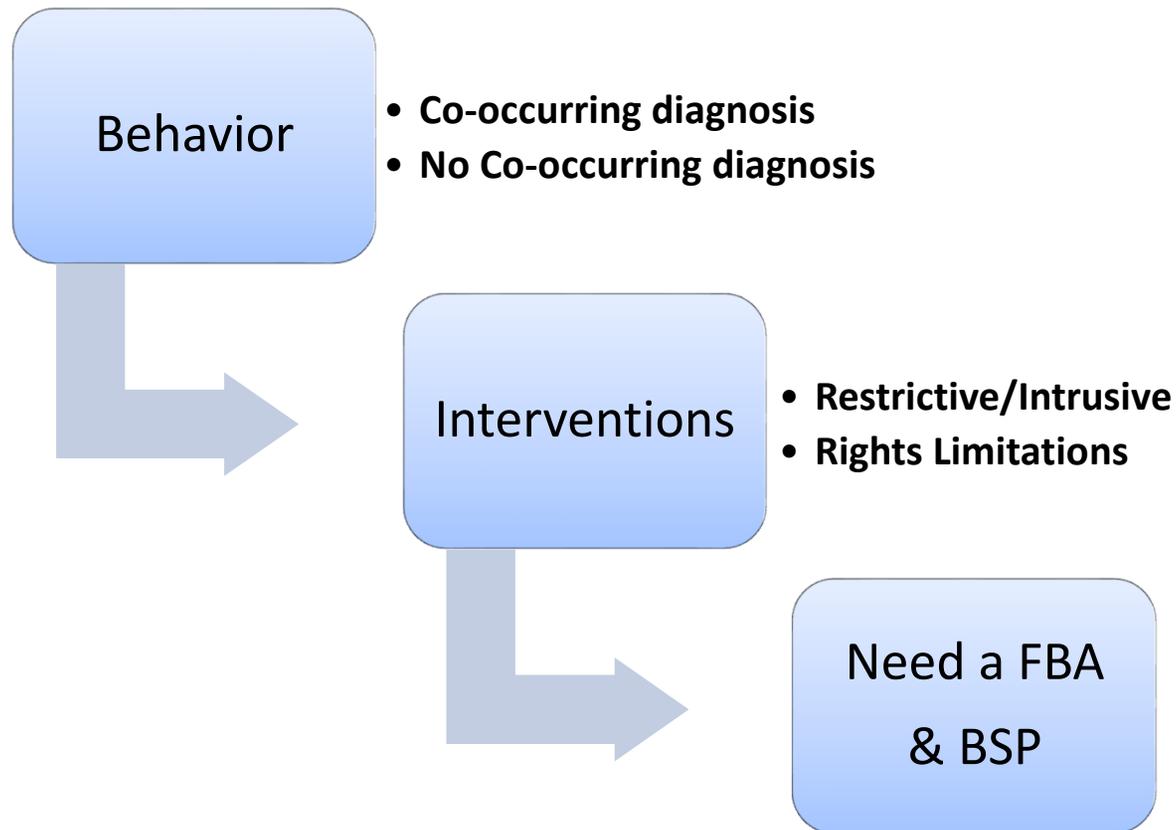


Behavior Support Plan (BSP), Cont'd.

- Outline **specific interventions** designed to decrease, control or eliminate challenging behaviors
- List any specific rights that are being restricted by an intervention
- Include methods for eliminating the need for reliance on the plan
 - **Fading Plan & Fading Criteria**



Option 2: BSPs



BSP Criteria: Ask yourself...

Does the behavior cause injury to self or others, interfere with the rights of others, and/or disrupt social functioning? **YES**

Does the behavior interfere with the performance of every day activities, is it undesirable and/or socially unacceptable, or does it interfere with the acquisition or use of desired skills/knowledge? **YES**

If related to a diagnosed psychiatric disorder, does behavior interfere with rights of others, disrupt social functioning, and/or injure self/others? **YES**

Have less intrusive or more positive interventions and strategies to increase adaptive behavior been tried? **YES**



Test Yourself: MP or BSP?

- Behavior is a symptom of a co-occurring psychiatric disorder that requires medication only.
 - **MP**
- Behavior is a symptom of a co-occurring psychiatric disorder that requires medication & restrictive interventions to preserve safety and rights for the individual and others.
 - **BSP**



What components are needed in a Functional Behavioral Assessment (FBA)?



FBA must have these 10 components (633.16)

1. Description of challenging behavior in observable and measurable terms;
2. Identification of the antecedents of behavior;



FBA Components

3. Identify contextual factors that create or contribute to behavior;
 - (i.e. cognitive, environmental, social, physical, medical, psychiatric)
4. Identify the likely reason or purpose for the challenging behavior;



FBA components

5. Identify the consequences that maintain the behavior;
6. Evaluate whether environmental or social alterations would reduce or eliminate the behavior;
7. Include an evaluation of preferred reinforcers;



FBA components

8. Multiple sources of data, including but not limited to:
 - a) Information from direct observation;
 - b) Information from interview or discussion w/ individual, parents, caregivers and service providers;
 - c) Review of clinical, medical or behavioral records
 - d) Additional data from individual's record



FBA components

9. Must not be based solely on an individual's documented history of challenging behaviors*;

*Exceptional circumstances (i.e., Unexpected admission to residential facility)

10. Must provide a baseline of the challenging behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day.



Once we have a FBA, who develops the Behavior Support Plan (BSP)?



Behavior Intervention Specialists

Behavior Intervention Specialist 1 (BIS 1)

- Masters from a clinical field of psych, SW, school or applied psych, and training in assessment; **OR**
- BCBA and Masters in behavior analysis or closely related field; **OR**
- NYS license in mental health counseling w/ appropriate experience.

Behavior Intervention Specialist 2 (BIS 2)

- BCBA and Masters in behavior analysis or closely related field; **OR**
- Masters in clinical treatment field or NYS license in mental health counseling and have approved specialized training in FBAs and BSPs; **OR**
- Bachelors in human services field, and experience, and is actively working towards graduate degree in applied psych, SW or special education.



What's the main difference? **RESPONSIBILITY!**

BSPS

BIS 2 – Under the supervision of BIS 1

BIS 1 – Independent if interventions are non-restrictive/intrusive

Licensed Psych/LCSW – supervise BIS 1 & 2



Said Another Way...

What's in the BSP?

- Only positive interventions*
 - Developed by BIS 2 or BIS 1
 - Supervised by BIS 1 or higher
- Restrictive/intrusive interventions*
 - Developed by BIS 2, BIS 1, Lic. Psych or LCSW
 - Supervised by Lic. Psych or LCSW



Requirements for Developing a BSP



BSP components from 633.16

All BSPs must:

1. Be developed on the basis of a [FBA](#) of the target behaviors;
2. Be developed in [consultation \(as appropriate\)](#) with person receiving service and others involved in implementation;
3. Be developed by a [BIS, licensed psych or LCSW](#);



BSP components

4. Include concrete, specific description of challenging behavior(s) targeted for intervention;
5. Include least restrictive/intrusive methods possible;
6. Include a hierarchy of interventions, strategies and supports – with the preferred methods being positive approaches;



BSP components

7. Include a [personalized plan](#) for actively reinforcing and teaching alternative skills and [adaptive \(replacement\) behaviors](#);
8. Provide a method of [data collection](#) for treatment monitoring;
9. Include a [schedule to review](#) the effectiveness of the interventions
 - At least semi-annual basis
 - Examine frequency, duration, and intensity of challenging/replacement behaviors



INTERVENTIONS

Positive vs Restrictive/Intrusive
Rights Restrictions
Fading Plans



Positive Interventions

- These are the *Preferred, Proactive Approaches*
- Where should we start?
 - ABC's of behavior:
 - **Antecedents** – Behaviors – Consequences
- Focus on Proactive Strategies:
 - Prevention and Setting Event Strategies
 - Teach → Model → Increase → Reward



Restrictive/Intrusive Interventions (1)

- **Additional Type of Interventions in Regulations**
- **Discouraged by OPWDD – Unless:**
 - There exists a clear risk to health and/or safety;
 - There is a violation of others' personal rights;
 - They are employed only after less intrusive/positive interventions have been unsuccessful.



Restrictive/Intrusive Interventions (2)

Examples

1. Any intermediate and/or restrictive **physical** intervention techniques;
2. Use of **time-out** (exclusionary and non-exclusionary);
3. Any **mechanical restraining device** with intent to modify or control challenging behavior;



Restrictive/Intrusive Interventions (3)

Examples cont.

4. Use of **medication** for behavioral control;
 - ❖ Not associated with a co-occurring diagnosed psychiatric disorder

5. Any **other specific methods** determined to be restrictive/intrusive.
 - ❖ Response cost
 - ❖ Overcorrection
 - ❖ Negative practice
 - ❖ Satiation



Rights Limitations 633.16 (J)(2)(i)

“Access to mail, telephone, visitation, personal property, electronic communication devices, program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance to manage challenging behavior.”



Protections: The “Do-Nots”

- Deprivations (punitive actions) involving sleep or food
- Prevention of adequate rest or a balanced and nutritious diet
- Change in the form/composition/timing and delivery of food as a consequence
- Emergency use of specific restrictive interventions
- Aversive conditioning



Stop and Think

- How long should a restrictive/intrusive intervention be used?
- How long should a person's rights be limited?

For any such intervention, we must start thinking about a **fading plan**, immediately!



Fading Plans 633.16 (E)(3)(e)

- Definition: *“A specific plan to fade the use of each restrictive or intrusive intervention, and/or limitation to a person’s rights.”*
- Fading Plan Goal: To eliminate the use of these interventions, and/or transition to the use of a less intrusive, more positive intervention;



Fading Plans Should Include:

- Planning **specific** to the individual
- **Stepwise**, gradual process
- Criteria for **reversal**
- Criteria for **completion**



Two Related Issues

Exceptions
Rights & Risks



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Exceptions

- Medical Immobilization/Protective Stabilization (**MIPS**) and/or Sedation
- **Emergency Evacuation Plans** and Techniques
- Not subject to the requirements of 633.16



Empowering & Enabling Individuals' Rights

- Person's **right to make decisions** must be consistently reinforced in daily life → **Empowerment!**
- People are supported in:
 - **Big** Life Decisions
 - **Everyday** Life Decisions



Risk and Person-Centered Planning

Key Concepts:

- **Thoughtful and meaningful conversations** are needed rather than risk avoidance and elimination of rights;
- Some risks are more **imagined** than real: “What if --- happens?”
- We sometimes **generalize** about risks from one area of a person’s life to another;
- **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.



Read All About It

- 633.16 Regulation
- HCBS Settings
Administrative
Memorandum
- OPWDD Website



In Closing...

- ❖ MPBs/BSPs address Symptoms/Challenging Behaviors
 - ❖ MPs & Medication
 - ❖ FBAs & BSPs
 - ❖ Considered to be “living documents”
- ❖ Not all interventions are created equal
 - ❖ Fade the restrictive, intrusive, limitations
- ❖ MIPS & Emergency Evacuation Plans
- ❖ Rights > Risk



Questions?



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Home and Community Based Services (HCBS) Settings Transition Plan Update

DQI Provider Training

Maryellen Moeser
Director
Continuous Quality Improvement
Division of Quality Improvement

Topics

- Introduction
- Elements of OPWDD's HCBS Settings Revised Transition Plan and Highlights of the CMS Non-residential Settings Guidance
- “Heightened Scrutiny” and Day Services— How do we plan to move forward?
- DQI's HCBS Settings Assessment Update
- Next Steps including Agency Quality Performance Initiative/DQI's Survey Redesign and what Providers can do now to prepare



Intent of New HCBS Rules:

- Better align HCBS Medicaid funding and program requirements with civil rights protections afforded under ADA
- Address concerns that in some states **HCBS used to fund “institutional-style” settings** lacking opportunities for people to engage meaningfully in their communities
- Ensure that individuals have **full access to the benefits of community living** and the opportunity to receive services in the **most integrated setting** appropriate to their needs
- Rules are outcome oriented—focuses on **nature and quality of individual experience** in the setting and whether individuals have the **“same degree of access”** as others in the community



Status of HCBS Transition Plan

- NYS Transition Plan submitted to CMS March 17, 2015
- OPWDD Transition Plan was revised in Feb. 2015 to include non-residential settings
- Public input period for revised Transition Plan through April 1st.
- HCBS Residential Assessment ongoing through September 2015 (Sample of sites and people)
- OPWDD working with ITS to provide provider reports of Assessment results
- Workgroups ongoing including Heightened Scrutiny and Day Settings



Major Action Items in Revised Transition Plan

Jan.-April 2015

- Legislative Authority -- NPA

July 2015

- Anticipated Waiver Resubmittal
- Develop PCP Regs effective 10/1

July 2016

- Conclude development of HCBS Waiver Regulations

October 2018

Ongoing monitoring/
Compliance with HCBS Settings Regs



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Office for People With
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Revised Transition Plan Integrates OPWDD's Transformation Agenda

NYS Plan to Increase Competitive Employment Incorporated

Increase Self-Direction Opportunities Plan Incorporated

CQL POMs Training; other communications and training initiatives

Development of Person Centered Protocol Pilot late 2015/early 2016

Implement NYS START Program fully by October 2018



Additional Revisions

- Transition Plan for Day Habilitation and Prevocational Services (Non-Residential Settings)
- Description of OPWDD's Proposed "Heightened Scrutiny Process"



Stakeholder Committee Work

Two Subgroups Meeting March– Summer 2015

Day
Habilitation/Prevocational
Led by Ceylane Meyers-Ruff,
OPWDD

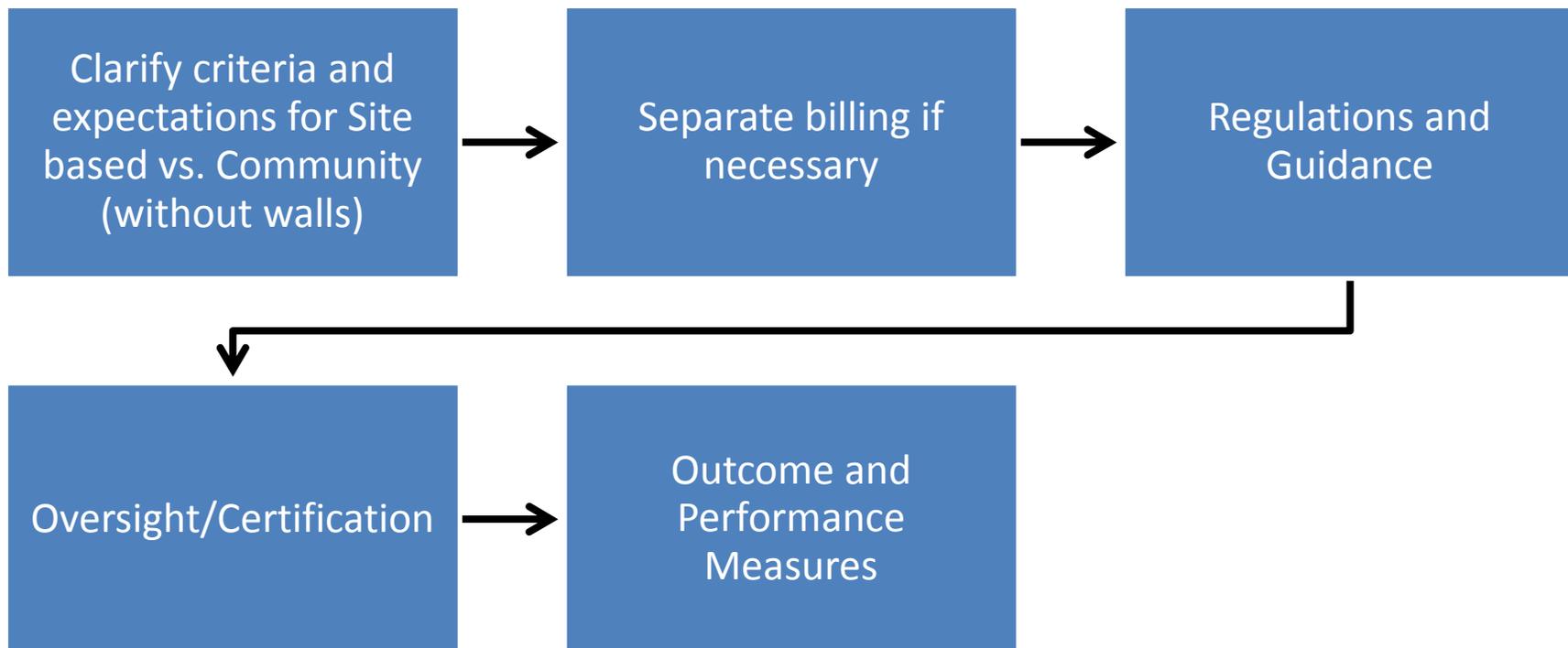
- Written recommendations for Criteria based on CMS guidance and OPWDD charge
- Will use existing prevocational services group with additional members added

“Heightened Scrutiny”
Led by Maryellen Moeser,
OPWDD

- Develop written guidance to field clarifying what triggers heightened scrutiny
- Develop the “evidence” package and review tool(s)



Remediation Plan for Day Habilitation and Prevocational Services – Achieve the following no later than October 2018



CMS Non-Residential Settings Guidance issued in mid Dec. 2014 for Incorporation in Day Settings Expectations

- ✓ Exploratory Questions for non-residential settings
- ✓ Final Question and Answers

Note: Non-residential options and choices must be consistent with both the transformation agreement and the guidance on HCBS Settings



Highlights of Non-Residential Guidance – Purpose

- Offer **considerations** as States assess non-residential settings
- Serve as **suggestions** to assist states and stakeholders in understanding what **indicators** might reflect the presence or absence of each quality in a setting
- States tailor their review to the type of services relevant in their state



Highlights of Non-residential Guidance

- The right service at the right time in the right setting
- The CMS regulation does not “prohibit facility-based or site-based settings.” However,
 - ✓ Such settings “must demonstrate the qualities of HCB settings, **ensure the individual’s experience is HCB and not institutional in nature,**” and “ensure that the setting **does not “isolate the individual from the broader community”**”
 - ✓ Settings designed specifically for people with disabilities and/or if individuals in setting are primarily people with disabilities, **the setting may be isolating unless the setting facilitates people going out into the broader community.**



Highlights of Non-residential Guidance

- Nature of service impacts how HCBS settings requirements get addressed especially when the service is highly clinical/medical in nature.
- People must have the option to be served in a setting that is not exclusive to people with the same or similar disabilities.



Summary Indicators in CMS Non-Residential Exploratory Questions

- Setting is **located in a community/building** located among other residential/businesses, etc. **that facilitates integration with the broader community**
- Reflects individual needs and preferences
- Policies and practices ensure **informed choice (i.e., opt. to visit/understand the options)**
- Options offered include **non-disability specific settings** such as volunteering in the community; engaging in non-disabled community activities such as the YMCA; etc.
- Options include the opportunity for people to **choose to combine more than one service delivery type or HCBS** in any given day/week (e.g., competitive employment and day habilitation)
- Tasks and activities are **comparable to activities for people of similar ages who do not receive HCBS**



Summary Indicators in CMS Non-Residential Exploratory Questions

- Opportunities for meaningful non-work activities in integrated community settings for period of time desired by person
- Individualized schedules that focus on needs, desires, and individual growth
- Freedom of movement inside/outside setting-people not restricted to one room or area
- Knowledge/access to info on age appropriate activities including competitive work, shopping, attending religious services, medical appts. dining out, etc. and who will facilitate/support these activities



Summary Indicators in CMS Non-Residential Exploratory Questions

- Individuals can choose with whom to do activities inside and outside the setting
- Access to meals/snacks at any time consistent with individuals in similar and/or same setting who do not receive HCBS
- Setting provides and posts information on Rights
- Setting does not prohibit individuals from engaging in legal activities in a manner different from non-disabled people
- Setting affords opportunities for tasks and activities matched to individual skills, abilities, and interests.



Summary indicators in CMS Non-Residential Exploratory Questions

- Setting affords people the opportunity to regularly and periodically update or change their preferences
- Setting ensures people are supported to make decisions and exercise autonomy to greatest extent possible
- Setting staff are knowledgeable about the capabilities, interests, preferences and needs of individuals and put this knowledge to practice



Summary of indicators in CMS Non-Residential Exploratory Questions

- Information about individuals kept private-i.e., no posting of schedules for PT, OT, medications, restricted diet, etc.
- Setting supports individuals who need assistance with personal appearance as they desire—this assistance is provided in private
- Respectful communication and interaction in manner that each person prefers to be addressed
- Informed consent obtained through PCP prior to modifications of any rights including the HCBS settings rights
- Setting offers secure place for storage of individual personal belongings
- Physical setting supports a variety of individual goals and needs (e.g., indoor and outdoor gathering spaces, places for solitary activities; etc.)



What is “Heightened Scrutiny”?

- A CMS process for submitting evidence to the CMS Secretary for settings “presumed not to be HCBS” where the State finds that the settings are not institutional and do not isolate people with disabilities and therefore can meet HCBS.
- State must overcome the presumption that such settings are not HCBS



Triggers for “Heightened Scrutiny”

- Locations that have qualities of institutions;
- Settings located in a building on the grounds of a public or private institution;
- settings that provide inpatient treatment;
- Settings immediately adjacent to public institutions;
- Any other setting that has the effect of isolating individuals from the broader community.
- Settings designed to provide multiple types of services and activities on-site;
- People in setting have limited, if any, interaction with broader community;
- Settings that use/authorize interventions/restrictions used in institutional settings;
- Settings that potentially isolate e.g., farmstead or disability specific farm community; gated community; residential schools;
- Multiple settings co-located and operationally related.



“Heightened Scrutiny” Process Timeline (Residential Settings)

Develop Criteria
and Guidance to
field and tools for
review
2015



Establish inventory
of settings that
need heightened
scrutiny
10/2015-9/2016



Review where each
site is in meeting
requirements and
evidence that site
can overcome the
presumption that it
is not HCBS—
ultimately up to
CMS



Update on HCBS Settings Residential Assessment Implementation by DQI



Reminder: Why is DQI doing an HCBS Settings “Assessment” for Certified Residential Settings?

- ❑ Part of OPWDD’s HCBS Settings Transition Plan
- ❑ Need to Collect **Baseline Information** from Assessment
- ❑ Need to **Identify Major Challenges** that OPWDD Must Address Systemically to Work Towards Full Compliance During the Transition Period
- ❑ Help to prepare providers for future expectations

Reminder: HCBS Settings ADM #2014-04

- ❑ The ADM describes the quality principles and standards that OPWDD will be assessing beginning November 2014, based upon the needs and preferences of individuals as indicated in their person-centered service plan.
- ❑ It is expected that providers will use the ADM and OPWDD's HCBS Setting Assessment Tools and CMS guidance and Exploratory Questions to actively plan and develop proactive approaches to working towards and maintaining full compliance with the HCBS Settings federal requirements.



How will Agencies be Informed of their Particular Results?

- ❑ OPWDD is working on an IT solution for informing agencies of results of HCBS Settings Assessment
- ❑ We hope to be able to provide a statewide averages report for providers to compare their own results



What Happens to State Level Results?

- ❑ Will aggregate results by domain area/section---percentage of Yeses/Total Yeses
- ❑ Actual results will help OPWDD Target areas/action plan for training and quality improvements at systems level to finalize the OPWDD Transition Plan.
- ❑ Data aggregation over time will help target quality improvement strategies and identify successes

Where is DQI Ultimately Headed with HCBS Settings, Agency Quality Performance and Survey Redesign?



It's all the same stuff!

Highly person-centered and holistic
Respect, self-determination, choice and autonomy
Shifts control from provider to individual
Enhancement of organizational culture
Knowledgeable/skilled work force



Agency Quality Performance

Phase I Quality Domains

Phase I work is complete. The workgroup has agreed upon the Quality Domains and the standards that represent quality in each of 6 domains. The complete matrix is available on OPWDD's website.



Agency Quality Performance

Phase II Deliverables (In Progress)

- Finalize the Quality Domains
- Incorporate domains into the DQI survey protocols, which are to be implemented by October 1, 2015 as part of the OPWDD HCBS Settings Transition Plan
- Finalize protocol sampling strategy

Anticipated Phase III Deliverables (2015 - 2016)

- Operationalize DD Care Coordination/DISCO Review for managed care
- Finalize quality rating levels
- Develop rating mechanism based on data collected through survey protocols
- Develop IT solution to aggregate data
- Develop provider performance reports and dashboards



What can Agencies Do Now To Prepare?

- ✓ Learn more and be prepared for additional due diligence (and documentation of these efforts)
- ✓ **Assess your operations**---Use CMS Exploratory Questions and OPWDD's Assessment Tools
 - Evaluate your policies and programs re: HCBS expectations
 - Review support planning and delivery practices for true person centeredness
 - Review training at all levels of your organization especially direct support professionals and integrate DSP competencies
- ✓ Quality Improvement: Is there an organizational approach to QI? **QI plan implemented? Is it effective?**
- ✓ Governance practices--Attentive to individuals' outcomes and changing expectations?
- ✓ **Actively communicate** with staff and people supported and their family members and advocates on these standards, compliance strategies and changes necessary and involve them in the improvement process
- ✓ **Solicit feedback from individuals served and their advocates** on how to do better through satisfaction surveys, focus groups, residence meetings, and other applicable forums.

Where to Get More Information?

OPWDD Public Announcement and Transition Plan:

http://www.opwdd.ny.gov/opwdd_services_supports/HCBS/announcement-for-public-content

OPWDD HCBS Settings Toolkit:

http://www.opwdd.ny.gov/opwdd_services_supports/HCBS/hcbs-settings-toolkit

www.hcbsadvocacy.org

CMS Toolkit: www.medicaid.gov/hcbs



Comments

Questions



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Thank you for your time and attention

Please let us know if you have any feedback on this training or if there are other topics that you would like to hear about in upcoming DQI Provider Training sessions

quality@opwdd.ny.gov

