



Medicaid Service Coordination (MSC)

# E-VISORY



ISSUE # 24-14

September 5, 2014

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](#).

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## **In This Issue:**

### **Materials for the September 10, 2014 MSC Supervisors Conference**

The MSC Supervisors Conference is being held on September 10, 2014 via videoconference and WebEx from 9:30am-12:30pm. The conference agenda is as follows: Front Door Changes and Overview of Seven Key Process Steps, Strengths and Risk Inventory Tool, Community Transition Services, Changes to Community Habilitation, and Money Follows the Person and Community Transition. **NOTE:** Attached to this E-Visory are the materials that will be referenced during the conference. There will not be any materials distributed on the day of the conference. Also, an evaluation has been attached to the conference materials, please complete the evaluation and return as your input and feedback is greatly appreciated.

### **Disability.gov Federal Website and Newsletter**

The federal government has a website that connects people with disabilities, their families and caregivers to helpful resources on topics such as how to apply for disability benefits, find a job, get health care or pay for accessible housing. This site also provides information on community organizations to help individuals get the supports they need. This site also produces the Disability Connection Newsletter; the recently released issue provides information and resources specific to the topics of education and school, including technology ideas for individual with Autism, sources for helping to prepare nutritional lunches, and ways for teachers to make their classrooms inclusive for all students. This is a monthly newsletter, interested individuals can subscribe by clicking the link at the bottom of the page. Visit [www.disability.gov](http://www.disability.gov) for more information.

Andrew M. Cuomo, Governor  Kerry A. Deane, Acting Commissioner

NYS Office For People With Developmental Disabilities  
**Putting People First**

**MSC Supervisors Conference**

September 10, 2014

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**Agenda**

- Welcome
- Medicaid Service Coordination Hot Topics
- Front Door Changes and Overview of 7 Key Process Steps
- Strengths & Risk Inventory Tool
- Community Transition Services (CTS)
- Money Follows the Person and Community Transitions

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**Welcome  
 &  
 Hot Topics**

**Anne Swartwout**  
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### Upcoming Trainings

- **Pathway To Employment**  
September 15, 2014 from 1:00-3:00 pm  
[http://www3.opwdd.ny.gov/wp/wp\\_catalogz2438.jsp](http://www3.opwdd.ny.gov/wp/wp_catalogz2438.jsp)
- **Person Centered Planning Requirements within the HCBS Settings Final Rule**  
October 23, 2014 from 10:00-12:00 or  
October 24, 2014 from 11:00-1:00  
[http://www3.opwdd.ny.gov/wp/wp\\_catalogp10202.jsp](http://www3.opwdd.ny.gov/wp/wp_catalogp10202.jsp)

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### Department of Health Findings

#### ISP Review

1. ISPs need to be signed by the service coordinator within 45 days of the review meeting.
2. Face-to-Face requirement for the Semi-Annual or Annual review.

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### Department of Health Findings

#### Waiver Habilitation Plans

1. Waiver Habilitation Plans need to be dated when signed.
2. Waiver Habilitation Plans need to include the appropriate/required safeguards.

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## Front Door Changes and Overview of 7 Key Process Steps

**Emilie Wright**  
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## Service Coordinator as Critical Communicator

**Your role is critical:**

- Helping individuals/families take the time to learn what's available and
- Even more important: helping individuals/families see themselves choosing other options

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## Service Coordinator as Critical Communicator

Some talking points for service coordinator with individuals and families:

- How OPWDD provides support is evolving
- Front Door process - designed to determine who the person is and what supports they NEED
- Role of family in supporting family member is critical and will be expanding in new designs for supports
- Limited funding within OPWDD system - team of service coordinator & individual/family must look at all options for support
- Becoming informed about all options that exist and/or can be designed is critical for individual/family so they can make informed choices

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**OPWDD** NYS Office For People With Developmental Disabilities  
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**NYS OPWDD's Front Door at a Glance**  
**June 1, 2013 – May 31, 2014**

- Total attending the Front Door Access to Services Information Session = 15,114
- Total for whom assessment process is completed = 11,966\*
- Total EAA Tools in Progress = 12,433
- Total EAA Tools Completed = 6,300

\* Includes both new DDP2s completed and/or verification of existing DDP2 (completed within 2 years and still relevant)

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**OPWDD** NYS Office For People With Developmental Disabilities  
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**Front Door Changes**  
**Fall 2014**

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**OPWDD** NYS Office For People With Developmental Disabilities  
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**Front Door Changes**

**Why?**

OPWDD is responding to feedback from individuals, families and service providers to develop ways to connect individuals to services they need more quickly

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### Front Door Changes

Starting with:

- Revision of *Front Door Access to Services Information Session* and *Access to Services Resource Booklet*
- Roll-out of OPWDD *Front Door Procedure Manual*
- Involvement of service coordinator throughout the process
- Introduction of targeted timeframes for all key steps in the Front Door Process

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### Front Door Changes

Process changes:

Assessment & service planning discussions produce *Front Door Preliminary Individualized Service Plan/Proposed Changes for Inclusion in the ISP Addendum (PISP)*:

- Front Door staff develops Front Door PISP and provides to service coordinator to assist in getting individual connected to some services and meeting some needs more quickly

Service coordinator works from Front Door PISP to:

1. get individual linked to initial services more quickly
2. work with individual/family to fully develop individual's service plan

*Service Authorization Letter*

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### 7 Front Door Process Steps

- Step 1 - Initial Contact
- Step 2 - OPWDD Eligibility Review
- Step 3 - Assessment & Review of Service Needs
- Step 4 - Quality Review & Approval of Services
- Step 5 - Service Development and Waiver Application
- Step 6 - Waiver Enrollment and Service Authorization
- Step 7 - Enrollment in Services

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**Putting People First**

## Step One

### Initial Contact

Targeted Timeframe: Within 2 business days

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**Putting People First** **Step 1**

### WHO should be referred to the Front Door?

Individuals who:

- Are not yet found to be OPWDD eligible
- Have OPWDD eligibility but are not receiving any OPWDD services
- Have OPWDD eligibility and are only receiving MSC or PCSS and want other waiver enrollment and services
- Have OPWDD eligibility and are transitioning from public or residential schools and either want services or want to add new services to their service package
- Are OPWDD eligible and are transitioning into the community from developmental centers, nursing homes or other long term placements

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**Putting People First** **Step 1**

### When to Make a Front Door Referral

- As soon as an individual contacts any OPWDD provider
- As soon as possible
- OPWDD provides information on how to sign up for the Front Door Information Sessions – look at [http://www.opwdd.ny.gov/welcome-front-door/information\\_sessions](http://www.opwdd.ny.gov/welcome-front-door/information_sessions)
- Individual/family can attend a session while their eligibility is being established

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**Putting People First** **Step 1**

### How to Make a Front Door Referral

Referral can be made by calling, faxing or e-mailing:  
 Contact info found at [http://www.opwdd.ny.gov/welcome-front-door/Front\\_Door\\_Contact\\_Numbers](http://www.opwdd.ny.gov/welcome-front-door/Front_Door_Contact_Numbers)

If the individual is:

1. **Already eligible:** send the person's name, DOB, current mailing address, phone number and best time of day to contact to Front Door Team
2. **Not yet eligible** and your agency is doing eligibility: send a copy of the TABS transmittal to Front Door Team
3. **Not eligible *and* needs eligibility established by the OPWDD Front Door Team:** send in the person's contact info (#1) or send a copy of the TABS transmittal (#2)

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**Putting People First** **Step 1**

### Initial Response/Referral & Information Gathering

Front Door staff will:

- Answer/return initial call from individual or family member requesting information
- Initiate referral/intake
- Determine whether OPWDD eligibility has been established. If not, discuss steps to pursue eligibility and availability of assistance
- Register in TABS if necessary
- Discuss and schedule OPWDD General Information Session (attendance is required)

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**Putting People First** **Step 1**

### Initial Response/Referral & Information Gathering

Front Door staff will (cont.):  
 Learn from individual/family the type of services they are interested in or seem to need:

- If individual is seeking "non-waiver" services, i.e., non-waiver Family Support Services (FSS) and Individual Support Services (ISS), can be enrolled as soon as OPWDD eligibility is established
- If individual is seeking "waiver" services, Front Door staff check on Medicaid enrollment and provide contact information for service coordination agencies

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**Putting People First** **Step 1**

**Initial Response/Referral & Information Gathering**

**Important Points for Service Coordinators:**  
**Step 1 -**

- Every Service Coordinator should attend a Front Door Information Session
- Front Door staff provide individual/family interested in waiver services with contact information for service coordination agencies
- Individuals/family begins process of selecting a service coordination agency and a service coordinator

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**Putting People First**

**Step Two**  
**OPWDD Eligibility Review**

**Targeted Timeframe: Within 22 business days**

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**Putting People First** **Step 2**

**OPWDD Eligibility Review**

Front Door staff will:  
 Confirm OPWDD eligibility or assist individual to obtain eligibility

OPWDD Eligibility Review is conducted using the 3 step process:

- **Note:** Entire DD eligibility process may take up to 90 days to complete
- Service Coordinators expected to assist with provisional eligibility if individual is active on their caseload

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**OPWDD Putting People First** **Step 2**

### OPWDD Eligibility Review

When individual has completed OPWDD Eligibility process, Regional Office (RO) staff:

- Provides results to individual/family and referring party via Eligibility Notice of Decision (NOD) letter

\*\* IMPORTANT - Regional Office uploads the Eligibility NOD in Supporting Docs in CHOICES.\*\*

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**OPWDD Putting People First** **Step 2**

### OPWDD Eligibility Review

**Important Points for Service Coordinators:**  
**Step 2 -**

- Front Door staff provide individual/family interested in waiver services with contact information for service coordination agencies
- Individuals/family begins process of selecting a service coordination agency and a service coordinator to help them with Front Door processes
- Enrollment in service coordination can occur prior to Assessment, but not prior to OPWDD Eligibility determination

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**OPWDD Putting People First**

## Step Three

### Assessment & Review of Service Needs

**Targeted Timeframe: Within 5 business days of OPWDD Eligibility Confirmation**

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**Putting People First** Step 3

### Assessment & Review of Service Needs

Front Door staff confirms selection of service coordination agency - participation in process by service coordinator is highly encouraged

Assessment process and discussion of individual's service requests and needs are collaborative conversations among individual/family, Front Door staff and service coordinator, if available Outcomes:

- Completed DDP2
- Initial service planning

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**Putting People First** Step 3

### Assessment & Review of Service Needs

**Important Points for Service Coordinators:**  
**Step 3 -**

- Service coordinator submits application materials (i.e., MSC1 and Ongoing and Comprehensive form)
- Service coordinator participates as much as possible in assessment process, discussion of individual's service requests/needs, and DDP2 completion or updating
- Service coordinator begins preparing waiver application materials when advised to do so by DDRO staff

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**Putting People First**

## Step Four

### Quality Review and Approval of Services

Targeted Timeframe: Within 7 business days

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**Putting People First** **Step 4**

### Quality Review and Approval of Services

- Quality Review (QR) of recommended services is completed to ensure that the services requested are appropriate
- RO Director/designee approves services

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**Putting People First** **Step 4**

### Quality Review and Approval of Services

**Important Points for Service Coordinators:**

Step 4 -

- Service coordinator provides additional justification regarding individual/family's service requests when requested by RO

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**Putting People First**

## Step Five

### Service Development and Waiver Application

**Targeted Timeframe: Within 14 business days of Quality Review**

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**Putting People First** **Step 5**

**Service Development and Waiver Application**

1. **Services supported by QR process, including approval by DDRO Director/designee, are recorded in EAA Tool**
2. **PISP Cover Letter and Front Door PISP/Proposed Changes for Inclusion in the ISP Addendum (for the small number of individuals who already have an ISP) are sent to individual/family and service coordinator within 4 days of quality review**

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**Putting People First** **Step 5**

**Service Development and Waiver Application**

**Upon receipt of Cover Letter and Front Door PISP/Proposed Changes for Inclusion in the ISP Addendum, service coordinator:**

- Works with individual/family to identify provider preferences,
- Lines up as many of the preferred providers as possible within the next 10 business days (approximately)
- Completes Service Authorization Request Form
- Submits Service Authorization Request Form and completed HCBS Waiver Application to the RO

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**Putting People First** **Step 5**

**Service Development and Waiver Application**

**Important Points for Service Coordinators: Step 5 -**

- Service coordinator receives:
  - Copies of Cover Letter and Front Door PISP listing approvable services
  - Blank Service Authorization Request Form and instructions

Service coordinator reviews Front Door PISP with individual/family:

- Confirms that services listed are consistent with what individual wishes to pursue
- Individual/family may choose to move forward with all services or may select only some

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**Putting People First** **Step 5**

## Service Development and Waiver Application

**Important Points for Service Coordinators:**  
Step 5 (cont.)

Service coordinator works to secure commitments from providers to deliver desired services  
After getting commitment from provider(s), service coordinator:

- Completes Service Authorization Request Form
  - Lists services individual decides not to pursue in "Declined Services" section of Service Authorization Request Form
- Works with individual/family to finalize Waiver Application, including LCED

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**Putting People First** **Step 5**

## Service Development and Waiver Application

**Important Points for Service Coordinators:**  
Step 5 (cont.)

Service coordinator submits Waiver Application with LCED and completed Service Authorization Request Form together as a packet to DDRO

Until full ISP has been finalized, service coordinator should continue to seek providers for other services listed for which provider has not been found

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**Putting People First**

# Step Six

## Waiver Enrollment and Service Authorization

**Targeted Timeframe: Within 7 business days**

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**Putting People First** **Step 6**

**Waiver Enrollment and Service Authorization**

- RO staff:
  - Receives HCBS Waiver Application and Service Authorization Request Form from service coordinator, and
  - Reviews them to ensure completeness and alignment of services requested with Front Door PISP
- Service Authorization Letter generated within two days of receipt of Service Authorization Request Form
- If HCBS waiver application meets all requirements, Waiver NOD is issued within 5 days

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**Putting People First** **Step 6**

**Waiver Enrollment and Service Authorization**

**Important Points for Service Coordinators:**

Step 6 -

- Service coordinator receives:
  - Copies of Waiver Notice of Decision (NOD) and Service Authorization Letter that lists each approved service, including quantities authorized and provider agencies when known
  - If a provider has not yet been identified by service coordinator, this will be noted.
  - Note: copy of the Service Authorization letter is also sent to identified providers

Service coordinator is responsible to follow up with identified providers to ensure that enrollment occurs for all authorized services

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**Putting People First**

**Step Seven**  
**Enrollment in Services**

**Targeted Timeframe: Within 5 business days of receiving DDP1**

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**Putting People First** Step 7

### Enrollment in Services

When notified by service coordinator that agency is authorized to deliver service to individual, agency prepares and submits DDP1 to RO indicating:

- Quantity of service agency agrees to provide, **AND**
- Whether person can be served within agency's existing resources OR new funding is required

Targeted Time Frame: Encouraged to submit within 5 days of service authorization

- If new funding is necessary, RO staff adds service to Development Plan (DV)
- Once added to DV, or if agency has resources, RO staff processes DDP1 in CHOICES

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**Putting People First** Step 7

### Enrollment in Services

**Important Points for Service Coordinators:**  
Step 7 -  
 Services are initiated and full ISP is developed; service coordinator:

- Ensures that all providers submit DDP1s for each service authorized for authorization by DDRO staff
- Ensures arrangements are made for individual to begin receiving services in a timely manner
- Works with individual/family to develop and implement full ISP within 60 days of receiving MSC or HCBS Waiver Enrollment, whichever comes first

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**Putting People First** Step 7

### Enrollment in Services

**Important Points for Service Coordinators:**  
Step 7 (cont.) -  
 When new services are identified/requested by an individual, service coordinator must:

- Assemble individual's support team (may include family members, advocate, representative, etc.) to discuss and recommend any new service
- Prepare and submit Service Amendment Request Form
- Incorporate new service into ISP upon approval by RO

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# QUESTIONS?

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## Strengths and Risk Inventory Tool

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### OPWDD Initiatives and Person-Centered Planning:

OPWDD has been making substantial effort to increase the availability of information and resources that can assist the field in **person-centered planning** and with enhancing the **quality** of supports and services.

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### Federal HCBS Settings Standards

- New Federal Home and Community-Based Services (HCBS) Settings Standards became effective on March 17, 2014.
- These new federal regulations outline specific person-centered planning processes and planning requirements.
- The federal regulations specify that *"the written plan must reflect **risk factors** and measures in place to minimize them, including individualized back-up plans and strategies when needed"*.

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### Risk

- There is a need for additional **tools** to help a person and his/her circle of support identify, discuss, and manage specific areas of risk.
- A **Strengths and Risk Inventory** has been developed as an **OPTIONAL** tool that can help guide person-centered planning conversations.

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**Background on the Strengths and Risk Inventory Tool:**

- The inventory tool was developed in 2013 by the Person-Centered Quality Committee, a stakeholder group comprised of:
  - Individuals receiving services
  - Self-advocates
  - Provider Representatives
  - Parents
  - State staff

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**Background on the Strengths and Risk Inventory Tool:**

The committee focused on providing recommendations and strategies related to person-centered planning practices that encourage individuals to make **meaningful choices** in areas related to health and well-being based on **informed decision-making**.

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**Risk and Person-Centered Planning 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:**

- 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/tool is as much about the person's **happiness** as it is **safety!**
- Safeguards must also ensure that the person's voice is heard as much as the voice of others.
- Opportunities for success and personal growth in life are also accompanied by the potential for harm. Positive and innovative approaches to safeguard planning are needed.

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**Strengths and Risk Inventory**

Utilizing a Strengths and Risk Inventory is a **best practice** that can help in the development of comprehensive, flexible, and **individualized** safeguards with individuals.

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**Review of the Strengths and Risk Inventory:**

- The tool is intended to be reviewed **as part of the person-centered planning process**, in conjunction with the person's MSC, circle of support, parents/family members, Direct Support Professionals, and agency personnel.

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### Design of the Tool:

- Items on the Inventory are worded in the **"first person"** and put the individual in charge of the discussion on his/her risks ("nothing about me without me!")
- Items are phrased **positively**, as "Conditions that help me to succeed", rather than as a risk area that is lacking, missing, or absent.
- Example: "I am able to make back-up plans and can adjust to changes in my schedule."

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### Examples:

- I have a stable source of income that covers basic living needs like shelter, food, transportation, and clothing.
- I live in a neighborhood where I feel safe and have access to needed and available resources.
- When my medication runs out, I know what to do.
- I do not participate in illegal behaviors or activities.
- I am aware of and have access to all possible exits that I can use during a fire and am able to safely evacuate my home in an emergency.

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### Examples:

- I know how to protect myself from abuse and exploitation from others.
- I am aware of safety rules for sharing a computer and for sharing my personal information with other people.
- I know how to identify and report any health concerns that I have to the appropriate people.

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**Instructions:**

- The inventory should be **re-visited over time** with the person **and** his/her circle of support.
- **It should be reviewed on a regular basis**, at least annually, as a person's needs and supports evolve and change.
- This tool can be used by **ANYONE** receiving services in **any program**.

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**\*Please Note\*:**

- This inventory is **not** intended to replace the process in place for determining risk for individuals who display behaviors that rise to a level warranting an offender-specific or specialized **clinical** risk assessment.
- Individuals who **self-direct** their services using self-hired staff must also adhere to those documentation requirements for risk identification and development of safeguards.

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**Using the Strengths and Risk Inventory:**

- **Not all risks are preventable**, but it is important to **demonstrate and document** that **thoughtful discussion** occurred and that there is agreement on appropriate **safeguards** that can mitigate those risks.

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## Strengths and Risk Inventory

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

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## 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.

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## Documentation:

- Important issues that have been identified should then be incorporated into the person's ISP, IPOP, Safeguards, and other important documents.
- Documents should be consistent in how the person's risks, needs, and supports are portrayed.
- All providers for an individual, including day and residential providers should be aware of key risks and strategies.

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**Document the following for any unmet need that has been identified:**

- Potential **barriers and factors** that impact the specific area of concern.
- **Short-term and long-term strategies** that can address the unmet need, such as:
  - Training and education for the individual and/or staff
  - Increased supports and/or supervision
  - Changes to services that are received

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**More information:**

The Strengths and Risk Inventory Tool and other valuable person-centered planning materials are available at:

[http://www.opwdd.ny.gov/opwdd\\_services\\_support/person\\_centered\\_planning/other-resources](http://www.opwdd.ny.gov/opwdd_services_support/person_centered_planning/other-resources)

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**Questions or Comments?**

We want your feedback!

E-mail: [quality@opwdd.ny.gov](mailto:quality@opwdd.ny.gov)

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## Community Transition Services (CTS) & Changes to Community Habilitation

**Tricia Downes**  
OPWDD HCBS Waiver Unit

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### Background

- This service was identified as a need prior to the 2009 Waiver Application.
- Developed in response to a need for services that remove the barriers preventing individuals from moving into non-certified settings.

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### Purpose of Community Transition Services

CTS is designed to cover certain non-recurring expenses associated with the establishment of a home or apartment.

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### Types of Allowable Expenses

- Furniture, window treatments, rugs/floor coverings, lamps/light bulbs, food preparation items, bed and bath linens.
- Set up fees and utility deposits, security deposits, pre-occupancy services necessary for the person's health and safety, moving expenses.

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### Non-Allowable Expenses

Recurring expenses and diversional or recreational expenses such as monthly rent/mortgage, regular utility charges, food, hygiene supplies, or diversional/recreational equipment.

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### Basic Rules for CTS

- The service requires prior authorization from OPWDD.
- An individual must be transitioning from an OPWDD operated or certified residential setting or residential school into a non-certified community living arrangement where the person is responsible for his or her own living expenses.

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### Basic Rules for CTS

- This service is a once in a lifetime expenditure.
- Maximum reimbursement is \$3,000 with documentation of allowable expenses incurred within 90 before or after the person's transition to the non-certified setting.
- Fiscal Intermediary Agencies (FI) will be the only agencies authorized to submit MA claims for CTS.

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### Implementation Date

Regulations have been submitted which request a November 15, 2014 implementation date for this service.

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### CTS Elements in the ISP

*Category of Waiver Service:*  
**Community Transition Services**

*Agency providing the Service:* **FI Agency**

*Effective date:* **The date the individual moves into the qualifying location**

*Frequency:* **One Time Expenditure**

*Duration:* **One Time Expenditure**

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### Additional Information

- FI agencies will be trained later in September
- Regulations are open for public comment until October 20
- Draft ADM is available for review

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### Changes to Community Habilitation

- CH has been an OPWDD service since 2010 for individuals residing in non-certified settings.
- Beginning on 10/1/2014, individuals residing in IRAs, CRs, or FCHs can be authorized to receive CH in lieu of other day services.
- Regulations were submitted to the Department Of State, and were open for comment through 9/8/2014.

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### Changes to Community Habilitation

- An ADM will be issued in advance of 10/1/2014 to describe the limits to this service for individuals residing in certified settings.
- The amount of CH that a person residing in a certified location can access will be limited and will be affected by other day services that the person is receiving (e.g. maximum combined service level).

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## Questions

Please contact the Waiver Unit by email at [peoplefirstwaiver@opwdd.ny.gov](mailto:peoplefirstwaiver@opwdd.ny.gov) or by phone at 518-486-6466

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## Money Follows the Person and Community Transition

**Dixie Yonkers**  
MFP Demonstration Project Director  
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**Cathy Turck**  
Project Coordinator for MFP  
[Cathy.Turck@opwdd.ny.gov](mailto:Cathy.Turck@opwdd.ny.gov)

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## Purpose of MFP

The purpose of the New York State MFP Demonstration is to enable New York State to transform long-term care (LTC) systems to ensure that seniors and individuals with physical and intellectual/ developmental disabilities (I/DD) have access to community-based services.

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### Background

- MFP is a federal Demonstration:
  - Originated under the Deficit Reduction Act of 2006
  - Extended through the Affordable Care Act
- MFP involves:
  - Assisting eligible individuals from ICFs & DCs to transition to qualified community settings
  - Enhanced federal reimbursement
  - Using enhanced funding for rebalancing activities
- “Money Follows the Person” is a misnomer. Federal funding derived from MFP goes to NYS to advance systems’ change related to deinstitutionalization, not directly to providers for support individual plans.

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### MFP – Part of OPWDD’s Larger Transformation

- OPWDD’s participation in MFP is just one part of OPWDD’s larger system transformation.
- Residential transformation is about serving people in the least restrictive environment, enabling people to move into more integrated settings.
- OPWDD has an ICF Transition Plan with ambitious annual targets; Plan is now approved by CMS.
- Not every person who leaves an ICF will participate in MFP. **Not all new community settings must be four or fewer people.** However, eventually all settings will be compliant with CMS expectations on HCBS settings.

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### Background on NY’s MFP Demonstration

- The NYS Department of Health (DOH) is the lead agency on the NYS MFP Demonstration. DOH has participated in MFP for about 7 years.
- NYS must provide outreach to individuals in institutional settings.
- OPWDD officially began participating in MFP on April 1, 2013.
- OPWDD must track MFP participants’ eligibility, participation dates and experience in the community and provide monthly reports to DOH which then sends the information to CMS.

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**Eligibility for MFP Participation**

- Individuals must have resided in a qualified institution for at least 90 days.
- The individual must have received at least one day of Medicaid in-patient service prior to leaving the institution.
- The individuals must be enrolled in the HCBS Waiver.
- Individuals must transition to a qualified residence.

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**Qualified Residences**

- A home owned or leased by the individual or his/her family member.
- An apartment with an individual lease.
- A community-based residence in which no more than four unrelated individuals reside.
- Family Care homes and IRAs are qualified residences.

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**Quality of Life Surveys**

- Baseline Survey – done within 30 days of leaving the institutional setting.
- 11-month, 24-month follow-up surveys.
- Data is sent to DOH each month, reported to CMS.
- OPWDD is also analyzing the data to determine needed transition process improvements.

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### MFP Goals

Calendar Year	People Transitioned	ICF Residents Contacted
CY 2013	65	300
CY 2014	215	800
CY 2015	280	1,000
CY 2016	315	1,200
<b>Total</b>	<b>875</b>	<b>3,300</b>

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### OPWDD's MFP Progress

As of 8/31/14

	2013 Goal	2013 Actual	2014 Goal	2014 Actual*
Total MFP participants	65	94	215	79 +29 108
Total outreach	300	717	800	227

\*Years run from January 1-December 31. 2014 will end December 31, 2014.

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### MFP Reporting Requirements

**Monthly**

- QOL completion dates, or reason not completed
- Participation Data - type of qualified institution & residence, enrollment start and end dates, re-enrollment dates, reason for participation ending

**Semi-Annually (a summary)**

- People who moved, # assessed but not enrolled in MFP, reasons why
- People who were re-institutionalized
- People who completed 365 days in MFP
- Time from assessment to transition
- Improvements and challenges
- Outreach accomplishments
- Challenges to secure housing
- Incidents of abuse, neglect, involvement with law enforcement
- Calls for emergency back-up, how well they were handled

**Annually** – Financial Projections

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### MFP Outreach

- OPWDD is required to inform its staff, voluntary service providers, individuals, family members and others about MFP and opportunities for more integrated support.
- Peer-based outreach to the individual through SANYS – in all institutional settings (ICFs, DCs, nursing homes)
- Outreach visits began in fall 2013.

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### Peer Outreach Process

1. SANYS contacts a residential manager to plan date/time of peer-visit.
2. The residential manager notifies family members and advocates of the date/time of the visit.
3. A SANYS coordinator and self-advocate visit the facility and use video and oral presentation to discuss opportunities to move with individuals and families. They leave flyers and posters.

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### Peer Outreach Process

4. The SANYS coordinator and self-advocate leave names of people who are interested in moving with the residential manager.
5. SANYS reports to Central Office its outreach visits and the names that have been referred.
6. Residential managers obtain signed Informed Consent forms during follow-up conversations so that Quality of Life surveys can be done.
7. MFP Regional “Leads” contact providers to confirm follow-up.

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### Outreach Message

1. People with disabilities can live in smaller homes and be a part of their communities.
2. New York State is offering people who reside in larger institutional settings the opportunity to live and have their needs met in the community.
3. If you would like to find out if you could possibly move from this home to a new home in the community, we will take your name and have someone follow up with you about how that might be possible.

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### Outreach Message

4. Moving takes a lot of planning and does not happen quickly. If you think you might want to move, we can have someone from OPWDD contact you and the people who help you to talk about what might work for you.
5. That meeting will take some time and will not happen for several weeks.
6. If you are interested in moving to a new, smaller home in the community and do not hear back from anyone about it, please let a staff person know. The staff person can notify a manager responsible for your services that you want to start planning for a new, smaller home in the community.

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### Outreach & Referral will Change

- DOH has issued a Request for Applications for statewide outreach and regional Transition Centers.
- One or two statewide contract(s) are expected to be in place by late 2014.
- Outreach contractor will provide outreach to all populations in nursing homes and to individuals in OPWDD ICFs.
- Transition Centers will assist with transition planning, temporary service coordination, referral follow-up, Quality of Life surveys, and data collection for all NYS MFP participants – **those with developmental disabilities and others who live in institutional settings.**

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### Outreach & Referral will Change

Transition Centers will:

- Help connect people to OPWDD's Front Door and Vacancy Management Process, not directly connect to MSC.
- Assist with connection to community supports.
- Assist the individual and family with readiness skills, counseling.
- Gather information from providers for CMS reporting.

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### MSC Role in MFP

- Connecting transitioning individuals to MSC **PRIOR TO MOVING – *VERY IMPORTANT***
- MSC agencies can bill an enhanced transitional rate, three times the regular rate, for people leaving ICFs, for one month, either the month of transition or the month after transition.
- In NYS, OPWDD's MFP participants must enroll in the HCBS Waiver upon discharge from the facility.
- CMS expects no gap in services for transitioning individuals.

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### MSC Role in MFP

- OPWDD obtains much needed MFP information from State Operations Offices, Regional Offices & residential providers.
- Waiver service providers may need to obtain some key information from MSCs – e.g. calls for emergency back-up, re-institutionalizations, moves to new homes.
- MSCs may be the best source of some of this information.

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### MSC Role in MFP

OPWDD Central Office will also email MSC agencies at the close of each month to obtain data on people who moved into non-certified settings. Data elements will be:

- Did the person move to a different location? (If yes, what kind of setting, where and when?)
- Did the person re-enter an institution? (If yes, where and when?)
- We'll ask for a one week turnaround.

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### ICF Transition Plan

Housing Options	8/1/13	9/3/14	12/31/14 Goal	12/31/15 Goal	12/31/16 Goal	12/31/17 Goal	10/1/18 Goal
SO ICF-Campus	994	605	731	493	268	181	150
SO ICF-Community	659	524	593	504	428	257	0
VO ICF	5669	5559	5102	4337	3686	2211	456*
<b>Total</b>	<b>7322</b>	<b>6688</b>	<b>6426</b>	<b>5334</b>	<b>4382</b>	<b>2649</b>	<b>606</b>

**We must achieve 457 transitions out of VOICFs in 2014.**

\* 456 VOICF opportunities that remain reflect Children's Residential Program opportunities.

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### Increasing IRA Capacity

Housing Options	8/1/13	9/3/14	12/31/14 Goal	12/31/15 Goal	12/31/16 Goal	12/31/17 Goal	10/1/18 Goal
IRA Supportive	2227	2125	2326	2475	2624	2823	3221
IRA Supervised	26685	27011	27088	27693	28298	29104	30721
<b>Total</b>	<b>28912</b>	<b>29136</b>	<b>29414</b>	<b>30168</b>	<b>30922</b>	<b>31927</b>	<b>33924</b>

**2014 Increases Needed:**

- 77 Supervised IRA opportunities
- 201 Supportive IRA opportunities
- 278 total new IRA opportunities

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### Guidance on ICF Transitions

**OPWDD has been working with providers and has recently (or will soon) release:**

- Message to Stakeholders
- ICF Transition Implementation Strategy
- Fiscal Policy for ICF Conversion
- ICF Conversion Guidance *(To be released soon)*
- Conversion/Transition Proposal Template *(To be released soon)*
- Communication tools for providers to use with individuals, families and the public (PPTs, Brochures) *(To be released soon)*

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### MFP/ICF Transitions Provider Education Sessions

- Five in-person sessions in September, around the state
- One statewide Videoconference
- Information is available on OPWDD website: <http://www.opwdd.ny.gov/transformation-agreement/mfp/provider-education>
- MFP Update, ICF Transitions Update, Provider Experience, Q&A

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### OPWDD's Community Transitions & MFP Resources

Community Transitions/MFP Web Page – Information for Providers  
<http://www.opwdd.ny.gov/transformation-agreement/mfp/overview>

- MFP Overview Fact Sheet
- MFP Reporting Guidance & Tracking Spreadsheet
- Fiscal Policy for ICF Conversions
- ICF Conversion Guidance & Proposal Template *(soon)*
- ICF Transition Implementation Strategy
- ICF Transition Communication Tools for Providers *(soon)*
- Transformation Flyer for Families
- OPWDD's Regional MFP Leads
- Quality of Life Survey and Guidance
- Informed Consent Form
- Outreach Flyer
- Link to request *We Have Choices* video
- [Community.Transitions@opwdd.ny.gov](mailto:Community.Transitions@opwdd.ny.gov) for questions

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**QUESTIONS?**

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**2014 MSC Supervisors Conferences**

December 10, 2014

Registration is now open for upcoming videoconferences or webinars at the following link:  
[http://www3.opwdd.ny.gov/wp/wp\\_catalogc1310.jsp](http://www3.opwdd.ny.gov/wp/wp_catalogc1310.jsp)

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**Thank You,**

An evaluation form has been included in your conference materials. Your feedback is greatly appreciated. Please complete and return your evaluation to:

[Angie.x.Francis@opwdd.ny.gov](mailto:Angie.x.Francis@opwdd.ny.gov)

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**Evaluation Form Findings**  
**September 10, 2014 MSC Supervisors Conference**

**Please check a rating for each statement:**

**I attended the webinar \_\_\_\_\_ I attended the video conference \_\_\_\_\_**

- 1. The session materials helped me to understand the subject matter.**  
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
- 2. The session content increased my understanding of the subject matter.**  
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
- 3. The subject matter will be useful to me in my job.**  
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
- 4. The presenter was knowledgeable about the subject matter.**  
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
- 5. The presentation style contributed positively to the program.**  
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
- 6. 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 return this evaluation to Angie Francis via email by **9/19/14** to: [angie.x.francis@opwdd.ny.gov](mailto:angie.x.francis@opwdd.ny.gov)