MSC E-VISORY

Issue #06-13 **March 6, 2013**

State of New York Office for People With Developmental Disabilities
Courtney Burke, Commissioner
Distributed by: Division of Person-Centered Supports
Gerald Huber, Deputy Commissioner

The MSC E-Visory is an electronic advisory which provides pertinent and timely information about programs and services available to individuals receiving MSC. Announcements about MSC training, conferences and meetings appear regularly. **MSC Supervisors: Please share this issue with all MSC Service Coordinators and others as appropriate.** In order to receive an email notification when a new MSC E-Visory is posted, please sign up for our mailing list (listserv). Listserv information and past issues can be accessed via the OPWDD website at www.opwdd.ny.gov or via the following link: http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/msc_e-visories

In This Issue:

Materials for MSC Supervisors Spring Conference

The MSC Supervisors Spring Video Conference/Webinar is being held on March 13, 2013.

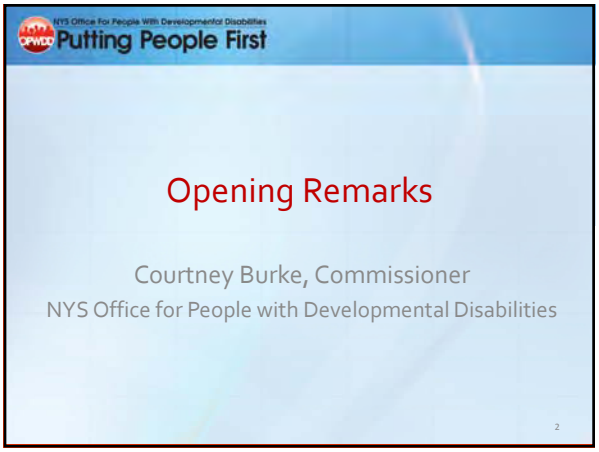
AM Session
9:30 am – 12:30 pm

PM Session
1:00 pm – 4:00 pm

This conference will focus on key OPWDD initiatives and the role of service coordination as it relates to these initiatives and overall system transformation.

NOTE: Attached to this E-Visory are the materials that will be referenced during the conference. An evaluation form has been included with the materials as your feed back is greatly appreciated.

OPWDD
NYS Office For People With Developmental Disabilities
Putting People First
MSC Supervisors
Video Conference / Webinar
March 13, 2013


Putting People First
Opening Remarks
Courtney Burke, Commissioner
NYS Office for People with Developmental Disabilities

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Overview
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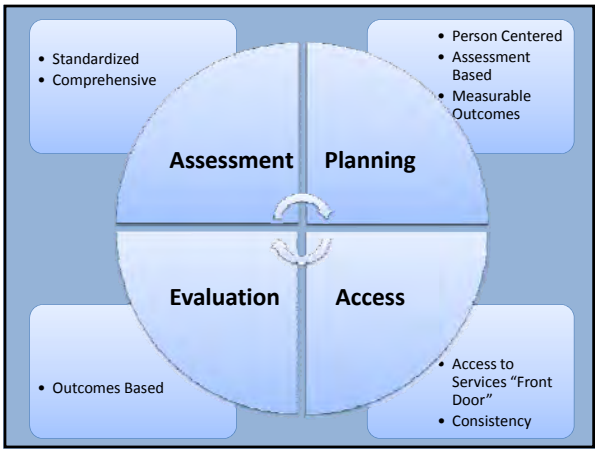
Care Coordination
Case Studies
RFA
Front Door
DISCO
ICS
Coordinated Assessment System (CAS)
RFI
People First Waiver
InterRAI
Pilots
COL
Managed Care
Personal Outcome Measures

Equity
Balance
Person Centered
T H E M E S
Needs Based
Outcomes Driven
Incentivized



Central Point of Contact
Linkage and Referral
Advocacy
Care Planning
Assessment
Monitoring
Record Keeping
Coordination with providers
Cost Management
Eligibility & Benefits Maintenance

Core Functions of Care Coordination

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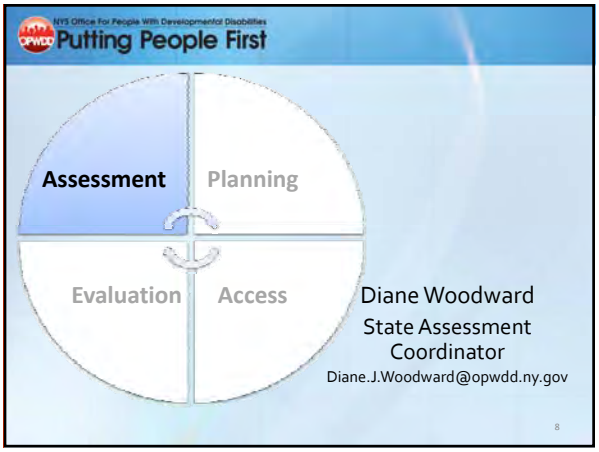

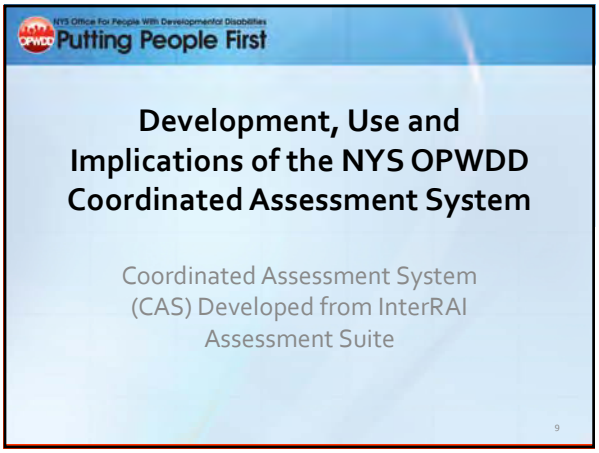

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Why Create A New Needs Assessment?

- 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

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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.

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Overview of the InterRAI Assessment Suite and the Coordinated Assessment System (CAS)

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InterRAI Assessment Suite

- ✓ Person-centered, strengths and needs-based
- ✓ Standardized
- ✓ Strong validity/reliability
  - Each item is highly researched and tested
- ✓ Comprehensive and holistic
  - Multiple domains and items, with no need to supplement with other tools
- ✓ Flexibility
  - Can customize tool by modifying/adding necessary items per domain
- ✓ Informs care planning process
  - Use of Collaborative Action Plans (CAPs) and Person-Centered Planning Items
- ✓ Informs acuity

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InterRAI DD Core 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

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New York State-specific InterRAI DD

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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

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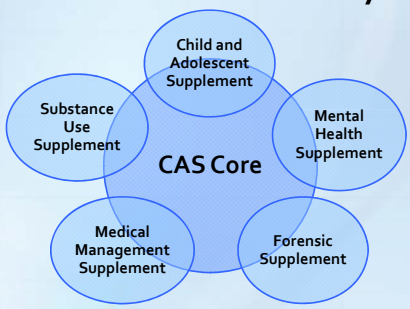
Coordinated Assessment System



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Current InterRAI DD CAPs

- Abuse
- Communication
- Continence
- 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

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CAS and the Case Study

- 18 Assessment Specialists hired to complete CAS for the case study
- Assessment Specialists received extensive training specific to the CAS
- CAS summary and CAPs will be used by agencies to inform care planning
- Ongoing review of the CAS, protocols and manual will continue throughout the case study
- Reliability and validity testing will be conducted

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

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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.

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DDP2 and The Coordinated Assessment System

- The CAS is comprehensive and inclusive of **ALL** environments. Only **ONE** CAS is completed versus multiple DDP2s.
- The CAS is designed to capture a "snapshot" of all domains of the individual's life.

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DDP2 and The Coordinated Assessment System

DDP2	CAS
• Completed by providers	• Completed by state assessment specialists
• Exclusively needs driven	• Inclusive of strengths, goals, and needs
• Completed with or without the individual present	• Must be completed with the individual (and supports) as an interview
• Does not provide summary information for planning	• Provides summary of information as well as suggestions and recommendations for care planning

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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

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For More Information…

InterRAI Integrated Assessment Suite:
www.interRAI.org

CAS specific questions:
coordinated.assessment@opwdd.ny.gov

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QUESTIONS?

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TODAY

- MSCs do person centered planning
- It is used to develop and implement the Individualized Service Plan

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FUTURE

What will **not** change:

- Person centered planning will continue to start with the person
- Person centered planning will continue to be an ongoing process
- Person centered planning will continue to capitalize and build on an individual's abilities and skills to form a quality lifestyle for the individual
- Person centered planning will continue to be used to inform a persons plan of care development
- The 8 Hallmarks of person centered planning will continue to be important.

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FUTURE

What will change:

- Care Coordinators will need to utilize essential elements to engage people in a successful person centered planning process.

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These Essential Elements 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

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Person-Directed: The individual directs the planning process and decides when and where planning meetings are held, what is discussed, and who is invited.

Person-Centered: 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.

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Outcome-Based: Supports, services and necessary training needed for the individual to achieve his or her goals, plans, and desires are identified. **Outcomes** are also identified as a means of measuring progress toward achieving specified goals.

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Information, Support & Accommodations: The individual receives comprehensive and unbiased information on all OPWDD services, community resources, and available providers. Support and accommodations to participate in the process are provided.

Wellness and Dignity of Risk: 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.

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Participation of those that the individual selects: Throughout the pre-planning and planning processes, the individual selects friends, family, and others to support him or her. Supports are provided to help the individual cultivate and strengthen desired relationships.

Community Integration: 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.

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FUTURE

- The DISCO will be responsible for ensuring that they have organizational characteristics that support person centered planning
- Person centered planning is expected to be part of and integrated into the entire culture of an agency and managed care entity

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The Organizational Characteristics are

1. Individual Awareness and Knowledge
2. Person Centered Culture
3. Training
4. Roles and Responsibilities
5. Quality Improvement

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Individual Awareness and Knowledge: The managed care entity provides information, support and training to individuals and circles so that they understand:

- person centered planning
- their rights to services that are person centered
- how this approach benefits them

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Person-Centered Culture: The managed care entity provides leadership, policy direction and activities that support implementing person centered planning at all levels of the organization.

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

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

Roles and Responsibilities: Person centered planning allows individuals to identify and work with chosen people and other supports. Roles and responsibilities for facilitation, planning, developing and implementing the plan are identified.

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Quality Improvement:

The managed care entity's quality improvement system includes a systemic approach for measuring the effectiveness of person centered planning and identifying barriers to successful person centered planning.

Best practices are identified and implemented (what is working and what is not working in supporting individuals).

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Organizational expectations and standards are in place to ensure:

- The individual is supported in directing the process
- Person centered planning is consistently done well

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Is this new?

NO

This just ensures continued alignment with person centered planning Hallmarks OPWDD has been promoting for years.

However, these critical elements will assist care coordinators in championing outcomes that individuals they support truly want.

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QUESTIONS?

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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

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Why Now? – 3 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?

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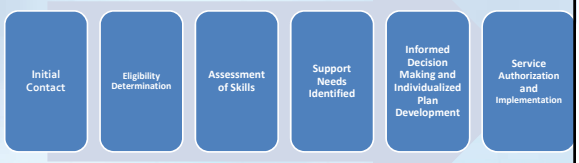
OPWDD's Front Door



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Front Door Goals

Facilitate OPWDD's approach to the delivery of services based on:

- ✓ A focus on the values of self determination and self-direction
- ✓ Resources to individuals based on needs, rather than the programs currently available
- ✓ More informed choice of supports and services
- ✓ Holistic use of paid and community supports
- ✓ Statewide consistency and availability of individualized and self-directed service options

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3 Approaches to Achieve Goals

Simplify Access to Self-Direction

Streamline Internal Processes

OPWDD & Provider Partnership Through Change

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SIMPLIFY ACCESS TO SELF-DIRECTION

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Development of an ICS Plan/Budget:

- Single, consistent statewide ICS application, budget & process
- Level of funding based on needs assessment & PRA
- Broader application of individual, portable budget and funding
- Allow individuals as much authority they &/or their families choose regarding self-directing the supports & services they receive & self-hiring the staff that delivers these services

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Who gets an ICS Plan/Budget?

An individual who is:

- New to OPWDD services (Phase 1)
- Amending/updating a CSS, Portal, Portal-like or Learning Institute Plan &/or getting ISS (Phase 2)
- Moving to a less restrictive setting (Phase 3)

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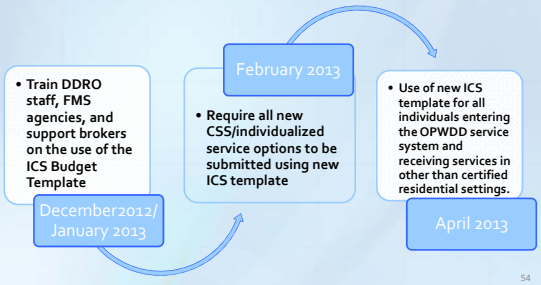
Timeline for Budget Template



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STREAMLINE INTERNAL PROCESSES

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Purpose of Streamlining Processes

- In response to OPWDD's reorganization of State Operations and Regional offices
- In order to prepare for the move to managed care
- To ensure that all people have access to the same information

Method to Streamline Processes

- Developed OPWDD Community of Practice with representation from all divisions
- Created process maps that recommended standards to OPWDD practices
- Established implementation plan to implement recommended changes

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Recommended Front Door Practices

- Standardized training for all individuals and families accessing services for the first time
- Standardized training for providers regarding their role in OPWDD's front door
- Standardized communication with local school districts regarding transition to adult services
- Development of additional points of contact between OPWDD's Regional Offices and individuals and families for information sharing purposes
- Development of tools to assist regional office in tracking new front door processes

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Timeline for Streamlining Internal Processes

February 2013
- Developed standardized letters to communicate with schools regarding the number of individuals expected to age into OPWDD supports and services

March 2013
- Develop & implement a standardized, statewide training curriculum for families and individuals interested in services through OPWDD

April 2013
- Development of an implementation plan that standardizes Regional Office Front Door processes will be completed

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OPWDD & PROVIDER PARTNERSHIP THROUGH CHANGE

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Areas for Increased Partnership

- Reinvestment Planning and Implementation
- Communication in Service Planning

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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.

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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

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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

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Role of the MSC in OPWDD's Front Door

The MSC acts as the conduit between OPWDD and the individual. S/he promotes OPWDDs 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

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Context
The Shape of Public Systems is Changing…

- Centrality of comprehensive service/care coordination
- More people with disabilities will be living with their families and in small supported settings
- Accountability and transparency are paramount
- Increased reliance on data
- CMS is a much bigger player

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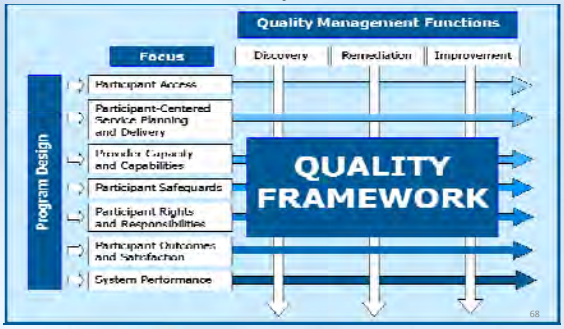
HCBS Quality Framework



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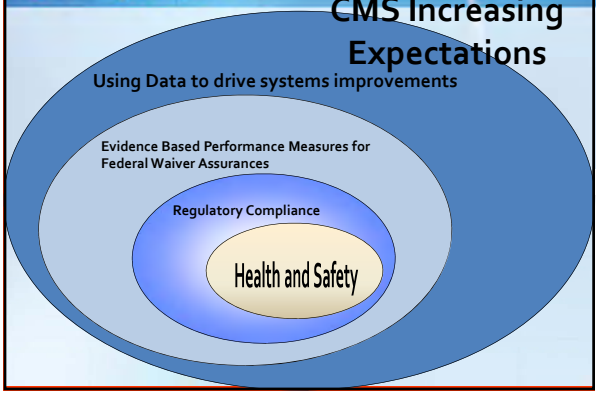
CMS Increasing Expectations



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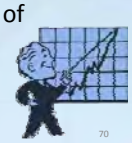
The Evolution of OPWDD's Quality Oversight

- 2009 HCBS Waiver Renewal – Metrics
- DQI was a paper-based system with limited ability to store or aggregate data.
- Vision – Move to individualized services
- DQI's review process built on review of certified sites' ability to operate
- NEEDS TO CHANGE!



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How do we make this Shift?

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

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

- Evolving system
  - Historically – Compliance/QA focus
  - Shifting from site-based "bricks & mortar" inspections to reviews focused on individuals and achievement of outcomes

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

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Current Status

- **Goal for People First Waiver: Quality outcome measures** at the individual, provider, managed care, and systems levels and a **continuous quality improvement approach** throughout the system
- Moving system to CAS assessment
- Continuing to work on activities outlined in the OPWDD comprehensive quality work plan submitted to CMS in January 2012 and restructuring OPWDD's continuous quality improvement processes
- Learning from the case studies

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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.

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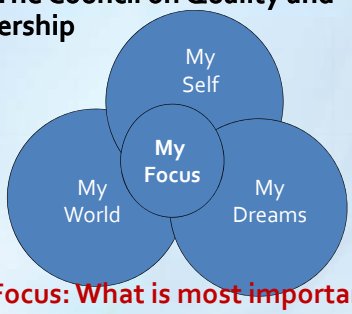
CQL The Council on Quality and Leadership



My Focus: What is most important to me now.

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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.

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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.

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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.

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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.

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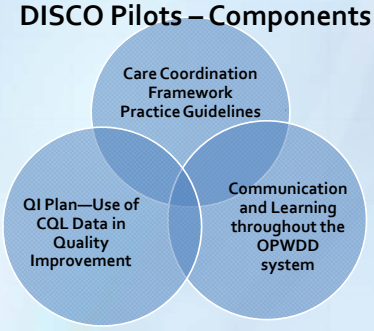
Proposal for Operationalizing POMs in DISCO Pilots – Components



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Role of OPWDD

- Promote, facilitate, and support the integration of POM expectations, education and learning throughout the system
- Develop review methodologies and quality incentives
- Develop requirements for DISCO contracts e.g., Care Coordination Framework, QI Plan, etc.
- Communicate results of reviews to stakeholders

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Role of DISCOs

- Integrate POM Philosophy/Expectations Throughout Network
- For QI Plan --Have access to trained/certified CQL interviewers to conduct POM interviews on a representative sample of members
- Aggregate and Report POM results to OPWDD annually
- Use POM results for continuous quality improvement initiatives and connect back to individual plans for those in the sample

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OPWDD Will:

- Develop IT system for CQL measurement/reporting
- 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)
- Validate that DISCOs are using POM measures and approach
- Collect/compile CQL data and develop system-wide Quality Improvement Strategies in conjunction with the analysis of CQL and other data on the system such as from NCI and InterRAI assessments

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Considerations

- ✓ IT solution is critical to success and effectiveness of this initiative
- ✓ Culture Shift: Focusing on individual outcomes/quality of life is a major shift and will require education, training, and on the job learning (e.g., case studies)
- ✓ OPWDD needs to develop and implement new review methodologies that focus on the person first

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What's Next?

- Learning from the Case Studies
- Develop a quality review procedure based on individual health, safety and achievement of outcomes to be piloted and revised during case studies and DISCO pilots

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QUESTIONS?

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Closing Remarks

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Upcoming MSC Supervisors Conference

Registration is now open for
June 12, 2013

Register through OPWDD Training Catalog
http://www3.opwdd.ny.gov/wp/index.jsp

- MSC Supervisors Conferences are held quarterly
- Special sessions are set up as necessary
- Additional information will be announced via the MSC E-Visory.

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Thank You

Your feedback is greatly appreciated

An evaluation form has been provided with the conference materials

Please share your ideas for upcoming session topics

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Evaluation Form:
MSC Supervisors Video Conference/Webinar
March 13, 2013

Please check a rating for each statement:

The session objectives were clearly explained.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

The session effectively met its stated objective.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

The session materials helped me to understand the subject matter.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

The session content increased my understanding of the subject matter.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

The subject matter will be useful to me in my job.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

The presenter was knowledgeable about the subject matter.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

I attended the webinar ___ I attended the video conference ____

The presentation style contributed positively to the program.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

The length of the session was appropriate.
__Strongly Agree __Agree __Neutral __Disagree __Strongly Disagree

What were the positive points of this presentation?

What improvements could be made to this presentation?

Recommendations for future topics:

Name (optional) _____
Title _____
Location _____

Thank you for your feedback!

Please leave this form at the training site or return it to Angie Francis via fax or email by March 27, 2013 to:
FAX: (518) 473-0054
EMAIL (scanned copy) to Angie.x.Francis@opwdd.ny.gov