

ATTACHMENT 3A

People First Waiver Commitments to Choice Worksheet

Summary: The following recommendations were compiled by the Access and Choice design team in response to the query – What components do we need to have in place to facilitate commitments to choice made by OPWDD? As this information represents the opinions of various team members, some statements may appear to contradict others.

COMMITMENT	WHAT COMPONENTS DO WE NEED TO HAVE IN PLACE TO FACILITATE THIS COMMITMENT?	RECOMMENDATIONS
<p>✓ Use of more flexible payment systems within care management environment that allows more individual control over choice of care and providers</p>	<p>I. Comprehensive, unbiased care coordination</p> <p>II. Ensure clarity and understanding</p> <p>III. Budget flexibility</p> <p>IV. Incentives to encourage conservative spending</p>	<p><u>I. Comprehensive, Unbiased Care Coordination</u></p> <ul style="list-style-type: none"> • The care coordinator job must be to help people explore a range of activities, including some that do not now exist • Separation of service provision and care coordination • Separation of housing and LTC support • Separation of housing and work • Establish the linkage between COS, PCP, PRA, etc. • Decision trees for care coordinators • Determination of needs/abilities/non-negotiables for individuals • Do not go to the lowest common denominator <p><u>II. Ensure Clarity and Understanding</u></p> <ul style="list-style-type: none"> • Clear, understandable systems • Transparent costs that are available ahead of time • Clear guidelines • Clear documents should be created to allow individuals to view this information AFTER initial conversation • Create other media for families – repetition, repetition, repetition will help families to understand what promises to be a very complex system • Educated case managers should meet with individuals and their families to initially describe the system • Have in place an accurate directory of service providers and services that are provided in the new system

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		<p style="text-align: center;"><u>III. Budget Flexibility</u></p> <ul style="list-style-type: none">• Individualized budget linked to ISP• There should be flexibility to allow for increased funds when a person’s condition changes• Emergency fund pool with fast processing. Unused allocated resources could be put into the emergency fund. Each MCO could be required to contribute a small percentage of funds to form a pool. This pool of money could be held by the state to mitigate the risk of the high cost of serving difficult clients. The pool could also be the source of workman’s compensation• Flexible hours – An individual utilizing Employer Authority should have the ability to change the amount of time allotted to them for self-hires when their circumstances change• Provide ability to spend money on a range of things beyond certified programs (e.g., Stipend for respite care, etc. that does not have to be from a certified provider)• Establish mechanisms to ensure individuals will have supports and services when they travel• Develop a system of service provision that allows for bundled services among different providers (a la carte)• Providers should structure services in such a way that allows maximum choice in groupings of services and individual service• Funding methodologies should be applicable statewide
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<p>✓ Reimbursement methodologies that ensure choice between plans and within plans choice of providers</p>	<p>I. Education</p> <p>II. Change in practice guidelines that promote person or member centered planning with the individuals and families at the center of a team process</p> <p>III. Flexible Funding</p>	<p><u>I. Education</u></p> <ul style="list-style-type: none"> • Create documents that clearly demonstrate the differentiation • Create frequently asked questions document • Encourage families to observe differences by visiting programs. Help them to create discussion questions. <p><u>III. Flexible Funding</u></p> <p>Funding must be portable so that it can move with the person being served</p>
<p>✓ Ample opportunity for self-direction including both employer and budget authority</p>	<p>I. Education</p> <p>II. Informed Choice within continuum of care</p> <p>III. Community integration</p> <p>IV. Support network</p> <p>V. Ability to avert and to prepare for emergencies</p> <p>VI. Advocacy</p> <p>VII. Strong needs assessment tool</p>	<p><u>I. Education Tools to Enhance Informed Choice</u></p> <ul style="list-style-type: none"> • Introduction to self direction training for everyone receiving or entering OPWDD services on what self-direction means and the responsibilities to all parties involved to help individuals and families • Training series developed on hiring staff, letting staff go, conflict resolution, incident reporting, documentation, etc. for those who choose to self-direct some or all of their supports and services – Could be offered online • Training and support for agencies that offer self-directed options • Ensure information is available in concise, easily understood language. • “Hot line” or “Help Desk” for questions • Use of accessible communication tools (translators, diagrams, pictures, demonstrations, etc.) • Provide navigation to and through “No Wrong Door” <p><u>II. Informed Choice within Continuum of Care</u></p> <ul style="list-style-type: none"> • A continuum of care will expand the opportunities with all levels of ability to self direct • OPWDD must demonstrate a visible commitment to self-direction in each DDSO region – Each DDSO should have at least one full-time point person designated to individualized and self-directed service initiatives • Incentivize self-direction

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		<ul style="list-style-type: none">• Individuals should have the choice of provider organizations, and for individualized services• Employer and budget authority• Parent subsidies• If the new system is to provide innovations, choice needs to be able to include options that do not now exist <p style="text-align: center;"><u>III. Community Integration</u></p> <ul style="list-style-type: none">• Provide services that increase community integration• Mentorships, peer groups, internships etc. will expand opportunities for individuals and help them to become less reliant on the DD system• Families helping families work through the system <p style="text-align: center;"><u>IV. Support Network</u></p> <ul style="list-style-type: none">• Circle of support should not be mandated• Those who chose to have a circle of support should have control over membership <p style="text-align: center;"><u>V. Emergency Preparedness</u></p> <ul style="list-style-type: none">• Emergency assistance should be readily available• List of emergency contacts and employee registry to serve as a backup for last minute cancellations <p style="text-align: center;"><u>VI. Advocacy</u></p> <ul style="list-style-type: none">• Independent oversight must be in place to make sure people aren't persuaded• Create opportunities for independent paid advisor/advocates to supplant or supplement Medicaid Service Coordinator (MSC)• Individuals transitioning from institutional settings are used to structure. They will need time to get used to advocating for themselves• Provide training for self-advocates and advocates on making informed decisions <p style="text-align: center;"><u>VII. Strong Needs Assessment Tool</u></p>
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		<ul style="list-style-type: none"> • Use a Strength Based Instrument (SIS)-like assessment tool that will be linked to personal resource allocation
<p>✓ Appropriate diversity of providers in line with individual interests in aligning their cultural, community, and family histories with a provider of choice</p>	<p>I. Network of providers: alignment of MCOs and provider agencies to multi-cultural agencies in their communities, development of networks that are culturally specific</p> <p>II. Contracted assurances that MCOs and providers meet the cultural needs of their members; language in contracts should specify requirements of meeting unique cultural, family and community needs</p> <p>III. Support existing multicultural agencies with provision of services</p> <p>IV. Cultural competence</p> <p>V. Incorporate aspects of culture into assessment tools</p>	<p><u>I. Network of Providers</u></p> <ul style="list-style-type: none"> • MCOs should be required to subcontract with other providers if they don't have services and supports in place that meet an individual's cultural expectations • A centralized, accessible system of minimally qualified individual service providers • Support partnerships with SANYS, Parent-to-Parent of NYS and others to conduct outreach and training activities <p><u>II. Contracted Assurances</u></p> <ul style="list-style-type: none"> • Agencies can have divisions that focus on specific areas to ensure cultural competency • Include in Individual Rights document the choice of utilizing services congruent to cultural community and family history • A provider agency does not have to be minority-based in order to be sensitive to diversity • Allow family members to be first choice advocates for individuals that require services <p><u>III. Support Existing Multicultural Agencies</u></p> <ul style="list-style-type: none"> • Create a system that continues the existence of small multicultural agencies <p><u>IV. Cultural Competence</u></p> <ul style="list-style-type: none"> • Ensure all agencies have training in cultural competence – Provide disability/cultural awareness training for all

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		<p>generic community agencies and organizations</p> <ul style="list-style-type: none"> • Incentivize agencies to access their workforce’s cultural diversity, including language • Require online translation access • Contact faith based groups for cultural interaction • Open doors to family members, incentivize ongoing involvement • Use of existing best practices and ‘real’ examples to solicit and promote participation of all providers, associations, etc. • Use of variety in media promotions <p><u>V. Culturally Sensitive Assessment Tools</u></p> <ul style="list-style-type: none"> • Ensure multicultural/family history needs are identified and expressed at the time of assessment
<p>✓ person-centered principles and person-centered systems of care</p>	<p>I. Person centered planning</p> <p>II. Outcome measures</p> <p>III. Ongoing Education</p>	<p><u>I. Person Centered Planning</u></p> <ul style="list-style-type: none"> • Person centered has to be the main theme or principle for service delivery • Provide training on the philosophy of person-centered practices for ALL staff working with MCOs or service providers <p><u>II. Outcome Measures</u></p> <ul style="list-style-type: none"> • Create outcomes and measures that objectively measure and assess an organization’s abilities. • Employ satisfaction surveys that allow individuals and their families to identify the positives and negatives of each organization. • Establish a committee of consumers/recipients to develop an evaluation/assessment tool to rate providers of services <p><u>III. Ongoing Education</u></p> <ul style="list-style-type: none"> • Require ongoing education for direct support professionals (DSPs) and for all levels of management • Create online interactive training course

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<p>✓ Provider network standards that ensure individuals can exercise choice among services and service providers, recognition of culturally and linguistically relevant supports, adequate medical/dental specialties</p>	<p>I. Implementation of criteria standards with the choice of at least two providers within geographic proximity</p> <p>II. Outcome Measures</p> <p>III. Contract language with MCOs and providers should reflect these standards</p>	<p><u>I. Implementation of Criteria Standards</u></p> <ul style="list-style-type: none"> • Develop standardized job descriptions that include minimum qualifications • Require all service providers to drive service delivery based on established valued outcomes. This includes culturally and linguistically relevant supports and adequate medical/dental specialties • Decisive action for agencies that continuously fail in customer satisfaction <p><u>II. Outcome Measures</u></p> <ul style="list-style-type: none"> • Develop a rating system of service providers • Study disproportionality and its effects. We need to know the economic effect of cultural bias. • Self assessments • Transparent publication of customer report cards – allow reporters to remain anonymous <p><u>III. Reflection of Standards in MCO Contracts</u></p> <ul style="list-style-type: none"> • Develop measures to ensure that MCOs do not form contracts with internal providers
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What Are the Essential Aspects of Individual Choice That Should be Incorporated in the 1115 Waiver?

CHOICE OF:	CURRENT BARRIERS AND POTENTIAL SYSTEM CHALLENGES TO BE ADDRESSED IN 1115 WAIVER	DESIRED CHARACTERISTICS	RECOMMENDATIONS FOR CHOICE WHAT DO WE NEED TO HAVE IN MCO CONTRACTS TO ENSURE INDIVIDUALS HAVE CHOICE?
<p>Care Management/Managed Care Organization</p>	<ul style="list-style-type: none"> • Information on differences between care management entities (i.e., service providers not readily available). • No reliable/independent information available to compare quality between providers to make an informed choice. • Managed Care Organization rules (e.g., reserves) may prevent desirable providers from becoming a managed care organization. 	<ul style="list-style-type: none"> • Individuals should have choice of care management entities in the geographic regions where they live. • Individuals need to be able to distinguish between the advantages and disadvantages of their choices—i.e. informed choice of care management entities. • There needs to be reliable and transparent information available for individuals to make an informed choice between care management entities. • Individuals must have portability—ability to change care management entities. 	<ul style="list-style-type: none"> • Ensure informed choice within a continuum of self-directed options • Create a ratio number of individuals/number of agencies and make sense of the ratio • MCOs must establish and update complete directories of all service providers available to them • A rating system must be established and assigned to service providers that is fair, unbiased and balanced that will give service providers and individuals the ability to examine quality • MCOs must establish measures to ensure employee competence. The performance criteria should emphasize diversity and individual choice

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			<ul style="list-style-type: none"> • MCOs need to have user friendly outreach and appeals processes. Individual authority (both budget and employer) must be protected in this contract. MCOs will have to provide information re: other MCOs. • Ensure that the firewall between MCOs and providers does not limit choice, especially in underserved areas.
<p>Service Provider</p>	<ul style="list-style-type: none"> • Individuals and families are challenged in determining which provider(s) in their region would best support their needs. • Many primary and specialty providers choose not to provide services to those w/intellectual disabilities or developmental disabilities due to the low Medicaid reimbursement rates. • Providers with all specialties and/or cultural diversities are not available in each region. 	<ul style="list-style-type: none"> • Individuals and families should have choice over which qualified agency (ies) provide their needed supports and services. • There should be an adequate number of primary and specialty providers in all geographic areas for individuals and families to choose from. • Individuals and families should be able to choose from a diverse provider base which aligns with the individual's interests and their cultural, community, and families histories. 	<ul style="list-style-type: none"> • Create tools and requirements to ensure informed choice. In addition, a system must be established to allow individuals to provide feedback • Providers must be mandated to provide a full array of services to individuals in their geographic area. This includes individuals who receive lower Medicaid reimbursement rates • Incentives should be established to allow providers to expand coverage to underserved regions • A system should be established to allow providers to hire individuals and family members to work in their catchment areas • An open enrollment season should be

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	<ul style="list-style-type: none"> • Many providers do not offer, support or encourage individuals and families to self-hire their staff. Agencies in particular are concerned about liability of staff they may not directly control. • Current provider and OPWDD administrative practices often limit portability. • Lack of portability often limits the individual's choices of providers and service options. 	<ul style="list-style-type: none"> • Individuals should be able to self-hire neighbors, relatives, friends, and other individuals to deliver some or all of their services to them (i.e., employer authority). • Individuals should be able to easily and seamlessly change service providers if they want to access alternative services. 	<p>established to allow individuals the opportunity to change providers based on their choice or needs</p> <ul style="list-style-type: none"> • Eliminate the artificial barriers to choice presented by DDSO regions. People should be able to live in a house or go to a day program because it works for them, not because it is in some artificial region • Service innovation and creativity should be incentivized • Establish measures to decrease dependence on services and increase the individual's responsibility for achieving their goals • Ensure regulations from DOL, OPWDD and the IRS are consistent and congruent with this purpose • The care coordinator or MCO should be involved in creating/implementing a back-up plan for self hires who cancel • Establish an accessible career ladder and provide higher pay for more experienced workers • Provide performance-based incentives
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<p>Services/Supports That Best Meet the Person’s Needs</p>	<ul style="list-style-type: none"> • The breadth of available service options varies by geographic location. • The resources available for approved supports and services is frequently less than the service needs identified. • Not all services are promoted in each DDSO district. • Priority needs are not consistently managed across DDSO districts which results in varying availability and access of services. • Choice of services is often restricted to available 	<ul style="list-style-type: none"> • A full array of services should be available in all geographic areas. • Services should adapt to the individual rather than having individuals adapt to existing services. • Specific services that best meet the person’s needs should be based on assessment, service planning and the individual’s life goals • Service coordinators, front-line responders, and other providers/ MCO representatives (?) should be well versed regarding the variety of service options available within the OPWDD, 	<ul style="list-style-type: none"> • In order to adapt to the individual, the function of DDSOs may have to change. People are more mobile and should not be restricted within DDSO geographical regions. Instead, DDSOs can function as Aging and Development Resource Centers or Disability Development Resource Centers • Establish a web presence for the promotion of services in each district. Create a search engine to allow individuals to find services in the areas where they live. Allow providers to generate electronic responses to help individuals find what they need • Create opportunities for neighboring counties to increase service delivery • Ensure that the discussion of goals is relevant and not demeaning. Service

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	<p>options.</p> <ul style="list-style-type: none"> • Not all service options are known by service coordinators and other front-line staff. • Seeking/Receiving services offered beyond those provided by the agency primary supporting an individual or family are often not promoted or encouraged. • It is difficult to access appropriate cross system supports. • Many generic community supports and services are not known to service coordinators and others. • Communities and community organizations are not well versed on how to support individuals with disabilities. 	<p>across other service systems, and within the generic community. [No Wrong Door].</p> <ul style="list-style-type: none"> • Individuals and families should have more control and self-direction over the supports and services they choose to meet their needs. 	<p>delivery should be cognizant of diverse levels of intellectual capacity</p> <ul style="list-style-type: none"> • Although services are partially based on goals, providers must be aware that goals are fluid. Providers should not impose a structure on an individual's goals • Ensure dollars are available • Quality check for DDSO if they are still responsible is critical. If it is an MCO/ACO, ensure the list of services is listed in the language of the contract • Knowledge is critical. Pre-test/post-test for care coordinators must be available. Care coordinators must have knowledge to retain position • Although services should adapt to the individual rather than having individuals adapt to existing services, a spirit of teamwork should still be maintained within the realm of service provision • Develop a case management/advocacy function and require MCOs to deliver services based on the individual plan developed
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			<ul style="list-style-type: none"> • MCOs must provide information about the array of services in an open and transparent manner • At minimum, MCOs should provide subsidized housing information. Ideally, MCOs and care coordinators will bear the responsibility of helping individuals search for housing and provide moving assistance
<p>Initial and On-Going Person-Centered Planning</p>	<ul style="list-style-type: none"> • There is a lack of qualified person centered planning facilitators statewide. • Some agencies see person centered planning as a separate and distinct process that is too time intensive and not compensated for in their rates. • The person centered planning process should be easily folded into the service plan or be used as the individual’s service plan. 	<ul style="list-style-type: none"> • All individuals served should have the option of a person-centered life plan that is developed in conjunction with the person and others they may choose. • The person centered life plan should be reviewed regularly and revised appropriately based on the needs and goals of the individual. 	<ul style="list-style-type: none"> • The term “person-centered planning” may not be appropriate. Some believe that the term imposes a negative spotlight by conveying the message that individuals with developmental disabilities are weak and vulnerable. This is reminiscent of institutional stigmas. A new term should be created that affords individuals a sense of strength and equality, e.g., “Individual Achievement Plan” or “Opportunity Plan” • All MCOs should be required to have qualified person-centered planning facilitators in their regions to meet the needs of individuals. • Initiate and incentivize process of becoming and keeping facilitators. Provide training and mentoring opportunities

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			<ul style="list-style-type: none"> • Determine outcomes/measure outcomes • Criteria should be established to ensure that the appropriate level of training/resources are committed to this crucial phase • Host inter-agency person centered planning workshops in different geographical regions to facilitate dialogue and share best practices
<p>Self-Direction via Personal Resource Allocations/Individualized Budgets</p>	<ul style="list-style-type: none"> • We do not currently have a standardized needs assessment instrument and/or assessment tool that is consistently applied to all people we serve. • The payment systems and funding are largely committed to institutional, more traditional, services rather than to flexible service options. • Many services have different funding (fee) 	<ul style="list-style-type: none"> • A standardized assessment tool should be developed that can be used to determine equitable personal resource allocations statewide. • Each person should have an individualized personal resource allocation. • The personal resource allocation level should be known to each individual and/or their representatives. • Individuals and families should be able to choose the 	<ul style="list-style-type: none"> • MCO contracts need to support consumer and family authority • An assessment tool should be utilized for all individuals who are currently receiving residential services to determine whether certain individuals are qualified to transition to a less restrictive environment. The individual may choose to stay in a more restrictive setting with cost sharing, or to move to a less restrictive environment • Implement a payment system that is based on the level/intensity of the service provided

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	<p>structures – even within a given agency.</p> <ul style="list-style-type: none"> • Resource availability for approved supports and services is frequently less than the service demand. • Ensure that individualized service options are easier to access. • The infrastructure to support more individualized service options is not well developed and differs geographically. 	<p>level of responsibility they want related to hiring their own staff (employer authority) and/or managing their individualized budget/resource allocation (employer authority).</p> <ul style="list-style-type: none"> • Portability of resource allocations should be seamless and easily accomplished 	<ul style="list-style-type: none"> • Create regionalized rates for the array of services to be provided within the categories for people. If agencies have significant differences among the initial rates, competition and choice will be affected • Provide financial information to individuals and families so that they will have a general idea of what things cost prior to budget allocation. Financial Planners should also be available for individuals and families • For emergency situations such as a car accident requiring a higher level of service, individuals should have the opportunity to choose same service providers when using no-fault insurance, workers compensation, and foster care. MCOs should negotiate with no-fault insurance providers to ensure that no-fault will cover the staff that they used prior to emergency situations • Individuals should have the opportunity to make out of pocket contributions. Though the expectation is not that individuals will pay in full, some people still want a sense of ownership and responsibility
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<p>Independent Advocacy</p>	<ul style="list-style-type: none"> • In current system, Medicaid Service Coordinators (MSCs) are charged with independent advocacy, however, service coordinators often feel compromised between advocating for the person served and sense of commitment to the purse strings of the agency they work for. 	<ul style="list-style-type: none"> • Individuals and families should have choice of an independent advocate/advocacy organization • Individuals should have the ability to choose an independent advocate to help them navigate their choices and options. 	<ul style="list-style-type: none"> • Each MCO must commit to ensuring that each person has the opportunity to enjoy an interesting and meaningful day • A system should be established that will allow and fund independent advocacy agencies as well as allowing parents, relatives and friends to advocate for individuals who receive services. This should be tied in to how agencies/individuals are rated for the services that they provide to individuals. • Programs to enhance skills of care coordinators/service coordinators must be developed.

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			<ul style="list-style-type: none"> • MCOs/providers/non-profits should be aware of OPWDDs supports /services services and vice-versa. Information sharing will improve the likelihood that individuals encounter well-informed staff • Individual advocacy should come from a variety of sources. Ombudsmen should have clout so MCOs will listen
<p>Employment/Meaningful Activities</p>	<ul style="list-style-type: none"> • Presently OPWDD serves over 45,000 people in various day habilitation programs and only 9,000 people in supported employment (SEMP). • There are few if any incentives for agencies to support people to utilize SEMP vs. day programs options. • Community businesses and organizations need to become more versed regarding the mutual benefits of supporting people with disabilities in work and volunteer opportunities. 	<ul style="list-style-type: none"> • Each individual should have a choice of whether they want to be employed and what kind of work they want to do. • For individuals who want to be employed, access to adequate employment related services should be provided to support them. • Appropriate supports should be available to assist people to volunteer or participate in communities in other. meaningful, productive ways. • Build greater partnerships and utilization of community and natural supports. 	<ul style="list-style-type: none"> • Every MCO should have a comprehensive employment program. These programs should be compatible with the diverse range of abilities, needs, and expectations of the population we serve. Vocational rehab should not be seen as a universal answer • MCOs should develop guidelines regarding meaningful activities. Adjust the reimbursement methodology for day habilitation to support the implementation of these guidelines • Requests for Proposals (RFPs) should be sent out to the service provider community, seeking creative ways to integrate more DD individuals in the business community. These RFPs should be designed to encourage the creation of social entrepreneurial initiatives to

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			<p>provide employment/volunteerism to individuals with developmental disabilities.</p> <ul style="list-style-type: none">• MCOs should form partnerships with companies to create opportunities that can lead to employment (e.g., internships, job shadowing, workshops, training programs and apprenticeships)• Some individuals are afraid that they will lose their benefits when they start working. MCOs must ensure that benefits will be available immediately should an individual lose their job. This concept must be conveyed clearly to individuals• Recognize the limitations set by ACCES-VR. Their outcomes truly look towards working with those individuals who will succeed in a short time frame. It does not encourage risk taking for agencies• Identify methodology to incorporate an adult PROJECT SEARCH. This program has proven its success with high school students. It has been replicated in other states for adults. Find ways to ensure its achievement in other forums
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<p>Living Arrangement</p>	<ul style="list-style-type: none"> • Many people reside in our system based on what choices were available at the time they came into the system versus where they wanted to. • Many people residing in supervised residences have the same developmental profiles as those living in supported residential sites or living on their own in the community with intermittent supports. • Creative options such as live-in caregivers, companions, etc. need to be developed that will enable people to live in their communities of support with less costly and formal supports. 	<ul style="list-style-type: none"> • Each individual should have the choice of where they live and who they live with. • Support the right of individuals to live in the most appropriate and restrictive community setting with an equitable level of resources and services as appropriate for their individual needs. • Use of assistive technology and environmental modifications to support individuals to live more independently in their communities of choice 	<ul style="list-style-type: none"> • The new system must be more responsive to non-institutional care models and provide the proper tools for individuals and organizations to make it work • Ensure new assessment tools truly measures the right needs and skills. The current DDP 2 doesn't measure an individual's abilities to be safe in their own home • The new assessment tool should look at people in their current living arrangement and determine who is ready to move to a less restrictive setting. This will make more resources available for individuals with more acute needs. • The state's entire family care program should be revised and utilized in a way that will create a whole new living option for individuals with developmental disabilities. A state-wide model could be developed to reduce costs where appropriate. • MCO contracts should support expanded and flexible family support services for individuals that live at home
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<p>Choice of Community</p>	<ul style="list-style-type: none"> • Staffing considerations 	<ul style="list-style-type: none"> • Individuals should have the 	<ul style="list-style-type: none"> • Align regulations with this desire. New

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<p>Integration Activities and Choice of How to Spend Free Time.</p>	<p>often prohibit the ability of individuals we serve to participate in activities that are meaningful to them or to become regulars in places that match their interests.</p> <ul style="list-style-type: none"> • Administrative practices often discourage independence. • The use of community supports have not been strongly encouraged, largely due to fear and liability issues. 	<p>choice of what activities they want to participate in that are meaningful to them.</p> <ul style="list-style-type: none"> • Where appropriate, the person centered planning process would be used to help determine areas of interest for individuals we serve. • Appropriate supports should be made available to support people in meaningful community activities. • Appropriate supports should be made available to support people to build and sustain meaningful relationships. • More focus placed on building greater partnerships within communities and utilizing community and natural supports to support people we serve. • Use of more generic transportation options. 	<p>regulations as a result of the NY Times article will decrease the likelihood of this happening as the desire for less risk taking will occur</p> <ul style="list-style-type: none"> • A system needs to be devised that will provide incentives to create different family care models for individuals to live in the community. The best way to have an individual become part of the community is to help them to become part of a family. Our current family care program is one dimensional. • Individuals must be apprised of options before they can make choices. MCOs should have the responsibility of compiling and synthesizing information so that it can be presented to individuals • MCOs should negotiate discounted membership rates for recreational facilities such as the YMCA • Foster relationships with local firefighters, police officers, veterans • Facilitate partnerships with students who have an interest in disability law, support service provision, communications, social work, advocacy, etc.
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			<ul style="list-style-type: none"> • Host community activities for recipients of developmental disability/mental health services
<p>OTHER</p>			<ul style="list-style-type: none"> • It is about the relationships that are created between individuals and the employees who support them. All systems must be consistent with that • “The quality of life for a person with developmental disabilities is only as strong as the weakest link within attendant care” – Wendy and Mike Orzel