

Section 4 — *Effective Provision of Supports, Choice, and Network Capacity*

Summary:

OPWDD’s intent in Section 4 of the Request for Information (RFI) was to seek broader input from the varied perspectives of stakeholders regarding the effective provision of supports, choice and network capacity. During the summer of 2011, the People First Waiver Design Teams recommended that the system of supports move away from those approaches which historically were institutional and “care taking” and instead build models that reinforce true citizenship through person-centered planning and support models that align with individual life interests and needs. Person-Centered Planning places an individual receiving services at the center of the planning process; it seeks to consider the person’s interests, needs, natural supports, and paid supports while developing a plan that supports the individual. By establishing person-centered planning as a foundation for effective support, the system will move away from a system that moves people into available “slots” and “programs” to a system that builds on a person’s strengths. Through feedback from the RFI respondents we have learned of many effective practices and practical suggestions for change.

Additionally, for individuals who present with complex needs such as significant medical needs, a dual mental health diagnosis or significant behavioral challenges, there is a need to expand the clinical supports available in community settings and ensure that those supports are available in the right delivery model to support an individual in the most integrated setting. The RFI sought feedback on the most appropriate approach to support people who have more complex needs. Numerous suggestions were provided from RFI respondents.

Choice was another concept that was explored within the RFI. Detailed feedback told us that maximizing options available for support through a person-centered planning process and flexible funding are key to creating an environment for true choice.

Quantitative Analysis:

The table below represents the analysis of the responses to the Effective Provision of Supports, Choice, and Network Capacity section of the RFI, which included a total of eight (8) questions.

OPWDD received a total of 251 separate responses from individuals who receive OPWDD services, providers, parents, advocates, self-advocates, associations, and other groups that wished to respond to

the RFI. RFI responses were submitted by single persons and from groups of individuals. Therefore, when we refer to “responses”, each “response” could represent the opinion of one individual or hundreds of individuals.

Analysis of the Effective Supports Section of the RFI by Question Number						
Question Number	Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
ES-1	162	64.54%	n/a	n/a	n/a	n/a
ES-2	163	64.94%	n/a	n/a	n/a	n/a
ES-3	140	55.78%	n/a	n/a	n/a	n/a
ES-4	143	56.97%	n/a	n/a	n/a	n/a
ES-5	150	59.76%	n/a	n/a	n/a	n/a
ES-6	108	43.03%	n/a	n/a	n/a	n/a
ES-7	112	44.62%	n/a	n/a	n/a	n/a
ES-8	116	46.22%	n/a	n/a	n/a	n/a

	Number of Responses	% of Total RFI Responses
TOTAL RFI responses that answered all questions in the Effective Supports section	69	27.49%
TOTAL RFI responses that did not answer any question in the Effective Supports section	60	23.90%
TOTAL RFI responses that answered one or more question, but not all questions in the Effective Supports section	122	48.61%
TOTAL Responses to RFI	251	100.00%

RFI Questions:

(ES-1) How would you recommend evaluating the adequacy of a person-centered plan to ensure it appropriately addresses the changing life needs of an individual receiving supports; including building and maintaining naturally supportive relationships, addressing future and contingency planning, and building models of support most in line with an individual’s expressed interests and needs? Please describe specific measures that you feel would be appropriate to make such a determination, where possible.

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
162	64.54%	n/a	n/a	n/a	n/a

Respondents suggested a variety of methods for evaluating the adequacy of a person-centered plan (PCP) to ensure it appropriately addresses the changing life needs of an individual receiving supports. Generally, it was noted that a sufficient PCP addresses emotional, social, vocational, personal and recreational needs. It was suggested that ensuring the presence of these dimensions of support should be the starting point of any evaluative process. Two of the most common suggestions were to re-evaluate the PCP regularly and conduct satisfaction surveys.

It was suggested that a PCP model be used to create, evaluate and sustain the plan of support and that the outcomes of the plan be continuously measured.

Respondents described the value they found in measureable outcomes which could guide life planning in the context of a flexible system. Respondents suggested objective measures to use in determining how well the provided supports meet the expressed needs of the individual.

Self-advocates noted that involving the individual being served is essential to evaluating the process. Gaining feedback and identifying needs is essential to ensure that a person's interests are reflected in their outcomes and goals. It was recommended that part of the evaluation consider individual satisfaction and the inclusion of individuals' goals and priorities in circle of support or team meetings.

Evaluation of the service system in meeting the changing needs of individuals was recommended by some respondents who suggested quality reviews of the DISCO's ability to access and utilize natural supports or offer opportunities that are self-directed. An oversight organization to ensure that the needs of the person are met, as well as personalized, independent service coordination were both noted as keys to effectively evaluating the PCP.

Respondents also recommended a long-term, longitudinal evaluation and suggested both qualitative and quantitative methods of analysis. Qualitative approaches centered on interviews, planning meetings, and the use of planning (PCP) tools to gain feedback for the continuous improvement of the plan as needs change. Tools frequently suggested included the Council on Quality and Leadership's Personal Outcome Measures, Beth Mount's Personal Futures Planning, and the National Core Indicators survey. One respondent suggested that data analysis quantify changes accomplished by the plan and the use of data collection software. The software recommended would require daily and weekly input on the individual's progress towards goals to alert supervisors when goals are being mastered or conversely, when progress

Self-Advocates Say...

SANYS forum participants stressed that the people who devised the plan and live it are the most effective evaluators of its adequacy. They can best say whether the plan's outcomes are being fairly supported by the Developmental Disabilities Individual Support and Care Coordination Organization (DISCO) and effectively implemented by providers. They indicated that success depends on two crucial elements:

- 1) There is a meaningful person centered plan that demonstrates a deep respect for, and understanding of, the individual's needs and interests;
- 2) Funders and providers are responsive in arranging and coordinating the supports and services necessary for the plan to succeed.

towards goals is below a tolerance threshold. This would inform the need for support changes as the individual's life changed.

Re-evaluation — Respondents suggested periodic review of the plan as a critical component to ensuring adequate supports as life changes. It was suggested that this review take place at regular intervals (such as biannually), whenever a change in functioning occurs, and whenever there is a significant life event (e.g. change in health status, job, residence, death in the family, etc.)

Surveys — A number of RFI respondents suggested surveying individuals, family members and advocates regarding their satisfaction with the process and attainment of their goals. Suggestions to facilitate this process included technology-based, self-reporting mechanisms for getting direct feedback from the individual receiving supports and conducting surveys with sufficient frequency that effectiveness can be measured and corrective actions taken in a timely manner.

Addressing Changing Life Needs — It was suggested that the PCP must be a “living document” and evolutionary in nature, updated with supports changing as an individual's life changes. It was suggested that the PCP process begin very early through education, and that a key agency requisite should be expertise in working with people of all ages and in all stages of life. It was suggested that there must be a mechanism in place to make amendments to the PCP almost immediately to allow needed flexibility in responding to changes in an individual's life.

It was further suggested that there must be opportunities for individuals to receive information and opportunities for further development and exploration. It was noted that ongoing information gathering enables the provider to know when something has changed in an individual's life.

Naturally Supportive Relationships — Respondents suggested that the PCP process start with baseline assessment of an individual's natural relationships and monitor if those relationships grow or deepen, including supportive relationships with community and spiritual resources. It was also suggested that agencies support families to keep individuals in their home communities to build naturally supportive family relationships.

It was suggested that the PCP should demonstrate a partnership between the individual, family, friends and paid supports through enhanced existing natural supports with paid services incorporated into the life of the individual. It was noted that ongoing communication with family, advocates and natural supports is crucial to the success of the PCP. One suggestion was to make local connections by building a network of relationships in a neighborhood that can lead to the identification of more local natural supports and resources.

It was suggested that the transition from paid supports to natural supports needs to be matched with mechanisms to increase paid supports again if the situation changes and a person needs more support. Emergency housing and respite were suggested as a safety net to allow families relief and support as needed.

Future and Contingency Planning — Respondents discussed the role of the PCP in planning for the future and ways to assist in contingency planning. It was suggested that the PCP should state the

individual's personal vision for the future, clearly indicating the individual's priorities. It was suggested that the impact of services must drive future decisions and that allowing individuals to roll personally-assigned unused funds forward could assist in planning for the future and contingencies. A safety net to account for contingencies was recommended, including an emergency protocol to allow for additional and immediate supports.

It was suggested that the care coordination team should be evaluated to determine that they are not only meeting current needs, but have anticipated future inevitabilities and have resources secured and allocated to respond when the time comes, averting a lapse in service or other crisis. Another respondent requested more parental and guardian training in futures and contingency planning.

Individual Models of Support — Respondents noted that creating an individual plan of support is the purpose of PCP development and suggested that individuals be ensured a choice of services and providers and access to an appeals process. It was suggested that agencies could be measured on their ability to serve people in least restrictive settings and increase or modify supports as necessary. It was suggested that a PCP model needs to be user friendly and simple to adjust to changing circumstances, and that the PCP's foundation should be community membership rather than participation in program services.

(ES-2) - How would you afford individuals with developmental disabilities and their family/advocate the opportunity for choice related to DISCOs and service providers within a care management environment?

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
163	64.94%	n/a	n/a	n/a	n/a

Respondents suggested that individuals and their families/advocates should be informed through outreach and empowered to access a variety of programs with differing parameters to promote real choice. Respondents noted these providers should be culturally and linguistically competent, and able to meet a wide variety of needs. It was suggested that key elements of ensuring choice include availability of services, elimination of conflicts of interest in the choosing process, and affirmative enforcement of the choice requirement. It was noted that it is important to make sure the individual and their family/advocate is involved in decisions, has a choice of care coordinator, and is provided the opportunity to make changes through periodic review and enrollment options. It was further suggested that protocols must be put in place to assure advocacy is available to individuals without strong family involvement, as well as a culturally sensitive process to identify and address barriers to access and to engage people in underserved communities. Lastly, it was noted that change will often be the result of trial and error, and that individuals should be given opportunities to learn about and try different things.

Other notions related to choice included that the system should allow all individuals to choose their home community and where they receive services, which is sometimes hampered by regulatory barriers.

Respondents also suggested that OPWDD's process of ensuring choice be based on Article 44 of Insurance Law, which is used by all other managed care entities in the State, to minimize complexity in implementation.

Choice of DISCOs and Provider Agencies — Respondents suggested that maximum choice should be provided to individuals and their family/advocates, and that providers of service should be allowed or encouraged to be part of more than one DISCO network. It was seen as essential that DISCOs maintain contracts with many providers to offer networks of providers that are clinically capable, geographically accessible and offer a wide range of services. It was suggested that DISCOs will need to be encouraged to incorporate a wide array of service providers from various service systems, and that each DISCO should offer an equal range of supports and services.

Respondents recommended that individuals and families/advocates be able to access providers who are not part of a particular DISCO network, and suggested that individuals residing in a particular region should be eligible to choose services from any DISCOs and service providers serving that area; minimum numbers and types of providers within the DISCO could be required. It was also suggested that referrals made by DISCOs must not only be made to their own programs or opportunities. To this end, it was recommended that DISCOs provide materials detailing all services available.

Some respondents thought that DISCOs should be available for a given geographical area due to transportation concerns, but more prominent was the notion that the individual should be able to choose any DISCO throughout state without penalty to enhance 'no wrong door' functionality and competition. It was suggested that individuals should be able to access services outside their DISCO network without penalty and that a statewide DISCO could cover a broad regional area and offer more choices than a regional provider.

While most respondents who broached the subject suggested mandating the existence of multiple DISCOs in a region, some voiced concerns that more than one DISCO in an area may not be practical for financial viability. It was suggested that the state must create a competitive environment in which multiple DISCOs exist within each geographic region.

Allowing the choice between multiple DISCOs, however, was a secondary concern for most respondents who saw the ability to choose care coordinators and service providers as more important to ensuring good supports are being delivered. To enhance choice, it was suggested that all providers in a region be encouraged to engage in multiple networks, and requested that individuals be able to keep long-standing relationships with existing providers. It was suggested that the focus of the DISCO could be more quality-oriented and focused on vetting providers to ensure that there are good choices between competent and dedicated providers who understand the needs of individuals with developmental disabilities.

Ideas for Enhancing Choice from Self-Advocates and Parents

Self-Advocate View

These views of self-advocates were submitted by the Self-Advocacy Association of New York State, solicited through a forum:

SANYS forum participants had the most consistent and strongly expressed views on the question of choice.. They are excited about OPWDD's commitment to choice and see choice as the waiver's most powerful transformational strategy. At the same time, they are aware of many attitudinal factors and practical barriers that now limit the full realization of choice. They think that choice of DISCOs will have little practical meaning to individuals and believe that the most emphasis should be placed on choice of providers and customized support options. SANYS forums contributors believe these factors relate to providing real choice:

- Choice can be advanced only through real person-centered planning that results in individualized budgets that lead to personalized support plans.
- Deciding where one's resources will be spent through portable budgets is the most powerful expression of choice.
- Meaningful choice requires information and knowledge of all options. DISCOs must proactively provide comprehensive information about the full range of supports.
- Choices should not be limited to the "menu" of existing services. Individuals and their circles/advocates and agencies must have real flexibility and practical, technical means to customize supports to meet individuals' choices.
- OPWDD and DISCOs must aggressively make self-directed or self determined supports widely known and more easily accessed.
- Informed choice also requires that OPWDD and DISCOs provide individuals and their circles easily accessible information about the quality of providers' services.
- Provider refusal to serve an individual should be limited to protect the individual's right to the provider of his/her choice.
- Choices should include non-traditional supports and services that are funded by the DISCO, e.g. generic senior citizens programs, community recreation programs like YMCA's, civic organizations, etc.
- There is great concern that DISCOs who are also service providers will steer individuals toward the services they provide.
- "What happens if this doesn't work out?" OPWDD should determine how to guarantee fallback options so that people are willing to try choices that involve some risk.
- The choice of continuing to be supported by one's family is limited by funding and program constraints. OPWDD should closely reexamine funding for the Family Support program and increase its flexibility.
- Residential choices for non-congregate living are limited by the lack of affordable appropriate housing. OPWDD should aggressively pursue the development of and broader access to generic housing that can be combined with residential supports tailored to individuals' needs.
- OPWDD should pursue new approaches for shared living and the changes in law, regulation and funding that will make shared living a possibility.

Parent View

This suggestion was submitted by the Parent Network of Western New York:

As DISCOs will assume both fiscal and care management responsibilities for families and individuals, the Parent Network recommends the funding of an independent entity to provide information and technical assistance to families. This entity should become part of the system design that will provide unbiased information on navigating the system. Each OPWDD Region should contract with at least one independent not-for-profit organization that will provide independent information and technical assistance for families and people with disabilities— this may be one organization for families and people with disabilities or could be separate.

The Parent Network proposes the establishment and funding of Family Information Centers:

- People with developmental disabilities and their families cannot be expected to self-direct without training and information.
- Families need access to unbiased information, independent of the funding, care management, and direct service provision of their family member.
- Information needs to be presented in a family friendly and culturally competent manner.
- Help families interpret and better understand information and resources they have received elsewhere such as documents provided from OPWDD and/or their DISCO.
- Provide a neutral environment for parent dialogue.
- Provide information about the new system as it initially rolls-out and continues to change during the 5- year plan.
- Direct assistance/support to families that is based on their individual needs.
- Provide disability specific trainings— eligibility and evaluation processes, transition, residential and employment opportunities, managing mental health and medical care, long-term planning, community resources, etc.
- Recognize circumstances that affect how particular sub-groups of people with disabilities are able to acquire critical information.
- Identify and implement evidence-based methods that specifically target the engagement of these groups.

Role of Care Coordination — Care coordinators were seen as key in the process of affording choice to individuals, and respondents said that DISCOs should ensure care coordinators are aware of area resources and look to multiple agencies when providing referrals for services. It was suggested that care coordinators should be independent and separated from the DISCO to ensure cost containment does not override the needs of the individual. Requiring care coordinators to spell out choices between DISCOs, and to be trained on available resources was also suggested.

Education, Information and Training — Respondents suggested an array of methods which could be used to educate individuals, families and advocates about their options and choices in planning their services. The educational opportunities described included in-person meetings, websites, a human service cooperative, and peer support networks. It was suggested by a family-based provider agency that family and self advocacy organizations are in the best position to provide peer supports to help individuals and families during their initial interaction with the system.

RFI respondents referred to a “menu” of services which could be provided to the individual and their family/advocate, but qualified this by also requesting a structure to respond to individual needs not provided on the standard menu.

It was suggested that there must be an entity that can educate the individual, family and advocates on how the care management system will work and what their rights and opportunities are within the system. Information noted as beneficial to provide included a full listing of all providers in the DISCO's network. Also noted as helpful were comparisons between options and data to assist individuals and their families in the decision-making process. Information and education to families on DISCO and provider agencies, as well as performance history, were suggested by respondents.

Some respondents suggested that these information-providing entities should be independent sources of training and technical assistance, and that organizations which are independent from care providers should play a central role in helping educate families. It was also recommended that the DDSO could have a continued role in communicating service options and background material on providers.

Self-Determination and Portability — A group of respondents focused on the use of individualized, portable budgets as the best way to promote choice. It was suggested that the most effective strategy for empowering individuals and caregivers to make meaningful choices is to enable them to control the expenditure of funds allocated based on an accurate assessment of individual needs. Respondents suggested that being in control of resources in a system in which money follows the person will provide individuals and families maximum choice so long as adequate options of providers exist.

Respondents noted that the individual should have right to direct funds and that the competition this generates is essential to quality improvement. Additionally, it was recommended that OPWDD create a self-determination option outside the managed care environment where families would receive a fixed stipend to purchase services and manage the budget themselves.

Ratings and Oversight — Respondents suggested that obtaining information on provider performance is key to choosing quality providers. A system of consumer ratings and reviews similar to Consumer Reports

or Amazon.com was suggested, as was a mechanism to elicit feedback to the DISCOs about their performance.

It was recommended that an independent party evaluate whether real choice is being offered and identify areas of improvement where appropriate. Respondents suggested that the State must enforce and hold accountable DISCOs that do not afford choice through oversight, financial consequences, independent evaluations, fair hearing process, transparency of decisions, and the dissemination of information. It was also noted that the quality management system should monitor the movement of individuals toward and away from each DISCO or provider to look for trends and allow remediation to ensure integrity of network, and ultimately choice.

(ES-3) - What mechanisms would you put in place to evaluate the adequacy of the opportunity for individuals with developmental disabilities and their family/advocate to have choice in providers? The choice of providers should incorporate cultural and programmatic diversity and clinical experience in the unique medical and clinical needs of individuals with developmental disabilities, in regions of the state which have limited participating providers.

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
140	55.78%	n/a	n/a	n/a	n/a

Respondents suggested a variety of methods to evaluate the opportunity for choice in selecting providers. Many respondents suggested customer satisfaction surveys conducted through an independent, objective process. These surveys would be primarily targeted to individuals, their families and advocates, and it was also suggested that administrative and direct care staff be interviewed. Respondents noted this data could be used to evaluate individual opportunities for choice or aggregated to evaluate entire DISCOs. It was requested that such results be made available to the public to aid in choosing quality providers.

Other suggestions for evaluating the adequacy of the opportunity for individuals to have choice in providers included evaluating specific personal outcome measures related to choice. A hotline for complaints and concerns, and methods for DISCOs and providers to gain feedback from individuals, families and advocates were also suggested. Other methods of evaluation suggested by RFI respondents included random audit and creation of oversight bodies.

Oversight Entities — Respondents suggested the involvement of a variety of third party entities to evaluate the availability of choice and provide advocacy if choice is not present. It was recommended that quality rankings for providers be set based on performance and achievement of outcomes. It was suggested that OPWDD should prescribe the policy related to choice and require DISCOs to articulate how they will implement and uphold the policy in public informational materials. Monitoring patterns of referrals was also suggested.

Respondents suggested that a Consumer Advisory Board and Family Advisory Board be established to monitor choice, diversity and clinical expertise were suggested, as well as a Network Advisory Board where all DISCO network members would have a say in how services are evaluated.

Cultural, Clinical, and Underserved Individuals' Needs — Suggestions related to evaluating the choice provided to individuals regarding cultural competence included requiring DISCOs to show cultural competency through production of a written plan, and mandatory training for all staff. It was also suggested that demographic data of a particular DISCO region should be evaluated, and monitoring should occur to determine if individuals receive information they can understand in their primary language. Other elements to evaluate which relate to cultural competence included board composition, intake procedures and initial interview questions.

For individuals living in underserved areas, it was noted as important to evaluate the connectedness and commitment of the provider and DISCO to those areas. Access to health services which target the needs of individuals with developmental disabilities was suggested as a criterion for evaluating the adequacy of choice of health services within a DISCO.

The Self-Hire Alternative — Several respondents suggested individual control over financial resources and self-hiring of staff ensures that each individual would have the opportunity to make choices. They also suggested a model whereby individuals and families are free to choose their own staff outside of a provider or DISCO framework.

Criteria and Requirements for Evaluation Suggested by RFI Respondents

Require care coordinators to present a minimum number of providers per service type
Providers and care coordinators offer services from multiple providers
Individuals should always have choice of providers other than the DISCO.
Sufficient variety of options in programs to fit individual needs
Sufficient variety of services are available in each region of the state
Minimum number of providers in each specialty or service area
Individuals, families and advocates have the chance to meet with different providers and choose the one they feel most comfortable with.
Movement of individuals between providers and/or DISCOs
Ability to easily move between providers without waiting for an opening
Person's role in hiring new staff or changing staff within a provider
Frequency in which choices are being offered for daily and major life decisions
Comparisons of supports available in each region of the state
Measurable factors such as the geographical location or providers, related transportation costs and opportunities, etc.

(ES-4) - The opportunity for individuals with developmental disabilities (with support from their family/advocate, if necessary) to self direct their supports and plan of care is an integral expectation in the People First Waiver. How do you recommend ensuring that self direction of resources and support plan is streamlined and readily available to individuals?

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
143	56.97%	n/a	n/a	n/a	n/a

Ready Availability

RFI respondents suggested a variety of models to enhance the ready availability of self-directed supports. Generally respondents voiced a desire for flexibility in funding and service provision, fiscal intermediaries and attention to quality outcomes. It was suggested that the “money follows the person” principle behind personal resource allocations (PRAs) and individualized budgets is key to ensuring individuals and their families or advocates have true control of self-direction. It was suggested that DISCOs need to operate in a culture of self-direction, and that the option to self-direct resources and supports is critical for every individual under the 1115 model.

Speaking Up For Ourselves

Self-advocates offered many suggestions for advancing awareness of, and interest in, self-directed services:

- Streamline overly complicated and cumbersome administrative processes, and make access substantially easier to navigate
- Self-directed budget categories should be broad, and funding should be flexible.
- Advance the "agency of choice" concept to utilize agency staff to assist in implementing and maintaining self-directed plans.
- DISCOs could advance self-directed services by keeping a clearinghouse of staff available.
- The availability of well-trained support brokers is essential.
- Fiscal incentives and the technical process means to convert resources from traditional models to self directed services.
- There should be quantitative goals and measures of progress in advancing these services.

These views of self-advocates were submitted by the Self-Advocacy Association of New York State, solicited through a forum.

A great variety of models were suggested to make self-directed supports readily available. On the one hand, some respondents suggested there be the possibility to opt out from DISCO care planning and capitated funding (still using the standardized assessment tool to determine the funding level) with the option to opt back in if desired. But more commonly it was suggested that self-direction be woven into the DISCO framework. Respondents suggested “boutique” DISCOs that specialize in self-direction and individualized services, or that self-direction should be a required service option for all DISCOs to offer.

Respondents suggested the use of blended models or “hybrid” plans where some services are self-directed and others are purchased (staying within a PRA.) Options which allow self-direction but do not require participants to handle administrative functions such as record keeping, billing and recruiting staff were recommended. It was further suggested that cost sharing should be allowed to subsidize

funding received through the service system, and that providers of self-directed supports should enlist the services of generic community agencies to expand support options and promote community inclusion.

Education and Outreach — Many respondents viewed the first step in making self-directed supports available as ensuring that individuals are aware of resources to be accessed. Respondents noted that everyone should hear about self-directed services and the expectations of self-direction. This includes a full and clear understanding of the expectations within the partnership of natural and paid resources to effectively support the individual and the role each player has within the process. Also, training on interviewing, hiring, and managing staff, as well as on rights and choices in varying service options, was suggested.

An OPWDD outreach campaign and philosophical and operational training for providers and DISCOs were also recommended as modes of education. Another idea noted was that service coordination could have a component to educate the individual along the way so the individual can increase his or her level of participation in the process. It was suggested that education should begin early, and that the intake session not only be used for gathering information, but as a forum through which individuals requesting services and their family/advocate can make it known to the DISCO how, when, and where they would like resources allocated.

It was suggested that there must be clear guidance regarding what is allowed in a self-directed plan, and databases of available services so that a full menu of opportunities can be presented. It was suggested that families or advocates be informed of the cost of various programs and the amount of funding that will be allocated to their family member so they can choose wisely among differing options.

Assistance — Respondents noted a variety of ways provider agencies could help individuals to access self-directed services. These modes of assistance would increase the availability of self-directed services by establishing supports for individuals and their family/advocates to create and sustain them.

Respondents noted that the initial planning process could include specific supports an individual would need to be able to self-direct, which could entail providing mentors for both individuals and their families as well as for service providers, or access to individuals and families/advocates who are using self-directed plans in order to share learning experiences with one another. It was also noted the DISCO could act as a mentor to families and provider agencies without experience in self-direction. Having well paid and informed coordinators to work with each individual was noted as essential.

Respondents noted that developing and maintaining an infrastructure for self-directed supports is key to supporting individuals and families to manage staff, logistics, and make good decisions. It was noted that it is important to incorporate personal care (home attendant) services as prominent models of self-direction are dependent upon them. Respondents recommended that DISCOs contract with experienced brokers and Fiscal Management Services (FMS) agencies.

Broad Access — Respondents noted that self-direction should be available to all individuals in all geographic areas, while some noted that some individuals will not be capable of self direction. Particular note was given to individuals who are non-verbal or those who lack strong family or advocate

involvement. It was also suggested that if an individual is unable to speak for themselves, a family member or advocate must be part of the individual's life or circle of support. Suggestions for including individuals who are non-verbal in self-directed models included using alternate communication strategies to accommodate different communication styles (sign language, pictures, etc.) to "learn to read the language of behavior". It was also suggested that any new system should use support brokers similar to current-day Consolidated Supports and Services (CSS) to make up for weak family or advocate involvement.

Four Models of Self-Direction Submitted by an RFI Respondent (in their words)

Note: In practice, these four categories should not be regarded as discrete, mutually-exclusive options. Each participant's plan should individually define the extent to which the person and/or his designated representative(s) will control or direct the provision of various services, using aspects of one or more of these modalities, which are described below:

Cash and Counseling means that a person, or his/her designated representative, is given actual physical control of funds allocated for services. Before this is done, the person/representative receives significant training on how to manage the funds and what the legal and reporting requirements are. The person/representative then presents a plan for use of the funds. Once approved, the person/representative receives monthly payments from which s/he pays for services and supports. The person would be able to shift funds among approved purposes as needed without prior approval. Proper documentation of services and supports purchased, including compliance with all relevant labor and tax withholding laws, must be maintained. The person/representative assumes all risks associated with the use of the funds.

Consumer-Directed Services and Supports are already available in New York State to people eligible for State Plan Medicaid-funded "homecare" through the Consumer Directed Personal Assistance Program (CDPAP). The extensive history of this program has demonstrated its greater cost-effectiveness and ability to improve consumer satisfaction and staff retention over that afforded by "traditional" homecare programs. The CDPAP model can easily be applied to most personalized services and supports offered by OPWDD to achieve the same beneficial results.

The elements of the CDPAP model are: Anyone eligible for Medicaid Personal Assistance Services (PAS) or for a higher level of "homecare", and who is "self-directing" or has a surrogate able and willing to direct the services, may participate. Attendants under the CDPAP program can assist with Activities of Daily Living (ADLs, i.e. bathing, dressing, using the toilet, eating) or Instrumental Activities of Daily Living (IADLs, i.e. shopping, budgeting, cooking, cleaning), any task that a Certified Home Health Aide (CHHA) can do (more medically-oriented tasks such as range-of-motion exercises, catheterization), and some tasks that Visiting Nurses do (such as maintaining tracheotomies and ventilators, and giving medication). There are no educational, licensure or certification requirements for these workers, and very little formal training is required.

Many agencies around the state are fiscal intermediaries for the CDPAP program and should be encouraged by DISCOs to bid for contracts to provide the CDPAP personal assistance service under the People First Waiver. Moreover, these agencies are among the most likely candidates to be able to expand the self-direction model to other OPWDD services, such as habilitation, respite, job coaching, and behavioral support services.

Self-Determination means the person designs and oversees the budget as well as the provision of services. OPWDD's current CSS model is a good start in this area. It does suffer from limitations that make it unattractive or unavailable to a large number of people, however. These include:

- The requirement for a Circle of Support. While these are beneficial to those who have them, many people with developmental disabilities currently living in segregated, congregate settings simply do not; there is no reason to prohibit people from exercising control over resources or having access to creative personalized service design opportunities in the meantime. A service coordinator is all that is needed to help a person develop and carry out a plan, provided that the person is allowed to use service/support brokers as needed.

- Excessive restrictions on spending, although CSS is supposed to allow for creative design of highly personalized, perhaps unconventional, services and supports.

Agency with Choice means the person chooses a provider agency that will handle most of the administration of services and supports for him or her. However, the person is allowed to choose, or at least approve or disapprove, the specific direct-care people who will provide services and is allowed to have those people work on a schedule that is convenient to him or her.

Submitted by the Southern Tier Independence Center, Inc.

Respondents suggested that advocacy should ensure broad access to readily available self-directed supports. It was suggested that individuals participate in self-advocacy training to gain the skills needed to create their own agenda, and that an expectation of self-direction be cultivated; it was also suggested that the individuals served must have a direct role in evaluation. One respondent noted that independent advocacy provides information, support and advice to individuals to enable them to create an individualized package of supports. A family member noted that this process has to be built on personal relationships to make it less intimidating to those involved.

Lastly, attention was paid to the notion of risk, and it was suggested that as part of explaining the nature and structure of self-directed supports, individuals and their family/advocates must understand that not all risk can be eliminated. A suggestion to resolve this was received as follows: "If individuals (or their families/advocates where appropriate) were given the assurance of a safety net should they find that they are either completely or partially unable to self-direct the process, more families may be willing to attempt this approach."

Streamlining

Respondents requested ways to make the process easier to understand and to develop simplistic care plans that target the specific needs of the individual. It was noted that self-directed supports generally result in better outcomes and may be less costly, but tend to be more time consuming when compared to traditional supports and services. To address this, respondents noted a variety of ways to reduce requirements and redundancies currently found in the OPWDD system and the CSS/Self-Determination model.

It was suggested that the process for completion and approval must be simplified to reduce requirements and redundancies. Respondents recommended that OPWDD streamline the development and application process behind the service plan and individualized budget and use simple, uncomplicated paperwork. It was suggested that as long as items are allowable, there should be no further questions as far as accessing desired supports as part of the budget. It was recommended that unnecessary reporting be eliminated, and a one-page budget that individuals and families can understand be utilized.

Respondents noted that the approval process for self-directed support plans should be simple, with the following streamlined process described by a respondent: "an assessment leads to a dollar amount; individuals and support circles create a plan and a budget within the allotted amount; submission to the DISCO, which must approve within 30 days." To expedite approval, it was recommended there be greater

limits on the number of people who need to review and approve the plan, and specific timeframes within the application process.

It was recommended that the DISCOs electronically publish their intake process and the formal supports that will be involved in assisting the individual in developing their self-directed plan. The hope is that the approval of plans would be expedited with a clear and transparent process.

Comparisons to Consolidated Supports and Services (CSS) — Respondents drew comparisons to the OPWDD Consolidated Supports and Service self-determination program, which allows individuals to direct their own supports. While many expressed great satisfaction with the CSS model, the criticism was offered that self-direction under CSS is very complex, and that the budget forms and documentation are excessive. As one family member put it, “Make it user friendly - the biggest barrier to the current CSS model is the complexity.”

(ES-5) - Although there may be some period of transition needed initially, ultimately the resources for all medical, behavioral health and dental services will also be included within the capitated payment provided to the DISCO. What strategies do you see as effective to ensure a competent network of providers to meet the unique needs of individuals with developmental disabilities?

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
150	59.76%	n/a	n/a	n/a	n/a

Respondents generally framed their responses in terms of steps which would be taken to build the network of medical, behavioral health and dental services, and the steps which would need to be taken to ensure and monitor the competence of the network.

Building the Competent Network

Respondents suggested a variety of strategies for building network capacity. Respondents noted that establishing the network would require advocacy and building strong working relationships with providers. It was suggested that OPWDD ensure that there are enough providers in an area to begin with, and then identify providers that specialize in certain areas. It was noted that specialization is important because of the multi-faceted and complex needs among people with developmental disabilities.



Respondents recommended that current providers should be included to maximize continuity in service, and suggested that the existing Article 16 and Article 28 network of clinics operated by developmental disability organizations are an essential component. It was suggested that there should be flexibility

afforded for out-of-network access. Step-down units or 24-hour clinics to address non life-threatening situations and avoid emergency room usage were also suggested.

Medical — Specific suggestions related to medical services included the diverse ideas of creating the ability and capacity for medical services to come into the homes of the medically frail, and on the other hand, developing a medical center for the disabled under one roof. It was also suggested that OPWDD should establish a network of regional tertiary care centers to provide specialty consultation and treatment. Support for community physicians was recommended, including continuing education for community providers and consultation from developmental disability healthcare experts at university centers.

Behavioral Health — Recommendations related to behavioral health included the establishment of behavioral crisis centers that can offer 24-hour support for individuals that have episodic mental health crises (rather than ERs.) It was suggested that these specialized centers for people with developmental disabilities could be based in Article 28 clinics or university-based programs.

Dental Services — It was suggested that it may be difficult to have community-based dentists provide dental care to the developmental disability population due to lack of actual encounters by private practice dentists, lack of knowledge and low Medicaid reimbursement. It was recommended that the Special Dentistry Task Force be involved in developing a quality assurance strategy.

Ensuring the Competence of the Network

RFI respondents suggested that in addition to having adequate and accessible services, the providers in a competent network should have adequate experience working with people with developmental disabilities. It was noted that ongoing collaboration and communication with the universe of providers is needed, and suggested that the care coordinator will be responsible to ensure communication related to individual care.

Respondents suggested a number of evaluation measures to ensure competency. These include competency standards which could include board certification or fellowship training in developmental disabilities and provider credentialing¹. Performance standards and development of a screening tool to assess the capability of providers to ensure quality care were suggested. It was furthermore noted that the ability of the individual to choose a network will drive quality through competition, and it was suggested that there should be no limit to the number of providers a DISCO can contract with.

It was suggested that DISCO policies should include the need to recruit providers based upon the demographics of its membership such as the cultural, linguistic, racial, ethnic and developmental disabilities background of its membership.

Training — Training was noted by respondents as key to ensuring competence. It was suggested that there be ongoing training on the field of developmental disabilities and the complex needs of individuals. Respondents suggested education and assistance to help providers understand the culture of the

¹ Provider credentialing is the process of review and verification of the information of a healthcare provider.

disability community are essential. It was also suggested that provider training requirements could be expanded to include licensure or other certification components.

Partnerships with Community Entities — Respondents suggested DISCOs consider affiliations with educational institutions, hospitals and clinics that foster a shared responsibility for training and educating. It was recommended that DISCOs partner with existing medical provider networks and that OPWDD provide grants to hospital systems to develop improved capacity to serve individuals with developmental disabilities. A suggestion was also received to utilize an Accountable Care Network and otherwise leverage existing networks of medical, behavioral, health and dental services that currently provide managed care services to the general population.

Payment — Adequate reimbursement was identified by many respondents as a key to ensuring the availability and willingness of competent providers to offer support. Suggestions related to payments included that payments should be linked to level of need, avoiding flat rates, and that all providers should be required to accept Medicaid as payment (see Contracts section below.)

A couple respondents provided this opinion of the future DISCOs' ability to provide medical, behavioral and dental services in a capitated environment: "If the DISCOs have sufficient enrollment that they can handle the risk associated with capitated payments, which include both acute, chronic and long-term healthcare needs of the enrolled population and long term habilitative care, then that should suffice. However, if OPWDD allows DISCOs with smaller enrollments, it should consider two separate capitated payments: one for acute, chronic and long-term healthcare and a separate one for long-term habilitative care."

Other respondents echoed the notion that there should be a threshold of supports for developmental disability service delivery that is mandated to prevent dollars from going to medical services at the expense of long-term community supports. A solution to this offered by a respondent was to also have an additional emergency fund for contingencies.

Contracts — Respondents suggested contracts and other agreements as tools to ensure the competency of providers. A contractual agreement or memorandum of understanding (MOU) to indicate each provider, their role, and the payment for providing service was recommended. It was recommended that there be clauses in contracts between providers and the DISCO which allow the DISCO to eliminate providers that bring competency into question.

It was suggested that providers who agree to contracts with a DISCO could be required to agree to accept Medicaid patients and meet requirements to ensure timely access to care, with a mechanism in place for holding the provider accountable. It was also noted that specialty medicines are limited in rural communities, and that DISCOs serving in rural communities may not be able to negotiate as effectively as DISCOs serving urban populations.

Oversight and Evaluation — Suggestions for oversight included the creation of an advisory board to evaluate quality or standards that are developed and a committee to review competency of providers in the network. Other suggestions included the use of outcomes-based measures and gathering satisfaction

and other data to create a public report card that reflects the quality of services provided. Respondents suggested that the process include gathering information from individuals, families and providers regarding their experience, as well as a rating system to identify who the competent providers are.

(ES-6) What provider or other community coalitions might be encouraged to develop needed service capacity for medical, behavioral health and dental services?

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
108	43.03%	n/a	n/a	n/a	n/a

Respondents suggested a number of coalitions and partnerships to develop service capacity for medical, behavioral health and dental services. Many respondents emphasized the use of local solutions, and that providers should be encouraged to partner with local services. It was recommended that outreach should be made to local healthcare clinics, mental health clinics, and dental practices. Coordinated transportation across several provider areas and mobile clinic services to remote locations were noted as ways to increase access.

It was suggested that providers leverage the existing network of Medicaid Managed Care providers. It was also recommended that specialized service providers and advocacy organizations should be consulted and encouraged to expand. Other respondents suggested partnerships with medical schools with programs in developmental disabilities and partnerships with universities. It was noted such partnerships could provide access to up-to-date research, technology and best practices, and also allow opportunity for students to work with people with developmental disabilities.

Specialized Community Services —

Respondents suggested a variety of community health resources to incorporate as part of a coalition. It was recommended that DISCOs connect to community-based clinics serving neighborhoods, and that the current array of Article 16 and Article 28 clinic providers now serve the specialty service needs of people with developmental disabilities.

It was suggested that access be expanded through the exploration of opportunities with community-based organizations (Community

 Coalition Candidates

Respondents suggested the following entities as possible coalition partners to develop needed service capacity for medical, behavioral and dental health.

Community resources: clinics (including Article 16 and Article 28 clinics,) hospitals, medical schools and university centers, local medical societies, faith communities, community groups such as service organizations, community boards, chambers of commerce

Local Governments and Provider Associations: County government departments, NYSACRA, NYSARC

New York State Government Agencies: Office of Mental Health, Department of Health, Office for the Aging, Department of Education, Office of Alcoholism and Substance Abuse, Office of Children and Family Services

Health Centers, Community Action Programs) which may not be current providers, but are more community focused and culturally identified with individuals. Respondents noted health or medical homes with appropriate networks of specialists as a model to consider as a starting point for building increased and expanded service capacity.

DISCO and Local Government Role — Respondents described the role of DISCO as responsible for cultivating relationships with additional providers to expand service capacity for medical, behavioral and dental health services. It was also suggested that DISCOs could be formed through coalitions of local providers.

Respondents suggested that local governments are knowledgeable in community need, and that DISCOs should contract with counties or county-based consortiums for managed, specialized health services. It was noted that local departments are involved with other service systems that impact the lives of people with developmental disabilities

Training — Respondents suggested that training be provided to medical professionals working with individuals with developmental disabilities. It was suggested that this training could both sensitize them to the needs of people with developmental disabilities and provide information on OPWDD services.

(ES-7) - Recognizing that individuals will be transitioning from highly structured state operated institutional settings, design team recommendations identified the need for effective clinical support models and crisis intervention models; what models have you found to be effective and how would you develop an appropriately responsive system of supports to ensure adequate individual safety and evidence based treatment approaches?

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
112	44.62%	n/a	n/a	n/a	n/a

Respondents suggested a myriad of clinical support and crisis intervention models for consideration. Suggestions for clinical supports included transitional homes, crisis intervention teams, and respite homes equipped with specially trained staff and professionals to help ensure the safety of the person and the community. It was also noted that an individual’s circle of support, if they have one, would be expected to step up in a crisis.

Other suggestions stressed the need for the availability of crisis beds as a diversion to emergency rooms and inpatient hospital beds for behavioral crises, and suggested that the key is response time and availability to reduce emergency room visits.

Best practices suggested for consideration included those identified by the federal Centers for Medicare & Medicaid Services involving crisis respite and intervention, the Waiver Design Team's recommendations, and experience from other states.

Responsiveness — Respondents offered a variety of suggestions and opinions related to developing a responsive system for individuals transitioning from highly structured settings. It was suggested that effective behavioral support systems must have multiple tiers of support in order to serve all individuals with graduated levels of residential care. It was recommended that one such tier of support be an intermediate level below full acute hospitalization, with 24-hour care provided during the crisis period followed by transition to a community home with supports.

It was suggested that an intense, individualized, and coordinated plan of care is essential to help transition an individual into a less restrictive setting, and short term residential options must be coordinated with local crisis intervention teams. Joint planning between state and community providers was noted as important.

Suggestions to ensure a responsive system included immediate response teams and a single point of entry to triage crisis situations quickly and efficiently. A 24/7 service hotline to reach clinical staff with immediate or quick follow-up and reassessment until stabilization was suggested. Mobile crisis teams that can be responsive around all areas of the state were also recommended.

Safety — Respondents recommended establishing a comprehensive assessment to address safety needs. It was noted that safety mechanisms and monitoring should be in place to help people successfully remain in the community during the implementation of the plan. The full use of technology was suggested as a way to ensure safety, reduce on-site supervision, and protect privacy rights of individuals through smart homes, remote health monitoring, and video surveillance technologies. It was submitted that safety relies on the availability of multiple staff to effectively manage behavioral crises, and to implement intensive treatment on a daily basis, as well as when issues emerge or re-emerge.

Clinical Support and Crisis Intervention Models Described by RFI Respondents

Alternative to Incarceration (ATI) is a service model that provides a variety of different approaches to the management of people with a developmental disability that are considered at-risk or who are involved in the Criminal Justice system.

Applied Behavior Analysis (ABA) includes a team of behavior analysts that oversee the programming, data collection, and analysis of individual supports. Intervention plans are created based on positive behavior supports, and data is used to make immediate changes.

Assertive Community Treatment (ACT) is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. ACT recipients receive the multidisciplinary support and staffing of a psychiatric unit, but within the comfort of their own home and community. The ACT team provides these necessary services as needed, 24 hours a day, seven days a week, and 365 days a year.

Critical Time Intervention is an empirically supported, time-limited case management model designed to prevent homelessness and other adverse outcomes in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing

themselves in satisfactory living arrangements with access to needed supports. The time-limited assistance during this critical period can provide the necessary supports to make the transition successful.

Interdisciplinary Treatment Team approach (traditional approach) – an internal team of professionals and clinicians assess the situation and develop an action plan.

OPWDD Intensive Behavioral Services is a model to assist caregivers in managing individuals with challenging behaviors before they reach critical stages. IBS has the ability to cut down on psychiatric hospital visits and stays as well as enabling the caregiver to learn about and understand their loved one's behavior; and ways to redirect inappropriate behaviors.

NYS Department of Health's Health Home Model - one integrated care management team coordinates and oversees health care, behavioral health, and substance abuse services.

Person-Centered Planning is a need-driven process and requires a full array of services which promote least-restrictive, normalized, community-based care. Approaches that provide the individual with activities of choice have been effective in modifying behaviors.

Relapse prevention is a cognitive-behavioral approach with the goal of identifying and preventing high-risk situations such as substance abuse, obsessive-compulsive behavior, sexual offending, obesity, and depression. It is the treatment of addictive behaviors that specifically addresses the nature of the relapse process and suggests coping strategies useful in maintaining change and supporting more successful outcomes.

Sanctuary Model - aligns with a modern movement toward "trauma-informed care." The idea behind it is that since most traumatic stress occurs within a social context, the most effective solution is to create a social context that can undo the damage done. The focus is on establishing a culture where healthy, healing relationships are fostered. Behavior planning is done as a group, and issues of power and control are examined regularly. Staff development is an ongoing, primary focus. Behavioral concerns are framed as understandable responses to trauma.

Support Staff and Family Assistance — Respondents spoke to the role and importance of support staff in managing difficult behaviors, and suggested consistency in staffing and flexibility to provide immediate, on-site support for the person in crisis. It was recommended that clinicians be on call to manage psychiatric and medical emergencies and that home-based behavior therapists be available, with the flexibility for 1:1 staffing as needed. It was noted that staff bonding practices where consistent staffing, positive relationship building, role playing and mentoring help people adapt and modify behaviors.

Training for the individual, family and support staff on how to anticipate and address crises was recommended, as were peer advocates and strong family involvement in the process. It was also suggested that OPWDD should be continually available for consultation and training.

Preventing Crises — It was recommended that any intervention program should establish the goal of prevention by understanding the situation, being positioned to recognize precursors, and providing the necessary support to positively affect the outcome. It was suggested that if behavioral concerns are recognized and addressed early in their development, often times they can be addressed via programs that provide in-home support and training for parents and other caregivers using a consulting model.

It was suggested that the availability of respite services gives needed breaks to families, and that all staff selected to work with individuals with behavioral challenges must be fully trained in methods of maintaining an environment which lessens the likelihood of situations that will encourage incidents.

(ES-8) - A key hypothesis of the waiver is that a fiscal structure that provides resources based upon a consistent needs assessment process will incentivize the development of innovative support plans that are more aligned with individual's interests and needs and which ensure that resources are allocated equitably. What innovative models of support have you heard about, implemented or would recommend within the People First Waiver that would be consistent with this hypothesis?

Number of Responses	% of Total RFI Responses	Yes Responses	% of Yes Responses	No Responses	% of No Responses
116	46.22%	n/a	n/a	n/a	n/a

To begin, respondents offered suggestions and opinions on what fosters and encourages innovation itself. It was suggested that innovation should be incentivized, recognized, and widely shared throughout the system to encourage replication. It was suggested that the State's support of experimentation and its capacity to allow the involved agencies to retain a level of operating surplus that supports such innovation is key to developing innovative models of support. Respondents suggested innovative models which are "flexible, creative, efficient and appropriate," and "models which adapt based on needs, not a canned service."

Respondents noted that OPWDD has a critical role to play in creating forums, opportunities, and training where innovation can be shared. It was also suggested that OPWDD review existing regulatory barriers to providing innovative services. Self-advocates shared other challenges they have found to creating innovative supports, including a lack of knowledge regarding the current availability of innovative options and the inability to readily convert existing base resources to alternate uses.

Financial Resources — Respondents spoke about the role of financial resources in innovation, noting that innovative and sustainable models of supports are most often created when a provider can identify a stable and continuous source of funds to finance it.

Respondents also spoke about the 'money follows the person' model based that looks at needs through recurring needs assessments for the creation of an individualized, needs-driven budget for services. It was suggested that to truly encourage innovation, the new system must provide standards and principles and encourage providers and individuals to do whatever they can to meet the goals within a set budget.

Self-Directed Services and Independence — A number of respondents suggested the expanded use of planning and self-directed services models. Comments included: "Those who self direct tend to be more fiscally responsible," and "The increasing establishment of support planning will generate an aggregate demand for different services than the market currently emphasizes – which will typically entail less costly, less restrictive and more natural types of supports and services."

It was suggested that the best way to encourage these models of support is to protect and nurture the growth of the planning philosophy and approach until it is strongly established. It was also suggested that individualized services can be expanded by utilizing licensed home care.

Self-Directed Services and Independence Models Noted by RFI Respondents:

- ▶ Consolidated Supports and Services (CSS). In this service model Person-Centered Planning is conducted to determine individual's interests and needs. An individualized budget is then developed based on this assessment. The FMS (Fiscal Management Services) role in CSS is to monitor, manage and report on whether the services actually provided are remaining within this budget. Individuals choose and manage their own staff, and support brokers guide them through the system. A recommendation was that the CSS process be simplified.
- ▶ The Person-Centered Planning Model (Dr. Beth Mount) is a best practice which emphasizes a person's capacity and the importance of planning. This model places the person at the center, surrounded by professional and natural supports.

Employment for People with Developmental Disabilities — Respondents suggested a number of prevocational or supported employment services for individuals who want to enter the workforce, attend college, and work in an integrated setting.

Employment Models Noted by RFI Respondents:

- ▶ Customized Employment utilizes an individualized approach to employment planning and job development. Task reassignment, job carving and job sharing are components of this model. Customized employment is a useful mechanism for enabling people, even those with the most severe disabilities, to participate in the mainstream workforce.
- ▶ Everybody Works! This approach relies upon a person-centered focus coupled with aggressive partnership with and outreach to private and public sector employers, including employers with available volunteer needs and opportunities.
- ▶ Supported and Enhanced Supported Employment Services provide support to individuals through customized job coaching and training. These were noted as programs that could be expanded to move people away from more segregated day service options.

Community and Residential Supports — It was recommended that innovative models of housing support and opportunities for involvement with community organizations should be encouraged in alignment with the interests and abilities of the person being served.

Community and Residential Models Noted by RFI Respondents:

- ▶ The KeyRing model fosters the development of natural supports that exist in the community and has enabled people to build a structure of mutual, natural supports. In this model the strengths of each person are used to help a neighbor. This results in the creation of relationships and community bonds.
- ▶ Intentional Community model - In an intentional community, connections are built among households that are within walking distance from one another. In this model, people with and without disabilities cook meals together, clean the house together, food shop and live an integrated work, social and cultural life.

- ▶ Shared living models were recommended by several respondents. One respondent suggested that the availability of appropriate technical assistance to enhance individualized supports and increased agency capacity to allow for ongoing training and support are two important tools to successful shared living arrangements.
- ▶ Assisted living was recommended as a model for aging individuals with developmental disabilities. Respondents noted that there are a great deal of support needs commonly held by both developmentally disabled and typically developing individuals.
- ▶ Innovative supportive living options for individuals with varying challenges - One model was described by a respondent: "In a cluster of 8 apartments in one garden apartment complex, staff are present 16 hours per day. This model has been successful in helping 15 long-term residents of community residence programs for people dually diagnosed with mental illness and developmental disabilities move to 2-person apartments and live more satisfying and independent lives."

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