Summary of Advisory and Input Group Recommendations

PART 1: Overall Recommendations Grouped by Topic

General Recommendations:

- Increase and expand pilot programs that show proof of concept and results for the various models presented on the whole person supports website. Continue to pilot all proposed models with an RFP process, allowing for innovation funding and evaluation.
- Strengthen culture of self-direction, personal choice, and person-centered care across all services and models.
- Emphasize collaboration among state agencies to enable blended funding models, allowing for customized and flexible person-centered supports.
- Implement an Interdisciplinary Team (IDT) or similar approach across all programs, with specialized care coordinators consulting with generalists for complex cases.
- Explore repurposing existing state-owned properties for pilot programs, particularly for IDD populations.
- Look for additional models that can be replicated where models were not highlighted by the coalition such as for people with autism and aggressive behaviors.
- Take the ideas generated by the coalition and present and apply them across all relevant agencies (DOH, OMH, etc.) where appropriate.

Staffing and Workforce Development

- Explore ways to broaden the roles of DSPs in ways that allow them to gain more expertise through credentials. Examples of credentials might include subjects such as serving individuals with complex medical needs, or supporting people who have aggressive behaviors, etc. Gaining such credentials would allow DSP to receive higher pay.
- Work to increase salaries of DSPs and PAY them MORE with a minimum standard of pay taking into account geography, experience, credentials and other factors. Consider higher pay for care managers as well.
- Find various ways to elevate the role of DSPs and their importance as professionals.
- Increase hands on training for HHA, CNAs, LPNs, RNs, social workers, family members, and DSPs to better handle individuals with complex needs, including autism and aggressive behaviors.
- Provide more social/emotional support to prevent burn out by DSPs.

Remote Monitoring and Tech

- Enable and encourage remote monitoring (when appropriate) for nurses and DSPs by adjusting regulations to allow more use of remote home monitoring technology for those who wish to live more independently and can do so safely. (Note: Use SANYS position on use of cameras).
- Allow use of remote consultation to prevent unnecessary use of emergency rooms – and allow the "capture" of medical dollars saved by allowing OPWDD providers to keep some of the savings from prevention of more expensive medical supports.
- Ensure equitable pay for remote and tele-support roles to prevent disincentives.
- Explore use of AI to help support people with medical monitoring and increased autonomy where appropriate.
- OPWDD should explore current technology that could be used in homes, on trips – but be cautious about people who might elope.

Housing

- Seek an exemption to the Nurse Practice Act around providing medications in non-certified settings.
- Allow for live-in caregivers or other flexible housing supports such as small collectives, philanthropic dollars or shared ownership
- Incorporate technology-first approaches (e.g., remote supervision, smart home devices) in IRAs for enhanced safety and independence.
- Increase universally designed architecture in all facilities to support aging in place and disability needs.
- Consider privacy concerns with technology solutions (e.g., cameras), ensuring resident consent and customized use policies. (Refer to SANYS policy position on this topic).

Education and Training Integration

- Collaborate with the State Education Department, medical schools, and other educational institutions to integrate disability awareness training into the standard curricula. Disability awareness would become a mandatory piece of curriculum for neurology and other clinical professions. In addition to disability awareness, the curriculum should include the review of principles such as self-advocacy and self-determination.
- Pilot a training in residency program to ensure medical professionals are equipped for challenges unique to persons with I/DD. A rotation w/ I/DD for residents could be an option. (Note: look at curriculum from Cris. Marchionne)

- Note that there is a "SCANS" training curriculum being developed by Institute for Exceptional Care and might be a primary resource when done.

Funding, Policy, Administrative or Regulatory Reform

- Provide more resources for self-direction programs to enhance sustainability and be able to utilize dollars in different ways. A workgroup of self-advocates and family members could help define allowable uses.
- Restructure the template for self-direction (need detail on how?)
- Help make self-direction more accessible to everyone by allowing dollars to be used to hire people who can help broker services when parents or natural supports are unable or lack the resources or time to manage self-directed services for a person with I/DD.
- Consider ways to alleviate care manager caseloads by calibrating the level of services and supports with actual need. This might include exploring other ways to manage caseloads like better utilizing existing natural supports.
- (Federal issue): Reduce the need to recertify a permanent disability.
- Strengthen integration between healthcare and OPWDD services to capture cost savings and reinvest in services. Do this by engaging DOH, OMH, and other agencies in blended funding discussions to ensure financial sustainability and a potential means to blend funding across Medicaid services (medical, behavioral, HCBS).
- Introduce budgeting flexibility for providers and for those self-directing in ways that improve efficiency in service delivery and improve the consumer experience.
- Through a workgroup, shift funding formulas to prioritize outcomes over units of service to drive meaningful improvements.
- Consider a streamlined process for managing funds in self-direction.
- Ensure supportive decision-making services are recognized as reimbursable and financially viable.
- Examine the billing practices that may prevent supports via Comm Hab or different settings

Enhancing Natural Supports, Self-Direction, and Aging in Place

- Reinforce the Circle of Support model to ensure individuals have control over their support systems.
- Explore live-in caregiver and paid neighbor models, with appropriate reimbursement structures that allow people to keep living in their home.
- Ensure every person has the right circle/person who can help make decisions for supports when families are unable to do this. (final decision should rest with the individual when capable).

- Establish more opportunities to provide guidance, education, and respite options for families and parents.
- Reinforce circle of support model to make sure the individual has control (enhance care management/brokerage).
- Look for ways to maximize use of volunteers as part of the circle of support.
- Look at ways to form and maintain circles of support.
- Look at “connector” model from Canada to see how best to connect people.
- Add a budget line for House Managers in self-direction.
- Residential habilitation is tied to certified residence – explore changing this.
- ICF/IRA vacancies are slow to fill – could OPWDD consider using current licensed beds that are unfilled for respite

Employment & Day Program Enhancements

- Implement an 'Employment First' approach, with a spectrum of employment options and day activities tailored to individual abilities and interests.
- Develop personalized schedules to allow for more independent and fulfilling day programs, moving away from rigid timetables.
- Acknowledge the need for a spectrum of activities beyond traditional employment, including inclusive community engagement options.

Part2: Recommendations from the Advisory Group Specific to Models Presented via Webinar that May Increase Whole Person Supports

PACE & Self-Direction

- Expand PACE to include a full range of services, including habilitation, housing, and medical services as a choice for people with I/DD.
- Explore pilot programs with multiple test groups to evaluate effectiveness of PACE across populations (and not just those over 55) – and even try including those with more complex needs.
- Identify barriers to provider use of PACE so more can/would be willing to participate.
- Implement self-direction within the PACE model, allowing individuals to designate hours for customized support based on their needs.
- Develop a per-person capitation rate for PACE with flexibility and cost-efficiency, aligning with OPWDD for effective implementation.
- Blend funding sources for a persons full set of services to enable providers to more simply manage services and allow more flexibility for individuals, families and providers.
- Investigate financial sustainability and long-term funding mechanisms, particularly for complex needs populations.

Care Management (SIP-PL-type model):

- If implementing a SIP-type model, establish a small multi-agency group to oversee progress and evaluate effectiveness.
- Allow care managers to customize services to individual needs.
- Enhance training for care coordinators, ensuring cross-system expertise.
- Develop specialty certifications (e.g., complex populations, behavioral health) linked to pay increases for care coordinators and DSPs.
- Address care coordinator turnover by offering targeted support, mentorship, and opportunities for specialization.
- Develop workload guidelines to maintain manageable caseloads for care managers to reduce burnout and turnover rates.
- Integrate technology solutions to alleviate administrative burdens and enhance coordination efficiency.
- Standardize templates that allow for customized, person-centered care planning rather than strict, impersonal checklists.

Smoothing Transitions for Housing Webinar:

- Enhance training for DSPs on transitions and build transition planning into life plans.
- Develop clearer guidelines for staff proximity requirements when utilizing remote home monitoring, possibly incorporating on-call or beeper systems.
- Include DSPs, HHAs, and CNAs in transition planning to ensure continuity of care.
- Continue to develop more flexibility in certified and non-certified supported housing options that provide greater individual choice (e.g., living arrangements) and independence (e.g., such as home enabled supports and technology options).
- Ensure that housing options allow for aging-in-place and community integration while maintaining necessary support.

Enhanced Self-Direction:

- Streamline guidelines for self-direction to make it easier for all to use.
- Address inequities by providing resources and support for families unable to participate due to time or financial limitations.
- Create a 'circle of support' model that ensures continuity of care even when primary caregivers (e.g., parents) are no longer available.
- Review reimbursement structures to minimize upfront costs for families.
- Develop flexible funding options, including Direct Payments, Individual Service Funds, Arranged Services, and Combination Options, to provide tailored financial solutions.

  o **Direct Payments** (Option 1) – Individuals receive funding directly to arrange their own care. o **Individual Service Fund** (Option 2) – A provider manages the budget, but the individual decides how it is spent. o **Arranged Services** (Option 3) – The local authority organizes care on behalf of the person. o **Combination of Options** (Option 4) – A mix of the above approaches.

- Provide self-direction training to non-family support staff, emphasizing independence and person-centered care.
- Offer specialized training for supporting complex cases, ensuring adequate expertise and safety measures.
- Increase the number of care managers to enhance availability.

Part 3: Instructions for the Steering Group

As you review these recommendations, please answer the following questions:

1. To what degree does implementing this recommendation impact some of the challenges outlined in the "case for change? use the following scale: 1- little; 2-some; 3-signficant

2. To what extent does this recommendation better promote whole person supports? use the following scale: 1- little; 2-some; 3-signficant

3. How actionable/feasible is this recommendation? 1-not actionable; 2- actionable with some effort; 3- actionable only with significant investment of time or resources