OVERVIEW OF IMPLEMENTATION STRATEGY GUIDELINES

Division of Developmental Disabilities
Bureau of Accreditation, Licensure and Certification
Life Choices Team 4

June 5, 2017

1

AGENDA

- Overview of CMS Regulations Governing Conflict of Interest Free Case Management (CFCM) and Person Centered Planning (PCP)
- Overview of Personal Plan Process
- Overview of Implementation Strategy Guidelines and Process
- Connecting the Implementation Strategy to the Personal Plan
- BALC and BQM Expectations for Provider Agencies

2

CONFLICT OF INTEREST FREE CASE MANAGEMENT (CFCM)

"Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person centered service plans in a geographic area also provides HCBS."

3

WHY IS CONFLICT OF INTEREST FREE CASE MANAGEMENT NECESSARY?

Among CMS' concerns about service provision in the absence of CFCM are that one or more of the following conflicts may arise:

- Undue influence over goals;
- Compromised individual choice of services;
- Misaligned financial incentives; or
- Provider self-referral

In addition to development of the PCP, other duties CMS requires be completed through a CFCM structure include:

- Assessment
- Service Plan Development
- Referral for Services
- Service Monitoring
- Remediation of Problems

CMS PERSON CENTERED PLANNING REQUIREMENTS

- The person centered planning process is driven by the individual
- The process includes people chosen by the individual
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual
- Reflects cultural considerations
- Includes strategies for solving disagreement
- Is made available to the person in a way that they can understand

- Offers choices to the individual regarding services and supports the individual receives and from whom
- Conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual
- May include whether and what services are self-directed
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others
- Includes risk factors and plans to minimize them

PERSON CENTERED PLANNING IN ILLINOIS

- Life Choices Team 4 developed draft materials that ISC agencies have been piloting across Illinois.
- Effective 7/1/17, ISC's will begin completing Discovery/ Assessment and developing a Personal Plan for HCBS participants.
- For people new to the Waiver, the ISC will share the Personal Plan with provider agencies at the direction of the person seeking services to determine whether the agency can meet the person's needs/interests.
- For people already in the Waiver, provider agency staff may be invited to join in the development of the Personal Plan (per the choice of the person) and will receive a copy of the Personal Plan from the ISC which will provide the basis for service delivery.

7

PROVIDER SELECTION PROCESS

- See handout

8

IMPLEMENTATION STRATEGY DEVELOPMENT, MONITORING, AND CHANGES

- See handout

9

PERSONAL PLAN KEY AREAS

- Home
- Important Relationships
- Career/Income
- Health and Wellbeing
- Life in the Community
- Choice and Decision-Making
- Future Plans

10

WHAT DO PROVIDER AGENCIES DO WITH THE PERSONAL PLAN?

1. Review the Personal Plan to determine whether you can support the person to pursue the outcomes included in the Plan.
2. Discuss with the person and ISC any areas of the Plan that may present challenges for your agency so the person can make an informed decision regarding who they want to support them.
3. Develop an "Implementation Strategy" to summarize how your agency will support the person to pursue the agreed-upon outcomes in the Personal Plan.
4. Train staff on the Implementation Strategy; monitor progress over time; update strategies, as necessary; notify ISC of significant concerns and/or when the individual expresses a change in desired outcomes.

11

WHAT IS AN "IMPLEMENTATION STRATEGY"?

- The Implementation Strategy is the set of instructions developed by the provider agency for staff to follow in supporting the person to pursue the outcomes included in the Personal Plan.
- The Implementation Strategy includes more details than the Personal Plan regarding how staff will support the person.
- Agencies can design their own Implementation Strategy tool or form based on the guidelines developed through the Life Choices initiative.
- Agencies may find that the current form they use to direct staff for implementing the ISP meets most/all of the requirements for the Implementation Strategy and may choose to continue using this tool.
- Generally speaking, agencies should find that the requirements for the Implementation Strategy are less prescriptive than the existing requirements for the ISP.

12

IMPLEMENTATION STRATEGY GUIDELINES

- The Implementation Strategy will be evaluated to assure:
  - consistency between the person's desired outcomes and provider-directed (including organizations and individuals) activities and support;
  - progress is measured over time toward achieving outcomes;
  - known risk factors are addressed; and
  - demonstrate compliance with HCBS requirements.
- The priorities, strengths, support needs and risk factors identified in the Personal Plan must be addressed and accounted for in the Implementation Strategy for those areas in which the provider is being paid to provide services

13

IMPLEMENTATION STRATEGY COMPONENTS

- Demographic and Descriptive Information that would be important for someone working directly with the person to know about him/her (this may include information included in the "Important Things to Know About the Person" section of the Personal Plan)
- For each of the key areas:
  - Priority Outcomes included in the Personal Plan detail on how the provider will assist the person to achieve this outcome
  - Other personal priorities/strengths the person has in each of the key areas summarized in the Personal Plan
  - On-going support needs in each area and detail on how these will be met (e.g. provider responsibility, natural support, etc)
  - Identified risk factors and the plan for mitigating risk
  - Identifies back-up plans and strategies for service delivery

14

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15

LET'S LOOK AT AN EXAMPLE

16

MEET JOE

Joe is a very private person. He does not easily trust others, especially peers as he has been taken advantage of in the past. He is a very hard worker and takes pride in his work. Having a job and making money is very important to him. He would like to work out in the community someday.

Joe can get frustrated when he is around others who do not share his values or when he does not meet the work goals that he has created for himself. He is a very likeable person. He is able to communicate well. He is very independent and would like to live on his own, in his own apartment, establish (non-disabled) relationships and find a girlfriend.

17

OVERVIEW OF AGENCY SUPPORTS

- Joe lives in CILA home with 5 peers. Joe did not choose his housemates but has expressed satisfaction with where he lives and has no immediate plans for moving.
- Joe attends Agency DT program where he is able to select from among several classes offered on a daily basis. Joe often chooses to remove himself from the group and look at magazines. Staff remind Joe that he is able to rejoin the group whenever he is ready.
- Agency has developed a Positive Behavior Support Plan to help Joe develop coping skills for being around others who do not share his values and work ethic.
- Joe has a structured picture calendar to remind him of daily chores, activities and personal routines which staff assist him in completing.
- Agency supports Joe in scheduling all medical/health-related appointments and adhering to physician-prescribed regimens including administering prescription medications

18

HOME

What is the person's priority outcome/requirement in this area?
Joe expresses satisfaction with where he lives but would like to move into a more independent setting at some point in the future.

Priorities/Strengths

- Joe enjoys being around others
- Joe likes to feel like he has an important role in his home
- Joe likes to follow a consistent morning and evening routine

Ongoing Supports

1. Joe will participate in "On My Own" class 1x/week at DT program where independent living skills are taught.
2. QIDP will assists Joe to identify 2 concrete skills (e.g. cooking, laundry) that he would like to improve and design a training strategy for staff to follow to support Joe to develop his skills. QIDP will review progress with Joe during monthly meetings and modify the training strategy as Joe progresses and/or expresses an interest in new skill areas.
3. DSP staff will support Joe to follow daily picture calendar of chores, activities and personal routines and maintain a record of support required to achieve completion.

Risk Factors

Joe doesn't have self-preservation skills to be at home without staff support. Joe lives in a 24-hour CILA setting where staff assure his safety and wellbeing.

Monitoring

DT program will summarize progress in class on a monthly basis. QIDP will meet with Joe monthly to review progress in DT class, skill acquisition and review home calendar. Joe's parents and ISC will receive a written summary of monthly review meetings.

Back Up Strategy

Agency provides continuous staff support. CILA Home Supervisor will assure the provision of designated ongoing supports in the absence of QIDP.

19

IMPORTANT RELATIONSHIPS

What is the person's priority outcome/requirement in this area?
Joe sees his family on a regular basis and also accesses places in the community that are too far to walk to by learning how to use public transportation.

Priorities/Strengths

- Making Friends
- Staying connected to immediate and extended family
- Supportive of others
- Very sensitive to others' feelings

Ongoing Supports

1. Joe will participate in community safety training class through DT 1x/week to learn safety and public transportation strategies.
2. Agency will assist Joe to obtain reduced fare RTA pass.
3. QIDP will establish monthly family visit and call schedule. CILA staff will support Joe to initiate calls to family per schedule and will support him to be ready for pick up by family for scheduled visits.
4. QIDP will confirm birthday visit with family 1 month in advance.
5. Joe will participate in "Family Ties" class at DT where he will receive support to maintain communication with his family via cards, online messaging and invitations to agency-sponsored events.
6. Staff will support Joe to interact with peers to establish friendships.

20

Risk Factors

Joe's current relationships are safe and positive but he has a history of being too trusting of strangers and being exploited by others (e.g. giving away money and valuables) in order to make friendships. Staff will accompany Joe in the community to support him in establishing safe and mutual friendships with others. Staff will discuss with Joe ways he can be supportive of others and friendly without giving away money and valuables.

Monitoring

QIDP will maintain a monthly calendar documenting completion of above activities and indicating reasons for any scheduled activities that were not completed. Calendar will be reviewed with Joe during monthly meetings to determine his satisfaction and input for upcoming month and will be forwarded to Joe's family and ISC.

Back Up Strategy

In the event a class is not available, DT staff will offer preferred alternatives and assure that class is rescheduled. Agency has CILA/DT coverage plan to assure continued availability of staff supports.

21

CAREER

What is the person's priority outcome/requirement in this area?
Having a paying job is important to Joe. He has never had a community job and wants to get a job where he has co-workers who are nice to him.

Priorities/Strengths

- Interest in working
- Open to many different options
- Wants to be a part of a team

Ongoing Supports

1. QIDP will assure Joe applies to DRS for employment support.
2. Joe will attend "Job Club" at the DT program to learn more about community employment options and develop work skills.
3. QIDP will take Joe to 2 community job sites/month to learn about employment options.
4. Upon referral from DRS, Joe will be assigned an Employment Specialist who will assist him in pursuing community employment.

Risk Factors

Risk factors include those already identified regarding the need for staff support to maintain his safety and not be exploited by others. These skill areas will be addressed in ongoing classes and interactions with Joe. Joe's Employment Specialist will consider these requirements in helping Joe pursue employment, as a safe and supportive work environment where co-workers do not pose a risk to Joe will be an important consideration.

Monitoring

QIDP will review employment activities with Joe during monthly meetings and document progress in monthly summary that will be shared with Joe's family and ISC.

Back Up Strategy

CILA Home Supervisor will assure the provision of designated ongoing supports in the absence of QIDP.

22

HEALTH AND WELL-BEING

What is the person's priority outcome/requirement in this area?
At the encouragement of his family, Joe agrees that following a healthy diet and getting regular exercise are priorities for him.

Priorities/Strengths

- Family support and encouragement
- Joe enjoys being physically active

Ongoing Supports

1. QIDP will schedule all health/medical appointments for Joe.
2. Joe will participate in "Exercise Club" at DT 3x/week.
3. Joe will participate in healthy cooking class at DT 1x/week.
4. Joe will participate in monthly household menu planning, cooking and grocery shopping.
5. Joe will be encouraged to use home outdoor space for regular physical exercise (e.g. basketball, neighborhood walks, gardening).

Risk Factors

No risk factors have been identified in this area.

Monitoring

DT will document Joe's participation in classes and share with QIDP. QIDP will discuss Joe's progress toward health outcomes with him during monthly meetings and update as warranted. Monthly summary will be shared with Joe's family and ISC.

Back Up Strategy

CILA Home Supervisor will assure completion of home activities in absence of QIDP. DT staff will assure Joe is encouraged to regularly exercise in the event of any cancelled classes.

23

LIFE IN THE COMMUNITY

What is the person's priority outcome/requirement in this area?
Joe would like to have more opportunities to participate in community activities, though he was not able to share any specific interests.

Priorities/Strengths

- Enjoys being occupied
- Enjoys being around others
- Willing to try new things

Ongoing Supports

1. DT program will review monthly community outing calendar with Joe to determine his interests and encourage him to sign up for at least 2 options.
2. Joe will participate in monthly house meetings with his housemates, DSP staff and QIDP to discuss upcoming community opportunities and collectively decide on 1 option each week.
3. QIDP will review the park district catalog with Joe each quarter to determine whether any options are of interest. QIDP will communicate with Joe's family to secure funding for any classes of interest.
4. DSP staff will support Joe to visit the park in his neighborhood at least weekly for exercise and recreation.

Monitoring

QIDP will maintain an monthly activity calendar that will be reviewed with Joe during monthly meetings and shared with his family. QIDP will discuss Joe's response to community activities with involved staff as well as Joe to determine interests, likes and dislikes.

24

Risk Factors

Joe is not able to safely maintain himself in the community without staff support. At this time, Joe has staff support for all community outings.

Monitoring

QIDP will maintain an monthly activity calendar that will be reviewed with Joe during monthly meetings and shared with his family. QIDP will discuss Joe's response to community activities with involved staff as well as Joe to determine interests, likes and dislikes.

Back Up Strategy

In the event a community activity cannot be carried out, DT staff will offer preferred alternatives and assure that the activity is rescheduled. Agency has CILA/DT coverage plan to assure continued availability of staff supports. CILA Home Supervisor will assure completion of any activities assigned to QIDP in the case of a vacancy in that position.

25

CHOICE AND DECISION MAKING

What is the person's priority outcome/requirement in this area?

Joe relies on support from his family to make important decisions and wants to continue to make routine decisions that affect his daily life

Priorities/Strengths

- Strong family involvement

Ongoing Supports

1. QIDP will maintain regular contact with Joe's family.
2. Joe will maintain regular contact with his family with staff support.
3. Staff will support Joe to make safe and healthy decisions as documented under other priority areas.

Risk Factors

Joe does not always make safe and healthy decisions for himself. This risk is addressed through the supports offered to Joe in this area and the availability of 24-hour staff support.

Monitoring

QIDP will discuss choice and decision-making with Joe during monthly meetings and document any concerns/progress in monthly summary that will be shared with family and ISC.

Back Up Strategy

Joe has 24-hour staff support to assist him in making safe and healthy choices

26

FUTURE PLANS

What is the person's priority outcome/requirement in this area?

Joe would like to have a community job and live more independently at some point in the future, though he has no immediate plans to change his current living arrangement.

Priorities/Strengths

- Enjoys many aspects of his present life
- Good support network

Ongoing Supports

1. Agency supports described in other priority areas of the Implementation Strategy address Joe's priority in this area.

Risk Factors

No risk factors other than those already described in the Implementation Strategy exist in this area.

Monitoring

QIDP will inform family and ISC if Joe shares any significant information or new priorities in this area.

Back Up Strategy

Joe has access to 24-hour staff support to discuss any concerns or changes that arise in this area.

27

BALC SURVEY EXPECTATIONS FY18

- For individuals receiving Waiver services who have not participated in the PCP process, records will be reviewed according to current Rule 115 & 119 expectations.
- For individuals who have participated in the PCP process and where agencies have developed implementation strategies to support the individual, records/interviews, and processes will be reviewed according to Conflict of Interest Free Case Management expectations.
- CMS HCBS Settings expectations will be (re)assessed according to the agency's previously submitted Plan of Correction. If your agency was not required to submit a Plan of Correction, BALC will recertify compliance in the areas of: choice, privacy, visitors, residency agreements, access to community, access to food, employment options and supports, income management, freedom of movement within the home and community, mitigation of risks, etc.

28

BALC SURVEY EXPECTATIONS FY18 (CONTINUED)

- Background and Training Checks, Policy reviews, Environmental/Health/Safety Checks will continue. Consumer and Staff interviews will be more extensive for those who are operating under the Conflict of Interest Free Case Management process.
- It will be expected that policies will reflect any changes that were reported in the Plan of Correction submitted to the Division regarding the HCBS Setting Regulations, i.e. Residency Agreements, Visitor Policies, etc. Implementation of those policies will be assessed through program observations and individual interviews.
- New Tools and worksheets are in the process of final revision and will be released and published upon final approval.

29

BQM REVIEW EXPECTATIONS FY18

- Sample selection process remains the same for purposes of waiver performance measures
  - Representative sample chosen at random from each waiver
  - Visits to individuals in the sample
  - Review is focused on individual services rather than on specific agency activities
- No change in waiver performance measures at this time
  - Changes may occur later, after adult waiver renewal is approved
  - Notice to provider agencies prior to any changes in data to be gathered

30

BQM REVIEW EXPECTATIONS FY18 (CONTINUED)

- For persons who do not yet have a Personal Plan developed by the ISC (when BQM arrives):
  - Same review process and expectations as current year including:
    - Review of current ISP at the provider agency to confirm annual update, developed in accord with ISP checklist, signed by required parties within required time frames, strategies to address health and safety risks, support to access healthcare services, services delivered in scope/amount/duration/frequency documented in the plan.
    - Restrictive interventions and rights restrictions are properly addressed

31

BQM REVIEW EXPECTATIONS FY18 (CONTINUED)

- For persons who have a Personal Plan developed by the ISC (at the time BQM arrives):
  - Responsibility for meeting performance measures related to the plan will rest with the ISC
  - Restrictive intervention/rights review responsibilities will continue to rest with the service provide
- Discussion with guardian will continue for all persons in the sample without regard to type of plan (ISP or PP) present
- Level of Care Determination/Redetermination, annual rights notice, and monitoring by ISC will continue for all persons in the sample without regard to type of plan (ISP or PP) present

32

BQM VISITS WILL ALSO INCLUDE:

- Visits to CILA and DT sites used by those in the sample
- Consultation with provider and ISC staff to identify areas of concern/difficulty related to person centered planning and conflict of interest free case management transition.
  - Assistance provided, where needed and appropriate
  - Tracking of issues to identify needed systemic actions
- Currently no determination about whether NCI Survey will continue for adults receiving waiver services

33

FUTURE PLANS FOR BQM

- In-depth look at personal outcome measures and supports
- Focus groups with persons receiving services and staff to identify areas of organizational strengths and opportunities for improvement
- Assistance with quality improvement strategies
- Development of comprehensive ISC review tool
- Notice will be provided prior to implementation of any changes to processes or tools

34

FOLLOW UP QUESTIONS

- Licensure and Certification
  - Felicia Gray, BALC
  - Felicia.Gray@illinois.gov
- Home Based Service Changes
  - http://www.dhs.state.il.us/page.aspx?item=93376
  - Dave Adden, DDD BPDMA
  - Dave.Adden@illinois.gov
- All Other Questions
  - Jayma Bernhard Page, BQM
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35