DDAWNY Cost Savings and Administrative Efficiencies

The DDAWNY Board worked with representatives of its committees to brainstorm what has been learned and opportunities for service delivery post COVID-19. The following have been identified as areas where efficiencies and cost savings measures would benefit the people we support, families and OPWDD. These ideas come from people who work in many different service agencies and a broad spectrum of professions. These concepts do not necessarily reflect the views of DDAWNY or any individual agency. However, the Board believes that the execution of many of these suggestions would result in a more effective and cost-efficient operations and produce the desired outcomes for the people we serve.

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# General Services

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| **Problem** | **Anticipated Solution** |
| Having multiple types of day services creates an unnecessary over complication, requires multiple service enrollments and the drafting of different plans. The time of the day in part dictates the service being called something else. | Combine day habilitation, community habilitation and supplemental day habilitation into one service that allows staff to work with individuals without the restriction of day, time or location. |
| If someone is enrolled in site-based respite, they cannot get respite support outside that site, even when a person’s needs change for that day. | Continue flexibility in service authorization (which has been permitted during the pandemic) with the ability to provide in home respite for those who are approved for site-based and vice versa. Respite is respite. |
| Telehealth-People often need supports that are not face to face, such as a verbal check in, or complete an activity for a person, or cueing and prompting, etc. During this pandemic, providers were allowed to support people in this way and it was highly effective. In addition, there are other circumstances where doing something for a person is needed such as when someone is sick or injured, had a bad seizure and needs to rest, or just getting out of the hospital. | Allow for the continued billing of remote services and allowable activities on behalf of the person. Telephonic or telehealth services can provide "step-by-step" guidance over the phone or computer. This reduces costs, keeps people connected and some people prefer not having a face to face. |
| Providers are required to complete a number of non-billable activities. Staff are paid during the completion of these activities without a revenue source. | Billing for monthly summaries, intake and discharge paperwork as well as writing staff action plans should be permitted. |
| Billing rules are overly complicated for groups of people, requiring an adjustment of the billing code for how many people are present. | Eliminate different billing amounts for 1, 2, 3 people/individual in a group. |
| Currently billing is not allowed during the day for children. | Allow billing during school hours (as was allowed during the pandemic). Set specific situations where this is allowable (i.e.: child is sick and home from school, caregiver has to go to work, etc.) |
| The process to get a person approved for a service is a lengthy process and it can be several weeks before getting an approval at the state level. | A more streamlined process is needed and timeframes established for faster approvals. There are several individuals who have sat home waiting for approvals for over a year. |
| The approval time for DDP1’s is too long. | DDP1’s should be approved within 48 hours. |

# Residential

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| **Problem** | **Anticipated Solution** |
| CRO screenings are required to be done multiple times for the same person. This is inefficient, holds a bed open too long and wastes the time of the person served and their family. | Only require an agency to screen a person once. |
| CRO screenings are required to be done in person. | Allow initial screening to be done over the phone or over zoom. Often the house may not be a good fit for a certain person and taking the time to do an in person screening inefficient. There are some cases where a file review itself may identify the mismatch between a person and a certain house. |
| There are times when a person is unable to spend over $2000 because of an illness or other circumstances like quarantine. | Allow some flexibility for a person to go over the $2000 threshold when special circumstances exist. |

# Behavior

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| **Problem** | **Anticipated Solution** |
| There are differences in DQI expectations and the regulation 633.16 Fading of Restrictions. This varies between surveyors. Specifically, not being able to use extinction or zero as a fading criteria. Forensic plans and Risk Management Plans are difficult to fade and there should be other options. i.e., these should be based on the Risk Assessment. Fading is not always person centered – i.e., behaviors like elopement and a lack of safety awareness are difficult to fade especially with the zero criteria. For individuals with Dementia, Alzheimer’s, or other neurocognitive degeneration diseases, the limitations are for health and safety. But, fading criteria are still required even when this is likely to worsen over time and not improve. | Separate Guidelines for fading for Risk Management or Forensic Plans. Currently there is no guidance surrounding this. Or, although an extra level is not preferred, the ability to have a Psychologist deem that fading a restriction is counterproductive or a significant safety concern could work. |
| Medications are considered restrictive and needing HRC review. Medications often change and the plans go from needing HRC, a full FBA and BSP, to not needing it and back again. This is time consuming for HRCs and Behavior staff, the HRC has little input as it is a medication. | Remove the requirement that considers daily psychotropic medications from being considered restrictive interventions and remove the need for them: to be reviewed by Human Rights Committee, require a fading plan and reviewed by a Psychologist or LCSW. This would not include PRNs or IMs, these would still need to be reviewed. If they must be reviewed, allow Day Habs to utilize Human Rights Committee and informed consent information from a Residential Site and remove the requirement for a Psychologist/LCSW to review. |
| **Credentialing**  Requires a Psychologist or LCSW with experience but this field does not qualify with the department of education to be able to acquire the necessary hours to sit for an LCSW exam. You cannot get the experience needed in this field and get your LCSW, so either you have the LCSW or the experience in the field – those doing this work have their hands tied. Not having this available means we lose good clinical staff because they want to further their professional credentials. The same applies for the LMHC – our services do not count as acceptable clinical hours towards an LMHC license.  Example: A person with may have more than the years experiences required to review plans without a psychologist. However, he/she may have LMSW training but not be eligible to take the LCSW exam because their work is not considered “Clinical Work” by the Office of Professions. Therefore these individuals cannot obtain “hours of clinical practice” required to apply to sit for the exam. OPWDD is requiring such high level of degrees because they consider what we are doing to be “clinical work” and requiring a set of credentials you cannot obtain while working in this field. | Have OPWDD seek approval from the Department of the Professions to define the work done by a BIS as “clinical” and allow supervised hours to count towards the LCSW exam. Also allow our services to count as acceptable clinical hours for LMHC. |
| The degree requirements for a BIS are too strict and cause many agencies to have positions open for an extended period of time – most more than 1 year. Having two categories of BIS’ does not seem to be purposeful. There is no pay difference. Five years’ experience directly in the field is difficult to find. The requirements do not include degrees like the Masters in Developmental Disabilities, or Special Education Teachers who can be behavior specialists in educational settings. Both of these should be acceptable.  Example: One agency reported that they had a Behavior Technician who was working her way through Grad School. She graduated from Niagara University (NU) with a Masters in Developmental Disabilities. Even though she took an entire semester in functional analysis, OPWDD does not consider the degree to be “Clinical” in nature. NU even advertises this degree as a Segway to being a behavioral specialist. However, the agency could not hire her and ultimately lost her to the county. | The BIS II credentials should be the minimum credentials, regardless of the type of plan they are writing as the restrictive plans all require a Psychologist or LCSW approval. Expand the list of accepted professions for a BIS to include Development Disabilities Masters, Special Education Degrees, Masters of Education in Counseling (We have gotten permission for this degree but it’s not explicitly listed). |

# Employment Services

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| **Problem** | **Anticipated Solution** |
| Individuals with life goals of achieving employment enter into the system with the individual, family and care coordinator taking an educated guess as to where in the service delivery continuum the person will be best supported and are then approved for that one service. As assessment and discovery activities occur, the initial service may be too restrictive (site based prevocational services) or not supported enough (SEMP). The provider agency, individual, family and care coordinator have to go through the RSA process to make the necessary adjustment in services. This is a lengthy, time consuming process that often leaves individuals frustrated in being “stuck” somewhere or sitting back at home as they wait for approval and the entire process starts over again. | Intake and approval process should match the Life Goal of employment and should include the array of employment services from Pathway to SEMP allowing the individual to move quickly from training to employment when the work environment to meet their current needs becomes available. The IDT team would meet and develop the employment plan that may include a combination of employment services that will ensure a successful life goal. Removal of silos between employment services would allow the individual to move fluidly from Site or Community Base Prevoc to SEMP and back if needed if there is job loss and additional training is needed to address the cause of the job loss and then back to SEMP if corrected quickly without waiting for approvals. The pause during the transition hurts the individual’s ability to receive the supports and services they need, strains the agency, burdens employer and ultimately disrupts service. |
| There are multiple versions of employment assessments depending on the Medicaid service all measuring similar things. The multiple tools make it difficult to measure an individual’s progress as the move through the continuum of services. | Can one tool or a list of essential job skills that are critical to success in employment be developed and a uniform assessment across Pathway, S/CPV and SEMP be put in place. Can providers be invited to have input into the design of one assessment tool for all employment services? |
| For the true intention of CPV to be achieved the services needs to move away from day service requirements and mirror supported employment services regulations. | Bundle all employment services under one authorization (not billing code) and have the ADMs mirror each other. This will allow for fluid movement through the levels of support being offered. When CPV is treated as an extension of day habilitation, true employment outcomes (like working on a weekend or past 3pm) will be difficult to achieve. |
| The prescriptive nature of Pathways makes the service cumbersome to deliver and is too prescriptive and not person centered in delivery. Everything in Pathway can be accomplished through CPV in a more flexible manner that meets the needs of the individual. | Eliminate this service and role the resources into CPV. |
| Ratios for supervision in CPV that are not rooted in evidence-based practices should be re-examined. | Re-evaluate and be based on what supervision and support levels are needed for supported/competitive employment and provide that level of support to the individual. |
| ETP – forms are abundant, cumbersome and do not allow for the type of discovery needed for individuals going forward. | Web based, streamline assessment tool in a fillable format that can be stored in the cloud would be very beneficial to staff who are working remotely in the community. Staff will mostly likely not be returning to traditional office space for the near future. |

# Care Coordination

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| **Problem** | **Anticipated Solution** |
| **Life Plans:**  The Life Plan time frame to publish is restrictive. It is not enough time to appropriately update, get approved, and get signatures from individuals/representatives.  Currently, individuals can be enrolled in Care Coordination and have less than 60 (Basic)/90 (Health Home) days to complete a Life Plan because of the current rule that the Life Plan completion deadline can be the HCBS Waiver enrollment date even if that is earlier than the CCO enrollment date. This does not allow enough time to develop a quality Life Plan for the newly enrolled individual.  Non-responsive guardians and individuals who do not have advocates but are not able to consent are not able to appropriately publish a Life Plan without guidance that is backed up by regulation. | Would like 45 days extended to 60 days for publishing the Life Plan. This will allow more time for approval process.  CCO (Care Coordination Organization) enrollment should be the starting point for 60/90 for publishing a Life Plan. Therefore, the waiver service should not be the date the clock starts for the Life Plan.  The ability to publish life plan when we show due diligence if signatures are not able to be obtained. Our suggestion is:   * In the event that a legal guardian is non-responsive, due diligence to obtain the approval would suffice to still be able to publish the Life Plan within the time frames and CCO would continue trying to obtain the approval and/or revisit the appropriateness of guardianship. * For individuals that do not have the ability to understand and provide consent to their Life Plan, and do not have a representative, each CCO could develop a committee, or other method, to satisfy the informed consent for these Life Plans. |
| **CCO Enrollment**  Individuals are currently enrolled in HCBS Waiver Services without being enrolled in a CCO. This does not allow the individual to have the appropriate services in place to oversee their waiver enrollment. | Allow flexibility for the enrollment date of the CCO to coincide with the waiver enrollment date (i.e. allow CCO enrollment before first of the month if waiver service is needed earlier). |
| **Tier Consideration**  Many individuals who have very high needs never seem to be able to meet the requirements to become a higher tier due to the way the score is calculated. | OPWDD/DOH to provide a better understanding of how Tier scores are determined and revisit what factors should determine them. Want to be able to use a Person-Centered approach to determine which individuals have high needs and to be able to prove that some individuals need a higher or lower level of service. The comprehensive assessment should drive the level of tier rather than services the person is enrolled in. |
| **LCED**  LCED processes lend themselves to errors and slow down enrollments and completions. | The LCED (Level of Care determination) Transmittal in Choices does not serve a purpose other than administrative and lends itself to user error. The date of the LCED redetermination should be the completion date of the LCED form itself, and this is what should pull into the monthly CCO Roster. (If this is not possible to eliminate the transmittal, the transmittal should be more automated to assure that it cannot populate unless the LCED is completed and that the LCED Completion date is auto-populated.) (The DDP2 (Developmental Disabilities Profile 2) already does this appropriately.)  Initial LCED process includes a lot of unnecessary back and forth between the Care Coordinator and the DDRO office. It would reduce back and forth to have the Care Coordinator submit the completed LCED already signed by a qualified medical provider with appropriate documentation for final signature from the DDRO. |
| **Due Dates**  Due dates for multiple items are inconsistently applied and causes extra administrative work. | Use consistent due dates (i.e. currently we have 365 days for LCED, Life Plan 365 until the end of the month, DDP2 annual). Recommend defining “annually” and be consistent with various due dates. We would suggest 365 days and up to the end of the same month (i.e. if done 3/15/20, would be due by 3/31/21). |

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| **Training**  Care Coordinators are required to complete a large amount of training courses, however, the content is not always helpful and the times are not convenient. Families also take some training that is not always relevant and convenient for them. | Front Door Information Sessions and Self-Direction Information Sessions- should always be online that individuals/families can take anytime.  Information sessions for families should be geared to the service the person is looking for and sign up as electives. (Self-Direction, Transition, CRO etc.)  Change SLMS Benefits Training frequency: Take each section separately for initial time taking it, then reduced refresher thereafter.  Change SLMS Trainings to being available online to be taken at any time rather than in scheduled webinar format which disrupts peoples’ workdays and puts them at the mercy of when they are scheduled rather than when they need them. |

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| **OPWDD Documents and Processes**  There are many OPWDD processes and documents that exist outside of CHOICES, which has more potential to be the one system used for all OPWDD processes. | Reduction in Paperwork - can all attachments to referrals and applications be uploaded to Choices? Can referrals and applications (including but not limited to SARF, RSA, CRO, etc.) be made electronic, with electronic signature options a central access point or easily attached electronically to an application, utilize technology to make application.  Authorization processes consistent for any service (RSA/SARF/CRO) submitted on Choices. There should be some kind alert mechanism within Choices so the CC would not need to send an additional email to the CCO alert email. The system should have required fields that would not allow incomplete request to be submitted.  Could all the waiver documents be completed electronically in Choices? (I.e. RSA, SARF, Documentation of Choices, etc.)  Give the ability to apply for services for providers using CHOICES to accept referrals – this would make the process of applying to OPWDD services consistent from agency to agency and allow for less administrative time to send the same application to multiple places. This should include Self Directed Services which currently uses a completely separate process. |
| **Face to Face Requirements**  Some families find face to face visits cumbersome and not useful. | Person Centered approach to the frequency of face to face. Allow people to determine how often they should be seen. Tier 4 participants particularly feel the monthly face to face is inconvenient for them.  More flexibility of the use of technology for all face to face contacts – allow video conferencing to be counted as face to face in some circumstances such as when the family prefers it. |
| **Assessments**  There are too many different assessments which are burdensome for individuals and families, including but not limited to the DDP2, CAS (Coordinated Assessment System), and IAM. These are duplicative in many ways but also not comprehensive enough in others. | We would like one comprehensive assessment to replace all of the separate ones which includes all needed areas of assessment in one place, and we would like the CCO to administer this, meaning eliminate the current CAS process which is burdensome on all parties since CAS assessors cannot access the needed information themselves without needing to get it from the CCO and it is another assessment that individuals and families feel is time consuming, duplicative, and lacks in benefit. |
| **Signatures and Approvals**  There is currently no standard definition of Representative or Advocate. This causes issues with knowing who can sign the Life Plan and other documents on behalf of an individual who is not able to sign their own documents. In addition, there is no pool of advocates to pull from for people who do not have natural supports. | Provide a clear definition of representative and advocate. Develop a way that we can find representatives that are realistic and guidance on how to proceed if no representative or advocate is available and the person is not competent/does not have the ability. Model something like Willowbrook CAB. Would like to have defined acceptable signatures in order to publish life plans on time in these situations. |
| **Access to Services**  Agencies report to Care Managers that they have a difficult time accessing higher needs funding for residential and day habilitation for individuals who have high needs, therefore making it difficult to get services for the individuals who need it the most. | Make it easier for agencies to access higher funding for those individuals that are hardest to serve as an incentive to serve them. |
| Medicaid Recertification for people with permanent developmental disabilities expiring every year is cumbersome to individuals and families. Additionally, the resource limit for Medicaid eligibility is very low and has not changed in many years. | Medicaid Recertification could be extended to three years versus annually.  Resource limits have been $2,000 for a very long time and need to be increased. |
| **Addendums**  Agencies were allowed the ability to complete Covid-related addendums with only a verbal approval from the individual, documented by the provider and signature from the Care Manager. They were also allowed to begin a service before the addendum was completed and given 60 days to complete the addendum from the start of the service. Keeping this method for all addendums would allow individuals to start services more quickly. | |

# Training

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| **Problem** | **Anticipated Solution** |
| Requiring all portions SCIP-R and Medication administration to be done in person is not necessary.  **Medication Administration:**  The Medication Administration class requirements are inflexible, outdated, and too long. | Allow for the use of technologies such as virtual classrooms or other online formats instead of in person trainings.  1. The 32- hour time requirement should be reduced with most portions offered in an online setting.  2. Allow Agency Trainers to teach it as long as an RN is available to advise and answer questions. An RN would still oversee the content and implementation of the curriculum.  3. Medication Administration certification should be extended and valid for 2 years instead of 1. |
| **SCIP-R**  Instructor Trainers must be developed by state employed Master Trainers; who do not have the time or resources to adequately support voluntary agencies in this. In the SCIP manual, Master Trainers are only allowed to be employed by OPWDD. | That Master Trainers are developed within the voluntary provider system and not just those employed by OPWDD. Or, allow veteran Instructor Trainers to develop new Instructor Trainers. |
| Our local DDRO Master Trainer does not have the ability to sign off on decisions.  For example, a modified SCIP-R physical intervention has to be approved locally, and then sent to central office for approval. This is a waste of time and resources. | Allow decisions to be made by the Master Trainer, at the local level. Specifically; modified SCIP-R physical interventions. |
| Not all agencies need to have all staff certified in all levels of SCIP, include all the current components of CORE. | Remove the requirement to be certified in CORE, that each agency can certify staff in the interventions they require across Core, Specialized, and Restrictive. This would allow class time requirement be adjusted to reflect what is taught and be less than 3 days. Most agencies do not teach all of the intervention techniques and could teach the curriculum in a shorter amount of time ethically and responsibly. |
| The SCIP recertification written test needs to be done in person. This should not be necessary. | Allow for a blended learning approach, with portions of the class being completed electronically. |
| Recertification of SCIP-R physical interventions occurs annually. It is time consuming and too frequent. | Continue to require the completion of the lecture portion of SCIP to be completed annually (with an online option available), but the recertification of physical interventions to be done on a two year cycle, the same as CPR. |
| **CPR**  Recently the American Heart Association and American Red Cross came out with guidelines for compression only CPR. There may be circumstances where employees many not feel comfortable doing the mouth to mouth portion of CPR (i.e., when someone has COVID). | OPWDD issued guidance that if there are personal safety concerns related to giving mouth to mouth then the employee is permitted to use compression only. The concern is that doing this would currently result in an incident of neglect. |
| **Front Door and Self-Direction Information Sessions**  Front Door Information Sessions and Self-Direction Information Sessions are difficult for families to attend, inconvenient in person and families have to wait to get into classes.  Classes are also long and too detailed about many services families will never need and don’t care about. | Classes should be online and broken up into sections so that individuals/families can take information sessions when it’s convenient and only for those areas of interest.  Change SLMS Benefits Training frequency: Take each section separately for initial time taking it, then reduced refresher thereafter. Available online to be taken at any time rather than in scheduled webinar format which disrupts peoples’ workdays and puts them at the mercy of when they are scheduled rather than when they need them. |
| The SLMS Benefits Training structure is rigid and disruptive, with required webinar attendance inconsistent with actual refresher needs. | Develop an online training that can be taken anytime. |

# Human Resources

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| **Problem** | **Anticipated Solution** |
| Someone with years of OPWDD or I/DD experience cannot quality if they do not have the qualifying degree. | Allow experience in lieu of a degree – for example if someone has 20 years of OPWDD experience but no degree, there should be a way that they can qualify as QIDP without that degree. Would it be possible to create more options for receiving QIDP status – similar to BIS regulations – where you could offer something like a qualifying degree and 1 year experience working with people with disabilities OR no degree and 10+ years’ experience working with people with disabilities OR a non-qualifying degree and 10+ years’ experience working with people with disabilities. |
| A signature from someone who is QIDP is required for plans and the requirements are so specific that it is sometimes hard to hire someone who meets the criteria, resulting in being shorthanded with QIDP staff | Because the degree requirements are so strict, when jobs requiring QIDP status are open, it is hard to recruit people who meet all required criteria (Bachelor’s Degree or higher in specific areas and at least one year of experience working with people with disabilities). It would be ideal if we could allow people who don’t meet the experience criteria but have the degree to be hired and allowed to get the experience while working. This could allow us to recruit new graduates and students with a Bachelor’s Degree working toward another degree that don’t have work experience but want to work in the field. |
| The “acceptable” degree to quality is vague and there is little to no guidance on what degrees could count if they do not fit exact working in the regulations. | While the actual regulation outlines some information – there are many degrees not specifically listed that appear to quality but individual providers are expected to interpret the regulation for themselves. There is no one at the state or federal level willing to provide guidance. We could like to see a list of specific degrees areas accepted or something that explains more than “human services field (including but not limited to: sociology, special education, rehabilitation counseling and psychology). By saying “not limited to” it leaves this too vague. |
| The “acceptable degrees to quality does not allow for credit hours in lieu of the degree itself – so someone with a qualifying minor would not be eligible. | We would like to see a way that credit hours would be accepted if the person has the experience required for QIDP status. If someone has 60 hours of psychology courses be a degree in finance, why couldn’t they be eligible for QIDP status? Sixty credit hours is generally accepted as the required hours for an Associate’s Degree, so that should be sufficient to meet the education criteria. |
| **Training**  The same training are required to be repeated for all provides that an employee work for – even if they work for them simultaneously. | All providers require specific trainings per OPWDD regulations – things like training on intellectual disabilities, the Justice Center/abuse, DSP code of Conduct, safety/OSHA, and corporate compliance are required and even if someone works at 3 providers at once, they have to complete the trainings over and over – why couldn’t providers accept training from other provides versus having employees retake the same content over and over?  Couldn’t a standardized course be developed by OPWDD that all providers use in order to have employees take the training one time? Many of these trainings are also required annually – do they really need to be refreshed annually if the content has not changed? Could a test be given to assess knowledge before requiring someone to take it? |

# Quality Management and Compliance

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| **Problem** | **Anticipated Solution** |
| **Regulatory Oversight**  Providers are subject to multiple oversight/regulatory bodies which often overlap and cause extra work.  For example, After WSIR submission review of 149 by OPWDD. The final determination is made by the Justice Center yet there is this added layer of review by OPWDD before it is released to the Justice Center. This layer of review has created delays and a lot of follow-up. Often times this review generates questions that were already answered in the 149 so providers end up copying and pasting information already available in the 149 to OPWDD. | Providers are surveyed by DQI who monitors investigations/incidents, OPWDD IMU monitors incidents and investigations and the Justice Center does the same. A recommendation would be for the oversight bodies to speak to one another before offering feedback and/or requesting additional information. An example would be, once the Justice Center has processed the incident, IMU should defer to the Justice Center and not ask the provider for information. |
| **CAP Audit**  Justice Center completes CAP audits. They are not completed timely, often going back 18-24 months. | CAP audits are being requested for an incident that is well over one year old and providers must go back up to 18-24 months to re-open an incident, verify actions placed then and respond to the Justice Center, more timely reviews would be more efficient for providers.  Completion should occur within 6 months to one year of the investigation date. |
| **Regulatory Oversight**  Many oversight bodies monitoring for health and safety. For example: Disability Rights of NY, OPWDD DQI, MHLS, Attorney General’s Office and OPWDD. Complaints can be made to any oversight body and multiple can be looking at one concern if a compliant was made for one person but to multiple oversight bodies. | One entity who monitors for health and safety, whether that is with reviews, periodic check-in’s etc. Perhaps with I/DD organizations if a report is made to multiple oversight bodies, one body will pick up the compliant/concern and investigate, instead of multiple contacts from different oversight bodies. |
| **Incident Management Communication**  OPWDD issues letters of non-compliance from the IMU division to the Board of Directors and CEO without verifying the information with the agency first. | OPWDD IMU should reach out to provider as well as checking WISR prior to sending letter of non-compliance to ensure their information is accurate. The undue stress placed on a provider can be avoided by communicating with the Director of QM or designee to verify information prior to sending out standard letter of non-compliance. |
| **Auditing**  Agency review audits conducted by OPWDD are broad, time consuming and sometimes duplicative. | OPWDD should identify areas that can be reviewed remotely, i.e. IRMA (Incident Management) as opposed to printed files of investigations.  To provide some provider relief OPWDD could allow agencies that have CQL accreditation to submit their CQL report/findings in lieu of the requirement for the Agency Protocol. |
| **Background Checking**  Direct Support professionals and other employees often float from agency to agency and/or work for multiple providers, however background checks are requested to be conducted by each provider. | Providers would benefit from having a shared system where background checks could be stored. This depository would be a cost savings for most, given that employees often work for multiple providers or move from agency to agency. |
| **Investigations**  OPWDD IMU inserts themselves into incident/investigations conclusions prior to sending to the Justice Center for review. Revisions are at times made, then forwarded to the Justice Center, who then has additional recommendations. | Feedback from both IMU and the Justice Center should be shared at one time to avoid opening and closing an investigation multiple times. What occurs is the investigation must be returned to the investigator for revisions, revisions are made, then sent to Incident Review Committee, then placed in IRMA, weeks later the investigations is reopened for additional work by the investigator, IRC and re-enter into IRMA. |
| **Electronic Platforms**  There are multiple online systems that providers must manage to track and incident. For example: VPCR, IRMA, WSIR. The same information has to be entered into each of these applications, making it duplicative work for data entry. | If the VPCR, IRMA and WSIR were merged into one application it would prevent duplication of data entry and better communication to and from providers and oversight bodies (IMU and Justice Center). |
| **Incident/Investigation Status**  Process for obtaining statuses of Justice Center related information is a barrier. The Incident Compliance Officer and/or IMU is requesting status of closure of investigation but providers are often waiting on the Justice Center. The provider receives correspondence from IMU as to why an incident hasn’t been closed, but often times it’s held up with the Justice Center. | Perhaps with the syncing of applications, the Justice Center can place periodic updates on the status of their review so providers are not trying to track information down from the Justice Center to respond to an inquiry by IMU. Currently there no requirement to tell the provider agencies the findings, or provide investigations in a timely manner to providers. Without this information readily available we cannot provide adequate follow up. |
| **Communication**  Providers lack a contact person and/or liaison with the Office of General Counsel – Justice Center. Providers have questions as to determinations but are unable to resolve their questions/concerns without this intermediary.  Improved communication between OPWDD and the NYS Justice Center. Frequently guidance for one body is not aligned with the other. | The creation of an email box or phone number for the Office of General Counsel would be beneficial in order to understand why findings are determined, as well as to question/inquire on the Justice Center investigations and findings. There is currently no process to inquire how they came to their findings, we are asked to bring the investigation and/or LOD to Incident Review but there is no way to ask for additional information as to the findings. |
| **Safety Plan for Renovations**  Providers must receive prior approval from OPWDD/DQI for renovations at certified sites. | Providers understand the need to have a safety plan in place when major construction to the physical plant of a site is being made so that everyone is safe and accommodations are made but don’t see why prior approval is required. The regulation (635) where it indicates that if renovations impact building codes that notification is made to the DDSO and DQI before the work starts but it’s unclear where it indicates prior approval is required- only notification prior to work being done. It specifies major renovations however, providers have received follow-up from DQI for minor renovations as well. Clarity is needed. |
| **Investigatory Interviews**  Investigations require face to face interviews for incident investigations. | Requiring face to face interviews for incident investigations should be left to the discretion of the organization, based on the specifics of the incident. This would improve efficiency in completion, reduce mileage, and time spent on the incident from all parties. |

# Self-Direction

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| **Problem** | **Anticipated Solution** |
| We need a more simplified and efficient orientation process for Self-Direction. Too much information is being provided and its overload for attendees. | A simple training on “need to knows” about waiver programs and the role of the state but self-directed specific education should be hosted by FIs/Brokers (it would be great if this could happen when they are choosing their providers as orientation information can be 100% applicable) For example, the state gives you a 101 orientation, you pick Agency A as your FI and meet with them for a Self-Directed orientation where they review not only SD regulations/process but integrate their specific procedures like using Evero, their business office process, how to hire at Agency A, etc. These are the things families really need to know in order to successfully operate and advocate within a SD budget; however, they differ with each provider. OR- create a standard training that FIs must adhere to and allow providers to train on everything. |
| There are inconsistent timeframes for approvals (CNBAs and Start Up Budgets). | Have approvals occur at a local level. This would decrease the wait time. IDGS and OTPS categories should not require a CNBA. This would limit the amount of CNBAs and reserve this process for true budget changes. |
| Technology needs to be an option for service delivery, facilitation of meetings and allow for representation when face to face services cannot be rendered. | For families that have access to technology, services on behalf of or via telehealth should be considered and be reimbursable post COVID. These options should be allowable and be something that is integrated into their service model.  Brokers should be able to utilize technology for planning and meetings. Mileage is not reimbursable for Brokers and this would have many benefits for them including being able to accommodate more cases in rural areas and allow them more time to assist families.  For families that do not have access to technology (internet, printer, scanner, zoom etc.), the broker and FI should be able to act as a representative. For example, wet signatures are required on certain forms. If a family cannot print, sign and scan, the FI/Broker should be able to do it on behalf of the family (this could be an attestation/consent the state requires they sign during start up and renewed annually). |
| Lack of Brokers has forced many people to wait to begin in Self Directed. | There should be a timeframe in which, if a Broker is not chosen or available, the responsibilities then falls to the FI provider. For example, if someone is going Self Directed and has chosen an FI but has been waiting for a Broker for 90 days, they should be able launch the startup budget and the FI should be able to assume the Broker role. There is a clear regulation regarding conflict of interest, but if you do not have a broker the conflict is not present and there should be a “plan B” clause. |
| Budget Template is old/out of date | There are lines in the budget template that are no longer used (transportation). The template itself should be updated to reflect what is needed by FI and Broker and should not include lines that are discontinued/not utilized. |
| Billing of indirect time seems to be a more complicated process than it needs to for providers. | When an agency bills for indirect time, at the end of the day, it is just part of the rate for direct services. If the reason for separation is to distinguish hours used in each category, agency systems can provide reports to show the utilization that we could submit (quarterly, annually etc.).  Example: Right now Agency B is re-working its fringe to create a fringe pool. It has successfully estimated a lump sum % for fringe that includes indirect costs; however, when taking a look at the state guidance and hearing from liaisons, indirect cannot be included in and needs to stay separate. Why? |