Preliminary Recommendations
Adult Intellectual Disabilities Redesign Workgroup

Prepared by Valerie Bradley and Lilia Teninty
Human Services Research Institute (for the Technical Assistance Collaborative)

Introduction

The Intellectual Disability Redesign Workgroup has had 3 meetings to discuss key issues in the reform of services and supports outlined in Senate File 525. There will be two more meetings prior to the preparation of the draft report that will go to the Legislature. In the interests of time, the group facilitators have prepared a summary of the recommendations and specific policy proposals for review by the group. The recommendations are broken down into 3 categories:

- Eligibility, assessment, and resource allocation
- Outcome measurement
- Core Services

Eligibility, Assessment and Resource Allocation

1. There should be a standardized assessment tool for the measurement of the support needs of people with intellectual/developmental disabilities services for planning purposes as well as for resource allocation. One tool that should be explored is the Supports Intensity Scale (AAIDD) which is a valid, reliable and normed instrument that assesses an individual's strengths as well as their needs for supports. This tool is being used in several states around the country to determine appropriate funding levels and/or individualized budgets. At the direction of the Legislature, DHS should explore the implementation of this assessment and its use for resource allocation. Given the need for a group of trained interviewers to conduct the SIS, the Legislature should consider vesting the administration of the SIS with the newly created regions.

2. A statewide process for determining eligibility should be instituted to ensure that there is a standardized process across counties. Current eligibility templates – including that used for Level of Care for the waiver – should be streamlined and where possible, include compatible elements.

3. Over the next year, the state should explore and plan for the expansion within the intellectual disability waiver of current eligibility requirements to include individuals with a developmental disability. The state should also consider consolidating waivers with overlapping target groups including the Ill and Handicapped waiver, the brain injury waiver, and the intellectual disability waiver. In order to accomplish this, it will be necessary for DHS to determine: how many of the individuals with developmental disabilities being served with county funds would meet waiver level of care; what services and supports they would require, and what the potential cost would be. The Legislature should ensure that DHS staff have the information they need (i.e., an accurate count of individuals with developmental disabilities currently served at the county level).

   With respect to the consolidation of waivers, it will be necessary for DHS at the direction of the Legislature, to analyze the current service arrays in the 3 waivers, the utilization and costs associated with each waiver, and the level of care requirements in order to determine the feasibility of combining one of more of the 3 waivers. In fact Iowa currently has waivers that mix populations and eligibility thresholds. It should be noted that CMS is currently receiving comments on a new rule that would allow states to develop cross population waivers.

4. In order to determine who would meet the "developmental disabilities" eligibility requirement, the state should develop criteria that include clinical/diagnostic as well as functional status. With respect to clinical/diagnostic requirements, at a minimum, they should include cerebral palsy, epilepsy, and autism. Functional characteristics can be derived from the current federal definition or could be aligned with a standardized functional/support needs tool.

5. In order to continue the progress made as part of Money Follows the Person in moving individuals out of the resource centers as well as out of private ICFs/MR, it will be necessary to examine what has worked and what has not worked to ensure the sustainability of community placements. Specifically, there needs to be increased concentration on the expansion of crisis services for individuals with co-occurring conditions, medical issues, and behavior challenges. This should include early prevention of behavioral crises through the use of applied behavior analysis and positive behavior supports. In addition to availability of crisis services, the state should consider ways to increase provider capacity and competency and develop outcome measures/incentives that promote community placement and retention.

Outcome Measurement

1. Measurement and monitoring of the performance of services and supports should be premised to a significant degree on the achievement of positive outcomes for individuals and families. Current monitoring processes should be reviewed to ensure that what is being measured is consistent with these outcomes.

2. Data regarding the performance of providers, regions as well as the state ID system should be aggregated and reported and made public to stakeholders across the state. This should include information from the Iowa Participant Experience Survey, case management profiles, provider reviews, and incident management systems. This recommendation recognizes that the discovery processes noted do not necessarily cover all individuals with ID/DD in all settings but DHS should begin to work with the data that it currently has and plan for the expansion of performance data over the next few years. This work should be done in conjunction with the development of regional quality assurance functions. DHS should be allocated staff resources to build and maintain this capability.

3. DHS should also be allocated staff resources to review and analyze data across systems (Department of Inspections and Appeals, county, school, and DHS), identify trends, and develop quality improvement strategies. DHS should develop a quality improvement committee that looks at data across discovery processes to develop a holistic view of the performance of the system. This same capacity should be developed at the regional level.

4. In collaboration with the provider association, DHS should work to develop more standardized and consistent family and individual satisfaction surveys that are based on those surveys currently being circulated by individual providers. A standardized satisfaction survey should be based on the consolidated quality of life measures developed by the redesign workgroups.

Core Services

1. All services currently offered to people with Intellectual Disabilities should be included as Core Services. This recommendation was made out of concern that the Legislature may interpret not listing a current service as an indication funding can stop immediately.

2. The following new services were recommended to be added to the service array:

a. Crisis Prevention and Intervention [1]
b. Behavioral Intervention, and Positive Behavior Support Services [2]
c. Mental Health Outreach [3]
d. Services focused on treatment of co-occurring disabilities, both mental illness and substance abuse
e. Speech, Occupational and Physical Therapies needed for habilitation and therefore beyond the scope of rehabilitative criteria on the State Plan.
f. Housing supports – finding and funding
g. Tele-health capabilities
h. Peer to Peer support
i. Guardianship services – Public guardian or similar entity with due process protections for individual.[4]

3. The list of Core Services (current and newly recommended) should be "Community First", prioritized based upon the goals and outcomes established in Iowa's Olmstead Plan. Specifically, services that expand and support community integration should be encouraged and expanded (i.e. Supported Community Living, transition services, Supported Employment, etc.) and services that are institutionally based should be phased-down in a thoughtful manner (i.e. ICF/MR, sheltered workshops, etc.)

4. Case management should be conflict-free and include the following functions:
    a. Waiver eligibility determination and annual level of care redetermination process.
    b. Independent assessment of a persons' needs[5]
    c. Ongoing monitoring of service delivery
    d. Identification of risk and planning to mitigate risk
    e. Consumer directed service planning
    f. Ability to access and navigate both local and state resources

[1] We learned from IME that they are currently drafting regulations to add this as a service to the waiver based on the IPART model.
[2] IME is drafting regulations on this service as well. Additional information and examples of other states' service definitions and provider qualifications may be useful to them.
[3] The workgroup did not fully discuss this service. It was added upon learning the IME is drafting regulations to add it to the current waiver.
[4] The workgroup did not fully discuss this issue. Guardianships should be limited to the specific area of incapacity that places individual at risk, e.g., medical, financial, personal and the need for guardianship reviewed at least annually. Guardians should be required to submit annual reports of activity. Individuals should have input into who is appointed as legal decision maker and provided avenues for making complaints about a guardian.
[5] It was noted in discussion by the workgroup that assessment will need to be fully independent from other case management functions if the state moves to a resource allocation model (i.e. if the assessment is connected to the funding amount a person receives).

5. Recommendations for employment related services include:
    a. Job Development
    b. Supported Employment
    c. Prevocational – Time limited and focused on an employment related goal
    d. Sheltered work – This service should receive a low priority (comparable to institutional services) based on the goals in the state's current Olmstead plan.

Workforce

1. As part of Money Follows the Person, Iowa has made the College of Direct Support available to any provider planning on serving people coming out of the Resource Centers or other ICFs/MR. Currently, 44 providers are participating. (See Attachment A for an overview of the CDS pilot in Iowa.) Based on the positive outcomes, the state should make the College of Direct Support available for free to all ID/DD providers in the state. In order to implement the statewide curriculum, there would need to be three types of administrators: the state administrator as primary point of contact for learning management system issues; regional administrators who would likely want to monitor local providers' utilization; as well as administrators at the individual provider level who would assign modules to staff members and review their progress.

2. The state should require that every DSP demonstrate a level of competency in the core curricula (e.g., 80%). Additional modules should be made available for supervisors and DSPs responsible for specialized support (e.g., medical support, behavioral support, etc.).

3. The state should provide financial incentives for those providers that support staff to secure a voluntary certification from the National Alliance of Direct Support

4. In order to support the costs involved in training staff, the current rate reimbursement formula should be changed to allow providers to bill such costs as a direct expense rather than an indirect cost.

5. Each region should have staff available to provide positive behavior supports training and to mount crisis intervention and prevention response modeled on the IPART initiative.

6. Technical assistance – including peer to peer consultation – should be available to providers for such issues as crisis intervention, workshop conversion, etc.

7. There needs to be cross training for mental health professionals regarding the needs of people with co-occurring disabilities. There should also be training for primary care practitioners regarding the appropriate response to behavioral issues among people with ID/DD.

Attachment A: Overview of College of Direct Support Pilot Program in Iowa

College of Direct Support Pilot Program in Iowa

Through a federally-funded pilot program, Iowa has had access to the College of Direct Support (CDS) curriculum and learning management system since January 2009. A primary goal of this program is to build the capacity of Iowa's direct support workforce to provide home and community-based services by filling training gaps identified by community providers. Since the pilot program began, 44 providers have enrolled more than 1,500 learners in the system, who have completed 13,117 lessons for a total of 11,836 training hours.

The Iowa Medicaid Enterprise secured unlimited access to CDS for agencies and individuals participating in the State's Money Follows the Person (MFP) demonstration grant, which supports the transition of individuals from intermediate care facilities for individuals with intellectual disabilities to community settings of their choice. The pilot, which runs through June of 2014, promotes the success of the MFP program and the implementation of the State's Olmstead Plan.

The CDS web-based curriculum and learning management system is available 24 hours a day, seven days a week for learners to improve their skills in providing supports for people across disabilities. CDS courses, which are competency-based and align with a nationally accepted set of competency areas and statements, include more than 30 courses and 130 lessons created for frontline direct support workers, supervisors and managers, professional team members, and families and guardians. The CDS learning management system allows managers to create programs of study, assign courses and monitor the progress of their staff. The system's mentoring features, along with its robust data collection and reporting tools, allow the state administrator for the pilot program, and administrator's at individual provider sites, to assess the impact of training on their staff and develop best practices for CDS implementation in the state.

Courses and Best Practices

The wide variety of courses are available through CDS address the problem of the high rate of turnover in the field, and current and future direct service workforce shortages. Providers in Iowa have relied on this variety to develop different plans for rolling out the CDS training for their staff and establishing best practices for Iowa. Following are several examples of provider roll-out of CDS:

- A large urban provider in northeast Iowa rolled out the use of CDS from the top down. Program managers and supervisory staff completed the first phase of training, which included taking a series of courses designed specifically for frontline supervisors and managers. Next, supervisors participated in general courses, which will, in turn, be assigned to the frontline staff who report to them. The frontline staff assignments were chosen specifically for staff working with individuals with intellectual disabilities or brain injuries. In its second year of participation of the pilot, this provider has replaced old methods of training with the CDS online curriculum, and has begun using the system's administrative tools to measure cost effectiveness and staff growth.
- A large agency with provider sites located throughout the state has been involved in the CDS pilot since it began. All new hires complete the entire 7-lesson course on Positive Behavior Supports, and then follow a year-long, individually designed training program. This provider has also initiated an on-the-job mentoring program, using system tools such as gradable checklists and online discussion groups to assure staff are putting into practice what they learn online.
- A small provider in northwest Iowa began using CDS on for training new employees, replacing a limited portion of their orientation training. They have since expanded the use of CDS for their orientation training, and have also developed a training program for frontline managers, both incumbent staff and those new to the position. In addition, the provider recently polled their entire staff to find out which courses they thought would help them do their jobs better. These courses are being assigned as monthly in-service trainings.

In the third year of the pilot, Meredith Field of the Center for Disabilities and Development, who serves as state administrator for the pilot program, is compiling outcome data, including best practices in the use of curriculum and tools, cost effectiveness for providers and increased staff competency. She is also developing a webinar series for provider administrators for training and sharing best practices.

Plans for expanding the pilot program beyond those participating in MFP are also in the works. The Iowa Association of Community Providers will administer this expansion, which soon will allow access to many more providers in the state.