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| **A** | **CAPACITY AND QUALITY GOAL:** **All case managers have both the time and capacity to focus on relational aspects of supporting people with I/DD and their families; case managers are available, knowledgeable and responsive.** |
|  | **System Change Priority Objectives** |  | **State Strategies** |  | **Case Management Entity Strategies** |
| 1 | **Define the role and responsibilities of case managers in state policy, creating a reasonable level of complexity for the individual case manager. Focus should be on relationships with the people receiving supports and their families.** | a | Clarify and communicate a well-defined role for case managers, what they do and don’t do, alignment to values, and provide training and information on core responsibilities to case managers, families, and people receiving supports. | b | Create a more manageable job for case managers, with room to be available and responsive, so they can communicate with people receiving supports and families, be an expert on less information, and have time to share information with people in ways that ensure understanding and comprehension by all team members. |
| 2 |  |  |  | c | Improve case manager job satisfaction and reduce turnover through implementation of best practices in case management, reduced caseloads, and aligning case management responsibilities with the people doing the work (eg, “let social workers be social workers, and find other ways to get the administrative paperwork done.”) |
| 3 |  |  |  | d | Create a clear expectation and space in the job to be local community experts. Take clerical and non-meaningful work out of case managers’ responsibilities. |
| 4 | **Improve the ability of CMEs to efficiently and effectively help people receive quality services and supports, while also reducing health and safety risks.** | e | Clarify, articulate through policy and create clear expectations and authority for monitoring across service settings (including in-home and integrated community). Hold CMEs accountable to monitoring requirements and face-to-face meetings.  |  |  |
| 5 |  | f | Allow more flexibility in the requirements for contact methods and frequency of contact, based upon individual needs and preferences, while still adhering to federal minimum standards and ensuring health and safety.  |  |   |
| 6 |  | g | Standardize the collaboration process across CCOs and CMEs to improve responsiveness and coordination. |  |  |
| 7 |  | h | Improve process and establish specific timelines for approval of ancillary services and any service/rate exceptions that must be approved by state staff. Consider lower thresholds for what can be authorized/approved at the CME level in order to increase responsiveness, timeliness and reduce the time spent by case managers seeking state approval. | i | Establish local processes and resources to share expertise and assistance for case managers seeking state approval for authorizations and exceptions on behalf of the people they support. |
| 8 | **Improve the knowledge and skills of case management staff statewide.** | j | Further standardize case management training and qualifications across all case management entities. Build real-world understanding of person-centered thinking in life situations. Create competency-based qualifications requiring demonstration of skills and knowledge in I/DD supports, not just process and compliance, including vision and values, understanding self-determination, choice, person-centered thinking, to be demonstrated by all CMs on an ongoing basis (beyond current initial orientation requirements.) | k | Offer comprehensive education and training on vision and values, self-determination, choice, person-centeredness, etc. for case managers, families, and people receiving supports. |
| 9 | **Expand CME capacity by making additional resources available to assist case management entities.** | l | Establish shared regional “subject matter experts” with deep knowledge on certain subjects (eg housing, CCOs, education) to work across multiple CMEs in support of all case managers who can then access this specialty technical assistance as needed. | m | Build in time for systems navigation, opportunities for case managers to seek assistance on behalf of individual customers. |
|  |  | n | Create capacity in the system for professional experts in person-centered thinking and planning (not the case managers) to facilitate large or important planning meetings (eg, especially at key transition points) instead of relying upon the CM to both facilitate and participate. |  |  |
| 10 | **Expand capacity by moving some functions to support services, instead of being provided by case managers.** | o | Establish a new service offering self-direction counseling and training, assistance with PSW identification/recruitment and management, support for individuals as employer of record, and other supports brokering functions, as a distinct service separate from case management (and distinct from current responsibilities of the statewide fiscal intermediary). Make accessible and require participation in training for individuals and families working with PSWs. When families are paid providers, require training about accountability, self-determination, values, conflict-of-interest. | p | In order to address the day-to-day details and coordination needs of individuals receiving in-home and/or non-residential day/employment services, especially those who are working with support team members from multiple organizations and/or multiple PSWs, service definitions should be revised to incorporate the expectation that all team members collaborate and communicate about day-to-day coordination, scheduling and issues of importance to the person as needed. DSPs and PSWs should be paid for this time. The frequency and process should be determined by the person and their team, and may require engagement on a frequent (weekly, biweekly or monthly) basis. |
| 11 |  | q | Establish a new service offering “community guide” or “community connections” as a distinct service outside of case managers, providing individualized community resource development, assistance with accommodations in integrated community participation, peer-to-peer navigation support, facilitation in establishing personal circles of support, and/or assistance in engaging with local non-disability organizations. (eg “community developer” role that is similar to the idea of the “job developer”) |  |  |
| 12 | **Establish statewide consistency in caseloads to improve responsiveness and quality of case management services delivered.** | r | The state should set maximum caseload size(s) per individual case manager as state policy for all CMEs, based upon an analysis of differences in population needs (eg children vs adults, urban vs rural, residential vs in-home) and geographic differences. | s | Make CME caseload policy decisions transparent for stakeholders, with annual public reporting on per case manager caseloads for all CMEs, disaggregated by county and population (adults vs children, in-home vs residential.) |
| 13 |  | t | Explore the establishment of clear guidelines in CME contracts to ensure that case management entities have consistent policies and procedures to support 24/7 responsiveness for urgent needs that do not rise to the level of crisis or emergency, as well as meetings and engagement outside of “business hours.” State needs to consider this expectation when determining funding and resources available to support this level of responsiveness. |  |  |
| 14 |  | u | As part of ISP development, ensure that every individual has a meaningful back-up plan when primary supports and/or services may not be available.  |  |  |

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| **B** | **CHOICE AND ACCESS GOAL:** **All people receiving I/DD supports (including children and people choosing residential settings) have meaningful choices in selecting a quality case management entity and accessing case management services aligned with their needs and preferences – regardless of age, service type, geography or cultural/language needs.** |
|  | **System Change Priority Objectives** |  | **State Strategies** |  | **Case Management Entity Strategies** |
| 15 | **Change the case management structure to ensure multiple choices for case management organizations are available to each person in all areas of the state.** | v | Establish real choice by developing opportunities for additional entities to provide case management services (on a local/regional basis, not necessarily tied to county geography), and for existing CMEs to expand the populations they serve, so that every person has a choice of at least two quality CMEs regardless of the type of services a person receives.  |  |  |
|  |  | w | Eliminate the current restriction on case management choice based on the type of services a person receives, so that people do not have to change case management entities unless they choose to do so. Ensure that this occurs with thoughtful planning, stakeholder engagement and adequate transition and change management efforts. |  |  |
| 16 |  | x | Create a routine state-led stakeholder process to annually evaluate CME size, geographic catchment area, and population growth patterns, with the possibility of recommending CME structure refinements. Evaluate the CME landscape and make transparent adjustments, with full stakeholder involvement. |  |  |
| 17 |  | y | In support of self-determination and choice/control, ensure that every person receiving supports has the choice of at least one CME that maintains a governance structure comprised of a majority of people receiving supports and family members, providing opportunity to engage in monitoring quality and performance of the CME and helping to direct policy and program decisions. |  |  |
| 18 | **Establish clear requirements regarding choice of case manager and create processes to support this choice for every person.** | z | Require case management entities to offer meaningful and informed choice among available case managers and ensure adequate capacity within the system for people to exercise these options. | aa | Provide written information, website bios and/or “matching” events allowing people and families to learn about individual case managers and make informed choices. |
| 19 |  |  |  | ab | Establish and preserve long-term relationships between case managers and customers/families by allowing adequate time for relationship-building as part of case management, supporting choice among case managers, and prioritizing maintenance of existing relationships in policy and practice. |
| 20 | **Establish neutral enrollment process for choosing case management entity.** | ac | Create a separate, neutral, unbiased front door entity or structure responsible for supporting intake, eligibility and enrollment in case management that could be either a local regional entity or state agency staff. | ad | Provide a venue and/or process across local CMEs for prospective customers to engage in informed choice prior to referral for enrollment. |
| 21 |  | ae | Create clear guidance and definition for choice advising, education and support related to case management, and what makes a person or entity qualified to render choice counseling to select from service and CME options, and among case managers within the CME.  | af | ODDS to send annual written notification of CME options to individuals and their designated representatives, including contact information for each CME and a description of the process for requesting changes to CM or CME, including timelines people should expect to encounter.  |

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| **C** | **EQUITY GOAL:** **Diverse people with I/DD, including children and their families, receive equitable case management services that are culturally and linguistically responsive.** |
|  | **System Change Priority Objectives** |  | State Strategies |  | Case Management Entity Strategies |
| 22 | **Ensure that case managers working with families of children have different skills and tools than those who work with adults.**  | ag | Establish a comprehensive statewide planning process to design and establish a unique and knowledgeable case management infrastructure for all children with I/DD, age birth to 21 (to align with timing related to educational services and Medicaid EPSDT, and to avoid transition of CM at age 18) which may include consideration of incorporating CIIS case management. The planning process should consider all options. |  |  |
| 23 |  | ah | Establish unique qualifications, caseloads, and training requirements for children’s case management staff. |  |  |
| 24 |  | ai | Expand state requirements of children’s case management to more explicitly address the planning, coordination and delivery of I/DD services to children in collaboration with other children’s systems (early childhood, K-12 education, child care, pediatric care, etc.) in order to improve consistency, reduce redundancy, align service plans and address support needs and preferences in the context of the family. |  |  |
| 25 | **Ensure a system that addresses culture and language needs as a mainstream function.** | aj | Establish statewide/regional technical assistance structure, led and staffed by people from different cultures and backgrounds, including people who can provide content-knowledgeable and timely interpretation and translation services, as well as navigation support in collaboration with case managers. Responsibilities would include supporting CMEs so that individualized materials (such as person-centered plans) are available on the same timeframes and of the same quality as English documents, regardless of language. | ak | Develop additional capacity within the case management entities to be more culturally responsive to customers. |
| 26 |  | al | Make all important statewide information and materials available in multiple languages (not just upon request). | am | Make all important local information and materials available in multiple languages (not just upon request).  |
| 27 |  | an | Require both CMEs and contracted entities (eg PPL) to meet cultural and language needs as part of contracts. Include measures related to meeting these needs as part of oversight and monitoring. |  |  |

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| **D** | **PERSON-CENTEREDNESS GOAL:** **All people with I/DD and their families are able to access person-centered supports that truly reflect their needs, wants and choices, with assistance from case management entities well-versed in person-centered thinking and planning.** |
|  | **System Change Priority Objectives** |  | State Strategies |  | Case Management Entity Strategies |
| 28 | **Redesign the ISP process with a systemwide re-set on person-centered plan development, participation and engagement. *(currently in progress)*** | ao | Reconsider the structure, steps and sequencing of the elements of the ISP process (and supporting materials and forms) in order to re-focus on the person. Develop a process where teams understand that the person-centered plan belongs to, and should be driven by, the person receiving supports.  |  |  |
| 29 |  | ap | Ensure adequate time and capacity to engage in the actual person-centered planning and meeting processes. Make it about the person, not the paperwork and forms. |  |  |
| 30 | **Improve training and integration of person-centered practices.** | aq | Case managers should have flexible schedules and team processes that allow for non-business hour availability and a more customer-service oriented responsiveness (without expecting each case manager to work excessive hours.) | ar | Prioritize person-centered thinking and planning training for CME staff, and implement person-centered thinking as a priority across the CME. |
| 31 | **Align policy and rules to support person-centered practices.** | as | Review federal and state requirements for case management functions to reduce administrative burden and ensure that the focus is on the person and providing true person-centered supports. |  |  |

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| **E** | **INFORMATION/COMMUNICATION GOAL:** **People with I/DD and their families are able to easily find and understand the information they need about I/DD supports, and have access to flexible and efficient communication options that meet their needs.** |
|  | **System Change Priority Objectives** |  | State Strategies |  | Case Management Entity Strategies |
| 32 | **Increase easy access to information about services, supports, and community resources.** | at | Create an easy-to-read “Road Map and Guide to Understanding DD Supports” (including Case Management) targeted for people seeking supports and their families, available in multiple languages. | au | Offer training to individuals and families to learn to advocate for themselves and learn about what case management does (and does not do), including support for diverse family participation. |
| 33 |  | aw | Make available comprehensive information, accessible in multiple languages and formats, that describes the expectations for case managers, offers upfront information and systems mapping, and helps people and families understand the roles and responsibilities of CMEs. | ax | Increase access to information resources for individuals, families, providers and case managers through multiple venues and processes. |
| 34 |  | ay | Develop tools to provide consistent information about case management and supports, regardless of CME. Strategies include website(s), videos, handouts, required text/information to be provided when people and families are making choices about CMEs. | az | Diversify access points to information – strategically and planfully, to get information to people in many ways (not just reliant on the case manager.) |
| 35 |  | ba | Create ODDS-maintained agency provider list (searchable by service, geography and capacity including language and culture) to complement existing employment services website, residential provider capacity list, and homecare worker registry. Cross-link all provider capacity websites. Use geo-mapping to assess statewide provider capacities using enrolled provider lists to identify needs and gaps, make this information public. |  |  |
| 36 | **Improve quality, efficiency and flexibility in communication processes, records sharing and information flow across teams including people receiving supports and families.** | bb | Invest in a centralized case management and communications system that is person-centered, user-friendly and accessible, with state staff, case management, person/family, and provider permissions and portals. System should allow for privacy controls driven by the person receiving supports, and include access to records such as assessment data, person-centered plans and service authorizations; offer secure communications and HIPAA-compliant information-sharing across combinations of team members as needed and consented by person; create efficiencies in clerical and communications processes.  | bc | Improve communication between case managers and providers regarding access to resources, meeting needs, honoring preferences, addressing ISP goals and implementing supports to meet those goals. |
| 37 |  | bd | Untangle policy and privacy issues around people’s preferred communication methods to increase flexibility and efficiency, providing for better email, texting, calling options. Identify tools and processes that will more allow for more fluid and accessible ways to communicate and share information while still maintaining privacy and confidentiality. | be | With permission from the person or guardian, communicate with family members of people living in provider-controlled residential settings (group homes, foster care) about monitoring, follow up, update activities. Make this the default (opt-out) so families are “in the loop.” |
| 38 |  | bf | Reset outward-facing language to reflect our values, and move away from traditional medical/institutional terminology. Get rid of terms like “Attendant Care” in our everyday system vocabulary. Recommit to words like “Community Inclusion” and “Community Living,” and create new terms that accurately and simply describe what people are asking for from the services, and what we intend to deliver. |  |  |

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| **F** | **ENGAGEMENT GOAL:**  **Quality and accountability of community stakeholder participation in state system change and decision-making processes is supported consistently.** |
|  | **System Change Priority Objectives** |  | State Strategies |  | Case Management Entity Strategies |
| 39 | **Establish clear expectations for state workgroups to increase effective stakeholder engagement.** | bg | Create consistent standards for stakeholder workgroups established by ODDS (or their contractors) that articulate requirements related to scheduling with participants, provide publicly-available minutes or other forms of documentation of discussion and agreement points, and publicly communicate the final decisions, products and/or results of the workgroup effort. |  |  |
| 40 |  | bh | Establish guidelines and expectations for state stakeholder workgroups to make it clear what is needed for each member, and from each member, to fully engage them and their representative groups and to tap their expertise. |  |  |
| 41 |  | bi | Create equitable opportunity for people with disabilities and people from multicultural backgrounds to participate and contribute to workgroups, including people who may be dually-diagnosed with I/DD and mental health disabilities, who experience homelessness, addiction, multi-generational poverty and trauma. Increase use of technology to better cover all parts of the state. |  |  |

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| **G** | **PERFORMANCE, QUALITY AND RESOURCES:** **Case management performance and payment aligns with the goals of person-centeredness.**  |
|  | **System Change Priority Objectives** |  | State Strategies |  | Case Management Entity Strategies |
| 42 | **Increase accountability and consistency statewide.** | bj | Require that all CMEs hold direct contracts with the state; end subcontracting option for counties. |  |  |
| 43 | **Develop quality assurance and performance measurement processes that incentivize quality person-centered outcomes.** | bk | Measure person-centeredness and self-determination as part of performance and quality metrics. Find balance in the approach to measuring person-centeredness – “The more one has to document how person-centered a plan is, the less person-centered that plan inherently becomes.” | bl | Ensure that the person (and individuals important to the person) have a critical role in defining and ensuring quality as the person/family sees it.  |
| 44 |  | bm | Track more data and information at the state level, including case management choices made by individuals, and individual movements to ensure timely completion of choice implementation. |  |  |
| 45 |  | bn | Improve review process – reviews are often conducted by a team or outside party unfamiliar with the person and their family, without validating information through interviews or experience surveys. |  |  |
| 46 | **Ensure funding incentivizes person-centered, quality case management in an equitable manner for all people receiving supports.** | bo | Revisit how case management services are paid for by the state, with rates and a payment structure to support capacity, equity, quality and differences among people’s needs. | bp | Support a change in performance expectations of case managers, moving away from meeting targets based on number of encounters, towards outcomes as a more person-centered approach. |