

New York



FY2014 TTI PROJECT:

Design a model Self-Directed Care (SDC) for individuals with SMI under the Medicaid authority of NY's 1115 waiver.

KEY OUTCOMES:

Introduction:

New York State Office of Mental Health (OMH) was awarded a TTI grant to assist in the design of a participant-directed service option for individuals with serious mental illness (SMI). Funding provided through the TTI grant was used to design a model Self-Directed Care (SDC) for individuals with SMI under the Medicaid authority of NY's 1115 waiver. The goal of a self-direction program pilot is to design a program model that may be tested in multiple sites in the state and then be brought up to scale in a managed behavioral health delivery system.

The program model and outcome variables reflected current policy priorities of state health agencies to integrate healthcare toward a person-centered, rehabilitation-oriented system consistent with CMS' ACA and Triple Aim, and federal and state Olmstead requirements and initiatives. NYS implemented BH self-direction post-pilot phase through HCBS services in an 1115 waiver.

Design Objectives of Pilot:

1. Create a model that, when replicated, can be scaled-up for delivery to all persons in NYS who qualify for self-direction in a Health and Recovery Plan (HARP).
2. Increased tenure in meaningful community living.
3. Use of self-directed services for the duration of the pilot demonstrates measurable improvements in a participant's reported: quality of life; community engagement; and empowerment.

Program Overview:

Self-direction is a tool to promote self-determination and recovery. The self-direction pilot relies on the belief that individuals with a psychiatric diagnosis/ disability are capable of choosing and purchasing services and supports that facilitate recovery-oriented goals. The principles of self-determination that this pilot will adhere to are:

- Freedom to choose a meaningful life in the community
- Authority over a targeted amount of dollars

- Support to organize resources in ways that are life enhancing and meaningful to the individual with a disability
- Responsibility for the wise use of public dollars and recognition of the contribution individuals with disabilities can make to their communities.
- Confirmation of the important leadership role that individuals with disabilities and their families must play in a newly re-designed system and support for the self-advocacy movement.

People participating in the self-direction program pilot (hereafter “Participants”) were supported by individuals (hereafter “Support Brokers” or “Brokers”) who took an active role in helping the participant achieve the recovery-oriented goals collaboratively determined in a personal “Action Plan”. The action plan is person-centered and is designed by the participants with assistance from their chosen broker, and other supporters such as family members, friends, and/ or peers.

Services and supports outlined for use in the action plan must be in line with overall recovery goals; these goals will not necessarily be treatment oriented, and will likely reflect the psycho-social pursuits a participant chooses to enhance their empowerment, community inclusion, and self-determination. Participants may include allowable HCBS and non-treatment supports into their action plan.

Program sites where self-direction is administered in the pilot will have a relationship with two third-party administrators. One of the administrators will be an organizing and oversight body (hereafter “Self-direction Administrator” or “Administrator”) that assists in helping brokers determine appropriate services and supports as needed, mediates participant inquiries and disputes, and coordinates a self-direction peer advisory council that meets at least quarterly to review and update education materials and pilot processes. The extent of the role for this administrator, delineated in detail in this report, will be established concretely in further coordination with stakeholders. The second administrator will be one or two third-party budget authorities (hereafter “Fiscal Intermediary”) that approve and pays for the total budget allocated in individualized action plans.

Pilot Demographics: A participant may be any individual eligible for HARP services, or eligible based on prior utilization methodology based on Medicaid ID number. Participants will voluntarily engage in self-direction, and may opt-out of the pilot at any time. The pilot will accommodate any willing and eligible participant, including individuals with unique or restrictive environments. Pilot implementation will begin small and scale up over a period of two to three years. Two to four sites will be selected across the state for initial start-up.

Responsibilities of the Participant: Participation in the pilot will be subjective to the capabilities and goals of each participant. The minimum responsibilities of the participant in the pilot program are: The Participant understands that participation in the pilot is voluntary; agrees to work with a Support Broker chosen by the participant; and agrees to create and adhere to an Action Plan.

Responsibilities of the Support Broker: The Support Broker will work one-on-one with the Participant to define their action plan, a comprehensive self-assessment and goal identification plan. The action plan requires an in-depth, person-centered exploration of the Participants’ current state of physical and mental health, level of activity and work, and future needs, preferences, and goals. The action plan includes steps the Participant, with support from the broker, will work toward for the specific recovery goals outlined in the plan.

Services Eligible for Self-Direction: These include Employment Support Services; Educational Support Services; Family Support and Training; Peer Services; Transportation (non-medical); Psychosocial Rehabilitation; and CPST.

Self-Directed Budget and Budget Authority: The self-directed budget for each Participant must be developed in accordance with the overall goals of the pilot, and be developed in relation to the particular recovery goals in the Participant's Action Plan. The self-directed budget must contain enough money to pay for all eligible treatment and non-treatment goods and services in a Participant's Action Plan. The recovery goals in each Participant's Action Plan will be reviewed, at minimum, on a quarterly basis. Self-directed budgets will be assigned a monthly "capitation" amount that is added to a debit card administered by the Fiscal Intermediary, which is an entity that provides budget authority for the scope of the project. The Fiscal Intermediary will track purchases in accordance with the approved budget. Despite a flexible budgeting approach that can be tailored to a participant's needs, each participant should have the option to plan for long term goals and devise a budget accordingly. Additionally, any unused portion of funds in a Participant's Action Plan should be "rolled over" from month to month, with no devaluation of funds.

Broker and Participant Training: CPI will develop an overall strategy for training brokers with key stakeholder input into the training process. The training process will include largely be conducted remotely using a web-based application to minimize cost and enhance standardization. CPI hosts a learning management system (LMS) that stores online tools and electronic content that can be used at the convenience of the learner. In addition, the LMS has the capacity to track participation in all of the learning activities and get feedback from learners. CPI will also work with the program leadership to develop electronic tools to teach clients about the self-directed care program. This will be in the form of a brief (5-10 minute) orientation to the program and its principles.

SDC Evaluation Plan: The goal of the evaluation plan produced by faculty in the Department of Psychiatry at Columbia University is to inform decision makers for future broader implementation of SDC. The final scope of the evaluation plan will be dependent on the available resources. Specific Aims include comparing program participants' outcomes to outcomes of similar non-participants with respect to employment, housing, quality of life, hospitalization and ER use, behavioral health and other healthcare expenditures. We hypothesize that, relative to comparable non-participants, SDC participants will have improved health, functioning, and quality of life at no greater cost to the State. A specific methodology, set of analysis procedures, analytic plan, outcome domains, and analyses is available upon request.

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