



Developmental Disabilities Division

STRATEGIC PLAN

Fiscal Years 2015-2017

Department of Health
Developmental Disabilities Division
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Message from the Director of Health

Aloha,

Services for people with intellectual and developmental disabilities in Hawaii have progressed substantially over the years. Since the closure of the Waimano Training School and Hospital in 1999 and the deinstitutionalization of all programs, Hawaii has built a system where individuals live and receive all services exclusively in the community. The Department of Health stands firmly behind the Developmental Disabilities Division's mission of providing quality person-centered and family-focused services and supports that promote self-determination.

As the national agenda becomes increasingly rooted in supporting individuals with intellectual and developmental disabilities to live completely self-determined lives in the community, the Department of Health will leverage the advances in federal laws and regulations that give states additional incentives to help individuals who want to engage in vocational training, seek and maintain employment, and live independently within the community. This Strategic Plan provides a clear foundation for moving the DDD forward in supporting individuals to have healthy, safe, meaningful and self-determined lives.

Sincerely,



Linda Rosen, M.D., M.P.H.
Director of Health



Message from the Chief of the Developmental Disabilities Division

Greetings,

The work of creating this Strategic Plan has been a collaborative effort over the course of a year. It includes perspectives from the Division's staff and multiple stakeholders. On behalf of the Developmental Disabilities Division, I would like to thank all who participated in the Strategic Planning process including the many people across the state that were interviewed, were part of our focus groups, or attended the statewide stakeholder meeting on July 23, 2014 at the Japanese Cultural Center in Honolulu. Your input has been invaluable in shaping the vision, mission, and guiding principles as well as the goals and objectives of this plan. I am especially proud that in the course of developing the Strategic Plan, we took a hard look at our work, the challenges we face and our hopes for the future.

Special thanks to the Strategic Planning Steering Committee that worked throughout the past year to guide the development of a plan that will carry the Division forward in providing effective services and supports for individuals in Hawaii with intellectual and developmental disabilities. Most importantly, we thank the individuals and their families served by the Division, who are our inspiration and our greatest honor to serve.

Sincerely,



Jeffrey Okamoto, M.D.
Interim Division Chief



Section 1: Executive Summary

This Strategic Plan covers the three year period of fiscal years 2015 through 2017.

Section 2, *The Developmental Disabilities Division's (DDD) Strategic Plan*, provides a brief history of the DDD, previous and recent planning efforts, and what we hoped to address with this plan.

Section 3, *Vision, Mission Guiding Principles*, provides a framework for what DDD is working to achieve. A key intent is to guide the DDD's work to be in alignment with its mission, and communicate DDD's commitment across individuals, families and stakeholders.

Section 4, *Strengths, Challenges and Opportunities*, discusses planning considerations including challenges facing service systems, emerging service delivery models and mandates, and the status of Hawaii's core system functions. Collectively, this information helped to frame the key issues and strategic priorities identified by staff and stakeholders.

Section 5, *Goals and Objectives*, presents the five priority areas the DDD will address over the course of this Strategic Plan

Section 6, *Communication Plan*, was developed to ensure that everyone who has an investment and role in implementing the Strategic Plan is well-informed about its status and results.



Section 2: The Developmental Disabilities Division's (DDD) Strategic Plan

Background

Outside of those that work in the DDD system and advocacy community, few people know that Hawaii was the first state to include concepts of self-determination and a planning process that focuses on the individual with an intellectual or developmental disability (I/DD) in its statutes. The present statute, H.R.S. §333F-2, mandates the Department of Health to develop, lead, administer, coordinate, monitor, evaluate, and set direction for a comprehensive system of supports and services for persons with developmental or intellectual disabilities in Hawaii. It directs the DOH to provide assistance in the least restrictive, individually appropriate environment and to “provide available supports and services based on a client-centered plan, which resulted from client choices and decision-making that allowed and respected client self-determination.”

The history leading up to the current statute reveals that in just over a decade, Hawaii moved from laying a foundation for deinstitutionalization to clearly mandating a system of services in the community that is person-centered and ensures self-determination. In 1987, Act 341, which became codified as H.R.S. §333F was hailed as a landmark bill for the rights and needs of people with I/DD and set the intent for a community-based system. It also created a separate Developmental Disabilities Division in the DOH. An amendment to H.R.S. §333F (Act 189) in 1995 went beyond a policy intent and mandated the closure of the Waimano Training School and Hospital (WTSH) by 1998. WTSH operated at the Waimano site since its establishment in 1921. When WTSH eventually closed completely in 1999, Hawaii became the ninth state to completely shut down its publicly-operated institutions for individuals with an I/DD. Act 189 also clarified that the DOH would maximize its funds for community services as state matching funds through the Title XIX Medicaid waiver programs, paving the way to develop a wider array of services through the leverage of federal programs. DDD now provides the majority of its services through the Medicaid Home and Community-based Services Waiver through an array of services provided statewide, and case-managed by State employees.

A separate amendment to §333F (Act 133) was signed into law in 1998 and extended the deadline to close WTSH set by Act 189 for another year until June 30, 1999. It was also significant in that it codified the recognition of the principles of consumer choice for self-determination for individuals with an I/DD. Act 133 amended H.R.S. §333F to provide for consumer-directed services placing the individual at the forefront, stipulating that DOH will assist the individual to develop the individualized service plan (“ISP”) with the help of family and friends. DOH was also mandated to identify funds to implement the ISP, and “allow consumers to direct the expenditure of the identified funds.” The bill of rights in H.R.S. §333F was amended to include the rights of the individual with an I/DD to control an identified amount of dollars to accomplish their plan and to direct the provision of resources, both paid and unpaid, to live a life in the community rich in community association and contribution, to have a valued role in the community through employment, participation in community activities, and volunteering, including being accountable for spending public dollars in ways that are life enhancing.



The *Makin* Settlement in 2000 and the Hawaii Disabilities Rights Center (HDRC) Settlement in 2005 were significant in establishing timelines for waiver admissions and instrumental in Hawaii having no waiting list for services to eligible individuals. The court found that the State's Medicaid statute, with its population limits and resulting wait lists, failed to offer HCBS in the most integrated setting appropriate to individualized needs, which could force individuals with disabilities into institutions to receive needed services, in violation of the American Disabilities Act's integration mandate. In response the State agreed to provide appropriate and needed home and community services, use its best efforts to obtain appropriations from the Legislature and Federal approval from CMS, and develop a comprehensive plan with public participation to move the waitlist at a reasonable pace. The 2005 HDRC Settlement, pursuant to a filing that alleged the state was not in compliance with *Makin*, made new legal claims that the practice of "deferring" waitlisted individuals was occurring. The state agreed to remedies. Assuring consistent compliance with the terms of the settlements is a key commitment of the DDD, and the Division has worked to ensure integration of operational practices to assure timely access to necessary services.

DDD operates on premises of promoting self-determination, community involvement, employment and self-employment, consumer directed services, independent living, and self-advocacy for the people it serves.

Previous Strategic Planning in DDD

DDD's last Strategic Plan was written for the years 2001-2005. It was developed in response to Senate Concurrent Resolution which required the DDD to develop a statewide comprehensive strategic plan to set direction for the way services and supports were to be provided. It further asked for an assessment of the system, a vision and philosophy for the future and outcome-based measures to address provision of long-term care services, the waitlist for services, self-determination of individuals, and the maximization of finances. The intent was to satisfy the *Makin* lawsuit and the *Olmstead* Decision, both pressing issues for the State at that time. The Strategic Plan provided outcome statements, performance targets, and strategies across four areas: Self Determination, Long Term Supports and Services, Waitlist for Services, and Maximization of Finances.

Action Plans were developed in 2005 for the years 2006-2010. A challenge of the Division has been to manage and systematically implement strategies. This issue has been identified in the current plan. Successful implementation of the Strategic Plan for 2015-2017 will require leadership, management accountability and communications.

In 2012, the Division convened a discussion on strategic issues with stakeholders. The meeting resulted in the identification of key concerns and issues in the DDD system including: 1) information technology, 2) staff development and resources, 3) communication with and within DDD, 4) employment, 5) health and dental health, 6) housing, 7) quality assurance and 8) self-advocacy. These discussions helped to frame the identification of strategic issues upon which goals and objectives were developed for this Strategic Plan (Fiscal Year 2015-2017)



Strategic Plan (Fiscal Year 2015-2017)

The Strategic Planning process set out to address important organizational issues. Beginning in the summer of 2013, DDD began to engage in a deliberate decision-making process to define what is important to stakeholders, what change forces must be considered as DDD moves to refine its infrastructure and capacities, and what the Division needs to work on in order to provide quality effective services to individuals with intellectual and developmental disabilities (I/DD) in Hawaii. Overall, the Strategic Planning process began to set the direction for DDD and, through building a common understanding of its mission, vision, goals and guiding principles, provided a template for all staff and stakeholders to make decisions that will move the organization forward.

A Steering Committee was established in the summer of 2013 to begin the work of developing a consensus-based process to develop a strategic plan. The Steering Committee was made up of Division staff, a self-advocate, a family member, a member of the Developmental Disabilities Council, and was supported through staffing from the Behavioral Health Administration. It developed a planning framework and agreements about the process including it should be flexible, participatory and continuous, and would develop consensus across stakeholders about goals, objectives and actions to achieve goals. The Steering Committee also adopted a communication plan addressed at ensuring communication about the planning process and iterative development of products with staff and stakeholders.

A detailed Action Plan will be developed and distributed that will add specific implementation strategies, accountability and timelines to the Goals and Objectives of this Strategic Plan. As well, separate plans will be developed for the Hospital/Dental Branch and the Neurotrauma program because of the need for strategies that are linked to this plan, but have enough detail to address the unique functions of these programs.



Section 3: Mission, Vision and Guiding Principles

DDD's mission, vision and guiding principles were developed over a period of one year. This lengthy but important process allowed for obtaining broad staff and community feedback across the state, and reflects a shared understanding of the Division's purpose, goals and underlying principles to guide its work moving into the future. It also demonstrates DDD's commitment to person-centered work, self-determination and community integration for people with intellectual and developmental disabilities.

DDD's mission, vision and guiding principles are:

Mission

Foster partnerships and provide quality person-centered and family-focused services and supports that promote self-determination.

Vision

Individuals with intellectual and developmental disabilities have healthy, safe, meaningful and self-determined lives

Guiding Principles

Individuals:

1. Are treated with respect and dignity;
2. Make their own choices;
3. Participate in the community;
4. Have opportunities to realize their goals including economic self-sufficiency;
5. Achieve positive outcomes through individualized services and natural supports; and
6. Are empowered to live self-determined lives.



The word family is used in the mission. Based on a suggestion from a family member, DDD is applying the following Definition of Family to its mission:

“We all come from families. Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. As family members, we nurture, protect, and influence each other. Families are dynamic and are cultures unto themselves, with different values and unique ways of realizing dreams. Together, our families become the source of our rich cultural heritage and spiritual diversity. Each family has strengths and qualities that flow from individual members and the family as a unit. Our families create neighborhoods, communities, states, and nations.” - *Definition of Family developed & adapted by New Mexico Legislative Young Children's Continuum & Coalition for Children*



Section 4: Strengths, Challenges and Opportunities

Planning Considerations

Individuals with intellectual and developmental disabilities (I/DD) often have complex needs that require a variety of services and supports in a range of settings that help them live self-determined lives in their communities. Nationally, primarily influenced by litigation, the Olmstead decision, and the Americans with Disabilities Act, the service delivery system for people with I/DD has increasingly moved to a home- and community-based services model. Far fewer people with I/DD live in institutions or congregate care settings.

The DDD, like systems across the United States, needs to respond to the rapidly changing landscape tied to operating a publicly-funded system of care. Providing services fully in the community is work that requires continuous refinement in order to ensure timely access to an effective array of services, coordinating care, ensuring quality oversight, and managing costs.

The 1915(c) Home and Community Based Services waiver which funds the bulk of DDD's services has a growing emphasis on quality and mandates for achieving full community integration for individuals receiving services and supports. Aligning the service system and quality assurances required by the waiver is a core requirement for DDD, requiring significant administrative resources and a continuous oversight and quality management program.

Challenges Facing Publicly Funded Service Systems

The paper Trends and Challenges in Publicly-Financed Care for Individuals with Intellectual and Developmental Disabilities published in 2012 outlines a number of important issues facing service delivery systems including:

- The rebalancing of the I/DD system of care toward a greater reliance on home- and community-based services;
- The community-based services and supports offered through most state waiver programs for persons with I/DD;
- The evolving role of the case manager;
- The evolving role of direct-service workers and independent providers, including paid family members;
- Allocation of resources;
- Transition from school to adult systems of care;
- Meaningful day activities and integrated employment;
- The challenge of caring for older adults with I/DD and their caregivers; and
- Quality oversight and community integration.

Olmstead Ruling

In 1999, the United States Supreme Court held in *Olmstead v. L.C.* a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. Specifically



the ruling said that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act (ADA). The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Olmstead continues to play a major role in shaping public policy that ensures self-determination. In 2009, the Civil Rights Division of the Department of Justice launched an aggressive effort to enforce the Supreme Court's decision in *Olmstead v. L.C.*, President Obama issued a proclamation launch the "Year of Community Living," and directed the Administration to redouble enforcement efforts. The Civil Rights Division has responded by working with state and local government officials, disability rights groups and attorneys around the country, and with representatives of the Department of Health and Human Services, to fashion an effective, nationwide program to enforce the integration mandate of the Department's regulation implementing Title II of the ADA.

New Models of Service Delivery

In 2013, the Center for Health Care Strategies released a policy brief about structuring new service delivery models for individual with I/DD, including models that have the potential to improve quality, resource allocation, integration of services, and cost-effectiveness. The policy brief asserted that innovations should be guided by principles of ensuring individuals and their families:

- *Access* to services and supports they need,
- *Choice*, including where they live and who provides services,
- *Outcomes*, including having systems that support achieving outcomes they desire,
- *Integration*, including service delivery that is integrated and coordinated to align programs and funding sources, and
- *Value* that is demonstrated to consumers as well as purchasers of services. This includes having comprehensive data collection and quality measurement.

The policy brief further described core structural elements that new models should address that include:

1. Coordinated array of services and supports: Integrating primary and acute medical care needs, behavioral health needs, and long-term services and supports, e.g., habilitation.



2. Stakeholder engagement: Incorporating the input of stakeholders in designing and managing these new models.
3. Support networks: Acknowledging individuals' support networks and incorporating those networks into life planning and resource allocation decisions. Models should adapt to changes in support networks over time, especially given the concern about aging caregivers as people with I/DD live longer.
4. Existing provider infrastructure: Incorporating a network design that includes critical providers, so that longstanding relationships between individuals with I/DD and their providers are not disrupted.
5. Financial alignment: Integrating available funding streams (Medicaid, Medicare, and state-funded services) and realigning incentives for improved quality. Savings generated should be reinvested to expand provider access and decrease waiting lists.
6. Risk assessment and resource allocation: Incorporating a standardized, comprehensive risk assessment for all individuals. Information from the assessment should be used to develop person-centered life plans that reflect the goals and strengths of people with I/DD and their circles of support. Periodic reassessments should guide – and adjust as necessary – resource allocation and the ratio of care managers to enrollees.
7. Performance measurement: Including measures of access, care coordination/transitions, member satisfaction, quality of life, and other key outcomes across a range of services and supports. To the extent permitted by federal regulations, performance data should be made available to the public.
8. IT infrastructure: Using information technology to collect real-time data on risk assessments, service needs, and service utilization, and sharing it with providers and care managers as well as individuals with I/DD and their representatives. Information technology systems should also be capable of collecting data needed for performance measurement.
9. Reimbursement rates: Structuring reimbursement rates to encourage providers to serve more people with I/DD and spend adequate time to address often complex needs. Systems should transition away from fee-for-service payments toward payments based on episodes of care, risk-based arrangements, or pay-for-performance models. In addition, the capitation rate for long-term services and supports should be adequate to ensure access to the appropriate amount, duration, and scope of services.
10. Life-long planning: Acknowledging the life-long needs of persons with I/DD. Programs must provide stable and coordinated transitions from school to employment and facilitate movement to independent living arrangements. Models must address the changing needs for services as both people with I/DD and their caregivers age, including meeting the urgent need for residential services when caregivers become incapacitated.

Hawaii Leads in Many Area; Has Room for Improvement in Others

Currently, fourteen states including Hawaii no longer operate an I/DD institution. The last state institution in the United States is projected to close within the next two decades. While many states continue to struggle to deinstitutionalize care for people with I/DD, Hawaii completely



closed its single state institution at Waimano in 1999 and developed a system that services and supports fully in the community. Hawaii is one of nine states reporting no waiting list for home and community based services, while other states would have to increase capacity by 16.6% to meet their current demand. It is among the states that have made the shift to smaller more personalized living settings, and relies primarily on integrated living options. Currently, 99% of people served by DDD live in residences serving 1-6 people and 61% in settings where 1-3 people live. Hawaii ranks in the top quartile of states in supporting individuals in family homes. It operates entirely on a community-centered service philosophy & practices which was codified in §333-F.

The recent report, *The Case for Inclusion* issued by United Cerebral Palsy ranks how states' Medicaid programs measure up in areas including how many individuals with I/DD are supported in the community, how many participate in competitive employment and family support services and how states are doing helping those in need, including serving those languishing on waiting lists. Overall, Hawaii ranked third in the nation across these indicators. However in the area of employment, Hawaii ranked last among the states in the category of Promoting Productivity with only 13.5% of individuals in supported or competitive employment. Hawaii also has a low overall fiscal effort for its I/DD services compared to other states. In 2011, Hawaii was ranked 34th among the states in its expenditures on services which was 26% below the national median.

The Centers for Medicare and Medicaid Services (CMS) Community Integration Rule

In March 2014, CMS finalized a new rule for Home and Community-Based Services (HCBS). This rule pertains specifically to Hawaii's waiver for intellectual and developmental disabilities. It describes the characteristics of settings that are considered to be home and community-based and establishes requirements applicable to person-centered planning. This new rule dramatically shifts the emphasis to the nature and quality of the beneficiary's experience and his or her desired outcomes. The expectation from CMS is that people receiving HCBS waiver services will be able to receive services in their community to the same degree as people who do not receive Medicaid services. All settings where home and community-based services are provided must be integrated in and support full access to the benefits of community living, including the ability to seek employment and work in integrated competitive settings; be selected by the individual from among available options; ensure individual rights; optimize autonomy & independence to make life choices; and facilitate the person's choices of services and who provides them.

CMS placed additional requirements in settings where the provider owns or controls the setting. People receiving HCBS must be afforded:

- A lease or other agreement with protections against eviction as other citizens of the state;
- Privacy in their place of residence;
- Control over their schedule and unrestricted access to food;
- The right to have visitors at any time; and
- A physically accessible living environment



Any modifications to these requirements must be included in the individual's service plan, developed through a person-centered planning process, and meeting all the additional documentation requirements set forth by CMS.

The rule applies to all Medicaid HCBS provided in both residential and daytime settings. Each state must assess current HCBS settings and prepare a statewide transition plan to bring settings into compliance if they do not currently meet the new requirements.

- Each state must submit its statewide transition plan no later than March 17, 2015, following a mandatory 30-day public comment period;
- Upon approval by CMS, the state may be granted up to four years to fully implement the plan, with all states required to be in full compliance no later than March 17, 2019.

Employment

DDD has long supported that each person has the ability to contribute to his or her community in meaningful ways - to be employed, to rent or own a home, and to be involved in the lives of others. However, as previously discussed, Hawaii's employment outcomes for people with I/DD lag behind the rest of the nation. The 2012 American Community Survey report found a low percentage of employment participation for people with a cognitive disability ages 16-64 (18.1% vs. national average of 22.5%). Of the 2,188 individuals served by the DDD in 2012, only 2% were served in integrated employment.

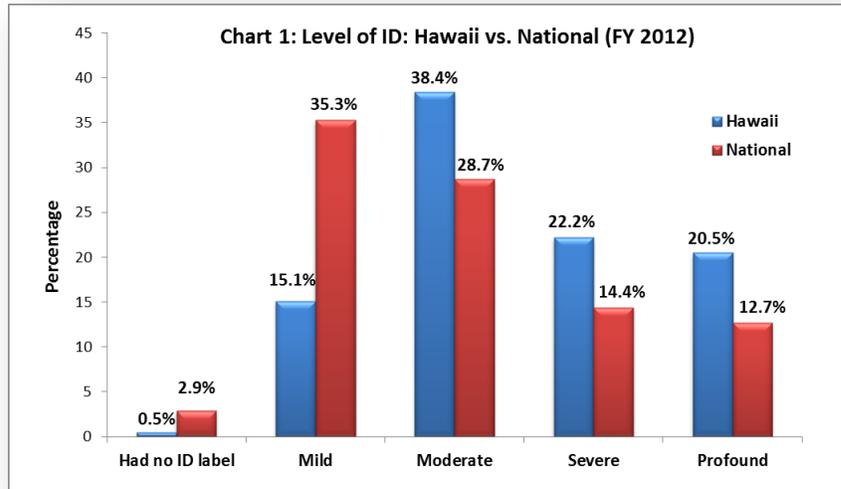
National Core Indicators (NCI) Findings

The NCI assess the outcomes of services provided to individuals with I/DD. State Developmental Disabilities Programs voluntarily contribute data to measure and track performance amongst states in the nation. Currently 39 states, including Hawaii, participate in the NCI assessment. The purpose of the NCI program is to support the National Association of State Directors of Developmental Disabilities Services (NASDDDS) member agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time, to compare results across states, and to establish national benchmarks." The NCI is an integral for many states' quality management systems and is aligned with basic requirements for assuring quality in HCBS waivers.

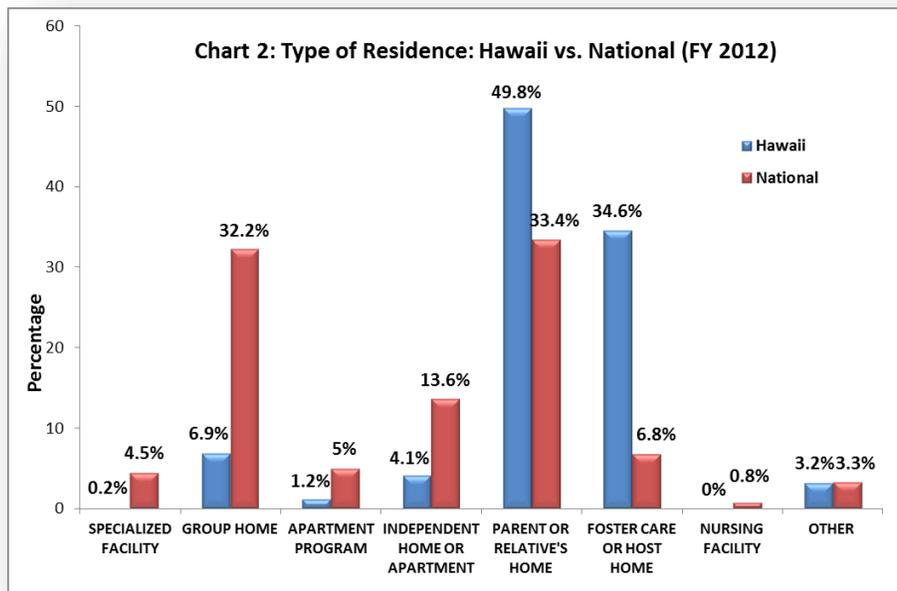


The results of Hawaii’s most recent NCI show:

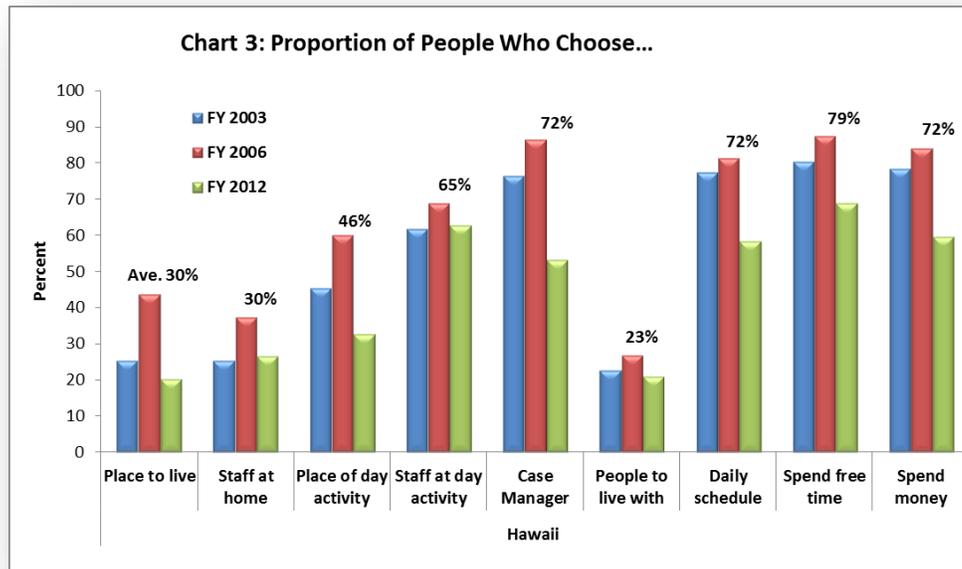
- Since Fiscal Year 2002, the first year Hawaii participated in the NCI, results show that Hawaii has more people in the “Moderate” I/DD category than the national sample which has more people in the “Mild” I/DD level (Chart 1: Level of I/DD)



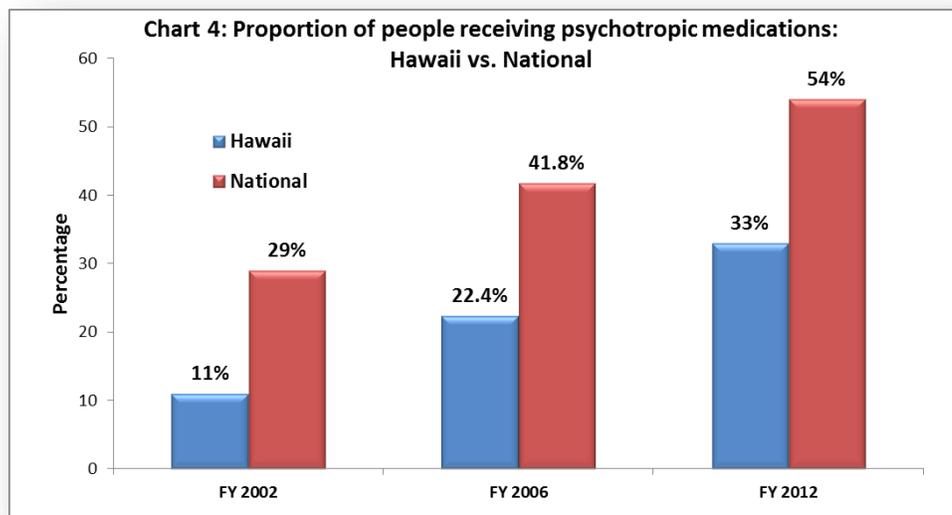
- Most of Hawaii DDD participants, and far more than the national sample, live with their family or in foster homes. Nationally far more people than in Hawaii live in specialized facilities, group homes, apartment programs, and independently. (Chart 2: Type of Residence)



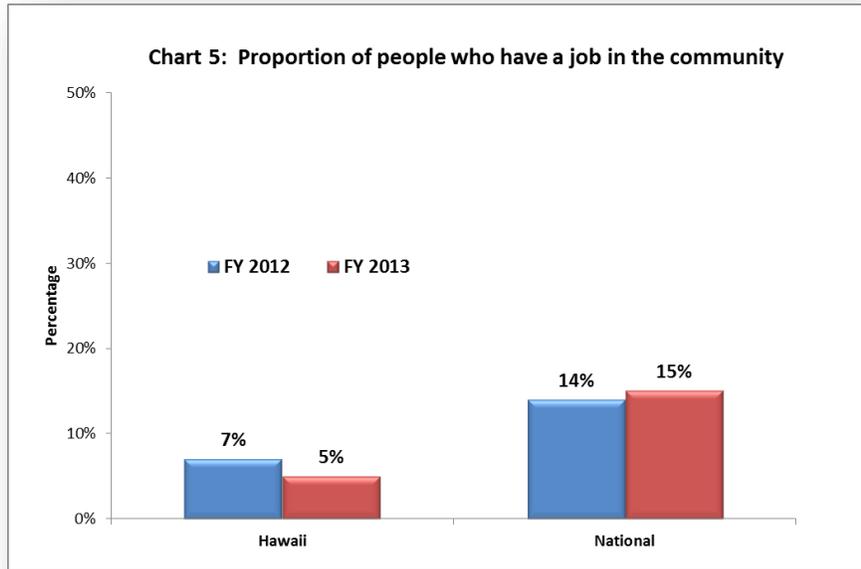
- Between FY2006 and FY2012, there was a decline in the proportion of people who had choices across all categories. Relatively smaller proportions of people had choices in the place to live, staff at their home, and people to live with. More people felt they chose their case manager, their daily schedules, how they spent their free time, and how they spend their money. (Chart 3: Proportion of People who Choose...)



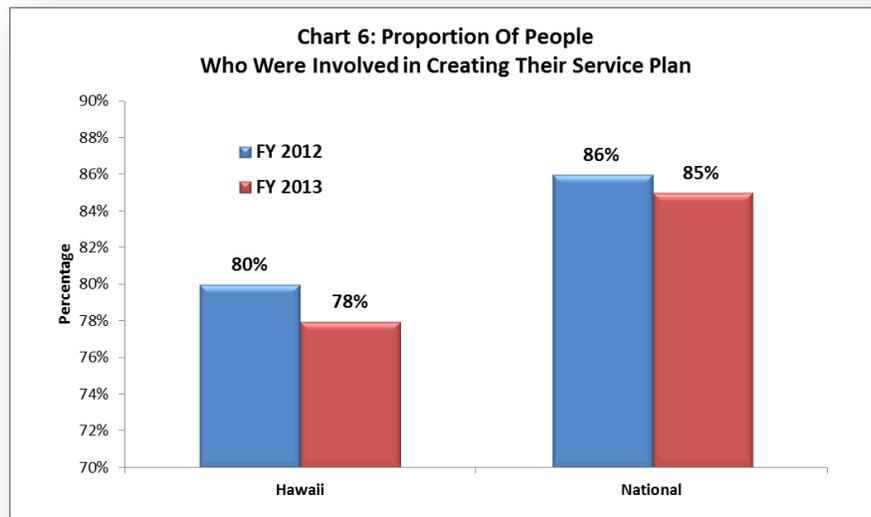
- Hawaii had far fewer people than the national sample who received psychotropic medications to address mood or anxiety. There has been a growing trend in the prescribing of psychotropic medication both in Hawaii and in the national sample. (Chart 4: Proportion of People Receiving Psychotropic Medications)



- Hawaii lags behind the rest of the nation in the proportion of people with I/DD who have a job in the community. In the most recent survey, only 5% of individuals in DDD had a job in the community. While the national data showed a slight increase between FY2012 and FY2013, Hawaii's results declined. (Chart 5: Proportion of People who Have a Job in the Community)



- A lower proportion of people in Hawaii than in the national sample were involved in creating their service plans. The percentage declined slightly in both the Hawaii and national sample between FY2012 and FY3013. (Chart 6: Proportion of People who were Involved in Creating Their Service Plan.)

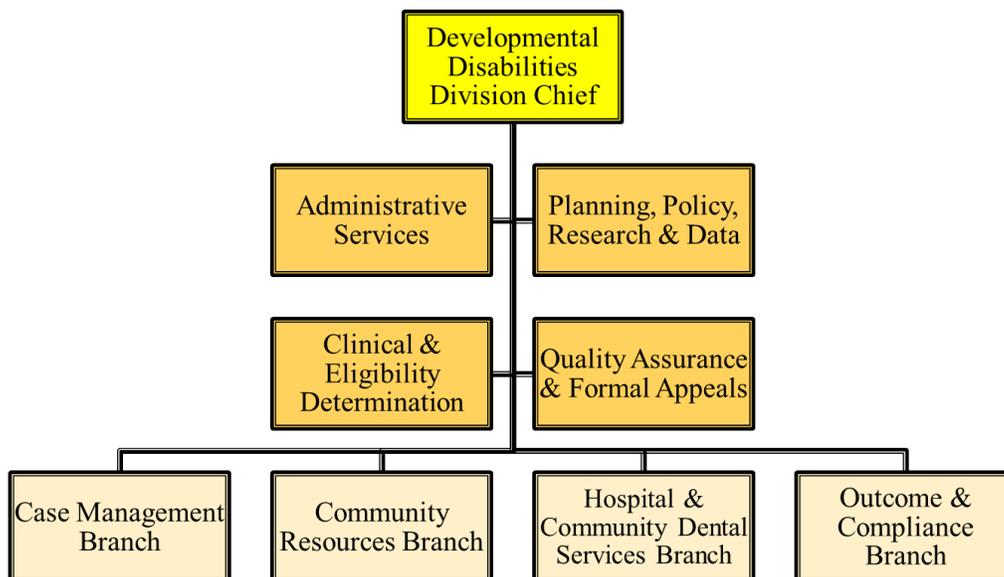


Reorganization

DDD is currently implementing a reorganization of its Division that was approved in December 2011. The reorganization is designed to allow DDD to optimally administer the statewide comprehensive system of services for persons with I/DD and promote self-determination and quality of life based on the principles of person-centered planning

The DDD reorganization includes the addition of two branches: the Community Resource Branch (CRB) established to develop and monitor resources to assure access of services and supports for individuals with I/DD and neurotrauma, and the Hospital & Community Dental Services (HCDSB) Branch established to oversee oral health programs for vulnerable populations including those with disabilities. It also established the Clinical & Eligibility Determination Services (CEDS) unit and the Planning, Policy, Research & Data (PPRD) unit, and added a compliance officer position to oversee Quality Assurance & Formal Appeals. The CEDS unit is responsible for the statewide centralized eligibility determination and redetermination processes and serves as a resource on clinical issues for the division. The PPRD unit manages policy, research, planning, legislation, and regulations pertaining to DDD. The Case Management Branch (CMB) was retained to operate the statewide case management system. The Outcomes and Compliance Branch (OCB), formerly the Disability Supports Branch, expanded its functions to monitor and evaluate program and participant outcomes, promote national best practices, ensure quality of care, oversee certifications of adult foster homes and manage consumer concerns.

The reorganized structure of the DDD is displayed below:



Interviews with Staff and Stakeholders

Over a hundred people across the state were interviewed or attended focus groups to help us gain understanding and deeper insight into the perspectives of people that work in and interact with the services system. These insights helped to identify the strategic priorities that the DDD should address over the next several years.

Insights and perspectives for the various role groups interviewed are displayed below:

Role	Needs	Insight
Adult Foster Home Certifier	To have Certifiers' role better understood and have systematic communication with case managers and ISP Teams	This rich resource is underutilized and needs to be better understood
Advocate	Know that decisions about services are timely, transparent and fair	A lack of standards and consistency means decisions can be unfair; there are inadequate resources to address system infrastructure
Branch Chief	Work in an organization with improved organization, management of workflow and accountability	DDD can improve through improved management and accountability
Caregiver	To feel supported	Caregivers are partners in providing care; they care about the individuals that live with them
Case managers	To have the organization understand and address system issues	Need for organizational support to provide effective case management services
Clinical Intervention Team	To have a clearly defined role statewide that all staff understand	Frustrated and disempowered to make decisions
Leader	Have a leadership team that is aligned, connected and capable of leading change	DDD needs a strong, competent, adequately resourced and sustainable system
Parent	Be an advocate for the population of people who need services and supports	Many unmet needs; need services that promote independence
Provider	Work in a system that focuses on standards, consistency and quality	There is risk in the system especially for people with medical/health issues



Role	Needs	Insight
Self-advocate	Improve self-determination and person-centered planning and assure individuals are heard at their ISP meetings	Staff need to act in concert with values of self-determination and a person-centered system
Supervisor	Focus on a greater connection and engagement with families.	This is a better way to make a difference

Key Themes and Strategic Priorities

Based on review of the data about the DDD program and insights gained from stakeholder interviews the following themes were identified:

- Build a stronger focus on measuring outcomes, service effectiveness, and philosophy of care
- Have greater consistency of implementation and oversight for quality
- Strengthen leadership and accountability
- Cultivate a positive organizational culture
- Develop a statewide focus
- Focus on a greater connection and engagement with families
- Reduce risk in the system including for people with medical/health issues
- Assure adequate resources to address system infrastructure and support the work of CMs
- Build an employment first focus
- Be responsive to mandates and CMS requirements

The themes were then translated into strategic priorities:

- Assure individuals are receiving services in alignment with best practices and in compliance with the CMS final rule for Home and Community-Based Services (HCBS)
- Build a stronger focus on: a) measuring and achieving outcomes at the individual and program levels, b) service effectiveness, and c) philosophy of care
- Strengthen connection and engagement with families and individuals and ensuring person-centered planning
- Improve leadership and accountability within the DDD program and cultivate a positive organizational culture



Section 5: Goals and Objectives

The following pages present the goals DDD is committed to achieving between now through fiscal year 2017. They represent the visions and aspirations of the Division. Also presented are the specific objectives which outline the strategies developed to reach the Division's goals.

DDD is in the process of developing Action Plans for each objective, and will specify the “who, what, when, where, and how” in order to attain goals.



Goal One

DDD will ensure the involvement and participation of individuals with I/DD and their families in activities of the Division at all levels.

Strategic Issue: There is a need for a greater focus on connection and engagement with families and individuals and ensuring person-centered planning. As one self-advocate wrote, “Are choices important from the point of view individuals who we serve? Working together with them and with their circle is very important! Planning with, not for, every individual we serve...we cannot afford to go back to institutionalized thinking!”

Objectives:

- 1.1 Ensure and continuously monitor that individuals and families are empowered participants who direct their planning process and choose their services through person-centered planning. Refine measurement of this by August 2015.
- 1.2 Ensure that oral and written communications with individuals and families are clear and understandable and that written communications are in accessible formats and languages that can be understood by April 2015.
- 1.3 Facilitate the development of family support groups to include discussing natural supports meet on a quarterly basis by May 2015.
- 1.4 Support the involvement and participation of individuals and families in program planning, evaluation and policy development by June 2015.
- 1.5 In partnership with self-advocates and family members, develop and implement a person and family-centered training curriculum that ensures self-determination and consumer control by May 2015.
- 1.6 Use National Core Indicator data obtained from the Family Survey, Family/Guardian survey, and Child/Family survey to identify at least three areas of focus for improvement by May 2015.



Community Integration

Goal Two

DDD will ensure individuals with intellectual and developmental disabilities (I/DD) have full access to the benefits of community living, the opportunity to receive quality services in the most integrated settings, engage in community life, and control personal resources.

Strategic Issue: DDD, in partnership with the Department of Human Services- MedQUEST Division (MQD), needs to ensure individuals are receiving services in alignment with best practices and in compliance with the U.S. Centers for Medicare & Medicaid Services (CMS) final rule for Home and Community-Based Services (HCBS). The new rule clarifies the types of settings in which Medicaid-funded HCBS may be delivered, and emphasizes the ability of people receiving HCBS to exercise choice about where they live and the services they receive. These settings include any location where HCBS (waiver) services and supports are provided, inclusive of non-residential and residential settings including those that are provider-owned or operated. The DDD will assist MQD to implement the statewide transition plan, called My Choice My Way.

Objectives:

- 2.1 Provide the supports individuals need to make informed choices regarding services, supports and who provides them, and that this happens during the individual's person-centered planning process. Refine measurement of this by March 2016
- 2.2 Collaborate with MQD and provider-owned or operated residential settings to meet all the qualities in 2.3, as well as all requirements of the CMS final rule for HCBS by July 2016.
- 2.3 Ensure that all non-residential settings where home and community services are provided, including but not limited to adult day and day habilitation settings, have been assessed and if found not in compliance with the CMS HCBS rule, have a written action plan to achieve full compliance by the CMS deadline of July 2016.

Ensure the model:

- Is integrated in and supports access to the greater community
- Supports individuals to choose the kind of places where they want to engage as members of the greater community, including non-disability specific settings
- Ensures individuals are provided opportunities to seek employment and work in competitive integrated settings



- 2.4 Collaborate with MQD and provider-owned or operated non-residential settings to develop action plans as needed to meet all requirements of the CMS final rule for HCBS by July 2016.
- 2.5 Ensure residential settings where home and community based services are delivered support full access to community life for individuals such that their access to and experiences in their community are similar to others who do not receive Medicaid funds by July 2017.

Supports will:

- Empower individuals to control their personal resources and receive services in the community
- Support individuals to choose the kind of place in which they want to live including non-disability specific settings, who they want to live with and options for private and shared living
- Ensure individual rights of privacy, dignity, and respect and freedom from coercion and restraint
- Optimize autonomy and independence for individuals in making life and service choices



Employment First

Goal Three

DDD will ensure individuals with intellectual and developmental disabilities (I/DD) have opportunities to seek employment and achieve personal outcomes to work in competitive integrated settings

Strategic Issue: DDD has been committed for years to promoting employment in competitive integrated work settings as the first and preferred outcome for working-age youth and adults with intellectual and development disabilities. Although Hawaii ranks among the top ten states offering the best services for people with intellectual and developmental disabilities, according to the 2014 report, The Case for Inclusion issued by United Cerebral Palsy, only 13% of individuals are in supported or competitive employment. Hawaii ranked last among the states in the category of Promoting Productivity. The CMS final rule for Home and Community-Based Services (HCBS) clarifies the types of settings in which Medicaid-funded HCBS may be delivered, emphasizes the ability of people receiving HCBS to exercise choice about where they live and the services they receive. It also requires that states provide opportunities for individuals to seek employment and work in competitive integrated settings.

Objectives:

- 3.1 Provide the supports individuals need to make informed choices about seeking opportunities for competitive integrated employment as evidenced by documentation in the individual's person-centered planning process by March 2016. The individual plan will:
 - Ensure choice of employment goals reflect the person's interests and talents while challenging their ability to learn and grow as an individual
 - Identify the person's immediate and future goals related to employment
 - Include an action plan to address how an individual will be supported to become employed or sustain employment, including addressing barriers to employment
- 3.2 Develop an employment training curriculum for case managers, individuals receiving supports, their families, providers, teachers, and others to strengthen capacity to promote employment and access to services by January 2016.
- 3.3 Establish and strengthen partnerships to support the establishment of pathways to community employment for individuals with I/DD by January 2016.
- 3.4 Identify metrics for measuring success in implementation of employment goals and opportunities for individuals, providers, and DDD by January 2016.



Achieving Outcomes through Effective Services

Goal Four

DDD will ensure quality person-centered planning, services and supports that result in positive outcomes for individuals with I/DD.

Strategic Issue: There is a need to build a stronger focus on: a) measuring and achieving outcomes at the individual and program levels, b) service effectiveness, and c) philosophy of care.

Objectives:

- 4.1 Involve stakeholders and self-advocates in defining outcomes to measure system performance by January 2015.
- 4.2 Design and implement a best practices Hawaii case management model with involvement of self-advocates that has a clear definition of case managers' roles, expectations and core competencies by January 2016.
- 4.3 Identify and provide training on evidence-based practices to help staff, providers, and individuals make decisions about care based on current best practices to support individuals with I/DD to live self-determined lives and achieve their optimal outcomes by July 2015.
- 4.4 Ensure systematic implementation of the Quality Assurance and Improvement Program by October 2014.
- 4.5 Implement expanded monitoring at all levels to include a focus on achieving service quality and effectiveness, reducing risks, and assuring the rights and choices of individuals with I/DD by July 2015.
- 4.6 Select and implement a health assessment and outcome monitoring tool by May 2015.



Leadership and Accountability

Goal Five

DDD managers and supervisors will develop leadership skills and accountability practices necessary to lead, inspire, and achieve organizational excellence.

Strategic Issue: There is a need for strengthened leadership and accountability, and to cultivate a positive organizational culture.

Objectives:

- 5.1 Use Implementation Plans for all of DDD's initiatives inclusive of the Strategic Plan with clear accountability and timelines to ensure timely and quality implementation of all activities by February 2015.
- 5.2 Develop an internal system of communication to ensure that all levels of the organization receive information pertinent to work and help staff to align behind the mission and core initiatives of DDD by February 2015.
- 5.3 Implement a staff development plan to provide support to staff at all levels of the organization through continuous learning based on best practices, defined core competencies and measureable performance standards by June 2015.
- 5.4 Support all DDD managers and supervisors through training in leadership and management skills that promote a positive organizational culture by July 2015.
- 5.5 Organizational decisions shall be data-driven and results will be shared through performance metrics by July 2015.
- 5.6 Communicate and invite feedback about the status of DDD's performance and initiatives and with staff, stakeholders, families, and individuals served by June 2015.



Section 6: Communication Plan

In order to build awareness, understanding, commitment and action for the Strategic Plan a Communication Plan was drafted in October 2013. Initially the Communication Plan identified tasks for immediate implementation to ensure stakeholder and staff involvement in the process developing of the Strategic Plan, most of which have been implemented. As well, it set a longer term agenda for broad-based communication of the Strategic Plan and for building project teams to implement the Plan. The overall intent of the Communication Plan is to internalize ongoing effective communication strategies as an integral part of the implementation. A goal is to involve everyone who has an investment and/or role in ensuring the successful implementation of the Strategic Plan. A key feature of the Communication Plan is to share the results and impact of the plan on a regular basis.

