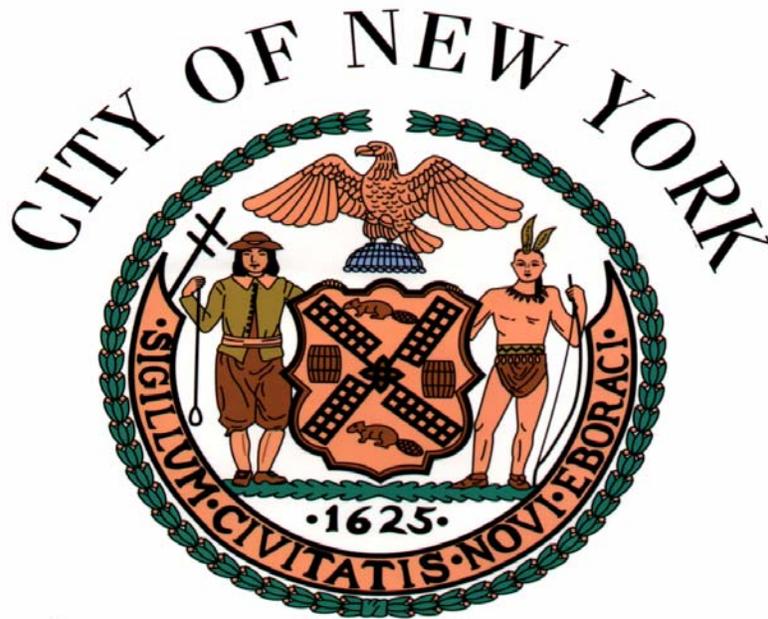


**NEW YORK CITY
DEPARTMENT OF HEALTH
AND MENTAL HYGIENE**



**LOCAL GOVERNMENTAL PLAN
MENTAL RETARDATION AND DEVELOPMENTAL
DISABILITIES SERVICES**

2006 – 2008

**Michael R. Bloomberg
Mayor**

**Thomas R. Frieden, M.D., M.P.H.
Commissioner
Department of Health & Mental Hygiene**

**Lloyd I. Sederer, M.D.
Executive Deputy Commissioner
Division of Mental Hygiene**



Message from the Executive Deputy Commissioner

I am pleased to present the 2006-2008 New York City Local Government Plan for Mental Retardation and Developmental Disabilities (MR/DD) Services. This plan is the culmination of a collaborative planning process with the City's local stakeholders and state partners, and reflects continued progress in implementing a comprehensive local planning process for MR/DD services in New York City.

The City's local planning process has guided the incremental development of an unparalleled service system addressing a broad range of residential and other service needs of individuals with MR/DD and their families. This planning is conducted within a framework established and supported by the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD), and made possible by the commitment and expertise of borough-based planning groups comprised of NYC consumers, families, providers, advocates and government representatives. Each year the City's local plan identifies with great specificity where continued service development is most indicated, and serves to ensure that continued and new funding is allocated accordingly. Additionally, this year's plan identifies NYC priorities regarding major management and system change, such as barriers to residential development and concerns about transportation services, which suggest new areas for government attention and action.

Significant progress has already been made this year in addressing three system-level concerns: i) the lack of psychiatric acute care for individuals with MR/DD; ii) the lack of access to alcohol and substance abuse treatment for adults with MR/DD and co-morbid mental illness; and iii) the lack of adequate transition planning for youth with MR/DD leaving the school system. Workgroups comprised of NYC stakeholders have worked during the past year to issue recommendations, which are now being implemented. These activities are discussed more fully in the plan.

Quality improvement continues to be a priority for the Division of Mental Hygiene of the Department of Health and Mental Hygiene (DMH). This year's plan describes DMH's continued commitment to promote quality improvement within the City's mental hygiene system and to support providers in conducting Continuous Quality Improvement (CQI) activities. Efforts by MR/DD providers to target and improve key aspects of care are described. DMH has continued to ensure a consumer voice in the evaluation of services by implementing a consumer perception of care survey in work and day training programs funded by the City. Data describing the survey results are presented, and indicate both significant satisfaction with services, as well as opportunities for improvement.

The need for more comprehensive and accurate planning data was again a focus of discussion during this planning cycle. We applaud OMRDD's continuing efforts to enhance the accuracy of the data it supplies to counties and NYC in support of local planning. We continue to strive to improve the quality of the data included in the City's plan. For the first time, this year's plan includes a demographic and services system profile of NYC, prevalence, utilization and unmet

need data, and a summary of service opportunities awarded based on last year's plan. With support from OMRDD, we anticipate continued progress in this area.

We thank our local planning partners, and hope this plan is instrumental in supporting continued progress among government, consumers, families, providers and other advocates in advancing the development of New York City's MR/DD services system.



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Brooklyn Mental Retardation/Developmental Disabilities Council and Consumer Council

Manhattan Developmental Disabilities Council and Consumer Council

Queens Mental Retardation/Developmental Disabilities Council and Consumer Council

Staten Island Developmental Disabilities Council and Consumer Council

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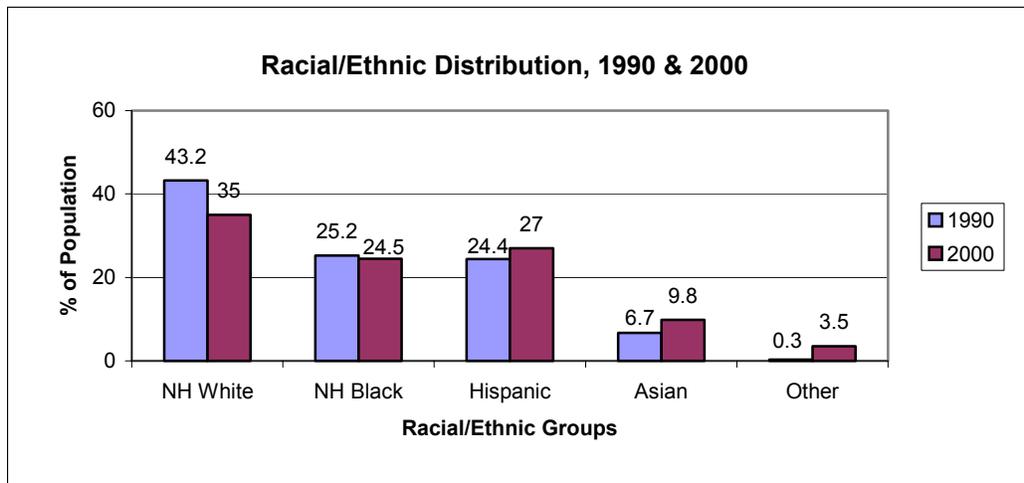
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I. COUNTY PROFILE

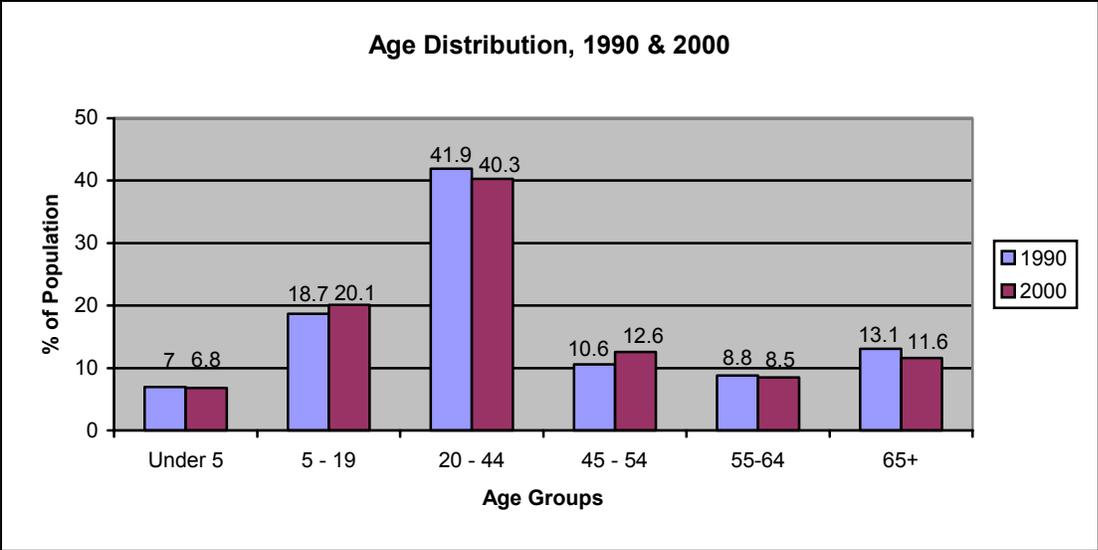
NYC Demographic Overview

NYC is the largest and most racially and ethnically diverse city in New York State. According to the latest census figures, NYC's population grew by more than 9% between 1990 and 2000 for a total population of just over 8 million people. The Department of City Planning estimates that by 2004, the city grew another 2% for a total population of 8,168,000. Immigration has played a crucial role in the City's growth, with nearly 1.2 million new immigrants coming to reside in the City during the 1990s. Thirty-six percent of NYC residents are now foreign-born and only about a quarter of them are proficient in English. In fact, residents claim national origin or racial/ethnic affiliation with 178 different countries and speak 138 languages.

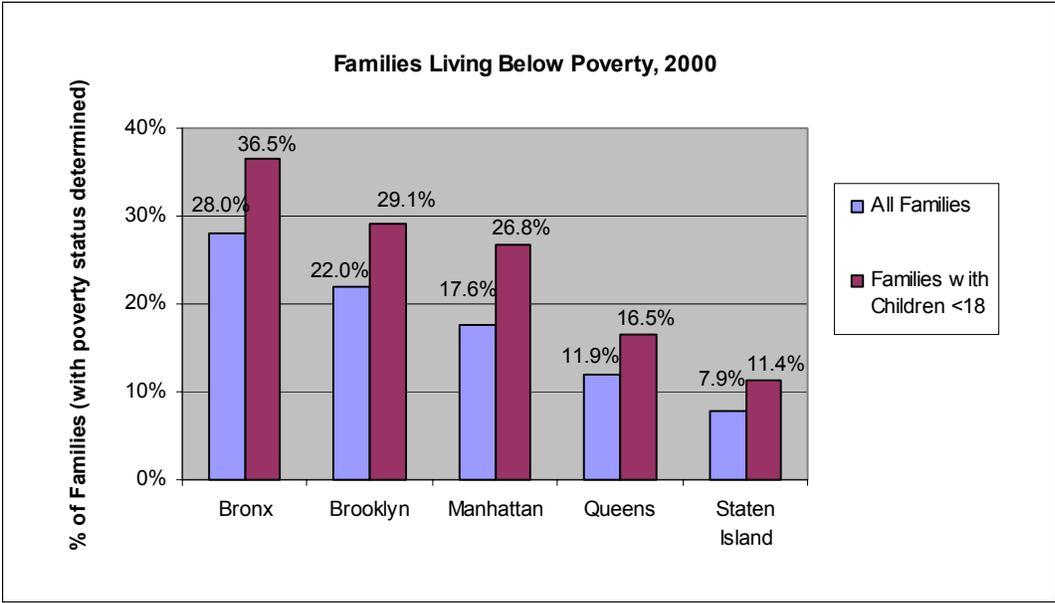
Thirty-five percent of City residents are Non-Hispanic White, 24.5% are Non-Hispanic Black, 27% are Hispanic, 9.8% are Asian and 3.5% are Other (predominantly Non-Hispanic of mixed race). As indicated in the chart below, the proportions of Hispanics, Asians and Other increased during the 1990s while the proportions of Non-Hispanic Whites and Non-Hispanic Blacks decreased, the former most significantly.



The overall age distribution in the City has changed little between 1990 and 2000. The proportion of children aged 5-19 and adults 45-54 years old increased slightly while the proportion of younger adults 20-44 years old and seniors 65 years and older decreased slightly. Perhaps the most interesting change occurred in the population 85 years and older. Although they are still a very small proportion of the population, their numbers grew almost 19%.



Between 1990 and 2000 the number of NYC residents living below the poverty line increased from about 1.4 to about 1.7 million, or from 19.3% to 21.3%, respectively. The numbers increased in all of the boroughs and across all major age groups. The chart below indicates, by borough, the percentage of families, including those with children under the age of 18, living below the poverty line in 2000. The Bronx shows the highest rates of families in poverty.

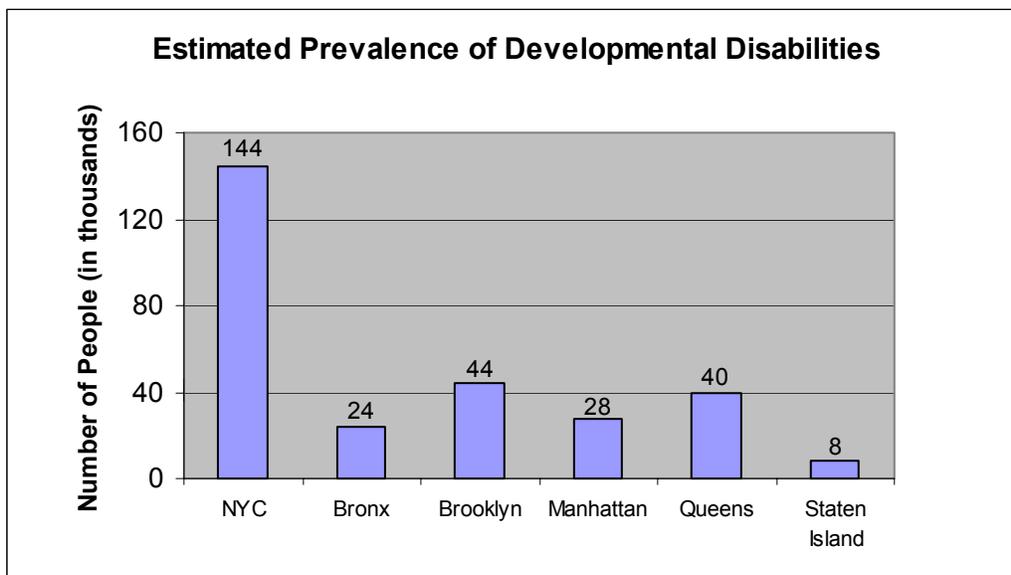


Prevalence, Utilization and Unmet Need

Comprehensive local planning involves the analysis of local prevalence, capacity and utilization data to determine unmet service needs. Gathering these data and establishing meaningful comparisons is an area where local governments often have difficulty and look to their State

partners for assistance. To help with local planning efforts, the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) provides local governments with annual DataPacks that present county-specific service enrollment and service need data. There have been concerns at the local level with the accuracy of these data, concerns that OMRDD shares. In addition, while OMRDD has a mechanism in place to verify residential waitlist information on a regular basis, similar processes have not yet been implemented to verify waitlist information for day services or family and individual support services. OMRDD made several adjustments this year in an attempt to improve the accuracy of the information provided in the DataPacks. The data presented in this section is the best available at this time for New York City.

Prevalence – According to information published in OMRDD’s 2006-2010 Comprehensive Plan, an estimated 1.8% of the New York State population have developmental disabilities (DD), as defined by the New York State Mental Hygiene Law. If this rate is applied to the 2000 Census data for New York City, an estimated 144,149 individuals in New York City have DD, including mental retardation. The chart below shows how these 144,149 individuals may be distributed proportionally across the five boroughs.



Utilization – Enrollment data provided in this year’s DataPacks show that over 8,000 individuals receive residential services, more than 16,000 receive adult day services, and close to 48,000 receive family and individual support services in NYC. This data should not, however, be aggregated to determine the total number of individuals enrolled in services, as some individuals are enrolled in more than one service category. These numbers are considerably lower than the estimated 144,149 individuals affected by DD in NYC. In their 2006-2010 Comprehensive Plan, OMRDD provides some reasons for the gap between estimated prevalence and the number of individuals who receive publicly-funded services: many receive services from other systems, some lack access to information about services and some choose not to access the publicly funded service system.

Unmet Need – This year’s DataPacks provided data regarding the number of unique individuals in need of specific services: 1,869 on the NYS CARES residential waitlist, 1,469 in need of day services, and 5,675 in need of family and individual support services. These numbers reflect the unmet needs identified by individuals who are already enrolled in OMRDD’s service system via their Developmental Disabilities Profile – 4 (DDP-4) data collection form. They do not account for individuals who are not known to the system and who may be in need of services. The table below breaks out these unmet service needs by borough.

Unmet Needs Reported in the DataPacks 2006-2008

	NYS CARES Residential Waitlist	Day Services	Family and Individual Support
Bronx	258	201	721
Brooklyn	764	572	1,950
Manhattan	307	162	752
Queens	388	468	1,827
Staten Island	152	66	425
NYC Total	1,869	1,469	5,675

Note: These three services categories are not mutually exclusive; a unique individual can be counted in one, both or all three categories.

It should be noted that while individuals involved in the planning process review this DataPack information, they do not always feel it is accurate. They often use their own local data and estimates of need to modify the DataPack information so they can more accurately determine the number of service opportunities to request for borough planning priorities.

II. SERVICE PRIORITIES FOR STATE FY 2007¹

This Plan’s Service Priorities section has two new additions. This year, OMRDD introduced a new optional category, Administration/Management Initiatives, as part of the local planning guidelines. This option was added in response to stakeholder requests to prioritize major management or systems change initiatives. The inclusion of an Administration/Management initiatives category in NYC’s Plan was strongly supported by planning participants since many priorities discussed each year involve management and systems change concerns. As such, priorities are listed in this section of the plan for four major service categories: administration/management initiatives, residential services, adult day services, and family and individual support services. Within each service category, priorities are listed by borough and by the specific service need in order of priority; where possible, priorities include the number of service opportunities being requested for FY 2007.²

¹ Information and definitions of OMRDD services can be found at:
<http://www.omr.state.ny.us/ws/servlets/WsNavigationServlet?action=services>

² Administration/Management priorities do not include the number of service opportunities being requested since these priorities address system-wide issues.

Another new addition this year is a summary of citywide service priorities. Previous plans have described service priorities at the borough level only. However, from a planning perspective, it is also important to see what needs and concerns are common across the City's five boroughs. In this year's Plan, the Service Priorities section begins with a summary of those priorities/concerns raised by at least four of the five boroughs.

Before detailing the service priorities requested for FY 2007, we present below a summary of the service opportunities awarded as a result of priorities requested in the 2005-2007 Local Plan. The following table shows this information, by borough and service category.

	Bronx	Brooklyn	Manhattan	Queens	Staten Island
Residential	78	60	34	64	89
Adult Day	73	75	42	71	38
Family & Individual Support	282	943	206	278	83

While these awards allowed for incremental growth in the service system according to priority concerns expressed in the 2005-2007 Local Plan, all identified need was not met. Unmet need from last year's Plan was carried over as part of the process of developing new service priorities for FY 2007, and the opportunities requested in the following section attempt to address them, along with newly-identified needs.

Summary of Citywide Service Priorities

A review of the service priorities developed for the five boroughs showed that many issues are shared by at least four boroughs. These common priorities are grouped below into three main categories: special populations, service access, and service enhancements. The priorities included here are described generally for all of NYC, and the priorities specific to each borough are included in the borough-specific listings of priorities starting on page 9. Those citywide service priorities that are in alignment with OMRDD's 2006-2010 planning goals are marked with an asterisk*.

Special Populations

Boroughs consistently identified a few specific populations as having specialized service needs that are not being adequately met by the existing service system:

- *Aging Consumers** – Consumers who are aging have unique residential and day service needs, such as co-occurring health concerns and different programming desires due to their stage in life. Considering the growth of this population, services need to be adapted to include appropriate programming, technology and staffing.
- *Dually-diagnosed consumers** – Individuals with a mental health or chemical dependence disorder are in need of innovative service models to best address their multiple treatment and service needs.

- *Consumers with intensive medical needs** – Medically-frail consumers have extremely intensive needs, especially for clinical services. Clinical services need to be provided on-site in day programs, and additional residential supports and services need to be provided to keep consumers in residences and minimize nursing home placements.
- *Consumers with challenging behaviors* – It is difficult to find appropriate residential and adult day services that include the intensive staffing and programming levels necessary to meet the needs of individuals with challenging behaviors.

Service Access

Boroughs consistently identified the following issues that hinder access to services:

- *Residential development** – The residential approval process needs to be expedited and more responsive so that housing opportunities, including barrier-free housing, can be developed in a timely manner consistent with NYC’s highly competitive housing market.
- *Transportation** – Resources are needed to provide and maintain adequate transportation services that ensure consumers’ access to needed services.
- *Day services* – There are adults who are not receiving any kind of day programming, including those who did not transition to adult day services from the Department of Education (DOE) system, and individuals who may have been rejected or discharged from a day program. These consumers need to have access to appropriate day service opportunities.
- *Respite/Recreation services* – There is a need for additional in-home and out-of-home respite and recreation services, including services after school, on weekends, and during summer and school holidays.

Service Enhancements

Boroughs consistently identified ways to enhance existing programs in order to better meet the comprehensive and individualized needs of consumers:

- *Parent training* – To ensure parents of children with DD are aware of all available supports, training and education services need to cover a wider range of issues including, but not limited to, benefits/entitlements, sexuality, transition services, and residential options.
- *Employment and work readiness training** – Many adult and young adult consumers are capable of and interested in employment opportunities. Day services need to provide additional work readiness training opportunities and support consumers with transitioning into employment, including competitive work.
- *Crisis services* – Crisis services need to be expanded to include more flexible intervention services that meet the needs of all consumers, especially those with more challenging behaviors. This may require more in-home supports, longer duration of services, creative service models (i.e., time-limited emergency housing), and improved coordination.

Administration/Management Initiatives

As noted above, this year’s Planning Guidelines included this new priority area in response to stakeholder requests to prioritize major management or systems change initiatives. In NYC we have chosen to use this priority area to discuss needs that meet the following criteria: require changes in existing regulations, policies and/or processes; require changes in traditional service models; or require government action beyond what is routine. Note that priorities included in this Administration/Management category are equal in weight to priorities included in the other priority categories (Residential, Adult Day, and Family and Individual Support).

This section opens with a discussion of three larger system-level concerns that were identified by NYC stakeholders and the progress to date in addressing these concerns. The following section outlines the borough-specific administration/management priorities developed by each borough during the priority-setting meetings.

Citywide Administration/Management Initiatives

In Fall 2004, at the request of leadership from the Division of Mental Hygiene of the Department of Health and Mental Hygiene (DMH), the Federation's³ MR/DD Borough Council Chairs identified three priority service system concerns where local government could have substantial impact:

- The lack of psychiatric inpatient capacity and acute psychiatric care alternatives for individuals with MR/DD who are in need of acute psychiatric treatment
- The lack of access to alcohol and substance abuse treatment for adults with MR/DD
- The lack of adequate transition planning for individuals with MR/DD who are aging out of the public school system into the adult MR/DD services system at ages 18-21

These priority concerns, which have also been identified as areas of concern in OMRDD's recent 2006-2010 Comprehensive Plan, are system-wide management issues that require changes to the current service delivery system as well as improved collaboration among state and local government and local service providers.

Workgroups comprised of Federation Borough Council members and DMH staff were established in Fall 2004 to develop recommendations to address each of these priority areas. Summaries of activities and accomplishments during the past year are described below.⁴

1. The lack of psychiatric inpatient capacity and acute psychiatric care alternatives for individuals with MR/DD who are in need of acute psychiatric treatment.

This workgroup was formed to develop recommendations for effective models for addressing the acute psychiatric care treatment needs of individuals dually diagnosed with MR/DD and mental illness (MR/DD-MI). During the course of its work, the workgroup has explored best practice service models and developed recommendations for innovative service-planning strategies for both adults and children.

Work in implementing these recommendations has begun. DMH is working in partnership with OMRDD, which plans to establish two or three intensive residential treatment programs for individuals with MR/DD and psychiatric disorders in different boroughs; these programs will be partnered with an identified nearby hospital that is interested in collaborating in the treatment of this population. The intensive treatment residences would turn to the hospitals if a higher level of care is needed, and discussions are underway about how the residence and hospital would work together to best ensure a timely and appropriate discharge disposition. In addition, the

³ The Federation for Mental Health, Mental Retardation and Alcoholism Services is an advisory body to DMH. It is comprised of mental hygiene service consumers, family members, provider agencies and advocates.

⁴ For a fuller discussion of these workgroups, refer to Section III of the 2005-2007 NYC Local Government plan for MR/DD Services (<http://www.nyc.gov/html/doh/downloads/pdf/bmrdd/bmrdd-localgovtplan-2006.pdf>).

partner hospitals could provide psychiatric consultation to the residents and residential program staff as needed, thereby helping to create earlier intervention and fewer acute care emergencies and hospitalizations. OMRDD plans to identify the residential providers in the fall of 2006, and DMH has approached potential hospital partners. It is anticipated that this new model will prove to be an effective approach to caring for adults with MR/DD and mental illness.

2. The lack of access to alcohol and substance abuse treatment for adults with MR/DD.

This workgroup was formed to improve access to inpatient substance abuse and alcohol treatment programs for consumers with MR/DD and a chemical dependence disorder. The goal is to provide MR/DD service providers, consumers and their families with a referral list of inpatient chemical dependence providers that have committed to provide tailored treatment to consumers with MR/DD.

The workgroup has identified the Alcohol Treatment Centers (ATCs) operated by the Office of Alcoholism and Substance Abuse Services (OASAS) as a resource for meeting the inpatient chemical dependence needs of consumers with MR/DD. The ATCs, one per borough, offer 28-day inpatient treatment for alcohol and substance abuse disorders. The workgroup visited each ATC to become oriented to what the facilities have to offer, as well as to engage in cross-training and dialogue with ATC staff regarding the service needs of individuals with MR/DD. These discussions focused on issues such as stigma, communication between ATC staff and referral sources, discharge planning, and the ability of MR/DD consumers to meet ATC requirements, such as remaining tobacco-free and performing self-care activities.

The workgroup and the ATCs agreed to a 6-month pilot project, from May 2006 to November 2006, for approximately 10-12 consumers. Referrals will be made through the Association for the Help of Retarded Children (AHRC), which currently provides the only outpatient program in NYC for individuals with MR/DD who have chemical dependence needs. Referrals have already begun, and the workgroup is in the process of developing a system for tracking referrals and evaluating the care received by individual consumers.

At the end of the 6-month pilot period, a review and summary will be completed and shared with OASAS. The plan is to broaden and coordinate the referral process so that providers and families can directly refer to the ATCs. While a referral process with the ATCs will improve access to services, there is still a need for additional services beyond what the ATCs can offer. As such, once the ATC referral process is effectively in place citywide, the workgroup will explore additional referral opportunities with other non-ATC chemical dependency providers, both inpatient and outpatient.

3. The lack of adequate transition planning for individuals with MR/DD who are aging out of the public school system into the adult services system at ages 18-21.

This workgroup was formed to develop a problem statement and potential solutions to improve transition planning for MR/DD consumers transitioning out of DOE services into the adult MR/DD system. The workgroup was comprised of parent advocates, voluntary non-profit providers, representatives from DMH, the Federation Borough Councils, OMRDD, DOE, and Vocational and Education Services for Individuals with Disabilities (VESID).

In February 2006, the workgroup completed a report detailing the problems and subsequent recommendations for change. The nine recommendations address: psychological evaluations; allocation of resources for transition planning; Individualized Education Program (IEP) format; internet-based resource directory; post-school tracking system; outreach and education; access to services; agency-level transition planning; and Medicaid Service Coordination. The full report is available in Appendix A.

Following the release of the report, OMRDD and the Federation members have been working with DOE to begin addressing some of the problems identified in the report. To date, solutions have been developed to rectify problems identified with psychological evaluations and service coordination issues. Regarding psychological evaluations, it was agreed that school psychologists responsible for testing and evaluating transitioning students will utilize a new eligibility determination packet, which includes previous evaluations with IQ tests and a new form DOE created for this purpose, thereby preventing the delays and costs associated with obtaining new IQ scores. In terms of service coordination, it was agreed that DOE will send information about Medicaid Service Coordination to families so they are aware of this service and can access it sooner for children before they turn 14 to ensure smoother transitioning. It is anticipated that additional solutions will be implemented moving forward.

* * * * *

During this year's borough-based planning meetings, several committees expressed concern about a group of individuals that appear to need assistance but are not eligible for DD services and/or the Medicaid Waiver. Moving forward, we will look to develop a workgroup that will estimate the number of individuals and identify alternate ways to meet the needs of these individuals.

Borough-Specific Administration/Management Priorities

Bronx

1. An expedited and a more responsive approval process that ensures that housing opportunities in general, and barrier-free housing in particular, are developed in a timely manner consistent with NYC's highly competitive housing market.
2. Sufficient staffing and environmental modifications in residential programs to successfully meet the needs of consumers with more intensive needs and/or behavioral challenges.
3. Time-limited emergency housing that can address crisis management and prevention for individuals and their families.
4. Improved collaboration between OMRDD, VESID and other state and local agencies to further promote supported employment for consumers.
5. Adequate funding to ensure a well-trained workforce and staff ratios that ensure quality of services, given the aging workforce and current demands for person-centered and individualized service delivery.
6. A continuum of health care services for individuals with DD during critical periods of transition from infancy, childhood, and adolescence as well as early and late adulthood.
7. Access to needed services and medical equipment for people with the severest challenges who, because of their complex needs, are often the least likely to be served.

Brooklyn

1. Additional funding for programs that provide educational services to children with DD who are deemed too severe to be served by the school system.
2. Time-limited residences that provide intensive psychiatric/therapeutic services to individuals with an acute mental health care need.
3. Adult transportation, including for individuals who are wheelchair-dependent.
4. Non-traditional day hospitalization options for individuals dually diagnosed with MR/DD and mental health disorders.
5. Enhanced support for consumers in vocational training to transition to supported work.
6. Improved coordination with DOE regarding:
 - Transportation for DD students to post-DOE programming
 - Psychological assessments for children to determine eligibility for OMRDD services
 - Increased travel training opportunities
7. Simplification of the process to develop Options for People through Services (OPTS) proposals.
8. Services for dually diagnosed individuals, specifically those with MR/DD who also have chronic mental health care needs.
9. Treatment and services for individuals with chemical dependence disorders.

Manhattan

1. A greatly expedited approval process, and consideration to placing Manhattan consumers in other boroughs, to address the tremendous obstacles to residential development in Manhattan.
2. Affordable and accessible housing for disabled individuals, families with a disabled member, and group homes for people with DD.
3. Collaborative partnerships between DOE and voluntary agencies to enhance the transition process into adult day services, to begin at least 3 years before graduation.
4. Funding to provide compensation to consumers for work activities in day habilitation.
5. Funding that accompanies out-of-borough residential placements to allow for appropriate adult day opportunities.
6. Reimbursement monies for individuals living independently, to cover expenses not otherwise covered.
7. Access to parenting, behavior management, and skills training for foster care parents with children with DD.
8. Cost of living adjustments for all services for people with DD, regardless of funding source.
9. Legal services, along the model of the Bronx Defenders, to advocate for and protect people with DD who are arrested.

Queens

1. Expedite the current system and approval process for adult day service programs that include clinical service enhancements.
2. An expedited and more responsive approval process that ensures housing opportunities are developed in a timely manner consistent with NYC's highly competitive housing market.
3. An expansion of intensive in-home crisis services to help families cope with individuals in crisis and keep the individual in the home, preventing crisis hospitalizations and residential placements.
4. Development of a systematic approach to obtaining accurate service needs data for effective service planning.

5. Time-limited residential opportunities for:
 - Individuals with DD and mental health issues who need crisis intervention services
 - Individuals with DD and alcohol and/or other substance abuse problems who require chemical dependence treatment and/or rehabilitation services
6. Time-limited, intensive day hospitalization or similar programs for dually diagnosed individuals with intensive psychiatric service needs.

Staten Island

1. Transportation services that facilitate community involvement and inclusion, and that ensure safe travel for residential, adult day, and family and individual support services consumers.
2. A simplified and expedited process for the development of new residential opportunities for individuals with special needs.
3. Certificate training programs for direct support professionals who work in residential, day and family and individual support service settings.
4. Time-limited residential programs for individuals who require therapeutic interventions for mental or chemical dependence disorders.
5. Reimbursement for goods and services for individuals with DD, with a four-week turn around time.

Residential Services

The need for residential services in New York State is tracked via the NYS CARES waitlist, and residential service development efforts focus on meeting the needs of those waitlisted individuals. This section lists NYS CARES waitlist totals for each borough, and describes specific priority residential needs.

Bronx

1. The following priorities highlight the needs of specific populations from a total of 409 waitlisted individuals in the Bronx:
 - Individuals of all ages with challenging behaviors who require clinical support and appropriate staffing in the residence
 - Individuals who require barrier-free living and in-house medical and nursing support
 - Individuals who require barrier-free living
 - Individuals who require 24-hour nursing care and possibly enhanced nursing support
2. Environmental modifications to residential settings to accommodate the changing needs of consumers.

Brooklyn

The following priorities highlight the needs of specific populations from a total of 764 waitlisted individuals in Brooklyn:

- Individuals who are aging with medical needs and/or ambulation difficulties
- Children diagnosed with autism
- Parents with DD and their dependent children

Manhattan

1. The following priorities highlight the needs of specific populations from a total of 469 waitlisted individuals in Manhattan:

- Difficult-to-place developmentally disabled adults with severely challenging behaviors, including high functioning adults with mental or chemical dependence disorders
 - Physically impaired, medically fragile, multiply-impaired and/or non-ambulatory adults with DD
 - Developmentally disabled adults with autism, traumatic brain injury (TBI), epilepsy, and other low-incidence disabilities
 - Developmentally disabled adults who are non-ambulatory but high-functioning
 - Developmentally disabled adults who are not medically fragile but have intensive medical needs, including non-ambulatory individuals
 - Developmentally disabled adults who are comparatively independent and need supported-apartment type Individual Residential Alternatives (IRAs)
 - Families with parents who have DD
 - Developmentally disabled individuals needing 24-hour medical care who desire alternatives to skilled nursing facilities (SNFs), including those already in SNFs who desire to return to OMRDD settings
 - Developmentally disabled individuals who are aging
2. Residential services for individuals in emergency situations.
 3. Residential services for individuals with urgent needs.

Queens

The following priorities highlight the needs of specific populations from a total of 615 waitlisted individuals in Queens:

- Individuals whose caretakers are at risk of being unable to provide ongoing care
- Individuals who are aging, specifically those who are non-ambulatory
- Individuals who are medically frail
- Individuals with dual diagnosis
- Individuals with DD who have children

Staten Island

1. The following priorities highlight the needs of specific populations from a total of 319 waitlisted individuals in Staten Island:
 - Individuals who are aging and have an increased need for skilled nursing services
 - Children and adolescents with autism
 - Children and adolescents with special needs (e.g., medically frail, behaviorally challenged, non-ambulatory)
 - Adolescents with MR/DD and a co-occurring mental or chemical dependence disorder
 - Adults with MR/DD, including autism
 - Adults with MR/DD and a co-occurring mental or chemical dependence disorder
 - IRA residents in need of hospice services
 - Individuals not previously on a waitlist but in need of an immediate/emergency placement
 - IRA residents in need of residential placements that house fewer than five people
2. Environmental modifications to residential settings to accommodate the changing needs of aging consumers.

Adult Day Services

Bronx

1. Options for individuals who are aging that will meet their changing needs. (30)
2. Intensive day services, with adequate staff ratios, for individuals with challenging behaviors and/or intensive needs. (25)
3. Opportunities for individuals, DOE graduates in particular, who are non-ambulatory and/or multiply handicapped. (15)
4. Day service opportunities that address employment/work-readiness training. (35)

Brooklyn

1. All day service models for DOE graduates with DD. (200)
2. Day service opportunities for individuals exhibiting challenging behaviors. (40)
3. Day service opportunities for individuals not enrolled in any program (i.e., rejected/discharged from programs or have never been in a program). (35)
4. Paid work experience along a continuum of work programs that provide travel training and transportation (pay needs to be commensurate with the Department of Labor minimum wage guidelines). (40)
5. Day service opportunities for individuals who are wheelchair-dependent. (25)
6. Individuals who are aging and/or individuals who are medically frail or in need of medical support. (25)
7. Supplemental day habilitation.⁵ (20)

Manhattan

1. Innovative and person-centered adult day program initiatives for individuals, particularly aging adults, whose needs cannot be met in traditional day program models. (20)
2. Day habilitation services, both newly developed and backfills, for individuals currently not served or aging out of DOE, designed to serve a mix of adults with DD, including those with intensive needs. (122)
3. Supported employment and transitional employment opportunities for adults currently not receiving services, especially those with more severe DD who require intensive staffing and transportation assistance or travel training. (53)
4. Work readiness/pre-vocational service opportunities for individuals with DD who: (41)
 - Are transitioning out of DOE
 - Have additional physical, medical, or psychiatric disabilities that impede the transition to employment
 - Have been in sheltered workshops for many years and are apprehensive about entering supportive or competitive employment

Queens

1. Day service programs, with transportation, in integrated settings for ambulatory and non-ambulatory DOE graduates with various developmental disabilities (dual diagnosis, autism spectrum disorder and others). (185)

⁵ Supplemental day habilitation is provided on weekends or weekdays after 3 pm and cannot be provided to people who live in 24-hour supervised group homes. It is available to people who live at home, in supportive IRA's or community residences, or family care only. It can be group or individual.

2. Blended day programs for consumers who work fewer than five days a week and need structured activities for the alternate days. (10)
3. Day service programs with transportation for geriatric and medically-frail consumers. (25)
4. Day service programs for persons without day programs. (5)

Staten Island

1. Day service opportunities for individuals with DD who have intensive medical and/or functional needs, challenging behaviors, or are non-ambulatory, and require specialized programming, staffing and training. (30)
2. Day service opportunities for individuals who are not in any day programs and who are not new graduates from DOE. (80)
3. Day services opportunities that address employment/work-readiness training. (36)
4. Supplemental day habilitation for individuals of all ages who are in need of additional day programming or different day programming than the regular day services. (50)
5. Options for individuals who are aging that meet their changing needs. (100)
6. Environmental modifications for all day service sites (i.e., program, work and volunteer). (10)

Family and Individual Support Services

Bronx

For all of the following, priority will be given to family and individual support proposals for individuals who are medically frail and/or behaviorally challenged.

1. Respite services with transportation for individuals ages 3 to 21, and/or adults who are mentally retarded and/or medically frail, autistic, dually diagnosed or blind, in the following order of priority: (60)
 - Summer and school holiday respite
 - After-school respite/recreation programs
 - Weekend respite (one day, two days or weekend away)
 - Planned free-standing respite
 - Non-camp vacation
2. Vacations for individuals who require enhanced staffing due to intensive medical/health care needs and/or behavioral challenges. (20)
3. Funding for evaluations (i.e., psychological evaluations and other required evaluations) to determine eligibility for individuals who do not have Medicaid. (30)
4. Improved parent education and training regarding the transition process from DOE into the adult MR/DD services system to ensure timely and appropriate transition planning; education and training needs to also address other relevant needs such as benefits planning. (n/a)

Brooklyn

1. In-home residential habilitation. (200)
2. Respite services, with transportation (where appropriate), for the following: (67)
 - School holidays
 - After-school (within the school district)/Program
 - Weekends
 - Overnight (in and out of home)
 - Emergency

- In-home
3. Reimbursement funds to families for goods and services. (539)
 4. Enhanced funds for transportation to include recreational programs and non-medical/clinical needs. (193)
 5. Summer day camps for children. (78)
 6. Service coordination for individuals who do not have Medicaid. (50)
 7. Crisis intervention that includes an in-home behavior management component. (40)
 8. Parent training and education on issues such as services, benefits/entitlements and how they interact. (n/a)⁶

Manhattan

1. Addition of one-on-one staff support to existing recreation programs in order to include currently unserved individuals with intensive needs of all kinds; this one-on-one staff support could also be provided on public transportation, Access-a-Ride, taxi, etc. (10)
2. After-school recreation opportunities, with transportation, for children ages 5-21, including non-ambulatory and behaviorally challenged children. (40)
3. After-program recreation opportunities, with transportation, for adults. (30)
4. Parent support groups. (40)
5. Expansion of existing OMRDD-funded programs that have waiting lists. (30)
6. Creative projects for a documented need (e.g., diaper co-op; training for parents with DD). (n/a)
7. New and/or expanded emergency respite sites and/or individual providers (similar to the family care model), especially for those with severely challenging behaviors. (15)
8. New or expanded reimbursement programs. (40)
9. Overnight respite to include non-ambulatory persons. (16)
10. Funding to cover increased transportation costs in existing recreation programs that have a transportation component. (n/a)

Queens

1. Crisis and overnight respite (in-home and out-of-home) for consumers with challenging behaviors. (26)
2. Year-round, 5-day-per-week after-school respite and recreation programs, with transportation, for children ages 3-21. (100)
3. Funding for evaluations for individuals seeking to establish OMRDD eligibility who do not have Medicaid. (260)
4. In-home respite for individuals of all ages. (28)
5. In-home residential habilitation. (40)
6. Family reimbursement for goods and services (e.g. transportation). (100)
7. Training and education for parents and caregivers regarding the options, procedures and process for service relocation and/or “switching” programs. (n/a)

Staten Island

1. In-home and out-of-home respite for individuals of all ages. (70)
2. Emergency/crisis respite services for individuals of all ages, including those who are non-ambulatory, medically fragile, or have severely challenging behaviors. (50)

⁶ N/A is noted where a number was not available.

3. Recreation, summer day camp, after-school, and school holiday respite opportunities, with transportation if needed, for individuals of all ages with DD, especially those who are non-ambulatory. (150)
4. Enhanced funding to meet the full cost of summer camp tuition and transportation fees. (50)
5. Overnight free-standing respite services for individuals with DD, especially those who are non-ambulatory. (25)
6. Education, outreach and training for families who have children with DD who are involved in the education system, with a focus on educational advocacy and outreach regarding information and referral services. (250)
7. Individual therapeutic support services for siblings and parents of individuals with DD. (25)
8. Vacation opportunities for older teens and adults with DD. (10)
9. Comprehensive crisis management and prevention response system for individuals of all ages with DD and a mental health disorder who are living at home; services need to include psychiatric services and skilled clinical support. (50)
10. In-home residential habilitation for individuals of all ages with DD. (50)
11. One-to-one staffing support for individuals who would otherwise be unable to attend recreation or summer camp programs. (20)

III. LOCAL SELF-ADVOCACY AND SELF-DETERMINATION ACTIVITIES

This year's plan guidelines from OMRDD requested that the supplementary narrative discuss the "activities Counties and agencies have engaged in, funded or supported that enhance self-determination and/or self-advocacy." The information presented in this section of the plan separates self-advocacy and self-determination because the activities carried out for each are distinct. However, it is important to note that they are interrelated and both ultimately aim to improve the lives of consumers by assisting them in asserting control in key aspects of their lives.

Self-Advocacy

Self-advocacy, as defined by the Self-Advocacy Association of New York State (SANYS), is the act of speaking up for oneself, making one's own choices in life, and learning about one's rights and responsibilities. In essence, it is about "living the way you want to and respecting the right of others to do the same."⁷

In September 2004, SANYS and OMRDD jointly sponsored a state-wide conference on self-advocacy, where they developed the following Vision Statement:

"Creating Partnerships for Community:

- People with developmental disabilities will live as fully included and contributing members of their community with the supports they need to participate in typical community events, activities, organizations and associations.
- People with developmental disabilities, supported by their families, friends, provider organizations and OMRDD, will live where they choose in their communities with the supports they need. A wide array of options including a variety of individualized and family supports will be available to all.

⁷ SANYS Website: <http://www.sanys.org/advocacy.htm>

- People with developmental disabilities will have a broad range of opportunities for competitive and supported employment, including intensive supports if needed, as well as opportunities for self-employment. For those who choose to volunteer in their community or pursue other interests, individualized supports will be available for these activities.”

Since the development of this vision statement, NYC’s boroughs have been carrying out various activities in order to promote self-advocacy at the local level. Several have hosted local self-advocacy retreats; two examples follow:

- In May 2006 the Metro Developmental Disabilities Service Office (DDSO) and the local planning group hosted a local retreat entitled "Conversations: Overcoming Barriers and Empowering People with Disabilities to Lead the Way.” This all-day event was attended by individuals, parents, families, advocates, community leaders, provider agencies, OMRDD staff and DOHMH staff. Discussions centered on ways to promote greater inclusion of people with disabilities into the community, and ways to enable them to pursue their dreams and become full and valued contributors.
- The Bernard Fineson DDSO held a local retreat in May 2006 entitled "Creating Partnerships in the Community - Advancing the Vision." The retreat included representatives from the DDSO, SANYS, self advocates, voluntary-agency executive staff, professionals, the Consumer Council Chairperson, the Director of Economic Development for the Queens Borough President's Office, employers and faith-based leaders from the community. The focus of the retreat was to present "best practices" in self-advocacy and further partner with the community.

In addition to local retreats, boroughs have coordinated various stakeholder meetings aimed at developing targeted strategies for implementing self-advocacy at the local level; two examples follow:

- The Bernard Fineson DDSO met with approximately 25 self advocates living in Queens and members of SANYS in order to develop initiatives for consumers with DD, including: continuing education for those currently employed; developing drop-in centers in the community as a place to socialize; teaming up young adults from DOE with seasoned self advocates to assist with transition; and establishing "blended" programs, such as day programs without walls.
- The Staten Island DDSO (SIDDSO) held several meetings resulting in: agencies working together to fund the participation of self advocates in the work of the Staten Island Developmental Disabilities Council; agencies and the SIDDSO more fully including self advocates in the operation of their respective organizations, principally through inclusion on important oversight and decision making committees; and getting more self advocates involved in the planning process.

Community education is another mechanism boroughs are focusing on to promote the self-advocacy vision statement and inclusion of consumers in the community. For instance, the Brooklyn DDSO intends to conduct various community education initiatives such as conferences, seminars, and retreats to inform individuals about the self-advocacy vision. One intended goal of these efforts is to ensure representation from self advocates in all service system managerial processes, including but not limited to Board of Directors and policy-making processes.

Finally, boroughs are also looking to consumer satisfaction surveys as a way to promote self-advocacy at the local level. For example, at the request of self-advocates in Manhattan and Brooklyn, the Metro and Brooklyn DDSOs conducted a consumer satisfaction survey to evaluate Access-A-Ride transportation services in all five boroughs. While the number of responses was proportionally low for the number mailed (93 out of 775, 12%), valuable information was obtained. A significant number (51%) of responses were negative. The most common complaints were punctuality, application processes/renewals and confusing use of military time. These concerns will be addressed in upcoming meetings of DDSO staff, self advocates and Access-A-Ride executive management.

Self-Determination

For many years now, SANYS and OMRDD have been working on various efforts to implement self-determination, which focuses on personal choice, self-directed services and flexible funding. It is a mechanism for increasing “consumer and family influence on how nonprofit providers expend funds on their behalf.”⁸ Currently, the main strategy for implementing self-determination is OMRDD’s Self-Determination Pilot Project, which allows individuals to manage their own budget using the Consolidated Supports and Services (CSS) Medicaid waiver. Through this pilot project, participants, along with their families and friends, decide what they want to do, identify related supports and services, and then develop a Self-Determination/Consolidated Supports and Services (SD/CSS) plan with the assistance of a start-up broker, circle of support, and the DDSO liaison. When the SD/CSS plan is approved, the participant manages their own budget, hires their own staff and decides on their own schedule, thereby managing their own life.

Through the use of CSS, and with the addition of start-up brokers and DDSO liaisons, OMRDD and SANYS hope to make self-determination widely available and to expand the number of people who participate. As of the writing of this plan, more than 40 individuals in NYC have engaged in the process of developing SD/CSS plans. Thirty-five individuals are in various stages of plan development, addressing desires that range from owning a business to leasing a vehicle for personal use. In addition, seven individuals in New York City have SD/CSS plans that have been approved and are being implemented; three examples follow:

- One individual will obtain help with his dream of becoming a public speaker in order to encourage agencies to hire individuals with disabilities. His plan includes a personal assistant to help with his daily needs and speech classes to gain public speaking skills. In the future he will also move into his own apartment.
- One young woman will get assistance to continue her college courses and live independently in her own apartment. Her plan includes hiring people to assist her with obtaining her course texts, getting to classes and taking class notes, as well as managing her apartment and accessing activities of interest within and outside of her community.
- One individual preferred to start his own business selling Judaica items rather than attend a regular day program. His plan includes a personal assistant to be his job coach, to assist him in selling his merchandise to stores, and to bring him to the gym once a week.

In addition to developing and implementing SD/CSS plans, boroughs are also focusing on outreach and education activities, stakeholder meetings and trainings to promote self-determination. Some examples of specific activities that have occurred during the year follow:

⁸ OMRDD 2006-2010 Comprehensive Plan (p.24)

- The Metro DDSO hosted a SD/CSS outreach session in June 2006 for the Bronx in order to raise awareness and to educate and inform families, individuals and agencies of the option to use SD/CSS and other OMRDD services.
- The Bernard Fineson DDSO coordinated multiple task force meetings throughout the year to bring together Self-Determination Liaisons with SANYS representatives to address issues related to the Self-Determination Pilot Project.
- The Brooklyn DDSO hosted a seminar in June 2006 which brought together 100 participants including providers, OMRDD, families and self advocates, to discuss ways to participate in self-determination.
- The SIDDSO organized various presentations and training sessions focusing on: the experiences of Self-Determination Liaisons from other counties; bringing together in a meeting an experienced start-up broker, SIDDSO's Medicaid Supervisors, and a select group of motivated Medicaid Service Coordinators; and training on self-determination by self-advocates and their families who are already enrolled in self-determination.

IV. CONTINUOUS QUALITY IMPROVEMENT INITIATIVE: QUALITY IMPACT

In the spring of 2006, DMH completed its second year of Quality IMPACT, a multi-year quality improvement initiative that aims to incrementally move the mental hygiene system toward more effective services, improved outcomes and the integration of evidence-based and innovative practices.

During FY 2006, 10 MR/DD clinics, 18 MR/DD work programs and 4 MR/DD day training programs participated in continuous quality improvement (CQI) activities. Each of the clinics implemented a CQI project intended to improve an aspect of service delivery that was identified by the clinic as needing improvement. DMH worked with each of these clinics to meet its project goals. All of the work programs and day training programs participated in a consumer perceptions of care survey. The primary purpose of the survey was to give MR/DD consumers a voice in improving the quality of services that they receive and to identify service areas that may benefit from further attention.

Continuous Quality Improvement Projects

Seven of the MR/DD clinics working on CQI projects during FY 2006 were concerned with increasing access to services, more specifically, improving show rates. Some programs focused on either initial or ongoing appointments; others tried to improve both. These seven programs developed a variety of creative strategies to engage their consumers. Some clinics streamlined their intake and other administrative practices to make it easier for consumers to access services. For example, one clinic developed a telephone engagement intervention: a student intern called new consumers scheduled for an evaluation to identify and work through potential barriers to keeping the appointment. While on the phone, the intern also validated contact information and clarified the clinic rules and expectations. Another clinic revised the progress note form used by its clinicians to include a place for noting the consumer's next appointment, which in turn, prompted the clinician to schedule a next appointment, if appropriate, or to remind the consumer of his/her next appointment, if already scheduled.

Two of the other MR/DD clinics doing independent projects in FY 2006 worked on expanded versions of their FY 2005 projects. One clinic that had worked on screening its adult clients for early Alzheimer's disease and dementia in FY 2005 rescreened its clients in FY 2006 to uncover several newly diagnosed cases. In response to its findings, the clinic developed a protocol to support annual screenings and modified staff training to include use of the protocol. A second clinic continued in FY 2006 to work on encouraging medical providers to respond more consistently and promptly to requests for information. Staff at this clinic was trained in the best strategies to use with unresponsive medical providers.

One MR/DD clinic, which serves children and adolescents, developed a project in FY 2006 to improve client and parent/caregiver participation in treatment and to meet treatment goals more efficiently. The clinic found that by focusing on shorter-term treatment goals, they were better able to improve outcomes.

In FY 2007, all 10 MR/DD clinics will be entering their third year in Quality IMPACT. As third year participants, they will continue to work on CQI projects that focus on areas they identify as needing improvement and DMH will continue to review and approve their project selections, plans and final outcomes. Because these programs have had the benefit of two prior years of CQI trainings and support from DMH, it is expected that they will be able to implement their CQI activities with more limited technical support from DMH. Oversight of these projects will now occur through DMH's program audit process as CQI takes its place as a standard and important component of the operations of MR/DD programs funded by DMH.

The Consumer Perceptions of Care Survey

Work Programs

In FY 2006, 16 work readiness programs and 2 transitional employment programs participated for a second consecutive year in a consumer perceptions of care survey. DMH staff interviewed 304 consumers, or about three quarters of all consumers enrolled in the 18 participating programs during the survey period. This is similar to the participation rate in FY 2005 when 305 consumers participated in the survey.

The table below summarizes the FY 2006 findings and compares them to the findings from FY 2005. Although the ratings on quality/appropriateness of services are slightly lower in FY 2006, in general, consumers continue to express satisfaction with the services that they receive. They continue to feel that they can do more things on their own and express satisfaction with the quality and amount of training offered to them.

In FY 2005 numerous consumers indicated that they wanted more choices offered to them and that what they learned at their programs could be better matched with their needs on the job. In FY 2006, many more consumers thought they were given sufficient choices and that their training matched their job requirements.

In FY 2006, an impressive 92.4% of consumers indicated that they were able to reach their goals. Although this may reflect a real increase from the year before when the percentage was only 33.1%, it is also likely that simplifying the wording of the question in FY 2006 to make it more understandable may explain, at least in part, the dramatic change (see table below for wording change).

MR/DD Work Programs: Summary Results of Consumer Perceptions of Care Survey

Questions	Average Scores Across All Programs (3=Yes, 2=Sometimes, 1=No)		Average Rates of "Yes" Responses Across All Programs	
	FY05	FY06	FY05	FY06
<u>Quality/Appropriateness of Services</u>				
1. Is the staff here nice to you?	2.96	2.89	96.3%	90.7%
2. Does the staff like to hear what you think?	2.85	2.77	87.6%	81.6%
3. Does the staff here let you decide things for yourself?	2.74	2.68	81.8%	78.5%
4. If you have a problem, does someone here at this program help you fix it?	2.90	2.83	93.7%	87.6%
5. Do you feel safe when you are at your program?	2.93	2.86	94.3%	86.8%
6. Does your counselor meet with you as often as you need?	Not Asked	2.71	Not Asked	79.1%
<u>Consumer Reported Outcomes</u>				
1. Have you reached your goals at this program?*	2.09	2.91	33.1%	92.4%
2. Since coming to this program can you do more things on your own?	2.79	2.82	85.9%	87.1%
3. Have you learned any new things at this program that will help you with working?	2.49	2.82	68.4%	87.9%
<u>Training Satisfaction</u>				
1. Do you get to choose what kind of training you do at your program?	2.06	2.57	48.2%	73.8%
2. Do you like being in this training?	2.80	2.91	85.2%	93.2%
3. Are you happy with how much training you are getting now?	2.80	2.81	86.0%	86.9%
4. Do you like this program?	2.87	2.87	91.4%	92.6%

Note: The FY 2006 as compared to the FY 2005 survey was somewhat shorter and the wording of a few of the questions somewhat simplified. (*The wording of this question in FY 2006 was changed appreciably because the experience of interviewers in FY 2005 indicated that the word "goals" was difficult for the consumers to understand. The wording in FY 2006 was "Have you been successful at the things you have been working on here?")

Day Training Programs

In FY 2006, DMH extended its survey work to include 4 day training programs. The Division developed its day training consumer survey through a consensus-building process that included providers, consumers and DMH staff. Forty-eight consumers, or about a third of the consumers enrolled in these 4 programs during the survey period, completed interviews with DMH staff.

Survey results, which are summarized in the table below, suggest that the majority of consumers have positive feelings about the services that they receive. They are satisfied with the quality and appropriateness of services and with what they are learning and accomplishing. Although most consumers report that they play a role in choosing their activities, almost a quarter of them report that they could be more involved in "picking the things (*they*) do" at their program.

MR/DD Day Training: Summary Results of Consumer Perceptions of Care Survey

Questions	Average Scores Across All Programs (3=Yes, 2=Sometimes, 1=No)	Average Rates of “Yes” Responses Across All Programs
<u>Quality/Appropriateness of Services</u>		
1. Is the staff here nice to you?	2.93	93.4%
2. If you have a problem, does someone here at this program help you fix it?	2.88	89.2%
3. Do you feel safe when you are at your program?	2.92	94.7%
4. Does the staff here take you out for trips into the community?	2.31*	62.4%*
<u>Consumer Reported Outcomes</u>		
1. Are you learning new things at this program?	2.69	81.6%
2. Since coming here can you do more things on your own?	2.86	89.8%
<u>Training Satisfaction</u>		
1. Do you like this program?	2.89	93.1%
2. Do you help pick the things you do here?	2.71	76.0%

* Program scores varied widely on this question. One program in particular accounts for the relatively low averages; that program does not consider community trips as part of its scope of service.

Because caregivers play a substantial role in caring for these consumers, who have significant communication limitations, DMH, with input from a workgroup of providers and consumers, developed a separate survey for them. The 4 participating programs helped to distribute 112 self-administered caregiver survey forms; 38 of them, or about one third, were completed and returned to DMH for analysis. The caregiver survey is currently being analyzed and results will be included in the individualized data reports that DMH sends to providers.

Looking ahead, DMH intends to conduct perceptions of care surveys biennially. Because the consumer population in these programs is relatively stable, a biennial survey will continue to provide sufficient data so that programs can respond to consumer concerns. DMH will continue to use survey data to inform its planning and evaluation activities.

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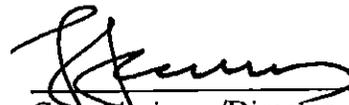
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Assurances

01 Assurance

Pursuant to Article 41 of the Mental Hygiene Law, and as Director of the Local Government Unit, I hereby assure and certify that directors of district developmental services offices, directors of community mental health centers, voluntary agencies, other providers of services, and consumers and consumer groups have been formally invited to participate in, and provide information for, the local planning process relative to the development of the 2005 Local Services Plan.

7/21/2006
Date

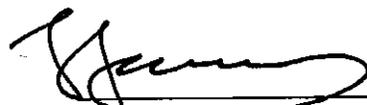


Commissioner/Director
Local Government Unit

02 Assurance

Pursuant to Article 41 of the Mental Hygiene Law, I hereby assure and certify that the Community Services Board has provided advice to the Director of Community Services and has participated in the development of the 2005 Local Government Plan. Additionally, I assure and certify that the full Board has had an opportunity to review and comment on the contents of the plan and has received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed with procedures outlined in the Mental Hygiene Law 41.16(c).

7/21/2006
Date



Commissioner/Director
Local Government Unit

04 Assurance

Pursuant to Article 41 of the Mental Hygiene Law, I, as Chairperson of the Subcommittee for Mental Retardation and Developmental Disabilities, assure and certify that the Subcommittee for Mental Retardation and Developmental Disabilities has provided advice and input to the Community Services Board and to the Director of Community Services relative to the development of the 2005 Local Services Plan as such relates to the field of services for those individuals represented by this subcommittee.

Additionally, I assure and certify that the Subcommittee has had an opportunity to review and comment on the contents of the plan and has received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c).

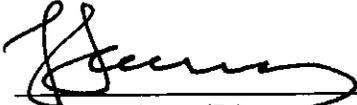
July 21, 2006
Date

Dr. Jim Norred
Chairperson
Subcommittee for MR/DD

05 Assurance

I assure and certify acknowledgement and compliance with the following: The information made available for the development of the Local Government Plan and its constructs includes confidential information concerning individuals served or proposed to be served by OMRDD or approved providers. Confidentiality is required by Mental Hygiene Law Section 33.13. The law prohibits one from making any further disclosure of confidential information unless disclosure is made pursuant to the provisions of Section 33.13.

7/21/2006
Date



Commissioner/Director
Local Government Unit

06 Assurance

On behalf of the Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, I, as director of the DDSO assure and certify that the development process and content of the 2006 Local Government Plan for _____ are in compliance with the requirements of Article 41 of the Mental Hygiene Law, and that they indicate that reasonable and appropriate efforts are being made to extend or improve local mental retardation and developmental disabilities services in accordance with Statewide priorities and goals.

7/31/06
Date

Bernard Finegan
DDSO Director for:
BERNARD FINEGAN DDSO

06 Assurance

On behalf of the Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, I, as director of the DDSO assure and certify that the development process and content of the 2006 Local Government Plan for METRO NY DDSO are in compliance with the requirements of Article 41 of the Mental Hygiene Law, and that they indicate that reasonable and appropriate efforts are being made to extend or improve local mental retardation and developmental disabilities services in accordance with Statewide priorities and goals.

8/16/06
Date

Hyun O Taylor
DDSO Director for:
METRO NY DDSO

06 Assurance

On behalf of the Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, I, as director of the DDSO assure and certify that the development process and content of the 2006 Local Government Plan for §1DDSO are in compliance with the requirements of Article 41 of the Mental Hygiene Law, and that they indicate that reasonable and appropriate efforts are being made to extend or improve local mental retardation and developmental disabilities services in accordance with Statewide priorities and goals.

August 3, 2006
Date


DDSO Director for:

Staten Island DDSO

06 Assurance

On behalf of the Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, I, as director of the DDSO assure and certify that the development process and content of the 2006 Local Government Plan for KINGS COUNTY are in compliance with the requirements of Article 41 of the Mental Hygiene Law, and that they indicate that reasonable and appropriate efforts are being made to extend or improve local mental retardation and developmental disabilities services in accordance with Statewide priorities and goals.

8.15.06
Date

Peter Uschakov
DDSO Director for:
BROOKLYN DDSO

APPENDIX

NYC TRANSITION COMMITTEE

PROBLEM STATEMENT AND RECOMMENDATIONS

October, 2005

INTRODUCTION

In November 2004, the Federation Co-Chairs and the Division of Mental Hygiene (DMH) in the New York City Department of Health and Mental Hygiene (DOHMH) agreed on three areas of priority needs for the MRDD community. It was agreed that DMH would begin collaborating with the Developmental Disabilities (DD) Councils on transition planning for young adults ages 18-21. A workgroup was created and tasked to develop a problem statement and potential solutions to improve transition planning for MRDD consumers transitioning out of Department of Education (DOE) services. The workgroup was composed of representatives from the DOE, the DD Councils, DMH, the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD), Vocational and Educational Services for Individuals with Disabilities (VESID), and several voluntary provider agencies. This document would be submitted to DMH and the Borough Council Co-Chairs for review and discussion of next steps.

PROBLEM STATEMENT

Parents and providers alike have expressed three areas of concern about the process of transitioning for young adults, ages 18-21, from the Department of Education (DOE) to the adult MRDD service system. First, school transition planning and transition services need to be better coordinated in order to properly meet the needs of these students and their families. Second, there are insufficient post-school opportunities for individuals who are transitioning. And third, the transition service needs of young people who have a developmental disability¹, use special education services while in the DOE, and continue to need specialized services after leaving the DOE, but do not qualify for OMRDD services, are not being met. Upon graduation, these students often cannot work independently, and there are insufficient pre-vocational services, specialized training programs, and employment with supports to assist them.

Transition services, as stipulated by the Federal Individuals with Disabilities Act (IDEA), are a coordinated set of activities for a student with a disability, designed to promote movement from school to post-school activities, which include but are not limited to post-secondary education, vocational training, integrated employment, independent living, or community participation.¹ IDEA requires that beginning at age 16 and updated annually, each student's Individualized Education Program (IEP) include a statement of the transition services needs of the student.

To estimate the scope of the issue the workgroup gathered the available data. The total public school register for 2004-2005 was 1,075,338; 158,193 of these students received special education services (includes all disabilities).² The majority of special education students who meet the criteria for MRDD are served in District 75 schools, the DOE district dedicated to serving students with severe disabilities. Data regarding 2005 projected needs of District 75, which serves 22,603 (ages 5-21) students in need of special education services, estimate that of a total 580 graduates, 395 are eligible to transition to OMRDD-funded adult day services, and that an additional 185 will transition to VESID for supported employment and vocational training

¹ 20 U.S.C. § 1401 (30); 34 C.F.R. 300.29

² DOE website (<http://www.nycenet.edu/offices/stats/default.htm>)

(note: some of the students in the latter category are not eligible for OMRDD services). Projections for 2006 indicate that of a total 655 students needing services, 416 will transition to OMRDD-funded services and 239 to VESID. For the 2004-2005 school year, there were 8,696³ developmentally disabled students transitioning out of special education in the other school districts (not including District 75). All of these students should be receiving or already have received transition planning to ensure that all on-going service needs are met in an adequate and timely fashion.

The workgroup identified several barriers to effective transition planning and services. For instance, many parents are not informed of or do not understand the importance of getting involved early in the transition process to ensure their children receive needed services after leaving school, particularly since DOE is responsible for providing the majority of the services a child needs until they reach the age of transition. Yet early participation by all parties, especially parents and teachers, is critical to the process. Another set of difficulties relates to evaluations. The evaluations conducted by DOE lack certain components that OMRDD requires for determining service eligibility, including individualized quotient (IQ) scores, and proof of age of onset. As it stands, DOE collects information on students by a strengths-based method in order to fill the students' academic and school-focused needs. It does not present the information that demonstrates level of disability and provides the details needed to establish eligibility for OMRDD services. Another problem is the inadequacy of the various data tracking mechanisms related to transition services. They are neither well coordinated nor comprehensive enough to meet the needs of those planning for transition services. Finally, there are insufficient post-school opportunities for those individuals who use special education services, but do not qualify for OMRDD-funded services.

RECOMMENDATIONS

Listed below are the recommendations of the workgroup, developed over several meetings. As discussion progressed, it became obvious that success in the development and implementation of an effective individual transition plan requires well-coordinated collaboration between the DOE, students, parents, teachers, service providers and other City and State agencies (DOHMH, VESID, OMRDD). Therefore, some of the recommendations that follow are targeted to multiple parties.

In parenthesis after the title of each recommendation, we have listed the agencies that we recommend as key to implementing each recommendation, with primary responsibility going to the agency in bold (where relevant).

1. Psychological Evaluations (DOE, OMRDD, VESID)

Psychological, psychosocial and medical assessments are needed to assist students in transitioning successfully into OMRDD/Waiver-funded services. The OMRDD eligibility standards require that full psychological evaluations are completed within three years, and updated within one year of being submitted to OMRDD for review. The psychological

³ Students diagnosed with Autism, Mental Retardation, a Learning Disability and Traumatic Brain Injury. Does not include students who dropped out, or moved. (Source: DOE Exit Statistics 10/05).

evaluations must have IQ scores, indicate age of onset and be signed-off/reviewed by a licensed psychologist. A Vineland Adaptive Behavior Scale is also needed for most students in order to verify eligibility.

Many of the school psychological evaluations do not have IQ scores and are therefore not acceptable to OMRDD. The result is that students (consumers) must visit clinics and hospitals to obtain evaluations for OMRDD services. This is often an unnecessary and duplicative process for the consumer and his/her family, which delays acceptance into OMRDD-funded services, results in some consumers having to stay home after graduation, and consequently increase a family's need for family support services. The workgroup recognizes that DOE's ability to provide evaluations will be impacted by issues such as the Jose P.ⁱⁱ court ruling on bilingual testing, and the Memo of Understanding between OMRDD and the State Education Department (SED) on access (See page 10). Both the ruling and the Memo should be reviewed before taking the next step towards collaborating around transition planning.

We recommend that:

- The transition plan (TP) for students eligible for OMRDD services outline a reasonable method for securing psychological evaluations that meet OMRDD requirements.
- Families use Article 16 clinics to complete evaluations necessary to determine OMRDD eligibility.
- OMRDD consider presumptive eligibility for students who have Supplemental Security Income (SSI) and have an outdated psychological documenting a valid disability. In these cases, students would not have to wait for updated testing in order to enter into OMRDD services. For example: an individual who has a disability and is receiving SSI or Social Security Disability Insurance (SSDI) benefits is presumed to be eligible for vocational rehabilitation services at VESID, unless VESID can demonstrate by clear and convincing evidence that the person cannot benefit from an employment outcome because of the severity of the individual's disability.
- The DOE facilitate early application to Medicaid Service Coordinationⁱⁱⁱ for students who are eligible so the Coordinators can assist with obtaining evaluations and other services.
- The DOE and OMRDD better disseminate information on OMRDD's eligibility requirements. The workgroup suggests OMRDD develop a fact sheet with clear language describing the eligibility requirements for the services it funds as well requirements for evaluations.

2. Allocation of Resources for Transition Planning (DOE)

We encourage DOE to allocate sufficient resources to the transition process, so each student can be as successful as possible.

We recommend that:

- Each District 75 and regular high school with students in special education have a dedicated Transition Linkage Coordinator who works with students identified as having a developmental disability, from age 14 until graduation, taking the curriculum and specialized transition needs of each student into account. Not all students require the

same level of services, and service intensity will increase as students get closer to graduation.

- Parent Coordinators^{iv} should be trained for and assigned some specific transition responsibilities such as disseminating transition information to parents.
- The role of the Placement and Referral Center for students with special needs should be expanded in all regions to help fill the void created by the reorganization of District 75 programs, and reduction in District 75 transition personnel.

3. IEP Format (DOE)

We recommend that the DOE improve the format of the IEP for students age 14 and older so it has a positive impact for the student and so that the entire document, and not just one page (page 10 of the IEP), reflects transition goals (See page 12). For instance, there can be more of a focus on vocational and employment related objectives and a plan for how to accomplish them for each student. The IEP can be redesigned to include specific instructional activities and curriculum planning that relate to each transitional goal, including a timeline for monitoring the achievement of those goals. The IEP should also identify the specific adult systems that should participate in the planning process. Since students are supposed to participate in every IEP meeting at which transition planning is discussed, the document should record the contribution of the student as well as his/her presence or absence.

4. Internet-Based Resource Directory (DMH)

We recommend the development of an Internet-Based Resource Directory that would be available to families, school staff, voluntary providers and Medicaid Service Coordinators at no cost. Resources for Children With Special Needs Inc. has a database on the web that can be searched by providers and that has two levels of access. Level one is available to everyone at no cost and contains basic agency contact information. Level two has detailed agency/program narrative information available to view. There is a cost to access this level. It might be possible to have DMH help support the funding of this site so that it can be available at no cost. The site could help Transition Coordinators, Medicaid Service Coordinators, and parents alike to access the appropriate contacts and investigate available programs in their community.

5. Post-School Tracking System (DOE, DMH, VESID, OMRDD)

The current transition planning and post-school service system does not track students beyond the first year after they leave DOE services, hence there is no comprehensive method for knowing how long students have to wait for placement and employment after leaving school, how long they stay in programs if placed, and whether they fall out of the system (end up staying at home and not participating in community activities). Currently OMRDD and VESID each track a subsection of consumers who move through their system, but there is no comprehensive process by which all consumers are accounted for and outcomes measured over time after they leave the DOE. Students who receive job placement through VESID are tracked for 90 days after the job placement is made.

We recommend that:

- DMH develop and coordinate a tracking system through collaboration with DOE, OMRDD, VESID, other relevant City agencies and voluntary provider agencies. The system would allow for better understanding of outcomes. Schools have reported that they continue to see students return to the school several years after graduation. Other students are not connected to, or lose connection with, the adult system. The tracking of outcomes (both successful and unsuccessful) will allow the DOE and the service system to identify future service needs, and areas that need improvement. It will also allow for identification of best practice models that are supported by outcomes.
- OMRDD modify the Developmental Disabilities Profile -1 (DDP-1) form, so that it indicates each student's school and year of graduation.
- VESID modify its CAMS (Case Management System) to include the year a student leaves DOE, continue to use it to track VESID consumers' progress through the system, and share the data from this system with the agency-level transition planning group (See recommendation 8).

6. **Outreach and Education** (DD Councils, DOE)

The workgroup appreciates that DOE, other agencies and the DD councils already expend a great deal of effort on outreach. We believe that through a more creative and coordinated approach, better education and outreach can be provided. DOE staff require education and training regarding the transition process and transition issues. We recommend that this include training on adult services, and the development and implementation of successful transition plans. For example, the "Manhattan Road Show" concept can be replicated in all boroughs: The councils create a small team of informed individuals that can go to the schools and provide training to administrators, teachers and paraprofessionals, families and students. The training should be provided to both high school and middle school staff.

In order to achieve greater outreach and education we also recommend that:

- Parent Coordinators be more involved in developing outreach opportunities. They can use their position as liaisons with parents to determine how to best design events that will be well attended.
- Transition/Career Fairs be arranged around a flexible schedule (such as in the early evenings) so that parents do not have to miss work to attend; and that fairs provide food, are combined with a student event, serve several schools at a time, and provide Metro cards to families. By merging fairs for several schools, resources can be shared, and combining the fair with a student event provides child-care for parents while they focus on transition issues.
- Borough fairs be organized regularly through a collaborative effort of all the stakeholders.
- Some DD Council meetings be held in the evening as another way to increase family involvement.
- Family education sessions/conferences like those held by Association for the Help of Retarded Children (AHRC) be supported and encouraged. This would give more families the opportunity to gain knowledge regarding transition planning.
- DOE develop a user-friendly family resource guide (DVD/video).
- Agency tours and visits for the family, student and school staff be arranged by the Transition Coordinator

7. **Access to Services** (DMH, OMRDD, VESID, Voluntary service providers)

Currently there are insufficient post school opportunities for students who are transitioning, resulting in some cases in waitlist for services or students staying at home for extended periods after graduation.

We recommend:

- That OMRDD, DMH and service agencies provide more and expand existing programs/services, for instance, Pre-Vocational^v, Day Habilitation^{vi} and Waiver^{vii} opportunities that meet the students' interests and would be available for students leaving school from ages 18-21.
- The development of more pre-work options, such as Work Readiness Programs, Work Training Programs, Occupational Skills Training.^{viii} These pre-work options should be created through a collaborative effort between VESID, DMH, and other available sources.
- Creative program development in all areas: vocational training, employment services, and specialty services for consumers with autism, and dual diagnoses (alcohol and drug issues).
- The development of more employment services for students who are developmentally disabled and dually diagnosed but not OMRDD-eligible. There is currently a void in these services areas. In addition, services should be designed so that students who travel independently while in school can continue to do so for post-school activities.
- Speeding up the OMRDD Waiver approval process so that students' entry into post-transition services is not delayed.
- Increasing funding for Supported Employment^{ix} services, specifically by increasing the number of opportunities for VESID to provide intensive services. In addition, increase the rates paid to provider agencies for VESID-extended services.
- Initiating referrals to VESID in the student's junior year in order to allow sufficient time for vocational planning.

8. **Agency-Level Transition Planning** (DMH, DOE , OMRDD, VESID, Voluntary service providers)

We recommend more consistent representation from the DOE, DMH, OMRDD, and VESID at the DD council Adult Day/Transition Committees meetings. In addition, as there are several agencies that are involved in the transition process, we recommend the formation of a citywide transition planning committee, which will meet regularly to review and monitor transition-related issues.

A successful transition process requires that all stakeholders we mention work in a collaborative manner in order to be effective for the students. Communities of Practice are groups of people who share a concern or passion for something they do, and learn how to do it better as they interact regularly. We recommend that the stakeholders involved in improving the transition process view themselves as a Community of Practice. By working in a truly collaborative manner, the agency-level transition planning group can ensure that transition planning no longer remains a priority concern for the MRDD community.

9. Medicaid Service Coordination (DMH, DOE, OMRDD, Voluntary service providers)

Medicaid Service Coordination is essential for helping busy and often-overwhelmed families navigate the various systems that affect students who are in need of OMRDD-funded services, or who transition out of special education services but do not qualify for OMRDD-funded services. Medicaid Service Coordinators can assist in getting families the evaluations appropriate to gain OMRDD Waiver eligibility^x, in completing benefit applications, and in locating vacancies in vocational and support services. Even so, there is often a high turnover rate with Medicaid Service Coordinators, and because there are no comprehensive resources, which document vacancies and the service agency details (See recommendation #4), they are often uninformed about appropriate opportunities for the individuals they serve.

We believe that improvements in Medicaid Service Coordination will benefit those individuals who are transitioning out of DOE by providing a central coordinating agent who will be involved throughout the transition.

We recommend that:

- DMH fund short-term Service Coordinators, during the transition period, for those students in need of services who are not OMRDD eligible and who are not Medicaid eligible (and so do not qualify for Medicaid Service Coordination). This group especially needs assistance with Service Coordination as there are few services earmarked for this population.
- OMRDD increase funding for Medicaid Service Coordination, so salaries can be increased and better quality staff obtained and retained.
- DOE arrange for early linkage between students and a (Medicaid) Service Coordinator, which should increase the likelihood that evaluations are obtained in a timely manner.
- It becomes a requirement that (Medicaid) Service Coordinators meet with school staff (at the school) at least quarterly, including attendance at the annual IEP meetings.
- Agencies collaborate to develop training for (Medicaid) Service Coordinators and other agency staff to understand the transition process and to help them work more effectively with schools.

PARTICIPANTS

Workgroup Co-chairs

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Dorothy Rick

Bronx DD Council
Division of Mental Hygiene

Brooklyn DD Council

Amy Freid
Lousie Masiello

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New York State Education Department –VESID

Alan Rubin

**MEMORANDUM OF UNDERSTANDING
BETWEEN THE NEW YORK STATE OFFICE OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES AND THE STATE EDUCATION DEPARTMENT
REGARDING COOPERATIVE EFFORTS TO IMPROVE ACCESS AND DELIVERY OF SERVICES TO
PERSONS WITH DEVELOPMENTAL DISABILITIES AND THEIR FAMILIES**

The Office of Mental Retardation and Developmental Disabilities (OMRDD) is responsible for coordination and delivery of services for individuals with developmental disabilities throughout New York State and the New York State Education Department (SED) is responsible for coordination and delivery of educational and vocational services, and administering independent living services for persons with disabilities in New York State.

Therefore, the Office of Mental Retardation and Developmental Disabilities and the State Education Department will integrate the resources of two major State systems to enable persons with developmental disabilities to take their rightful place as participating members of their communities.

The agencies' expanded efforts will address a broad spectrum of joint initiatives including assisting families of young children with developmental disabilities in accessing appropriate services, enhancing integration of services within the schools and creating lifelong learning opportunities, broadening vocational opportunities, and enabling a fuller, richer, and more independent use of the community for those persons with lifelong disabilities.

OMRDD and SED agree to:

Increase access to services for persons with developmental disabilities and their families through:

- Cooperative interchange of information
- Strengthened training and technical assistance for parents, school boards, professional and instructional staff, and service providers;
- Coordinated prevention and public education;
- Early identification of individuals through needs assessment processes that assure early access to services;
- Increased opportunities for inclusion of individuals with developmental disabilities with peers who are not disabled.
- Collaboration in the provision of assistive technology;
- Enhanced interaction between schools and district offices of OMRD; and
- Joint development and delivery of programs and services.

Enhance the involvement of individuals with developmental disabilities in school district programs, facilities and services, through:

- Expanded array of family support, recreational, child care, and other services provided in community settings through collocation of services;
- Enhanced integration of clinic and other Medicaid services in educational settings;
- Enhanced lifelong learning through access to adult and other educational opportunities; and
- Environments which encourage the inclusion of individuals with developmental disabilities in school and community settings.

Enhance transition to adult services through:

- More effective and earlier coordination between educational and adult services;
- Improved preparation of youth for employment through expanded integrated employment opportunities;
- Streamlined access to lifelong support services;
- Increased participation in independent living services;

- Continuity between school and community-based vocational training and integrated employment, including supported employment;
- Increased involvement of business and industry in the educational and vocational process; and
- Opportunities for access to lifelong learning in community based and educational settings, including post-secondary education.

Support family preservation through:

- Joint activities to provide the social and education supports necessary to assist families to keep their child at home or in their home communities.
- Increased decision-making by families in the planning process; and
- Joint training for families to encourage participation in their children's learning and development.

In summary, the OMRDD and the SED agree to coordinate their planning, budgeting and service delivery efforts in order to ensure that programs and services for persons with developmental disabilities and their families provide opportunities for lifelong learning, increased employment options, and greater participation in the community.

Thomas Sobol, Commissioner
New York State Education
Department

Elin Howe, Commissioner
New York State Office of
Mental Retardation and
Developmental Disabilities

SAMPLE: Page 10, New York City Department of Education Individualized Education Program

Student Johnson, Samantha

NYC ID# 222222222

Date of Conference 3/22/2004

CSE Case# 10-22222

Transition

LONG TERM ADULT OUTCOMES

(Beginning at age 14 or younger if appropriate, state long term outcomes based on the student's preferences, needs and interests.)

Community Integration: Samantha wants to go to movies, dances and restaurants.
Post-Secondary Placement: Samantha wants to work.
Independent Living: Samantha wants to live with her family in a big house.
Employment: Samantha wants to work in a music store.

Diploma Objective

Regents Diploma Advanced Regents Diploma Local Diploma IEP Diploma

Expected High School Completion Date 6/2007 Credits Earned _____ As of Date _____

Transition Services

(Required for students 15 years of age and older.)

Instructional Activities: Samantha will identify and obtain materials required for daily activities across all environments.

Responsible Party: Parent School Student Agency _____ Fall Spring Summer

Community Integration: Samantha will take part in weekly shopping trips.

Responsible Party: Parent School Student Agency _____ Fall Spring Summer

Post High School: Samantha will take part in a community based work study program.

Responsible Party: Parent School Student Agency _____ Fall Spring Summer

Independent Living: Samantha will practice routines for home and work.

Responsible Party: Parent School Student Agency _____ Fall Spring Summer

Acquisition of Daily Living Skills Functional Vocational Assessment Needed Not Needed

Responsible Party: Parent School Student Agency _____ Fall Spring Summer

Section 1.03(22) of the New York State Mental Hygiene Law is the legal base for eligibility determination and defines Developmental Disability as:

A disability of a person that:

- (a)(1) Is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment or autism;
 - (2) Is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such persons; or
 - (3) Is attributable to dyslexia resulting from a disability described in (1) or (2);
- (b) Originates before such person attains age twenty-two;
- (c) Has continued or can be expected to continue indefinitely; and
- (d) Constitutes a substantial handicap to such person's ability to function normally in society.

(Source: http://www.omr.state.ny.us/wt/publications/wt_advisory_guidelines_text.jsp)

ii Jose P. v. Ambach (filed December 14, 1979). The court ordered the DOE to “take all actions reasonably necessary to accomplish timely evaluations and placements in appropriate programs of all children with handicapping conditions. Under the original judgment, the DOE was ordered to make a large number of changes related to a variety of areas including: (1) development of an “outreach office” for identifying children in potential need of special education services; (2) establishment of a “school-based team” at each school for the purposes of evaluation and placement; (3) development of a plan to establish procedures for the evaluation of English Language Learners; (4) development and dissemination of informational materials regarding parental rights; (5) compilation of a set of standard operating procedures; (6) development of a data bank and data tracking system; and (7) submission of monthly reports. Source: *Hehir T., Figueroa, R., Damm, S. et al. (9/20/2005). Comprehensive Management Review and Evaluation of Special Education.*

Comprehensive Management Review and Evaluation of Special Education.

iii Medicaid Service Coordinators are available to consumers who have Medicaid and assist consumers in planning for and accessing desired supports and services. They are required to meet with a family at least once per month, and assist each consumer to develop, implement and maintain a plan (Individualized Service Plan) for services and supports in order to meet the consumer’s goals. *Medicaid Service Coordinator Basic Agreement (2000) OMRDD*

iv The Parent Coordinator is part of the administrative team working under the supervision of the principal. The parent coordinator will engage with and involve parents in the school community by working with the principal, school leadership team, parent associations, community groups and parent advisory councils. This position focuses on creating a welcoming environment for parents. The parent coordinator will identify parent and related school/community issues and work with the principal to see they are addressed in a timely manner. Source: Parent Coordinator Human Resource Guide (2003) *New York City Department of Education, Division of Human Resources.*

<http://www.nycenet.edu/offices/dhr/forms2/PARENTCOORDINATORhandbookdecember4revised.pdf>

v These programs explore career possibilities and help students learn job seeking skills and develop plans for a job search. *Transition Matters: From School to Independence (2003) Resources for Children with Special Needs.*

vi This program provides developmental training, structured activities and specialized assistance to enable individuals to engage in non-vocational activities in community settings. *Transition Matters: From School to Independence (2003) Resources for Children with Special Needs.*

vii The Home and Community-Based services waiver program is the Medicaid program alternative to providing long-term care in institutional settings. Specific services covered by the waiver are residential habilitation, day habilitation, prevocational services,

supported employment, respite services, environmental modifications, adaptive equipment, plan of care services, family education and training, and consolidated supports and services. *Source: Centers for Medicare and Medicaid Services (9/16/04)*
<http://www.cms.hhs.gov/medicaid/1915c/default.asp>

viii Programs that prepare people for the possibility of holding a job by teaching career exploration, job hunting techniques, and work-ready behavior. They often include community-based internships, travel training, and job placement with job coaching.
Transition Matters: From School to Independence (2003) Resources for Children with Special Needs.

ix Supported Employment is paid competitive work that offers ongoing support services in integrated settings for individuals with the most severe disabilities. Supported Employment is intended for individuals for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of a most severe disability. Available through VESID or the HCBS waiver. *Source: <http://www.vesid.nysed.gov/supportedemployment/guidelines.htm>*

x Waiver eligibility includes all the criteria an individual has to meet before they can received services through the Home and Community-based Services waiver. They are based on the mental hygiene law definition of a disability (Endnote i) and additionally require that 1) The individual receive Medicaid, 2) (S)he has limited income/assets if over age 18, 3)(S)he has appropriate living arrangements 4) (S)he is eligible for institutional level care and 5) funds are available through the local Developmental Disabilities Service Office (DDSO) to provide services. *The Key to Individualized Services, The Home and Community Based Services Waiver Provider Guide (1997), Bureau of Mental Retardation and Developmental Disabilities Services.*