Office of Developmental Programs (ODP)

Everyday Lives: Values in Action

Information Sharing & Advisory Committee (ISAC)

RECOMMENDATIONS & STRATEGIES

2024

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Acronyms

AE	Administrative Entity
ASERT	Autism Services, Education, Resources & Training
AWC	Agency with Choice
CDS	College of Direct Support
CIE	Competitive Integrated Employment
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice
CPS	Community Participation Support
CtLC	Charting the LifeCourse
CWDS	Commonwealth Workforce Development System
ECHO	Extension for Community Healthcare Options
EDL	Everyday Lives
FSS	Family Support Services
HCBS	Home & Community Based Services
HCQU	Health Care Quality Unit
HRST	Health Risk Screening Tool
HTTP	Housing Transition & Tenancy Providers
ID/A	Intellectual Disability/Autism
IM4Q	Independent Monitoring for Quality
ISAC	Information Sharing & Advisory Committee
ISP	Individual Support Plan
LMS	Learning Management System
NADSP	National Alliance for Direct Support Professionals
NCI	National Core Indicators
ODP	Office of Developmental Programs
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health & Substance Abuse Services
OVR	Office of Vocational Rehabilitation
PA	Pennsylvania
PAFN	Pennsylvania Family Network
PDS	Participant-Directed Services
PRE	Periodic Risk Evaluation
PUNS	Prioritization of Urgency of Need for Services
QA&I	Quality Assessment and Improvement
QM	Quality Management
QOLQ	Quality of Life Questionnaire
RM	Risk Management
SAPNA	Self-Advocacy Power Network for All

SC	Supports Coordinator
SIB-R	Scales of Independent Behavior
SIS	Supports Intensity Scale
SCO	Supports Coordination Organization
START	Systemic, Therapeutic, Assessment, Resources & Treatment Model
TRAIN	Trauma Recovery for Autistic, Intellectually Disabled and Neurodiverse Individuals
VF/EA	Vendor Fiscal/Employer Agent

Recommendation 1: Assure Effective Communication

Every person has an effective way to communicate in order to express choice and ensure his or her health and safety. All forms of communication should consider and include the individual's language preferences and use of current technology.

STRATEGIES *for* #1

1. Issue the communication policy bulletin.

- Define communication and the ways people communicate.
- Assert that everyone can communicate in one way or another (such as but not limited to behavior, eye gaze, visual gestural); however, not everyone can communicate effectively and meaningfully.
- Specify roles and expectations; consistently providing communication services and supports and striving to support everyone to communicate effectively and meaningfully.
- Include the applicable 6100 regulations.
- Require a communication policy.
- Be available in plain language or easy read.

2. The Individual Support Plan (ISP) and the planning process will start with communication.

3. Use data to identify people in service that have communication access needs. Better utilize data through Supports Intensity Scale (SIS) and PA Plus, Health Risk Screening Tool (HRST), Scales of Independent Behavior (SIB-R), Quality of Life Questionnaire (QOLQ), and Periodic Risk Evaluation (PRE), etc.

4. Increase the number of professionals with expertise in communication to work with individuals with intellectual disabilities or autism across the lifespan.

5. Accommodate preferred language and all ways people communicate including individuals and families, and best communication partners.

6. Continue to develop and share tools, resources, and trainings in order to support the implementation/adoption of “communication-first thinking” in Pennsylvania.

Recommendation 2: Promote Self-Direction, Choice, and Control

Personal choice and control over all aspects of life must be supported for every person. Choice about where to live, whom to live with, what to do for a living, and how to have fun all are key choices in life, as are seemingly small choices: such as what to eat, what to wear, when to wake up in the morning, and when to go to bed. It is important to be able to trust the people who provide assistance, to feel confident that they respect you and your right to manage your life, and to enjoy each other's company.

Self-direction works when individuals have clear and understandable information, opportunities to exercise choice, and assistance with making decisions when needed. Self-direction is only possible when family, friends, and people who provide supports respect the individual's preferences and their right to make mistakes and facilitate the implementation of the individual's decisions.

STRATEGIES *for* #2

1. Ensure choice and control over all aspects of life are supported for individuals in licensed settings. Measure and track regulatory compliance with regulations associated with choice and control.

2. Support personal choice and control for everyone by promoting and expanding use of Participant-Directed Services (PDS). PDS are a way for people to choose their own staff and direct how their services are provided. People may direct one, some, or all services based on personal preference and need.
    - Revise the Pennsylvania Guide to PDS to be more accessible and include plain-language explanations of how to use the Vendor/Fiscal Employer Agent (VF/EA) and Agency with Choice (AWC) service models.
    - Create accessible supplemental materials that provide easy-to-understand summaries of participant-direction and direct people to the Guide to PDS.

3. Assure the availability of fiscal intermediary services. Permit more than one AWC to operate within a county/Administrative Entity (AE), allowing greater access to AWC services and expanded participant choice.

4. Create and promote the Individual's Bill of Rights. There are over 30 individual rights protected by the Chapter 6100 regulations. The rights are not always easy to understand because regulations can be hard to read. The Individual's Bill of Rights must present individual rights in plain language, preferred languages, and easy read options so everyone can understand them. In addition to helping people understand their rights, the Individual's Bill of Rights will be used when measuring compliance to ensure that rights are protected.

5. Expand use of the Life Sharing and Supported Living Services. Life Sharing is a regulated residential service where an individual becomes a member of a private household. Supported Living is a residential service provided in a home that is owned, rented, or leased by the participant. Both Life Sharing and Supported Living offer a great deal of individual choice and control. This strategy supports the transition and diversion of individuals from more restrictive residential settings to less-restrictive private homes.

Recommendation 3: Increase Employment

Employment is a centerpiece of adulthood and must be available for every person. The benefits of employment for people with disabilities are significant and are the same as for people without disabilities.

STRATEGIES *for* #3

1. Inform individuals and families about employment opportunities and the impact of employment on benefits throughout the life stages of early childhood, school age, and transition to adulthood.

2. Strengthen outreach to businesses through local employment coalitions to support individuals to obtain competitive integrated employment (CIE).

3. Support individuals receiving subminimum wage to gain CIE.

4. Support families before, during, and after an individual's transition to CIE.

5. Work with the Office of Vocational Rehabilitation (OVR) to develop a process for AEs and SCs to obtain relevant information from OVR's Commonwealth Workforce Development System (CWDS) to facilitate individual transitions between the two offices.

6. Support provider transformation from focusing on workshop/subminimum wage activities to services that support CIE.

7. Facilitate public-private partnerships and local interagency coalitions to support employment opportunities and encourage innovation.

8. Provide training and technical assistance to supports coordinators (SCs), individuals, and families to increase awareness of benefits counseling, including how benefits counseling supports CIE and transitions from subminimum wage to CIE.

9. Promote and increase county and state government hiring of people with disabilities.

10. Support the growth and advancement of post-secondary education programs.

11. Disseminate county-level employment reports that include comparisons by race to AEs and local employment coalitions. Engage employment leads and coalitions in discussion about racial disparities and support adoption of local strategies to address the disparities.

12. Establish and implement employment related performance measures for supports coordination and residential services. Standards must be reasonable and account for acuity of support needs of individuals, individual choice, economic conditions at the local level, and level of influence of the service provider.

13. Collect and publish data from prevocational service providers (in both licensed day habilitation and prevocational facilities) on rates of moving people to CIE.

14. Provide training and ongoing technical assistance to providers and SCs on barriers to employment and potential solutions such as how Community Participation Support (CPS) can be used as a wraparound service for people with CIE and services that support employment that are available through other agencies.

Recommendation 4: Support Families throughout the Lifespan

The vast majority of people with disabilities in Pennsylvania live with their families. Families need support in order make an everyday life possible throughout the person's lifetime. Families need information, resources, and training. They need connections with other families and support services. Listening to people with disabilities and their families is key to providing supports that help them achieve an everyday life.

STRATEGIES *for* #4

1. The Charting the LifeCourse (CtLC) framework is the foundation for intake so that individuals and families can start developing their vision and access integrated supports to respond to immediate needs. Families receive all information about possible/available services and supports, as well as where to go when they are ready for next steps.

2. Support the work of the PA Family Network (PAFN) to reach families with a consistent message of the importance of family expectations of a good life for family members and opportunities for discovery and navigation of support/service systems and community-based resources.

3. Support the continued growth of regional collaboratives, through the Community of Practice (CoP), so that communities and all stakeholders experience genuine direction and ownership in local approaches to ensure equal access and support of individuals and families.

4. Align supports coordination with the CtLC framework so that SCs have the skills and capacity to encourage, explore, and plan with individuals and families about their vision of a good life and achieve short and long-term goals towards that vision of an everyday life now and in the future.

5. With most individuals living with their families, whether they receive formal services or not, Family Caregivers are supported to plan across life transitions, from birth throughout the arc of life. This includes financial planning, benefits planning, better planning tools, and SCs assisting in planning. Family caregivers need information, connection, and services and supports.

6. Develop materials in plain language, like the Gold Book, that lead families to information, connections, opportunities, supports, and resources needed to build everyday lives for all.

7. Strategize multiple ways to disseminate information to families. Communication avenues include counties, providers, ISAC members, email distribution lists, school districts, advocacy organizations, OVR, social media, and traditional media at the local and state level.

8. Focus on the engagement of cross-systems partners to build capacity across fields (e.g., medical, hospital social workers, etc.) in the CoP for Supporting Families to recognize their roles in supporting families to have strong visions and high expectations. The value their roles play in improving access for families to needed information, connection to other families, simplifying the processes of accessing supports, and services throughout the lifespan is essential.

9. People with disabilities who are parents, or who are planning to become parents, should be supported to plan for their needs as a family. Support should include planning with the SC. ODP will develop concrete expectations for how to support parents with disabilities and those who plan to become parents. Individuals will have the support they need to explore family planning.

Recommendation 5: Promote Health, Wellness, and Safety

Promote physical and mental health, wellness, and personal safety for every individual and his or her family. Promoting physical and mental health means providing information about health and wellness, emotional support, and encouragement. Tools that help every individual adopt a healthy lifestyle — including good nutrition, healthy diets, physical activity, and strategies to reduce and manage stress and protect oneself from all types of abuse and exploitation — must be provided.

STRATEGIES *for* #5

1. Promote improved healthcare for individuals with intellectual disability, autism, and other developmental disabilities. This includes physical, behavioral, and dental healthcare.
    - Incorporate a focus on health and wellness into the individual planning process.
    - Use the HRST to inform individual planning.
    - Offer training on the Fatal Five and other health conditions to broader audiences in both live and on-line formats.
        - Highlight effective monitoring done by providers.
    - Pursue new waiver service for telehealth assessment availability with healthcare professionals with expertise in supporting individuals.
    - Develop trainings for healthcare providers [Autism Services, Education, Resources & Training (ASERT), Health Care Quality Units (HCQUs)].
    - Promote inclusion of health care providers in the planning process recognizing individual preferences and decisions.

2. Direct people to existing resources with information on healthy living. Develop resources where inadequate information exists.
    - Provide outreach and education for SCs on these topics to promote incorporation into the ISP.
    - Continue to encourage health professionals to become eligible providers for available waiver services for wellness.
    - Promote health literacy to increase individuals' capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
    - Education for individuals, about insurance options, delivered by individuals.
    - Education on preventive health.

3. Support and promote resources for healthy sexuality, problematic sexual behavior, and recovery from sexual trauma.
    - Identify experts in the field in PA available to support individuals and families with recommendations and strategies.
    - Promote and build capacity for availability of therapists with expertise in addressing trauma in individuals with intellectual disabilities and/or autism (ID/A).

4. Increase preparedness for biological, environmental, and other critical situations that require significant and potentially sudden changes in standard activities in order to protect health and wellness, and access needs.
    - Utilize and disseminate guidelines and best practices.
    - Participate in the further development of AIDinPA.org as a platform to inform and educate.
    - Explore additional training opportunities, such as with shelters, healthcare settings, and emergency response agencies.

5. HCQUs and ASERT will work independently and in coordination to develop outreach to promote wellness to individuals living with families, including people on the waiting list, engaging partners including Self-Advocacy Power Network for All (SAPNA), the PAFN, and Temple.

6. Broaden the use of physical and behavioral health data to understand health, wellness and safety needs and risks, and to inform ODP planning and direction of supports such as waiver development, HCQU and ASERT activities.
    - Monitor trends in reporting sexual abuse incidents.
    - Monitor abuse dashboard.
    - Monitor trends for Fatal 5 and other serious injury.
    - Consider possible role of artificial intelligence in examining data.
    - Explore HCQU access to Health Information Exchanges.

7. Create an initiative to promote physical activity among all stakeholders. Ensure:
    - Inclusive for all,
    - Resources for people who use wheelchairs or have other mobility supports,
    - Partnering with community resources such as Special Olympics,
    - Events held are inclusive, and
    - Education about choice and impact on health.

Recommendation 6: Support People with Complex Needs

People with disabilities who have both physical and behavioral health needs receive the medical treatment and supports needed throughout their lifespan. People are more able to live an everyday life when individuals, families, and providers plan and prepare to provide and modify supports as needs and challenges change. Opportunities for a full community life are dependent on adequate supports and the commitment to build capacity within the larger human service delivery system.

STRATEGIES *for* #6

1. Support the use of an inclusive, structured educational process to address capacity building across the spectrum of stakeholder needs. ODP will partner with other Program Offices as appropriate in this strategy, including the Office of Mental Health and Substance Abuse Services (OMHSAS). Areas of focus that are in progress, in planning, or may be considered in the future include, but are not limited to:

- Capacity Building Institute,
- Residential Learning Collaboratives,
- Capacity Building for Children with Multisystem Involvement,
- Justice System Involvement including the Department of Corrections,
- Aging/Late Life Issues, and
- Institute on Physical Health and Health Equity (with Department of Health involvement).

2. Improved support for individuals, their families and other support providers related to complex medical needs. ODP will develop, in coordination with the HCQUs and ASERTs, increased access to standardized information and guidance for individuals with new onset or longstanding complex medical health needs, their families and other support providers.

3. Improved use of data and consideration for additional data collection. Use data related to individuals (including children) with complex medical needs, complex dental needs or complex mental health needs to inform ODP policy and program design. Data should be comprehensive with respect to healthcare disciplines and specialties. Data should be inclusive of LGBTQIA+ care, when available, including transgender care. This data will enhance the development of:

- Training and education,
- Strategies to target identified health risks, and
- Improved capacity to support people with complex needs.

4. Increase capacity and proficiency of behavioral supports.

- Promote best practice standards for behavioral support.
- Continue use of Online Training Modules for Functional Behavior Assessment.
- Pilot the Systemic, Therapeutic, Assessment, Resources & Treatment (START) model and the associated training and educational opportunities.
- Conduct behavioral support roundtables.

5. Conduct an annual conference addressing the support of individuals with complex needs for a broad range of stakeholders.

6. Advance the availability and use of Certified Peer Specialists for individuals with ID/A.

7. Provide novel approaches to the support of individuals with complex needs and maintain/ enhance current effective platforms that include but are not limited to:

- START Model,
- Trauma Recovery for Autistic, Intellectually Disabled and Neurodiverse Individuals (TRAIN),
- Project Reassure,
- Project Extension for Community Healthcare Options (ECHO),
- Dual Diagnosis Curriculum,
- Functional Behavior Assessment Modules,

- AIDinPA.org, and
- Professional Conference Series.

8. ODP will explore ways to promote interest in, and competencies for, meeting the healthcare and support needs for individuals with ID/A. This strategy will also promote access to these areas of need for individuals from childhood through late life. Areas of focus will include:

- Nursing
  - In home, pediatric and adult
  - Hospital, clinic, or agency based,
- Physician and other advanced practice providers
  - Physical health
  - Behavioral health, and
- Therapies.

9. Increase capacity to support children with complex needs.

- Recognize the varying support needs for younger children, adolescents, and transition age individuals.
- Expand the pool of available Life Sharers and families to support children with complex needs by promoting awareness and increasing interest in becoming providers.
- Expand the pool of providers of Family Medical Support Assistance.
- Work collaboratively with the Office of Medical Assistance Programs (OMAP) to increase pediatric in-home nursing capacity.
- Work collaboratively with OMAP to explore the possibility of creating a credentialing process for state plan services that would allow family members to become paid providers of skilled care for children in the home.

10. Build capacity to provide safe, restorative, and therapeutic homes for adults with dual diagnosis and adults with autism, by establishing:

- Clear standards for clinical expertise, and
- Corresponding funding for clinically enhanced services.

Recommendation 7: Develop and Support Qualified Staff

People with disabilities receiving services benefit when staff who support them are well trained. Values, ethics, and person-centered decision-making can be learned and used in daily practice through mentorship and training. Providing professional training that strengthens relationships and partnerships between individuals, families, and Direct Support Professionals (DSPs) will improve the quality of support.

STRATEGIES *for* #7

1. Adopt the Direct Work Force Core Competencies, which were developed by the Centers for Medicare and Medicaid Services (CMS) and embedded in the National Alliance for Direct Support Professionals (NADSP) and the College of Direct Support (CDS).

a. Incentivize Core Competencies by:

- Identifying providers who have adjusted pay scales to promote/incentivize completion of Direct Support Professional (DSP) and Frontline Supervisor (FLS) credentialing,
- Reviewing the payment models of other states to report on how DSP credentialing is incentivized elsewhere, and
- Developing payment models that incentive provider adoption and sustainability of DSP/FLS credentialing.

b. Engage families and individuals in the discussion of Core Competencies to include:

- An explanation of the Core Competencies, and
- Conveying ODP's expectations regarding the implementation of Core Competencies/credentialing.

2. ODP will establish and implement credentialed training programs based on standard curriculum and testing in an attempt to maintain and develop qualified staff, decrease the rate of turnover, and promote staff retention and provider capacity. This strategy will include training for DSPs as well as other professionals, such as Benefits Counselors.

3. Build incentives into the reimbursement system to promote staff credentials, encourage professional growth and development, and adopt incentive-based training and credentialing. This includes reviewing other states' models, where success has been achieved, to learn from those who have attempted and have identified hurdles to progress.

4. Promote the use of and improve the usability and functionality of MyODP.org, to include allowing for greater access, upgrading the Learning Management System (LMS) software, and promoting the CDS and other courses available via the site.

Recommendation 8: Simplify the System

The system of supports and funding of those supports must be as straightforward and uncomplicated as possible. This will allow for greater understanding and use of the system by everyone — most importantly the individual needing and receiving supports.

STRATEGIES *for* #8

1. Redesign the ISP process and format to reduce the time needed to complete and update the ISP, streamline the ISP, and increase the positive experience of individuals and families, and all stakeholders.

2. Provide a user-friendly ISP that increases flexibility and promotes ease of access for the individual, their family, and supporters to manage services and supports.

3. Design and implement an enterprise case management system with input from all stakeholders to provide direct access to individual plan information for individuals, families, and authorized providers; and optimize and automate workflow processes where possible, leveraging existing information from other Medical Assistance (MA) systems via near real-time data exchanges to reduce the time it takes from enrollment to begin providing services to individuals.

Recommendation 9: Improve Quality

Together we must plan and deliver services and supports that adhere to our values, measure person-centered outcomes, and continuously improve an individual's quality of life. All stakeholders must be engaged in the process of measuring how well services assist people in achieving an everyday life.

STRATEGIES *for* #9

1. Maintain the Information Sharing and Advisory Committee (ISAC) as ODP's Stakeholder Quality Council. Publish an ISAC annual report to show the results of implementation of approved recommendations and strategies across the system. The ISAC will continue to use the quality improvement framework to plan and implement improvements, gauge progress, and assess whether we achieve outcomes as intended, make changes as needed, and embed successful practices in the system.

2. Continue to offer ODP's Quality Management (QM) Certification Curriculum to build system capacity in applying QM principles and practices across the system.

3. Continue to engage in annual participation of Independent Monitoring for Quality (IM4Q) and National Core Indicators (NCI) surveys as valuable tools for collecting satisfaction data about how individuals and families feel about services received from the ODP system. ODP will:
    - **a.** Continue to use this data to measure the progress of identified ISAC performance measures,
    - **b.** Continue to scan the environment for additional opportunities for use of this data, and
    - **c.** Adjust data collection practices, as needed, to address any new CMS Home and Community-Based Services (HCBS) Quality Measure Set requirements.

4. Improve quality of services through establishment, application and updating of performance standards, use of standardized quality metrics, and aligning payment with outcomes. Share results of this process to assist individuals, self-advocates, families, and supporters to make informed choices about providers and services.

5. Maintain the Quality Assessment and Improvement (QA&I) process as ODP's annual process for monitoring the system's performance in supporting individuals and families. Publish a QA&I annual report to show the results.

6. Develop and refine an ODP Risk Management (RM) Framework. This involves mapping and evaluating existing RM activities for opportunities for improvement in the system intended to help keep individuals safe. Goals of this work include use of a framework to develop a common language and shared understanding across the system, having effective strategies and efficient tools to address various risk types within the system, and overall reduced harm to individuals.

7. Revise the QM Strategy Bulletin and include incorporation and alignment with RM strategies to support greater understanding of ODP's Culture of Quality and Safety.* Fostering a Culture of Quality and Safety can lead to better outcomes for people receiving services.

A **Culture of Quality involves a set of common characteristics that include desire to understand contributors to quality issues, recognition that mistakes occur, and blame is not useful, shared responsibility for identifying and acting on improvement opportunities, and ongoing feedback across all levels to achieve quality. A **Culture of Safety** fosters a culture that is focused on preventing, detecting, and minimizing exposure to danger and errors without blaming others. In a **Culture of Quality and Safety** there is a shared understanding of trust and learning, as well as a deep commitment to the common mission, vision, and values among all agencies and stakeholders. Fostering a Culture of Quality and Safety can lead to better outcomes for people receiving services and those caring for them to ensure freedom from harm.*

Recommendation 10: Expand Options for Community Living

Expand the range of housing options in the community so all people can live where and with whom they want to live. Listening to people with disabilities and their families, providers, and Support Coordinators will help people locate affordable and accessible housing, find house mates, and identify housing resources/supports and other government benefits that, when blended with natural supports, will promote an everyday life.

STRATEGIES *for* #10

1. Monitor and evaluate the number of qualified providers of Housing Transition and Tenancy Services (HTTS) across the state to ensure sufficient access. Track utilization of HTTS.

2. Develop a training for SCOs, AEs and providers on HTTS.

- The training should include information on the financial impact.
- Provide training on the varied options for community living.
- Help SCs to understand that residential services should not be the first option. Ensure SCs understand how to offer the service to meet individuals' needs and how to manage requests for residential services when other options are limited.
- Provide training and guidance to SCs on how to navigate difficult conversations.
- Focus on person's strengths rather than what they can't do.
- Understand the assistive technology available to support independent living.
- Use CtLC tools for SCs and team to plan for independent living.
- Include competency-based tests to ensure understanding.

3. Expand understanding of what is possible.

- Promote development and distribution of education/training/technical assistance to individuals to increase knowledge of options and their ability to make informed choices.
- Ensure development and distribution of education/training/technical assistance for families through the Supporting Families initiative. This should include planning for the future so that families can explore what is possible. The education should include items like ABLE accounts, sustaining housing, and community support.
- Evaluate and improve the education and support for individuals to budget for their housing needs.
- Develop training to be applicable to everyone, including families and individuals with different economic access and who speak different languages. It's hard for people to think about what is possible as it relates to living independently.
- Develop guidance and other resources to ensure families understand that this is possible for individuals with complex needs. Show people what is possible – Life Sharing and supported living.
- Explore options to assist families to understand Life Sharing is beneficial and answer "if I can't do it how can another family do it?"
- Explore live-in caregiver, house parent.
- Ensure information is available for families who have language barriers so that they understand what is possible.

4. Track movement of people by living arrangement.

5. Continue to develop supported living service availability that enables individuals to live in their own homes with the support of an agency available to provide guidance and assistance as needed.

- Continue to promote this service as an alternative to residential habilitation. Use the transition incentive payment to assist in promoting the supported living service.
- Propose the transition incentive payment to be expanded/shared with the supported living provider.
- Develop more specific material to help SCs explain the benefit of the services to individuals and families.
- Ensure availability of pest eradication.

6. Explore implementation of ODP HCBS housing vouchers to support affordable, accessible housing options for individuals with IDD. Implement, track, and evaluate the success of the Housing Pilot.

7. Provide access to home modifications, transportation, and supportive and/or assistive technology to support people to live in their homes.

- Continue to help SCs and providers learn how to access technology to promote independence.
- Review current barriers individuals are experiencing for use of ride share under current ODP policies.

Recommendation 11: Increase Community Participation

Being involved in community life creates opportunities for new experiences and interests, the potential to develop friendships, and the ability to make a contribution to the community. An inter-dependent life, where people with and without disabilities are connected, enriches all of our lives.

STRATEGIES *for* #11

1. Promote and support opportunities for Person-Centered Thinking and Planning training that focuses on assisting individuals to implement their community inclusion plan through identifying new experiences, promoting engagement in new activities, and making new connections that are important to them, in their local community.

2. Continue the statewide practice of community participation that facilitates valued and active participation in a broad range of integrated activities that build on the person's interests, preferences, and strengths while reflecting the person's desires for employment, community involvement, and membership.

3. Promote and support opportunities for peer-to peer-education, self-advocacy and discussion for individuals and their families regarding potential goals for being supported in the community and successful community inclusion.

4. Support providers to develop and implement the individual's plans for community inclusion and/or CIE outcomes that meet the individual's choice, preferences, and goals.

5. Develop and provide training to SCs on facilitating planning, discussion, and effective monitoring to support individuals to become more involved in community life.

6. Develop and disseminate new ideas and approaches on how to provide creative solutions to transportation barriers.

7. Analyze data and collect examples to identify providers, AEs, and individuals who have demonstrated successful community inclusion goals, strategies, and/or initiatives and share best practices through training, technical assistance, and other accessible and innovative methods.

Recommendation 12: Provide Community Services to Everyone

People with disabilities — whether living on their own, with families, or in institutions — are waiting for community services. The goal is to build a system having the capacity to provide services in a timely fashion for all people who need supports.

STRATEGIES *for* #12

1. Individuals and their families receive SC service; information about local resources and services (e.g., OVR, Medicaid, aging, housing supports, income supports, justice related supports, and victim services); information to connect with family and self-advocacy support organizations; and Family Support Service (FSS) using Base and block grant funding.

Supports coordination should provide individuals and families with tools and support to create a vision of an everyday life that:

- **a.** Considers local community resources in an everyday life: daily and community living, social and spirituality, healthy lifestyles, security, civic engagement, and advocacy,
- **b.** Builds on the personal strengths, interests, relationships, resources, and opportunities within the person's and family's lives, and
- **c.** Serves as the overall framework to provide publicly funded services which align with their everyday life.

2. ODP will implement its Multi-Year Growth Strategy aimed at ending the Emergency Waiting List for adults aged 21+. *This strategy is contingent upon passage of the Governor's proposed budget.

3. Update the Prioritization of Urgency of Need for Services (PUNS) instrument and conduct ongoing training on the PUNS tool for:
    a. Individuals, families, SCs and AEs, and
    b. SCs on facilitating discussion to inform the PUNS. *Updates to the PUNS instrument are contingent upon implementation of ODP's Multi-Year Growth Strategy which is dependent on the passing of the Governor's proposed budget.

4. ODP will provide training, resource bundles, and technical assistance to law enforcement and criminal justice systems regarding intellectual disability and autism on available supports and services in order to:
    a. Prevent individuals from being arrested,
    b. Promote interagency collaboration if an individual becomes involved with the criminal justice system,
    c. Focus efforts on "intercept 0" to connect people with community services before they become justice involved,
    d. Improve supports to individuals who have been victims of crimes, and
    e. Ensure individuals who may be eligible for services are referred by corrections facilities to appropriate counties so that eligibility can be determined, and appropriate supports can be identified to facilitate a safe introduction to the community.

5. Develop expertise with Providers, AEs and SCOs by providing training to:
    a. Identify individuals at risk for becoming involved in the justice system and to implement risk mitigation strategies,
    b. Navigate the criminal justice system to support diversion and increase collective system capacity to support individuals involved with the criminal justice system, and
    c. Establish standards for SCOs to have expertise in supporting justice involved individuals.

6. ODP will issue an annual report on progress in addressing the waiting list. The report will include strategies to address ending the waiting list for eligible adults in PA. *Contingent on budget approval.

7. Provide outreach and communication to autism and Children with Medically Complex Conditions communities and system partners about the expanded eligibility in ODP Programs.

8. Building on the success of ODP's approach to managing waiver capacity for high school graduates, ODP will develop strategies and train AEs to implement more efficient waiver capacity management strategies giving AEs more flexibility while serving more people.

Recommendation 13: Evaluate Future Innovations Based on Everyday Lives Principles

Future consideration of service models and reimbursement strategies must be based on the principles of person-centered planning, individual choice, control over who provides services and where, and access to/full engagement in community life. Innovative approaches should be evaluated based on the recommendations of *Everyday Lives (EDL)*, including employment, recognizing, and supporting the role of families, and meeting the diverse needs of all individuals. Stakeholders should be fully engaged in designing, implementing and monitoring the outcomes and effectiveness of innovative service models and service delivery systems.

STRATEGIES *for* #13

1. Adherence to the values and principles of EDL and person-centered planning, individual choice and control over who provides services and where, and support access to the greater community and full engagement in community life, as required by the Federal HCBS Rule.

2. Meaningful engagement of stakeholders (including individuals, family members, county governments, providers, SCOs, and advocates) in designing, implementing, and monitoring provider and system performance and outcomes.

3. Recognition that payment models should align with outcomes and assume that individuals require supports across the lifespan, that their needs are not episodic or time-limited but are ongoing and ever changing throughout life. Investment in skill development and job placement and training may not realize savings for a number of years into the future.

4. Ensure that HCBS enable people to live and engage in community life while ensuring individuals have their medical, mental/behavioral health, and dental needs met.

5. Recognition that individuals' and families' needs, and social conditions change over time creating new challenges to which service systems must adapt. These changes include increased numbers of individuals with dual diagnosis, autism, medical complexities, additional medical conditions, or disabilities due to aging.

6. Adoption of a performance evaluation system founded in the principles of EDL and the federal (HCBS) rule.

7. Recognition that most individuals are supported by their families throughout life. An effective service system respects the valued role of families and understands that supporting families is critical to achieving good outcomes for individuals.

8. Recognition that professionals are often supporting individuals with the most intimate aspects of their lives, from personal care to the experience and response to trauma, to health and mental health related matters, to sexuality and relationships. Individuals have a right to self-determination, dignity, and respect in all aspects of their lives.

Recommendation 14: Promote Racial Equity (New)

Communities are richer, more just, and stronger when we honor and respect the whole of racial diversity. Access to a quality, person-centered, culturally competent system of supports and funding must be equally available regardless of race. Services must include planning over a life span and address racial disparities, including disparate outcomes. The duty to ensure that racial diversity is promoted and supported, at all levels within the services system, must be embraced.

STRATEGIES *for* #14

1. Consistently include breakdowns by race, in data analysis and reporting, to support identification of racial equity performance improvement opportunities and incorporation into quality management plans to drive improvement activities and use to measure progress on these activities.

2. Develop and provide peer training for self-advocates on racial bias and racial equity.

3. Support organizations with tools to understand and improve their racial equity performance and ensure increasing levels of racial diversity and inclusion, across all levels of their organization, as part of their quality management strategy.

4. Explore ethnicity data availability to incorporate in analysis and reporting.