Nevada's Aging and Disability Services Division

Nevada's Strategic Plan for Integration of Developmental Services and Early Intervention Services into the ADSD

2014

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They include families, advocates, health care professionals, and providers at businesses and organizations that serve residents throughout the state.

Leadership for this plan came from Nevada's Aging and Disability Services Division. The plan was developed by a Steering Committee that dedicated countless hours to ensure the integration is successful.

Hundreds of participants helped to shape this plan by completing surveys, participating in key informant interviews and attending meetings. Their assistance is gratefully acknowledged.

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GLOSSARY

Aging and Disability Resource Centers (ADRC) – Aging and Disability Resource Centers have been funded in Nevada to create a single, coordinated system of information and access for all persons seeking long-term support to minimize confusion, enhance individual choice, and support informed decision-making.

Age in Place - Older adults and people who have disabilities want to live as independently as possible for as long as possible in their homes and communities.

Elder Abuse - A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

Family-Centered - Family-centered practice is a way of working with families, both formally and informally, across service systems to enhance their capacity to care for and protect their children. It focuses on needs within the context of their families and communities and builds on families' strengths to achieve optimal outcomes. Families are defined broadly to include birth, blended, kinship, and foster and adoptive families.[1]

Family Resource Center (FRC) – The State of Nevada defines a family resource center as "a facility within an at-risk neighborhood where families who reside within that neighborhood or a contiguous at-risk neighborhood may obtain: 1. An assessment of their eligibility for social services, 2. Social Services; and 3. Referrals to obtain social services from other social service agencies or organizations." Family Resource Centers emphasize community based, resident driven, collaborative programs that are culturally competent, accessible and flexible.

Fidelity – Fidelity is defined as the extent to which delivery of an intervention adheres to the protocol or program model originally developed[2].

Frontier Areas – Frontier areas are sparsely populated rural areas that are isolated from population centers and services. Frontier is defined as places having a population density of six or fewer people per square mile.

Home and Community Based Services (HCBS) – A wide array of home and community based services that an individual may need to avoid institutionalization such as case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and other services.

Housing and Urban Development (HUD) – A federal agency that provides and funds a variety of housing programs including affordable housing.

Livable Community - A community that has appropriate housing at a price people can afford. It is built around green spaces and has places to shop, socialize and play nearby. Residents know where to find the local library, health services, schools and other community facilities. Many of these are within walking or cycling distance, and form a core for the community. Good transit provides connections to other destinations outside the community.

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[1] US Department of Health and Human Services, Administration for Children and Families.

[2] Mowbray, C.T., Holter, M.C., Teague, G.B., & Bybee, D. (2003). Fidelity criteria: Development, measurement, and validation. American Journal of Evaluation, 24, 315-340.

Long-Term Care (LTC) - LTC describes a number of different scenarios, all of which include providing a continuum of services that may include medical care, housing, social services, recreation, and other services to persons with disabilities or chronic care needs. These include a continuum of options including in-home care, senior apartments, assisted living facilities nursing homes and many other settings.

Memorandum of Understanding (MOU) - A legal document outlining the terms and details of an agreement between parties, including each party's requirements and responsibilities.

Management Information System (MIS) - An information system that integrates data from all the departments it serves and provides operations and management with the information they require.

Person-centered – Person-centered practice is defined as treatment and care that places the person at the center of their own care and considers first and foremost the needs of the person receiving the care. It is also known as person-centered care, patient-centered care and client-centered care. Person-centered practice is treating persons/patients/clients, as they want to be treated[3].

Poverty - The state of being poor; lack of the means of providing material needs or comforts. Usually defined by state and federal agencies.

No Wrong Door - A no wrong door approach provides people with, or links them to, appropriate service regardless of where they enter the system of care. Services must be accessible from multiple points of entry and be perceived as welcoming, caring and accepting by the consumer. This principle commits all services to respond to the individual's stated and assessed needs through either direct service or linkage to appropriate programs, as opposed to sending a person from one agency (or department) to another[4].

Respite Care – Respite care is the short-term supervision or care and time-limited breaks for families of a dependent elderly, ill, or individual with a disability, children with a developmental delay, and adults with an intellectual disability or related condition. Respite care services are designed to offer families/caregivers the opportunity for a break from care giving responsibilities.

Rural Area -- U.S. Census defines rural as: Territory, population and housing units not classified as urban. "Rural" classification cuts across other hierarchies and can be in metropolitan or non-metropolitan areas.

Safety net services – Safety net is defined as community provided welfare services at local and state level geared towards reducing poverty in the community. It can include housing, jobs and money for utility bills and food or food coupons.

Self-Determination – A characteristic of a person that leads them to make choices and decisions based on their own preferences and interests, to monitor and regulate their own actions and to be goal-oriented and self-directing.[5]

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[3] Definition adapted from retrieval on November 11, 2013 from: http://www.health.vic.gov.au/older/toolkit/02PersonCentredPractice/docs/Guide%20to%20implentating%20Person%20centred%20practice.pdf

[4] Retrieved on November 11, 2013 from: http://www.nowrongdoor.org.au/policy_procedures.html

[5] Retrieved on January 23, 2014 from: http://www.ngsd.org/everyone/what-self-determination

Self Neglect - Self neglect refers to situations in which there is no perpetrator and neglect is the result of the person refusing care and/or being unable to care for themselves.

Seniors - A person 60+ years of age, of relatively advanced age, especially a person at or over the age of retirement.

Standards of Service Delivery – Service delivery standards are a set of clear and public criteria with explicit indicators that define service delivery performance that can be monitored and reviewed[6].

System of Care – The system of care model is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports[7].

Universal Design –An approach to the design of products, services and environments to be usable by as many people as possible regardless of age, ability or situation.

Urban Area - Urban areas are defined as both urban clusters (2,500 people but fewer than 50,000) and urbanized areas (population density of at least 1,000 people per square mile of land area that together have a minimum residential population of at least 50,000 people.)

Walkable Community - A community in which pedestrians have safe places to walk that take them to the places they want to travel on foot (or via wheelchair). A walkable community has made a conscious effort to afford pedestrians an equal status with motorists and other road users and to encourage more people to walk. It is measured by public perceptions about the importance of walking in the community and about the feasibility of walking as a mode of transportation.

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[6] Retrieved on November 11, 2013 from: http://www.decd.sa.gov.au/docs/documents/1/ServiceDeliveryStandardsf.pdf

[7] Retrieved on November 11, 2013 from: http://www.tapartnership.org/SOC/SOCvalues.php

INTRODUCTION & PURPOSE OF THE PLAN

DIVISION DESCRIPTION AND PLANNING NEED

The Aging and Disability Services Division (ADSD) represents Nevadans who are aged or have a disability, regardless of age, and assists the broader community that touches their lives. Through advocacy, counseling and a broad array of supportive services, ADSD strives to create an environment that enables all of the Nevadans they serve to be self-sufficient, independent and safe.

In 1971 the Nevada State Legislature established the Division for Aging Services, now ADSD. Since its inception more than 40 years ago, ADSD has been the primary state agency working on behalf of Nevada's elders by developing, implementing and coordinating programs for seniors throughout the state. In 2009, ADSD's mission was expanded to include persons with disabilities.

In the 2013 Nevada Legislature, Assembly Bill (AB) 488 took integration a step further by transferring Developmental Services (DS) and Nevada Early Intervention Services (NEIS) to ADSD. Formerly DS was housed within Mental Health and Developmental Services (MHDS) and NEIS was housed within the Health Division. (Since then, Health and MHDS have also merged to become the Division of Public and Behavioral Health.)

The benefits of integrating the services include a better ability to:

- Promote community living for Nevadans with disabilities of all ages (across the lifespan)
- Create and enhance strategies to ensure the necessary services and supports
- Provide a responsive and effective service system that acknowledges unique needs
- Firmly establish no wrong door for services
- Expand outreach efforts
- Promote seamless service delivery including transitions across programs to obtain the full spectrum of care and better service coordination for participants with similar needs
- Improve access to information on community services and supports such as housing, employment, education, social participation, etc.
- Create a similar comprehensive community provider application and oversight process
- Strengthen basic infrastructure such as information technology (IT), fiscal and accountability

THE BACKDROP: NEVADA'S SENIORS AND PERSONS WITH DISABILITIES

As noted in a January 2012 Legislative Counsel Bureau Research Brief, Nevada has been one of the fastest growing states in the United States for the last 20 years, increasing in total population from 1,201,833 in 1990 to 2,700,551 in 2010. It was also the fourth consecutive decade in which Nevada was the country's fastest-growing state and had a population growth rate over 50%. The two major age groups, which grew at a faster rate than the general population, are children, representing 24.6 % of the total population, and senior adults, ages 65 or older, at 12 % of the total State population.[8]

It was estimated in 2012 that Nevada's population was 2,758,931. Of that population, it is estimated that 12.5% are age 65 or older.[9] The percentage of non-institutionalized, male or female, all ages, all races, regardless of ethnicity, with all education levels in Nevada that reported a disability in 2011 was 11.4%. This includes children ages three and under with a reported disability.

In Nevada, there are approximately 195,000 children under the age of 4 and another 565,000 between the ages of 5 and 19. Studies conducted by the American Pediatric Association have indicated that approximately 13% of children under the age of 3 have a developmental delay. In Nevada, this would create a potential pool of 25,350 children who may have a developmental delay. The ability to serve these children is measured by a factor called the penetration rate. Nevada's penetration rate is 1.3 % of the total population. In comparison, the national average penetration rate is 2.79% of young children with an individual family service plan (IFSP). In addition, Nevadans age 65 and older who report a disability is estimated at 34.5% of the population.[10] When comparing the number of people estimated to have a developmental delay compared to those served (or the penetration rate of services) a state of the state's report estimates that Nevada serves 16% of those in need compared to the national average of 31%.[11] To meet the national average, Nevada would have to serve an additional 15% or 6,417 persons.

All Nevadans have experienced challenges in receiving services in the past five years due to the economic recession and its impact on Nevada. Increased demand on services is due to high unemployment, housing foreclosures, Nevada's budget challenges and issues such as in-migration of retirees, aging of the existing population, and the out-migration of younger people – especially from rural communities.

Overwhelmingly, Nevadans want to live their lives in their own communities. Nationally, four out of five older individuals prefer home care when they need help. Enabling children to achieve their optimal development, adults to live in the setting of their choice, and seniors to age in place requires a significant commitment to ensuring that resources and community-based services are available, accessible and provide quality care. The integration plan is designed to achieve those objectives by effectively bringing NEIS and DS into ADSD and aligning service delivery strategies. The plan will:

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[8] Research Division, Legislative Counsel Bureau Policy and Program Report, January 2012
[9] Retrieved from http://quickfacts.census.gov/qfd/states/32000.html on April 20, 2013.
[10] Retrieved from http://www.disabilitystatistics.org/reports/acs.cfm?statistic=1 on April 20, 2013, maintained by Cornell University.
[11] Retrieved from http://www.stateofthestates.org/documents/Nevada.pdf on January 24, 2014.

- Create a functional team representing NEIS, DS, and Aging and Disability Services that can identify and resolve integration issues while communicating to the staff and public;
- Define the path and process to integrate NEIS and DS into Aging and Disability Services in a manner that provides high quality services that meet the community's needs while responding to policy, compliance, and legal mandates; and
- Optimize funding and service delivery opportunities.

As previously noted, there are a number of strengths that can be built upon in the planning process. One is that NEIS, DS, and Aging and Disability Services have a similar service delivery mode that focuses on high quality, community-based services that are person directed and that provide personal choice. At the same time, the merger of these programs will allow consolidation of effort in areas such as staff training, grant writing, quality assurance, provider development and contract monitoring. It will also reduce duplication of services, align expectations and provide a seamless transition from one service to another.

SYSTEMS DESCRIPTION

The service delivery system within Nevada has changed considerably over the past decade and more. Changes reflect Nevada's population growth, new federal regulations and legislation enacted within the state to better serve Nevadans. This section describes the system prior to and following the merger to provide context for the integration plan. The activities listed in the following timeline are highlights that have led to integration.

In 2000, the Olmstead Decision, along with the Americans with Disabilities Act, provided guidance to states identifying that people should be served in the most integrated setting. It prohibited states from unnecessarily institutionalizing persons with disabilities and encouraged states to develop community-based living and work options.

The Nevada Department of Health and Human Services (DHHS), in an effort to address the Olmstead Decision and the Americans with Disabilities Act, requested funding during the 2001 Legislative Session for a Strategic Plan for Persons with Disabilities and for Senior Services.

2001 At the time the Legislature funded the plan, Nevada was experiencing great population growth and was interested in addressing the following issues.

- 157% growth in requests for disability services over the prior decade
- 56% growth in senior population over the prior decade
- Lack of integrated services
- Lack of integrated information system
- Expanding need for community-based options/requests for Home and Community-Based Waiver (HCBW) services
- Flat funding of services
- Increased need for children's services to address behavioral health and autism
- Increased need for services to address behavioral health in adults and seniors with dementia and Alzheimer's disease, traumatic brain injury, and other memory-related illnesses
- Lack of facilities to house people with challenging behaviors to prevent persons from being transported and cared for out-of-state
- AB 513 authorized four strategic plans related to Senior Services, Persons with Disabilities (Provider rate Study), Rural Health Issues and Rates Paid for Services

2003 The DHHS and the Legislature funded a number of programs to address these issues.

- General Fund dollars added to Senior Rx Program ($2.8M) due to rapid growth and the Senior Rx Discount Program also authorized ($300K)
- Disability Rx Program created (2.5% of Tobacco money)
- Office of Disability Services established in the DHHS Director's Office - transfer from Department of Employment, Training and Rehabilitation
- Community-Based Services and the Governor's Council on Developmental Disabilities transferred – goal to centralize services

- Facility Oversight and Community Integration Services (FOCIS) housed in the Division of Health Care, Financing and Policy started in 2003 to assist nursing home residents to transition back into the community
- Personal Care Services (PCS) expanded to include community-based providers to improve service access
- AB 395 passed creating quality of nursing care account (6% Provider Tax)
- AB 164 passed imposing surcharge on telephone access lines to provide communication access for persons deaf and hard of hearing
- SB 174 passed transferring $1.1 million from Aging Services to Office of Community-Based Services to fund personal care assistant service – finding that Office of Community-Based Services was not properly funded
- Health Insurance for Work Advancement (HIWA) approved allowing Medicaid Coverage through a buy-in mechanism for persons with disabilities who were employed
- Governor appointed Strategic Planning and Accountability Committee's to monitor the progress of the state on the strategic plans for Senior Services and Persons with Disabilities

2005 In the 2005 Legislature, several key bills were enacted.

- AB 524 passed to coordinate Senior Rx with Medicare Part D Rx coverage effective January 1, 2006 and Senior Rx converted from "insured" to "self-insured" model
- AB 284 passed establishing Assisted Living Waiver funding a model implemented in southern Nevada
- DS initiated pilot program to provide assistive payments averaging $1,100/month to 52 children ages 2 – 10 diagnosed with intellectual disability and autism [using Temporary Assistance for Needy Families (TANF) money]

2007 By 2007, much progress had been made related to Olmstead. Autism continued to be an emerging need in Nevada.

- The final 20 remaining institutional beds at Sierra Regional Center were eliminated and converted to community-based options (e.g., intensive services and the Crisis, Prevention and Intervention Program to support behavioral health needs in the community)
- AB 629 passed, creating Nevada Autism Task Force and appropriating $2M in general funds for Autism Services
- AB 454 passed, allowing Disability Services to implement a comprehensive Provider Certification Process assuring individuals are always in safe environments promoting their health, well-being, and safety as well as providing for ongoing monitoring and improvement of provider practices
- ADSD received the first of a series of grants to design Aging and Disability Resource Centers.
- Senate Bill (SB) 79 created the Nevada Commission on Services for Persons with Disabilities within the DHHS to determine and evaluate needs of persons with disabilities, promote program modifications and provide legislative recommendations

2009 System redesign affected a number of programs and agencies in the state.

- Legislature approved Senate Bill 434 to consolidate the Office of Disability Services located in the DHHS Director's Office with Division for Aging Services, which was renamed the Aging and Disability Services Division

- Developmental Disabilities Council, Community-Based Services for persons with physical disabilities, and IDEA Part C Office were transferred to ADSD
- Senior Rx and Disability Rx were transferred from Healthy Nevada Fund to their own budget account in ADSD
- Legislature approved additional $3.2 million for autism services, bringing the total to $5.2 million
- The NEIS budget introduced the use of community providers to expand availability of services
- Legislature approved creation of Volunteer Long-Term Care Ombudsman Program to be administered by ADSD to increase residents' in long-term care settings timely access to the Ombudsman program – implementation July 2011
- AB 9 created the statutory Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs to study the service needs of these groups
- Regulations to protect seniors were strengthened and clarified in the areas of Elder Protective Services, Assisted Living and Residential facilities for groups.
- ADSD identified "core services" necessary to assist seniors to remain in community based settings
- Changes to the guardianship laws helped assure easier access to public administrators and guardians for seniors in need. Provisions from the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act are incorporated in the law to allow easier transfer of guardianship from one state to another.

2011 Nevada continued efforts to improve service delivery while facing the ongoing impacts of the recession.

- Developmental Disabilities Council/budget account moved back to the DHHS Director's Office from an ADSD – autonomy issue
- Senior Citizen's Property Tax Assistance program was eliminated, saving approximately $6M each year
- Senior Medicare Patrol program was transferred from the Attorney General's office to ADSD
- AB 345 passed establishing Autism Treatment Assistance Program (ATAP) as primary treatment program – funds transferred from MHDS self-directed autism program
- Elder Protective Services (EPS) addressed by the Legislature as a result of Clark County transferring EPS function to the State effective May 2010 – 15 new staff approved
- Ancillary services were approved for the Elder Protective Services program, strengthening the intervention to remedy abusive situations – Temporary Assistance to Displaced Seniors, EPS Homemaker Services, Mental Capacity Evaluations, and Emergency Service Funds
- Division of Health Care Financing and Policy received Medicaid *Money Follows the Person* (MFP) Grant April 1, 2011 (runs thru 2016)
- Although legislation to review, re-evaluate and potentially repeal existing committees was ultimately vetoed, the Senior Strategic Plan Accountability Committee (SPAC) was re-evaluated for effectiveness and was not repealed, in part, due to its activeness, frequency in meeting, and annual reporting
- Senate Bill 421 amended the approach to allocating the tobacco settlement funds through the Fund for a Healthy Nevada and required input from the Commission on Services for Persons with Disabilities (CSPD), Commission on Aging, and Grants Management Advisory Committee regarding service priorities for the funding

- CMS approved HCBW (CHIP) and the Waiver for Elderly Adults in Residential Care (WEARC) to develop flexibility so money can be used for services needed
- The Volunteer Long-Term Care Ombudsman was implemented in July 2011

2013 Steps to strengthen lifespan services continue as the state slowly recovers from the recession.

- The Alzheimer's Task Force was created (AB 80) and Respite Care Program was expanded (SB 86) for people experiencing early onset Alzheimer's or dementia
- NEIS was transferred from the Health Division to ADSD and received additional funding to address front end quality and provider development
- IDEA Part C Office was transferred to the DHHS Director's Office oversight
- Autism Treatment Assistance Program received $11.7M over the biennium through general fund and tobacco settlement dollars
    - FY 14 slots = 307
    - FY 15 slots = 572
- Developmental Regional Center budgets (Desert, Sierra and Rural) and Family Preservation Program budget were transferred from MHDS to ADSD
- Desert Regional Center received 52 new staff to support caseload growth and individuals requiring intensive behavioral support -- $24.4M added to budget

2014 The transition of NEIS and DS into ADSD changed the makeup of ADSD considerably. From July 1-December 31, 2013, in addition to the integration planning efforts, ADSD has engaged staff throughout the state to promote performance with a focus on outcomes, accountability and transparency. This includes:

- Developing information systems to promote the collection of meaningful data across programs that previously could not interact with each other;
- Engaging a variety of unique stakeholders to understand their issues and ensure their involvement in the integration process;
- Ongoing, proactive identification and pursuit of new funding sources and opportunities with a focus on receiving additional grant funding for services;
- Implementing innovative strategies such as combining waivers with a nursing home level of care Home and Community Based Waiver (HCBW), HCBW for persons with physical disabilities (referred to as Physical Disability Waiver or WIN), and HCBW for Assisted Living (AL) and applying for and implementing CMS Balancing Incentive Payment Program (BIPP);
- Continuous learning to understand the Affordable Care Act and how this new health care system will impact ADSD and those it serves; and
- Continue to work with (National) State Employment Leadership Network on supporting Nevada's effort to improve integrated employment outcomes.

The pre- and post-merger budget is as follows:

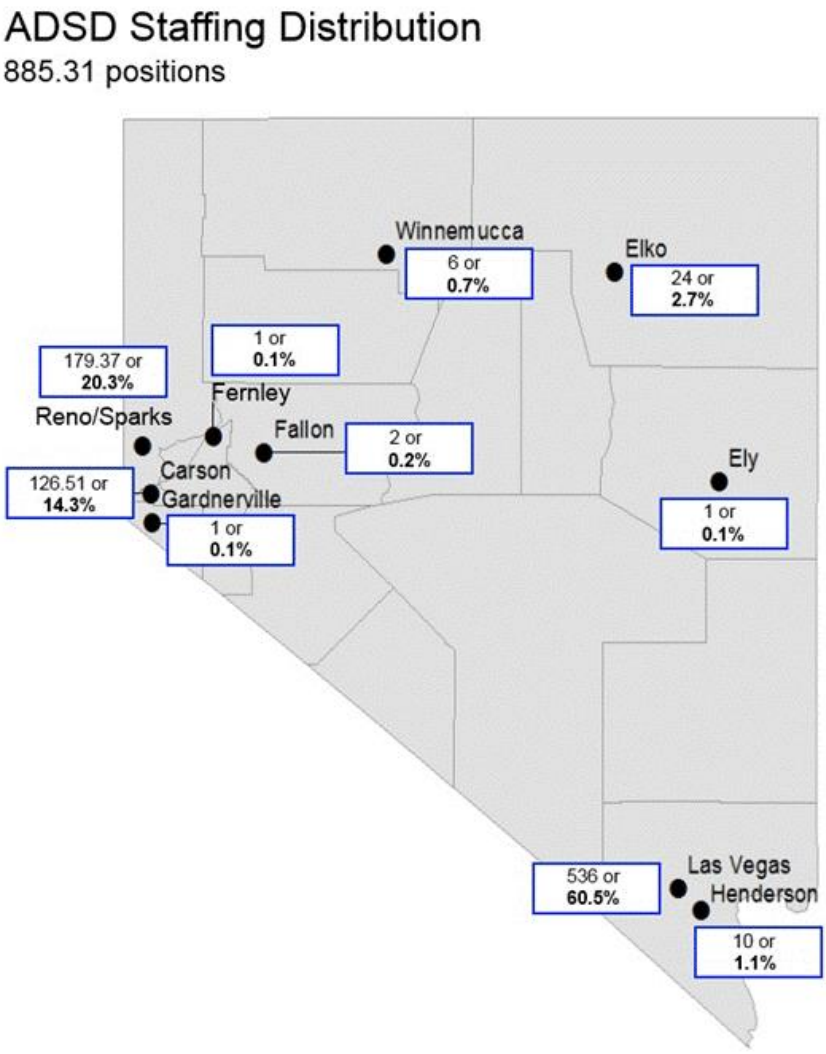
	Pre-Merger		Post-Merger	
	FY12	FY13	FY14	FY15
Aging/Disability Services	$44,034,757	$53,221,496	$56,689,202	$61,143,472
Early Intervention Services	$24,349,892	$27,782,827	$33,579,668	$37,136,995
Intellectual Disabilities	$131,277,812	$140,575,623	$149,199,526	$156,440,975
Totals:	**$199,662,4691**	**$221,579,946**	**$239,468,396**	**$254,721,442**

Prior to approval of integration, at the beginning of June 2013, there was a combined total of 767 positions.

- ADSD had 232 positions
- NV Early Intervention in the Health Division had 170 positions
- Developmental Services in the Division of Mental Health and DS had 365 positions

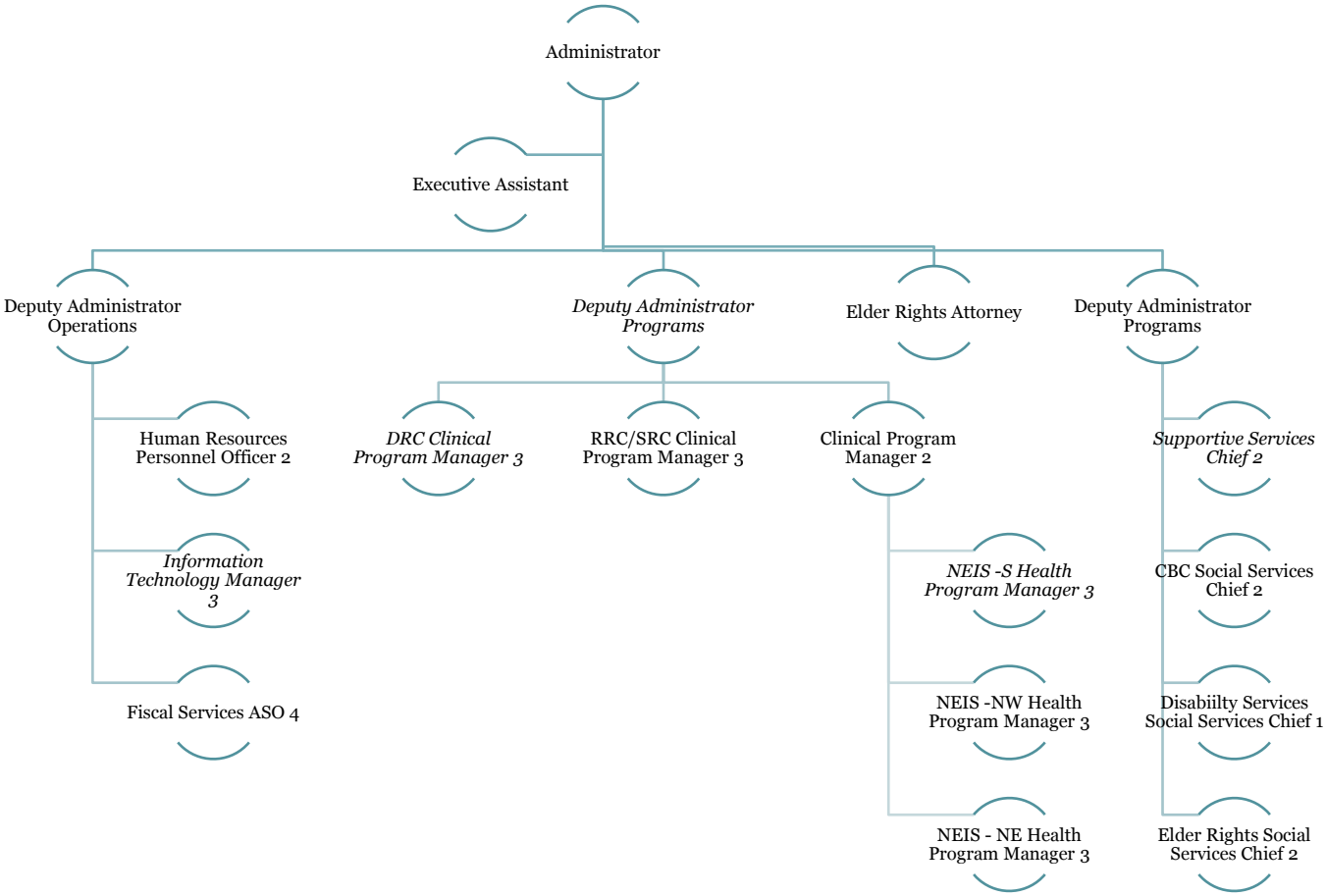
Looking forward past the merger, in Fiscal 14/15, 885.31 full-time equivalent positions (including full and part-time positions) have been approved.

- Aging and Disability Services has 270.51 positions
- NV Early Intervention Services has 208.37 positions
- DS has 406.43 positions



ORGANIZATIONAL STRUCTURE

ADSD provides services across the state with positions allocated by service and site. There are 19 administrative positions for ADSD that solely support its administration. Additional supervisory positions are located at service sites across the state and oversee direct services. In the chart below, position titles in *italics* indicate the position is based in Las Vegas. The Administrative structure, post-merger will result in an organization redesign as follows.


Administrator
Executive Assistant
Deputy Administrator Operations
Deputy Administrator Programs
Elder Rights Attorney
Deputy Administrator Programs
Human Resources Personnel Officer 2
Information Technology Manager 3
Fiscal Services ASO 4
DRC Clinical Program Manager 3
RRC/SRC Clinical Program Manager 3
Clinical Program Manager 2
NEIS -S Health Program Manager 3
NEIS -NW Health Program Manager 3
NEIS - NE Health Program Manager 3
Supportive Services Chief 2
CBC Social Services Chief 2
Disabiilty Services Social Services Chief 1
Elder Rights Social Services Chief 2

VISION AND PLANNING PRINCIPLES

ADSD functions within the framework of the following vision, mission and philosophy statements.

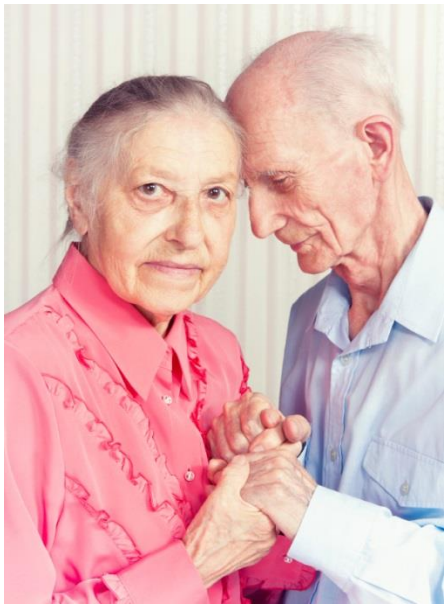
Vision: Nevadans, regardless of age or ability will enjoy a meaningful life led with dignity and self-determination.

Mission: The mission of ADSD is to ensure the provision of effective supports and services to meet the needs of individuals and families*, helping them lead independent, meaningful and dignified lives.

** Families include caregivers, supports or families as they define them.*

Philosophy: ADSD seeks to understand and respond to the individual and his/her needs using principles of

- Accessibility
- Accountability
- Culturally and linguistically appropriate services
- Ethics
- Mutual respect
- Timeliness
- Transparency



The purpose of this plan is to provide an integrated, innovative, sustainable system in which partners work together to provide highly effective programs that improve the lives of those we serve and strengthens the community.

SITUATIONAL ANALYSIS

A situational analysis was completed under the direction of the Steering Committee. Key informant interviews, focus group discussions, and staff surveys were used as a mechanism to identify strengths, challenges, and issues that integration efforts should consider and address. This information was combined with other data and independent research to identify best practices and emerging trends in integration efforts. The results of this analysis were presented to the Steering Committee and were intended to inform decisions in the development of a strategic plan to outline an effective integration framework to effectively bring Nevada Early Intervention Services (NEIS) and Developmental Services (DS) into ADSD and align service delivery strategies to achieve ADSD's objectives.

A summary is provided here.

KEY INFORMANT INTERVIEWS

From July through August 2013, 17 key informant interviews were conducted by phone. Key informants were interviewed to ensure that families, service providers and policymakers representing the array of interests concerned with the integration of services into ADSD have an opportunity to guide the planning and integration process.

FOCUS GROUP DISCUSSIONS

From August through September 2013, 12 focus groups hosting a total of 131 participants were held with consumers, caregivers, family members and advocates at multiple locations in the north, south, and rural areas of Nevada. The purpose of the focus groups was to inform the public about ADSD integration efforts as well as gather perspectives and recommendations regarding priorities and strategies relevant to each service population (children with special needs, adolescents and adults with developmental delays, persons with disabilities, and the aged) and each geographic area to be served by the newly integrated ADSD. Representatives included adults with disabilities, seniors, providers, parents, caregivers of consumers, and advocates for all types of services.

STAFF SURVEYS

From October 30 through November 11, ADSD staff and provider surveys were collected to solicit information on "what works" within the current system and to capture solutions to the critical issues as well as suggestions about accomplishing the goals related to integration efforts. There were a total of 381 surveys collected from staff and providers across the state, with a majority of respondents agreeing with the critical issues, goals and activities as established by the Steering Committee.

KEY NEEDS OF NEVADANS THAT ADSD SHOULD ADDRESS

Key informants and focus group participants were asked to describe the most significant needs or challenges facing people who use services. Information was collected in an effort to assess the extent to which needs are currently being met and to identify the greatest gaps in services.

The following four themes emerged.

- A growing population of Nevadans will need services at a time when sufficient resources are not available to meet those needs.
- Access to care is oftentimes interrupted by the lack of available primary care providers, specialty providers, transportation, and community-based housing, respite and socialization options, training and employment opportunities. There was a clear indication that overall funding to meet basic and special needs is not sufficient.
- There is a need for a service delivery system that supports people throughout the lifespan with specific supports during times of transition.
- There is a lack of awareness regarding services available and a lack of clarity about how to navigate the service delivery system.

SERVICE SUFFICIENCY

All consumer groups in every part of the state identified the need for sufficient services to meet the needs of the population. Direct services identified included therapy (occupational, speech, and physical), supportive living arrangements, respite for caregivers, employment and productive activities. Supportive services were also identified as a need and included access to basic needs (food, shelter, clothing, and medical/dental care) socialization opportunities, health and fitness outlets, and transportation options.

> *"We have created all of the efficiencies that we can. There is no more "fat" to shave. We are in desperate need of additional resources to minimally serve our clients."*
>
> Focus Group Participant

ACCESS TO CARE

Access to care was identified as a critical need. Access was inclusive of transportation needs, a sufficient provider network, medical/insurance coverage and financial assistance, as well as timely service delivery.

- **Transportation:** Transportation that ensures timely access to medical appointments, socialization opportunities, and the ability to live an independent life was identified by groups as a need. Urban areas suffer from urban sprawl, making the transportation system difficult and often time-consuming to navigate. Rural areas often suffer from a lack of transportation routes and limited timeframes with which to travel. Though the reasons differed, the challenge was the same.

Transportation was repeatedly listed as a need throughout key informant interviews and focus group discussions.

- **Provider Network:** Access to a sufficient provider network was identified as a need for all forms of health care needs including medical, dental, and mental health as well as occupational, speech, and physical therapy to persons requiring those services. There was also a significant amount of discussion around the need for consistency in the workforce that serves persons in every consumer group.
- **Medical Coverage and Financial Assistance for Medical Needs:** Health care coverage was identified as a need by all consumer groups as was financial assistance to fill common coverage gaps .
- **Timely Service Delivery:** Accessing services when needed, and not having to endure long wait times due to eligibility approvals, staffing shortages, or system overloads was a consistent theme.

SEAMLESS SERVICE DELIVERY SYSTEM

The need for a system that supports people throughout their lifespan was identified as a significant desire by consumer groups throughout the state. There was considerable discussion by multiple individuals and groups around the need to have a system that is adequately informed at every level, supports people through their life transitions, and works with other complimentary systems on behalf of the consumer.

INFORMATION AND EDUCATION

Knowing what services are available and how to navigate the system to ensure access was another identified need. As one focus group participant stated:

> "People need to know what is available. Oftentimes, people don't know what they don't know. We need to make more information available so that people understand what resources are available."

This sentiment was combined with the need to understand how to navigate the system which provides services. Once a consumer or family member of a consumer is aware of services, there is a need to understand where to go to get them and how to access those services.

The tables on the following page demonstrate needs that were particular to either a specific service population or within a region of the state.

> *"People are not always given the correct information when they seek out assistance. This can prevent people from being able to access care. Sometimes they are shuffled from place to place until they finally get services. By that time, they are too tired to utilize them."*
>
> Focus Group Participant

Needs that were Identified Specific to each Service Population

Early Intervention Services:

- Direct services vs. parent training model
- Services provided in the child and/or parent's native language

Developmental Services:

- Workforce development for transition aged youth (TAY).
- Socialization skills/opportunities.
- Repetition and structure to daily activities
- Consistency in caregivers
- Housing options

Aging and Disability Services:

- Sufficient housing and supports to encourage independent living arrangements
- Supports for aging seniors with developmental disabilities
- Lack of support system could be a safety factor for seniors – "Who will check up on us?"

Needs that were Identified as Specific to Northern, Southern and Rural Communities

North:

- Additional access to Medicaid

South:

- Additional service access points

Rural:

- Access to services locally
- Qualified and retained staffing
- Sufficient provider networks
- More transportation supports
- Community support/funding

HOW THE SERVICE DELIVERY SYSTEM WORKS

Stakeholders were asked to share their opinions about the programs and services currently managed by ADSD and to assess internal coordination as well as across systems. The goal of this exploration was to identify what works and what does not when seeking services.

Cross-cutting issues that were universally expressed across all consumer populations and geographical locations in the state included the following.

- Services are provided in silos, transitional assistance is not provided, and access is largely determined by individuals as opposed to consistent application of policies/procedures.
- Eligibility is not flexible, leaving a gap of people who need service but that are deemed ineligible, or forcing people into financial ruin.
- There are a lack of services, providers, and choices for consumers.
- Waitlists have become a typical business practice with some persons aging out before receiving help.

FRACTURED SYSTEM

More than half the key informants described the current model of service delivery as being "siloed." As one informant stated, "in the Division itself, as it is configured, there are silos that create barriers." They described a system where provider and recipient alike often don't know "where to go for what."

Many described the current system as "unpredictable." Rather than any agreed upon and reinforced standards of service delivery, key informants noted that the outcome of a referral often depends on the persistence of the caller, their knowledge of programs, services and jargon, an ability to navigate the system, and the personal attributes and approach of the person that answers the phone when they call for assistance or the caseworker assigned to them.

A fear expressed by many was that, as integration takes place, the siloed systems will only compound the barriers to services. This was seen as the greatest risk related to the integration; namely that it would be business as usual with distinct service delivery systems working alongside, and sometimes in ignorance of, their sister agencies. It was reinforced many times in a majority of the interviews that if a comprehensive shift in culture away from a siloed approach to services did not come from the integration, it would be a wasted opportunity.

> *"We need to establish a different culture within the service delivery system. We need to train staff to make sure that everyone is providing equal access."*
>
> Focus Group Participant

Providers described a similar scenario, where they contact or refer to a specific, known resource rather than chancing that they will reach someone who won't help them resolve an issue, either because they don't know the system well enough themselves, or they apply rules and regulations differently than a counterpart. This uncertainty in encountering an "ad hoc" system of service delivery often results in frustration or mistrust.

RIGID ELIGIBILITY REQUIREMENTS

- Many people described a system that is so bureaucratic and inflexible, that often times it fails to meet the needs of the persons it is intended to serve. "There are so many eligibility requirements that make accessing services difficult. The system should have more flexibility to allow it to respond to the unique needs of individuals."
- "In order to qualify for services, one must deplete all their financial resources. Once their financial resources are depleted, they are left with few options to supplement their basic needs."
- "It is typical practice to determine eligibility for services based on an IQ score (70 being the threshold). This practice leaves a significant gap of kids left unserved. The kids that exceed this IQ threshold, but that are delayed, are the ones that could see the most gains from intervention, and yet they are deemed ineligible. It is not a policy to use the IQ score as a bottom-line qualifier, but it has become common practice."
- "We need to reduce/eliminate the red tape that currently exists in being able to negotiate services for people. More flexibility in the funding/eligibility would allow us to provide the services that are individualized in nature."

> *"Eligibility requirements are different at every stage. What you qualified for before changes. ADSD should have the same eligibility criteria. Use the same forms across the state and the Division. Use standardized forms regionally."*
>
> Key Informant

INADEQUATE SERVICE OPTIONS

The current system configuration does not offer sufficient service options to truly assist people, leaving them with little to no choice for care or with no care at all. There was repeated testimony regarding the lack of sufficient service provision (quantity), service array, and service providers to meet the need of Nevadans requiring support from ADSD. As one focus group participant stated:

> "Consumers need to be provided choices. There are little choices about where our clients are going to live, who is going to serve them, and who they can access for advocacy."

EXCESSIVELY LONG WAIT LISTS

- Wait lists were described as a typical way of conducting business, to the extent that some stakeholders deemed it an intentional strategy "to dissuade clients from accessing services due to a lack of resources." "Wait times for services appointments or for approval from medical coverage can take months."
- "One person told me on the phone that Nevada has the worst services in the whole nation and that I shouldn't move my loved one here."
- "Waitlists should not exist. Give people the help they need when they need it."

The following tables demonstrate concerns that were particular to either a specific service population or within a region of the state.

Concerns that were Identified Specific to each Service Population
Early Intervention Services: • Consultation services between providers is not funded
Developmental Services: • Eligibility is determined by IQ score (in practice/not policy) • Lack of sufficient support for transition aged youth • Staff are underpaid and undertrained • Federal guidelines limit the time individuals with disabilities, who can only be cared for within a controlled employment environment, can be in a facility even if no other option exists • Children needing intensive support are sent out of state
Aging and Disability Services: • Long telephone wait times • Rude service providers • State is unprepared for the "Silver Tsunami" • Technology acts as a barrier to service • Need for more face-to-face service options

Concerns that were Identified as Specific to Northern, Southern and Rural Communities
North: • There were no concerns identified specific to the Northern portion of the state
South: • Leadership is concentrated in Carson City, whereas it needs to be more equally distributed • Urban sprawl has resulted in access issues
Rural: • State does not support travel of state employees, resulting in no services being deployed • Services can be influenced by people and personalities • No local Welfare/SSI offices

A common concern echoed universally was the fear that integration will only result in a larger base of persons needing services from a system that will continue to be short staffed, under informed and reactive (as opposed to pro-active) in their approach to serve. To address this concern, as well as the conditions that support it, there was widespread agreement that the integration of ADSD should have a "no wrong door" approach.

STRATEGIC OPPORTUNITIES THAT INTEGRATION OFFERS

A number of strengths were identified that informants felt should be leveraged and built upon during integration including the existing leadership of ADSD, effective programs, fine, committed staff and a wealth of knowledge that can be leveraged across programs. Efficiencies across the system were the greatest strategic opportunity that the integration offers, according to key informants. This includes streamlined eligibility and admission processes, universal application forms, enhanced coordination and collaboration, collection of meaningful data, implementation of proven, preventative interventions, reduction in funding for administration, and greater investment in services. All of these were identified as strategic opportunities by key informants.

As one key informant noted,

"In theory [integration] is great. I see the opportunity to build a cradle-to-grave system for a consumer base that can result in a strong voice at the state that can advocate on behalf of the vulnerable. ADSD can seize the opportunity to speak in a singular voice, championing and acting as a convener."

As previously noted, there was universal agreement that the integration of ADSD should have a no wrong door approach. The results would be evident in:

- Efficiencies across the system;
- Streamlined eligibility and admission processes, universal application forms;
- Enhanced coordination and collaboration;
- Collection of meaningful data;
- Implementation of proven preventative interventions;
- Reduction in funding for administration; and
- Greater investment in services.

> *"ADSD could identify the commonalities between the three service populations that would be served under the newly configured ADSD. In doing this, the organization can leverage what works with one population to assist in serving another.*
>
> Focus Group Participant

CRITICAL ISSUES TO BE ADDRESSED THROUGH INTEGRATION

DEVELOP A UNIVERSAL PERSON-CENTERED FRAMEWORK

Key informants embraced the purpose of the integration, often referring to it in their own words as "cradle to grave" or "birth to death" and noted that rather than seeing an individual as a person who is aging, person with a disability or person with special needs, that they all be seen as part of a family, a community and the state. Implementing what was described as a "family-centered framework" was the way one key informant described the issue.

- "Other barriers are funding driven, when funds come from outside they come with rules, and you don't want them to be too fungible, but there are gaps in services because someone doesn't fit in the disability box or the elderly box the way it's drawn."
- We need to see how to knock down the barriers so there aren't chasms because of the way we define things."
- "There are two cultures, one that is very helpful and passionate, and one that is very mean. Kindness and compassion are contagious. If it's not present in all leadership, it can't permeate the Division."
- "This idea of being able to have a platform that manages across lines so that a door, cubicle or program doesn't keep persons from services and results in greater dollars through cost savings is exciting."
- "ADSD needs to frame outreach and communication in a family-centered framework. There is frustration that when people aged out of a service they had to give up their provider or had to access a different provider network. We want to find a way to reassure everyone that we are all family here."
- "Just having the right structure so that everyone knows where they fall and it doesn't create more siloes. Those deputies have to see the big picture, not just a single issue. The deputies need to be committed to it."

IMPLEMENT A STANDARDIZED SYSTEM OF CARE/SERVICE DELIVERY

Key informants described a fragmented, siloed system that did not engender predictability, trust or confidence that it would meet a person's needs. One key informant described a case where someone went to drop off a home-delivered meal. The person receiving the meal hadn't been outside in three weeks because they were unable to navigate physically out their front door and had no access to transportation. The provider reported that the person delivering the meal dropped off the food and left. Without standardized, shared understanding of ADSD services, mission and role, there is no likelihood that providers and their staff will all identify an issue, report it, and assist the person in getting services, even if they are eligible and the services are available. Many examples like this were provided that illustrated the lack of uniform policies, procedures, practices and determinations across ADSD.

- "The biggest gap is that our state does a 'band aid,' just enough to keep out of trouble, there is a lack of consistency across providers and agencies. No standards of care are articulated to care managers."
- "I do see a disparity across what each community provider is using and how they are doing diagnosis. There is a lack of consistency of services."
- "Clients have to complete multiple applications within ADSD depending on how they are being defined and who is referring them to where."

Key informants envision a system that is aligned horizontally (across programs, agencies and communities) as well as vertically (from administration to support staff) in the approach to delivering services.

ESTABLISH AN ACCOUNTABILITY FRAMEWORK

There is broad consensus that the integration must result in greater accountability. The integration plan should outline clear goals and objectives linked to an improved system of care with better access to services. Measurable criteria should be established for each goal that will demonstrate success. The integration plan should set the vision and course for a new service delivery model and approach. The model should result in efficiencies and eliminate waste. Challenges in accountability were described.

- "Information sharing and data systems are a problem, whether it is SAMS tool, or something else, the systems to share information could be used to greater effect to share information. If I do the work up, don't send them to another agency who will just ask them the same questions."
- "Data, ensuring quality of services across programs and the state, and accountability with a coordinated data system is needed."
- "Data driven, evidence-based services are needed rather than funding what has been funded in the past without trying to demonstrate that the program works."
- "Early intervention should have oversight but not provide services. They should ensure that community providers are doing what they are being paid to do."
- "Measure progress quarterly and ensure accountability."
- "Collect meaningful outcomes and then go to the Legislature and tell them what is needed with data that demonstrates needs and that ADSD is accountable for the funding it receives."
- "In government, sometimes, compliance mentality can overrule operations but it needs not to be the primary lens that folks are looking through. It is important that they have a compliance mentality with a mission focus rather than a strict compliance mentality."

INVEST IN HUMAN RESOURCES AND PROFESSIONAL DEVELOPMENT

The theme of workforce and professional development was described in several ways. One issue was the lack of sufficient qualified personnel across Nevada, particularly in rural areas, to provide needed services including screening, assessment, diagnosis, and the provision of specialty care. The qualifications of those who are funded to provide community-based services and the effectiveness of the services were also noted. Finally, cross training is needed to ensure that the staff understands all that ADSD provides, has empathy for its target populations, and has the ability to provide seamless services.

- "Need a qualified, well-paid workforce to serve persons with disabilities and the aging population."
- "Community providers are paid poorly and have no benefits. Good people with a passion for the work often leave to make more money doing something they don't care about because they have to provide for their family."
- "There is a lack of a knowledgeable workforce."
- "In some parts of the state there is only one provider qualified to provide a certain service. So you end up on a waiting list. Or, if you have a conflict with them, there is nowhere else to go."
- "If you don't live in Clark or Washoe it is really difficult to access services. It is hard for school districts to find service providers."
- "Is the plan to get the state out of the business of direct services? If the role is to shift to monitoring how well the contractors performed and you have a good hands-on caseworker, [you would be] giving them a new role that they may not be good at."

RESOURCE DEVELOPMENT

- Every key informant said there is not sufficient funding to meet the needs of Nevada's citizens when it comes to services provided by ADSD. This was described for all subpopulations and the system was repeatedly described as a "band aid" approach. Many expressed a hope that the integration would result in additional services for direct services from the savings that are anticipated. Some went so far as to note that, if administrative spending remains the same within ADSD after the integration, the integration would be a failure. A number of specific resources were identified as lacking. "The biggest challenge is the time, long wait and not enough people to cover the needs."

- "Early intervention for a long time has had a waiting list. Often, they have been able to legally remove people off the waiting list but the children don't get the type, amount, or frequency of services statewide."
- "Nutrition and food security is a huge need. I read the community assessment of the Grants Management [Advisory Committee] and the picture is very depressing."
- "Lack of employment opportunities for older adults and persons with disabilities – it is a lack of preparation for jobs and a lack of availability of jobs. They are not even getting considered for jobs because of age and ability."
- "Way too much funding into community training centers and segregated environments that don't pay a living wage instead of going into community providers where they can be integrated and get a living wage.[12]"
- "Another overarching issue is poverty for persons with disabilities, which is perpetuated by not making a living wage."
- "Transportation. Distances between each of our communities plus the distances for specialty treatment is an all-day trip and for dialysis you need to do it three days a week. It is almost not doable."
    - "Transportation is a huge issue that affects both persons with disabilities and seniors. In rural areas it is a barrier to employment, social interaction, everything. In urban areas it is available to persons with disabilities but is very expensive."
- "Mental Health. There is a lack of mental health services. Services that are available are very limited and target the severely mentally ill and are limited with what they can provide. They can provide medication but not support to take the medication. The person spirals down until they are connected with law enforcement or disconnected from all other supports and are more critical in need than they would have been previously."
- "Case management. It is super confusing for the client when multiple agencies are providing services in the home and they don't know what agency. They need to have one person to call to own and manage the case."
    - "We need case managers who can do home visiting."
    - "Services in homes would be more beneficial. Care coordinators go out but not the counselors."
    - "Case management for people of all income levels is a need. If your income is too high for a waiver and trying to figure out the system is very difficult."
- "Workforce and specialty workforce is a gap. Districts have to use outside service providers and that is expensive when you have to contract out."
- "Deaf and hard of hearing population has very minimal resources. It is hard to find interpreters. AB 210 takes in communication needs of deaf and hard of hearing. The challenge for districts is to find the teachers of [American Sign Language]. Most districts just try to find a teacher for deaf and hard of hearing students and can't find them let alone interpreters."

> *"Overall there is inadequate funding for services, long waiting lists, tight eligibility for services, and everyone waiting for specialty services."*
>
> *Key Informant*

[12] Note: Steering Committee members noted that this comment refers to persons who are paid significantly less than minimum wage, from pennies to dollars per hour.

CRITICAL INTEGRATION ISSUES

The top critical integration issues as identified in the situational analysis and adopted by the Committee are listed here.

Issues Impacting ADSD

A. The critical issue is the need for customer service. ADSD should establish a culture of shared ownership across ADSD where all staff approach their work from a person-centered, solution-oriented mindset, and are determined to assist those in need regardless of their age, circumstance or primary presenting issue. This mindset should promote collaboration, coordination and communication so that there truly is no wrong door or point of contact within ADSD. ADSD should identify policies to ensure the framework is implemented.

B. The system of care and decisions about service delivery implementation within ADSD should be aligned with ADSD vision and mission. ADSD should ensure that policies and procedures are also clearly articulated and understood. Standards of care for all ADSD services should be outcome and evidence based and implemented with fidelity across the state. From first contact forward, processes for collecting information, making referrals, determining eligibility, and providing services should be clear, coherent, and consistently implemented. Three key components of the system of care need to be the focus for integration.

   i. **Access:** Ensure that the community is aware of services and how to access them and that services are accessible, available and supportive in every community.

   ii. **Transitions:** Identify and map the processes and approach to assist individuals to seamlessly transition through providers, services, agencies, schools and systems.

   iii. **Collaboration across Programs and Services:** Increase communication, strengthen coordination, and promote collaboration across systems, sectors, agencies, and counties in order to maximize resources and achieve better outcomes for Nevadans who are receiving services.

C. Ensure that outcome-based, measurable criteria are in place to demonstrate the impact of ADSD services. Collect and report data uniformly across services and ADSD using universal data elements. Ensure quality of care standards are developed and implemented.

Issues Related to the Broader System

D. The critical issue is to ensure a sufficient, qualified workforce across the state. Build the capacity of providers to address unmet needs. Provide cross training to maximize resources and advance knowledge of all services within all programs and staff of ADSD.

E. It is critical to pursue funding and promote the development of resources to meet each persons' needs. This includes ensuring there are sufficient providers and that services such as specialty care, housing, food security, transportation, education, training and employment, medical, case management, behavioral health, and co-occurring disorder treatment are available.

GOALS AND OBJECTIVES

The Steering Committee developed goals and clear, measurable, specific objectives for the plan. Goals are designed to address critical issues as identified in the previous section and cover activities from January 2014 through December 2019

Goal I. Increase funding and services to meet national or state accepted funding levels by service population to achieve ADSD penetration rates.

A. Establish acceptable reimbursement rates by service type.
B. Implement a strategic financing plan to secure resources for ADSD.
C. Fund services and support for the coordination and delivery of services.

Goal II. Adopt and Implement a Universal, Person-Centered Framework throughout ADSD by December 31, 2014.

A. Define and implement the customer service philosophy and include family in the framework for customer service delivery.

Goal III. Establish a Standardized, Evidence-based Service Delivery System for all ADSD programs, regardless of population or region by July 1, 2015. Three key components of the system of care that need to be the focus for integration include: 1) Access, 2) Transportation, and 3) Collaboration.

A. Define and implement a standardized service delivery system.
B. Develop solutions for standardizing and sharing (as appropriate) client records, including information technology (IT) for electronic records.
C. Implement evidence-based practice (EBP).
D. Create an evaluation plan and system for measuring and analyzing outcomes for each program based on EBP model.
E. Develop criteria and process for measuring the effectiveness of the person-centered plan based on outcomes.

Goal IV. Adopt and report on criteria that demonstrate outcomes and efficiencies.

A. Establish universal data elements to be collected for all services.
B. Prioritize and adopt meaningful performance measurements for quality.
C. Establish reporting standards for all services that can provide information to support continuous quality improvement (CQI) efforts.
D. Report annually to the public the outcome measure results.
E. Develop and/or expand CQI efforts to improve systems throughout ADSD.

Goal V. Develop a system to recruit and retain a highly-trained, adaptive, skilled workforce.

A. Develop a recruitment and retention plan for an adaptive, skilled ADSD workforce.
B. Develop and implement customer service training throughout ADSD.
C. Develop and implement a process for continuous educational opportunities to enhance a person-centered approach toward service delivery.

FUTURE VIEW - A FIVE YEAR MAP TO LIFESPAN SERVICES

The vision for lifespan services includes developing a statewide approach to integrating common program areas such as clinical/behavioral health, program/policy development, quality assurance/ evaluation, and the development of a collaborative grant process. The goal is to assure all program areas are supported to integrate health and wellness for individuals as well as for service delivery. ADSD is committed to supporting the full range of services across the lifespan. The goal and action plan included in the following section incorporates steps to integrate the program areas described below.

Clinical/Behavioral Health

Clinical and behavioral health services support individuals to live as independently as possible in their home community. The clinical/behavioral health will include the following services.

Eligibility – Review application and clinical documentation to determine eligibility for programs with a clinical criterion. Identification and review of functional limitations will be reviewed as part of the eligibility process.

Consultation – Provide consultation for individuals, families and community providers to assist individuals with emotional and behavioral concerns in the least restrictive setting. Clinical staffs assess the individual's needs and assist the individual to coordinate needed services in the community.

Crisis Prevention and Intervention - Provides intensive service coordination, crisis prevention, and intervention for individuals living in the community. The primary goal of the program is to assist individuals to live and work in the most integrated settings and to participate fully in their community. Program assists individuals and community providers to address behavioral and emotional issues by assessing behavior, analyzing data, creating treatment plans, and assisting the provider to implement treatment.

Oversight of Restrictive Interventions – Clinical/Behavioral Health staff will direct and participate in reviewing restrictive interventions to assure efficacy, safety, and human rights.

Training for Staff – Provide training for staff related to common mental health and behavioral health issues. Assist staff with skills for addressing mental health and behavioral health with consumers and in individual support plans.

Program Development

Program development will include statewide development of program standards and written program handbooks and manuals for consumers to assure transparency and as a guide for accessing service delivery. This group will focus on the following.

Training for Staff– Develop training modules and peer mentoring program to support program needs such as facilitation skills, person directed planning, assessment of individual support needs, consumer rights and collaboration skills.

Housing – Develop a plan for addressing accessible housing needs for consumers including a manual that covers housing options and procedures for accessing low income housing.

Publications – Develop and update program handbooks and manuals for consumers, families and community providers to guide them in accessing services. Publish all handbooks, manuals and forms

on ADSD website and make them available through the Aging and Disability Resource Centers and the ADRC website.

Home and Community-Based Waiver – Identify and assess needed consumer services, making amendments to the HCBW if appropriate. Continuously review HCBW performance measures to assure Nevada programs meet objectives for community-based programs.

Policy Development – Develop policy to guide the development and delivery of all services.

Collaboration with Community Partners – Collaborate with community partners to assure quality services are available within Nevada communities.

Wellness - Integrate wellness activities within all services delivered through ADSD.

Quality Assurance/Evaluation

A statewide quality assurance and evaluation process will assure compliance with federal and state regulations as well as high quality service delivery. This program will address the following.

Human Rights Committee – Develop a Human Rights Committee to review complaints regarding rights violations and make recommendations to address any violations.

Provider Certification – Assess and evaluate providers of service to assure compliance with Nevada standards and regulations. Investigate complaints and allocations of abuse and neglect for programs covered under NRS 200.5091. Work with providers to address any concerns or issues identified during the investigation. Make recommendations to providers to enhance their ability to provide quality, individualized services. A proactive approach to service concerns is an ADSD value.

Compliance with Federal and State Regulations – Assure compliance with state and federal regulations that affect all services. Develop protocols and procedures to assure a standardized approach to review of services delivery. The process will include customer satisfaction, written assessment of the service including data, service delivered, and the plan for future services.

Development of Standards – Develop standards and criteria for each program as well as a scope of work for the provider of the service. All standards, policies, and protocols will be available for public review on ADSD website.

Development of Providers for Areas of Unmet Needs – Identify unmet needs and program gaps and recruit qualified providers through a web-based application process and Request for Proposals process.

Training for Staff – Develop training to address quality for the front end of the service system and standardize a review process for monthly review of services.

Data Collection and Analysis of Data with Written Recommendations – Create a data dictionary and a protocol for the collection and analysis of data elements. Create and identify reports dealing with the analysis of the data with recommendations for using the data to guide the system.

Performance Measures – Identify performance measures to evaluate program efficiency and assure continuous review of data for guiding changes in programs.

Policy Development Related to Quality and Evaluation of Services –Develop and implement policy and evaluation to guide the service system.

Grants/Community Collaboration

The program will use a statewide approach to securing grants. The focus will be on identification of possible grant opportunities and collaboration with community partners to write and implement the grants.

Grant Writing - Collaborate with community partners to write and implement grants.

Monitoring and Evaluation – Monitor ADSD grants and evaluate efficiency and compliance of grant goals and objectives.

Integration requires a new relationship between staff, systems and structure. The model that has guided the planning process is based on moving along a continuum from communication to consolidation. The Relationship Intensity Continuum[13] is a framework for planning effective system integration efforts. It is comprised of the following characteristics.

- ✓ **Communication**—Clear, consistent and nonjudgmental discussions; giving or exchanging information in order to maintain meaningful relationships. Individual programs or causes are totally separate.
- ✓ **Cooperation**—Assisting each other with respective activities, giving general support, information, and/or endorsement for each other's programs, services, or objectives.
- ✓ **Coordination**—Joint activities and communications are more intensive and far-reaching. Agencies or individuals engage in joint planning and synchronization of schedules, activities, goals, objectives, and events.
- ✓ **Collaboration**—Agencies, individuals, or groups willingly relinquish some of their autonomy in the interest of mutual gains or outcomes. True collaboration involves actual changes in agency, group, or individual behavior to support collective goals or ideals.
- ✓ **Convergence**—Relationships evolve from collaboration to actual restructuring of services, programs, memberships, budgets, missions, objectives, and staff.
- ✓ **Consolidation**—Agency, group, or individual behavior, operations, policies, budgets, staff, and power are united and harmonized. Individual autonomy or gains have been fully relinquished, common outcomes and identity adopted.

Over time, ADSD will work through and measure its progress against the levels of the following table to achieve integration. Items with a **√** mark indicate they are incorporated into the integration plan.

ENHANCED RELATIONSHIP INTENSITY SCALE

Level 1: Communication	■ Procedures for information sharing **√**
	■ Regular interagency meetings on common problems and opportunities

[13] This is a modified version of the service delivery continuum developed in El Paso County, Colorado, as reported in Ragan, M. (2003). Building comprehensive human service systems. *Focus 22*(3), 58-62 and was published by Colbert, t. and Noyes, J.L. (2008) Human Services Systems Integration: A Conceptual Framework; Institute for Research on Poverty, Discussion Paper no. 1333-08.

	■ Informal service 'brokering' arrangements **√**
Cooperation	■ Task forces, advisory groups, committees that review/approve plans **√**
	■ Consensus concerning best practices **√**
	■ Cross system dialogue and/or training **√**
	■ Cooperative monitoring / case reviews
Level 2: Coordination	■ Formal interagency agreements to "coordinate"
	■ Joint mission statement / principles **√**
	■ Joint training/retraining/cross training **√**
	■ Contractual procedures for resolving inter-agency disputes
	■ Temporary personnel reassignments
	■ Coordinated eligibility standards
Collaboration	■ Coordinated personnel qualification standards **√**
	■ Single application form / process **√**
	■ Common case management protocols **√**
	■ Centralized functional administration **√**
	■ Coordinated IT / (re) programming authority **√**
Level 3: Convergence	■ Contractual provisions for fund transfers / reallocations
	■ Contractual "lead agency" agreements
	■ Pooled resources / budget contributions
Consolidation	■ Multi-agency/multi-task/multi-discipline service plans and budgets
	■ Seamless interagency service delivery teams
	■ Fully blended interagency planning / division of labor / responsibility
	■ Shared human capital / physical capital assets

INTEGRATION PLAN

The following two tables highlight the goals, objectives, timing, milestones and benchmarks for integration. The first table highlights lead parties responsible for implementing and reporting on progress via milestone and benchmark achievement. The second table, which begins on Page 48, details the timing to achieve objectives. These plans will be used as a management tool to track and communicate status of the integration.

Objective	Milestones	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
A. Establish acceptable reimbursement rates by service type.	A.1 Identify service types.	Medicaid Rate Unit and ADSD Fiscal Department	3/31/14	An adopted reimbursement schedule by March 31,2014
	A.2 Identify rates in similar States.			
	A.3 Prioritize service types that the rates are most critical to improve.			
	A.4 Seek buy-in from Medicaid on the methodology prior to the rate study.			
	A.5 Seek funds by partnering with University, Medicaid funds and/or general funds for rate studies.			
	A.6 Conduct rate studies.			

Objective	Milestones	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
	A.7 Promote study results with the Governor, the DHHS, and the Legislature to fund the new rates.			
	A.8 Implement new rates.			
B. Implement a strategic financing plan to secure resources for ADSD.	B.1 Work with the Legislature to adequately fund safety net services for vulnerable populations.	ADSD Leadership and ADSD Grants Management Unit	By 2019 with progress made in 2015 and 2017 legislative sessions.	Increase ADSD funding by 15%
	B.2 Fund federally mandated programs at appropriate levels to avoid non-compliance and penalties.	ASO/ Program Directors QA staff and Directors of Various Programs Advocates, stakeholders		
	B.3 Pursue grants from charitable organizations and foundations.			
	B.4 Develop private-public partnerships.			
	B.5 Maximize the use of Medicaid and private insurance.			

Objective	Milestones	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
C. Fund services and support for the coordination and delivery of services.	C.1 Create a system to quantify service needs.	ADSD Administrator	1/16	Eligible recipients receive services within 90 days of request
	C.2 Draft service need plans.			

Objective	Milestones	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
A. Define and implement the customer service philosophy and include family in the framework for customer service delivery.	A.1 Develop a universal, person-centered framework for ADSD.	Person-Centered Framework Workgroup	12/31/14	Framework and curriculum adopted and all staff trained
	A.2 Develop materials that provide an overview of ADSD's person-centered philosophy and how that is implemented in the service system.			Website post of philosophy statement
	A.3 Develop and implement customer service training throughout ADSD.			Training evaluation

Strategy	Milestones	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
A. Define and implement a standardized service delivery system.	A.1 Create an ADSD Communication Plan.	Program Planner	7/1/15	New Name Legislative approval Communication plan
	A.2 Provide a consistent access point to consumers, advocates and for coordination of service provision, and assistance during periods of transition.		7/1/15	800-number and outreach collateral
	A.3 Establish core competencies and timelines for each position within ADSD.	Supervisors Workgroup	12/31/14	Standards adopted
	A.4 Establish core competencies and timelines for contract providers of ADSD services in 2014.	Quality Assurance Team	12/31/14	Standards in place
B. Develop solutions for standardizing and sharing (as appropriate) client records including information technology (IT) for electronic records.	B.1 Evaluate Federal and State reporting and retention guidelines for all programs.	Program Planner	7/1/14	Completed HIPAA compliance review
	B.2 Determine ability to gather and share information across programs/agency.			
	B.3 Develop internal procedures for sharing individual records when it is appropriate (factoring in the varying			

Strategy	Milestones	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
	privacy laws that pertain to each program), including release of information documents for clients.			
	B.4 Train staff regarding procedure.			
	B.5 Inventory what been done in this area.			
	B.6 Develop IT solutions for electronic records that respect the work process and differing program requirements.			
C. Implement evidence-based practice (EBP).	C.1 Inventory and assess current practices and treatment models and identify programs lacking EBP.	Chiefs and Program Managers	12/31/14	Individual Support Plans include evidence-based practices
	C.2 Identify programs that partially implement EBP. Identify models for implementation in programs lacking EBP.			
	C.3 Identify action plans or identify alternative models for programs with partial implementation (as needed).			
	C.4 Identify training and staff development needs related to EBP.			

Strategy	Milestones	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
D. Create an evaluation plan and system for measuring and analyzing outcomes for each program based on EBP model.	D.1 Each program that implements EBP will develop an evaluation plan that includes criteria for measuring outcomes, standard measurements, and a standardized instrument.	Chiefs and Program Managers	6/31/15	EBP evaluation plan
	D.2 Each program will establish a process for implementing and reporting on the outcomes according to their evaluation plan.			
	D.3 Review and revise program delivery standards based on the evaluation report and use as a basis for making program enhancements or corrections as needed.			
E. Develop criteria and process for measuring the effectiveness of the person-centered plan based on outcomes.	E.1 Develop criteria for determining the elements of PCP that impact service outcomes.	Service Coordinators Supervisors Workgroup	12/31/15	PCP standardized tool and measurements
	E.2 Create a series of measurements including satisfaction surveys.			
	E.3 Create a standardized tool and method of assessment.			

Objective	Milestone	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
A. Establish universal data elements to be collected for all services.	A.1 Create a crosswalk of data elements currently being collected by programs to identify similarities and variances.	ADSD Deputies State work group of those who do data gathering, monthly reporting for the DHHS --- CLEO	12/31/14	Crosswalk completed
	A.2 Inventory federal and state requirements required for compliance reporting.	ADSD Deputies		
	A.3 Identify the basic data elements and means of measurement/assessment, benchmarking and reporting, including cost per eligible, wait times, and service level provided.	ADSD Deputies		
	A.4 Ensure that the methodology is consistent and possible across programs.	ADSD Deputies		
B. Prioritize and adopt meaningful performance	B.1 Create crosswalk of performance measures currently being collected.	ADSD Deputies	12/31/14	Adoption of performance measures by program
	B.2 Analyze whether the performance	ADSD Deputies		

Objective	Milestone	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
measurements for quality.	indicators are meaningful.			
	B.3 Develop measures that help identify effectiveness of current programs based on quality measures.	ADSD Deputies		
C. Establish reporting standards for all services that can provide information to support continuous quality improvement (CQI) efforts.	C.1 Identify the key elements of CQI.	ADSD Deputies ADSD QA Team	12/31/14	CQI Plan
	C.2 Establish and publicize reporting frequency.	ADSD Management		
	C.3 Implement questionnaire for individuals served by ADSD as well as Providers to find out how they perceive the agency is serving them.	ADSD Commission Workgroup		
	C.4 Utilize questionnaire results to develop specific CQI goal.			
	C.5 Update CQI plan annually.			
D. Report annually to the public the outcome measure results.	D.1 Identify what data is to be reported.	Management Analysts and QA Team	12/31/14	Annual report to the public
	D.2 Identify who will review reports and updates prior to publication/release.	Management Analysts and QA Team		
	D.3 Develop a reporting calendar/timeline.	Management Analysts and QA Team		

Objective	Milestone	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
	D.4 Identify logistics of how reports will be published and ensure they are available to the public and posted on a website.	ADSD Commission Workgroup		
E. Develop and/or expand CQI efforts to improve systems throughout ADSD.	E.1 Develop an ADSD CQI Team and define roles and responsibilities.	Administrator Stakeholders	6/30/15	Team identified; By-laws/charter established
	E.2 Identify CQI plan for ADSD system improvements.	CQI Team		
	E.3 Establish local Quality Improvement (QI) Committees (by July 2014) including consumers, family members, staff, providers of service, concerned community members.	• CQI Committee • Each area assigns QA staff as a representative		Committees identified; by-laws/charter established
	E.4 Implement CQI Plan.	CQI Team		QI plan

Objective	Milestone	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success

Objective	Milestone	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
A. Develop a recruitment and retention plan for an adaptive, skilled ADSD workforce.	A.1 Identify infrastructure needs necessary to ensure staff have the tools, time and resources to be successful in their positions.	Program Supervisors Workgroup	6/30/17	Mentoring Program Revised workloads Adjusted pay scales Incentive package Internship program
	A.2 Evaluate existing workloads and adjust to be achievable.	Program Supervisors Workgroup		
	A.3 Adjust rates to incentivize employment.	Legislature		
	A.4 Provide online training to educate staff in a low cost, high tech method.	IT Manager		
	A.5 Implement internships to recruit workforce.	Legislature Program Supervisors Workgroup		
	A.6 Create a mentoring program with criteria and agreements for commitment.	Program Supervisors Workgroup		
	A.7 Identify non-financial incentives such as educational work release time, loan repayment program, license supervision, flexible hours and other options.	Human Resources		
B. Develop and implement customer service	B.1 Cross train all regarding eligibility and services available through ADSD.	Deputies of Programs	12/31/14	Training Evaluation Webpage
	B.2 Develop a customer's bill of rights.	Program Planner		

Objective	Milestone	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
training throughout ADSD.	B.3 Create and implement business practices that enhance all staff's ability to get the service to the consumer.	Service Coordinators Supervisors Workgroup		
	B.4 Set clear guidelines for providing customer friendly service in all areas of the service system. Incorporate in all staff orientation and work performance.	Human Resources Manager		
	B.5 Provide sensitivity training and ongoing mentoring for staff -- Address the issue of stress with staff providing "first contact" information for consumers.	Service Coordinators Supervisors Workgroup		
	B.6 Gain customer satisfaction feedback from a variety of sources --- Phone calls, interviews, calling into system.	QA Team		
	B.7 Develop a web page which identifies important elements of service delivery and how state staff and providers are performing.	Quality Assurance and IT Manager		
C. Develop and implement a process for continuous educational opportunities to enhance a person-	C.1 Develop webinars and other online training opportunities.	Training officers/Personnel	12/31/14	Webinar
	C.2 Develop webinars and other learning opportunities for consumers and families on topics related to self-advocacy and self-determination.			

Objective	Milestone	Responsible Party/Parties	Timeline for Completion	Benchmarks for Measuring Success
centered approach toward service delivery.				

The table that follows includes timing for planned completion linked to the identified actions steps for implementation.

. Increase funding and services to meet national or state accepted funding levels by service population to achieve ADSD penetration rates.											
Objective	3/31/2014	7/1/2014	12/31/2014	Year 2015	6/30/2015	7/1/2015	12/31/2015	1/1/2016	Year 2017	7/1/2017	Year 2019
A. Establish acceptable reimbursement rates by service type.	X										
B. Implement a strategic financing plan to secure resources for ADSD.				progress					progress		X
C. Fund services and support for the coordination and delivery of services.								X			

Objective	3/31/2014	7/1/2014	12/31/2014	Year 2015	6/30/2015	7/1/2015	12/31/2015	1/1/2016	Year 2017	7/1/2017	Year 2019
A. Define and implement the customer service philosophy and include family in the framework for customer service delivery.			X								

Objective	3/31/2014	7/1/2014	12/31/2014	Year 2015	6/30/2015	7/1/2015	12/31/2015	1/1/2016	Year 2017	7/1/2017	Year 2019
A. Define and implement a standardized service delivery system.			X		X						
B. Develop solutions for standardizing and sharing (as appropriate) client records including information technology (IT) for electronic records.		X									
C. Implement evidence-based practice (EBP).			X								

Objective	3/31/2014	7/1/2014	12/31/2014	Year 2015	6/30/2015	7/1/2015	12/31/2015	1/1/2016	Year 2017	7/1/2017	Year 2019
D. Create an evaluation plan and system for measuring and analyzing outcomes for each program based on EBP model.					X						
E. Develop criteria and process for measuring the effectiveness of the person-centered plan based on outcomes.							X				

Objective	3/31/2014	7/1/2014	12/31/2014	Year 2015	6/30/2015	7/1/2015	12/31/2015	1/1/2016	Year 2017	7/1/2017	Year 2019
A. Establish universal data elements to be collected for all services.			X								
B. Prioritize and adopt meaningful performance measurements for quality.			X								
C. Establish reporting standards for all services that can provide information to support continuous			X								

Objective	3/31/2014	7/1/2014	12/31/2014	Year 2015	6/30/2015	7/1/2015	12/31/2015	1/1/2016	Year 2017	7/1/2017	Year 2019
quality improvement (CQI) efforts.											
D. Report annually to the public the outcome measure results.			X								
E. Develop and/or expand CQI efforts to improve systems throughout ADSD.					X						

Objective	3/31/2014	7/1/2014	12/31/2014	Year 2015	6/30/2015	7/1/2015	12/31/2015	1/1/2016	Year 2017	7/1/2017	Year 2019
A. Develop a recruitment and retention plan for an adaptive, skilled ADSD workforce.										X	
B. Develop and implement customer service training throughout ADSD.			X								
C. Develop and implement a process for continuous educational opportunities to enhance a person-centered approach toward service delivery.			X								

PROVISIONS FOR UPDATING THE PLAN

The plan will be used as a management tool and will be updated at least quarterly beginning in April 2014. An annual review and update to the plan will be completed each year beginning in December 2014. The updated plan will be posted on ADSD website and available to the public. It will be provided to stakeholder groups and commissions as they assess and evaluate related strategic plans.

GAPS IN SERVICES ACROSS THE LIFESPAN

The following gaps in services were identified during the planning process and will be used to inform Goals 2 and 3 of integration.

1. Children ages 3 to 22 with a disability unless they have autism or an intellectual disability
    a. No services offered outside of the school
    b. Lack of collaboration between the counties that offer services
    c. Lack of respite care for families and caregivers
2. Services for the blind
    a. No services available to serve the newly blind
    b. Supportive case management on demand
3. Services for persons with traumatic brain injury
    a. Lack of rehabilitation programs across the state
    b. Lack of wraparound and follow-up
    c. Supportive case management on demand
4. Services for children and adults who are deaf or hard of hearing
    a. Lack of certified deaf interpreters
    b. Supportive case management on demand
5. Shortage of non-emergency and non-medical transportation for all populations in all areas of the state
6. Affordable, accommodating housing options for seniors and persons with disabilities
7. In-home services are restricted by eligibility for all populations
8. Behavioral health services for all populations served by ADSD
9. Shortage of home-delivered meals
10. Lack of providers for specific needed services across the state
11. Lack of long-term case management to remain in place
12. Lack of supported and integrated employment positions

APPENDIX A STAFF AND PROVIDER OUTREACH SUMMARY INTRODUCTION

AGING AND DISABILITY SERVICES DIVISION INTEGRATION EFFORTS

In the 2013 Nevada Legislature a bill was passed that transfers Nevada Early Intervention Services (NEIS), previously within the Health Division, and Developmental Services (DS), previously within Mental Health and Developmental Services, into ADSD. The benefits of integrating the services include a better ability to:

- Promote community living for Nevadans with disabilities of all ages (across the lifespan);
- Create and enhance strategies to ensure the necessary services and supports;
- Provide a responsive and effective service system;
- Firmly establish a single point of entry for services;
- Expand outreach efforts;
- Reduce transitions across programs to obtain the full spectrum of care and better service coordination for participants with similar needs;
- Improve access to information on community services and supports such as housing, employment, education, social participation, etc.;
- Create a similar comprehensive community provider application and oversight process; and
- Strengthen basic infrastructure such as information technology (IT) and Fiscal.

The critical phase of the integration process involved a series of outreach events designed to understand the concerns, issues and perspectives of system stakeholders. Outreach events consisted of five strategies: (1) key informant interviews; (2) a series of town hall meetings; (3) surveys aimed at consumers; (4) surveys aimed at ADSD staff and service providers and (5) a series of focus group meetings.

This report summarizes the findings of ADSD staff and service provider surveys.

PURPOSE OF STAFF AND PROVIDER SURVEYS

A survey was issued to ADSD staff and service providers in an effort to solicit information on what works and to capture solutions to the critical issues as well as suggestions about accomplishing the goals related to integration efforts.

METHODS

A Steering Committee, charged with guiding the integration plan, approved a total of 26 questions posed in the survey tool which can be found in the Appendix.

Provider surveys were distributed through the Steering Committee with support provided by SEI when copies of the survey were requested directly from service providers. The completion of the staff survey was requested by ADSD leadership directly. The surveys were completed either online through Survey Monkey or in hard copy form and sent back to SEI for data entry and analysis.

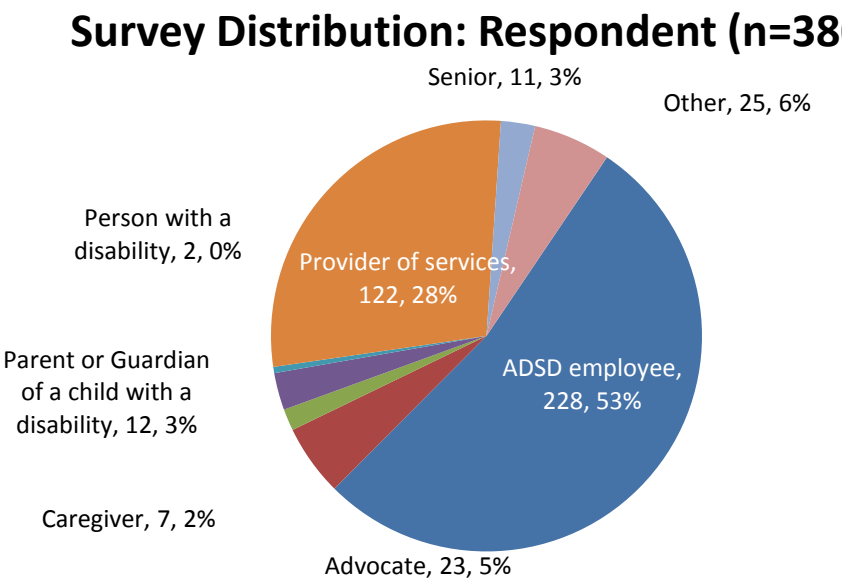
Surveys were collected over a period of 11 days (October 30 – November 11, 2013). A total of 381 surveys were collected from staff and providers from across the state. The responses contain values that at times exceed the number of surveys collected as respondents were offered the option of choosing more than one answer to selected questions. Conversely, there are questions in which the number of responses does not meet the threshold of surveys collected (381) as respondents provided no answer to the question.

SURVEY RESPONDENTS PROFILE

RESPONDENT SELF-IDENTIFICATION

There were a total of 381 surveys collected from staff and providers across the state. The survey tool asked respondents to identify a category that best described their profile/affiliation. The table below demonstrates that the majority of surveys received were from respondents that identified themselves as ADSD employees (228 or 53%) and providers of services (122 or 28%). Surveys were also completed by advocates (23 or 5%), parents or guardians of a child with a disability (12 or 3%), caregivers (7 or 2%), or persons with a disability (2 or 0%). Twenty-five of the 380 respondents selected "other."

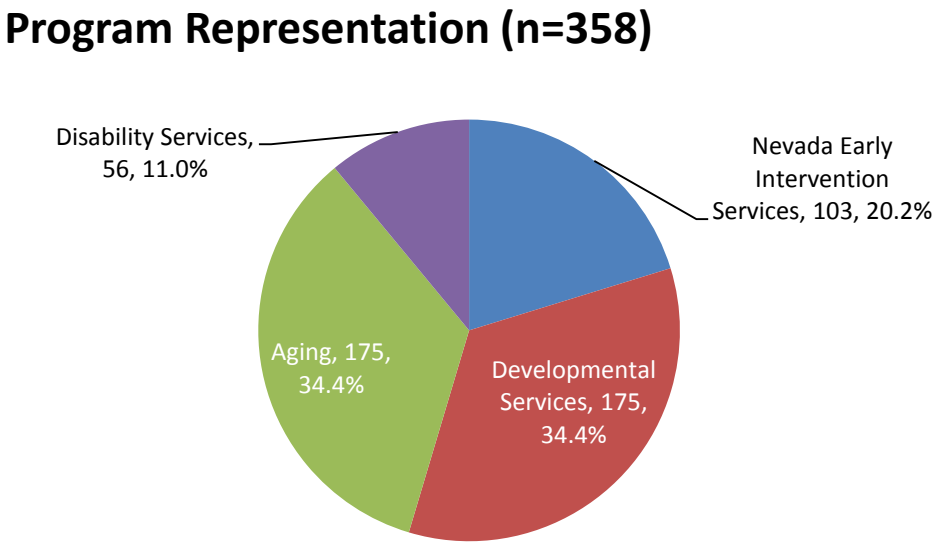
Figure 1: Survey Breakout



PROGRAM REPRESENTATION

The survey listed programs from NEIS, DS, and Aging, and Disability Services. Respondents were asked to identify the program(s) that they represent.

Figure 2: Program Representation

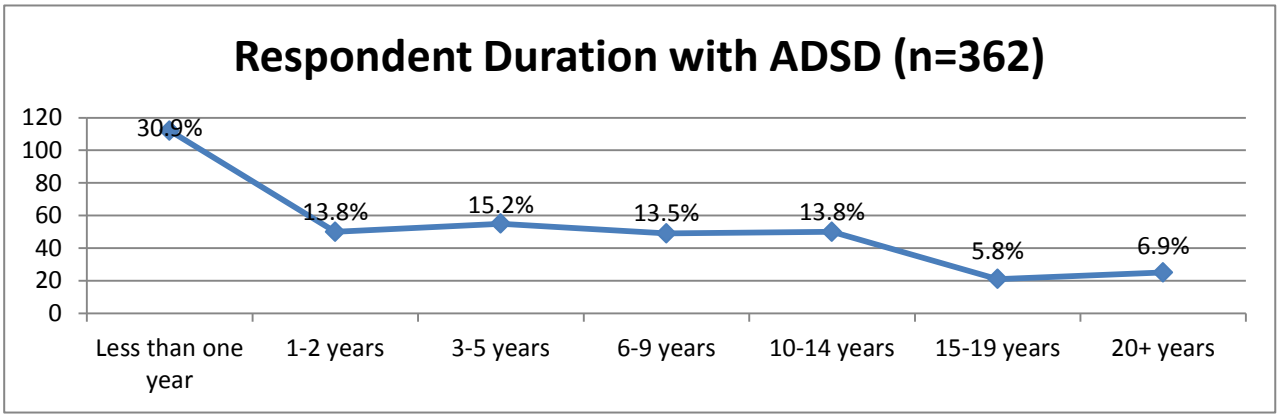


Respondents representing Aging and DS comprised the majority of surveys collected, totaling 34.4% (175 surveys) of the surveys received. Respondents representing NEIS totaled 20.2% (103 surveys) and respondents representing Disability Services totaled 11.0% (56 surveys).

RESPONDENT LENGTH OF SERVICE IN THE FIELD

Respondents were asked to indicate how long they have been a part of ADSD. About a third of respondents (30.9%) have worked with ADSD for less than one year and 12.7% of respondents have worked with ADSD for 15 years or more.

Figure 3: Duration with ADSD

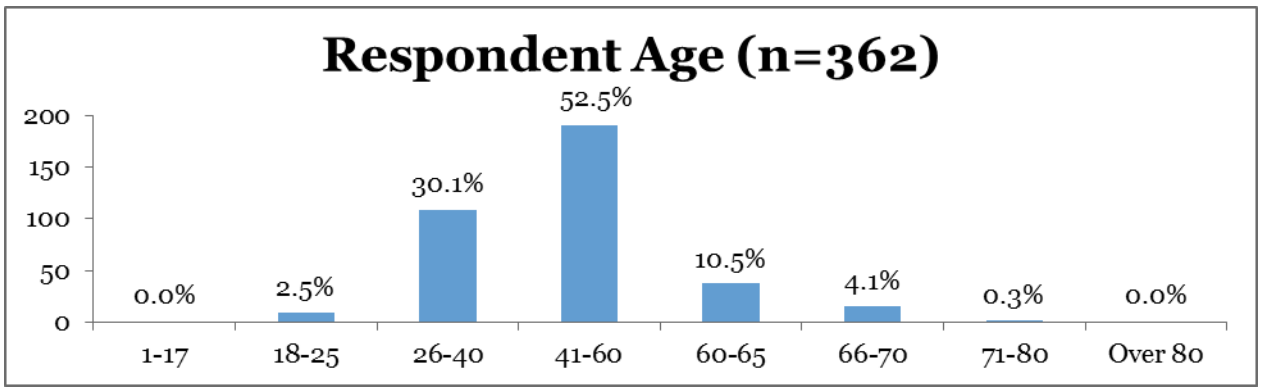


All survey respondents representing the various programs (NEIS, DS, and ADSD) had similar percentages for their duration with ADSD with the exception of NEIS. Out of the 99 NEIS respondents, 51.5% worked with ADSD for less than one year while only 5% worked with ADSD for 15 years or more (a natural result of the recent merger).

RESPONDENT AGE

The ages of respondents ranged from 18 to 70 years of age with the majority between 41 to 60 years (52.5% or 190 respondents). All service areas had similar numbers except for Disability Services. Respondents from Disability Services ranged between 26 to 70 years of age with the majority between 26 to 40 years (48.2% or 27 out of 56).

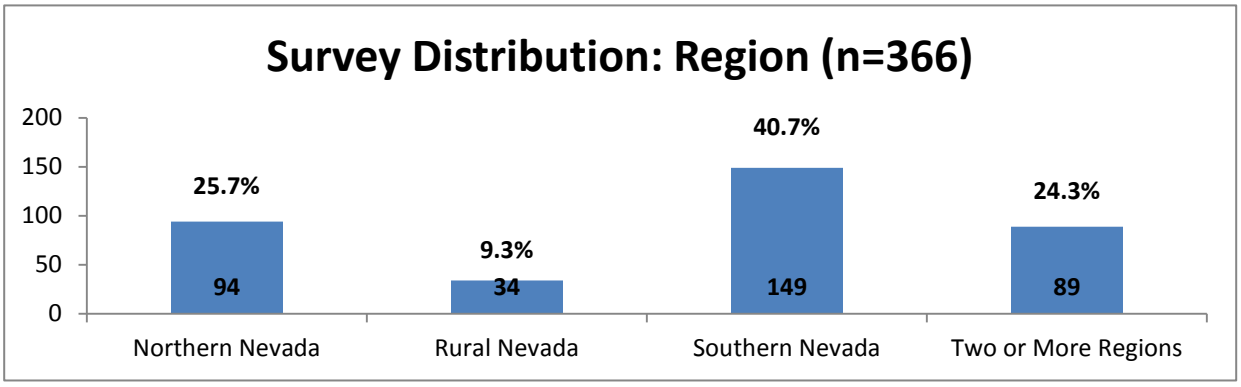
Figure 4: Respondent Age



GEOGRAPHICAL REPRESENTATION

Respondents were asked to identify the region in which they provided services.

Figure 5: Survey Distribution by Region



Of the 381 surveys, almost half (40.7% or 149 surveys) were returned from providers in Southern Nevada. Northern Nevada providers represented 27.7% (94) of the survey respondents, while 9.3% (34 surveys) were received from providers in Rural Nevada. Eighty-nine or 24.3% of surveys collected represent providers whose service area covers two or more regions of the state.

FINDINGS

A number of key themes emerged from the staff and provider surveys. In addition to cross-cutting themes that apply to the overall integration of Aging and Disability Services in Nevada, there are also themes that are specific to NEIS, DS, Disability Services, and Aging Services.

CRITICAL ISSUES

Critical Issues that had been identified through focus groups and key informant interviews and confirmed by the Steering Committee were presented in the survey.

AGREEMENT ON CRITICAL ISSUES

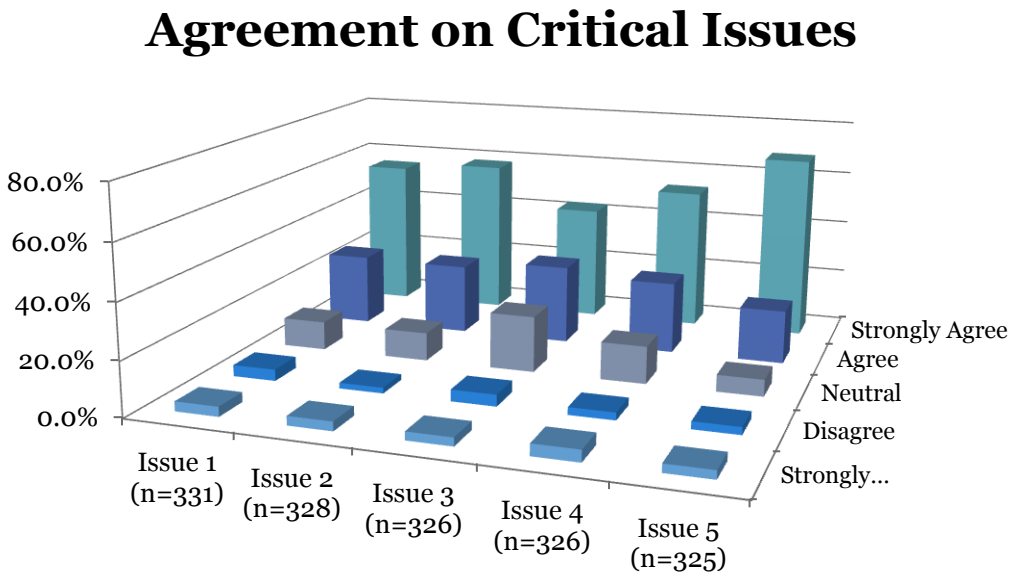
Survey respondents were asked to identify the degree to which they agreed that the issue was critical for Nevada with five representing strong agreement and one representing strong disagreement. The table on the following page represents the responses to each of the five critical issues.

Table 1: Critical Issues

	Critical Issue	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Issue 1 n=331	**The critical issue is the need for customer service.** ADSD should establish a culture of shared ownership across ADSD where all staff approach their work from a person-centered, solution-oriented mindset, and are determined to assist those in need regardless of their age, circumstance or primary presenting issue. This mindset should promote collaboration, coordination and communication so that there truly is no wrong door or point of contact within ADSD. ADSD should identify policies to ensure the framework is implemented.	**55.3%**	**26.3%**	**10.6%**	**4.2%**	**3.6%**
Issue 2 n=328	**The system of care and decisions about service delivery implementation within ADSD should be aligned with ADSD vision and mission.** ADSD should ensure that policies and procedures are also clearly articulated and understood. Standards of care for all ADSD services should be outcome- and evidence-based, and implemented with fidelity. From first contact on, processes for collecting information, making referrals, determining eligibility, and providing services should be clear, coherent and consistently implemented. Three key components of the system of care need to be the focus for integration. i. **Access**: Ensure that the community is aware of services and how to access them and that services are accessible, available and supportive in every community. ii. **Transitions**: Identify and map the processes and approach to assist individuals to seamlessly transition through providers, services, agencies, schools and systems. iii. **Collaboration across Programs and Services**: Increase communication, strengthen coordination, and promote collaboration across systems, sectors, agencies and counties in order to maximize resources and achieve better outcomes for Nevadans who are receiving services.	**58.2%**	**25.9%**	**10.4%**	**2.1%**	**3.4%**
Issue 3 n=326	**Ensure that outcome-based, measurable criteria are in place to demonstrate the impact of ADSD services and to quantify the cost savings from integration and the investment of those resources in services.** Collect and report data uniformly across services and ADSD using universal data elements. Ensure quality of care standards are developed and implemented.	**42.9%**	**29.1%**	**20.6%**	**4.3%**	**3.1%**
Issue 4 n=326	**The critical issue is to ensure a sufficient, qualified workforce across the state**. Build the capacity of providers to address unmet needs. Provide cross training to maximize resources and advance knowledge of all services within all programs and staff of ADSD.	**52.8%**	**26.4%**	**13.8%**	**2.8%**	**4.3%**
Issue 5 n=325	**It is critical to pursue funding and promote the development of resources to meet client needs.** This includes sufficient providers and services such as specialty care, housing, food security, transportation, education, training and employment, medical, case management, behavioral health and co-occurring disorder treatment.	**68.3%**	**19.7%**	**6.2%**	**2.8%**	**3.1%**

Figure 6 below, represents the agreement and disagreement on critical issues collectively across all areas.

Figure 6: Agreement on Critical Issues



	Issue 1 (n=331)	Issue 2 (n=328)	Issue 3 (n=326)	Issue 4 (n=326)	Issue 5 (n=325)
Strongly Disagree	3.6%	3.4%	3.1%	4.3%	3.1%
Disagree	4.2%	2.1%	4.3%	2.8%	2.8%
Neutral	10.6%	10.4%	20.6%	13.8%	6.2%
Agree	26.3%	25.9%	29.1%	26.4%	19.7%
Strongly Agree	55.3%	58.2%	42.9%	52.8%	68.3%

Agreement on critical issues was consistent among all four represented service areas (NEIS, DS Aging, and Disability Services).

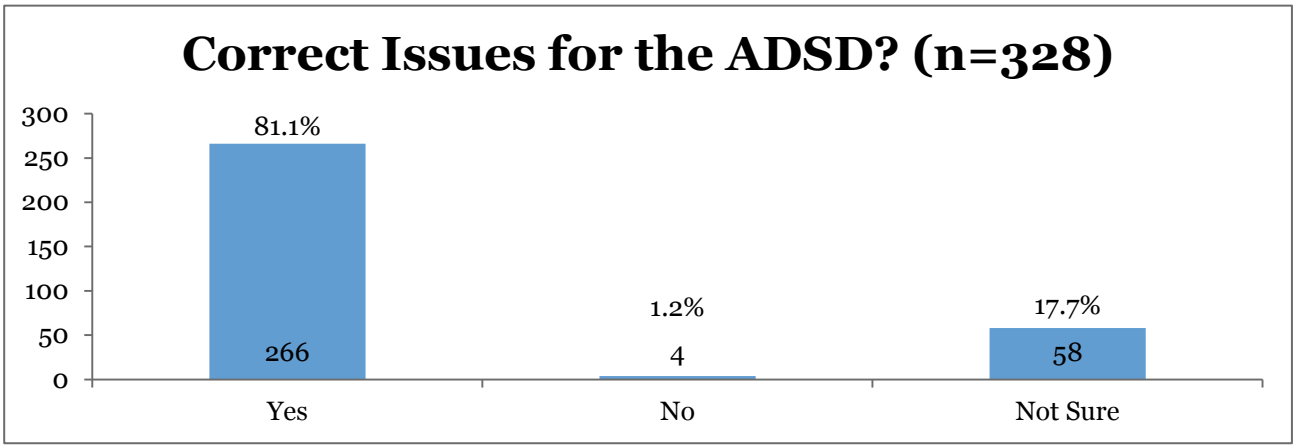
- **81.6%** of survey respondents either strongly agree or agree with Critical Issue 1: The need for customer service.
- **84.1%** of survey respondents either strongly agree or agree with Critical Issue 2: The system of care and decisions about service delivery implementation within ADSD should be aligned with ADSD vision and mission.
- **72%** of survey respondents either strongly agree or agree with Critical Issue 3: Ensure that outcome-based, measurable criteria are in place to demonstrate the impact of ADSD services.
- **79.2%** of survey respondents either strongly agree or agree with Critical Issue 4: Ensure a sufficient, qualified workforce across the state.

- **88%** of survey respondents either strongly agree or agree with Critical Issue 5: It is critical to pursue funding and promote the development of resources to meet client needs.

CORRECT CRITICAL ISSUES FOR ADSD

The survey asked whether these five issues were the right issues for ADSD to target. A majority of respondents believed the five critical issues were the correct issues (81.1% or 266) while only four were not in agreement (1.2%) and 58 were unsure (17.7%).

Figure 7: Correct Issues for ADSD



IMPORTANCE OF EACH CRITICAL ISSUE

Respondents were also asked to rank each critical issue on their importance. The issues were ranked between one and five with one representing the issue having the most importance. The average rankings were calculated by summing the ranks for the particular issue and dividing that by the number of respondents.

Table 2: Rank of Critical Issues

Rank	Critical Issue	Avg. Rating	n
1	**Issue 2:** The system of care and decisions about service delivery implementation within ADSD should be aligned with ADSD vision and mission.	2.54	307
2	**Issue 1:** The critical issue is the need for customer service.	2.62	307
3	**Issue 5:** It is critical to pursue funding and promote the development of resources to meet client needs. This includes sufficient providers and services such as specialty care, housing, food security, transportation, education, training and employment, medical, case management, behavioral health and co-occurring disorder treatment.	2.79	307
4	**Issue 4:** The critical issue is to ensure a sufficient, qualified workforce across the state. Build the capacity of providers to address unmet needs.	3.22	307

Rank	Critical Issue	Avg. Rating	n
5	**Issue 3:** Ensure that outcome-based, measurable criteria are in place to demonstrate the impact of ADSD services and to quantify the cost savings from integration and the investment of those resources in services.	3.84	307

The average rankings were fairly close with a range between 2.54 and 3.84. The highest ranked issue was issue 2; the system of care and decisions about service delivery implementation within ADSD should be aligned with ADSD vision and mission. The lowest ranked issue was issue 3; ensure that outcome-based, measurable criteria are in place to demonstrate the impact of ADSD services.

Table 3: Ranks of Critical Issues

Critical Issue	Consistently Ranked	Percentage of Respondents	n
Issue 1	1	28.0%	307
Issue 5	1	28.0%	307
Issue 2	1	27.7%	307
Issue 4	4	27.7%	307
Issue 3	5	37.5%	307

Table 5 represents how each issue was most commonly ranked. Issues 1, 2, and 5 were consistently ranked with a score of 1 (having the most importance), while issue 3 was consistently ranked with a score of 5 (having the lowest importance).

GOALS

Draft goals were developed by the Steering Committee to address each of the critical issues. Survey respondents were asked to identify on a scale of one to five, the degree to which they agreed with the goals as established. A score of 1 represented strong disagreement, while a score of 5 represented strong agreement. The table below represents the responses to each of the five goals.

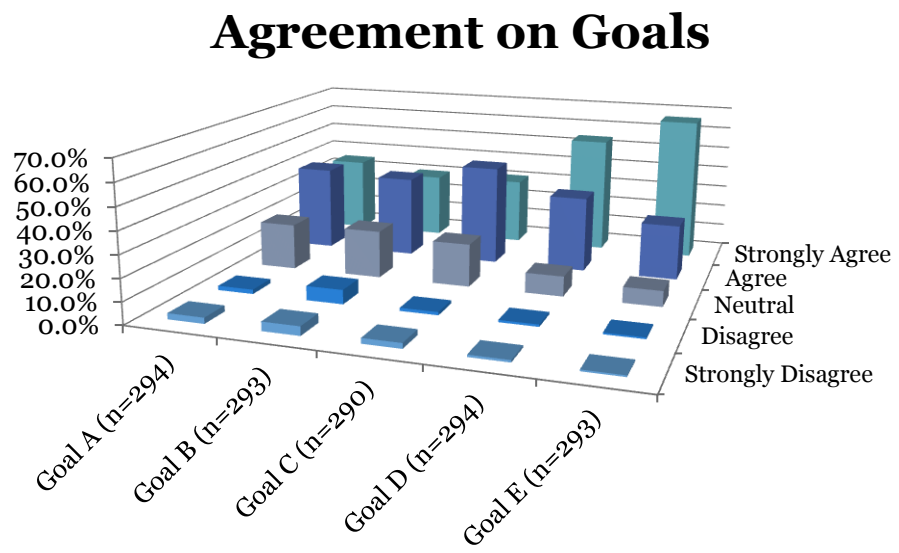
Table 4: Goals

	Goals	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Goal A n=294	Adopt and Implement a Universal, Person-Centered Framework throughout ADSD by December 3, 2014.	**35.0%**	**39.1%**	**21.1%**	**2.0%**	**2.7%**
Goal B n=293	Establish a Standardized, Evidence-based Service Delivery System for all ADSD programs, regardless of population or region.	**30.0%**	**37.5%**	**21.8%**	**6.5%**	**4.1%**
Goal C n=290	Adopt and report on criteria that demonstrate outcomes, efficiency and cost-effectiveness.	**30.7%**	**45.9%**	**19.7%**	**1.4%**	**2.4%**
Goal D	Develop a system to recruit and retain	**54.1%**	**34.7%**	**9.2%**	**1.1%**	**1.1%**

	Goals	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
n=294	a highly-trained, adaptive, skilled workforce.					
Goal E n=293	Increase funding and services to meet national funding levels by service population.	**66.2%**	**25.3%**	**7.2%**	**0.7%**	**0.7%**

Figure 8 below, represents the agreement and disagreement on goals collectively across all areas.

Figure 8: Agreement on Goals



	Goal A (n=294)	Goal B (n=293)	Goal C (n=290)	Goal D (n=294)	Goal E (n=293)
Strongly Disagree	2.7%	4.1%	2.4%	1.0%	0.7%
Disagree	2.0%	6.5%	1.4%	1.0%	0.7%
Neutral	21.1%	21.8%	19.7%	9.2%	7.2%
Agree	39.1%	37.5%	45.9%	34.7%	25.3%
Strongly Agree	35.0%	30.0%	30.7%	54.1%	66.2%

A majority of respondents were in agreement on each goal.

- **74.1%** of survey respondents either strongly agree or agree with Goal A: Adopt and Implement a Universal, Person-Centered Framework.
- **67.5%** of survey respondents either strongly agree or agree with Goal B: Establish a Standardized, Evidence-based Service Delivery System for all ADSD programs, regardless of population or region.

- **76.6**% of survey respondents either strongly agree or agree with Goal C: Adopt and report on criteria that demonstrate outcomes, efficiency and cost-effectiveness. .
- **88.8**% of survey respondents either strongly agree or agree with Goal D: Develop a system to recruit and retain a highly-trained, adaptive, skilled workforce.
- **91.5**% of survey respondents either strongly agree or agree with Goal E: Increase funding and services to meet national funding levels by service population.

ACTIVITIES

Each goal that was developed had a number of potential activities identified to support achievement. Survey respondents were asked to identify on a scale of one to five, the degree to which they agreed with the activities as established.

5= Strongly Agree 4= Agree 3= Neutral 2= Disagree 1= Strongly Disagree

The table below has combined the 4 and 5 scores and represents them as a percentage of the respondents in agreement with the activities. Conversely, it has combined the 1 and 2 scores and represents them in as a percentage of the respondents in disagreement with the activities. Items in bold had the highest response. Neutral scores are not included in the table below.

Figure 9: List of Sub-goals

Goal ID	Description	Disagreement	Agreement
A.1 n=290	Define the customer service philosophy and include family in the framework for customer service delivery.	2.1%	82.8%
A.2 n=289	Develop a universal application.	8.7%	64.0%
A.3 n=287	Link customer service standards to work performance standards.	8.4%	60.9%
A.4 n=289	Measure satisfaction rates for services.	3.8%	74.0%
A.5 n=289	Develop and provide sensitivity training.	5.2%	75.4%
A.6 n=292	Adopt policies that empower staff to innovate and customize.	2.4%	87.0%
A.7 n=290	Measure achievement of outcomes on the person-centered plan.	3.8%	79.3%
A.8 n=291	Report transparently, in a manner understandable to the public, how ADSD and its providers are doing and are performing.	0.3%	81.1%
B.1 n=292	Educate and sensitize the general public about the value of people of all ages and abilities.	1.0%	86.7%
B.2 n=290	Inform consumers about available services and access points using multi-media approaches.	1.3%	88.3%
B.3 n=289	Develop and consistently implement policies and procedures that ensure equal access to services.	1.3%	88.9%
B.4 n=291	Develop service coordination standards that promote a single point of contact to assist a client throughout their entire lifespan, providing a consistent access point to consumers, advocacy and coordination of service provision,	7.2%	77.0%

Goal ID	Description	Disagreement	Agreement
	and assistance during periods of transition.		
B.5 n=288	Establish service outcome measures and evaluate programs based on those measures.	1.7%	76.1%
B.6 n=288	Implement a pro-active service delivery model, shifting the responsibility from the consumer to the provider to facilitate solutions and transitions.	**13.2%**	**62.9%**
B.7 n=290	Utilize a centralized data bank that can maintain a consumer's eligibility paperwork and service history ,which can be utilized throughout the lifespan as well as between systems.	2.8%	79.7%
C.1 n=289	Establish universal data elements to be collected for all services.	6.2%	70.2%
C.2 n=289	Prioritize and adopt meaningful performance measurements for quality and cost.	2.4%	78.2%
C.3 n=289	Establish reporting standards for all services that can provide information to support continuous quality improvement (CQI) efforts.	2.4%	78.9%
C.4 n=285	Expand CQI efforts to improve systems throughout ADSD.	3.5%	72.6%
C.5 n=288	Report annually to the public the outcome measure results.	4.2%	**63.9%**
D.1 n=294	Implement interview tools to match candidates to the positions for which they are best suited.	3.0%	80.3%
D.2 n=292	Create and implement a culture of professional development and support that entrusts all personnel to uphold ADSD's mission and philosophy.	0.3%	89.4%
D.3 n=293	Provide training to develop a better understanding of the needs of people with special needs (developmental delay, physical disability, or aging conditions) to better serve in their professional capacities.	0.6%	92.9%
D.4 n=292	Empower those working within the system to adopt a pro-active approach to service delivery.	0.3%	89.7%
D.5 n=294	Develop incentives and rewards for high performing personnel.	4.0%	78.6%
D.6 n=293	Implement mentoring and job shadowing across agencies to build a career pathway.	2.4%	82.3%
E.1 n=294	Work with the Legislature to adequately fund safety net services for vulnerable populations.	0.6%	92.8%

Goal ID	Description	Disagreement	Agreement
E.2 n=292	Fund federally mandated programs at appropriate levels to avoid penalties.	0.6%	87.6%
E.3 n=294	Pursuing grants and foundations.	1.0%	91.9%
E.4 n=292	Pursue private-public partnerships.	1.4%	83.6%
E.5 n=289	Partner with other state entities to draw down all federal funding.	2.1%	81.0%
E.6 n=290	Maximize the use of existing federal funding.	1.0%	89.1%
E.7 n=293	Maximize the use of Medicaid and private insurance.	1.0%	88.4%
E.8 n=295	Ensure systems are in place to bill Medicaid while preventing fraud.	1.4%	89.5%

Goals B.6 and C.4 had the lowest percentage of agreement with 62.9% and 63.9% respectively while goal C.4 had the highest percentage of disagreement with 13.2%. All other goals had a high percentage of agreement with a low percentage of disagreement.

STAFF AND PROVIDER INPUT

The last portion of the staff and provider survey included open-ended questions that were designed to further inform the Steering Committee in their development of a plan for integration. The results of the questions are summarized below and are in the order collected in the survey instrument.

WHAT WORKS WELL IN NEVADA?

Respondents were asked to describe what works well in Nevada and should be continued to achieve the goals. Of the 381 surveys collected, a total of 113 participants provided a response to this open-ended question. Responses listed most included partnerships, staff, and programs provided to clients.

Responses indicate that the partnerships and collaborations of ADSD with other state agencies, programs, and community providers are currently working well and should be continued. Additionally, there were a number of responses that indicated that ADSD has a strong workforce that is dedicated to providing client-centered care that meets an individual's unique needs. Lastly, respondents indicated a desire to maintain current program offerings, with minimal disruption to existing providers.

WHAT ARE THE STRENGTHS IN NEVADA?

Respondents were asked to describe the strengths upon which Nevada should build. Of the 381 surveys collected, a total of 126 participants provided a response to this open-ended question. Input provided by staff and providers who completed this portion of the survey centered on the quality of staff and benefit of community partnerships.

Many respondents expressed the opinion that Nevada's human resources was its greatest asset and that the current workforce was committed to providing caring and individualized care despite the limited resources available. Respondents indicated that the state should focus on building upon that platform by both investing (monetarily and otherwise) in existing staff as well as hiring new staff to meet the needs of consumers.

Respondents also indicated that a strong partnership with providers and community-based organizations was a strength that should be maintained and nurtured. Respondents indicated that the state should continue to work with providers by sharing information, and investing in their capacity to serve from a strength-based perspective.

WHAT ARE YOUR CONCERNS REGARDING INTEGRATION?

Respondents were asked to describe their greatest concern about integration. Of the 381 surveys collected, a total of 152 participants provided a response to this open-ended question. Concerns listed most often included the following.

- A lack of clarity among staff regarding integration efforts and how it will affect employees, providers, and consumers.
- Integration will result in an additional workload to a workforce that is already stretched thin.
- A lack of buy-in from staff would result in ADSD continuing to work in silos.
- Universal approach to service across service sectors will result in a lack of person-centered service delivery.
- Individual service sectors would not receive the same attention, considerations, and funding as others – a concern shared by all service sectors representing early intervention, disability services, aging and disability services.
- Losing sight of the goal to serve people while focusing on the need to integrate processes and attain outcomes.
- There was a concern that becoming a larger organization would only serve to hinder teamwork, communication and, ultimately, service to clients.

WHAT IS THE GREATEST BARRIER YOU ENCOUNTER?

Respondents were asked to describe the greatest barrier that they experience in trying to do their job. Of the 381 surveys collected, a total of 168 participants provided a response to this open-ended question. The issues addressed most often as barriers included the lack of funding to support client services, insufficient workforce supports, and a lack of supportive leadership.

The most significant barrier for employees trying to do their job centered on a lack of funding. Comments provided indicate that the lack of funding within the DHHS has led to an insufficient workforce and doesn't offer the breadth or depth of services necessary to respond to the needs of clients. Additionally, the workforce currently in place in not sufficiently compensated or supported by leadership with the appropriate training or communication measures needed to ensure a stable workforce. There were multiple comments about the low morale of staff and the disappointment with leadership throughout the transitional process.

WHAT WOULD YOU LIKE AS A RESULT OF INTEGRATION?

Respondents were asked to describe one thing they would like to see come out of integration. Of the 381 surveys collected, a total of 152 participants provided a response to this open-ended question.

The overwhelming hope of integration was that people would be able to access and receive comprehensive person-centered care from a system that respects the individual and sufficiently serves them. Additional aspirations of what integration could achieve included the following.

- Additional staff supports to include better pay, promotional opportunities, teamwork facilitation and open communication strategies
- Improved partnerships and collaborations
- Improved transitional support for clients across the lifespan
- Establishment of clear and consistently applied policies and procedures.

> *I would like for the process to be more person-centered, not only in philosophy but in application.*
>
> Survey Respondent

CONCLUSION

All four service areas, NEIS, DS, Aging, and Disability Services, had similar responses throughout the survey with a majority of respondents agreeing with the critical issues, goals and activities as established by the Steering Committee. While a majority of all service area respondents agreed with the issues, goals and activities, NEIS consistently had a higher percentage of respondents who disagreed with the critical issues and goals than the other service areas.

The most important issue that was identified was the need for sufficient resources to support clients served under the new configuration of ADSD. Services identified as most important to a client's ability to live independently were case management and home care. The activity that was ranked as most important to achieve sufficient service levels was working with the Legislature to adequately fund safety net services for vulnerable populations. Open-ended questions revealed that the majority of respondents identified human resources as the primary strength that the integration efforts will need to support to ensure integration efforts are a success, while concerns centered on the feasibility of integration and the need for open communication and a coherent plan.