



Access and Choice Design Team Meeting Summary

Access and Choice Design Team	Date of Meeting: August 16, 2011
<p>Present: Shameka Andrews; Al Coley; John Gleason; Gerald Huber; Lauren Lange; John Maltby; Maryellen Moeser; Chris Nemeth; Shelly Okure; Wendy Orzel; Bradley Pivar; Bob Vasko; Barbara Wale; Roger Sibley; Peter Smergut, Anne Swartwout;</p> <p>Absent: Joe Gerardi; Chris Muller</p> <p>Special Guest(s): John Kemmer</p>	
Discussion Topics	Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.
<p>Welcome and Background:</p>	<ul style="list-style-type: none"> ▪ Meeting Objectives: Jerry indicated that this meeting would be more technical than past meetings. We will be gaining a broad understanding of various assessment tools used in other state developmental disability systems. From this we will make recommendations to the steering committee related to our charter questions. From the experience of other states, it is likely that we will need a consultant to come in and do a cost benefit analysis of modifying our current assessment/planning tools vs. adopting another assessment tool with our necessary modifications. ▪ Approval of July 29th meeting summary: The summary was accepted as written. One question was posed regarding the new location of interviews from experts that were visible on the OPWDD People First website. These videos can still be found on the website in a folder labeled 'Waiver Resources'. ▪ Updates on the other Design Teams: + Fiscal Sustainability: John Kemmer provided a





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	<p>brief overview. A draft report of recommendations has been prepared and reviewed by the Design Team.</p> <ul style="list-style-type: none"> ▪ Recommendations include (a) capitated payments driven by an assessment tool (b) assessment tool should have significant levels built in that are sensitive to various needs. (c) once the assessment tool is determined EVERYONE is assessed, even those who are currently receiving OPWDD services and (d) that the MCO/ACOs be a not-for-profit but that they may subcontract with providers who are for-profit. ▪ Concern was expressed about those who may not meet the new assessment criteria. It was stated that the intent is not to pull homes away from people who we've been supporting. Implementation planning will address the thoughtful rollout of assessments over the course of the five year waiver. ▪ It was also emphasized that the new fiscal structure is not likely to be based on historical costs for agencies at the end of the day and there may be some transition planning needed here as well. <p>+ Care Coordination: Anne Swartwout reported. The design team is looking at what service coordinators are currently doing and the expectation of care coordination in a managed care environment and are using these to develop some quality metrics for care coordination in conjunction with the Quality design team.</p> <ul style="list-style-type: none"> ▪ Care coordination is being viewed as a team approach and an integrated approach so other needed experts and providers can be brought on to the team. ▪ The issue of the role of care coordination for people who self-direct was discussed. Currently people who self direct are vulnerable if staff they self-hire cancel at a late hour and there is no-one else available to support them. There have been times when people were forced to remain in bed
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for 12-24 hours before another staff’s shift begins. This is not acceptable. This will be brought back to the care coordination design team. The Access and Choice Design Team previously recommended that a back-up system be put in place to avoid these crisis situations for people who self-direct/self-hire.

- Quality:** Anne presented. This design team is working to develop a quality ranking system (matrix) for service providers ranging from a score of 1 to 5. There is much clarity on the criteria for a rank of 1 or 2, but they are working on differentials for levels 4&5. The design team may recommend outside consultants for assistance.
- Once the quality matrix is developed it will be shared with providers to make them aware of what they will be reviewed against and to help their transition to the new quality requirements/ reforms.
 - The design team will recommend that satisfaction be tied into the needs quality tool.
 - The idea of satisfaction surveys was raised. The Quality design team has focused more on how to determine people are satisfied; particularly those who may not easily or readily communicate for themselves.
 - Changing the process more towards satisfaction strategies may move us from rigid regulatory standards which may be a challenge given the current OPWDD environment.
 - REAL incentives need to be developed and provided for individuals and families that ensure that people served can be supported in new environments. This must be a priority.
 - Incentives must also be developed for providers as they meet the challenge of supporting people in more community based and less restrictive settings.

Services and Benefits: Maryellen reported.





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	<ul style="list-style-type: none"> • A self direction subcommittee was developed comprised of representatives from each of the design teams. They have met twice. The primary focus has been on person centered planning as a foundation for the entire service system including self-direction. Discussed was also the notion of how self direction fits into a managed care environment and to all supports and services • Jerry stated that there can be a fundamental tension between self-direction and managed care and this will be a challenge as we work towards implementation • Recommendations from this workgroup are forthcoming. <ul style="list-style-type: none"> ▪ The 1115 Steering Committee will meet before our next scheduled meeting (8/29/11). Jerry will provide a report on preliminary recommendations from Access and Choice that align into our three focus areas: <ul style="list-style-type: none"> ▪ Access through No Wrong Door ▪ Factors that drive Needs Assessment ▪ Promoting Individual Choice in an MCO environment ▪ The August 29th meeting of the Access and Choice design team will be designed to pull the final design team recommendations together. The Choice Charts will be finalized and used as a resource for this meeting.
<p>Overview of reviews and findings from the Assessment Tools Technical Workgroup:</p>	<ul style="list-style-type: none"> • Each member of the technical workgroup provided a presentation on the assessment tool that they reviewed and lessons learned/applicability to the People First Waiver. This information is contained in the Assessment Tools Technical Workgroup Report. • There was much discussion regarding the team’s recommendation from June 20th that assessment be “independent” and what exactly “independence” means. While there was general agreement that the base assessment that drives payment should be





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independent from those that get paid, there appeared to be different perceptions of “independence”. Does independent mean a separate entity conducting assessments or can there be firewalls? A separate entity will likely drive higher administrative costs for the system which could take funds away from the provision of care, however, if care management entities conduct assessments that are tied to funding methodologies, they would essentially be determining their payment level for each person served—a major conflict of interest that could potentially drive unnecessary expenditures. There was also discussion that initial assessment may be an appropriate role for the state if capacity and qualifications exist to perform this function.

- There was also discussion of the assessment vs. personal outcomes and how these can be integrated. How do you do an assessment if you don’t know the outcomes that the person wants to achieve?

Information and Lessons Learned from Assessment Reviews:

Developmental Disabilities Profile (DDP) (developed by New York State 25 years ago):

- **Kansas:** John Kemmer noted that in his review of Kansas (that uses the Developmental Disabilities Profile (DDP)), the state initially had 600 assessors (500 were case managers) and reduced this to 100 (not case managers), with quarterly training, supervision, and screening reviews to test inter-rater reliability. What they learned was that they had more reliable results from the assessment when they moved to using a lesser number of assessors that were not case managers (independent) and the assessors were better trained.
- **Ohio:** DDP- not good at accessing children, not





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	<p>good at assessing behavioral needs, screener limitations can lead to lesser quality of assessment. Ohio does not use the DDP for people who choose self-direction. Links assessment to funding range.</p> <ul style="list-style-type: none"> • Neither state’s assessment system addressed medication administration. <p>Wisconsin Functional Screen (state specific tool):</p> <ul style="list-style-type: none"> • Wisconsin functional screen: ADLs – strong component, focus on employment, mentally ill – not included at first, no wrong door – aging and developmental resource centers (one stop shop), intense training with a bachelor’s. Much of the tool is online. Less than 20% of people using the Aging and Disability Resource Centers (ADRC) were actually found to be eligible for the waiver; the vast majority was given information and referral (“light touch”). • Bachelor’s degree and online certification required; must pass a certification course before being able to do the screening. • This is not the tool to use if we only need assessment tool for people with developmental disabilities, however, if we are looking at “No Wrong Door” and universal assessment across the long-term care population, this type of instrument may be a viable option. Can look at this model also for integration of “no wrong door” with assessment and use of technology. <p>Florida Situational Questionnaire (state specific tool):</p> <ul style="list-style-type: none"> • Used to assess 30,000 people in 18 months, significant training of assessors required. There is a moratorium on the number of people that can be in Florida’s waiver and Florida has a significant waiting list—20,000. There does not appear to be a lot of empirical data on the tool. • One lesson learned is not to create unrealistic expectations as in Florida; use of the assessment
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	<p>does not mean that the person will receive supports/services.</p> <ul style="list-style-type: none"> Reviewer does not believe the tool should be considered for further review by OPWDD because it appears to be a deficiency based approach, is based more on a medical model, does not include people first type language, and doesn't appear to truly measure a person's overall developmental growth or strength areas. Reviewer does not see this tool providing better information than other tools that the group is looking at. <p>Inventory for Client and Agency Planning (ICAP) (national tool):</p> <ul style="list-style-type: none"> ICAP – used in 17 states, 20 year old instrument. TN has three lawsuits in play involving ICAP and is unhappy with it and moving to the Supports Intensity Scale (SIS). The ICAP includes adaptive & maladaptive behaviors; it is deficit focused and doesn't account for community supports. Not suitable for vocational planning. Primarily appears to be used for entitlements. Some states have tiered evaluation systems that tie to payment levels. Designed to be administered by someone with the level of a Qualified Mental Retardation Professional (QMRP). Person administering needs 3 months of knowledge of the person – evaluation takes ½ hour. Many states that have used the ICAP are transitioning to other tools such as the SIS. The team agreed that this tool does not appear to merit further consideration as it does not appear to exhibit a person-centered strengths-based approach. <p>Connecticut Level of Need (LON) (state specific tool):</p> <ul style="list-style-type: none"> Developed around 2005, used federal grant money. Multi-year consultant led piece, multi-disciplinary team. Comprehensive in scope; the instrument's relative brevity is impressive given its large breath of topical coverage. It was always intended to drive
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	<p>rates. No comparison between person already in system and a new person. Multi-year funding scheme to switch over.</p> <ul style="list-style-type: none"> • Score of 1-8 and assigned a funding level based on that. The instrument is more community geared and less focused on 24/7 residential support. • Adoption of this instrument by CT was not arrived at quickly or cheaply. The instrument does not appear to require supplemental information for rate setting purposes. • Tool is relatively new and has not been adopted by other states so validation data is not as large as what is available for SIS or ICAP. • CT’s post-implementation review indicates that underdeveloped IT systems helped cause many bumps in the road and hindered the coordination/ capacity necessary for such massive change. <p>Child and Adult Needs and Strengths (CANS):</p> <ul style="list-style-type: none"> • Developed by John Lyons. Public domain tool, can be modified for needs of a population; states have flexibility to mandate their own qualifications for administering it; it is web-based. Certification for using it is web-based. • Tool is fundamentally rooted in planning and therefore may not be as specific as other tools. Has inter-rater reliability • Was not developed specifically for people with developmental disabilities. • OPWDD modified and uses it in the Intensive Behavioral Services (IBS) Program. • Strengths based and many questions relating to natural supports • Other states use it for certain populations (e.g., Indiana; Massachusetts. Each state modifies for their own use. • Annual conference conducted by developers of the tool. • OMH, OCFS use the instrument. • Tool starts from a broad based approach—would fit
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	<p>well with No Wrong Door philosophy.</p> <ul style="list-style-type: none"> • Can be adapted for funding allocation purposes. • OPWDD would need to modify the instrument for our purposes were we to adopt it. <p>Supports Intensity Scale (SIS) (national tool):</p> <ul style="list-style-type: none"> • Developed by American Association for Individuals with Developmental Disabilities (AAIDD). Specific to dd population. Used by 22 states and overseas. Newer tool/more current. Utah, North Carolina, TN, Hawaii, and other states have or are in process of switching from ICAP to SIS. • Assesses for functional needs—objective measure of function—seems to tie into person-centered planning approaches as well; also includes assistive technology needs, employment, social life • Easily connects to budgeting/funding methodology but some tinkering would likely be needed. • Transparency • Usually only done – every 4 or 5 years • Does need to be supplemented for health needs. Some states use the SIS in conjunction with the Health Risk Screening Tool (HRST). • Multi-lingual versions available. • Enables broad-based comparison of national data • Rigorous training requirements; 4 year degree recommended; takes 1-3 hours to administer; and would likely be up-front costs associated with it, however, any assessment tools initiated would have both direct and indirect costs associated with them—these costs need to be compared “apples to apples” as well as looked at in light of the long-term savings and quality of life individual benefits that can be derived from availability of valid needs assessment that can help people be more independent and thus ultimately result in long-term savings. • According to reviewer, NY would likely need 100 trained assessors to administer the tool every 4 years—400 assessors to administer yearly (children’s SIS would be done more frequently) • Several agencies in NYS already use the SIS.
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Health Risk Screening Tool (HRST):

- See attachment that describes the tool.
- Tool is a screening not an assessment. It is web-based with very impressive logic built into the system. Can be administered by direct support professionals with knowledge of the person—it does not utilize clinical language requiring health care professionals to administer.
- Assigns a health care rating between 1 and 5. Goes much further than the DDP with health factors.
- Points to health risks that may need further attention.
- Web-based tool provides training suggestions and other information based on answers to the questions. Potentially very helpful to direct support professionals.
- The web-based system has the ability to trend results for individuals and on an aggregate level by whatever categories you want (e.g., DDSO, region, provider, etc.).
- Could be very useful to establish baseline health ratings and track improvements. Useful for disease management and comprehensive integrated care planning. Could be a driver for reducing Medicaid costs for unnecessary crisis health care/hospitalization because the tool is designed to be an early warning system for preventative measures. Seems to be an excellent supplemental tool to use with assessment and care planning. Designed to work with state policy—e.g., in Georgia anyone with a rating of 3 and above requires review by a nurse.
- Integrates with other electronic databases/recordkeeping systems.
- Federal government reimburses 50% of costs in Georgia for use of the tool. Full cost is about \$35 per year per person.





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<p>Needs Assessment: Lessons Learned, Discussion and Recommendations:</p>	<p>The following are some of the general lessons/advice learned from the research and reviews of assessment tools:</p> <ul style="list-style-type: none"> • Any funding methodology/algorithm needs to take into account other areas of the person’s life. The assessment should not be the only driver. • Not likely to be one tool that is going to meet all our needs/purposes for initial assessment. We must keep in mind that there is a difference between assessment and care planning tools that are based off of assessments. There must be seamless integration of these pieces. • Integrated technology is critical. • Must involve stakeholders in the process every step of the way. • Must not create unrealistic expectations for assessment if they cannot be delivered upon. • There must be regular and ongoing training and consistency with all assessors. There must be oversight/review systems in place. • Anecdotally, the fewer the number of assessors and the better trained they are, the better the assessment results are likely to be. <p>Preliminary Recommendations:</p> <ul style="list-style-type: none"> • The group recommends that the HRST be considered further as a potential early starter in our care management pilots. It has potential to provide valuable research data, reduce costly health care by focusing caregivers on preventative measures; information is readily available for direct care professionals in an easy to understand language.
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	<p>Consider piloting the HRST.</p> <ul style="list-style-type: none"> • Conduct further review and analysis of the SIS and the CANS by engaging developers in conference calls and following up further. Also look further into the CT LON in relation to potentially modifying the DDP. Assess work that would need to be done to modify these instruments to meet OPWDD waiver needs. Engage consultants to conduct a cost-benefit analysis for OPWDD with regard to selecting assessment instruments. Consider designing pilots either prior to and/or in consultation with consultants.
Next Steps	<ul style="list-style-type: none"> • Preliminary report for the Steering Committee to be sent to DT members by 8/17. • Comments on Assessment Tool reviews and report and Worksheet on Needs Assessment to Maryellen by 8/19. • Full report of design team recommendations scheduled for review at the August 29th meeting.

