



## Access and Choice Design Team Meeting Summary

<b>Access and Choice Design Team</b>	<b>Date of Meeting:</b> June 20, 2011
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<p><b>Present:</b> Bradley Pivar; Shameka Andrews; Joe Gerardi; John Maltby; Chris Nemeth; Shelly Okure; Wendy Orzel; Peter Smergut; Maryellen Moeser (OPWDD coordinator).</p> <p><b>Absent:</b> Gerald Huber; John Gleason; Barbara Wale; Evie Fields.</p>
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Discussion Topics	Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.
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<p>Overview of briefing material and key questions for design team.</p>	<ul style="list-style-type: none"> <li>• The team discussed the briefing materials outlined in the Access and Choice Design Team PowerPoint including eligibility and access to OPWDD’s service system, the tools currently used in OPWDD’s system for various purposes related to needs assessment and service planning, and challenges in the current system related to access and choice including some strengths and weaknesses of OPWDD’s Developmental Disabilities Profile (DDP).</li> <li>• Additional challenges identified by design team members include:             <ul style="list-style-type: none"> <li>✓ perception across the system that individuals will lose benefits if they work full-time and this is a significant deterrent to seeking employment for people with developmental disabilities (applicable to the Benefits and Services Design Team);</li> <li>✓ balancing abilities and strength based approaches with the needs assessment and still access funding streams;</li> </ul> </li> </ul>
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### Access and Choice Design Team Meeting Summary

	<ul style="list-style-type: none"> <li>✓ Individuals/family members fear that once services and supports that are no longer needed are given up, they will not be able to access them again when needed;</li> <li>✓ inconsistent awareness and availability of service options such as Consolidated and Supports and Services (CSS) (Benefits and Services Design Team);</li> <li>✓ lack of incentives for people to move from twenty-four hour staffed residential settings to less restrictive settings and for providers to offer this option and work with individuals on this goal/transition; and</li> <li>✓ perception that OPWDD’s system provides the “Cadillac service package or nothing”</li> </ul>
<p>Guided Brainstorming:</p> <p>(a) What are the factors and support needs that should be considered in a needs assessment instrument that will drive resource allocation decision making for people with developmental disabilities?</p> <p>(b) What are the factors that should be considered in the administration of a systems-wide needs assessment that will drive resource allocation decision making?</p>	<p>The team discussed the following factors and considerations related to needs assessment and equitable resource allocation and proposed that a technical workgroup be formed to look at needs assessment tools from other states (see action items below) to supplement this list:</p> <ul style="list-style-type: none"> <li>• <b>Independent assessments:</b> the team discussed the need for an unbiased party to perform the assessments, to have a quality review of assessments, and to ensure accuracy and other checks and balances in the needs assessment system. The entity/organization that conducts the needs assessment should be independent from providers that get paid to deliver supports and services.</li> <li>• <b>Flexibility:</b> Needs assessment that drives resource allocation needs to build in flexibility to address emergency and crisis needs without staffing for these emergencies all the time. Flexibility is needed to adapt to changes in the</li> </ul>





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	<p>person’s support needs (e.g., if a primary caregiver is ill). The needs assessment cannot be on “automatic pilot”.</p> <ul style="list-style-type: none"> <li>• <b>Predictability:</b> resources are available when people need them but people do not need to grasp resources/services all at once because of fear of resources/services not being available when needed. Consider level of support/resources that are needed on the person’s worst day.</li> <li>• <b>Strength-based approach:</b> The strengths of the person need to be a part of the needs assessment process. In addition, the ability of the person to make decisions and self-advocate should also be assessed.</li> <li>• <b>Qualifications and Checks and Balances:</b> The needs assessment tool is only as good as the person conducting the needs assessment and the information that is available. There needs to be consistency in qualifications, training for people that complete the assessments, independent quality review of assessments, and other checks and balances in the system.</li> <li>• <b>No Wrong Door:</b> Adequate qualifications and training was further discussed in relation to the concept of “No Wrong Door”. It was noted by a design team member that everyone involved in the service delivery system, even individuals who answer phones, should have adequate training and information so they don’t send people to the wrong door which often happens today (a self-advocate noted that it could sometimes take 3 weeks to 3 months to find the right door with the current system).</li> <li>• <b>Transparency:</b> transparency and/or thorough use of web-based technology are components that need to be integrated in the needs assessment and resulting resource allocation process.</li> </ul>
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- Choice:** The team discussed that people need equal access to the full menu of services and that the advantages and disadvantages of each service needs to be articulated so that persons with developmental disabilities can make informed choices about the supports and services that can best meet their needs and goals (also relevant for Services and Benefits). The team believes that all individuals that choose to self-direct an individualized budget should have the right to do so. Also discussed was that a person should have the right to say “no” without having it deemed a “behavior”. It was noted that the right to privacy should be emphasized.
- Choice and Risk:** discussion on risks and choice related to needs assessment e.g., if the needs assessment indicates that a person needs a certain support to address health/safety risk factors but the person chooses not to receive the service, how would this be addressed especially if the provider and/or Managed Care Organization (MCO) is responsible for the health and safety of the person and assumes the risk.
- Community inclusion and Choice:** How much does the person want and how much does the person have access to now? This needs further discussion as the team felt that this was a “value” that is interpreted differently by the “system” and that community inclusion has different meaning that has evolved over time (e.g., used to mean a bus ride). The person should have a choice of community inclusion opportunities and how much is provided.
- Needs Assessment and Person-Centered Planning:** The team discussed that needs assessment included a person-centered planning component in that the needs assessment should take into account what the person’s life goals and desires are as well as their needs. Open question





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	<p>for further exploration is how to connect needs assessment with person-centered planning.</p>
<p>Discussion Points related to other design team charters and open questions:</p>	<ul style="list-style-type: none"> <li>• Move away from defining programs and define outcomes instead (for consideration by Services and Benefits Team).</li> <li>• Use of the term “habilitation” drives policy that we are trying to make people “normal”—think about moving away from this terminology (for consideration by Services and Benefits Team).</li> <li>• Concern was expressed by a parent that “managed care” could be viewed as a disincentive to person-centered planning and self-direction (for consideration by Fiscal Sustainability Team e.g., incentivizing person-centered planning and self-direction).</li> </ul>

Action Items		
<u>Action Item</u>	<u>Owner</u>	<u>Due Date</u>
<p>Establish technical subgroup to review needs assessment tools from other states including the Supports Intensity Scale (SIS), the Inventory for Client and Agency Planning (ICAP), Connecticut Level of Need (LON) instrument; Florida Situational Questionnaire, and the CAANS DD to identify components that are missing from the developmental disabilities profile and to answer other key questions. John Maltby and Peter Smergut agreed to work on this technical subgroup with a designated and knowledgeable OPWDD staff person.</p>	<p>Jerry Huber</p>	<p>June 30, 2011</p>
Additional Documents of Reference		
<p>See resource guide.</p>		

**Next Meeting Tentatively Scheduled for July 13, 2011 from 9:00 AM-12:30 PM**





## Access and Choice Design Team Meeting Summary





## Care Coordination Design Team Meeting Summary

<b>Care Coordination Design Team</b>	<b>Date of Meeting: June 20, 2011</b>
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<p><b>Present:</b></p> <ul style="list-style-type: none"> <li>• Jill Gentile</li> <li>• Robert Budd</li> <li>• Bill Bird</li> <li>• Nick Cappoletti</li> <li>• Donna Colonna</li> <li>• Jane Davis-Bunt</li> <li>• Maria Bediako</li> </ul>	<p><b>Absent:</b></p> <ul style="list-style-type: none"> <li>• Maggie Hoffman</li> <li>• Michael Kennedy</li> <li>• Hope Levy</li> <li>• Eric Pasternak</li> <li>• Sheryl WhiteScott</li> <li>• Susan Wanamaker</li> </ul>
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<b>Discussion Topics</b>	<b>Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.</b>
<p>Whole Group Discussion: What is not working in the current system?</p>	<p>The group brainstormed and presented their ideas about what aspects of the current care coordination system are not working. They then categorized these ideas into the following themes:</p> <ul style="list-style-type: none"> <li>• Access to the system                             <ul style="list-style-type: none"> <li>○ MSC does not always have knowledge or expertise of available services, especially across systems</li> <li>○ Having a crisis is sometimes the only way to access the system</li> <li>○ Often receive either too much or not enough support</li> <li>○ Often can't get a hold of service coordinator in a timely manner due to caseload</li> <li>○ Lack of back-up when coordinator is not available</li> </ul> </li> <li>• Care Coordinator Qualifications                             <ul style="list-style-type: none"> <li>○ High turnover rates for service coordinators</li> <li>○ High caseloads</li> <li>○ Limited education and awareness of issues specific to individuals' needs</li> </ul> </li> </ul>





### Care Coordination Design Team Meeting Summary

- Limited training and entry level qualifications
- Lack of consensus on guidelines for care for individuals
- Difficulty to find partners who really understand self-direction
- Service coordinators often don't understand how fiscal issues affect service availability
- Knowledge limited to OPWDD services
- Lack of sensitivity to cultural needs
  
- Cross System Coordination
  - Care coordination is often not independent from service provision – potential for conflict of interest. There is some pressure to push people toward certain providers
  - Fragmentation of care and a lack of bridges between behavioral, medical, pediatric, early intervention and primary care
  - Redundancies of oversight between OPWDD, Department of Social Services (DSS), Homecare, health care, etc
  - Segregated service providers
  - Lack of expertise in area of behavioral interventions
  - Limited use of technology to make connections
  - Limited crisis intervention services
  - Lack of coordination between day activities or work and home and health services
  
- Person Centered Plan
  - Often there is not sufficient time to complete the true person centered planning process
  - Individual's plan, data, benchmarks should be created by the individual
  - Does not create empowerment to deliver on goals and outcomes
  
- Fiscal
  - Need a stable, predictable reimbursement structure that is easy to understand, flexible, and responsive to individual need
  - Regional disconnect between upstate and downstate
  - Cost prohibitive to providers to provide the more





### Care Coordination Design Team Meeting Summary

	<p>specialized services</p> <ul style="list-style-type: none"> <li>• Quality             <ul style="list-style-type: none"> <li>○ Too much time spent on compliance and regulation</li> <li>○ Requires too much assessment of need versus delivery of services</li> <li>○ Outcomes are hard to measure and are not consistent across services</li> <li>○ Individuals must receive 90 days of MSC whether they want or need it</li> </ul> </li> <li>• Suggestions for the future system             <ul style="list-style-type: none"> <li>○ Create a proactive frame of reference that connects individual to all system/natural supports and changing needs of life</li> <li>○ Create a single point of engagement for information, access, advocacy, and mentorship</li> </ul> </li> </ul>
<p>Small Group Break-Out: What considerations should be integrated into any model of comprehensive care coordination/case management for people with developmental disabilities (and various subpopulations, e.g., children, aging, forensic/risk, medically involved, medically frail, etc.) in a care management environment ?</p>	<ul style="list-style-type: none"> <li>• Sustainability</li> <li>• Need to be able to easily transition into increased support between incidents</li> <li>• There needs to be enough time to establish the relationship</li> <li>• Should be weighted in terms of what level of intensity and reimbursement</li> <li>• Equity of access to the services (funding)</li> <li>• Needs to be coordination with technology and mentoring</li> <li>• Continuity through technology (EI already doing it)</li> <li>• Portability of information through technology</li> <li>• When something is not working where do they go?</li> <li>• Unified quality of service with measurable metrics</li> </ul>
<p>Small Group Break Out: Consider whether the person's needs assessment should correlate to the type/intensity/level/model of comprehensive care coordination.</p>	<ul style="list-style-type: none"> <li>• Flexible and cross trained</li> <li>• Choice and know what the choices are</li> <li>• Some need more intensity and this should be provided</li> <li>• Independent quality assessment</li> <li>• Needs assessment to define dollars</li> <li>• A system change to balance the scales of currently assigned dollars</li> <li>• A mechanism to allow for permanent need changes</li> <li>• Episodic care management for emergencies</li> <li>• National benchmarks may be helpful</li> </ul>





### Care Coordination Design Team Meeting Summary

	<ul style="list-style-type: none"> <li>• Technical Assistance may be needed for what needs assessment tools are being used in other states to implement budgeting</li> </ul>
<p>Small Group Break Out: What choices should the individual have (e.g., choice of care coordination providers; choice of services provided under the care coordination model; choice of health, behavioral health and/or long-term service providers; and choice of specific services and resulting outcomes to be delivered through the People First Waiver)?</p>	<ul style="list-style-type: none"> <li>• Yes to all. How do we empower the individual to have that choice and to make that choice work?</li> <li>• Coordination model needs to have some teeth</li> <li>• Choice is not absolute, but we don't want a managed care entity to be able to tell individuals that valid choices are off the table.</li> <li>• Flexibility is crucial</li> </ul>
<p>Small Group Break Out: Consider roles and responsibilities of the care coordination provider and person(s) delivering the service (must address assurance and monitoring of health and safety (a component of the HCBS quality framework)).</p>	<ul style="list-style-type: none"> <li>• Health home service coordination should be a team or a circle of support which can expand and/or contract depending on individual needs. There should still be choice within teams.</li> <li>• In quality metrics, care coordination is responsible to hold providers and selves accountable</li> <li>• Purchasing need not be from historical/traditional providers, but can expand on the definition of workers as well. Mental health model utilizes peer services</li> </ul>
<p>Small Group Break Out: What are the components of the system that should be independent from comprehensive care coordination (e.g., service authorization, resource allocation, service delivery, etc.)?</p>	<ul style="list-style-type: none"> <li>• Eligibility</li> <li>• Needs assessment</li> <li>• There is potential for advocacy both within and outside of the care coordination role</li> </ul>
<p>Small Group Break Out: Given that advocacy is an important component of the current service coordination model, how should this function be addressed in a comprehensive care coordination model?</p>	<ul style="list-style-type: none"> <li>• At the direction of the individual/family</li> <li>• The group questioned if advocacy should be within or outside of comprehensive care coordination based on the need for impartiality to be maintained</li> </ul>

<b>Action Items</b>		
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### Care Coordination Design Team Meeting Summary

<u>Action Item</u>	<u>Owner</u>	<u>Due Date</u>
Needs assessments from other states. What is working in other states?  Connect with Access Design team.	Jill Gentile and Robert Budd	July 13, 2011
Optional VC presentation on managed care models for long term care. What is working in other states? Connect with People First Waiver team to determine method to gather and share information.	Jill Gentile and Robert Budd	July 13, 2011
<b>Additional Documents of Reference</b>		
See Resource Guide		

**Next Meeting:**

**July 13, 2011**

**10am – 2pm**

**75 Morton Street, New York, NY**





## Benefits and Services Team Meeting Summary

**Benefits and Services Design Team**

**June 20, 2011**

**Present:**

Pat Dowse, Diana McCourt, Susan Platkin, Sharon Rockwell Linne, Jordan Jankus, Pasquale Ginese, Fredda Rosen, Karen Gillette, Debra Bojarski, Margaret Mikol, Max Donatelli, Amy Cohen Anneling, Suzanne Sennett, Angela Lauria-Gunnink

**Absent:**

Joann Dolan, Kate Bishop, Laurie Kelley

**Discussion Topics**

**Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.**

Review of Benefits and Services Design Team Powerpoint and discussion of Team Charter

The Team thoughtfully discussed our current service delivery system, statistics associated with our current system, and accepted the Team charter. PowerPoint highlights:

- Between 1975 and 2010 Institutional Services Declined While Community Services Dramatically Increased (graph);
- Demographic Trends – 1990-2020 (graph);
- The Future: Diagnostic Trends 1990-2020 (graph);
- Residential Services – 2011 (data breakdown);
- Day Activities - 2011 (data breakdown);
- Non-Institutional OPWDD Medicaid Spending SFY 09-10;
- On Average, Medicaid Expenditures for Seniors with Developmental Disabilities are 20% Higher Per Person than other Adults with DD;
- Increasing Percent of DD Population Served is over 50+ and/or has Multi-System or Complex Needs that Generally Drive Higher Per Capita Medicaid Expenses – 1989-2015 (graph);
- Statewide Growth of PRA's and Individual Budgets – 2003-2010 (graph);
- Trend in People Receiving Rent Subsidies – 2007-2010 (graph);





### Benefits and Services Team Meeting Summary

	<ul style="list-style-type: none"> <li>• Percentage of People in a Less Restrictive Living Situation -2009-2010 (graph);</li> <li>• OPWDD Emergency Room Visit Data -2006-2010;</li> <li>• OPWDD Hospitalization Data (All) – 2006-2010;</li> <li>• People in Day Services Receiving SEMP (Working Age and All People) – 2007-2010 (graph);</li> <li>• Percentage of People Who Would Like to go to a Different Day Program/Daily Activity by Residential Setting -2009-2010 (NCI-NY);</li> <li>• Percentage of People Who Would Like to Live Somewhere Else by Residential Setting -2009-2010 (NCI-NY);</li> <li>• Percentage of People who would Like to Work Somewhere Else -2009-2010 (NCI-NY);</li> <li>• People who Feel Lonely by Residential Setting - 2009-2010 (NCI-NY); and</li> <li>• 2011 County Priority Outcomes.</li> </ul>
<p>Team brainstorming session on the ideal system of supports and services for the future and the subpopulations of individuals that the new system needs to support</p>	<p>The Team brainstormed and presented their ideas about the ideal system of supports and services in order for the Team to think outside the current OPWDD delivery system. The responses below will shape their recommendations for the future direction of our new service system:</p> <p>Delivery system characteristics include:</p> <ul style="list-style-type: none"> <li>• Services should be <b>timely, flexible, fluid</b> and <b>responsive</b> to individual needs.</li> <li>• Service planning should be truly <b>person-centered</b> and <b>strength-based</b>.</li> <li>• The person’s <b>choice</b> should be honored and the system over all should <b>welcome change</b> and be <b>non-technical/user friendly</b>.</li> <li>• <b>Self-directed</b> services should be widely available (and support for self-direction must be provided).</li> </ul> <p>While there was a clear recognition of the broad scope of individuals that must be supported by our system, the group highlighted some key issues related to defining our population.</p>





### Benefits and Services Team Meeting Summary

	<ul style="list-style-type: none"> <li>• First and foremost was the recognition that our system must support people over their entire lifetime.</li> <li>• In addition, the team spoke to the need to have a system of supports and services that could adequately respond to those with challenging behaviors and significant care and support needs as well as those who are highly functioning.</li> <li>• Also identified was the need for the system to be responsive to those who are employed, rather than the person’s employment goals being shaped by what is offered through the service delivery system.</li> </ul> <p>There was discussion of the need for services to be geared to promote lifelong learning and movement for the person – both as they move towards greater independence, and then, as they might require additional support in later stages of their life.</p> <p>Service components that were identified as critical supports include:</p> <ul style="list-style-type: none"> <li>• Community-based psychiatry;</li> <li>• Alternative transportation other than vans;</li> <li>• Rural supports;</li> <li>• Ombudsman (not the State); and</li> <li>• Self-administration of medications.</li> </ul>
<p>Team homework assignment in regard to the ideal system of supports and services for the future (above)</p>	<p>Team members are asked to answer the following question in relation to the brainstorming exercise (due July 1). The brainstorming exercise and homework assignment will help shape the July 11<sup>th</sup> Team meeting.</p> <p style="text-align: center;">“What do we need to be able to let go of for this new system to work well?”</p>
<p>Team brainstorming of Benefits and Services Charter questions</p>	<p>The Benefits and Services Design Team then broke out into three groups and discussed sets of Charter questions. The following are the Team’s <i>preliminarily ideas</i> which</p>





### Benefits and Services Team Meeting Summary

establish a framework for future meetings.

***How can self-direction and self-determination be expanded and enhanced?***

- The team discussed how we need to spread the word about self-direction and self-determination as many individuals do not know about these programs.
- The use of technology needs to be improved which will help streamline the process.

***What specialized residential, community, and behavioral services are needed for people leaving institutional settings and how do these services differ from what is available today in the developmental disabilities service system?***

- Discussion focused on the need for improved transitional services for individuals living in institutions. Also, the Team focused on having the appropriate tools ranging from mentoring to working with challenging behaviors to address the needs of the individual.

***What are the barriers for individuals with developmental disabilities to move to their own homes and apartments?***

- The team discussed financing and accessibility issues as well as adaptive technology, individuals who are risk adverse, and the need for staff training.

***What services/supports need to be created, strengthened and/or enhanced in order for children and other people with developmental disabilities to remain in the homes of their parents, family members and/or relatives longer, particularly when primary caregivers are aging?***





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- Discussion focused on maximizing community supports outside of the OPWDD system and investing in home modifications. In addition, respite needs to be available and accessible to everyone.

***How can the People First Waiver better support and integrate services for children across systems?***

- The Team agreed that there are a number of key transitional and linkage issues that need to be explored. These include the dually enrolled Early Intervention (EI) candidates, better outreach to the foster care system and professional organizations, and having services be more accessible to the dually diagnosed.

***How can the People First Waiver encourage and promote employment first opportunities for people with developmental disabilities?***

- Team members discussed how there needs to be better coordination between OPWDD, the State Education Department (SED), and Department of Labor (DOL). In addition, there needs to be increased education about how social security and other benefits are affected by employment as the fear of losing benefits is a deterrent to employment for some individuals served. Employment related options need to be incentivized over day options.

***What, if any, crisis intervention/stabilization services should be made available under the People First Waiver for people with developmental disabilities?***

- The discussion focused on the need to develop responsive, highly skilled crisis intervention services that keep intermittent “crises” from unraveling long term service and living arrangements. There was also significant discussion of how to change current





### Benefits and Services Team Meeting Summary

	<p>“impulses” in the system – such as relying on emergency room and hospitalization for health/ medical interventions that should be managed in a more cost effective manner.</p>
Team prioritizing homework	<ul style="list-style-type: none"> <li>Team members are asked to rank discussion topics that they believe the Team should bring their collective wisdom around and speak about during our next Team meeting. The Team will work under the assumption that all of their ideas will be reported to the Steering Committee and the larger group. For this exercise, the Team needs to focus on where our time will be best spent during our Team meetings. Therefore, as they prioritize, they will focus on what is crucially important and what priorities need additional committee work to help define outcomes and implementation strategies (due July 1). These responses will help frame our July 11 Team meeting.</li> </ul>
Messages to other Team members	<p>As a closing exercise on 06/20/11, each Benefits and Design Team member shared a key message to their fellow Design teams as they move forward. This detailed list was shared with the other Design teams on 06/21/11.</p>

Action Items		
<u>Item</u>	<u>Owner</u>	<u>Due Date</u>
Send out Team roster, Powerpoint Presentations, Charters, prioritization exercise, and survey of upcoming meetings to all Team members	Angela	06/21/11
Messages to fellow Design Teams	Angela	06/21/11
Homework assignment to Team Members: “What do we need to be able to let go of for this new system to work Well?” (based on above discussion topics)	All Team Members	Due back from Team 07/01/11
E-mail prioritization exercise to Team. Team to respond by:	Angela / All Team Members	07/01/11
Solidify upcoming meeting dates/locations	Angela	June 24

Additional Documents of Reference
PowerPoint Presentation
NCI Data Briefs (dual diagnosis, autism, self direct)





## Benefits and Services Team Meeting Summary

### Upcoming Team Meetings:

July 11, 2011	OPWDD Room 4B
July 27, 2011	NYCRO (75 Morton Street)
August 16, 2011	OPWDD Room 4B
August 29, 2011	OPWDD Room 4B





### Quality Design Team Meeting Summary

<b>Quality Design Team:</b>		<b>Date of Meeting: June 20, 2011</b>	
<b>Present:</b> Stan Butkus Jan Abelseth Kate Bishop Michael Doherty Richard Monck Chris Muller-Dahlmann Maxine George Judith Berek		Bridget Cariello Deborah Burkhardt Marisa Geitner  <b>Absent:</b> Louie Lopez Douglas Patterson Robin Hickey	
<b>Discussion Topics</b>		<b>Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.</b>	
<p>Team focus was defined and agreed to by the group as the need to develop a quality structure that will relate to the 1115 waiver. The structure needs to focus on individual outcome measures, be transparent and be driven by established metrics of quality as opposed to compliance based.</p>		<ul style="list-style-type: none"> <li>• There was a great deal of discussion focused on the current methodologies for measuring quality and the need to shift those methods as the 1115 waiver moves forward. There was agreement from the group that we need to ensure that the health and safety needs of individuals is a core expectation. Questions related to service delivery and supports in non-certified sites and the appropriate measures for quality were discussed.</li> <li>• There was discussion regarding a shift of measurement from compliance to the outcomes evident in people’s lives and individual satisfaction regarding the supports that they receive. The use of data from National Core Indicators (NCI) measures and from Council on Quality and Leadership (CQL) were shared and discussed.</li> <li>• Additional discussion related to ensuring that needs are addressed with an appropriate plan of care in line with the assessment and that quality is measured based upon the degree to which the plan is implemented and effective to bring about</li> </ul>	





### Quality Design Team Meeting Summary

	<p>positive outcomes in the person’s life. The level of complexity of the care plans, and related quality oversight, will be driven by the level of assessed need.</p>
<p>Use of incentives</p>	<ul style="list-style-type: none"> <li>• The development of a rating system for providers was discussed utilizing a 1-5 scale of quality. It was suggested that to incentivize quality, those agencies that were at a level 1 or 2 suggesting low performance would be closely monitored for their ability to meet health and safety needs for people. A greater level of technical assistance and oversight would be provided to low performing agencies. Additionally, agencies at a 1 rating would be on the early alert list and would not be able to take on new admissions or development.</li> <li>• Agencies that are rated as a 5 would be considered for the role of a Managed Care Organization (MCO). The concept of financial incentives for demonstrated quality was discussed and agreed to by the team. The rating information would be readily available – thus demonstrating transparency.</li> </ul>
<p>Development of a matrix to establish measureable indicators of quality across established waiver goal areas.</p>	<ul style="list-style-type: none"> <li>• The areas of health, home, relationships and meaningful activity were identified as the variables that require measurement when applying a quality framework.</li> <li>• Outcomes in these areas as they relate to the individual, family, workforce, supports and services (agency), care coordination and health and safety require defined metrics/quality indicators.</li> <li>• Within the measurements focus must be given to ensuring evidence based practices and establishing variable standards based on the needs assessment for individuals.</li> </ul>

Action Items		
<u>Action Item</u>	<u>Owner</u>	<u>Due Date</u>





**Quality Design Team Meeting Summary**

Break down the categories established in the matrix and identify potential measures of quality from existing quality indicators (National Core Indicators (NCI), Council on Quality and Leadership (CQL), and Division of Quality Management (DQM))	Kate Bishop Deb Burkhardt	July 15, 2011
Set up presentations from outside quality experts, other state agencies, Department of Health (DOH), and other states (Tennessee) to evaluate potential quality frameworks that could be considered.	Stan Butkus:CQL Chris Muller: NCI Deb Burkhardt – Tennessee Judy Berek-DOH	July 15, 2011
<b>Additional Documents of Reference</b>		
<b>Appendix D, E – provided by Dr. Butkus for distribution</b>		
<b>Tennessee Quality Measures – provided by Deborah Burkhardt</b>		

**Next Meetings:**

July 15, 2011	9:30 – 4pm	44 Holland Ave, Albany NY - CR 4B
July 26, 2011	10:00 – 4pm	75 Morton St NYC
August 12, 2011	9:30 - 4pm	Albany loc TBD
August 23, 2011	9:30 – 4pm	Albany loc TBD





## Fiscal Sustainability Design Team Meeting Summary

**Fiscal Sustainability Design Team**

**Date of Meeting: June 20, 2011, 1-4pm**

**Present:**

Tina Chirico, Deb Franchini, Henry Hamelin, Eric Harris, Steve Holmes, Alden Kaplan, John Kemmer, Jay Kiyonaga, David Liscomb, Kate Marlay, Amy Murrisky, Ramon Rodriguez, Pat Sarli, Jeff Sinsebox, Seth Stein, Louis Tehan

**Absent:** Anne Klingner, Keith McGriff, Regis Obijiski, Michael Rogers

**Discussion Topics**

**Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.**

Review of design team charter

- The design team charter was accepted by team without any changes.

Briefing book highlights / key concepts

- Briefing Book highlights:
  - While unit cost or per person costs have increased at the rate of inflation, our population served is growing at a greater rate than the general population as a result of increased life expectancies related to certain diagnoses and an increase in the number of children accessing services.
  - Discussed historical expenditure and recipient data for OPWDD services and non-OPWDD services that were included in the briefing book. Two further analyses were requested. Please see (B) and (C) in “Action Items” section for details.
  - Achieving financial sustainability requires improved efficiencies, i.e. bending the cost curve. The 1115 waiver must support and encourage the development of service/support packages that are both less costly and better tailored to individual needs and goals.
- Key Conceptual Considerations:
  - Basis of reimbursement will no longer be “fee for service”. Types of reimbursement models that were discussed are capitation reimbursement models with managed care



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Commissioner



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Governor



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**Fiscal Sustainability Design Team Meeting Summary**

	<p>systems, Accountable Care Organization (ACO) systems, and PACE systems. Inherent in these systems is the acceptance of risk by the entity. Stop loss or reinsurance mechanisms will be considered.</p> <ul style="list-style-type: none"> <li>○ An information technology (IT) system will be needed that can be quickly developed or adapted to balance case mix and reimbursement on a real-time or near-real-time basis.</li> <li>○ The funding mechanism should be flexible enough to accommodate desired People First Waiver design features, as well as the choices and needs of the individual.</li> <li>○ The financing agreements should allow for portability of funds and flexibility relating to Individual choice, including geographical area.</li> <li>○ The financial structure should be implemented in a way that ensures that individuals' voices are heard and their choices are respected.</li> </ul> <ul style="list-style-type: none"> <li>● Possible topics for technical workgroups:             <ul style="list-style-type: none"> <li>○ To address needed changes to Federal and or State laws and regulations to accommodate our People First waiver</li> <li>○ To explore broader use of shared living as a less expensive model that respects choice</li> <li>○ Mechanisms to provide equitable housing opportunities across the state</li> <li>○ Ways to reduce paperwork that does not add value in order to decrease costs and aid in focusing on the person</li> <li>○ Implement an assessment/eligibility tool that leads to individual choice</li> <li>○ Consideration of a pay for performance model to recognize higher compensation and benefits (including education) for direct support professionals, tied to outcomes</li> <li>○ Look into the SSI state supplement which currently incentivizes congregate care settings, rather than independent living</li> </ul> </li> </ul>
<p>Review of other systems</p>	<ul style="list-style-type: none"> <li>● A design team sub-group was created to review</li> </ul>





### Fiscal Sustainability Design Team Meeting Summary

	<p>other state systems including Arizona, North Carolina, Vermont, and Wisconsin. Members include: Tina Chirico, Alden Kaplan, Steve Holmes, John Kemmer, and Jeff Sinsebox. The results of the review will be presented at the next design team meeting. A conference call to be scheduled with the sub-group and OPWDD staff to coordinate efforts within the next few days. See (A) in “Action Items” section for detail.</p>
<p>Business Items / Future Meetings</p>	<ul style="list-style-type: none"> <li>• Email addresses and other contact information were confirmed with the design team members.</li> <li>• Reasonable travel will be reimbursed. OPWDD design team staff will forward specifics by email.</li> <li>• Any articles or other reference material that team members feel would be helpful in the design team process should be discussed with Deb Franchini, who will be responsible for communicating the information to other Fiscal Sustainability Design Team members and other 1115 Waiver design teams.</li> <li>• Future meeting dates and times were provided. Team members will contact OPWDD as soon as possible to confirm attendance at the scheduled meeting and provide notice for the need for video conferencing or special accommodations.</li> </ul>

<b>Action Items</b>		
<u>Action Item</u>	<u>Owner</u>	<u>Due Date</u>
(A) Design Team Subgroup: Review of systems in use in Arizona, North Carolina, Vermont, and Wisconsin.	Tina Chirico, Alden Kaplan, Steve Holmes, John Kemmer, Jeff Sinsebox	7/13/2011
(B) Completion of analysis of OPWDD Medicaid expenditures for SFY 09-10	Eric Harris	7/13/2011
(C) Review of the range in current per capita payments for supervised IRAs, ICFs, and supportive IRAs. Data would be summarized to reflect the following: <ul style="list-style-type: none"> <li>o Highest Rate</li> </ul>	Eric Harris	7/13/2011





**Fiscal Sustainability Design Team Meeting Summary**

<ul style="list-style-type: none"> <li>○ Lowest Rate</li> <li>○ Mean Rate</li> <li>○ Median Rate</li> </ul>		
<p>Provide link to the Braddock Study, which was mentioned in the morning kick-off meeting session.</p> <ul style="list-style-type: none"> <li>○ The State of the States in Developmental Disabilities, University of Colorado Department of Psychiatry</li> </ul> <p><a href="https://www.cu.edu/ColemanInstitute/stateofthestates/aboutSOS.html">https://www.cu.edu/ColemanInstitute/stateofthestates/aboutSOS.html</a></p>	<p>OPWDD Design Team Staff</p>	<p>7/13/2011</p>

**Next Meeting:           Wednesday, July 13, 2011**  
**11am – 4pm**  
**44 Holland Avenue, Room 4B**  
**Albany, NY 12229**



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