**Current State Assessment**

| | Strengths | Challenges | External Factors | Data Sources | IDEAS |
|---|---|---|---|---|---|
| **Planning** (objectives, strategic plans, execution) | | | | | |
| **State level planning** | * Commitment of Leadership; Improved Data Capacity. *Positive movement on new regulations | * Rate reform slow to materialize. * DD does not have a state of state like Kids Count. *Need caseload projections *Lack of adequate staff for planning purposes and daily operations; Structural deficit issues and unnecessarily burdensome authorization system(1/4ly auths, periodic SIS, complex tier system) require more emphasis on problem solving and budget solutions than long term planning. | *CMS requirements; Existing state medicaid plan; Administration and GA budgets | *The Braddock Report *BHDDH/DDD | Develop a State Trends and Future Planning process w/ caseload estimating component |
| **Community level planning** | | | | Notes from Family / Community Forums | |
| **Provider level planning** | * Assoc has a multi-year strategic plan with annual focus. * Commitment of providers; Expertise in delivery of supports and services. *Agencies have strong working plan moving forward for increasing community access, employment and person centerdness | *Structural deficit issues and unnecessarily burdensome system making planning in excess of three months extremely difficult. *Lack of clinical expertise around outcomes and data capture | *BHDDH regs; CMS requirements; Existing state Medicaid plan; Admin and GA budgets | *CPN Policy Agenda and Annual Plan updates *BHDDH/DDD | |
| **Programming** (options, accessibility, quality) | | | | | |
| **Generall** | *Range of providers; infrastructure; supporting people in the community that other states do not; Careful & skillful, operate from a strong philosophical base | *Inadequate funding, staffing; Youth in transition, esp. DCYF supported who are looking for placement; State seeking system change without sufficiently investing in existing services | | | Across all program areas, each new initiative while potentially accruing long term benefits to the system, creates time and resource pressure on already understaffed providers and DDD partners. |

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| **Residential Services** | * Process for receiving and reviewing Residential Referrerrals has been somewhat streamlined over recent history. *Process for receiving and reviewing Residential referrals has been somewhat streamlined in recent past. *Robust community residece and network and in-home supports. | *Frequently the profile of those being referred for residential service is significantly hightened or acute that they do not match well with existing GH residents. Resulting in long-term vacancies, people unserved, relocation of existing residents to accomodate new referrals. Significant impact on aging family members and their older adult sons, daughters, sibs. *Lack of affordable, accessible housing. * Significant recruitment & | *Decision by policy makers to move away from this level of support and place greater emphasis on shared living; Inadequate funding to support the current system | BHDDH/Provider Networks | |
| **Shared Living, Self-Directed** | * Alternatives to traditional services; Increasing individual control. *Flexibility and choice for the individual | Concern for adequate quality oversight; Limited supply of host families; Difficulty for ind. In Self-Directed to adequately hire and retain staff. *Stipends insufficient to appeal to potential home providers, Insufficient & inflexible respite; Instability of payments | BHDDH policy | BHDDH/Provider Networks | Embed more flexibility with proactive resources built in (i.e. respite, elim head on the bed payments). This service lends itself to an APM |

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| **Day/Community Supports** | *Some flexibiltiy and choice. *Agency continues to deliver quality arts-based programming and continue to increase community-based support. | *In dividuals living at home with families often need 30 hours/week of support so parents can work. With the move aweay from congregate day services, current funding is wholly inadequate to meet this need. *Billing ratios are not person-centered and drive group activities. *No clear definitions or funding to support integrated day supports, despite development of certification standards *Family need often outweighs individuals desire to partake in what is often more costly services (job development, community based day, etc.,), many new referrals are not pursuing what they would most like to do. For those in group homes, who MUST have a traditional schedule of a 30-hour day program due to the requirement of providing 24-hour care, these individuals are even less able to use their day authorization creatively; Staff | Consent Decree | BHDDH,/ Provider networks; Court Monitor, DOJ | Decouple ratios from billing |

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| **Employment Services** | *New emphasis on employment w/ wide conceptual support and some additional funding from PCSEPP. *We have developed a small but effective employment team and have 20 enrolled in PCSEPP | *Move to comm-based integrated emp difficult due to lack of staffing and funding; No "seed money" provided to help providers develop/ramp up employment programs; lack of jobs available for participants. *PCSEPP remains unwieldy- difficult to bill. More upfront funds are required for agencies to develop certified employment teams. *Due to high cost of emp. services, there are limited dollars within the authorizations (even when braiding w/ PCSEPP and ORS). Utilizing these supports for many people is not viable | Consent Decree | BHDDH,/ Provider networks; Court Monitor, DOJ | |
| **Service Coordination** | This function plays a critical role in overall coordination of the person's plan and healthcare and takes place at the point of service; The role is part of our infrastructure provides far more than plan-writing. *Dedicated state staff do their best to meet the needs of all individuals. *Agency has a strong support coordination team who have all attended person centered planning facilitation class at Sherlock Ctr. | *Unrealistic caseloads for the DD Social Workers. *The time built into the rate model for SC is insufficient, esp as we move toward a person-centered planning process. *RHD provides day and employment supports to a significant number of Participants for whom we are not the support coordination agency- meaning we are pouring man hours into unfunded work. | BHDDH budget; New HCBS regulations | BHDDH; Provider Networks | Maintain funding for agency service coordinators and adjust state social worker caseloads to assume the CFCM function |
| **Transportation** | | *No efficient state-wide system. *Access to flexible transportation is extremely limited. *Transportation dollars insufficient to transport Participants from areas with no RIDE access. *Amount of transportation funding in the rate model is insufficient, especailly as we move toward more individualized schedules. | | | *Reevaluate funding embedded in the rate model and create more and flexible options for people to access and pay for tranpostation. |

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| Funding | Strengths | Challenges | External Factors | Data Sources | IDEAS |
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| **Structure / Funding Model** | *Concept of the Individual Funding Model is valued. *Represents an attempt to ensure accountability of all parties involved in the funding, provision and reciept of supports and services. | *Quarterly auths are burdensome for providers and DD staff, Fee for service in 15 minute units causes significant revenue shortfalls as a result of absenteeism without corresponding reduction of staffing expenses. *Difficult to track and bill for; requires alot of manpower for processing; Impact financial sustainability; Rates have not been updated and do not reflect changing expectations for taining, person-centered services, etc. Community and center based rates causing shortfalls because of underutilization of community based day rates. *Elimiates provider ability to utilize funding in moreflexible, person-centered ways. *Families at times have unrealiztic expectations, i.e. a 30 hr/week expectation with 11 of worth of funding. | State budget office / staff; BHDDH, General Assembly | State budget office / staff; BHDDH, General Assembly | Decouple ratios from billing - focus on flexibility; maintain an individualized approach; aliign resources with actual cost of service; acknowledge consultant's admission that they knew there was not enough money in the system to support the rate model. |
| **Individual and/or global expenditures** | An ernest attempt to provide individuals with funding necessary to meet their service needs | Structural deficit has never been adequately addressed; No formal mechanism for caseload increases; No recognition of CPI; Failure to adequately account for the need to increase wages to attract and retain staff | | *State and GA budget staff; BHDDH staff; Providers; Rate assumptions around hourly wage and true cost of benefits | |
| **Historical expenditures** | *In years back, funding was adequate, monthly expenditures could be used across program lines and support provision was as a result far more flexible and individualized | *Less transparency in the way BHDDH utilized information such as cost reports than in the current system, | State budget office staff; BHDDH; Providers | State budget office staff; BHDDH; Providers ; Braddock Report | |

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| **Individual /Family Experience** | | | | | |
| **Eligibility/Assessment** | The process for determining elegibility is better defined now that in the past and DD has made great strides in promoting an earlier start to this process for youth in highschool. | Misunderstanding of families in relation to access to services (elegibility, waiver applicaiton, tier package assignment, actual authorizations, etc.) | | | |
| **Availability** | | *Projected need for services is unclear; *Staffing shortages impeed availability of service v. demand. *Inadequate resources for high-need individuals place them at risk of institutionalization. | | | |
| **Accesibility** | | Language barriers continue to exist at the state level. | | | |