**Current State Assessment - Provider Input**

| | 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 (quarterly 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 General Assembly budgets | *The Braddock Report *BHDDH/DDD | *Develop a State Trends and Future Planning process with caseload estimating component *Include providers, families, community partners |
| Community level planning | *Good networks *Reach people the state might miss | Planning in isolation | Eligibility process | 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 *Administration and General Assembly budgets *Day-to-day demands | *CPN Policy Agenda and Annual Plan updates *BHDDH/DDD | Must include state and community partners |
| **Programming** (options, accessibility, quality) | | | | | |
| General | *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 referrals has been somewhat streamlined over recent history *Robust community residece and network and in-home supports *Responsive | *Frequently, the profile of those being referred for residential services is significantly hightened or acute and they do not match well with existing group home residents. This results in long-term vacancies, people unserved, and relocation of existing residents to accomodate new referrals. This has a significant impact on aging family members and their older adult children/siblings. *Lack of affordable, accessible housing *Significant recruitment/retention issues | *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 *Increase individual control *Provide flexibility and choice for the individual | *Concern for adequate oversight *Limited supply of host families *Difficulty for to adequately hire and retain staff for self-directed individuals *Stipends insufficient to appeal to potential home providers *Insufficient and inflexible respite *Instability of payments *Lack of respite/step up/step down | BHDDH policy | BHDDH/Provider Networks | *Embed more flexibility with proactive resources built in (i.e. respite, eliminate head on the bed payments) *This service lends itself to an APM |
| Day/Community Supports | *Some flexibiltiy and choice *Agency continues to deliver quality arts-based programming and continues to increase community-based support | *Individuals living at home with families often need 30 hours/week of support so parents can work. With the move away 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 individual 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 shortages impact the wait time for receiving community-based services *Move to community-based integrated activities is extremely difficult due to lack of staffing/funding | Consent Decree | *BHDDH/Provider networks *Court Monitor, DOJ | Decouple ratios from billing |
| Employment Services | *New emphasis on employment with 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 community-based integrated employment difficult due to lack of staffing/funding *No "seed money" provided to help providers develop/ramp up employment programs *Lack of jobs available for participants *PCSEPP remains unwieldy and difficult to bill. More upfront funds are required for agencies to develop certified employment teams *Due to high cost of these services, there are limited dollars within the authorizations (even when braiding w/ PCSEPP and ORS) so utilizing these supports is not viable for many people | Consent Decree | BHDDH/ Provider networks *Court Monitor, DOJ | No one included employers in this discussion, need more employers on board, provide incentives |

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| 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 and 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 the person centered planning facilitation class at the Sherlock Center | *Unrealistic caseloads for DD Social Workers *The time built into the rate model for support coordination is insufficient, especially 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 conflict-free case management 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 *Costly, regardless of who provides | | | *Reevaluate funding embedded in the rate model and create more flexible ways for people to access and pay for transportation *Open ADA corridor |
| **Funding** | | | | | |
| 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, FFS 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 training, person-centered services, etc. *Community and center-based rates causing shortfalls because of underutilization of community-based day rates *Eliminates provider ability to utilize funding in more flexible, person-centered ways *Families at times have unrealistic expectations, i.e. a 30 hour/week expectation with 11 hours worth of funding | *State budget office/staff *BHDDH *General Assembly | *State budget office/staff *BHDDH *General Assembly | *Decouple ratios from billing and focus on flexibility *Maintain an individualized approach *Align 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 |

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| Individual and/or global expenditures | *An earnest 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 | |
| **Individual/Family Experience** | | | | | |
| Eligibility/Assessment | *Process for determining eligibility is better defined now that in the past *DD has made great strides in promoting an earlier start to this process for youth in high school | Misunderstanding of families in relation to access to services (eligibility, waiver applicaiton, tier package assignment, actual authorizations, etc.) *Families need to know when to start applying to BHDDH, ORS, etc. | | | |
| Availability | | *Projected need for services is unclear *Staffing shortages impede availability of service vs. demand *Inadequate resources for high-need individuals place them at risk of institutionalization | | | |
| Accessibility | | Language barriers continue to exist at the state level | | | |