

Governor's Commission on Community-Based Alternatives For Persons With Disabilities

Assessment Sub-Committee Five Year Strategic Plan
Version 3.0

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Assessment Sub-Committee Five Year Strategic Plan

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Background: This document summarizes a proposed five-year plan for the Assessment Sub-Committee of the Governor's Commission on Community-Based Alternatives For Persons With Disabilities. It builds upon a prior strategic plan and will serve as a guide to specific initiatives of the Sub-Committee.

In April 2006, the Assessment Sub-Committee entered into a consulting contract to obtain assistance in reviewing current goals of the Sub-Committee while also providing input to the future direction and priorities of the Sub-Committee.

This draft strategic plan is the result of consultant analysis of the current goals and objectives of the Sub-Committee, the changing climate and mandates for programs serving persons with disabilities and targets of opportunity for reform or innovation.

The current goals of the Sub-Committee concentrate on the need for proper, objective assessment of persons residing in facilities to provide every opportunity possible for living in a home or community based setting. They also call attention to the need for consumers and other stakeholders to have accessible information on available housing and service options. (*See Appendix I for a the current goals of the Sub-Committee.*)

Since these goals were framed, federal agencies have launched several new initiatives designed to encourage transition from facilities and enhance home and community based services (HCBS). These new initiatives (such as Money Follows The Person) offer Delaware a framework and potential source of federal funding (assuming Delaware can provide the match) to advance important goals of the Sub-Committee.

Consequently, the current goals of the Sub-Committee are best integrated into a larger programmatic push for more aggressive community transition and consumer supports on their alternative living options. In addition, the current goals have spurred fresh thinking about areas of need and opportunity for the work of the Sub-Committee as a force for positive, constructive improvement in current programs serving persons with disabilities.

As framed, the proposed new Five Year Plan builds off the current mission and goals of the Sub-Committee. Proposed refinements to the Strategic Plan are highlighted in the balance of this draft plan document.

Proposed Mission of the Assessment/System Design Sub-Committee: Over the next five years, the Sub-Committee will foster the creation of a consumer-centric delivery model for public and privately supported services to persons with disabilities that is:

- Flexible;
- Outcomes based;
- User-friendly;
- Responsive to changing needs;
- Encourages independence;
- Provides services in the least restrictive setting;
- Prioritizes the growth of home and community based supports; Encourages consumer self-management; and,
- Cost effective.

Consumer Focus: Understandably, the Sub-Committee will promote services and supports to persons with disabilities of all ages and all types of disability. However, the Sub-Committee will focus on persons whose disabilities are continuing in character (chronic/permanent) and that are likely to limit physical mobility and/or imperil emotional health, threaten

independence, limit consumers' capacities to manage their own affairs and/or risk causing informal caregiver burnout.

Guiding Principles: The Sub-Committee will pursue its mission by adopting a strategy having the following elements:

1. In order to better serve the broader interests of the Commission as a whole, the Sub-Committee will expand its orientation from a focus on primarily the development of a common assessment tool, to the broader issues and opportunities related to systems integration and systems building initiatives which will guide future service delivery.
2. The Sub-Committee will position itself to work with both governmental entities and private entities to enhance services to persons with disabilities.
3. The Sub-Committee will assist in the development of tools and information that promote self-management, personal choice and self-directed care.
4. The Sub-Committee will work collaboratively with governmental programs to identify opportunities for systems change and transformation that advance, in substantive and timely ways, a more consumer-friendly, responsive service delivery system for persons with disabilities.
5. The Sub-Committee will serve as a clearinghouse for innovative service delivery models, encourage cross-fertilization of best practices and identify new resource opportunities. The Sub-Committee will be a strong voice for solutions that are cost-effective and realistic in terms of the limitations of public funding.

**Sub-Committee Identity In
Terms of Systems-
Building**

- Provide "Idea" Leadership
- Facilitate Working Relationships and Collaboration
- Be a Voice for Continuous Improvement
- Promote Innovation
- Encourage Systems-Thinking
- Encourage Interconnectedness
- Foster Accountability
- Create an Investment Orientation

6. The Sub-Committee will support other Sub-Committees of the Commission to identify ways to integrate programmatic initiatives into a broader system framework – specifically housing, employment, transportation and health care services and the Money Follows the Person initiative.

7. The Sub-Committee will become a trusted source of information about persons with disabilities that can be used to support both policy analysis and advocacy. Working with both public and private agencies, the Sub-Committee will advocate for improved data describing the needs and capacities of persons with disabilities residing in Delaware as well as timely and descriptive data on consumers currently receiving services, the services they receive and/or the costs being incurred. (*Note: Any data created for use in policy analysis or advocacy will be aggregate information and not include any confidential information on individual consumers*)

Key Goals of the Strategic Plan: The Sub-Committee's proposed five-year plan is organized around five goals and a set of related objectives and action plans for each goal. The goals are designed to provide specific and meaningful direction to the Sub-Committee's mission in support of the Commission as a whole. The five proposed goals to guide the Sub-Committee are:

Goal 1: Promote the benefits of a crosscutting, generic "model" for consumer self-management that can be integrated into State-administered programs serving persons with disabilities.

Goal 2: Enhance consumer access to information and tools critical to self-management and self-directed care.

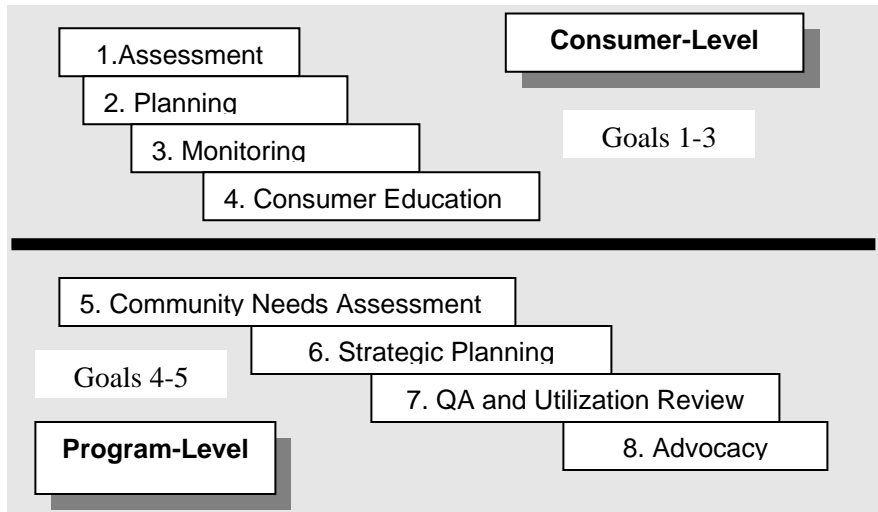
Goal 3: Support the development of a cross-cutting, common assessment model for use in screening, eligibility determination and/or as a support to care planning, by fostering a care management model and IT supports for

care managers and ensuring residents of various facilities are properly assessed for community transition.

Goal 4: Support the commitment and capacity within state agencies to develop, on an annual basis, a profile of consumers served by current state funded/administered programs based on the adoption of common, core consumer descriptors across key programs serving persons with disabilities.

Goal 5: Support the commitment and capacity within state agencies to implement and utilize a common, core set of performance measures that measure the impact of current programs on persons with disabilities and/or their informal caregivers.

Collectively, these goals seek to realign several common processes that underpin the provision of services and supports to persons with disabilities. These processes occur at two levels – 1) at the individual consumer/client level where decisions are made about needs, services and resource use, and 2) at the program level where decisions and action must be taken on generically the same issues – needs, services and resource use.



This strategic plan seeks to harmonize the decision-making at both levels and make them both consumer-centric -- a simple idea with considerable implications.

Ideally, these eight processes will be retooled and integrated into one overall process that can replace the separate, disconnected business processes currently in use for individual HCBS programs for persons with disabilities.

Process improvements involve workflow definition, staffing specifications and development of automation tools to increase efficiency and effectiveness of each element of the business processes. Several basic management concepts shape the processes covered by the strategic plan of the Sub-Committee, including:

- ❑ Consumer-centric orientation
- ❑ Use of outcomes to focus decisions and resources
- ❑ Use of best-practice, evidence based guidelines and benchmarking
- ❑ Establishing clear accountability for performance
- ❑ Continuous review and improvement

In the next five years, the Sub-Committee will take on the realignment of these eight functions as part of building a better foundation for the provision of services for persons with disabilities. These management process improvements will, in turn, encourage the transformation of current programs into a more well defined, consumer-centric system of care.

Timetable: Given the nature of these goals, the timetable for completion of most of the action plan tasks is less than five years. The goals relate to what might be called the “building blocks” for the next-generation of programs serving persons with disabilities. Consequently, the sooner the building blocks are in place, the sooner the preferred delivery model can emerge and positively impact on the lives of persons with disabilities in Delaware.

Dependencies: To ensure the impact of the Sub-Committee’s work is maximized, it is critical that the Commission as a whole and the Sub-Committee continuously assess and, as necessary, align its priorities and plans with the shifting mandates of Medicaid and related federal programs as well as priorities of the Governor and the Legislature.

Federal legislation, policies and capacity building initiatives can alter the timing, priority or even the basic goals or objectives of the strategic plan. In the near term, it will be important to tune the strategic plan of the Sub-Committee to emerging priorities and opportunities presented federal initiatives such as the Deficit Reduction Act, Money Follows the Person, CMS quality improvement initiatives, Real Choice/New Freedom Initiatives and the recent spate of CMS systems transformation grant opportunities that all bear on the agenda of the Sub-Committee. It will be important for the Sub-Committee to monitor these federal initiatives (as well as those of applicable accreditation bodies) to take full advantage of the federal impetus for reform and potential funding to bring about reform at the state and local level.

Relationships and Required Support: Pursuit of these goals will require a close working relationship with state agencies and the state legislature. The Commission will also need staff support to implement the action plan, either in the form of contracted personnel (currently the University of Delaware Center for Disability Studies), active participation by Sub-Committee members and/or support provided by state agency staff supporting the work and functioning of the Sub-Committee.

This strategic plan, while focused on state-administered programs, would be less than complete if it didn’t leave the door open for opportunities to forge closer ties with private insurers, interest groups such as AARP, Disabled Veterans, etc.), disease-based national associations (MS Society, Arthritis Foundation etc.), large employers and unions to deal with common issues and concerns related to persons with disabilities. There are many potential opportunities to broaden the impact of the Sub-Committee’s work into the private sector, once an innovative, pro-active agenda for systems- building can show promise of cost-benefits to other

key stakeholders challenged to find new ways to meet the needs of persons with disabilities.

Return on Investment: As framed, the strategic plan is virtually synonymous with an investment plan for upgrading a service delivery model. All of the goals and related objectives of the proposed strategic plan involve upgrading the infrastructure of a services delivery system, in particular the management capacities at both the consumer and the program level. The Sub-Committee is advocating for a higher level of inter-program collaboration including adopting common business processes, where appropriate, sharing various IT tools and incorporating key concepts for a consumer-centric delivery system in common ways across various programs that are state-administered. If the Sub-Committee is investing in a more coherent, integrated services delivery model, what is the potential return on investment? What tangible benefits will be achieved through the proposed capacity-building projects included in the strategic plan and for whom?

Ultimately the primary beneficiary of a better “system of care” is the consumer and/or their informal family caregiver. The consumer benefits to be promoted through implementation of this proposed plan include:

- ❑ More consumers equipped to self-manage, better informed, more knowledgeable
- ❑ Reduced dependence on care managers and service coordinators.
- ❑ Reduced personal crises due to improper self-care
- ❑ Reduced risks for high cost care
- ❑ Reduced risks of informal caregiver burnout
- ❑ Higher consumer satisfaction with the consumer-centric nature of the services delivery system

Professionals involved in provision of services as well as program managers and policy makers should benefit as well. We expect improved systems management capabilities. Better data and better tools for program will emerge that will allow state agencies and the Commission to assess service delivery capacities, service use, potential gaps in services

and, over time, inefficiencies or areas where current services are ineffectual.

A framework for performance accountability can evolve from the development priorities included in this plan. Performance measurement and benchmarking will become integral to management, not peripheral. Expectations will be more clearly framed and in consumer-centric terms.

In the end, the Sub-Committee is positioning itself to be a strong voice for a more coherent, comprehensive delivery system that is accountable and consumer centric. When individual program “silos” are diminished and common features and attributes for a more consumer-centric delivery system are in place, the Sub-Committee will have taken a large step toward accomplishing its mission.

In the pages that follow, each proposed goal is summarized. Specific objectives related to each goal are listed. For each objective, the major action tasks to be completed are also listed.

Goal 1: Promote the development and corresponding benefits of a cross-cutting, generic “model” for consumer self-management that can be integrated into State administered programs serving persons with disabilities.

Objectives and Key Action Steps	Performance Measure	Responsibility	Achieve By:	Public Policy/Legislative Initiatives	Fiscal Impact
Objective #1: Incorporate person-centered planning as an integral element of all state-administered programs serving persons with disabilities.	# of programs adopting PCP	Sub-Committee with staff support from State agencies	August 2007	Policy statement on use of PCP integrated into strategic plans of each DHSS Division	Staff training to support implementation -- \$50k in content development IT mods – roll into care mgt IT initiative in next goal
Review current person-centered planning models					
Identify current usage in DE state-administered programs					
Identify ways to remediate any gaps in usage					
Develop a training program to expand awareness and usage					
Objective #2: Implement self-directed care as an option in all key state-administered programs.	# of programs with SDC option # of consumers using SDC	Sub-Committee with staff support from State agencies	January 2008	Refined service definition for SDC supports – financial agent services etc.	
Review current SDC usage in DE state-administered programs					
Examine barriers to usage and targeting criteria for usage					
Identify enabling supports and services to support SDC usage					
Analyze potential level of SDC usage based on client profiles					
Set numeric targets to achieve re. SDC adoption and usage					

Goal 1. Background and Discussion: We are in an era where businesses and government have become more “customer -oriented”. Now, more than ever, consumers are more savvy, seek options and expect to have more information at their fingertips to make decisions and preside over their own circumstances. They are less likely to want to cede their autonomy and ability to preside over their own life decisions to professionals. In recent years, Internet access has made it much easier for

consumers to “find their voice” and feel more empowered to make good decisions. And this growing consumer movement is producing positive results. In recent years both providers and public payers of programs serving persons with disabilities have become more consumer centric. Consumer advocates have been instrumental in creating this orientation.

Promoting Self-Management: Moving forward, the challenge for the Sub-Committee is to find ways to refine the services delivery model(s) for persons with disabilities to more fully integrate the concept of being consumer-centric and to ensure this concept is rooted in all the key programs that serve persons with disabilities. Federal agencies are pushing for this through various health and long term care programs they fund. No doubt consumer advocates will continue to advocate for these concepts as well. And in the middle are state-administered programs.

In Delaware there are numerous individual, state-administered programs serving persons with disabilities. Virtually all the current programs are encouraging the concept of consumer self-management in some form or fashion.

The Sub-Committee, in this goal area, has the opportunity to work collaboratively with state-administered programs to further the adoption of the consumer-centric concept in ways that fit the realities of public programs and just as important in consistent ways across individual programs. As this occurs, it is the plan of the Sub-Committee to be a visible advocate for these same concepts in the private sector by working with private agencies, businesses and private insurers.

While it is unlikely, even unnecessary, to require each program to employ an identical model for consumer self-management, the Sub-Committee *should facilitate discussion and consensus on the common elements of self-management and approaches to implementation that can be used across programs.* A generic model for consumer self-management can encourage greater commitment and support for this concept within programs and it can encourage collaboration and mutual support across programs to development of tools and content for consumer self-management that can be shared by programs.

Development of a generic model requires consensus on basic terms and concepts related to consumer self-management. It requires establishing generic goals for consumer self-management and related performance measures. And it should lead to creation of generic educational and

training content and creation of generic means for distribution of this educational content to consumers (and their informal caregivers).

Definitions: Consumer centric services are defined to be services where consumers (and/or their informal caregivers) are encouraged to take a proactive role in assessing, planning and directing the supports they need. Put differently, consumers are encouraged to self-manage. In the course of self-managing, consumers, providers and care managers are adopting person-centered planning methodologies that identify consumer interests, priorities and goals to guide a service plan or plan of care. Self-directed care refers to the capacity of consumers to hire and fire their own aides and is one element of a broader concept of self-management.

Goal 1. Approach: The self-management “model” to be advanced by the Sub-Committee will describe the capacities, knowledge, and activities associated with self-management by a consumer and/or their informal caregivers – including self-monitoring capacities, self-directed care, participation in person-centered planning, self-advocacy, use of I&R services, consultation with professionals and participation in peer support activities.

A useful design for self-management, as implemented in Delaware for persons with disabilities, must take into account the variability in consumers’ capacities and willingness to self-manage. We know it is not for everyone.

Research suggests that consumers must want to self-manage and believe in their capacities to do so (sometimes called self-efficacy). Some people accept the challenge and confidently move forward. Others want to self-manage but constantly struggle to find their way or stick with a given approach. Others resist change or the demands of self-management and the personal responsibilities of doing so.

Given these realities, a model for self-management can’t be idealized, assuming each consumer (or informal caregiver) is rational, motivated and persistent. Honest, practical supports must be built into the model.

The model for self-management that emerges assumes that all consumers must be: 1) informed; 2) connected; and 3) empowered to self-manage. The model must be flexible enough to help consumers move toward a higher level of self-management that takes into account their self-efficacy and their knowledge levels. That flexibility and responsiveness is a key element of design for the self-management model.

Person-Centered Planning: Two aspects of self-management are a priority for development in this strategic plan. The first relates to person-centered planning. The Sub-Committee will, as a goal, seek the widespread adoption of person-centered planning in all state-administered programs for persons with disabilities. There are many different methods for person-centered planning in use. Examples include Essential Lifestyles Planning (ELP), MAPS, etc.

The Sub-Committee will encourage review of the different methods and the adoption of one model that has the most utility and applicability to diverse programs. Adopting one model can simplify and streamline the tools, content and staff development efforts required to implement person-centered planning across programs. Working with program managers, the Sub-Committee will facilitate the development of a plan for adaptation and implementation of the preferred model. As needed, the Sub-Committee will facilitate the creation of training materials to professionals in positions where person-centered planning occurs at the consumer level – care managers, service supervisors, residential service managers etc.

At the program level, the Sub-Committee will encourage the adoption of person-centered planning concepts to infuse annual planning and

budgeting processes for key state-administered programs. This means defining generic interests and preferences of persons with disabilities and looking at ways to address those preferences through services and supports funded by state-administered programs.

Self-Directed Care: A second priority of this plan is the expansion of the option for self-directed care. Self-directed care, as conventionally defined, refers to the option for consumers to manage aides who assist them with normal ADL/IADLs. Arising from the Cash and Counseling demonstration projects, self-directed care is a concept being promoted by CMS for use in Medicaid-funded HCBS. Other federal programs such as the Administration on Aging are joining with CMS to promote this concept.

Different perspectives exist in terms of the cost benefits of self-directed care. Many advocates view it as an essential attribute of a consumer-centric system. Others fear the potential for misuse especially when family members are hired. Not infrequently the division of responsibility between a consumer engaged in self-directed care and the continued presence of a service coordinator or care manager can confuse or complicate the use of self-directed care.

Despite the potential issues in use of self-directed care, the Sub-Committee views this to be an important feature of a consumer-centric delivery system. Consequently, the Sub-Committee is committed to working with advocates, consumers and program managers to determine how best to introduce and evolve this concept in Delaware.

Goal 2: Consistent with the generic model for consumer self-management, enhance consumer and informal caregiver access to information and tools critical to self-management and self-directed care.

Objectives and Key Action Steps	Performance Measure	Responsibility	Achieve By:	Public Policy/Legislative Initiatives	Fiscal Impact
Objective #1: Improve access to self-management tools and information using Web technologies for all persons in Delaware with disabilities regardless of whether they are clients of state administered programs or not.	# of consumers using self-mgt Web portal # of programs supporting self mgt option	DHSS as lead agency – recruit a Web technology coordinator	Initial Deployment by Dec 2007; All DHSS disability programs Dec. 2008	Waiver modifications to formalize use of self-management and underwrite self-mgt support services.	Development \$300k Operational Support \$/Year: \$250k
Identify key decisions and roles in self-management to be supported					
Assess generic information needs for self-management – like information on current services					
Identify current sources and access methods for generic information needs					
Identify access challenges or packaging issues to consider in developing generic information for self-management					
Review current information for self-management already in use by current state-administered programs					
Review private sector programs that foster self-management, included selected disease management programs					
Review available Web platforms designed to support consumer self-mgt					
Develop performance specifications and desired functionality for Web based content					
Select preferred platform					
Identify on-going sources of local content to support self-management					
Explore methods for peer support as part of a self-management support model					
Determine what information packaging strategies fit the goals for consumer self-management to be advanced by the Sub-Committee					
Customize the platform as required					

Develop content specific to Delaware programs and consumers					
Identify specific disabilities that can be used in a pilot test of specialized content to support consumer self-management (e.g. autism, etc.)					
Develop the specialized content					
Test the content and dissemination model (Web portal and related printed materials)					
Set up publicity and advertising of the new self-management support service across programs targeted to adopt the new self-management capability over the next five years					
Objective #2: Improve accessibility to local experts on issues of interest or concern to persons with disabilities and/or their informal caregivers using Web technology.	At least ** professionals in place on different topics ** Queries/Yr	Commission Sub-Committees plus state agencies	December 2007	Practice Act revisions might be required to allow advice or counseling via the Internet	None – Should be possible to recruit professionals on a volunteer basis
Identify areas of expertise that consumers require access to					
Develop protocols for accessing and using experts					
Recruit experts					
Develop bios of professionals and related info for placement on Web portal					
Brief the professionals					
Monitor utilization and refine service as required					

Goal 2. Background and Discussion: It’s one thing to allow for, or encourage, consumer self-management. It’s quite another to build the supports necessary to bring about widespread consumer self-management. In this goal area, the Sub-Committee will identify and build capacities across state-administered as well as private programs to provide information and tools that help consumers with disabilities self-manage.

When we discuss consumer self-management, we include provision for a vital role by informal caregivers. While it is impossible to characterize every nuance and combination of ways that persons with disabilities and informal caregivers work together, we know it is important to include the perspective and the role of the informal caregiver in the self-management process, especially when children are involved or there as significant cognitive impairments.

Two levels of information and tools are need to promote and expand consumer self-management: 1) generic information and tools useful to consumers regardless of their specific disability; 2) information and tools that account for unique or special challenges persons with specific disabilities may face.

Goal 2. Approach: In this proposed strategic plan, the Sub-Committee will focus on information and tools for self-management that are broadly applicable and useful, regardless of the type of disability. Then, for pilot project purposes, the Sub-Committee will select two or three types of disability and identify what types of specialized tools and information are needed either by the consumer or their informal caregivers; for example, children with autism, persons with MS, persons with profound hearing loss, or persons with paralysis.

The Sub-Committee will pursue this goal area using Web technologies as a primary tool for providing information and tools for self-management. The Web is a versatile platform and one that more and more people have access to, via assistive technologies. However, it is important to point out that Web access and usage by persons with disabilities has lagged.

A recent study showed that approximately 40% of persons with disabilities live in homes with Internet access but only 24% of them actually use the Internet. (Research and Training Center on Disability in Rural Communities). Access in rural areas is even more limited. And with the rapid transformation of the Internet, broadband access is increasingly a must in terms of taking advantage of what the Internet has to offer. Still, the long range potential of the Internet to be universally accessible and a powerful medium for information sharing and communications is undeniable.

Delaware, to be progressive, needs a pro-active, if not aggressive, plan to seek ways to capitalize on the use of the Internet as a tool for consumer self-management as well as a platform for program management by state program administrators.

Ideally, DHSS should coordinate the emergence of this Web portal and provide the funding necessary to support its continued evolution and use. However, the Sub-Committee will also pursue options for a public-private partnership that can bring private insurers and providers in as cosponsors and supporters. The Sub-Committee will request that DHSS designate a staff position that can be charged with planning and implementing a Web portal for consumer self-management across programs.

Given the commitment to a generic model for self-management, the Sub-Committee will pursue the development of generic Web portal that can be used by persons with disabilities across individual programs as well as persons with disabilities who are not currently enrolled in any state-administered programs. Key attributes of the Web portal include the following:

Principally for Consumer Self-Management. The Web portal should be expressly designed to support and encourage self-management. It can't be a Web application designed for professionals that simply allows for consumer access. Such systems treat consumer self-management as an after-thought.

Responsive to Informal Caregivers: It is recommended that the Web portal provide special content and supports for informal caregivers.

Local Identity: The Web portal should have a Delaware identity and provide for the inclusion of local expertise, local service resources and content of interest to persons with disabilities contributed by professionals in Delaware. The local content should be supplemented with relevant, timely national content on disability topics.

Fosters a Virtual Community: The Web portal should encourage three way communication among consumers, their informal caregivers (no matter where they live) and the local professionals who are assisting the consumers (care managers/service coordinators etc.) and even the direct services providers.

Content Rich: Relevant, timely and fresh content are key to a consumer-centric Web portal. New and fresh content is a key reason consumers return to Web portal on a frequent basis. The content needs to be geared to key knowledge areas associated with self-management.

Leverages Local Expertise: The Web portal should become a vehicle for consumers to connect with local professionals when they have questions as part of their self-management. Access should be convenient for the consumer. Just as important, professionals need an efficient and effective way to provide their expertise. Web technologies in the form of chat rooms, discussion forums, blogs, Ask a Question features and even video conferencing are time-savers for professionals.

Scaleable: The Web portal should provide for expanded use – both in terms of the number of users but also expanded frequency and extent of

use by individual users. The portal should have the potential to serve anyone in Delaware who is struggling to self-manage or be a responsive informal caregiver.

Accessible: The Sub-Committee will facilitate review computer assistive technologies to ensure a Web portal initiative can achieve a high level of accessibility while not compromising some of the core capabilities considered crucial to learning, peer support or self-monitoring.

The Sub-Committee will work to create an initial Web presence to support self-management as soon as resources permit by working closely with DHSS as a lead agency. Once in place, the Sub-Committee expects to continuously explore ways to refine and expand the use of the Web portal, based on experience in Delaware, emerging technologies, experiences in other states and interests of other potential co-sponsors such as private insurers, local providers or various advocacy groups.

Goal 3: Support the development of a cross-cutting, common assessment model for use in screening, eligibility determination and/or as a support to care planning, by fostering a consumer-oriented care management model and IT supports for care managers while ensuring residents of various facilities are properly assessed for community transition.

Objectives and Key Action Steps	Performance Measure	Responsibility	Achieve By:	Public Policy/Legislative Initiatives	Fiscal Impact
Objective #1: Support the development of a crosscutting care management automation/IT platform used by DHSS that can incorporate a common, core assessment tool.	Integrated CM IT installed in DHSS	DHSS DMMA/DIRM with a inter-Divisional Work group	June 2009	None	Development - \$2.0 million Annual Operational Support - \$200k (Assumes CMS funding support)
Develop a vision for a next-generation more for care management/services coordination					
Identify key staff skills and supports required to adopt a next-generation care management model					
Assess the common demands for a common care mgt IT					
Determine basic functionality for the required care mgt IT					
Establish specifications for common assessment and screening					
Identify functional tie-in of care mgt IT with consumer self-mgt tools to be developed with the support of the Commission					
Identify specifications for person-centered planning					
Establish outcomes framework to integrate into care mgt IT					
Establish process and capacity of best practice modeling					
Identify funding options for the care mgt IT					
Develop a work team to guide development/implementation					
Develop an RFP to select package/vendor					
Select a preferred application/package for adaptation					
Customize the application					
Establish implementation timetable					
Provide training and orientation to users					
Implement new IT system					
Objective #2: Support the creation of tools and protocols for assessing consumer capacities and needs for assistance in enhancing their capacities for self-management that can be implemented/shared across multiple state-funded and supported programs as well as privately funded or insured programs (e.g. workmen’s compensation, employer EAP programs etc.).	New assessment tools to determine consumer self-mgt capacities	Sub-Committee supported by the Univ. of Delaware Center for Disability Studies	Dec 2009	None	None – Costs are minor and subsumed in Objective 1.

Identify primary domains that describe self-mgt capacity					
Establish assessment logic for ascertaining self-mgt capacity					
Identify generic knowledge areas for self-management					
Develop content requirements tied to identified knowledge areas for self management					
Develop tools to assess consumers for core knowledge areas					
Test and validate the tools as required					
Package the tools for use as part of integrated care mgt IT					
Package the tools for self-use by consumers and informal caregivers via the Web					
Provide training and orientation to advocacy groups and providers on the use of the assessment tools					
Develop programs that can subsidize Internet access for consumers/families unable to secure Internet access.					

(The integrated assessment tool will include common, core data elements, related risk screening, adherence to the master client index, capacity to review consumer self-management capacities and built-in triggers/algorithms that help prioritize needs and identify appropriate consumer-centric outcomes.)

Goal 3. Background and Discussion: A long-standing priority of the Sub-Committee is standardization of screening and assessment tools across programs serving persons with disabilities.

Challenges: First, we need to put this goal in context. Existing screening and assessment tools used by various program vary by purpose and application. Some tools are used to screen for eligibility. Others are used to assess needs as part of a care management and plan of care process. Others are used to pinpoint special risks or circumstances that require some form of special intervention. Still others are used to provide a basis for performance measurement or outcomes tracking. To no surprise, some of the instruments are used for multiple purposes.

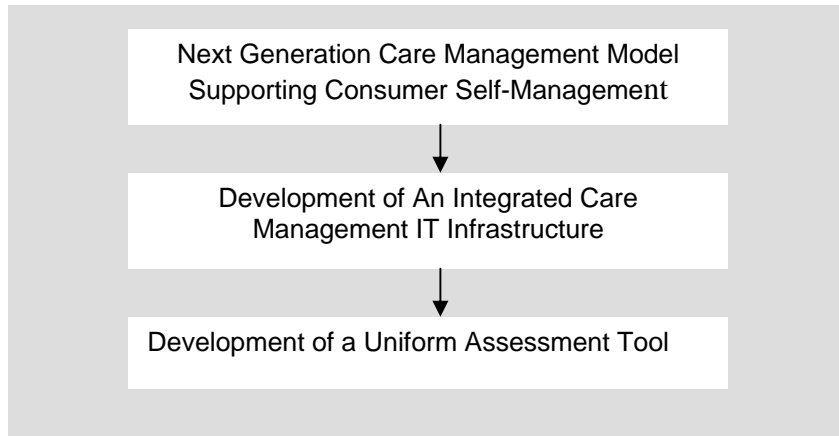
Review of currently used tools suggests that the current tools vary in scope and depth of assessment. Some provide a comprehensive and in-depth review of a client/consumer but provide little by way of profiling of either informal supports or consumer capacities for self-management.

Adoption of a single assessment tool is not immediately practical since the IT infrastructure to support a common tool is not in place. Various individual, state-administered programs have existing, stand-alone IT applications built around individual and customized screening and assessment tools. These systems and the potential costs of modifying or replacing them has been a barrier to adoption of a uniform assessment. To no surprise, various federal mandates and oversight requirements for individual programs are also a barrier to implementation of a common assessment tool.

Goal 3. Approach: While pursuit of a single, uniform, integrated assessment tool may not be a short-term goal, the Sub-Committee is committed to fostering improved, and, more comparable, screening and assessment data as an objective to be realized within the five year strategic plan. That said, there are equally important goals to pursue, namely the adoption of improved models for care management and the creation of a stronger IT infrastructure to support care management. Without these improvements, the value of a uniform assessment tool will

be greatly diminished. In fact, these improvements are necessary pre-conditions to pursuit and adoption of a uniform assessment.

Over a five-year period, the Sub-Committee will move toward a uniform assessment along three sequential tracks.



As can be seen in the graphic, the “pre-conditions” for a uniform assessment tool need to be implemented. Adoption of a uniform assessment is the culmination, not the beginning, of a larger initiative. Simply put, the larger goal for the Sub-Committee is to help establish a next generation model for care management that dovetails with consumer self-management. To be successful, the care management model will require new and improved IT infrastructure that supports multiple care management programs in DHSS and other state agencies as appropriate. Once an integrated, shared IT infrastructure emerges, it will be much easier for the Sub-Committee to advocate for a uniform assessment instrument.

Encouraging a Next-Generation Care Management Model:

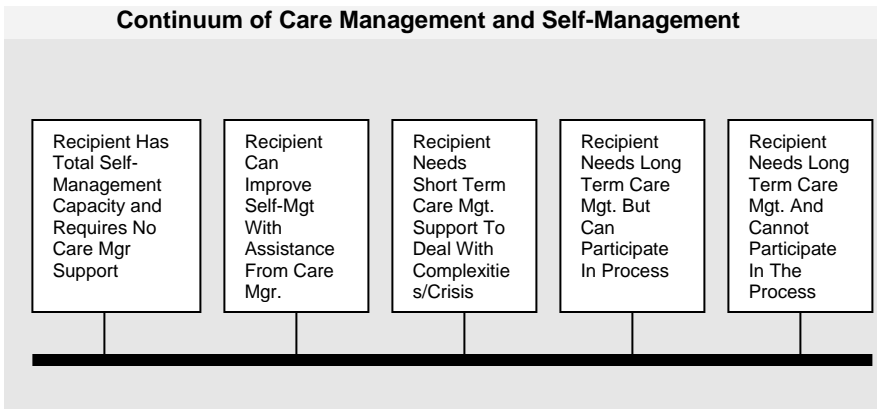
Enhanced capacities for consumer self-management require parallel commitment to enhanced care management/service coordination delivery

models. One must complement the other. To that end, the Sub-Committee will encourage a care management model that balances administrative functions with consumer support discussions. To illustrate the scope of responsibilities and capacities built into the next generation model, see the graphic below:

Management Functions	Support Functions
Assess	Educate
Automated assessment add/edit	Knowledge building for self-management
Trigger generation	Skills development for self-management
Risk screening	Measurement of learning progress
Plan	Counsel
Problem area assignment	Problem-solving
Service(s) specifications	Sounding board
Best practice protocol selection	Reassurance
Adopt protocols to individual needs	Coaching
Selection of appropriate care mgt model	Crisis counseling
Person centered planning support	Encouragement
Budget	Provide I&A
Projected units	Information on local resources
Projected costs by service & problem area	Referrals to local resources
Comparison against budget targets	Coaching on how to seek services
Capitation and PM/PM pricing	Waiting list management
Authorize/Certify	Advocate
Provider selection	Representation
Eligibility for service spans	Expedited liaison
Reassessment scheduling	Mediation
Notification	Crisis intervention
Monitor	
Vitals tracking	Community events
Plan compliance by providers	Self-management tasks
Outcomes tracking	Professional interactions
Incident Reporting	Medications

In order to encourage self-management, the Sub-Committee will encourage and support the use of care managers as a resource to consumer’s choosing to self-manage. As appropriate, care managers will

be equipped in terms of information, tools and time to spend teaching, educating, counseling or reassuring consumers who are self-managing. As envisioned by the Sub-Committee, care management and self-management will form a continuum. Care management tasks and consumer supports will take into account the consumer’s level of self-capacities. And the model will take into account the possibility that the consumer’s capacity for self-management may fluctuate. See graphic below.



Equipping Care Managers to Support Self-Management – The Sub-Committee will work with state-administered programs to develop new and expanded tools for consumer education and training. Web technologies will provide the platform for education and training but provision will be made for education and training supports using other venues as well.

Basic materials are needed on self-management that can be used across programs to provide an introduction to self-management and ways consumers (or informal caregivers) can self-manage. Special topic materials for specific self-management tasks should emerge as well. For example, disease self-management programs for persons with diabetes describe standards of care, specific self-monitoring tasks that should occur, dietary guidelines, exercise recommendations and when specific

tests should be scheduled. Similar guidelines can be developed for specific disabilities and chronic conditions that frequently result in disabilities.

Support Integrated Care Management IT: Based on recent consultant input to the Sub-Committee, the focus of the strategic plan will shift from an exclusive focus on a uniform assessment to a focus on the promotion of common tools and technologies for use by care managers/service coordinators of various DHSS programs.

The absence of strong case management IT tools in various programs serving persons with disabilities is a substantial deficit. The most notable example is the TAP system used by DSAAPD and DSS to support care managers and eligibility determination staff. TAP has been in use many years and is in need of replacement. Other Divisions have IT applications that are under review for potential upgrading or replacement. DDDS has a client registry application that is potentially a candidate for refinement and upgrades. A consultant is currently reviewing DDDS systems. DSAMH is in the midst of upgrading its “clinical” information system used to support multiple services and programs.

DMMA has just submitted a Systems Transformation grant application to CMS requesting funds to support the development of a new case management information system. If funded, this grant will provide crucial funding for this important IT initiative. The Sub-Committee will seek ways to participate in the discussions and planning for this initiative and advocate for assessment methodologies and tools that support person-centered planning. If not funded, the Sub-Committee will continue to encourage and support grant applications to CMS to secure funding for this IT initiative.

As input to this process, the Sub-Committee will work with DHSS staff to ensure the care management information system supports a next-generation care management model. Of importance, the next-generation care management model should dovetail with a parallel commitment to encourage consumer self-management, where feasible.

The Sub-Committee will encourage simplification and automation of the administrative aspects of case management, as feasible, in order to free up the time of care managers in all programs to work more closely with consumers and their informal supports. To that end, better IT support for care managers is critical, especially work flow tools that reduce paperwork, speed up processing of assessment, planning, budgeting, authorization and monitoring task and improve care management decision-making in these important tasks.

Assessment Tool Attributes: The model assessment instrument that emerges to support the next-generation care management model will include functionality that permits assessment not only of conditions and service needs but the capacities and interests of consumer (and/or their informal caregivers) to self-manage or self-direct their own care. ***The model assessment tool will provide for built-in intelligence through integration of triggers that signal potential areas of need or problem areas that a plan of care should address. The model assessment tool will also include provision for consumer assessment of personal interests, concerns and goals critical to person-centered planning (for example, the Essential Lifestyles Planning (ELP) model currently in use by DDS.)***

The model assessment tool will be designed for automation. The model assessment instrument will become a guide and point of reference for subsequent efforts by state-administered programs to upgrade or otherwise change currently deployed screening and assessment tools.

See Appendix II for a summary of the features and data domains of a uniform assessment tool that could be used with various programs serving persons with disabilities in Delaware.

See Appendix III for a list of problem areas that a uniform assessment tool could trigger in terms of a focus for a plan of services and supports developed in collaboration with a consumer.

Assessments In Support for Community Transition/Money Follows the Person Initiatives: In Delaware, like other states, new initiatives are being developed that support community options for persons in institutional settings of care. These initiatives require the capacity to accurately assess institutionally placed consumers for their potential and interest in a community transition. The Sub-Committee will work with state agencies to develop a review criteria and assessment methodology that can be used to identify candidates for community placement.

For residents in nursing facilities, the Sub-Committee will promote the active use of RAI-MDS data to screen residents that are potential candidates for transition back into a community setting. The RAI-MDS data will help profile residents in terms of ADL/IADL status, cognitive status, mood/behavior, capacity to self-manage, interest in community placement and the presence of family or friends who have an interest in helping with a community transition. The Sub-Committee will undertake this initiative in conjunction with the Money Follows the Person proposal design and/or project team, if Delaware is awarded a MFP grant.

Providing Consumers Internet Access – The Sub-Committee will explore ways to encourage or provide support to consumers and/or informal family members with Internet access that are unable to secure access on their own. Internet access is increasingly a digital divide where those without Internet access are disenfranchised in numerous ways.

In summary, creating and implementing a next-generation care management model that enhances consumer self-management is a five-year priority for the Sub-Committee. As part of that priority, the Sub-Committee will encourage an integrated care management IT infrastructure that will support the introduction of a uniform assessment.

Goal 4: Build the commitment and capacity within State Agencies to develop, annually, a profile of consumers served by current state funded/administered programs based on the adoption of common, core consumer descriptors across key programs serving persons with disabilities.

Objectives and Key Action Steps	Performance Measure	Responsibility	Achieve By:	Public Policy/Legislative Initiatives	Fiscal Impact
Objective #1: Support the creation of a “data repository” or repository of consumer profile and services utilization/expenditure data on persons with disabilities by facilitating the implementation of a Medicaid funded, enterprise-level data warehouse capacity by DHSS.	Data Mart for Disability Service Programs in Place – DHSS, DOL, DSCYF	DHSS DMMA and DSS lead for Data Warehouse infrastructure	June 2010	Continued approval or reservation of funding for data warehousing initiative. (\$3 million currently set-aside)	Development Costs: \$50k Operating costs in data warehouse budget
Advocate for DHSS implementation of a data warehouse					
Provide input to the RFP to procure data warehouse product					
Facilitate/encourage interagency and interdivisional planning for data warehouse usage and support					
Facilitate development of specifications for the data sets and functionality of a data mart for disability programs					
Develop a query request that can be used to create an initial profile of persons with disabilities currently served by Medicaid					
Objective #2: Support the creation of a decision support system tied to a disability information repository that can support continued advocacy and policy analysis for state administered programs.	Annual Consumer Utilization Profile based on Data Mart	DHSS DMMA and DSS lead for Data Warehouse infrastructure	June 2011	None	Operational support and analysis -- \$40k/year for PT analyst
Develop an initial profile of Medicaid recipients with disabilities (for most recent full Medicaid year)					
Develop requirements for data mart query and analysis functionality required by the Commission or its representatives					
Provide input and guidance to initial prototyping of a data mart query and decision support tool set					
Review initial profiles and tabulations produced via the mart					
Make recommendations for refinement and expanded use of the data mart for policy development and advocacy					
Routinely review data mart reports once operational					

Goal 4. Background and Discussion: The Governor’s Commission on Community-Based Alternatives For Persons With Disabilities is a vehicle for advocacy, facilitating policy development for state-administered programs and encouraging program development. In all of these roles, the Commission depends upon timely and useful information about community needs/capacities related to persons with disabilities and descriptive data on current service delivery capacities and benefits. Ideally the Commission should be able to describe and analyze the full range of programs and services provided to persons with disabilities, regardless of whether it is a private or funding program. Realistically, the near-term focus is on publicly funded programs and more precisely state-administered programs.

At this stage, the Commission needs to establish the capacity to assemble and analyze data on persons served in the following programs:

- ❑ DHSS -- DDDS
- ❑ DHSS -- DSAAPD
- ❑ DHSS – DSAMH
- ❑ DHSS – DMMA
- ❑ DHSS – DVI
- ❑ DHSS – DLTCRP
- ❑ DHSS - DSS
- ❑ DOL- DVR
- ❑ DSCYF

At the same time, the Commission needs to work with state programs to support routine community needs assessments and/or acquisition of secondary data that help estimate the number of persons in Delaware with disabilities as well as their characteristics.



One data set is compared to the other. For this to occur we need to promote the use of common terms and descriptors to facilitate comparison.

Over the next five years the Sub-Committee will progressively expand the capacities to describe community needs and the clients served through state-administered programs, both individually and in the form of a composite profile.

Goal 4. Approach: Moving forward, the Sub-Committee will act as the clearinghouse and primary impetus for the collection and organization of data describing both those persons in the community needing services and those persons currently served by state-administered programs.

Given advances in IT technology, the Sub-Committee proposes to support the creation of a data warehousing/decisions support system capacity within DHHS that can be used to aggregate and analyze information on persons served, services provided and costs incurred for all key programs serving persons with disabilities in Delaware.

Creation of a Data Repository (Mart) for Disabilities Data: To facilitate timely and frequent use of the program utilization data for disability programs, the Sub-Committee will encourage the creation of a “data repository” for the key programs of interest to the Sub-Committee.

The data repository will have the following characteristics and capabilities:

- ❑ Incorporate key operational data collected by key programs serving persons with disabilities;
- ❑ Include information on persons served, services utilization and expenditures;
- ❑ Allow aggregation and comparison of data across programs;

- ❑ Rely on the adoption of common client descriptors across programs in the absence of a uniform assessment tool.
- ❑ Include tools for query and analysis of the data;
- ❑ Be operational within three years;
- ❑ Be updated with operational data at least annually, with a goal of updates at least quarterly within five years.

The data repository development will be facilitated by several near-term initiatives of the Sub-Committee designed to buttress the need for and value of a data repository. The Sub-Committee will, in the first year of the five-year plan, advocate with state agencies for the following:

Core Client Descriptors: Agreement on a core set of client descriptors that can be integrated into current IT applications as soon as possible. The initial list of common descriptors will be limited and include such universal descriptors as age, sex, race/ethnicity, zip code of residence. Where feasible, agreement will be sought on a second tier of descriptors such as living arrangement, marital status, type of residence, educational level, employment status, and certain health or functioning status indicators such as: ADL/IADL status, primary diagnosis etc. Additional common descriptors will arise by further analysis and discussion among program management staffs, facilitated and/or supported by the Sub-Committee.

Where commonality cannot be achieved, the Sub-Committee will encourage and support the creation of crosswalks of data terms and coding options that mitigate the disparity in data terms across individual programs.

Interim Steps in Anticipation of a Data Repository: Assuming the presence of a data repository is at least two or three years away, the Sub-Committee will seek to create several interim data products that can support advocacy and policy development in the area of disabilities.

Specific interim initiatives (to be completed in the next 24 months) include:

- ❑ Identification of a staff person in DHSS with a Business Objects license and the experience to analyze MMIS data on disability related services in support of Departmental planning and Commission projects.
- ❑ Acquisition of RAI-MDS data on all nursing facility admissions in Delaware by developing a data use agreement with CMS that will allow these federal data to be released to the State of Delaware for analysis purposes.
- ❑ Creation of an initial profile of Medicaid recipients who are considered disabled using MMIS data. The Sub-Committee will provide a list of programs whose clientele, in their entirety, are considered to be persons with disabilities as well as a list of client descriptors (including diagnoses) that can be used to screen all MMIS/DCIS recipient data to identify persons with disabilities.
- ❑ Develop an estimate of the unduplicated number of persons served with disabilities, taking in account multiple programs that a single consumer may be enrolled in as a client.
- ❑ Develop a profile of Medicaid expenditures across all categories of service for persons with disabilities.
- ❑ For individual Medicaid categories of service, develop a profile in the variability of spending for persons by disabilities within pre-defined cohorts like age and sex.
- ❑ Review, and as necessary, encourage compliance by all programs with the use of the Master Client Index maintained by DHSS. This would include DOL, DVR programs and possibly DSCYF programs as well.

- ❑ Review secondary sources of information that are available that provide prevalence rates that can be used for estimating the number of persons with disabilities in Delaware based on functioning levels, specific disabilities and related socio-demographics.

The Sub-Committee will establish the capacity through staff support to the Sub-Committee or working collaboratively with state agencies or academic institutions to periodically update the prevalence rates “library” and produce an updated community needs profile at least every two years.

Goal 5: Build the commitment and capacity within State Agencies to implement and utilize a common, core set of performance measures that measure the impact of current programs on persons with disabilities and/or their informal caregivers.

Objectives and Key Action Steps	Performance Measure	Responsibility	Achieve By:	Public Policy/Legislative Initiatives	Fiscal Impact
Objective #1: Institute an annual review of consumer benefits and impact based on the adoption of a common, crosscutting set of performance measures.	Annual Performance Measure Report	DHHS, DMS as lead	June 2011	None	.25 FTE or approximately \$25k/year
Facilitate development of a potential common performance measures that are consumer based					
Work with departments and divisions to achieve agreement on common performance measures to be adopted					
Development agreement on implementation plan					
Determine what changes in data collection, if any, will be required to support use of the common measures					
Develop a template for an integrated consumer impact/benefit profile (report layout and data presentation)					
Develop the initial presentation of performance measures					
Refine template as required to ensure utility to Commission and program measures					
Determine utility of cross-program comparisons based on use of common measures					
Use the profiles in advocacy efforts of the Commission					
Objective #2: Secure the inclusion of performance measures assessing the impact of state programs on persons with disabilities into the State and department annual strategic planning/budgeting process.	Core Measures Adopted by Department Divisions	DHHS, DMS as lead	June 2012	Departmental directives for amended strategic planning process	None, assuming the IT infrastructure to support outcomes measurement is in place.
Review current measures built into strategic planning process					
Develop a pilot test recommendation with selected Depts.					
Work with the Legislature to build support and the capacity to use consumer outcomes data					
Conduct the pilot test					
Evaluate test results and develop recommendations for inclusion of consumer outcome measures in annual budgeting					
Identify staff development educational needs that will support continuous quality improvement					

Identify Web technologies and platforms can support professional staff development.					
Establish a pilot project for staff development.					
Develop an annual quality review forum.					
Develop a best-practices library that all the programs can contribute to and use.					

Goal 5. Background and Discussion: As noted in Goal 4, the Commission serves in an advocacy role, facilitates policy development and supports program development initiatives. Just as timely and accurate data on consumers and their services use are critical to each of these roles, so is performance measurement data on current programs.

To chart new directions and pursue new ideas and innovation, it is important to know the benefits and results of current programs. The Sub-Committee, in this goal area, will seek to improve the capacity of program managers and, by extension, the Commission itself to measure performance/benefits of state-administered programs. Over time that capacity will extend to privately funded programs as well such as workmen’s compensation programs and specific disease management programs that include significant numbers of persons with disabilities.

Of specific and immediate interest is performance measures that highlight consumer conditions, capacities, circumstances and how they change as a result of services and supports provided from state-administered programs.

The targeted programs covered by this goal include:

- DHSS -- DDDS
- DHSS -- DSAAPD
- DHSS – DSAMH
- DHSS – DMMA
- DHSS – DVI
- DHSS – DLTCRP

- DHSS - DSS
- DOL- DVR
- DSCYF

Goal 5. Approach: The Sub-Committee will support the creation of a summary set of performance measures (outcomes or benchmarks) that can be presented to program administrators of state-administered programs for possible implementation and use. The measures will have “universality”, meaning they cover performance results of common interest across multiple programs. Other, program specific performance measures will continue to be used. However, the Sub-Committee will advocate for a common set of core performance measures that can be used to summarize aggregate performance across multiple state-administered programs.

Types of Performance Measurement: Generically, there are three types of performance measures of interest:

- Quality measures
- Utilization measures
- Impact or outcome measures

These categories are not strictly mutually exclusive. There can be some overlap depending upon the intended use and users.

The Sub-Committee will seek to standardize, where appropriate, performance measures for state-administered programs serving persons with disabilities. At the same time, the Sub-Committee will expand its

capacity to review performance of state-administered programs based on the implementation of a more standardized set of performance measures.

Realistically, there are limits to standardization. Outside regulatory bodies and individual federal funding sources dictate the use of various performance measures. State programs cannot simply abandon the use of current measures and adopt a new set of common measures. Rather, existing performance measures used within individual programs must be analyzed to determine what commonality exists and where opportunities for standardization or an acceptable “cross-walk” can occur.

External Requirements for Performance Measurement: The Sub-Committee, with consultant support, has reviewed, on a preliminary basis, national/federal reporting and performance measurement requirements of funding sources or accreditation bodies that bear on the task of performance measurement in Delaware. Notable examples include:

- DSAMH
 - NOMS – National Outcomes Measures mandated by U.S. DHHS, SAMHSA
 - TEDS – Treatment Episode Data Sets
 - JCAHCO/ORYX
- DSAAPD
 - NAPIS – National Aging Program Information System required by the U.S. DHSS Administration on Aging (AoA)
 - POMP – Performance Outcomes Measurement Project required by AOA
- DDDS
 - National Core Indicators from NASDDDS

CARF

- All Divisions Using Medicaid Funds
 - Waiver Requirements
 - CMS Quality Framework Draft Measures
 - RAI-MDS – used in nursing facility assessment and performance assessment
 - OASIS – used in home health assessment and performance assessment
 - NCQA – focused on managed care organizations serving a Medicaid eligible population
- DOL, DVR
 - Rehabilitation Services Administration standardized reporting and measurement guidelines

In light of the diversity of performance measurement tools and protocols in place, the Sub-Committee will seek simple, practical ways to move toward a more common/uniform outcomes framework for programs serving persons with disabilities.

Priority Initiatives: Specific initiatives to be undertaken and supported by the Sub-Committee will include:

- Sponsorship or facilitation of work sessions that can encourage the adoption of a core set of quality indicators and utilization measures by key programs. The focus of the quality indicators initiative will be HCBS. As appropriate, the CMS quality framework for HCBS will be used to support the identification of common quality indicators that can be used across individual programs.
- Promotion of a common set of consumer-oriented outcome or impact measures.

- ❑ Creation of a capacity within the State of Delaware to produce a periodic consumer outcomes report (at least every two years).
- ❑ Creation of an annual quality forum for all programs serving persons with disabilities to discuss common issues and approaches.
- ❑ Creation of a best practices and evidence-based protocols library that is Web-based and immediately accessible to program personnel responsible for program management or services delivery.
- ❑ Creation of a Web portal that can be accessed by program professionals to enhance their knowledge and skills – a form of continuing education and support.

Adopting Common Consumer Outcomes: A high priority for this goal area is the creation of a common set of client outcomes to use as a basis for advocacy and policy development by the Commission. These outcomes should reflect priority needs of persons with disabilities and be a common focus across programs. The Sub-Committee has supported a common review of potential common outcome measures. This review identified an initial set of consumer-oriented “impact” outcomes for use in the Strategic Plan of the Sub-Committee. The preliminary list includes:

- ❑ Is able to obtain or keep a job or enroll and stay in school.
- ❑ Has a safe, decent and stable place to live.
- ❑ Socially connected
- ❑ Practicing self-management consistent with capacities
- ❑ Averts/avoids crisis behavior and crisis episodes
 - Court/legal system
 - Emergency services due to risk behaviors (alcoholism/drug use, behavioral issues, etc.)

This initial list will continue to be refined over the next five years. The consensus outcomes will, in turn, be used as a framework for outcomes performance review within three years (no later than June 2010).

Measuring Consumer Satisfaction: The Sub-Committee will encourage and support the development of routine consumer satisfaction ratings with individual programs, as a long-term goal, across various programs serving persons with disabilities. The satisfaction measures will serve as a primary tool by the Sub-Committee to assess the quality of services from a consumer perspective.

As feasible, the Sub-Committee will promote the adoption of a common timeframe, methodology and tool for measuring consumer satisfaction with the goal of creating a comprehensive profile of consumer satisfaction across individual programs.

Integrating Performance Measures into the Strategic Planning Process of Both the Commission and State Agencies. Currently neither the strategic planning process of the Commission nor the strategic planning process of state agencies/divisions is based on consumer/client outcomes. In part this is due to the problems of measure creation, data collection and analysis of outcomes, especially those rooted in the changing conditions and circumstances of consumers/clients. While the Sub-Committee recognizes the difficulties of using client outcomes as a basis for strategic planning, the value of their inclusion is considerable.

Legislators will have better information on what programs are designed to accomplish and how consumers benefit by participating in the programs that are supported with state funding (including match funding for federal programs). This will not happen overnight. However, in the course of a five-year strategic plan, the Sub-Committee expects to be refine its own strategic plan to be more consumer-outcomes based while encouraging revisions in the annual planning and budgeting process used by state agencies to incorporate consumer outcomes measures more explicitly. This can begin modestly and proceed incrementally.

Cost Summary: The proposed five-year plan for the Sub-Committee involves an expanded purpose or mission and five goals related to improving the capacities of principally the public programs for persons with disabilities. The estimated costs for the plan by year are summarized in the chart below.

Objectives and Key Action Steps	Achieve By:	Year 1 7/1/07	Year 2 7/1/08	Year 3 7/1/09	Year 4 7/1/10	Year 5 7/1/11	Total \$
Goal 1: Promote the development and corresponding benefits of a cross-cutting, generic “model” for consumer self-management that can be integrated into State administered programs serving persons with disabilities.	January 2008	\$50,000 consulting services	\$0	\$0	\$0	\$0	\$50,000.
Goal 2: Consistent with the generic model for consumer self-management, enhance consumer and informal caregiver access to information and tools critical to self-management and self-directed care.	December 2008	\$200,000 for development	\$100,000 for development \$125,000 for operations	\$250,000 for operations	\$250,000 for operations	\$250,000 for operations	\$1,175,000.
Goal 3: Foster a consumer-oriented care management model and IT supports for care managers while ensuring residents of various facilities are properly assessed for community transition.	December 2009	\$1,000,000 for development	\$1,000,000 for development	\$200,000 for operations	\$200,000 for operations	\$200,000 for operations	\$2,600,000
Goal 4: Build the commitment and capacity within State Agencies to develop, on a periodic basis (annually), a profile of consumers served by current state funded/administered programs based on the adoption of common, core consumer descriptors across key programs serving persons with disabilities.	June 2011	\$0	\$0	\$90,000	\$90,000	\$90,000	\$270,000
Goal 5: Build the commitment and capacity within State Agencies to implement and utilize a common, core set of performance measures that measure the impact of current programs on persons with disabilities and/or their informal caregivers.	June 2012	.25 FTE or \$25,000	.25 FTE or \$25,000	.25 FTE or \$25,000	.25 FTE or \$25,000	.25 FTE or \$25,000	\$125,000
Total		\$1,275,000	\$1,250,000	\$565,000	\$565,000	\$565,000	\$4,220,000

Appendix I.

Current Mission and Goals of the Assessment Sub-Committee

The current mission statement of the Assessment Sub-Committee is:

- ❑ To educate clients regarding least restrictive living options;
- ❑ To develop appropriate tools to determine client's interest in least restrictive options;
- ❑ To provide assessments which will facilitate transition planning;
- ❑ To develop databases created through assessment findings to facilitate transition (through the engagement of all stakeholders in the process)

The current strategy statement includes seven goals related to the Sub-Committee's mission:

Goal 1. Establish and implement a practice of assessing all adult individuals regardless of severity of disability residing in nursing facilities, intermediate care facilities, and other institutions every three months to determine their desire for home and community based service options.

Goal 2. Every six months assess all individuals in nursing facilities, ICFs, ICF/MRs and other institutions who have expressed interest for community placement through the MDS assessment process to determine the needed support for home and community-based living.

Goal 3. Contract with a non-state agency(ies) to conduct an independent assessment, free from financial or other conflicts. Non-state affiliated agencies must conduct both initial and on-going assessments.

Goal 4a. Create a State-hosted database of assessment results and findings to include age, sex, disability, needs and preferences consistent with state and federal confidentiality requirements.

Goal 4b. The State of Delaware must use the databases created through assessment findings to facilitate the transition of individuals who desire community-based living in as expeditious a manner as possible.

Goal 5. Ensure that a process for assessing individuals with severe and persistent mental illness, cognitive disabilities, and physical disabilities exiting a prison system or involuntary treatment facilities is provided in a timely and appropriate manner prior to release.

Goal 6. Establish a fair and equitable process of assessing all individuals residing in other settings, such as group homes, natural family settings, or supportive living environments, to determine appropriate preferences and needs.

Goal 7. Develop and maintain a user-friendly array of up-to-date information that includes residential, health care, employment, transportation, and educational resources. This information should allow for a comprehensive list of available services to be used by service providers and individuals with disabilities, and all other involved stakeholders.

APPENDIX II.

**Proposed Features of a Uniform Assessment Instrument
For Use
In Delaware Programs Serving Persons With Disabilities**

Introduction: One important goal of the Sub-Committee has been adoption of a uniform, single assessment instrument that could be used across state-administered programs and services provided to persons with disabilities. VieBridge, as part of its study for the Commission, has analyzed what a uniform assessment instrument might include. The analysis results are summarized below in terms of the possible data domains for an assessment.

Each assessment domain should include a series of assessment questions and related responses. The most significant recommendation is for the inclusion of “triggers” that identify a possible problem or need. Triggers are combinations of responses to specific assessment questions.

The proposed assessment tool includes the following domains:

A. Face Sheet	M. Disease History
B. Cognitive Status	N. Health Conditions
C. Communication/Hearing Patterns	O. Pain
D. Vision Patterns	P. Falls/Fractures
E. Mood	Q. Oral/Nutritional Status
F. Behavior	R. Ulcer/Skin Conditions
G. Social Functioning	S. Informal Caregiver Supports
H. Essential Lifestyles Appraisal	T. Finances
I. Physical Functioning	U. Home Environment
J. Continence	V. Medications
K. Active Diagnoses	W. Current Services
L. Special Treatment/Care Needs	X. Recent Medical Care Episodes

Predictably, any attempt to create a uniform assessment results in a product that is full of compromises. Some program specific detail is left out. For certain programs, the scope of assessment will appear too broad. The challenge of a uniform assessment is inclusiveness. Different programs and services require different types of information when assessing needs, conditions or circumstances of the consumer -- for example, the requirement to assess for both skilled and unskilled services

or the requirement to assess persons of all ages or in multiple settings of care.

Embedded Assessment Concepts: The assessment domains that fit the range of programs supporting persons with disabilities are based on several basic assumptions, including:

- ❑ Be comprehensive
- ❑ Take a snapshot of the current situation
- ❑ Capture not just objectively defined, observable conditions but the consumers wishes, interests and goals, i.e. provide support to person-centered planning
- ❑ Review the capacities of informal caregivers
- ❑ Cover both skilled and unskilled services needs
- ❑ Work for all age groups including children.
- ❑ Be granular – collect enough details to support a targeted, explicit plan of care or services plan
- ❑ Provide for longitudinal assessment of consumers’ changing needs and circumstances
- ❑ Facilitate comparison of consumer needs and conditions by using closed-end responses.

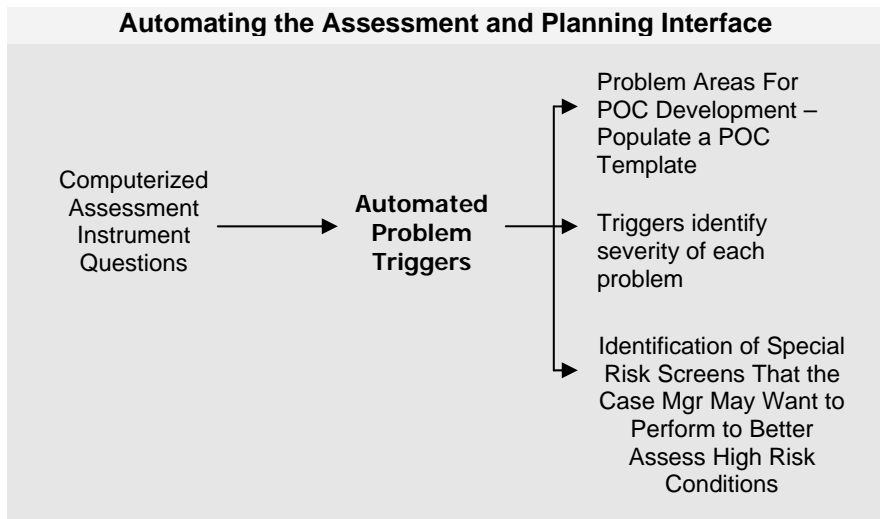
As constructed, the proposed assessment data elements are for use in support of care planning. It is not a simple screening tool but a comprehensive assessment tool. It is designed for automation. In fact, its power and potential is only realized if it is automated.

Implications for Planning: A major goal of assessment is improved planning for services. Design of an assessment tool necessarily includes consideration of the planning tools and processes that would take advantage of the assessment tool’s findings.

The Sub-Committee will encourage the creation of a planning methodology that incorporates person-centered planning concepts. The uniform assessment tool will provide a format and framework to capture information on a consumer’s interests, concerns, goals and preferences for services and supports.

The clinical and functional elements of the assessment tool will identify problem areas that a plan of care should address.

The Sub-Committee recommends the integration of traditional “plan of care” methodology with a planning process based on person centered planning. This is a critical departure from current practice.



One integrated planning format should be adopted and used for all services and supports while allowing for identification of tasks and activities identified as responsive to person-centered goals and interests.

For clinical and functional needs, the planning methodology should provide for the option of acuity scoring and be able to support case mix reimbursement. That way providers (and consumers) can implement individual plan budgets that reflect the complexity and level of service need (acuity).

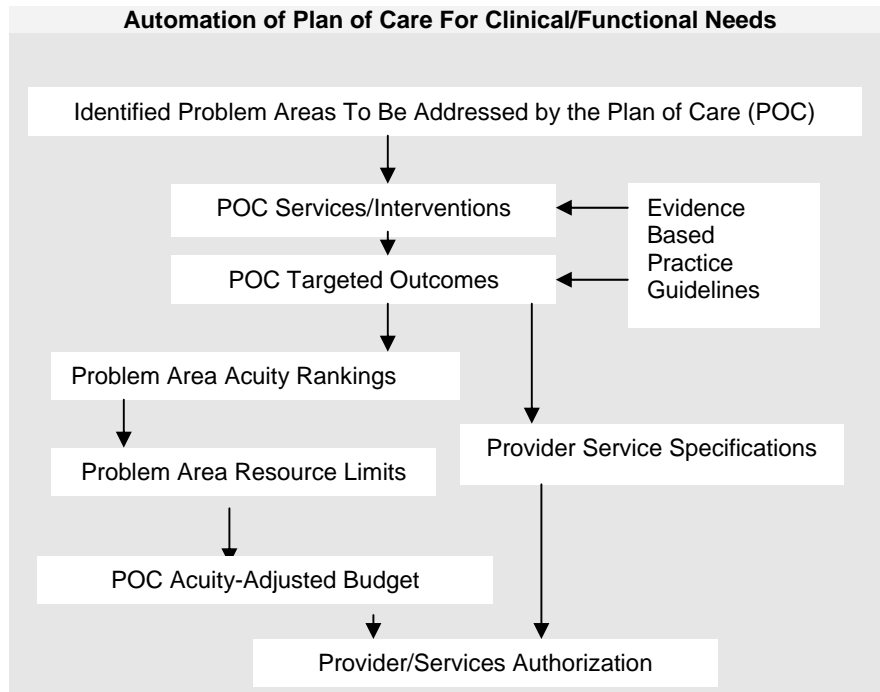
The plan of care methodology should allow for use of best-practice templates that allow the both consumers and care managers to have the benefit of what prior experience and research show as effective solutions to consumer needs.

All aspects of the plan of care should be automated, including the computerization of the goals, strategies and tasks tied to personal – centered needs and interests.

Provision for measurable plan outcomes is recommended. And provision should be made for outcomes tracking with the plan of care. The plan outcomes should be consistent with “program level” outcomes used for program management, policy development and advocacy. As example, employment outcomes used in an individual plan of care should be framed or expressed consistently with employment outcomes used to assess program performance.

Key quality measures and utilization management measures should be embedded in the assessment and planning methodology implemented as part of a next-generation care management model.

The Sub-Committee considers the development of a uniform assessment and a retooled plan-of- care methodology as a multi-year development project. Initially, DHSS, as a lead agency, will be encouraged to frame the essential elements of a next-generation care management model.



With these specifications, including work flow automation requirements, the design for an integrated care management information system that is supportive the next-generation care management design will ensure a new and improved model for care coordination emerges that empowers care managers to work closely with consumers in their journey toward self-management and greatly increases the accountability for consumer outcomes.

Collectively these recommendations are designed to encourage plans-of-care that will improve oversight, outcomes assessment and resource utilization across all state-administered disability programs.

APPENDIX III.

Potential Problem Areas Triggered by a Uniform Assessment

Introduction: The potential problem areas supported by a uniform assessment are listed in the left-most column. For comparison purposes, the problem areas supported by the current RAI-MDS assessment tool used by all nursing facilities are listed in the right-most column. In the middle column, the problem areas supported a uniform assessment tool developed for home care services, based on the RAI-MDS methodology, are listed.

Suggested Problem Areas	As a Point of Reference: RAI-HC CAPS	As a Point of Reference: RAI-MDS RAPS
Self-Management Difficulties	Adherence	
Informal Caregiver Deficits	Brittle Support System	
ADL Support Needs	ADL/Rehab Potential	ADL Functional/Rehab Potential
IADL Support Needs	IADL	
Fall Risks	Falls	Falls
<i>Lack of Fitness/Endurance</i>		
Mental Health Signs/Diagnoses	Psychotropic Drugs	Delirium + Psychotropic Drug Use
<i>Activity Deficits</i>		Activities
Socially Inappropriate/Disruptive Behaviors	Behavior	Behavioral Symptoms
Social Functioning/Isolation	Social Function	
Mood Issues	Depression and Anxiety	Mood State
Risk Behaviors (Alcohol/SA/Smoking)	Alcohol Abuse or Hazardous drinking	
<i>Psycho-Social Well Being</i>		Psychosocial Well Being
Cognitive Impairments	Cognition	Cognitive Loss
Abuse and Neglect Risks	Elder abuse	
Communication Disorder	Communication disorder	Communication
Vision/Hearing Deficits	Visual Function	Visual Function
Skin Conditions (Non Ulcer)	Skin & Foot Conditions	
Pressure Ulcers	Pressure Ulcers	Pressure Ulcers
Nutrition (Other than obesity)	Nutrition	Nutritional Status
Obesity		
Dehydration	Dehydration	Dehydration/Fluid Maintenance
<i>Respiratory Conditions</i>	Cardio-Respiratory	
<i>Cardio-vascular Conditions</i>	Cardio-Respiratory	
Allergies		
Persistent Pain	Pain	
Urinary Incontinence	UI/indwelling catheter	UI/Indwelling catheter
Bowel Incontinence	Bowel Mgt	

Oral Health Problems	Oral Health	Dental Care
Skilled Treatment Needs		
Telehealth/Monitoring		
<i>Death and Dying</i>	Palliative Care	
Home Safety/Comfort Problems	Environmental Assessment	
<i>Housing Need</i>		
<i>Transportation Needs</i>		
Medications Mgt Difficulties		
Assistive Devices		
<i>Employment Assistance</i>	Institutional Risk	Feeding Tubes
	Preventive Health Measures	Physical Restraints
	Reduction in Formal Services	
	Health Promotion	

APPENDIX IV.
Consultant Qualifications

Alan Ackman

Project Consultant

Mr. Ackman has over thirty years experience working in health and long term care programs as a consultant and systems analyst. He has in-depth experience and knowledge of home and community-based long term care programs, having worked with numerous federal and state funded aging and disability programs since 1972. He has worked with the U.S. Department of Health and Human Services on numerous projects in the past thirty years and with state agencies in twenty-six different states on various initiatives focused on improved health and long term care services delivery and business processes.

Mr. Ackman has also provided extensive assistance to community health and long term care providers throughout the U.S. and Canada in the areas of disease management, managed long term care, and the use of enabling technologies to enhance patient outcomes. Mr. Ackman has also provided consultant support to major U.S. and international companies seeking to develop new solutions for health care that target seniors and other persons with disabilities.

Mr. Ackman has led various projects focused on enhanced services delivery to homebound elderly, improving I&A and care management processes and refining program management capacities at all levels. He has been a primary consultant on state and local initiatives in several states to introduce a single portal of entry concept. He was the lead consultant on the federal NAPIS reporting initiative following the Congressional mandate for client tracking and reporting. He was heavily involved in the health care reform planning at the federal level in the early Nineties and has worked with many State Medicaid waiver initiatives across the U.S., including those seeking to introduce global budgeting,

managed LTC principles, performance contracting and case mix technologies into Medicaid funded HCBS programs.

Employment	Related Project Experience	
VieBridge, Inc. Herndon Virginia	President	2002 to Present

Mr. Ackman founded VieBridge as a specialty provider of Web-based applications for the chronic health care market. As founder, Mr. Ackman has been responsible for developing a new product for the chronic care market, raising development funding and building alliances and opportunities with other companies. Example projects managed by Mr. Ackman include:

NC Department of Health and Human Services, Division of Medical Assistance (Performed as personal consultant) (2005-2006): Provided consulting assistance to DMA in the development of a direction for HCBS enhancements, developed the specifications for a uniform screening program for long term care now being implemented, developed the initial specifications for automation of assessment and care planning functions as part of a integrated model for care management capable of supporting HCBS and adult care home programs. Helped reshape the basic framework and financial impact assessment for a utilization review program for Medicaid PCS services. Developed the initial specifications for a case-mix reimbursement methodology that can be implemented with Medicaid waiver programs (and other HCBS programs) in response to a legislative mandate. Drafted sections of the CMS Systems Transformation Grant application that was funded in September 2006. In the course of providing the assistance, Mr. Ackman worked closely with the DMA clinical policy and program section responsible for facility and community care programs.

State of Delaware: Governor’s Commission on Community-Based Alternatives For Persons With Disabilities (2006 – Present): Serving as consultant to the Commission with responsibility for development of recommendations for realignment of State funded programs serving persons with disabilities, focusing on integrated assessment, performance measures/outcomes, and tools and content that can enhance consumer self-management.

Chronic Care Consortium of NJ (2002- 2006): Principal consultant and architect for design of innovative models for use of Web technology/IT services to enhance continuity of care and self-management capacities of seniors and the physically disabled. Currently consulting and coordinating a special two-year grant from the Robert Wood Johnson Grant awarded to the Consortium to look at innovative use of Web technologies to promote disease self-management for CHF, diabetes and obesity.

VNA of Central Jersey (2003- 2005): Managing two year test of telehealth technologies designed to enhance client learning, improve remote monitoring of vital signs and enhance care management capacities for regular home health clients and their Medicaid waiver clients (Aging and Disabled and HIV/AIDS).

CentraState Healthcare System (2002-2004): Managed project to assess new ways to enhance post acute care based on enhanced risk screening/assessment and use of Web technologies for post acute/outpatient education services and with their Health Awareness Center programs.

The Groves, Kansas City, Missouri (2004- Present): Assisting this large CCRC examine how to diversify into community services and at the same time strengthen quality of services based on use of IT/Web technologies related to risk screening, assessment, satisfaction instruments, and disease management models.

Monmouth County Office on Aging (2003 – Present): Managed development of VieBridge Connections as a Web-based tool for enhancing capacities of care managers/care coordinators to work with frail, at-risk seniors and informal caregivers using a comprehensive Web portal. VieBridge Connections has been successfully tested and is now in day-to-day use in Monmouth County with plans underway to expand its use to multiple target populations and with widespread sponsorship and usage of local health and social service providers.

Nestlé/WalMart Joint Initiative (2004 – 2006): Principal consultant to a joint Nestlé and WalMart strategic initiative in the area of wellness and chronic care focused on the use of Web technologies and innovative models for self-management. Responsible for design of models for use of self-screening and self-management tools that will enhance employee wellness and redefine commercial offerings to persons struggling with chronic conditions or basic issues of wellness.

State of New Jersey (2003): Conducted initial system requirements analysis for the design of enhanced intake, screening and I&A services associated with a single portal of entry model for publicly and privately funded home and community based long term care services.

Millenium Healthcare Solutions – Edison NJ	Chief Operating Officer	1997 - 2002
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MHS is a spin-off from AT&T as part of the AT&T trivestiture in 1996 that was formed in order to exploit the use of telecommunications technologies to improve health care delivery. This multi-million company specializes in the provision of telehealth applications that support remote diagnosis, treatment and education of patients. As COO, Mr. Ackman was responsible for deployment of over thirty scientists, engineers and systems consultants in support of product development and customer operations. Directed project planning and execution for multiple projects and office locations, served as part of the senior

management team, directed all health and chronic care projects. Specific projects managed or overseen by Mr. Ackman included:

Michigan Department of Community Health (1999 – 2001): Development of telehealth program for use in the Michigan Medicaid waiver program, involving a pilot in five different regions of the state.

Pardee Hospital (2000 – 2001): Installation of telehealth program, focusing on the installation of telehealth units for use by community case managers and the hospital’s home health agency. Developing, testing and supporting software applications, which support the Pardee Hospital geriatric, care programs as well.

New Jersey Department of Health and Senior Affairs (2000 – 2001): Introduction of telehealth applications to local county programs, initially focusing on the clients of the NJ EASE case management programs (in four counties) and nutrition programs.

Delaware Department of Health and Social Services (2000 – 2001): Development of a design for a data warehouse and decision support model to support the Department’s management of a diverse, complex and expensive set of long term care programs that serve a frail, chronically ill population.

NC Institute of Medicine – (2000 – 2001): Development of forecasts of the demand for long term care services based on risk criteria and eligibility standards now in force for public programs, focusing on the State of North Carolina.

North Carolina Department of Health and Human Services, Division of Medicaid Assistance (2000-2001): Introduction of prototype assessment software into a sample of North Carolina counties operating a Medicaid waiver program that funds a broad range of home and community based services to frail, chronically ill elderly and physically disabled.

U.S. Department of Health and Human Services, Public Health Service (1999 – 2000): Developed guidelines and specifications for information system requirements and outcomes measurement for public mental health systems administered by all 50 states.

Mecklenburg County Department of Social Services (Charlotte, North Carolina) – In conjunction with Nestlé, sponsorship of Nutrition 2000, a research project involving a new model for the provision of home delivered meals, based on the use of new automation technologies, frozen meals, risk assessments and new home delivery models.

SAVANT, Inc. Reston, VA	Chief Consultant	1973-1996
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As chief consultant, Mr. Ackman directed a specialty consulting and software development practice for over twenty years focused on health and long term care markets. He personally directed dozens of projects funded by government agencies and contracts with health care providers, insurers and private corporations interested in reaching the health care market with new products. SAVANT, Inc. was acquired by Millennium Healthcare Solutions, Edison, New Jersey. Examples of projects directed by Mr. Ackman while at SAVANT include:

Delaware Department of Health and Social Services (1996 -- 1998): Part of a team selected to help Delaware assess the implications and options for use of managed care concepts in support of publicly supported long term care, especially services funded through the Medicaid program. Responsible for computer modeling, forecasting and cost estimation of different options for managed long term care. Under a separate contract, developed a multi-year plan to improve the management and information systems capacities of the Department in the area of long term care. The plan highlights the implementation of outcome measures and a data mart for long term care performance data.

Detroit Area Agency on Aging (1998 - 1999): Responsible for the redesign of the home delivered and congregate meal programs (serving over 4,000 meals per day). The redesign included the procurement process, operations, assessment, meal delivery and quality assurance. The role of the home delivered meal program was also considered in the new Medicaid Waiver program run by the Area Agency.

The Groves, Independence, Missouri (2001): Responsible for the development of a market analysis and strategic plan for a large continuing care retirement community in Independence, Missouri, based on an excellence model. The strategic planning process involves working with a strategic planning committee composed of Board and staff of the organization. The plan will be used to guide investment decisions by the sponsoring organization and specific changes to day-to-day operations of the independent living facility, assisted living facility and 300 bed nursing facility.

State of Michigan (1998 – 2000): Provided technical assistance on the development of options and approaches to introduction of managed care concepts to publicly funded long term care programs. Responsible for assessment of operational implications to local agencies of a transition to managed long term care.

New York City Department for the Aging (1997): Provision of assistance in the development of a design and implementation strategy for managed long term care suitable for the large, complex service delivery system in place in New York City and the specific role of the Department for the Aging.

Nestlé SA (1997): Providing assistance in developing strategies for enhancing the provision of nutritional services to a homebound population. Responsible for site development and testing of new strategies.

North Carolina Department of Health and Human Services (1997 -- 1998): Provided assistance in the development of strategies and action plans for long term care, focusing on improved access mechanisms and options for coordinating or integrating health and long term care for the elderly and

disabled populations using provider networks. Developed concepts to guide a set of demonstration projects. Developed systems specifications to support clinical management and care coordination activities to be performed by provider networks formed under the new strategy.

Departments of Health and Social Services, Unifour Counties, North Carolina (1997 - 1998): Responsible for an analysis of the strengths and capacities of local public agencies and long term care services providers in a four county area (Alexander, Burke, Caldwell and Catawba Counties) to initiate community level changes in the long term care delivery systems. Provided technical assistance on the design of a provider network for long term care and related implementation strategies.

Administration on Aging, U.S. Department of Health and Human Services (1997-1998): Responsible for development of initial designs for an evaluation of federally funded programs which support the provision of community based long term care services. Also, served as consultant on the design of an evaluation of the AoA programs included in Operation Restore Trust, a federal initiative to combat fraud and abuse in Medicare and Medicaid programs.

American Association of Retired Persons (AARP) and the National Assoc. of Area Agencies on Aging (1996 - 1997): Provision of analysis support in a study of Medicare risk contractors and their contacts with, and use of, community based long term care services and the capacities of area agencies on aging.

Hawaii Executive Office on Aging (1996): Provided training and technical assistance on performance based management, the introduction of management information systems responsive to external reporting requirements and the introduction of performance contracting procedures.

Florida Commission For Long Term Care (1995 -- 1996): Responsible for the development of forecasts of service use and costs associated with the frail elderly and physically disabled populations in Florida. Developed a forecasting model designed to test assumptions and policy options related to

nursing home use, assisted living and home care options incorporating multiple variables related to functional disability levels, cognitive impairment status, economic factors, resources and bed supply. The forecasts were used by legislative staff to help frame long range and short term strategies for long term care reform in Florida. This work was coordinated by the University of South Florida and Florida International University.

North Carolina Department of Human Resources, Division of Aging (1994 - 1996): Responsible for the evaluation of two pilot projects, which test different models for managed access for the high-risk elderly. Assessed the effectiveness of models for managed access, the protocols for linking health and long term care services, procedures for assessment, care planning and enrollment in services. Reviewed services utilization and client outcomes. The Kate B. Reynolds Charitable Trust funded the project and related evaluation.

D.C Office on Aging (1996): Provided training and technical assistance on issues related to performance reporting and analysis of contractual data supplied by the service providers supported by the Office on Aging.

Oregon Department of Human Resources, Senior and Disabled Services Division (1996): Coordinated work sessions aimed at development of managed care organizations able to offer long term care services under a risk arrangement, either as a separate plan or combined with Medicare funded primary and acute care services. Responsible for background analysis, development of options and facilitation of discussion of the options.

State of West Virginia (1994 - 1995): Provided assistance to the Health Care Reform Commission and the Department of Human Resources in the development of a service delivery model(s) for long term care based on the concept of managed care. Assisted a managed care task force/work group through the concept formulation, analysis and proposal development phases. Developed concept papers to support the process.

Duke Endowment/Valdese Hospital (1992-1995): Served as Principal Consultant of three year study to develop new models for integrating hospital care with community services based on the use of clinical pathways, case management and targeting of high utilizers among the rural elderly in three hospital service areas in North Carolina. The project was supported by a grant from the Duke Endowment and involved working with multiple rural/community hospitals as pilot sites for clinical pathways development.

National Aging Information Center (1995- 1997) Responsible for strategic planning and overall direction of the Center's training and technical assistance activities. The Center, funded by the U.S. Department of Health and Human Services, was organized to be a key technical resource to agencies and organizations providing long term care services to the elderly. The staff included information services specialists, statisticians and systems analysts, all of whom were focused on increasing the use of information systems technology, performance management and information utilization capacities of long term care organizations.

Administration on Aging (AoA), U.S. Department of Health and Human Services (1992-1998): Provided support to AoA staff in the development of the national reporting requirements related to the creation of the National Aging Program Information System (NAPIS). Organized and facilitated the work of two task forces providing input to AoA on reporting requirements. Prepared the draft requirements and all subsequent revisions. Prepared technical assistance and briefing materials on NAPIS for internal use by AoA and distribution to the National Network on Aging. Developed the guidelines for electronic transmission of the data and suggested methods for organizing reporting systems in states to comply with the AoA NAPIS requirements. Conducted national evaluation of the feasibility of the new reporting requirements. Provided assistance in development of the submission of NAPIS to the Office of Management and Budget for approval.

Administration on Aging (AoA), U.S. Department of Health and Human Services (1992-1995): Provided support to AoA staff in the design and development of a statistical data base, in support of health care reform, on

home and community based services provided to the functionally impaired elderly in all fifty states. Developed the detailed survey instrument used to collect information from all states; reviewed and edited all survey data, prepared various profiles and tabulations of the data for use by AoA. Developed analyses in support of Health Care University, Congressional hearings and briefings for other federal agencies. The effort also entailed acquisition and integration of other data sets describing home and community based long term care at the state level.

State of Ohio (1994 - 1995): Provided assistance to the Ohio Department of Aging in designing and implementing an outcome-based approach to management of home and community based care programs for the elderly. Responsible for designing a plan of reorganization of the Department of Aging; development of new management processes at the state and sub-state levels which incorporated principles of managed care and outcomes management to use as a basis for contracting and quality assurance.

Independence Regional Health Center, Kansas City (1986- 1992): Provided on-going assistance to a 450 bed hospital in design and implementation of a long range plan addressing the development of a comprehensive service

system for older persons, including forecasting service needs, analysis of case mix data, design of consolidated models for utilization review, quality assurance and case management plus design of a membership program for seniors sponsored by the hospital.

Blue Cross/Blue Shield of Kansas City (1986-1987): Developed a design for case management and community-based services to Medicare enrollees of the Total Health Care HMO, a Blue Cross subsidiary serving the Medicare managed care market.

Rush-Presbyterian -- St. Lukes Medical Center, Chicago, Illinois (1986-1987): Assisted in design of a master plan for linking the capabilities of the Bowman Center for the Elderly, a skilled unit with multiple community services, to Anchor HMO, a Medicare qualified competitive medical plan.

Education

Proficiencies and Training

Bachelors of Arts and Masters Studies -- Systems
Methods/Government 1967 and 1969 – University of Illinois