Local Perspectives on Opportunities for Medicaid Reform

A NYS CLMHD Technical Assistance Project

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Background
The New York State Department of Health (NYS DOH), together with the Office of Mental Health (NYS OMH), the Office of Alcoholism and Substance Abuse (NYS OASAS) and the Office of Mental Retardation/Developmental Disabilities (NYS OMRDD), is interested in soliciting input from a number of stakeholder groups regarding practical ideas and suggestions to improve the service delivery system for individuals with special needs. Of particular interest are suggestions regarding:

- Opportunities to redirect funds from expensive to more cost-effective services;
- Opportunities to enhance systems collaboration; and
- Opportunities to improve services for special populations—particularly those served across multiple systems.

Representing local mental hygiene directors and commissioners in each of the 57 counties and the City of New York, the New York State Conference of Local Mental Hygiene Directors (the Conference) is extremely well-positioned to respond to the state agencies’ invitation for input. Directors of community services face the daily challenges associated with planning for and delivering services to meet the needs of individuals and families affected by mental illness, developmental disability and/or chemical dependency, and as such, have an important perspective to share.

To formulate a consensus-based response to the State, the Conference invited its members to participate in a structured focus group with the following objective: “To develop a practical overview, from the perspective of local directors of community services, that focuses on the key issues related to more effective and efficient management and delivery of Medicaid-funded services to individuals with mental health, chemical dependency and/or mental retardation/developmental disabilities needs.” This paper presents the key strategies that emerged from that process and is intended to serve as a springboard for further discussion.

Methods
Data to inform this response were initially gathered during a three-hour focus group session involving representatives from five counties and New York City. Efforts were made to ensure that the group was balanced to represent both urban and rural counties, direct service providers, as well as counties that contract with community-based providers for services.

During the course of the session, participants were asked to consider the three primary populations—those with mental health needs, those with chemical dependency needs, and those in need of MRDD services. Within in each group, discussion focused on specific subpopulations of special concern and aimed to describe:

- What the local service delivery system should look like—the ideal state;
- Ideas that seem to be working at the local level—innovative approaches we can build on;
- Barriers—elements that prevent counties from working most effectively at the local level; and
- Action steps—recommended changes to address identified barriers and move counties closer to the ideal state.

Note that while the questions focused on Medicaid-funded services, discussion regarding issues and potential solutions extended beyond Medicaid to include other essential supports. Results of the focus group were synthesized and then shared with participants for review, comment and expansion. To help ensure that the feedback received was sufficiently representative, the information was shared with

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1 Participants in the initial focus groups included: Arthur Johnson (Commissioner, Department of Social Services and Office of Mental Health – Broome County), Brian Hart (Director, Community Services – Chemung County), Larry Tingley (Director, Community Services – Jefferson County), William Swingly (Director, Community Services – Ontario County), George Roets (Director, Community Services – Schuyler and Yates counties), Trish Marsik (Assistant Commissioner for Mental Health – NYC) and Richard Delaney (Director for Policy & Planning, DOHMH – NYC).
several other counties for additional input\(^2\). While some needs expressed were unique to specific counties, there was general agreement regarding core issues. In addition, there was the sense that any steps taken to reform Medicaid, and to transform the system more broadly, ought to be guided by some core concepts, including:

- Focus on the individual in the development of a personal plan of care, including mental health, chemical dependency, and physical health care.
- Offer more flexibility in the use of funding for services.
- Provide real choice for individuals in selecting the services/options needed to achieve their individual goals and objectives.
- Measure outcomes and use these data to inform decision-making.
- Promote disease management and care management approaches, including those that address critical social and environmental factors, to produce a shift from high-cost to lower-cost care.
- Develop integrated health care information systems linking patients and all levels of care.

With these concepts as a backdrop, we believe the central themes outlined in the sections that follow, along with the more specific strategies offered, resonate with local directors of community services across the State. As becomes very clear in review of these themes, a central, cross-cutting concern relates to the silos that local Directors of Community Services—and ultimately the people they serve—operate within. There are simply too many disconnected segments (e.g., regulations, reimbursement, information management systems, etc.) in what should be a comprehensive continuum of care. Integration and elimination of these silos is critical not only to reforming Medicaid, but the healthcare system as a whole.

**Ensure Access to Basic Supports**

There is a subset of recipients whose interactions with the Mental Health and/or Chemical Dependency systems are characterized by sporadic episodes of expensive acute care (emergency department and/or inpatient), with suboptimal engagement in the more cost-effective, community-based services needed to support progression toward recovery. Many of these individuals lack access to the very basic supports needed to maintain the continuity essential to maximize the impact of mental health or chemical dependency services. These consumers cycle on and off of Medicaid coverage, often resulting in service interruptions. Finding better options to reduce the regulatory and fiscal complexity and break this cycle is critical to effective local management. The CLMHD also encourages all measures to reduce the number of uninsured individuals across the State. The recently adopted measure which will suspend rather than terminate Medicaid coverage for jail inmates is an example of a progressive policy initiative supporting community integration for persons with significant mental health needs.

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\(^2\) Counties providing input via review and comment included: Susan Delehanty (Director, Community Services – Franklin County), Phil Endress (Commissioner, Erie County Department of Mental Health), Sherrie Gillette (Director, Community Services – Clinton County), Margaret Hirst (Division Chief – Chemical Dependency Services, Dutchess County Department of Mental Hygiene), Robert Long (Deputy Commissioner, Department of Mental Health – Onondaga County), Michael O’Leary (Director, Community Services, Columbia County), and Steve Snell (Director, Community Services – Wyoming County).
Strategies to Consider: Options to improve services include:

- Work with the State to improve or streamline Medicaid eligibility requirements and recertification process. Strengthen efforts to achieve health insurance coverage for all residents. *(Improve Services to Special Populations)*
- Identify flexible funds to serve as a bridge so services can be maintained while coverage is reinstated. *(Improve Services to Special Populations)*
- Provide training and education for local Department of Social Services staff in working with the vulnerable populations that fall under the auspice of local departments of mental hygiene. *(Enhance Systems Collaboration)*
- Target specialized case management strategies toward this difficult to engage population, evaluate the outcomes, and fine tune approaches as needed. *(Improve Services to Special Populations)*

The above all have implications for enhancing service continuity and improving care for those hardest to engage and serve.

More safe and appropriate housing options are needed in most areas. Without this essential support, consumers experience less stability and use expensive, acute services more frequently. While it makes sense to work with the State to obtain additional OMH, OASAS and OMRDD licensed housing where possible, in most areas, this option will not be enough to meet current needs. In particular, OMH-licensed congregate housing is less than ideal for many consumers, both because of the relatively high cost and the segregated settings. Other options will need to be explored.

Strategies to Consider: Options to address constraints related to housing could include:

- Provide funds for flexible housing. In many cases, resources are eaten up by expensive housing options which could be reinvested and devoted to more “natural setting” solutions with support, stretching dollars, facilitating community integration (and therefore sustainability) and promoting recovery. Different counties or regions could take some new housing dollars, existing housing capacity or a combination of the two, and convert the resources into flexible alternatives in the community. *(Redirect Funds to More Cost-Effective Options; Improve Services to Special Populations; Enhance Systems [County] Collaboration)*
- Expand more cost-effective housing strategies (like supported housing) and develop new models to effectively support individuals with serious mental illness (SMI) in scattered sites. *(Redirect Funds to More Cost-Effective Options; Improve Services to Special Populations)*
- Utilize wraparound dollars and other flexible local funds to purchase housing from local property manager(s)—with other needed supports “pushed in”—regardless of what service system they are coming from. *(Redirect Funds to More Cost-Effective Options; Improve Services to Special Populations)*
- Promote the dissemination of effective local housing models across counties to encourage/support innovation in this area. *(Redirect Funds to More Cost-Effective Options; Improve Services to Special Populations)*
- Allow needed services and supports to be provided at licensed housing programs that are overseen by a “sister” state agency so that the complex needs of individuals are met in a collaborative and comprehensive manner. *(Enhance Systems Collaboration; Improve Services to Special Populations)*
- Provide more State aid dollars to ensure essential but non-Medicaid reimbursed services are adequately funded. *(Improve Services to Special Populations)*
✓ Explore incentive-based reimbursement models that reward positive outcomes. At a minimum NYSOMH could support incentive and outcome-based reimbursement pilots connected to implementation of the PROS program and in its new initiative to restructure mental health outpatient payments. *(Improve Services to Special Populations, Redirect Funds to More Cost-Effective Options)*

Additional funding in this area, coupled with more flexibility and local creativity in the use of existing dollars, could result in a shift from higher-end, more costly services to more cost-effective options—providing essential support to more individuals, and building systems that are more sustainable locally.

**Services and Supports Must Be Driven by the Needs of the Person**

For all disability areas (mental health, chemical dependency, MR/DD or some combination thereof), care should be driven by the goals, dreams, and wishes of the individual—not by categorical funding and current services. While there is strong agreement that the person-centered approach optimizes the prospects for recovery and community integration, additional resources will be required at the local level to expand this approach. Resource needs include:

- Staff training, education and ongoing support in emerging and best practice models; and
- Some level of flexible funds to purchase services and supports not currently offered as part of the current service delivery systems.

**Strategies to Consider:**

✓ Support the blending/braiding of categorical funding to provide a “single checkbook” for use in delivering person-centered care. This could take the form of a partnership with a managed care organization (a strategy currently pursued by the Western New York Care Coordination Program), or one of several “self-directed care” models being piloted in other states. Key to either option will be removing bureaucratic barriers and supporting a local locus of control. *(Redirect Funds to More Cost-Effective Options; Improve Services to Special Populations; Enhance Systems Collaboration)*

✓ Establish a mechanism for cross-systems licensure reciprocity that would allow for service co-location. We need to be able to serve people in integrated settings. *(Improve Services to Special Populations; Enhance Systems Collaboration)*

✓ Support and promote community-based research. That is, encourage line staff to discover what works best locally, but provide the technical assistance needed to evolve new approaches into legitimate, evidence-based practices. *(Improve Services to Special Populations)*

Each of the above strategies has implications for improving care to those served across systems.

**Integrate Services – Mental Health, Chemical Dependency, MR/DD and Physical Health Care—Including Pharmacy**

The needs of those who are most difficult to serve are complex and many individuals are served by multiple systems. While we are dealing with a population challenged by chronic illnesses, the current system is largely based on an acute care model that assumes a person diagnosed with a mental illness (or chemical dependency problem) is treated and then recovers (much like one does from a broken leg). Serious mental illness, however, is a chronic disease that is often cyclical in nature—recovery is not linear. It is also profoundly impacted by concomitant social and environmental conditions. As such, a “chronic disease management” model (such as those used effectively for individuals with diabetes or COPD) is much more appropriate for this population. There needs to be ongoing care management and services that flex with the individual’s current needs (intense at times, and less intense most of the time).
In addition, providers must be able to collaborate and to exchange critical information about care plans, goals, medications and other health concerns. We need to be able to create incentives for organizations and individuals to address the more complex needs of individuals in a way that promotes recovery. In order to move in the direction of more integrated services, counties need:

- A model (or models) for integrated service coordination (including managed care). This should include the opportunity for services and staff to move with the person over time through their recovery;
- Training, education, and ongoing support for staff to effectively assume this responsibility; and
- The information management capacity to assemble and provide access to the data necessary to support this process (or established relationships with organizations that have this capability).

**Strategies to Consider:**

- The Personal Health Advantage Plan, as envisioned under the next phase of the Western New York Care Coordination Program, provides a model for how this approach could work at the local and regional level. *(Redirect Funds to More Cost-Effective Options; Improve Services to Special Populations; Enhance Systems Collaboration)*
- Foster opportunities for counties to learn from organizations in other states that are making inroads in this area and determine how these practices can be deployed locally. For example, Community Care, a Pennsylvania-based behavioral health Medicaid managed care plan, is having success with their clinical care management program. This program targets high-cost users and aims to shift service use patterns through screening, utilization management, and provider collaboration (including offering training to providers in dealing with high need clients). *(Redirect Funds to More Cost-Effective Options; Improve Services to Special Populations)*
- Explore opportunities for partnering with local insurers/foundations to fund and evaluate other options for improving service integration. *(Improve Services to Special Populations)*

**Provide More Funding Flexibility/Local Control**

Directors of Community Services and their staff are knowledgeable about the needs of the populations they serve and the resources within their communities. At present, there is clear focus on:

- Improving coordination of services for clients served across systems to enhance care quality and use resources most effectively;
- Structuring individual services plans in accord with the person’s goals and priorities; and
- Taking better advantage of naturally occurring community supports and resources to develop sustainable plans for recovery.

As such, local Directors of Community Services could be extremely well-positioned to drive the innovative practices in response to current needs. However, to do so, more funding flexibility at the local level is needed.
Strategies to Consider:

✓ Create additional opportunities for priority populations that would allow for blended funding. Incorporate performance expectations and measures so that new models could be evaluated for effectiveness in achieving desired outcomes (e.g., a local, capitated model where the LGU controls the flow of dollars and payments are tied to outcomes). *(Improve Services to Special Populations)*

✓ Explore options for improved integration of community-based and state-operated mental health services. For example, OMH could consider a pilot program where localities would assume the responsibility for managing the use of state-operated specialized services based on a budget that offers service flexibility and the opportunity to generate savings for reinvestment in less costly, community-based services. *(Redirect Funds to More Cost-Effective Options)*

We believe that pursuing the strategies outlined above would result in more effective and efficient management and delivery of Medicaid-funded services to individuals with mental health, chemical dependency and/or mental retardation/developmental disabilities needs. In addition, each of these strategies is tied—either directly or indirectly—to areas of special interest to leaders at the Department of Health, Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office of Mental Retardation/Developmental Disability, including:

- Opportunities to redirect funds from more expensive to more cost-effective services;
- Opportunities to enhance systems collaboration; and
- Opportunities to improve services for special populations—particularly those served across multiple systems.

We hope this brief overview provides a springboard for the more detailed conversations needed to advance these ideas.
<table>
<thead>
<tr>
<th>Population</th>
<th>Desired State</th>
<th>What Is Working at the Local Level? (Best/Promising Practices)</th>
<th>Barriers (What Gets in the Way?)</th>
<th>Action Steps (What Can Be Done to Remove/Get Around the Barriers?)</th>
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</table>
| Mental Health: Subgroups of special concern: | • Integration of all essential services—mental health, chemical dependency, MR/DD and physical health.  
  o Chronic conditions are of particular concern for this subgroup.  
  • More management capacity at the local (county) level—need to be able to track recipients moving in and out of care and look at the full spectrum of services.  
  • Ability to offer differential reimbursement rates—to correspond to different levels of service and to incentivize service providers and performance.  
  • Assisted Outpatient Treatment (AOT).  
  • ACT Teams—particularly in rural settings.  
  • Care Coordination based on individual needs and goals. This approach is proving effective within the 6-county Western New York Care Coordination Program.  
  • One Finger Lakes region county is utilizing wrap dollars and other flexible funds to purchase housing—with needed supports pushed in.  
  • Medication management—NYC has seen some success with this.  
  • PROS—potentially useful model. Will need to work to determine how to implement successfully at the local level.  
  • Pre-paid mental health plan is working well in Broome County. Provides a coordinated plan and can pay for a fuller complement of services.  
  • Service interruptions due to people who cycle on/off Medicaid coverage/other benefits. Sanctions are rigid—and have a big impact on ability to provide care.  
  • Workforce issues—capacity at DSS and lack of understanding of MH populations (this applies to CD as well).  
  • Not enough housing to provide stable base. Some is poor quality. This is a client issue and a workforce issue (i.e., buildings and ability to staff them).  
  • Insufficient access to key physical health services. Medicaid reimbursement rates are so low that there are not enough primary care MDs and dentists to meet current needs.  
  o May be less problematic in counties with high enrollment in managed care counties (e.g., Broome).  
| Action Steps (What Can Be Done to Remove/Get Around the Barriers?) | • Education and training to reduce stigma improve ability of other supporting systems to work with the population. |

- Adults with Serious and Persistent Mental Illness
- Those served across systems
- Older Adults
- Sex Offenders
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<td>• Need infrastructure for management—Staff, Processes, Data systems.</td>
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<td>• Stigma—e.g., Emergency Dept. responses, primary care, law enforcement, etc.</td>
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<td>• Transportation, especially in rural areas.</td>
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<td>• Pharmacy costs for SPMI are going up rapidly but little tie-in to outcomes/changed behavior.</td>
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<td>• Geriatric—diagnoses are much harder. Many not seen as MH patients and aren’t getting the right/comprehensive treatments.</td>
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<td>• Sex offenders are going to crowd out services to traditional MH population.</td>
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<td>• Role of State facilities—there needs to be a better definition of what state facilities do. They are critical to ensuring full service integration.</td>
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| Mental Health: Children with Serious Emotional Disturbance                 | - The ability to integrate services across all providers—including DSS programs and supports.  
- More at-home services delivered earlier—expanded wraparound.  
- More focus on the family.  
- The ability to provide service off-site—including at schools, etc. Service co-location.  
- Enough acute care beds to treat children locally when care is needed at this level.  
- A population waiver rather than a carve-out focus.  
- Emphasis on early identification and treatment—this will help reduce multi-system kids. | - Single Point of Access (SPOA) is effective, but there are too many kids in need.  
- Waiver works.  
- Leveraging preventive dollars where possible.  
- Moving into schools—helps with service integration and simplifies transport. Improves both access and outcomes.  
- Behavioral Health Connects—Pennsylvania-based program  
- There are a number of best practices to guide treatment of trauma/PTSD. | - Medicaid won’t pay for all/integrated services. Child Health Plus and Family Health Plus don’t pay enough to do what is needed.  
- Categorical funding limits county ability to develop comprehensive responses.  
- Not enough funding to pay for management/coordination—essential part of service delivery.  
- Addressing children with SED is increasingly challenging—more and more complex systems.  
- Lack of precision regarding definition of mental health and behavioral issues—sending kids to the juvenile justice system.  
- Defining children with autism—diagnosing and treating them.  
- Lack of facilities/services to treat eating disorders. | - Integrate with local early intervention programming to better address early needs. |
### Population

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<th>Subgroups of special concern:</th>
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<tr>
<td><strong>High-Risk/High Need</strong> (the 80/20 subgroup)</td>
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<tr>
<td>People served across systems</td>
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### Desired State

- Truly integrated services for co-occurring disorders—it shouldn’t be as difficult as it is.
- Service integration—needs to include physical health care and basic supports (e.g., housing).
- System is based on the needs of the person.
- Structured to recognize harm reduction—and the recovery progression—takes relapse into consideration.
- The ability to better advertise/spread promising medical research that can improve outcomes among this population. Educate providers and counties about what works and how to manage it.

### What Is Working at the Local Level? (Best/Promising Practices)

- Pharmacological therapy—appears to have promising results. We need to take better advantage of these options.
- Case management with flexible service dollars to bridge the gaps in benefits.
- Use of evidence-based treatment models for special populations (e.g., CBT for criminal justice populations, DBT for individuals with co-occurring disorders.)

### Barriers (What Gets in the Way?)

- Access to safe, appropriate housing—available when client needs it so services can be provided.
- For those served across systems, there are culture, funding, organizational and regulatory challenges. The CD and MH workforces have different orientations.
- Workforce issues are significant—need more qualified professionals, but w/some flexibility in qualifications. What should the qualifications be for professionals who serve this population? Need to ensure ability to staff—particularly in rural areas (e.g., CASACs are difficult to recruit and retain.)
- Trauma—need to improve understanding and offer better responses. Large increases in youth needing chemical dependency care, but staffing and facilities development has not followed.

### Action Steps (What Can Be Done to Remove/Get Around the Barriers?)

- Support more flexible housing options -- particularly “damp housing.” Many of the current services require abstinence.
- Increase rental subsidy funds with funding for case management and service dollars.
- Consider a companion bill to MHL 41.34. Site selection for individuals with addictions is not protected under this law and should be as they are identified as individuals with brain disease in Article 1 (MHL).
- Agencies should consider modifying regulations for MH / CD documentation in the same chart to better support an integrated treatment approach.
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<td>• Separation of management information systems causes fragmentation and inefficiency. We are not taking full advantage of technology to improve efficiency. For example, the DSS system may not be accessed by any other system. It would be helpful to be able to finger image DSS applicants in the jail rather than having to transport them with Corrections staff and restraints to DSS for finger imaging. Also, we could use technology to do face-to-face interviews for incarcerated individuals or those in rural areas where transportation is difficult.</td>
<td>• Some of the welfare reform requirements clash with the treatment and relapse cycle that is part of the recovery process. For example, this is the only disability group that has to be assessed and then have attendance at treatment monitored. If a person relapses and drops</td>
<td>• Collaboration between OASAS / OMH to create long-term inpatient program for individuals with co-occurring disorders. • Take better advantage of technology to increase efficiency across systems / settings • Provide funding for community needs assessment</td>
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### Population vs Desired State

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<tr>
<td>Mental Retardation/Developmental Disabilities:</td>
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<tr>
<td>Subgroups of special concern:</td>
<td></td>
</tr>
<tr>
<td>• Children (Ages 0-21)</td>
<td></td>
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<tr>
<td>• MH/MRDD</td>
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### What is Working at the Local Level? (Best/Promising Practices)

- There is more local flexibility with funding streams so that counties can purchase the right mix of services for individuals.
- There should be a good way to define/appeal an MRDD designation by the state.
- Shouldn’t be funded by Medicaid—most recipients require hands-on care for a lifetime. Should be a completely separate funding stream.
- Ability to respond to crisis needs.
- Presumptive eligibility for crisis services.
- Blended crisis response teams.
- Respite / Smaller IRAs.
- Smaller IRAs’ involvement with local adult centers.
- In the OMH and OASAS systems providers can bill up to 3 visits for evaluation purposes. That practice would be useful in the OMRDD system as well.
- Self-Advocacy Internship Program.
- NY Cares II helps, but doesn’t meet all of the needs.

### Barriers (What Gets in the Way?)

- Lack of cross-system resources.
- Not enough children’s beds in the MRDD system.
- Gathering the appropriate documentation for eligibility – it’s too onerous for families and outside agencies.
- Not enough awareness of the benefits associated with receiving services.
- Stigma.
- State requires County to prove MRDD designation in questionable cases.
- Change in eligibility criteria caused a significant change.

### Action Steps (What Can Be Done to Remove/Get Around the Barriers?)

- Create cross-system response teams and share costs across systems.
- Develop cross-system family care settings, and allow waiver services in foster care to wrap DD services around child and family.
- The DDSOs should use clinical staff to do evaluations, and allow initial services and crisis services to be delivered while eligibility is pending.
- Create more
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<td>“Step Down” settings for discharge from 9.39 hospitals.</td>
<td>number of individuals (and their families) to fall through the cracks.</td>
<td>incentives for local internships.</td>
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<td></td>
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<td>More inclusive employment / volunteer opportunities.</td>
<td>For those with MH and MRDD issues, often neither system takes responsibility.</td>
<td>Partner with local Long Term Care departments to develop integrated settings (e.g., some of the larger IRAs and ICFs could be downsized and non-DD beds / assisted living arrangements could be developed within the same building).</td>
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<td>Integrated living options for elderly (living / socializing w/non-DD adults)</td>
<td>As individuals live longer, the system is being stressed—more individuals, different service/support needs, and pressure on family members.</td>
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<td>The system is being reactive to building systems rather than identifying proactive need (e.g., building the beds ahead of time).</td>
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<td>Hospitals won’t take MR patients because they fear they’ll have no options for discharge</td>
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<td>State MR believes that 0-21 is responsibility of schools—only provide services after 22.</td>
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