



## **CALIFORNIA COMMUNITY CHOICES**

# **Final Strategic Plan CORE ELEMENTS**

**June 15, 2007**

Exhibit 1 – Strategic Plan Face Sheet

Exhibit 2 – Strategic Planning Structure and Process

Exhibit 3 – Logic Model

Exhibit 4 – Mission and Vision Statement

Exhibit 5 – System Readiness Update

Exhibit 7 – Updated Individual Goals, Objectives and Strategies

Exhibit 8 – Implementation Chart

Exhibit 9 – Implementation Plan

## Exhibit 1: Strategic Plan Face Sheet

Draft Plan \_\_\_\_\_ Final Plan  6/15/07  
 State Medicaid Director \_\_\_\_\_ Stan Rosenstein \_\_\_\_\_  
 Endorsement: \_\_\_\_\_ Print Name \_\_\_\_\_ Signature \_\_\_\_\_

### Consumer/Family Participation

Name	Organizational Affiliation	Organization Type
Laura Williams	Californians for Disability Rights, Inc.	Advocacy
Teddie-Joy Remhild	Personal Assistance Services Council of LA County	In-Home Support Services
Joan B. Lee	Gray Panthers	Aging
Wesley Mukoyama	Yu-Ai Kai/Japanese American Community Senior Services	Community-Based Advocate Organization
Vicki Farrell	Association of California Caregiver Resource Centers	Caregiver Association
Eldon Luce	Placer County In-Home Supportive Services Public Authority	Paid Caregiver

### Non-Consumer/Other Stakeholder Participation

Name	Organizational Affiliation	Organization Type
Barbara Biglieri	California Association for Health Services at Home	Home Health
Mivic Hirose	California Hospital Association	Hospital Association
Deborah Doctor	Protection & Advocacy, Inc	Disability Advocate
Evalyn Greb	San Diego County Aging and Independence Services	Area Agency on Aging/ADRC
Kimberly Martinson	Transportation Management Association of San Francisco	Transportation
Sharon Turner	Sierra Nevada Home Care	Home Health
June Simmons	Partners in Care Foundation	Community-Based Health Organization
Allison Ruff	Assembly Committee on Aging and Long-Term Care	Legislative Staff
Robert Petty	Alliance on Aging	Information and Assistance

## Project Team

Name	Role/ Grant Activity	Affiliation
<b>State Contacts</b>		
Karol Swartzlander	<b><u>Project Director:</u></b> provides project management and oversight; leads strategic planning process; coordinates activities across state departments; facilitates state processes; communication-liaison with CMS	California Health and Human Services Agency
Eileen Kostanecki Assistant Secretary <i>(acting for Sarah Steenhausen, Assistant Secretary)</i>	<b><u>Project Supervisor:</u></b> provides project oversight and technical assistance	California Health and Human Services Agency
<b>California Institute on Human Services (CIHS)</b>		<b>Subcontractor</b>
Linda Blong	<b><u>CIHS Director of Projects and Subcontractor Lead:</u></b> supervises all subcontract activities: budget and reporting; development of strategic planning process; contracted services for research; contracted staff supervision; and project planning	Sonoma State University
Megan Juring	<b><u>Technical Assistant:</u></b> provides technical assistance throughout development and implementation	Sonoma State University
Kimberly Carey	<b><u>Administrative Analyst:</u></b> coordinates all meeting and travel logistics, reimbursement procedures, and invoices; tracks contracts and maintains records and correspondence	Sonoma State University
Eric Glunt	<b><u>Research Evaluator:</u></b> lead project evaluator – develops evaluation plan; works closely with project team and Advisory Committee	Sonoma State University
<b>CIHS Contractors</b>		
Tony Sauer	<b><u>Senior Policy Analyst:</u></b> coordinates stakeholder and public outreach efforts; assists with development/ implementation of project grant; provides policy consultation on long term-care and disability issues	Consultant

Name	Role/ Grant Activity	Affiliation
Monique Parrish	<u><b>Strategic Planning and Long-Term Care Policy Specialist:</b></u> facilitates strategic planning process; conducts policy analysis; develops strategic plan and reports	Consultant

### State Department Advisory Group

Name/Title	Department
Kathleen J. Billingsley, R.N., Deputy Director, Licensing and Certification Program	Health Services <sup>1</sup> (Public Health)
Lora Connolly, Deputy Director	Aging
Jim Knight, Assistant Chief, Federal Programs Operations Section	Developmental Services
Ben Harville, Chief, Independent Living Section	Rehabilitation
Mark Helmar, Chief, Office of Long Term Care	Health Services (Health Care Services)
Eva Lopez, Deputy Director, Adult Services Division	Social Services
Dave Neilsen, Chief, Community Services and Supports Policy Section	Mental Health
Doug Robins, Chief, Home and Community-Based Services Branch	Health Services (Health Care Services)

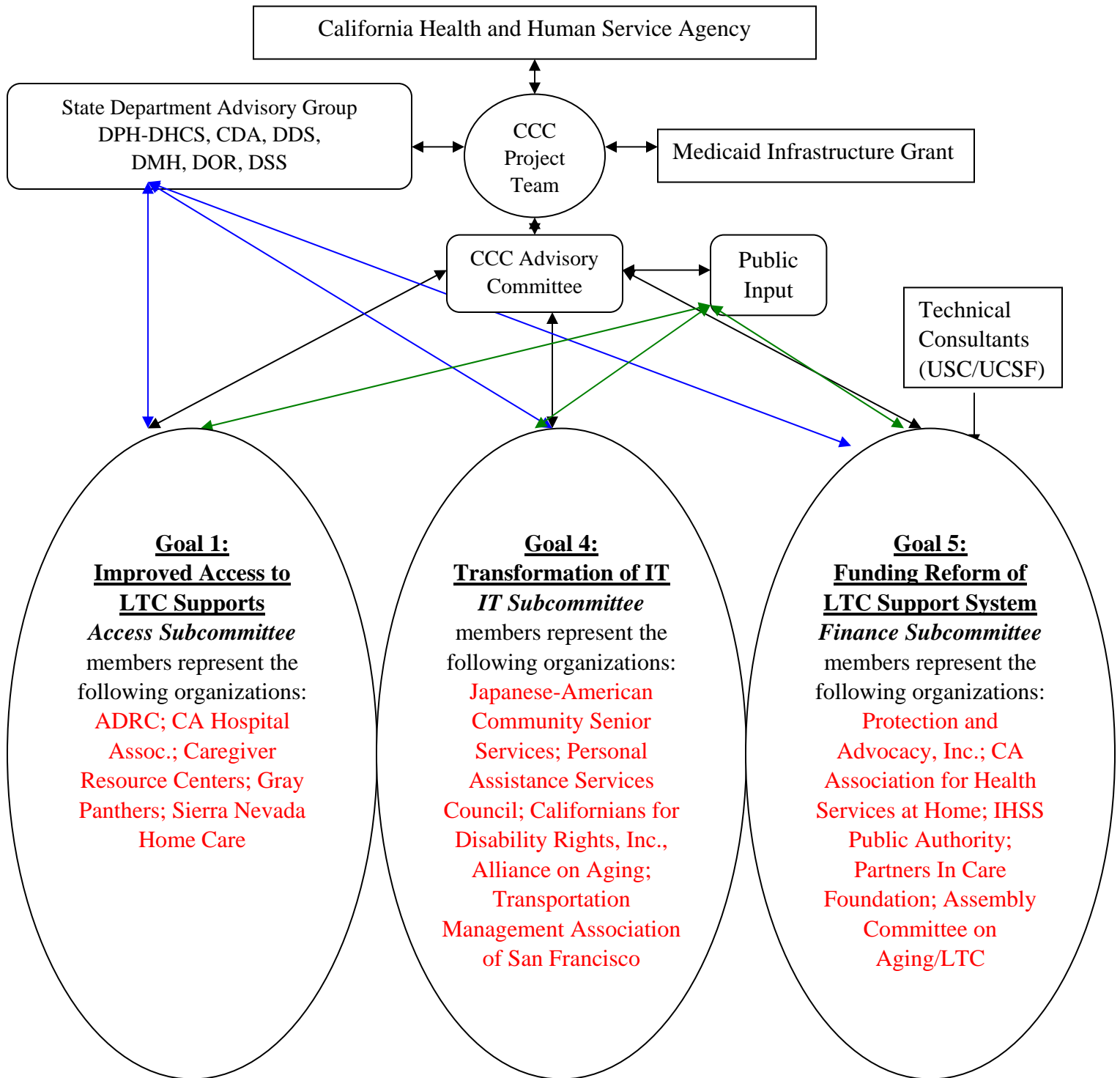
---

<sup>1</sup> Effective July 1, 2007, the Department of Health Services will be divided into two separate departments: Department of Public Health and Department of Health Care Services.

## **Strategic Plan Review Process**

California Community Choices Strategic Plan represents a dynamic and “living” document reflective of and responsive to California consumers with long-term support needs. Feedback from the public, stakeholders, state departments, and subcommittees of the California Community Choices Advisory Committee will inform the ongoing strategic plan review process. Members of the California Community Choices Advisory Committee will evaluate project feedback and progress toward achieving identified goals and objectives quarterly. The Committee will recommend updates and revisions to the Strategic Plan accordingly. Changes to the plan will be made available to the public on the project website.

## Exhibit 2: Strategic Planning Structure and Process <sup>2 3</sup>



<sup>2</sup> The Goal Numbers (1, 4, and 5) reflect the federal goals selected for the Community Choices project.

<sup>3</sup> The following page lists the legend for all exhibits in the Strategic Plan.

## **Legend**

<b>Title</b>	<b>Acronym</b>
California Health and Human Services Agency	CHHS
California Community Choices Project	CCC
California Community Choices Project Team	CCC PT
California Community Choices Advisory Committee	CCC AC
California Department of Aging	CDA
California Department of Mental Health	DMH
California Department of Rehabilitation	DOR
California Department of Developmental Services	DDS
California Department of Social Services	DSS
California Department of Health Services	DHS
California Department of Public Health	DPH
Department of Health Care Services	DHCS
Long-Term Care	LTC
California Department of Finance	DOF
California State Independent Living Council	SILC
Home and Community-Based Services	HCBS
Community Link Resource Centers	CLRCs
Aging and Disability Resource Centers	ADRCs
<b>Goal #1:</b> Improved Access To Long-Term Support Services: Development Of One-Stop System	Goal 1
<b>Goal #4:</b> Transformation of Information Technology to Support Systems Change	Goal 4
<b>Goal #5:</b> Creation Of A System That More Effectively Manages The Funding For Long-Term Supports That Promote Community Living Options	Goal 5
Subcommittee ( <i>of the Advisory Committee</i> ) for Goal # 1	Access Subcommittee
Subcommittee ( <i>of the Advisory Committee</i> ) for Goal # 4	IT Subcommittee
Subcommittee ( <i>of the Advisory Committee</i> ) for Goal # 5	Finance Subcommittee
In-Home Support Services	IHSS
Home Health	H/H
Community-Based Organizations	CBOs
Medicaid Infrastructure Grant – CA Health Incentives Information Project	MIG
University of Southern California	USC
University of California, San Francisco	UCSF
Supplemental Security Income	SSI
State Supplementary Payment Program	SSP
Money Follows the Person Grants	MFP
Information & Referral	I & R

Title	Acronym
Mobility Action Plan Implementation Project	MAP
Area Agency on Aging	AAA
Independent Living Center	ILC
Administration on Aging	AoA

## **Definitions**

**Long-Term Care:** represents a continuum of supports and services which could include but are not limited to personal services, rehabilitation therapies, home health care, and acute care. These services can be delivered in a variety of settings such as inpatient (rehabilitation facility, nursing home, mental hospital) or outpatient basis, or at home, depending on the recipient's needs and preferences, the availability of informal support, and the source of reimbursement.

**Critical Pathways:** refers to the referral and triage channels between health and long-term care facilities and the home and community-based network system to promote comprehensive health and social service supports on behalf of individuals at-risk for institutionalization.

**At-Risk Populations:** in the context of the aging and LTC field, generally refers to individuals with unmet long-term care needs and/or barriers to access, who are vulnerable to unnecessary institutionalization.

**Home and Community-Based Services (HCBS):** generally refers to programs, services, and providers/vendors in the community. A more refined definition for the purpose of this project will be developed during the project's implementation period.

**In-Home Support Services (IHSS):** provides personal care and domestic services to low-income persons with disabilities, to allow these individuals to live safely at home rather than in costly and less desirable out-of-home placement facilities. IHSS is a consumer-directed entitlement program, with specific eligibility criteria.

**Olmstead Decision:** the 1999 U.S. Supreme Court Olmstead Decision affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs.

**Medi-Cal:** the Medicaid program in California.

**The Coleman Care Transitions Intervention Model:** references a consumer empowerment model designed to stimulate change in practice and care delivery systems to improve transitions from one care setting to another – the term “Care Transitions” refers to the movement consumers make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

**Who, or which, entity, is facilitating the process?**

The California Health and Human Services Agency (CHHS) is the lead state agency facilitating the California Community Choices grant. As the state's umbrella agency for health and human services, CHHS has oversight responsibility for 11 state departments, and one state board. CHHS is dedicated to promoting access to essential health and human services for California's most disadvantaged and at-risk residents through its administration of a wide variety of critical projects and initiatives, including the Community Choices project. Project Director Karol Swartzlander is responsible for managing the grant with the project's Advisory Committee (California Community Choices Advisory Committee) and project partners.

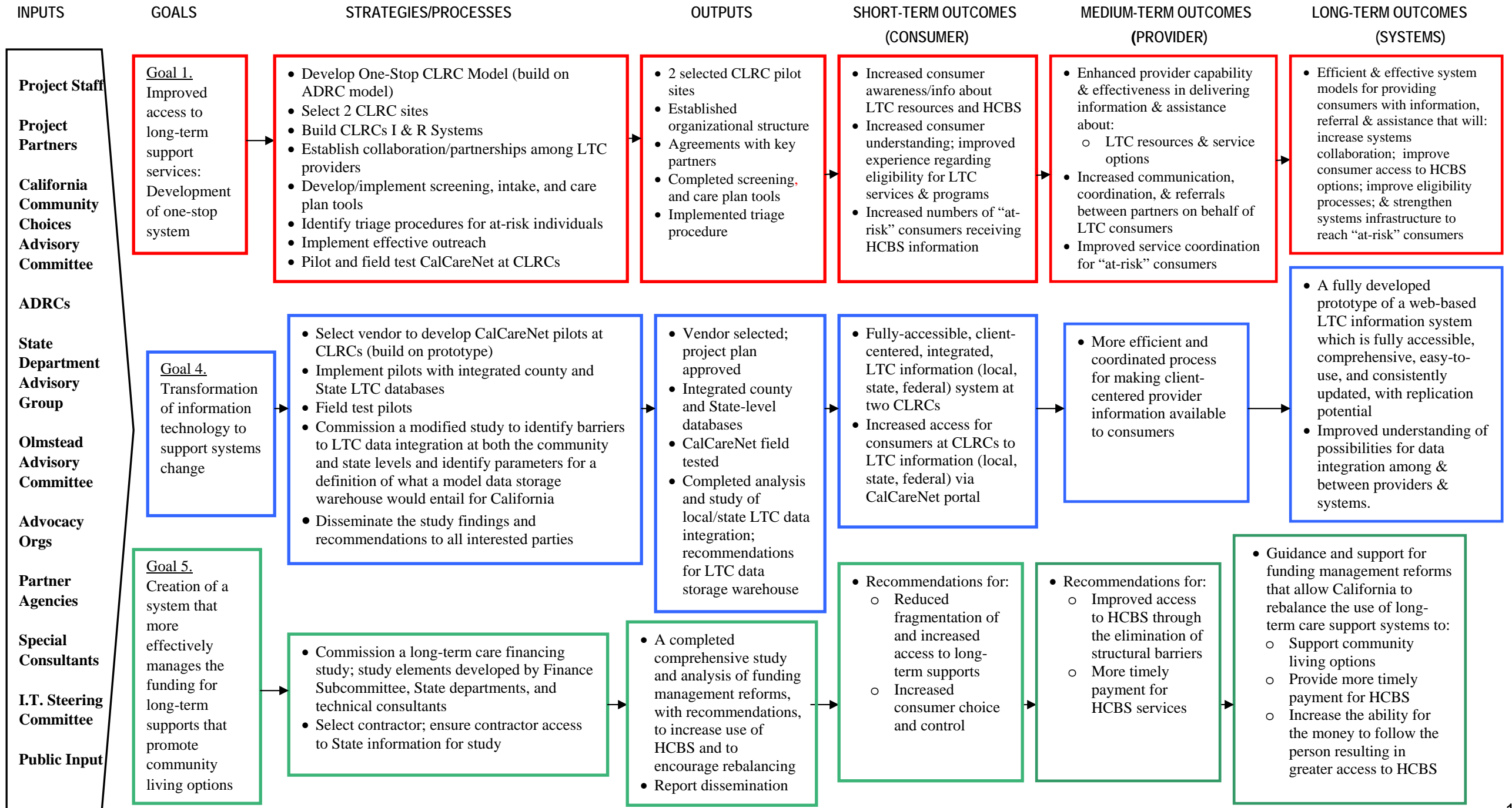
**Which entities were newly created/formed for the strategic planning process?**

The California Community Choices Advisory Committee was formed through a public application process. Members were selected based on their background, expertise, and ability to substantively contribute to oversight of the project during the grant period. A diverse group of participants represents the current Advisory Committee. The committee includes a combination of both consumer and non-consumer stakeholders representing the following types of organizations: consumer advocacy groups; disability advocacy organizations; community-based health organizations; community-based organizations; aging advocates; and caregiver advocacy and service support groups. From the Advisory Committee, subcommittees for each of the three goal areas were formed. Subcommittees met to review specific objectives, strategies, outputs and outcomes for each respective goal area and report back to the larger Advisory Committee. Subcommittee members played a fundamental role in revising proposed strategies to achieve specific objectives. A parallel State Department Advisory Group was also created to provide additional project support and guidance. Representatives from the following state departments serve on this group: Mental Health, Public Health, Health Care Services, Social Services, Aging, Developmental Disabilities, and Rehabilitation. During project implementation, representatives from housing and transportation departments will be invited to participate on the State Department Advisory Group.

**How do participants interact?**

Advisory Committee members have participated in the strategic planning process through a series of strategic planning public meetings and subcommittee meetings. These key participants actively interacted with project staff, and each other, throughout the strategic planning process. All of the input processes were characterized by open discussion and debate, with majority opinion as the ultimate arbiter of disagreement. Information about the project was disseminated via e-mail, phone contacts, conference calls, and state department presentations. The public contributed their feedback to the formation of the strategic plan through these mechanisms as well as through a series of scheduled public meetings and the project website, which solicited input through two online surveys. As part of a feedback loop, the public was informed about developments to the strategic plan, including changes made based on findings from the California Community Choices: Public Input Survey Findings Strategic Planning Phase, via the project website.

# Exhibit 3: California Community Choices Logic Model



## **Exhibit 4: Mission and Vision Statement\***

### ***Mission Statement***

We are a statewide partnership committed to developing an infrastructure that will increase access to, capacity of, and funding for home and community-based services to provide all Californians with greater choice in how and where they receive long-term care services, in accordance with the Olmstead Principles.\*

\*The 1999 U.S. Supreme Court Olmstead Decision affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs.

### ***Vision Statement***

California will have strategies and recommendations for its long-term care system, featuring replicable and sustainable models that empower individuals through enhanced opportunities for choice and independence.

---

\* Developed by the California Community Choices Advisory Committee, January 23, 2007.

## Exhibit 5: System Readiness Update

	Current Status	Citation for Information Supporting Assessment
<p><b>Political and State Agency Leadership</b></p>	<p><b>CHHS</b> – Statewide implementation of California Community Choices will begin 7/1/07 and will be completed by 9/30/11.</p> <p><b>Money Follows the Person (MFP) Demonstration Project</b> – awarded to California, January 2007, to provide approximately 2000 persons residing in health care institutions (including seniors and persons with disabilities of all ages) the opportunity to return to the community. The project period is January 1, 2007 through December 31, 2011. The MFP project will develop infrastructure and resources necessary to facilitate a viable transition process. A significant component of infrastructure development includes the establishment of local Community Transition Teams, whose effectiveness and long-term viability will be evaluated during the project period. Where physically possible, depending on geographic location, the MFP project will coordinate with ADRCs /CLRCs to establish a linkage that will facilitate ADRC/CLRC referrals to appropriate MFP Community Transition Teams. The MFP project will also identify and address a number of barriers older adults and persons with disabilities encounter living in the community. These barriers, such as limited access to services and supports as well as inadequate, or nonexistent, services and supports that promote community living options, are of interest to the California Community Choices project. Community Choices is dedicated to assisting older adults and persons with disability live in the most integrated setting possible in the community. As a result, Community Choices will closely follow both MFP findings and developments in this area. The second component of the MFP project</p>	

	Current Status	Citation for Information Supporting Assessment
	<p>will entail working with state partners and other stakeholders to identify and address barriers to long-term care systems rebalancing. This component will rely on the LTC Financing study that will be conducted as part of the Community Choices project.</p> <p><b>The Governor's Proposed Budget 2007-2008</b> proposes the following:</p> <ul style="list-style-type: none"> <li>• \$9.3 million (\$4.6 million General Fund) to adjust the Nursing Facility A/B Waiver Cap for inflationary cost increases that have occurred since the existing waiver was negotiated in 2002.</li> <li>• The Governor's Budget includes \$4 million (\$1.9 million General Fund) which includes 47 full-time positions to implement Adult Day Health Care program reforms and develop a new rate methodology to increase California's ability to retain federal funding and help ensure services remain available for qualified beneficiaries, as required by Chapter 691, Statutes of 2006 (SB 1755).</li> <li>• \$1.5 billion General Fund for the IHSS program. The average monthly caseload in this program is estimated to be 395,100 recipients in 2007-08, a 5.4 percent increase over the 2006-07 projected level.</li> <li>• Continued funding to achieve closure of Agnews Developmental Center in June 2008 – addressing the transition of consumers from the Center to the community and state employees to community-based services.</li> <li>• Revenues to the Mental Health Services Fund are projected to increase by \$312.1 million in 2006-07 and \$495.7 million in 2007-08, for a total estimate of \$1.6 billion in 2006-07 and \$1.8 billion in</li> </ul>	

	<b>Current Status</b>	<b>Citation for Information Supporting Assessment</b>
	<p>2007-08. Funds are continuously appropriated to the Department of Mental Health for county implementation of the Mental Health Services Act (MHSA).</p> <ul style="list-style-type: none"> <li>• \$547,000 Choices for Independence Grant (Federal Funds for an Evidenced-Based Health Promotion Initiative for Older Californians) that will implement education and training models addressing chronic disease self-care, fall prevention and exercise encouragement in five counties. Total Grant Amount is \$840,000.</li> </ul> <p>SB 162 establishes a Department of Public Health (DPH) within the existing California Health and Human Services Agency and provides statutory authority to transfer responsibilities from the California Department of Health Services (CDHS) to the new DPH, effective July 1, 2007. CDHS will be renamed the Department of Health Care Services (DHCS).</p>	
<b>Stakeholder Support / Mediation</b>	<p><b>Advisory Committees:</b> Members of the California Community Choices Advisory Committee provide input and guidance to the development and implementation of the project. The committee’s first meeting, addressing the Strategic Plan, was held on January 23, 2007. A second meeting to finalize the draft Strategic Plan was held on April 11, 2007.</p> <p><b>Subcommittee meetings</b> addressing three goals: Goal 1 (Improved access to LTC support services), Goal 4 (Transformation of Information Technology), and Goal 5 (System that effectively manages funding for LTC supports and promotes community living options) met throughout the strategic planning process and will continue to meet to provide further development and monitor related project activities during project</p>	<p>Public meeting attendee list</p> <p>Schedule of Project sub-committee meetings</p>

	<b>Current Status</b>	<b>Citation for Information Supporting Assessment</b>
	<p>implementation.</p> <p><b>Forums/Focus Groups/Surveys</b> – a combination of public input sessions, targeted organization/state department presentations, key informant interviews with state department representatives, and online surveys were conducted during the strategic planning process to gather stakeholder feedback on the Community Choices project priorities. Several ongoing themes emerged from the California Community Choices Survey findings: (1) accessibility; (2) diverse and effective information dissemination; (3) comprehensive assistance and service delivery; and (4) Medi-Cal flexibility with increased options for financing home and community-based services.</p> <p>Post-White House Conference on Aging for California held November 29-30. Attendees identified action objectives for the following issues: Disease Management, Rural Healthcare Access, Transitional Care, Health Promotion; Cultural Diversity, Intergenerational Activities, Mobility; Housing; Access to Employment Opportunities, Workforce Capacity, and Direct Care Workers. Forum attendees identified the housing and mobility objectives as most urgent and recognized cultural diversity as an essential element of all the priority objectives.</p>	<p>See Appendix A “California Community Choices: Public Input Survey Findings Strategic Planning Phase”</p> <p>Post-White House Conference on Aging report (2/07)</p>
<b>Progress with System Reform</b>	<p><b>Olmstead Advisory Committee</b> – The Committee is responsible for the following: providing input to CHHS regarding its efforts to implement the <a href="#">California Olmstead Plan</a>; recommending actions to improve California's long-term care system; and, creating opportunities to fund expanded or new activities to support individuals with disabilities in their community. Members of the committee continue to actively</p>	

	Current Status	Citation for Information Supporting Assessment
	<p>participate in systems reform on behalf of promoting home and community based long-term support services and options. On March 23, 2007, the committee held a LTC/Olmstead Education Briefing to educate legislative staff on California’s long-term care system, the Olmstead decision, changing dynamics, and critical issues to address related to choice and independence for persons with disabilities.</p> <p>The first <b>Olmstead Stakeholder Meeting</b> to address LTC Rebalancing will be held in summer 2007. The meeting will initiate discussion between state departments, policy makers, and stakeholders to establish what LTC Rebalancing means to CA and where the state should be with respect to this issue. It will also provide an opportunity for committee members to identify potential short-term rebalancing goals focused on achievable, measurable results. The State is committed to reviewing this work as well as recommendations from the Community Choices LTC Financing study.</p> <p><b>Nursing Facility/Acute Hospital Waiver program (NF Waiver Program) stakeholder meeting</b> (first) to address reform of the Department of Health Services will begin processing Waiver Personal Care Services timesheets twice a month, effective March 2007 and is currently researching waiver-related options, based on the stakeholder feedback.</p> <p>Two <b><i>Aging and Disability Resource Centers (ADRCs)</i></b>, established by the California Department of Aging (CDA), are in operation in California, in San Diego and Del Norte counties. Both act as “coordinated points of entry” for providing information and enabling consumers, caregivers and providers to make informed choices about</p>	<p>Nursing Facility/Acute Hospital Waiver program (NF Waiver Program) Stakeholder Meeting</p>

	<b>Current Status</b>	<b>Citation for Information Supporting Assessment</b>
	<p>long-term support services. Recently, CDA enhanced the ADRC model in San Diego to serve persons with disabilities of all ages – not just seniors- through a newly defined partnership between the San Diego Area Agency on Aging (AAA) and the local Independent Living Center (ILC). Due to the success of this collaborative model, CDA is planning to submit a proposal to the Administration on Aging (AoA) (June 2007) to establish two new ADRCs. The new ADRCs will continue to build on and create additional linkages between the AAA and ILC network to:</p> <p>(1) provide consumer information and assistance; (2) assist the public in navigating the long-term service support system; and (3) advocate for expanded resources and systems change. If funded, the new AoA grant, along with the Community Choices project, will enable California to realize six ADRC/CLRC pilot sites over the next few years. The six centers will be dedicated to providing information, referrals and assistance for all Californians navigating the long-term care system. Equally important, the centers will increase access to home and community-based services. To integrate the efforts of the ADRCs and CLRCs, an ADRC/CLRC Coalition, part of the Community Choices project, will be developed to enhance synergy among and between the centers. The primary purposes of the Coalition include the following: exchanging information on lessons-learned and best practices; identifying a standard screening tool and procedures for client intake and assessment; and creating a set of common data elements to be used across ADRCs/CLRCs. Lessons-learned from the unique practices of the CLRCs, such as targeting individuals at risk of institutionalization and use of the Eric Coleman Care Transitions Intervention Model, may provide a foundation for beta testing and replication in the ADRCs. As such, the Community Choices project will work closely with CDA to</p>	

	Current Status	Citation for Information Supporting Assessment
	<p>ensure these grant efforts result in a more coordinated system of care that effectively assists consumers to remain in or return to the most integrated living environment possible.</p> <p><b><u>Mobility Action Plan (MAP) Implementation Project:</u></b> The Department of Transportation has initiated the MAP Implementation Project and has invited participation of a wide range of representatives from agencies administering human service transportation programs and consumer advocacy organizations to participate in an advisory capacity. The goal of the project is to coordinate human services transportation programs to simplify access, reduce duplication, and enhance cost efficiencies. The first advisory committee meeting was held in April 2007. The project period will run through April 2008. CHSSA Assistant Secretary Eileen Kostanecki will act as co-chair of the MAP Advisory Committee. Choices Advisory Committee members, Kimberly Martinson and Teddie-Joy Remhild, will participate on the MAP Advisory Committee, ensuring a bidirectional flow of information between the MAP and Choices Advisory Committees.</p> <p>The Community Options and Assessment Protocol (COAP), proposed by Assembly Bill (AB) 3019 (Daucher, 2006) would have authorized CHHS to work with specified state departments, a technical contractor and interested stakeholders to develop a protocol whereby multiple home and community-based programs could share core consumer data and make cross-referrals in order to improve consumer access to critical services. AB 3019 was not approved by the Legislature. As such, the COAP, which was incorporated into the California Community Choices grant application initial design, Goal 1, Objective 2, has been removed</p>	

	Current Status	Citation for Information Supporting Assessment
	<p>from the project plan.</p> <p>AB 2979 (Richman, 2006) would have authorized implementation of two types of Medi-Cal managed care plans: Medicare HMO Wraparound and Integration Plus Community Choices. Both plans would have coordinated Medi-Cal and Medicare benefits to improve the continuity of acute care, primary care and long-term care and to simplify health care access for consumers. AB 2979 was not approved by the Legislature.</p>	
<b>Other Major Factors</b>	<p>The <b>California Health Incentives Improvement Project (CHIIP)</b> is a multi-agency collaborative effort targeting barriers to the gainful employment of persons with disabilities, in particular health care and personal assistance barriers. The project was initiated in 2002 with a <b>Medicaid Infrastructure Grant</b>. In their <i>Comprehensive Strategy for the Employment of People with Disabilities</i>, approved by CMS in early 2006, CHIIP outlines outreach and training in two areas: (1) the Medi-Cal 250% Working Disabled Program, a Medicaid Buy-In program that allows persons with disabilities to earn income and maintain healthcare benefits by buying into Medi-Cal with a monthly premium; and (2) the provisions associated with the IHSS program that allow individuals to use personal assistant services in the workplace as well as at home. Despite an increased enrollment rate for the Medi-Cal Working Disabled Program, 67% since May 2005, many consumers with disabilities are still unaware of these work incentives. Consequently, CHIIP has developed a statewide campaign to educate consumers about available benefits to assist persons with disabilities to sustain gainful employment.</p> <p>Furthermore, CHIIP helps fund innovative tools related to benefits planning. These tools, such as the website</p>	

	<b>Current Status</b>	<b>Citation for Information Supporting Assessment</b>
	<p><a href="http://www.disabilitybenefits101.org/index.htm">http://www.disabilitybenefits101.org/index.htm</a>, enable workers, job seekers, and service providers to understand the connections between work and benefits. Because the CLRC component of the Community Choices project is committed to educating and assisting consumers about community living options which support self sufficiency and quality of life in the community, CHIIP will provide cross-training to CLRC staff and community partners on benefits planning and resources. These tools will also be linked to the CalCareNet website, further supporting the CHIIP and Community Choices shared goal of a local information network supporting persons with disabilities as they make transitions in life.</p> <p>The Department of Rehabilitation and the State Independent Living Council have commissioned a review and analysis of the State Medi-Cal Plan. The final report, scheduled to be released in June 2007, will make recommendations to increase access to services that will maximize opportunities for individuals to live in the most integrated setting possible. This report will be used to inform the LTC Financing study.</p>	

## Exhibit 7: Updated Individual Goals, Objectives, and Strategies

Goal 1: Improved Access To Long-Term Support Services: Development Of One-Stop System.					
Objectives		Consumer Outcomes	Provider Outcomes	Systems Outcomes	
1.1	California will provide awareness, information, and assistance in accessing home and community-based services	<ul style="list-style-type: none"> <li>• Increased consumer awareness of and information about:                             <ul style="list-style-type: none"> <li>➢ LTC resources and service options</li> </ul> </li> <li>• Increased consumer awareness of and information about HCBS                             <ul style="list-style-type: none"> <li>➢ Community-based LTC resources and service options</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced provider capability and effectiveness in delivering information and assistance about:                             <ul style="list-style-type: none"> <li>➢ LTC resources and service options</li> </ul> </li> <li>• Increased communication between community partners (CLRCs and key partners) to facilitate LTC program eligibility, application, and referral processes</li> </ul>	<ul style="list-style-type: none"> <li>• Efficient and effective system of providing consumers with information, referral, and assistance through building on the one-stop system</li> <li>• Increased systems collaboration on behalf of providing consumer-centered aging and long-term care information, support, and services</li> <li>• Improved consumer options for accessing HCBS information and referrals</li> <li>• One or more models with potential for replicability throughout the State based on strengthened partnerships between CLRCs, ADRCs and community partners</li> </ul>	
1.2	Streamline the Multiple Eligibility Processes	<ul style="list-style-type: none"> <li>• Increased consumer understanding regarding eligibility for LTC services and programs</li> <li>• Improved consumer eligibility experience</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced eligibility procedures between CLRC and community partners                             <ul style="list-style-type: none"> <li>➢ Decreased redundancy in provider requested information from consumer</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Streamlined access to needed services                             <ul style="list-style-type: none"> <li>➢ CLRC Triage system</li> </ul> </li> </ul>	
1.3	Target Individuals who are at Imminent Risk for	<ul style="list-style-type: none"> <li>• Increased numbers of “at-risk” consumers receiving information and support</li> </ul>	<ul style="list-style-type: none"> <li>• Improved coordination between providers to identify and reach targeted</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthened systems infrastructure to reach “at-risk” consumers</li> </ul>	

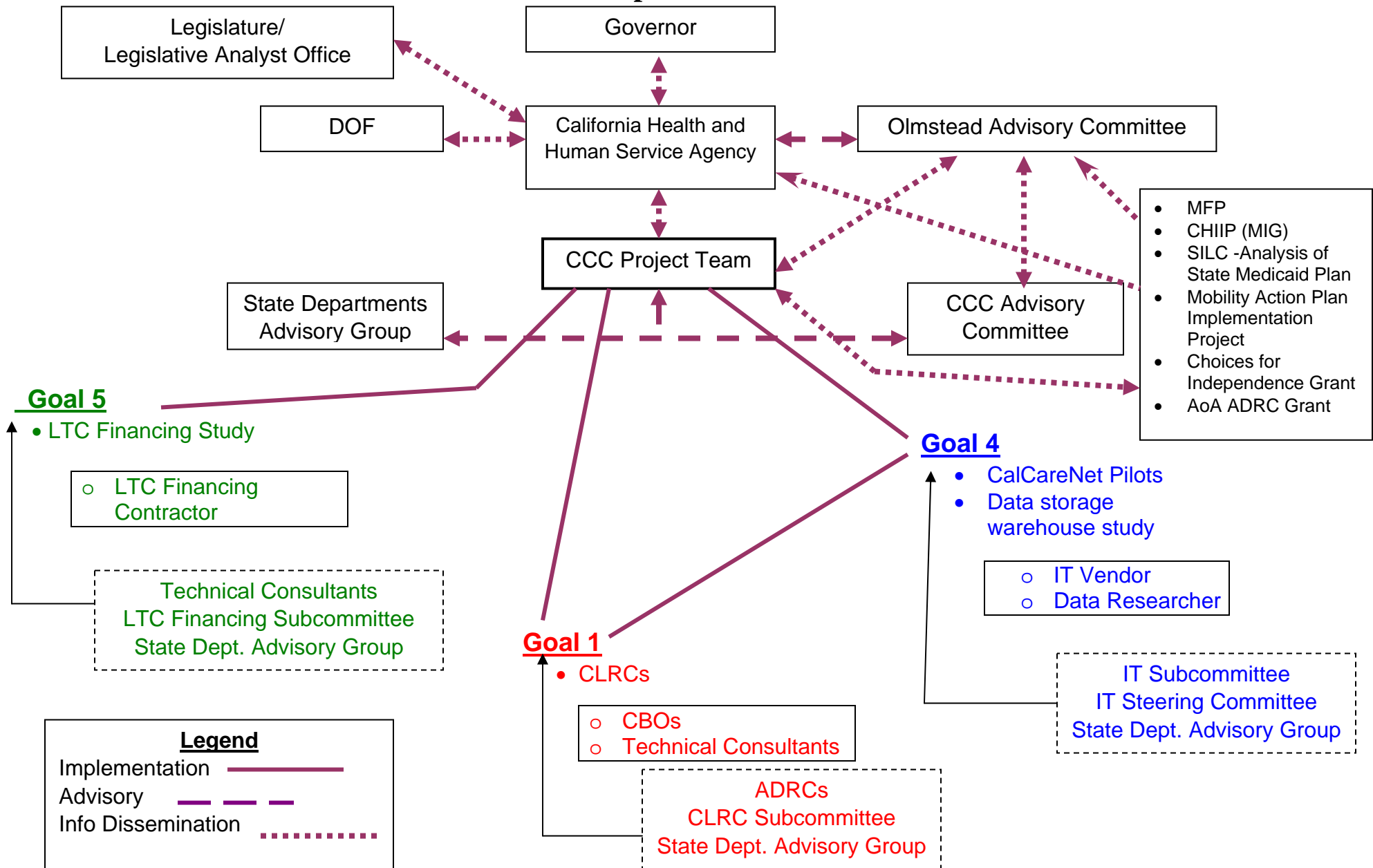
<b>Goal 1: Improved Access To Long-Term Support Services: Development Of One-Stop System.</b>			
<b>Objectives</b>	<b>Consumer Outcomes</b>	<b>Provider Outcomes</b>	<b>Systems Outcomes</b>
Institutionalization	about: <ul style="list-style-type: none"> <li>➢ Home and community-based services</li> </ul>	population of “at-risk” consumers <ul style="list-style-type: none"> <li>• Increased referrals between critical pathway providers and CLRCs</li> <li>• Increased number of triage and referral providers identifying at-risk individuals and participating in LTC Coalition</li> </ul>	<ul style="list-style-type: none"> <li>➢ Increased numbers of LTC providers identifying “at risk” individuals, evidenced by increased referrals to the CLRC</li> </ul>

<b>Goal 4: Transformation of Information Technology to Support Systems Change</b>				
<b>Objectives</b>	<b>Consumer Outcomes</b>	<b>Provider Outcomes</b>	<b>Systems Outcomes</b>	
4.1	Design IT applications that will support program practices and processes that are consistent with participant-centered principles and enable consumers to direct their own services	<ul style="list-style-type: none"> <li>• Client-centered, integrated, CalCareNet pilots hosting wide-range of LTC information (local, state, federal) system via CalCareNet portal includes:               <ul style="list-style-type: none"> <li>➢ Consumer Needs Profile</li> <li>➢ Personal health folders</li> <li>➢ Health information</li> <li>➢ Fully Accessible (Section 508 WC3)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• More efficient and coordinated process for making client-centered provider information available to consumers:               <ul style="list-style-type: none"> <li>➢ Long-term care service options</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A fully developed prototype of a web-based LTC information system which is fully accessible, comprehensive, easy-to-use, and consistently updated</li> </ul>
4.2	Improve client access to long-term services through the use of integrated IT systems	<ul style="list-style-type: none"> <li>• Increased access to statewide LTC information (local, state, federal) via CalCareNet portal:               <ul style="list-style-type: none"> <li>➢ Fully Accessible (Section 508 WC3)</li> <li>➢ Easy-to-use</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• More efficient and coordinated process for making client-centered provider information available to consumers:               <ul style="list-style-type: none"> <li>➢ Long-term care service options</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A web-based LTC information system model with the potential for replicability to improve the state’s LTC information infrastructure</li> </ul>

<b>Goal 4: Transformation of Information Technology to Support Systems Change</b>					
<b>Objectives</b>		<b>Consumer Outcomes</b>	<b>Provider Outcomes</b>	<b>Systems Outcomes</b>	
		<ul style="list-style-type: none"> <li>➤ Comprehensive</li> <li>➤ Client-centered</li> <li>➤ Fast</li> <li>➤ Consistently and regularly responded to and updated and monitored</li> </ul>			
4.3	Use integrated IT systems to monitor the quality of services rendered		<ul style="list-style-type: none"> <li>• Improved understanding of possibilities for data integration among and between providers and systems</li> </ul>		<ul style="list-style-type: none"> <li>• Improved understanding of possibilities for data integration among and between providers and systems</li> </ul>

<b>Goal 5: Creation Of A System That More Effectively Manages The Funding For Long-Term Supports That Promote Community Living Options</b>					
<b>Objectives</b>		<b>Consumer Outcomes</b>	<b>Provider Outcomes</b>	<b>Systems Outcomes</b>	
5.2	Develop and Implement More Flexible Payment Methodologies	<ul style="list-style-type: none"> <li>• Recommendations for:               <ul style="list-style-type: none"> <li>○ Reduced fragmentation of and increased access to long-term supports</li> <li>○ Increased consumer choice and control</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Recommendations for:               <ul style="list-style-type: none"> <li>○ Improved access to HCBS through the elimination of structural barriers</li> <li>○ More timely payment for HCBS services</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Guidance and support for funding management reforms that allow California to rebalance the use of long-term care support systems to:               <ul style="list-style-type: none"> <li>○ Support community living options</li> <li>○ Eliminate bias in payment/reimbursement practices toward institutionalization</li> <li>○ Provide more timely payment for HCBS services</li> <li>○ Increase the ability for the money to follow the person resulting in greater access to HCBS</li> </ul> </li> </ul>

## Exhibit 8: Implementation Chart<sup>4</sup>



<sup>4</sup> The Goal Numbers (1, 4, and 5) reflect the federal goals selected for the Community Choices project.

## Exhibit 9: Implementation Plan

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p style="text-align: center;"><b>Goal 1</b></p> <p><b><i>Improved Access to long-term support services: development of one-stop system</i></b></p> <p><b><i>1.1 California will provide awareness, information, and assistance in accessing HCBS.</i></b></p>	<ul style="list-style-type: none"> <li>• Build upon the ADRC model to improve CLRC capacity for information and referral (this primary strategy complements ADRC and CHIIP efforts):               <ul style="list-style-type: none"> <li>➢ Convene current ADRCs, state-level staff, and Access Subcommittee to identify ADRC lessons-learned and best practices for information and referral and to explore the possibility of testing and/or piloting CalCareNet at ADRCs</li> </ul> </li> <li>• Develop a Request for Proposal (RFP) to conduct a solicitation process to select community-based organization(s) to operate two new one-stops/Community Link Resource Centers (CLRCs), to reach more Californians needing long-term care information, planning and services. The CLRCs will focus on: building Information and Referral Systems Capacity; minimizing consumer confusion; and enhancing individual choices of and increased access to HCBS.               <ul style="list-style-type: none"> <li>➢ Minimum RFP criteria to include proposed organizational structure and service delivery model (staff; program services – screening, counseling, eligibility determination, short-term case management, referrals - including housing and transportation, and assistance; target population), and business plan (budget, timeline); demonstrated existence of existing local Web-based long-term care information database; a letter of support from the local long-</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Identification of lessons-learned and best practices from current ADRCs to inform RFP development</li> <li>• RFP developed</li> <li>• Solicitation process to identify CLRCs conducted.</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b><i>1.1. California will provide awareness, information, and assistance in accessing HCBS (continued)</i></b></p>	<p>term care web-based network; major urban/suburban area; entity can broadly address consumer needs inclusive of California's diverse ethnic, cultural, language, and identity groups; evidence of commitment to working with CalCareNet in order to inform design, populate database, and test programming and user interface; and letters of support from identified key partner agencies.</p> <ul style="list-style-type: none"> <li>• Host two bidder conferences: one in northern Calif.; one in southern Calif.</li> <li>• Select and implement CLRCs in two county/regions (expands the ADRC information, referral and assistance model )</li> <li>• Selected CLRC sites to finalize the following: <ul style="list-style-type: none"> <li>➢ Organizational structure and service delivery model</li> <li>➢ Service implementation plan with viable timeline</li> <li>➢ Outreach and marketing plan with outreach materials for new service system and structure <ul style="list-style-type: none"> <li>▪ Ongoing outreach efforts should include diverse approaches, e.g., print media, radio/TV PSAs, pharmacies, hospitals, etc.</li> </ul> </li> </ul> </li> <li>• Conduct presentations and other outreach to community-based, advocacy and health organizations to make consumers aware of availability of one-stops and CalCareNet: <ul style="list-style-type: none"> <li>➢ Pilot and field test CalCareNet at CLRCs: <ul style="list-style-type: none"> <li>▪ Provide appropriate cross-program training on CalCareNet;</li> <li>▪ Obtain feedback from staff/consumers on</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Two pilot county/regions selected</li> <li>• Organizational structure, service delivery model and implementation timeline, and business plan for each CLRC completed</li> <li>• CLRC education and outreach plan and materials completed, approved, and implemented</li> <li>• #/ type of outreach/marketing activities</li> <li>• # of community partner meetings</li> <li>• CalCareNet implemented in CLRC</li> <li>• Trained CLRC staff on CalCareNet;</li> <li>• Field tested and pilot tested CalCareNet; revised the portal based upon feedback</li> <li>• Verified that prototype meets Section 508 and WC3 federal and industry web-accessible standards</li> <li>• Ongoing evaluation and feedback from CLRCs/ADRCs on CalCareNet</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b><i>1.1. California will provide awareness, information, and assistance in accessing HCBS (continued)</i></b></p>	<p>CalCareNet field test/pilot.</p> <ul style="list-style-type: none"> <li>• Improve communication and collaboration among LTC providers: <ul style="list-style-type: none"> <li>➢ Establish local CLRC/ADRC Coalition/Advisory group (provides a critical forum for information exchange and current ADRC mentoring of CLRC sites)</li> <li>➢ Establish community connections and collaboration</li> <li>➢ Evaluate effectiveness of Community Kiosks established in San Diego’s ADRC (2007) for potential replication in CLRCs as appropriate.</li> </ul> </li> <li>• Provide screening for early identification of needs and connection to services: <ul style="list-style-type: none"> <li>➢ Identify and/or create brief screening tool for CLRCs (work with ADRCs) <ul style="list-style-type: none"> <li>▪ Short-term case management with appropriate care plan, if needed</li> <li>▪ Create a set of common data elements to be used across ADRC/CLRCs in collaboration with technical consultant.</li> </ul> </li> </ul> </li> <li>• Explore how opportunities for branding help advance systems’ accessibility</li> </ul>	<ul style="list-style-type: none"> <li>• # of established Agreements and/or partnerships between CLRCs and community partners, including advocacy organizations</li> <li>• Evidence of ADRC/CLRC coalition activities (# meetings, shared project information/ activities, discussion of opportunities for systems branding, etc.)</li> <li>• Evaluation of San Diego Community Kiosks and recommendations for CLRCs</li> <li>• Completed or identified screening tool</li> <li>• Implementation of common data elements in screening tool</li> <li>• # consumers served (via website and counselor or by phone)</li> <li>• # consumers identified at risk via screening tool</li> </ul>
<p><b><i>1.2. Streamline the Multiple Eligibility Processes</i></b></p>	<ul style="list-style-type: none"> <li>• Develop and implement screening procedures (work with ADRCs) <ul style="list-style-type: none"> <li>➢ Intake to include range of appropriate information needed (demographics, Medi-Cal/Medicare eligibility, income and assets, LTC needs, etc.)</li> <li>➢ Triage to appropriate information, services and programs.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Completed comprehensive screening tool</li> <li>• Procedures to triage to appropriate resources based on information gathered in screening tool</li> <li>• # referrals made to appropriate information, services and</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
	<ul style="list-style-type: none"> <li>• Provide short-term case management to guide client through eligibility process and multi-level referrals using the comprehensive screening tool</li> <li>• Facilitate the individuals' transition from one service provider to the next:               <ul style="list-style-type: none"> <li>➢ Identify mechanisms for improving consumer access, eligibility, and referral processes.</li> <li>➢ Establish referral protocols with key partners</li> <li>➢ Identify key information that can be shared with partners to avoid unnecessary duplication.</li> <li>➢ Use Eric Coleman's Care Transitions Intervention Model to educate and empower consumers (potential for replication at ADRCs in the future)</li> </ul> </li> </ul>	<p>programs</p> <ul style="list-style-type: none"> <li>• Service plan form (to identify set of referrals)</li> <li>• # follow up/short-term care management contacts regarding service plan</li> <li>• # consumers trained on Eric Coleman's Care Transitions Intervention Model</li> </ul>
<p><b><i>1.3. Target Individuals who are at Imminent Risk for Institutionalization</i></b></p>	<ul style="list-style-type: none"> <li>• Develop and implement effective triage system targeting individuals at risk of institutionalization (potential for replication at ADRCs in the future):               <ul style="list-style-type: none"> <li>➢ Conduct community assessment to identify providers who serve "at-risk individuals at imminent risk of institutionalization"</li> <li>➢ Create linkages to critical pathways; building local cross-program infrastructures (including comprehensive health and social services); increasing rapid responses for individuals at imminent risk of institutionalization (especially hospitals)</li> <li>➢ Establish functional markers to identify at risk individuals</li> <li>➢ Establish and link mechanisms between and among community partners (hospitals/SNFs/CBOs) to provide at-risk individuals community-based LTC options and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Completed community assessment to identify critical pathways for targeting at risk individuals</li> <li>• Established triage system</li> <li>• # community partners collaborating on improved triage system</li> <li>• # "individuals at-risk" for institutionalization" served</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b>1.3. Target Individuals who are at Imminent Risk for Institutionalization (continued)</b></p>	<p>support (e.g., meals, housing, etc)</p> <ul style="list-style-type: none"> <li>➤ Monitor development of federal-level standardized hospital discharge assessment protocols</li> </ul>	
	<p style="text-align: center;"><b><i>Sustainability of Project Activities</i></b></p> <ul style="list-style-type: none"> <li>• The following action steps will support long-term sustainability of ADRC/CLRC activities in CA: <ul style="list-style-type: none"> <li>➤ Produce a final report, with collaboration from CDA and DOR, documenting the success and benefits of the ADRC/CLRC models in CA. Outcomes from the following related initiatives will be incorporated into the report: <ul style="list-style-type: none"> <li>▪ Conduct a survey of Area Agencies on Aging, County Adult Services programs, IHSS public authorities, Independent Living Centers, etc. to assess potential of organizations to house future ADRC/CLRC sites</li> <li>▪ Develop recommendations for expanding flexible and sustainable ADRC/CLRC model(s) that will position California to take advantage of funding opportunities</li> <li>▪ Identification of potential avenues for continued funding of ADRC/CLRC expansion</li> </ul> </li> <li>➤ Educate stakeholders (including private foundations), department policy makers and legislative staff about the success and benefits of ADRC/CLRC models</li> <li>➤ Establish a Sustainability Committee, including State Departments, Advisory Committee members and other stakeholders (beginning</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Final report documenting success and benefits of ADRC/CLRC models in CA – to include outcomes from related initiatives</li> <li>• Documented efforts to educate stakeholders and others regarding the success and benefits of ADRC/CLRC models</li> <li>• Established Sustainability Committee</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
	year 5) to support expansion/sustainability of ADRC/CLRCs and other project goals	

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b>Goal 4</b>  <b><i>4.1. Design Information Technology (IT) applications that will support program practices and processes that are consistent with participant-centered principles and enable consumers to direct their own services.</i></b></p>	<ul style="list-style-type: none"> <li>➤ Build on the CalCareNet Portal Enhancement Project to implement a piloted version of the site at the two Community Link Resource Centers (CLRCs); the piloted prototype, to be completed in a replicable template necessary for statewide expansion, will provide a comprehensive, easy-to-use, fully accessible, consistently updated Web-based aging and long-term care information and assistance system which provides consumers with an opportunity to direct their own services</li> <li>➤ Convene CalCareNet Portal Enhancement Project Steering &amp; Advisory Committees, with representatives from the IT Subcommittee, to establish a baseline assessment of the CalCareNet Portal Enhancement project; review that project's final report; and identify support or additional representation needed to evaluate the project's status and calendaring for next steps</li> <li>➤ Establish new Steering Committee for the California Community Choices CalCareNet pilot project (to include members of CCC IT Subcommittee)</li> <li>➤ Develop an IT procurement plan for the development of CalCareNet pilots at two CLRCs. Contractor must include the following</li> </ul>	<ul style="list-style-type: none"> <li>➤ CalCareNet Portal Enhancement Project Steering and Advisory Committee recommendations (with CCC Information Technology (IT) subcommittee input) regarding expansion of CalCareNet</li> <li>➤ Newly established Steering Committee for California Community Choices CalCareNet project</li> <li>➤ IT Procurement plan (signed off by the State) – includes management principles</li> <li>➤ Plan for CalCareNet expansion with funding assessment</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b><i>4.1. Design IT applications that will support program practices and processes that are consistent with participant-centered principles and enable consumers to direct their own services (continued)</i></b></p>	<p>information in the application proposal:</p> <ul style="list-style-type: none"> <li>➤ Proposed approach for expanding existing prototype based on evaluation of CalCareNet Portal Enhancement Project;</li> <li>➤ Proposed project management plan;</li> <li>➤ Proposed risk management plan;</li> <li>➤ Proposed economic analysis and project funding plan;</li> <li>➤ Proposed plan/schedule for maintenance (upkeep) of resources and database;</li> <li>➤ Proposed quality assurance mechanisms to meet consumer quality needs (to include a feedback mechanism for all site components to assess relevance and quality);</li> <li>➤ Proposed plan to make site fully accessible to all persons (consistent with Section 508 federal standards and WC3 industry standards), including architecture which provides alternate text for each information element, and a plan for addressing accessibility needs of persons without computers or who require other technologies to access the site;</li> <li>➤ Proposed approach for monitoring, evaluating, and reporting project issues or concerns;</li> <li>➤ Proposed plan to create a culturally competent site which supports diversity of all persons (includes language, ability, access, etc.); and</li> <li>➤ Proposed plan to make the site secure (includes client information protection)</li> <li>➤ Proposed statewide expansion plan with funding assessment in Year 4 of project (plan will be used by Sustainability Committee to</li> </ul>	<ul style="list-style-type: none"> <li>➤ Competitive process resulting in selected vendor</li> <li>➤ Vendor-produced plan for expanding existing prototype to two pilot sites</li> <li>➤ Implemented CalCareNet at two CLRCs</li> <li>➤ Trained ADRC/CLRC staff on Web-based applications</li> <li>➤ Field tested and pilot tested the enhanced CalCareNet with HCBS professionals and consumers and revised the portal based upon feedback and evaluation results; implemented procedures/processes to ensure site quality and consumer satisfaction</li> <li>➤ Verified that prototype meets Section 508 and WC3 federal and industry web-</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b><i>4.1. Design IT applications that will support program practices and processes that are consistent with participant-centered principles and enable consumers to direct their own services (continued)</i></b></p>	<p>explore public-private partnerships and availability of local government funding for CalCareNet expansion)</p> <ul style="list-style-type: none"> <li>➤ Conduct competitive solicitation process and award contract to successful vendor</li> <li>➤ Select vendor</li> <li>➤ Community Choices Project Director with project Steering Committee to monitor contractor progress on all related project plans</li> <li>➤ Contractor to conduct user testing at the pilot sites to ascertain compliance with WC3 and 508</li> <li>➤ CLRCs and contractor to establish and train specialists (navigators) to provide in-person assistance to persons with disability seeking access to information on the CalCareNet site</li> </ul>	<p>accessible standards</p> <ul style="list-style-type: none"> <li>➤ Trained specialists (navigators) to provide in-person assistance to persons with disability seeking access to information on the CalCareNet site</li> <li>➤ Conducted and documented formative evaluation of the objectives and IT transformation goal; based on evaluation, determine next steps for statewide implementation of CalCareNet template/architecture system</li> </ul>
<p><b><i>4.2. Improve client access to long-term services through the use of integrated IT</i></b></p>	<ul style="list-style-type: none"> <li>➤ Incorporate the various Web-based resources and data depositories already in existence in California:</li> <li>➤ Connect State-level program databases</li> <li>➤ Vendor to subcontract an experienced consultant in web accessibility to review final prototype for various forms of accessible technology</li> </ul>	<ul style="list-style-type: none"> <li>➤ Connected and integrated county, community-based, and regional resource databases (into CalCareNet) for two pilot sites</li> <li>➤ State-level databases incorporated and connected into CalCareNet prototype/template</li> <li>➤ Completion of all required project deliverables as specified in contract, e.g., completion of plan/schedule for IT system maintenance (updating); implementation of quality assurance</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b>4.2. Improve client access to long-term services through the use of integrated IT (continued)</b></p>		<p>mechanisms integrated into finalized CalCareNet system</p> <ul style="list-style-type: none"> <li>➤ Monthly (required) progress reports, regularly scheduled meetings with advisory groups, and final summary report; quarterly reports to the full advisory committee</li> <li>➤ Fully tested prototype for every ability</li> </ul>
<p><b>4.3. Use integrated IT systems to monitor the quality of services rendered.</b></p>	<ul style="list-style-type: none"> <li>➤ Commission a modified study to identify barriers to LTC data integration at both the community and state levels and identify parameters for a definition of what a model data storage warehouse would entail for California:</li> <li>➤ Identify scope of work associated with the study</li> <li>➤ Review access to and availability of local and State information necessary for vendor to complete study</li> <li>➤ Select specialist(s) to conduct study</li> <li>➤ Disseminate the study findings and recommendations to all interested parties</li> </ul>	<ul style="list-style-type: none"> <li>➤ Selected specialist</li> <li>➤ Completed study identifying local and state barriers to incorporation of data integration with a definition of what a model data storage warehouse would entail for California and recommendations/next steps for funding and implementing a model data storage warehouse</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p align="center"><b>Goal 5</b></p> <p><b><i>5.2. Develop and Implement More Flexible Payment Methodologies</i></b></p>	<ul style="list-style-type: none"> <li>➤ Commission a long-term care financing study to examine the laws, regulations, policies, practices and payment methodologies related to long-term care financing in California. The study shall include recommendations (funding, payment methodology, policy, etc) focused on increasing consumer access to and funding of home and community-based services through rebalancing spending on long-term care services in California (The study will inform Olmstead Advisory Committee efforts in this area and the MFP Demonstration Project)</li>   <li>➤ Establish a scope of work for the LTC Financing Study contractor</li> <li>➤ Include baseline definitions for both institutional and home and community-based long-term care services in CA</li> <li>➤ Engage Finance Subcommittee, state departments and technical consultants in the refinement of study elements to be incorporated into the LTC Financing study design. <u>Preliminary study elements may include, but are not limited to:</u></li> <li>➤ Preliminary literature review to identify existing resources, studies and analysis on long-term care in California.</li> <li>➤ Examination of the basic structure of state and local administration of long-term care supports</li> <li>➤ Demographic indicators for demand for long-term supports; utilization data to indicate the levels of services currently available and service gaps;</li> </ul>	<ul style="list-style-type: none"> <li>➤ LTC Financing Study Scope of Work defined</li> <li>➤ Elements of LTC Financing Study defined (with input from Finance Subcommittee, state departments, and technical consultants)</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b>5.2. Develop and Implement More Flexible Payment Methodologies</b> (continued)</p>	<p>historical and political factors that influence systems change</p> <ul style="list-style-type: none"> <li>➤ Identification of current long-term care services in California and funding streams for each long-term care service</li> <li>➤ A historical analysis of long-term care Medi-Cal expenditures in California, including::</li> <li>➤ Total Medi-Cal long-term care spending on home and community-based services compared to institutional services</li> <li>➤ The rate of change for Medi-Cal long-term care spending compared to the national average</li> <li>➤ Medi-Cal long-term care per capita spending on home and community-based services and institutional services</li> <li>➤ The rate of change for Medi-Cal long-term care spending compared to other states for both home and community-based and institutional services</li> <li>➤ The change in the number of institutional beds and the number of Medi-Cal waiver slots</li> <li>➤ An analysis of projected future long-term care needs, expenditures and trends in California</li> <li>➤ A comprehensive analysis of laws and regulations (or lack of laws and regulations) that impact consumer access to home and community-based services, including identification of structural barriers and recommendations to eliminate those barriers</li> <li>➤ An analysis of fiscal incentives and disincentives that would encourage institutionalization and recommendations to remove any institutional bias in payment/reimbursement practices</li> </ul>	

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b>5.2. Develop and Implement More Flexible Payment Methodologies</b> (continued)</p>	<ul style="list-style-type: none"> <li>➤ A charting of the laws, regulations, policies for each LTC service by funding source</li> <li>➤ An examination of rates paid for HCBS and to providers/vendors across programs, including an analysis of the differences and (historical) rationale for establishment of various rates</li> <li>➤ Identify how current rate structure impacts access to home and community-based services.</li> <li>➤ Examination of payment/fiscal constraints prescribed by federal and state control agencies</li> <li>➤ Identification of payment strategies that can more effectively manage funding and increase access to home and community-based services, including an examination of the potential to establish a standardized rate structure for HCBS across target populations and among providers (that would incorporate geographic cost of living adjustments):</li> <li>➤ Analyze the cost of a standardized HCBS rate structure to both the state and federal government</li> <li>➤ Analyze the cost of expanding HCBS waiver and State Plan services (including both new and expansion of underutilized existing services) and any potential savings from preventing or reducing hospital or nursing home stays</li> <li>➤ Examine the potential for establishing the structural and financial mechanisms that would allow presumptive Medi-Cal eligibility and fast track assessment for individuals (at risk of institutionalization) to access HCBS</li> <li>➤ Examination of the potential for establishing global budgeting for all LTC services</li> </ul>	

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><b>5.2. Develop and Implement More Flexible Payment Methodologies</b> <i>(continued)</i></p>	<p>(institutional and HCBS)</p> <ul style="list-style-type: none"> <li>➤ Analysis of the potential benefits and opportunities for “downsizing funding”, e.g. Developmental Services</li> <li>➤ Work with State departments to ensure access to data and information necessary to complete financing study</li> <li>➤ Establish criteria for recruitment and selection of expert researcher to conduct financing study</li> <li>➤ Select and contract with researcher to conduct LTC financing study</li> <li>➤ Initiate LTC Financing study activities</li> <li>➤ Engage stakeholder involvement (including consumers, advocates, caregivers, families, long-term care services providers, long-term care labor workforce, state departments and policymakers) in the LTC Financing study</li> <li>➤ Require researcher to provide bi-monthly progress reports to LTC Finance Subcommittee; quarterly reports to the full Advisory committee</li> <li>➤ Disseminate the long-term care financing study findings to all interested parties. An important strategy for system-wide transformation in California is the completion of the study by January 2009. This will enable current project staff and the Advisory Committee to promote reform efforts (with activities detailed below) before the end of the current Administration in December 2010</li> <li>➤ Advisory Committee will adopt and ratify preferred recommendations and present them as a</li> </ul>	<ul style="list-style-type: none"> <li>➤ Evidence of access to State department authorization for Study Researcher</li> <li>➤ Contract with researcher to conduct the study</li> <li>➤ LTC Financing study design and timeline for completion finalized</li> <li>➤ Recorded stakeholder involvement in LTC study, e.g., meetings, input, review of findings, etc.</li> <li>➤ Bi-monthly study progress reports to the Advisory Committee</li> <li>➤ A completed comprehensive study and analysis of funding management reforms that will help increase use of HCBS and encourage rebalancing of the long-term care system</li> <li>➤ Recommendations on how to implement long-term care funding management</li> </ul>

Goals & Objectives	Strategies/Major Action Steps	Outputs
<p><i>5.2. Develop and Implement More Flexible Payment Methodologies (continued)</i></p>	<p>desired reform agenda to the Administration and Legislature</p> <ul style="list-style-type: none"> <li>➤ Actively engage and dialogue with stakeholders, including the California Community Choices and Olmstead Advisory Committees, department policy makers and legislative staff in finance reform discussions</li> <li>➤ Function as a resource for the State Legislature and stakeholders seeking to implement legal and regulatory reform and changes in policy and practice that would increase access to and use of HCBS</li> <li>➤ Explore possibility of establishing a staff position beyond grant period to: (1) continue coordination of efforts across state departments; (2) facilitate incremental statewide expansion of ADRCs/CLRCs and the CalCareNet website; and (3) actively engage stakeholders, department policy makers, and legislative staff in finance reform discussions and goal formation</li> </ul>	<p>reform</p> <ul style="list-style-type: none"> <li>➤ Broad dissemination of study findings and recommendations</li> </ul>