NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Payment Advisory Group – Services for the Intellectually/Developmentally Disabled

I/DD VBP Advisory Group Meeting 1

Meeting Date: January 21, 2016 - 1 – 4pm

January 2016

Introductions

Part I

A. Intellectually/Developmentally Disabled (I/DD) VBP Advisory Group Overview

I/DD VBP Advisory Group in Context

- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- $6.4 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)
- Value Based Payment
  - Fundamental transformation of the Medicaid payment system, shifting away from volume and rewarding value
  - Development of Advisory Groups (I/DD)
  - Development of VBP arrangements (Episodic, chronic, subpopulations

NYS OPWDD Transformation Panel

- Build on success of current system
- Offer support for family members and direct support professionals
- Involve individuals and families in system improvement

I/DD VBP Advisory Group Composition

Comprehensive Stakeholder Engagement

- Comprehensive stakeholder engagement has been a key component to the development of the Value Based Payment Roadmap.
- We will continue engaging stakeholders as we develop and define opportunities for value based payment arrangements.

Composition of the I/DD VBP AG includes:

- Experience and knowledge focused on the specific care or condition being discussed
- Industry knowledge and experience
- Geographic diversity
- Total care spectrum as it relates to the specific care or condition being discussed

I/DD VBP Advisory Group (I/DD VBP AG): Objectives

- Understand the State's visions for the Roadmap to Value Based Payment
- Review VBP arrangement for people with I/DD receiving services
- Make recommendations to the State on:
  - Quality measures
  - Data and other support required for providers to be successful
  - Other implementation details related to VBP

- Definitions are standard, but financial arrangements between plans and providers around the bundles are not set by the State

I/DD VBP Advisory Group Timeline

Meeting 1

Creating the Right Incentives – Paying for Value

- Working group agenda overview
- The role of VBP in achieving high quality, cost effective care
- I/DD Services in transition - The Transformation Agenda
- High value care in a I/DD context - Total care, total population models with DISCOs, ACOs, and/or IPAs

Meeting 2

A Deeper Dive – the I/DD Population and Total Cost of Care

- Overview total cost of care for I/DD subpopulation
- VBP arrangements for the I/DD subpopulation
- A more nuanced view of use patterns of acute and LTSS

Meeting 3

Defining High Value Care for the I/DD population

- Defining the value premise
- Special considerations for the I/DD population
- Traditional medical and clinical intervention logic
- Nontraditional intervention logic
- Outcome measures to consider – an overview of "food for thought"

Meeting 4

Defining High Value Care for the I/DD population (continued)

- Goal is to select quality measures to incentivize strategic goals
- Process and method for selection
- Detailed review of quality measures – definition and method for collection and calculation
- Facilitated quality measure selection

Meeting 5

Wrap-up Remaining Issues & Considerations

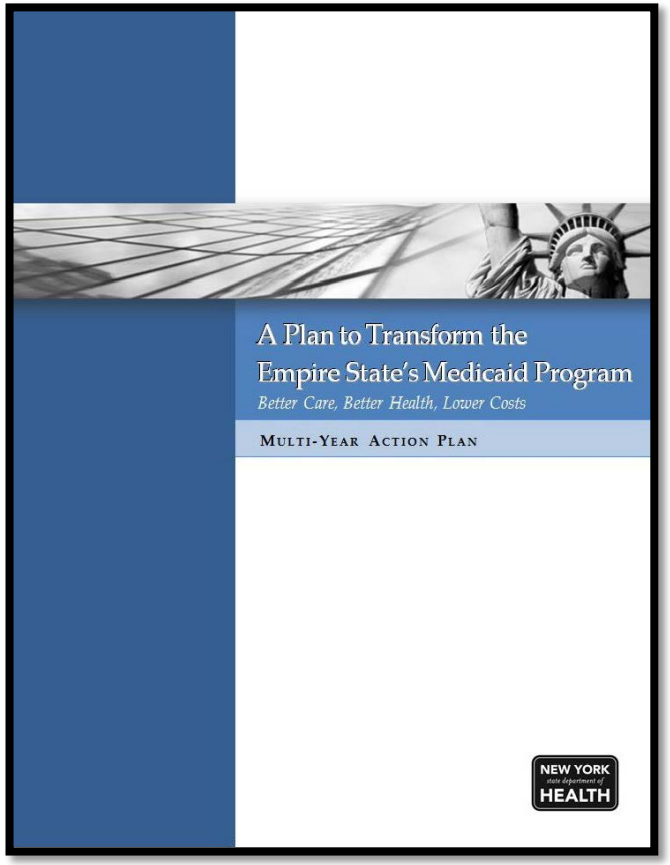
- Agenda TBD

Part II

A. The Role of VBP in Achieving Quality, Cost Effective Care

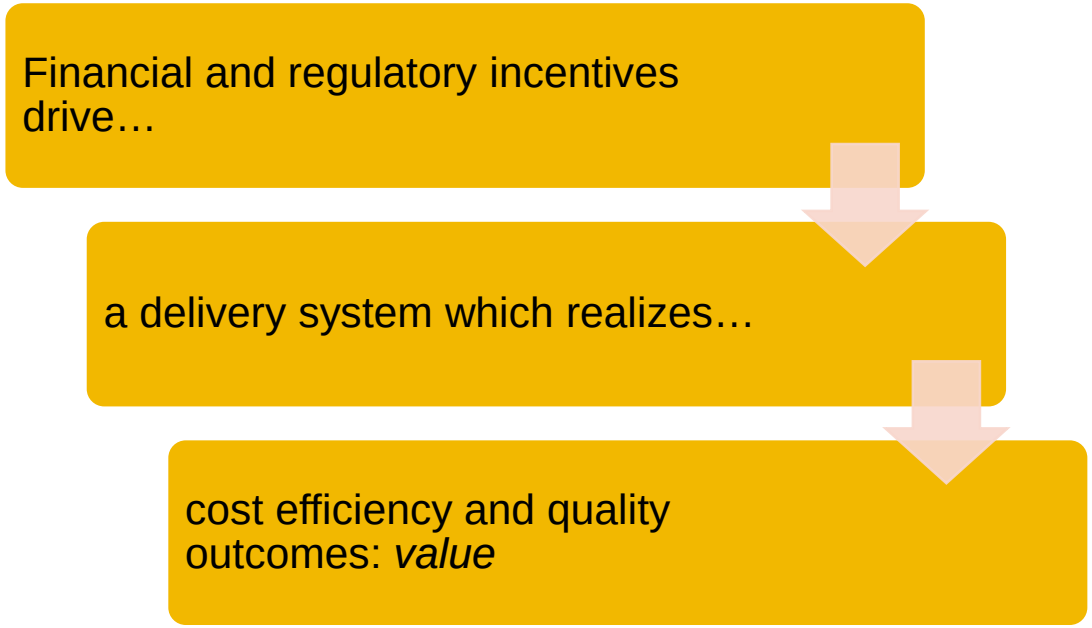
Medicaid Redesign Team – More than 200 Initiatives A Method and Plan for Long-Term Transformation

- In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT).
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York's health care delivery system
- In April 2014, New York State and CMS finalized agreement Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $6.4 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)



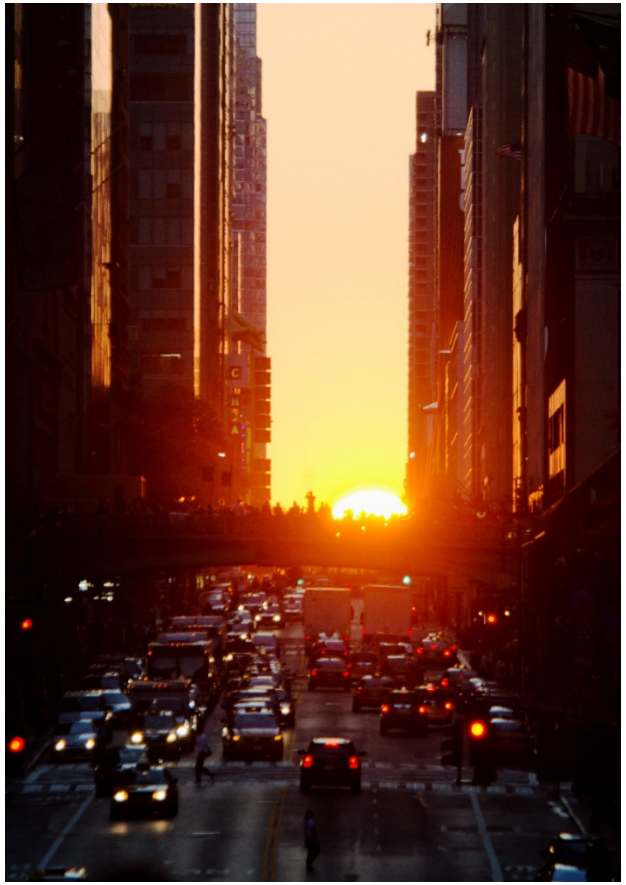
Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration



Payment Reform: Moving Towards Value Based Payments

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver)
- The State and CMS have committed to the Roadmap
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced

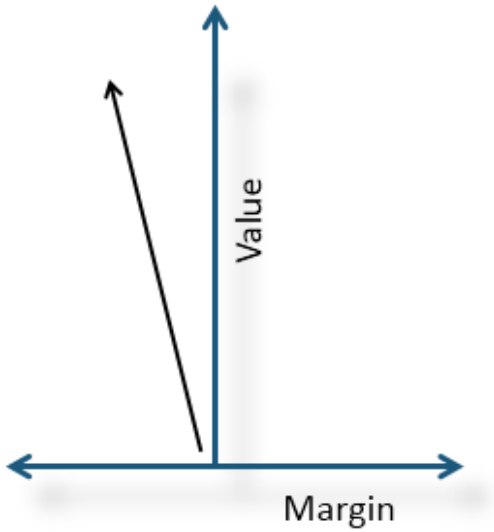


Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins by realizing value.

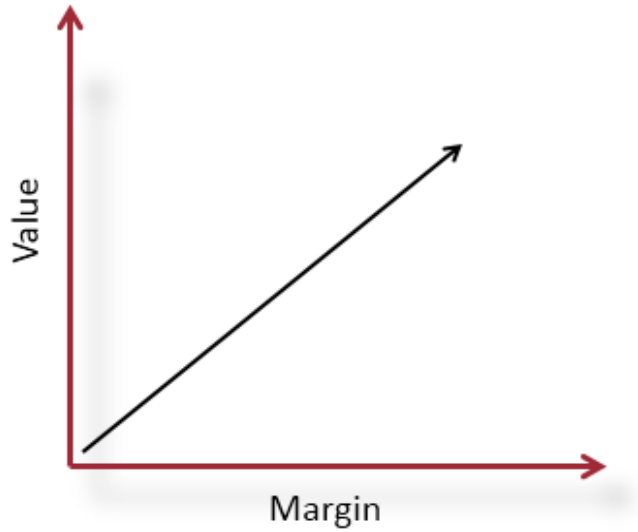
Current State

Increasing the value of care delivered more often than not threatens providers' margins



Future State

When VBP is done well, providers' margins go up when the value of care delivered increases



Goal – Reward Value not Volume

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based prevention activities

- Maternity Care (including first month of baby) — **Episodic**
- Chronic care (Diabetes, CHF, Hypertension, Asthma, Depression, Bipolar …)
- Diabetes
- COPD
- Depression & Anxiety
- HIV/AIDS
- Multimorbid disabled / frail elderly (MLTC/FIDA population)
- Severe SMI/SUD conditions (HARP population)
- Intellectually/Developmentally Disabled population
- Foster Care

Continuous

Population Health Focus on Overall Outcomes and *Total* Costs of Care

Sub-Population Focus on Outcomes and Costs *Within* Sub-Population / Episode

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The Path Towards Payment Reform: A Menu of Options

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities; **and the I/DD subpopulation**

- ➢ Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- ➢ 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing what integrated services to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

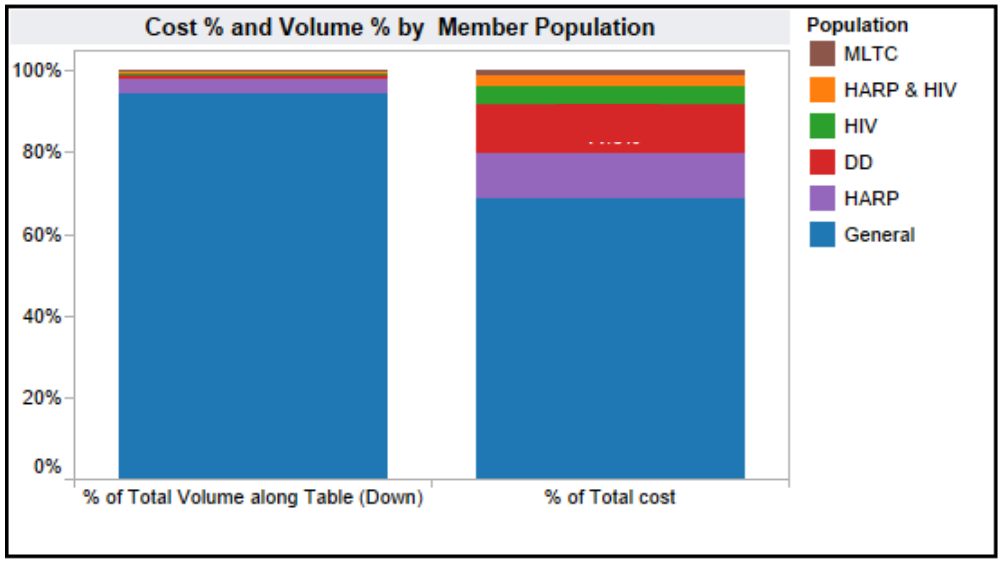
Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

Key Defining Factors of the New York VBP Approach

1. Addressing all of the Medicaid program in a holistic, all-encompassing approach rather than a pilot or piecemeal plan
2. Leveraging the Managed Care Organizations (MCO) to deliver the payment reforms jointly with the providers
3. Addressing the need to change provider business models through positive financial incentives
4. Allowing for maximum flexibility in the implementation for stakeholders while maintaining a robust, standardized framework
5. Maximum focus on transparency of costs and outcomes of care

The Total Medicaid Population: General Population and Sub-populations

All analytics for the New York State (NYS) project are done on NYS Medicaid claims data. The total population is divided into the general population and four specific subpopulations (MLTC, Behavioral Health, HIV/AIDS, and I/DD). Data does not include the Medicaid or Medicare costs for dually eligible individuals.



Note: This graph is based on 2013 claims data for **non-dual** Medicaid members.

- Subpopulations are contracted for the total cost of care for their Medicaid members.
- For the general population, bundles are used to cluster and contract care.
  - A bundle is a patient centered (rather than provider-centered) grouping of claims focused on the integrated care for a condition.
  - Example bundles: Depression, Maternity, etc.

Developing a Subpopulation VBP Arrangement – The Need to Identify Quality Measures

Quality measures will be used to determine the level of quality of care, and ultimately, will inform opportunity for savings when the quality metrics have been achieved.

1. Identify existing quality measures: QARR, HEDIS, DSRIP, NQF, etc.
2. Analyze additional sources of quality measure sources, specific to the subpopulation.
3. Gather appropriate quality measures for inclusion in the subpopulation VBP arrangement, based on clinical relevance, reliability & validity, and feasibility.
4. Prioritize quality measures for incorporation into the VBP Pilot phase and subsequent VBP implementation phase.

Part III

A. I/DD Services in Transition - The Transformation Agenda

- *"Changing complex systems is never easy or fast, but in Managed Care and Value Based Payments we have models based on the simple idea that rewarding good outcomes and containing costs in a measurably effective system works for all: it makes sense for each individual and for everyone who depends on the system of care, now and for years to come." (Draft Recommendations, p. 5)*

Transformation Panel Draft Recommendations: The Imperative to Transform

The transformed system must:

- Build on the successes of the current system in helping the individuals OPWDD supports participate as citizens in the community whenever possible;
- Offer support for the family members and the direct support professionals who are the foundation of our systems of care;
- Involve individuals and families as much as possible.

Note: The data and analysis in the next section are from the *State of the States in Developmental Disabilities*, which is a comparative, longitudinal study of states' performance in financing intellectual and developmental disabilities (I/DD) services and supports. The study is primarily funded by the U.S. Administration on Intellectual and Developmental Disabilities, U.S. Department of Health and Human Services. The Project is located in Boulder, Colorado at the Coleman Institute for Cognitive Disabilities and administered by the University of Colorado Department of Psychiatry in the CU School of Medicine. The Project maintains a 35-year I/DD data set on all 50 states, DC, and preliminary data on the U.S. Territories, and can be accessed at http://www.stateofthestates.org/index.php/publications1/technical-reports

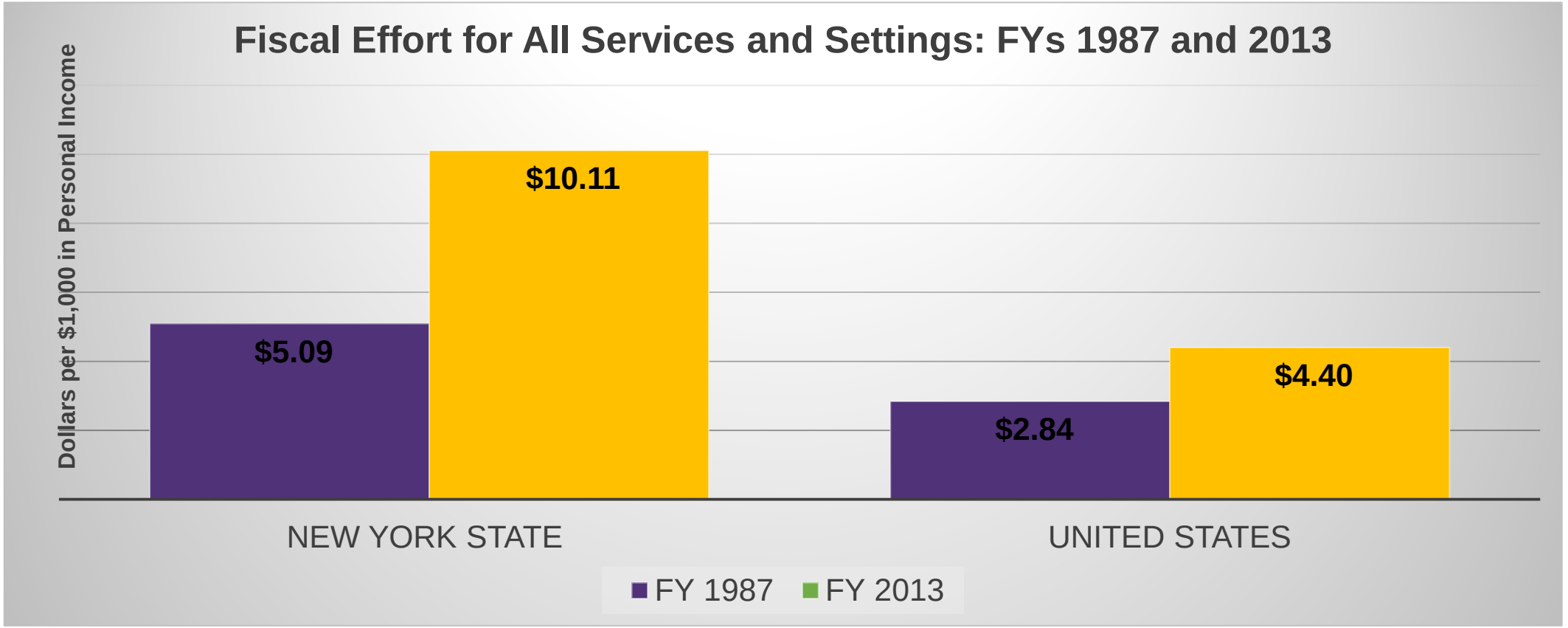
Transformation Panel Draft Recommendations: The Shared Vision

All future program models and system corrections should be grounded in the following principles:

- Does it help promote the integration of people and services into the community?
- Does it encourage the active involvement of people with disabilities and their families?
- Does it broaden the range of choices and options for individuals?
- Does it foster independence?
- Does it take those at the higher end of need into account?
- Does it use data to measure and evaluate quality and satisfaction?
- Is it clear and realistic in its language?

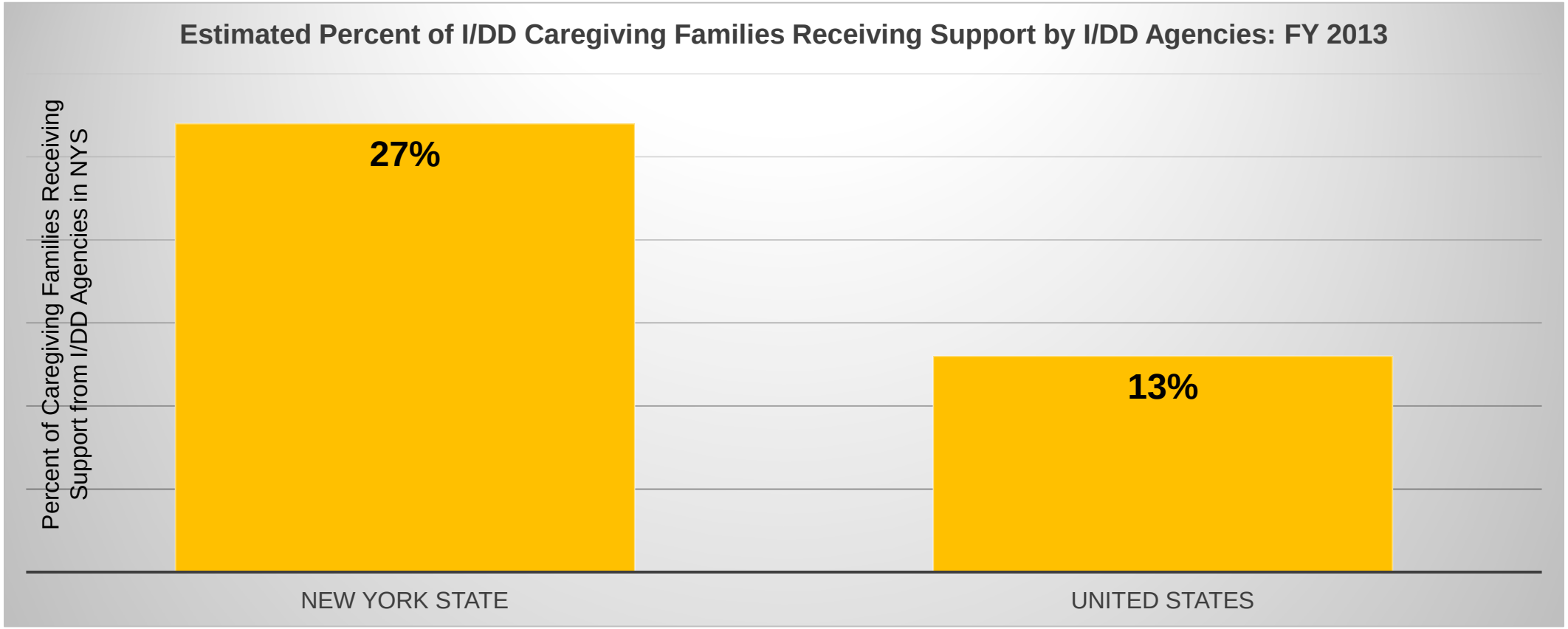
(*Draft Recommendations*, p. 19)

Building on the Successes: New York's Overall Fiscal Effort for I/DD Services is Significantly Higher than the National Norm



Source: Braddock et al. Coleman Institute and Department of Psychiatry, University of Colorado, 2014. Available at: http://www.stateofthestates.org/

Building on Successes: A Larger Percentage of Caregiving Families Receive Support by I/DD Agencies in New York State



Source: Braddock et al. Coleman Institute and Department of Psychiatry, University of Colorado, 2014. Available at: http://www.stateofthestates.org/

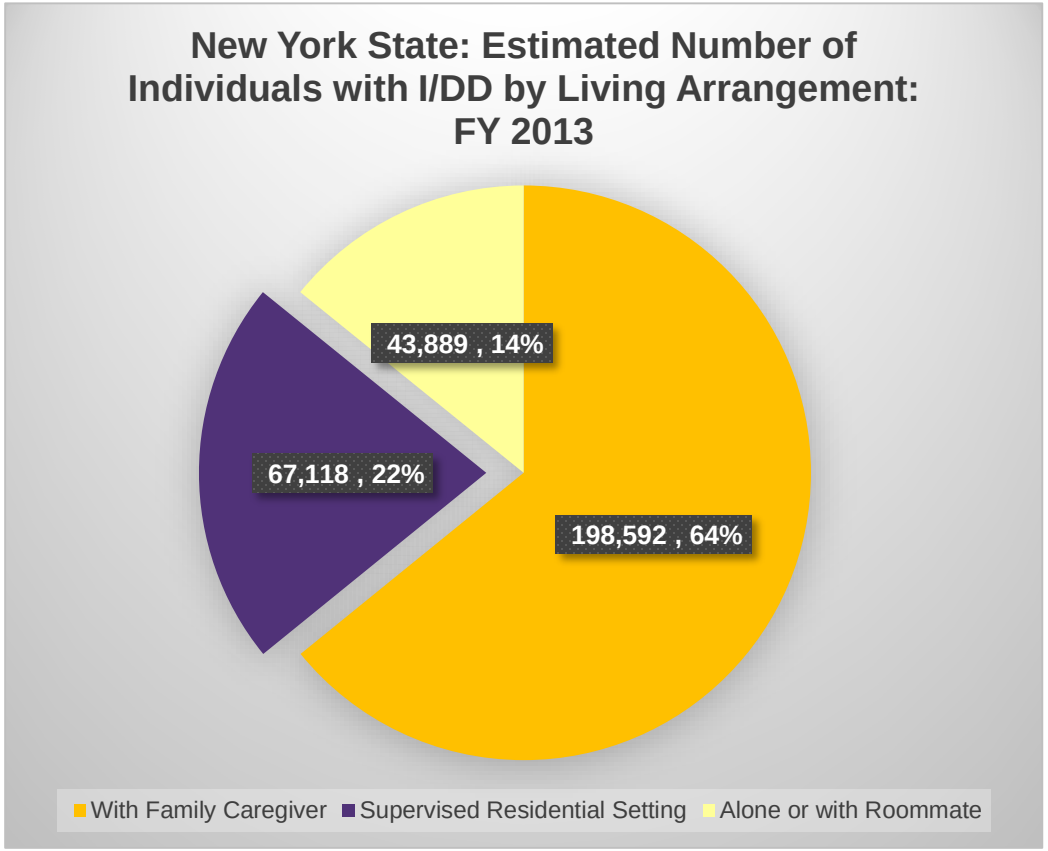
Transformation Panel Draft Recommendations: Residential Support

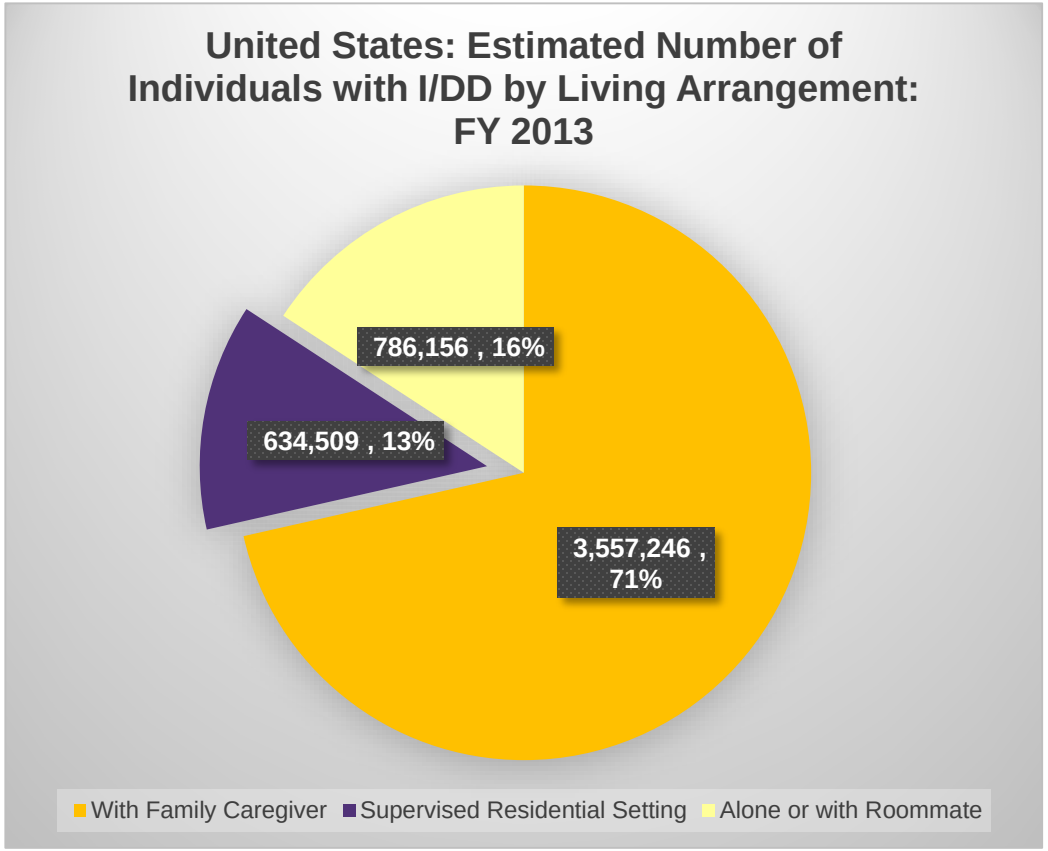
"…the era of one-size-fits-all models has passed—people want and need choices in how and where they live. Institutions were once the only option, but today the inclusion of people with developmental disabilities in the community is a real and achievable goal for many." (Draft Recommendations, p. 13)

Residential support should:

- Establish a system of flexible housing supports;
- Ensure that individuals living at home and those living in institutional settings have access to residential services based on need;
- Pursue an affordable housing strategy to increase investments/focus on statewide investments in affordable housing for the I/DD population;
- Engage in outreach and community education;
- Work with Intermediate Care Facilities residents and providers ensure meaningful opportunities for home and community-based services.

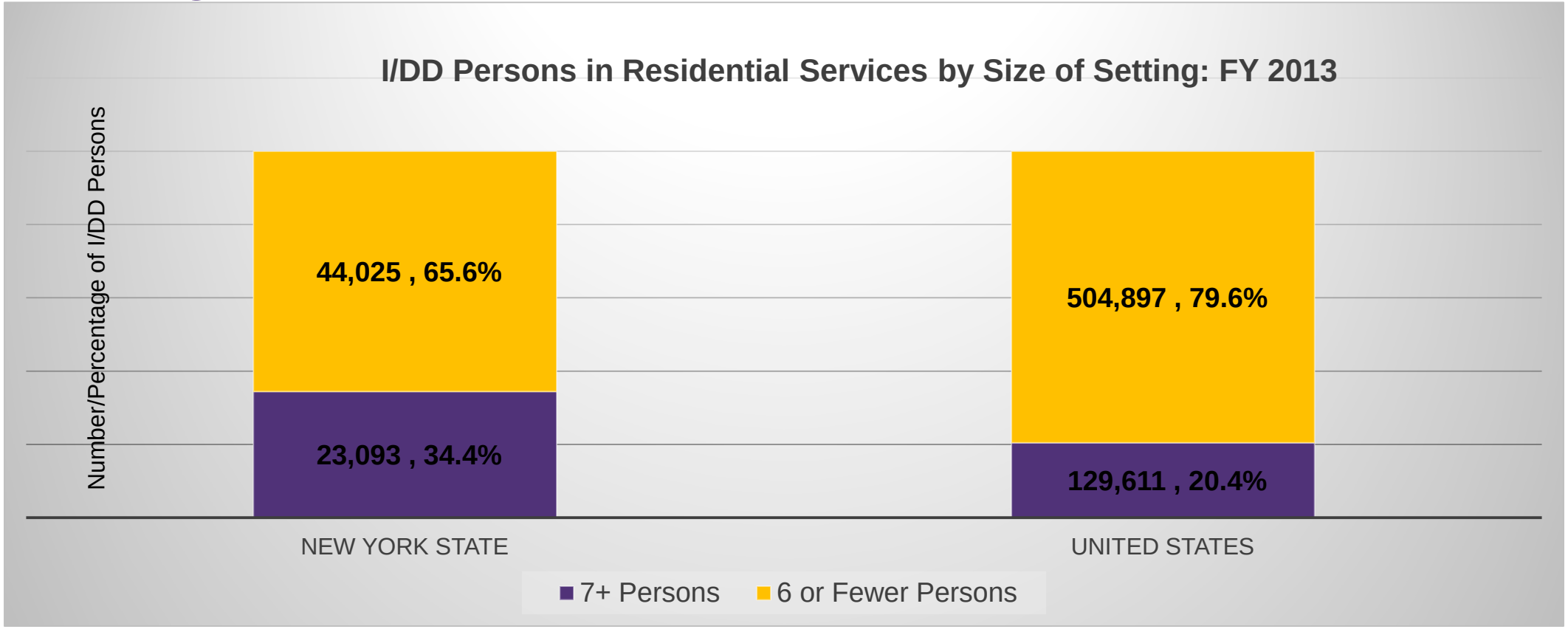
Residential Support: New York Serves a Larger Proportion of I/DD Individuals in Supervised Residential Settings





Source: *Braddock et al. Coleman Institute and Department of Psychiatry, University of Colorado, 2014. Available at: http://www.stateofthestates.org/*

Residential Support: Supervised Residential Settings for I/DD Individuals in New York State More Frequently Settings with 7+ Persons



Source: KPMG analysis based on Braddock et al. Coleman Institute and Department of Psychiatry, University of Colorado, 2014. Available at: http://www.stateofthestates.org/

A Closer Look: Higher Use of Supervised Settings 7-15 Private ICF's and Other Residential Placements; Less Supported Living

Persons Served by Setting: FY 2013				
	New York State		United States	
	Number	Percentage	Number	Percentage
16+ Persons	**4,429**	**6.6%**	**73,609**	**11.6%**
Nursing Facilities	1,883	2.8%	26,678	4.2%
State Institutions	1,015	1.5%	24,675	3.9%
Private ICF/ID	952	1.4%	18,027	2.8%
Other Residential	579	0.9%	4,229	0.7%
7-15 Persons	**18,664**	**27.8%**	**56,002**	**8.8%**
Public ICF/ID	59	0.1%	1,318	0.2%
Private ICF/ID	4,158	6.2%	18,777	3.0%
Other Residential	14,447	21.5%	35,907	5.7%
6 or Fewer Persons	**44,025**	**65.6%**	**504,897**	**79.6%**
Public ICF/ID	34	0.1%	257	0.0%
Private ICF/ID	454	0.7%	20,326	3.2%
Supported Living	26,955	40.2%	293,956	46.3%
Other Residential	16,582	24.7%	190,358	30.0%
Total	**67,118**	**100.0%**	**634,508**	**100.0%**

Source: KPMG analysis based on Braddock et al. Coleman Institute and Department of Psychiatry, University of Colorado, 2014. Available at: http://www.stateofthestates.org/

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Transformation Panel Draft Recommendations: Employment and Life in the Community

"There are many challenges and no quick fixes, but as we move away from a focus on group settings there is plenty of room for new approaches that promote real and meaningful involvement in community life." (Draft Recommendations, p. 13)

Future programs and rules should:

- Develop a flexible day service model;
- Conduct a media campaign to encourage businesses to employ people with I/DD;
- Develop more volunteer opportunities to forge relationships in the community and pathways to employment;
- Assist students in transition from high school to employment;
- Develop retirement strategies for those who may not want to pursue employment;
- Explore supplement transportation strategies such as on-demand services;
- Ensure continuity of employment for those involved in sheltered workshop transition;
- Set a percentage goal for the number of people with developmental disabilities employed by OPWDD.

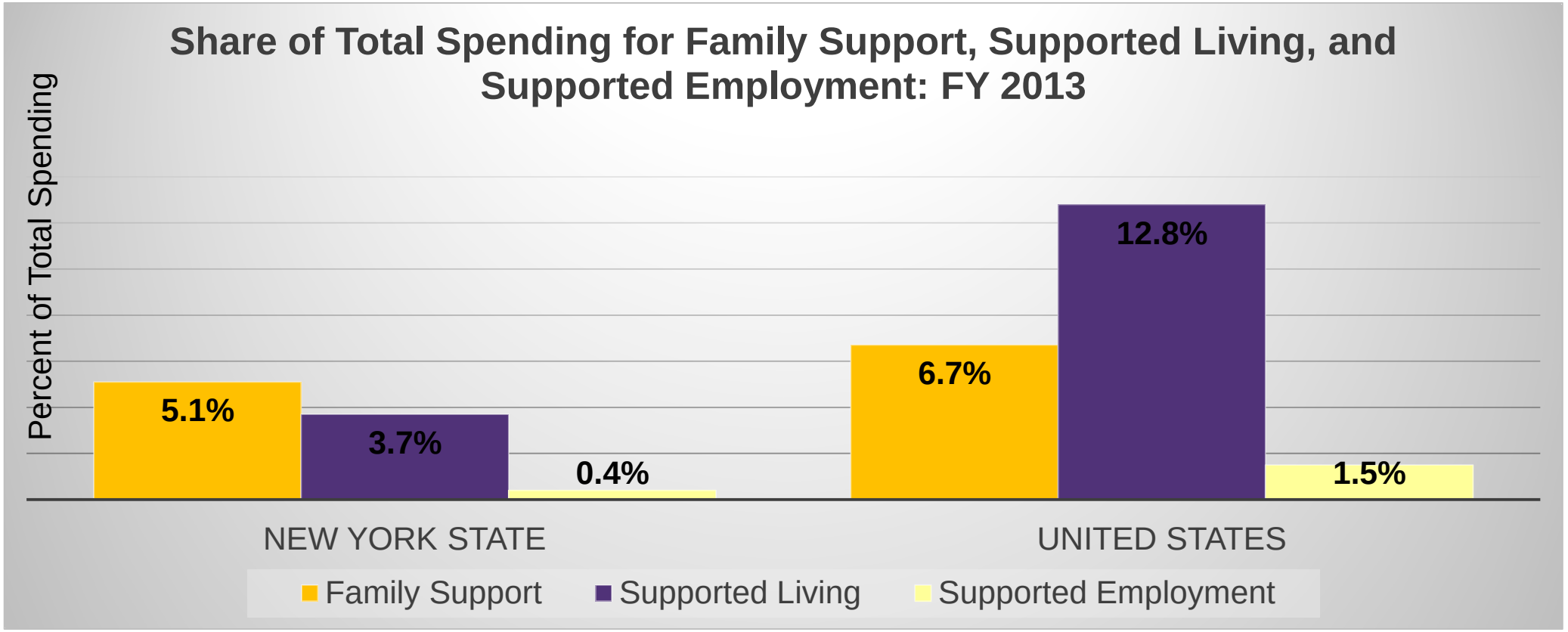
Transformation Panel Draft Recommendations: Self-Determination

"Self-determination may not be the right service delivery option for everyone, but all of us like to have some control over our lives. That's why our systems of support need to move away from a regimented approach to make choice a reality." (Draft Recommendations, p. 13)

In the future the system should:

- Simplify rules and requirements for self-direction;
- Establish a peer mentoring program to help individuals and families understand self-direction;
- Ensure that funding is sufficient for individuals with higher needs to self-direct;
- Develop strategies to infuse self-determination in all aspects of OPWDD service delivery;
- Develop strategies to better utilize community resources available to the general public, and foster relationships between people with developmental disabilities and their non-disabled peers.

Employment and Life in the Community: Share of Total Spending for Family Support, Supported Living, and Supported Employment



Source: Braddock et al. Coleman Institute and Department of Psychiatry, University of Colorado, 2014. Available at: http://www.stateofthestates.org

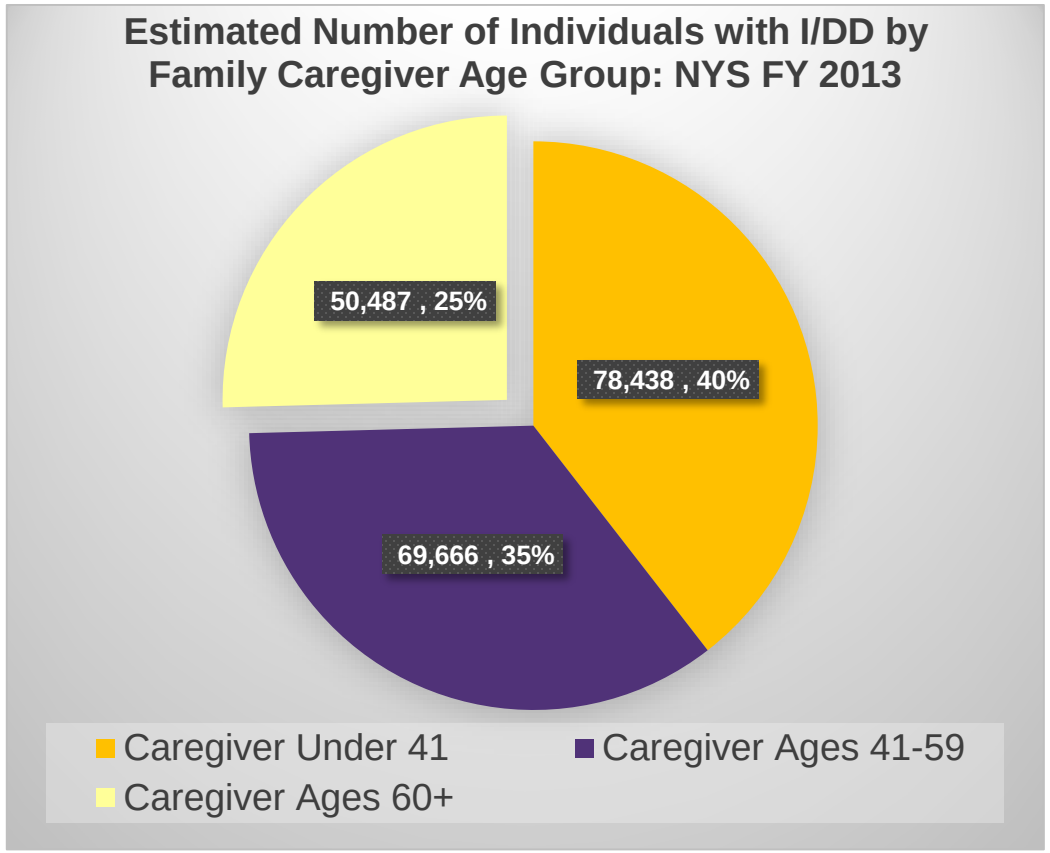
Transformation Panel Draft Recommendations: Supporting Staff and Family Caregivers

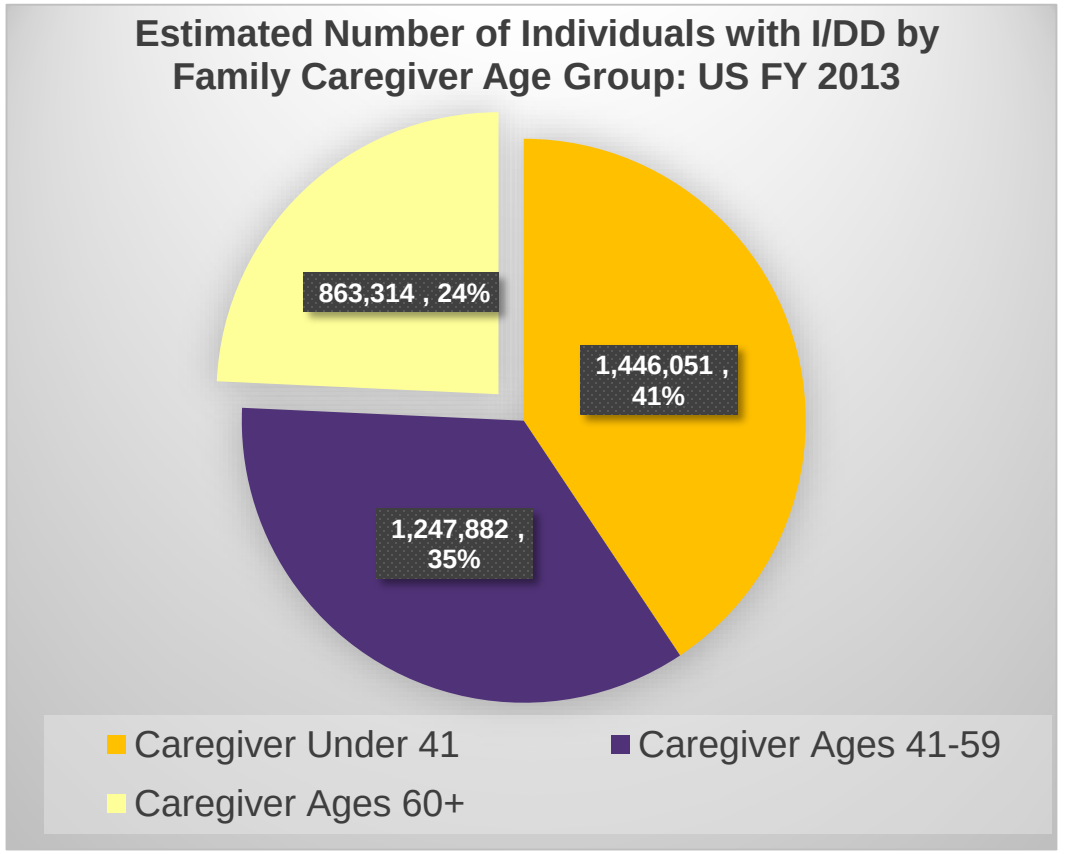
"People with disabilities are supported by family and friends as well as paid caregivers, and all these people deserve and need to be supported in turn. … Careful consideration needs to be given to ensure resources are available to families who are caring for their loved ones at home, and steps taken to address immediate needs as well as plan for long-term residential support." (Draft Recommendations, p. 14)

Staff and Family Caregivers should be supported by the following:

- Implement a second phase of comprehensive training for Front Door staff to better equip them as they develop effective service plans with individuals and families;
- Advocate for appropriate compensation for Direct Support Professionals;
- Implement the START crisis response model statewide;
- Implement care coordination in a way that incorporates the expertise of existing Medicaid Service Coordinators;
- Explore creative models for supporting caregivers, including sharing resources among families
- Review respite needs;
- Engage in yearly outreach for those on the Residential Request List.

Supporting Staff and Family Caregivers: A Sizeable Proportion of the Estimated I/DD Population is Living at Home with Aging Caregivers





Source: *Source: Braddock et al. Coleman Institute and Department of Psychiatry, University of Colorado, 2014. Available at: http://www.stateofthestates.org*

Refer to Appendix for methodology of data

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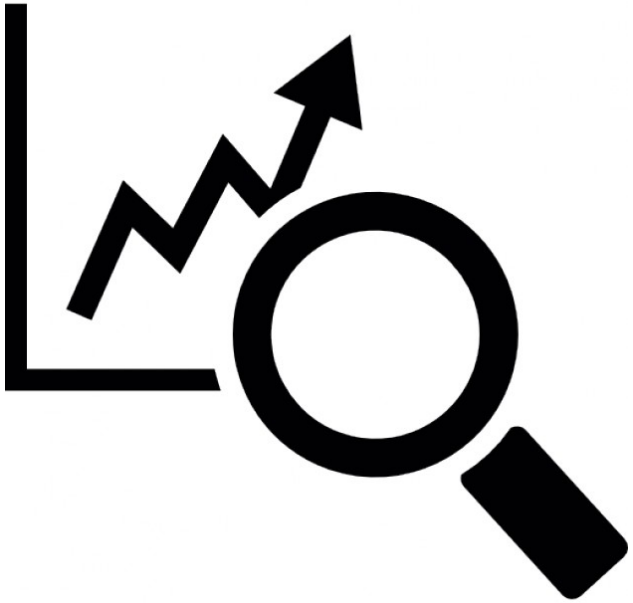
New York State's Performance on the National Core Indicators

- New York State's performance relative to other states is reflected in the National Core Indicators (NCI)
  - NCI is a voluntary effort by state developmental disability agencies to gauge their own performance using a common and nationally validated set of measures.
  - NCI uses 100 standard performance measures (or "indicators") to assess the outcomes of services provided to individuals and their families.
- New York State NCI Standings
  - New York State underperforms the NCI average in the domains of individual choice and work.
  - Access to transportation is also 10 points below the NCI average.
  - In the health domain, NYS does relatively well relative to the NCI average.



National Core Indicator Domains

Individual Outcomes

Addresses how well the public system aids adults with developmental disabilities to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination. Other indicators in this domain probe how satisfied individuals are with services and supports.

Health, Welfare, and Rights

Addresses (a) safety and personal security; (b) health and wellness; and (c) protection of and respect for individual rights

System Performance

Addresses (a) service coordination; (b) family and individual participation in provider-level decisions; (c) the utilization of and outlays for various types of services and supports; (d) cultural competency; and (e) access to services.

Family Indicators

Addresses how well the public system assists children and adults with developmental disabilities, and their families, to exercise choice and control in their decision-making, participate in their communities, and maintain family relationships. Additional indicators probe how satisfied families are with services and supports they receive, and how supports have affected their lives.

Staff Stability

Addresses provider staff stability and competence of direct contact staff.

National Core Indicators: NYS Below the NCI Average

Choice

5 points below in 5 of 9 indicators

- Chose Roommates Or Chose To Live Alone
- Chose Day Program Or Regular Activity
- Chose Staff
- Decides How To Spend Free Time
- Chooses How To Spend Money

Work

5 points below in four indicators

- Worked 10 Of The Last 12 Months In A Paid Community Job
- Average Months At Current Paid Community Job
- Receives Benefits At Paid Community Job
- Four Most Common Fields Of Paid Community Employment- Food Preparation And Food Service

All Other

At least 5 points below in 3 other indicators

- Has A Best Friend
- Always Has A Way To Get Places – 10 points below NCI average
- Engages In Regular, Moderate Physical Activity At Least 30 Minutes A Day 3x/week

National Core Indicators: NYS Above the NCI Average

All Other

3 indicators 5 or more points above the NCI average

- Went On Vacation In The Past Year
- Four Most Common Fields Of Paid Community Employment - Building And Grounds Cleaning Or Maintenance
- Volunteers
- Case Manager/Service Coordinator Calls Person Back Right Away

Health

6 of 11 indicators 5 points or more above NCI average

- Had A Dental Exam In The Past Year
- Had An Eye Exam Or Vision Screening (In The Past Year)
- Had A Hearing Test (In The Past Five Years)
- Had A Mammogram (In The Past Two Years, Women 40 And Over)
- Had A Colorectal Cancer Screening (In The Past Year, Age 50 And Over)
- Had A Flu Vaccine (In The Past Year)

See Appendix for additional detail on indicators and New York's scores.

Part IV- System Platforms

High value care in a DD context – Total care, total population models

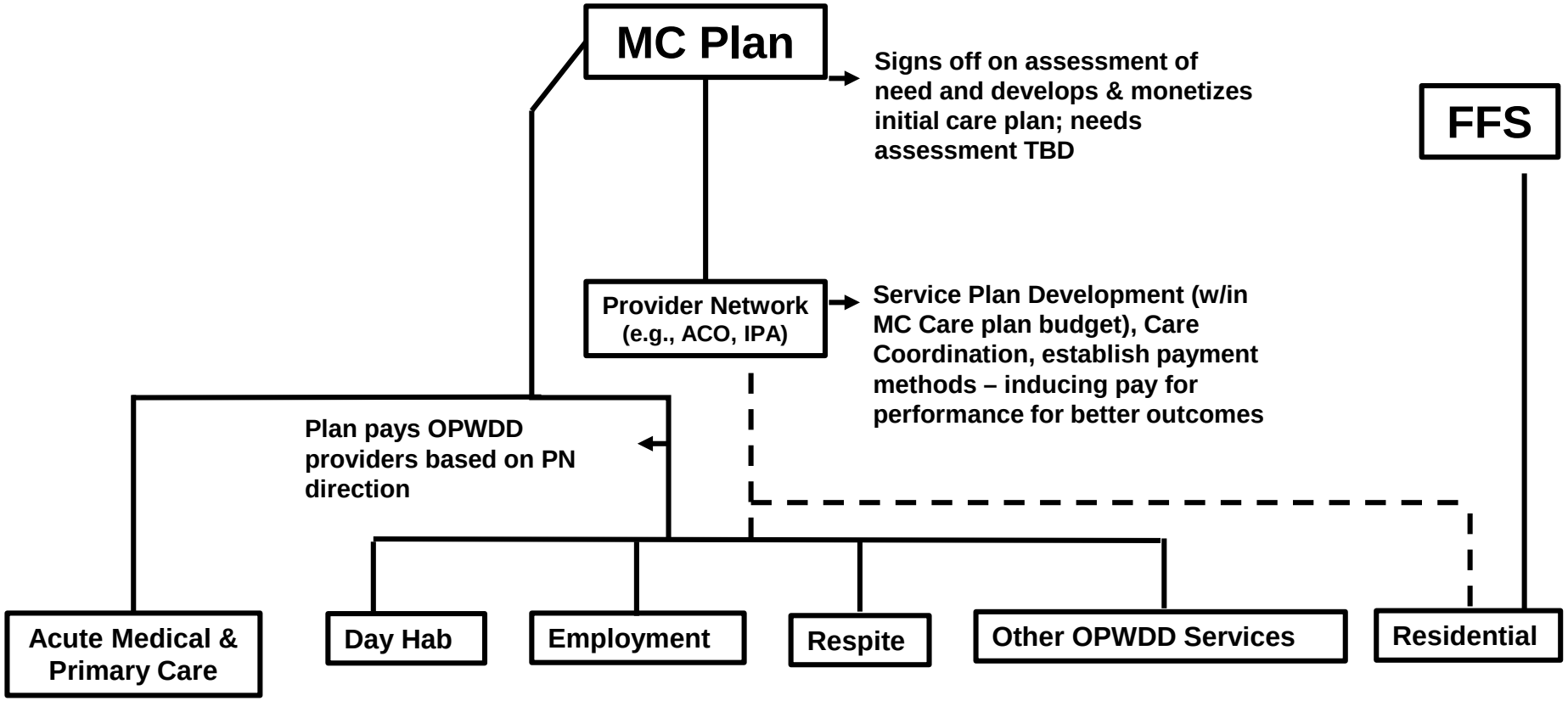
- *"We need modern, responsive and effective platforms to meet the varied demands of individuals and families. Our current system was built for a different time and now we need more streamlined and cost-effective alternatives. … By focusing on what works—by measuring outcomes and rewarding providers who achieve results for people—platforms like value based payments work for everyone." (Draft Recommendations, p. 17)*

Transformation Panel Draft Recommendations: System Platforms

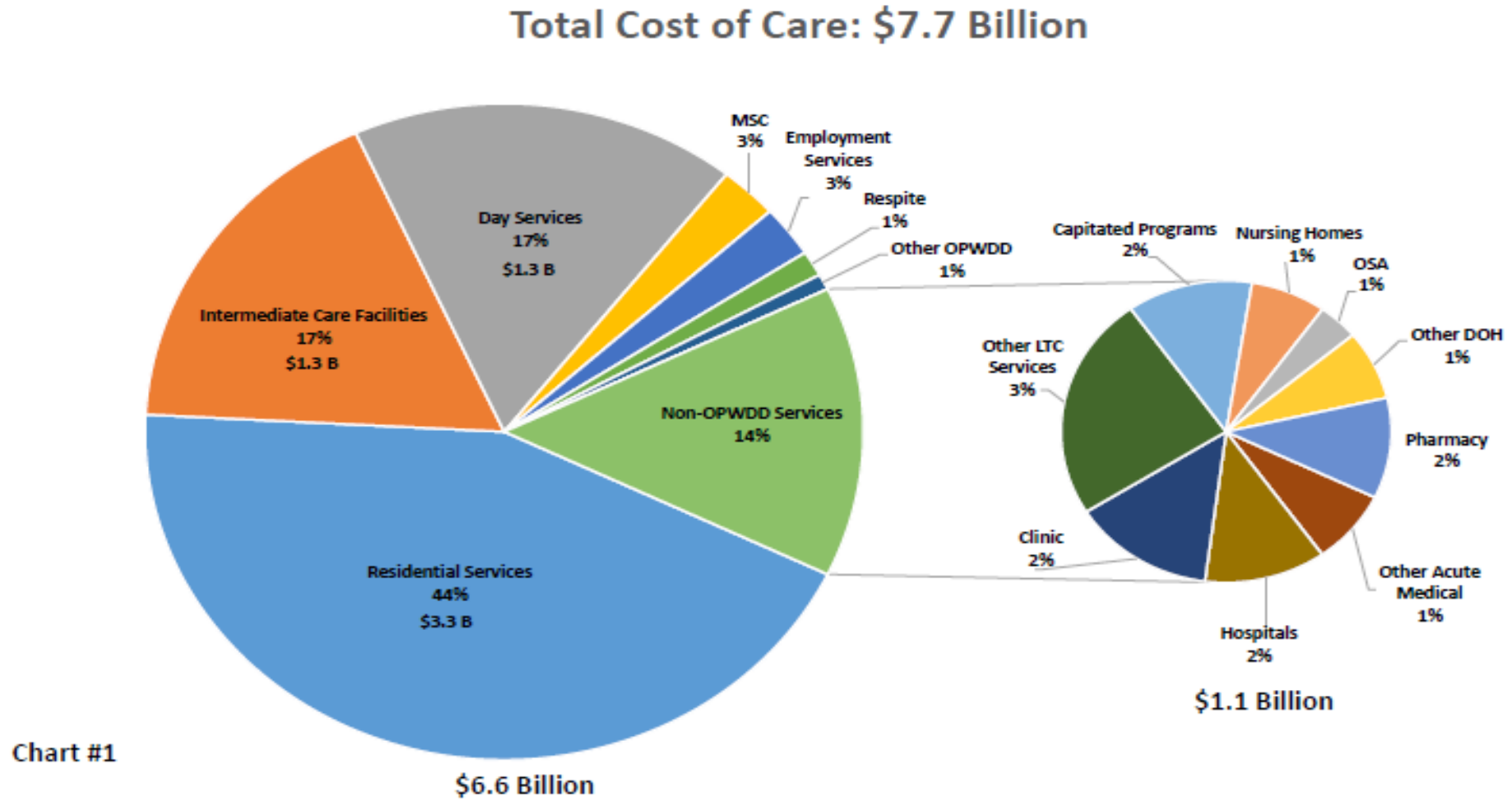
The system platforms should:

- Transition to a value based payments system guided by stakeholders who help develop data driven quality measures;
- Develop a “safety net guarantee” so that a person can try different things and know they can return to their former level of services if needed;
- Ensure that individuals who have been cared for by family members at home receive at least equal priority for more extensive services when they are needed;
- Ensure accountability by providing online access to information, pricing, services, etc. via portals and individual accounts;
- Create flexibility and streamline the system so it is more responsive to a wide variety of needs;
- Begin managed care demonstrations with community based supports and services, but consider initially not including certified residential services.

MCO – Provider Network Alternative (without Residential)



The Challenge of a Integrating Services for I/DD Individuals – Distribution of 2014 Medicaid Costs



Source: DOH Analysis

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Questions / Open Discussion

I/DD VBP Advisory Group Meeting # 2

Meeting 2: Deeper Dive - the I/DD Population and Total Cost of Care

- Overview total cost of care for I/DD subpopulation
- VBP arrangements for subpopulations
- A more nuanced view of use patterns of acute and Long-Term Support Services

Appendix

More information on the method used by the Coleman Institute to Estimate the I/DD Population Demographics

The Estimated Number of Individuals with I/DD by Family Caregiver Age Group is derived from the methodology described in the original research paper *Demography of Family Households by* Fujiura, G. T. (1998).

A profile was developed from the **Survey of Income and Program Participation**, a national household survey, which is a nationally representative, probability based survey of economic well being conducted annually by the **U.S. Census Bureau** since 1983.

- The profile was designed to establish a demographic profile (populations size, characteristics, and economic status) of Americans with I/DD supported outside of the formal long-term residential care system.

Methodology

- **Survey -** Randomly selected households are interviewed longitudinally at 4 month intervals for up to 3 year periods.
  - The extension of the interview period beyond one year for each sample and the introduction of new surveys each calendar year establishes overlapping samples; that is, two cohorts interviewed during the same time period. The overlapping samples are especially useful for an analysis of a low prevalence population such as individuals with I/DD because the concurrence of data collection allows combination of two sets of survey data into a substantially larger sample.
- **Screened for ID/DD** – criteria discussed on the following slide.
- **Household relationships -** Variations in living arrangements were reduced to three fundamental types of household units in which a person could live:
  - 1. in a family household
  - 2. with a spouse
  - 3. in a self-headed household.
- Population estimates were computed by summing the weights of person or household in the sample or subgroups.
  - Weights were calculated by the Census Bureau and represented the inverse of selection probability.

Source: Fujiura, G. T. (1998). Demography of Family Households. *American Journal on Mental Retardation, 103*, 225-235.

More information on the method used by the Coleman Institute to Estimate the I/DD Population Demographics (cont'd)

Screening for ID/DD

- Individuals ages 15 years or older were included in the analysis if a diagnosis of Intellectual Disability was cited or if the individual had a related developmental disability. Respondent citation of Intellectual Disability was represented in two different forms: (a) as a specific query ("Does ___ have intellectual disability?") or (b) as the cause of an activity limitation. Identification of a related developmental disability among adults was based on the model employed by Fujiura and Yamaki (1997) in a companion analysis of ethnic variations in developmental disabilities prevalence. Conditions included autism, cerebral palsy, or epilepsy and evidence of three or more limitations in the life activity domains outlined in the Developmental Disabilities Act (independent living, language, learning, mobility, self-care, self-direction, and work).
- Children 14 years or younger were identified as having a developmental disability if the household respondent attributed a limitation or need for specialized services to the conditions of autism, cerebral palsy, epilepsy, head or spinal cord injury, or paralysis of any kind. The inclusion criterion was any condition assumed to entail a need for lifelong support.

National Core Indicators Adult Consumer Indicators: New York State vs NCI Average

= Below average by at least 5 points **= Above average by at least 5 points**

	%		NYS
	NYS	NCI	Above/(Below)
Choice- People Make Choices About Their Lives And Are Actively Engaged In Planning Their Services And Supports			
Chose Home	47	51	-4
Chose Roommates Or Chose To Live Alone	33	44	-11
Chose Paid Community Job	83	83	0
Chose Day Program Or Regular Activity	50	59	-9
Chose Staff	51	65	-14
Decides Daily Schedule	78	82	-4
Decides How To Spend Free Time	85	91	-6
Chooses How To Spend Money	81	87	-6
Chose Case Manager/Service Coordinator	65	63	2

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf

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Community Inclusion - People Have Support To Participate In Everyday Community Activities			
Went Out Shopping In The Past Month	91	87	4
Average Times Went Out Shopping In The Past Month	4.1	4.1	0
Went Out On Errands In The Past Month	85	83	2
Average Times Went Out On Errands In The Past Month	2.7	2.9	-0.2
Went Out For Entertainment In The Past Month	71	71	0
Average Times Went Out For Entertainment In The Past Month	2.5	2.7	-0.2
Went Out To Eat In The Past Month	76	83	-7
Average Times Went Out To Eat In The Past Month	2.9	3.7	-0.8
Went Out To Religious Services In The Past Month	37	48	-11
Average Times Went Out To Religious Services In The Past Month	1.3	1.8	-0.5
Went Out For Exercise In The Past Month	57	59	-2
Average Times Went Out For Exercise In The Past Month	6.3	6.6	-0.3
Went On Vacation In The Past Year	52	45	7
Average Times Went On Vacation In The Past Year	0.7	0.7	0

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf

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Work - People Have Support To Find And Maintain Community Integrated Employment			
Has A Paid Job In The Community	12	16	-4
Type Of Paid Employment In The Community - Individually-Supported	37	33	4
Type Of Paid Employment In The Community - Competitive	33	34	-1
Type Of Paid Employment In The Community - Group-Supported	30	34	-4
Worked 10 Of The Last 12 Months In A Paid Community Job	76	84	-8
Average Months At Current Paid Community Job	53.1	69.4	-16.3
Recieves Benefits At Paid Community Job	20	25	-5
Four Most Common Fields Of Paid Community Employment- Food Preparation And Food Service	13	18	-5
Four Most Common Fields Of Paid Community Employment - Building And Grounds Cleaning Or Maintenance	38	33	5
Four Most Common Fields Of Paid Community Employment - Retail	15	15	0
Four Most Common Fields Of Paid Community Employment - Assembly, Manufacturing, Or Packaging	10	9	1
Wants A Paid Job In The Community	53	49	4
Has Community Employment As A Goal In Service Plan	27	25	2
Attends A Day Program Or Regular Activity	75	71	4
Volunteers	37	32	5

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf

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Self-Determination - People Have Authority And Are Supported To Direct And Manage Their Own Services			
Uses Self-Directed Supports	5	8	-3
Relationships - People Have Friends And Relationships			
Has Friends	72	76	-4
Has A Best Friend	74	79	-5
Can See Friends	80	78	2
Can See Family	83	80	3
Feels Lonely	40	40	0
Can Go On A Date	85	83	2
Can Help Other People	84	86	-2
Satisfaction - People Are Satisfied With The Services And Supports They Receive			
Likes Home	88	90	-2
Wants To Live Somewhere Else	23	26	-3
Talks With Neighbors	66	65	1
Likes Paid Community Job	93	93	0
Wants To Work Somewhere Else	33	30	3
Likes Day Program Or Regular Activity	89	88	1
Wants To Go Somewhere Else Or Do Something Else During The Day	33	34	-1

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf

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Service Coordination - Case Managers/Service Coordinators Are Accessible, Responsive, And Support The Person'S Participation In Service Planning			
Met Case Manager/Service Coordinator	97	95	2
Case Manager/Service Coordinator Asks What Person Wants	86	88	-2
Case Manager/Service Coordinator Helps Get What Person Needs	84	88	-4
Case Manager/Service Coordinator Calls Person Back Right Away	82	75	7
Staff Come When They Are Supposed To	93	94	-1
Has Help Needed To Work Out Problems With Staff	93	92	1
Person Helped Make Service Plan	86	87	-1
Access - Publicly-Funded Services Are Readily Available To Individuals Who Need And Qualify For Them			
Gets Needed Services	83	82	1
Staff Have The Right Training To Meet Person'S Needs	91	93	-2
Always Has A Way To Get Places	74	84	-10

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf

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Health - People Secure Needed Health Services			
Has A Primary Care Doctor	99	98	1
In Poor Health	3	5	-2
Had A Physical Exam In The Past Year	91	88	3
Had A Dental Exam In The Past Year	86	79	7
Had An Eye Exam Or Vision Screening (In The Past Year)	67	59	8
Had A Hearing Test (In The Past Five Years)	75	65	10
Had A Pap Test (In The Past Three Years, Women)	69	67	2
Had A Mammogram (In The Past Two Years, Women 40 And Over)	83	75	8
Had A Colorectal Cancer Screening (In The Past Year, Age 50 And Over)	24	19	5
Had A Flu Vaccine (In The Past Year)	83	78	5
Has Ever Been Vaccinated For Pneumonia	45	41	4

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf

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Medication - Medications Are Managed Effectively And Appropriately			
Takes At Least One Medication For Mood Disorders, Anxiety, Behavior Challenges, Or Psychotic Disorders	53	55	-2
Wellness - People Are Supported To Maintain Healthy Habits			
Engages In Regular, Moderate Physical Activity At Least 30 Minutes A Day Three Days A Week.	17	22	-5
BMI (Body Mass Index) Underweight	6	5	1
BMI (Body Mass Index) Normal Weight	35	33	2
BMI (Body Mass Index) Overweight	28	29	-1
BMI (Body Mass Index) Obese	31	33	-2
Chews Or Smokes Tobacco	6	7	-1

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf

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Respect And Rights - People Receive The Same Respect And Protections As Others In The Community.			
Home Is Never Entered Without Permission	86	89	-3
Bedroom Is Never Entered Without Permission	82	83	-1
Can Be Alone At Home With Visitors Or Friends	75	77	-2
Has Enough Privacy At Home	90	91	-1
Mail Or Email Is Never Read By Others Without Permission	85	86	-1
Can Use Phone And Internet Without Restrictions	94	89	5
Staff Treat Person With Respect	94	93	1
Has Participated In A Self-Advocacy Meeting, Conference, Or Event	30	33	-3
Safety - People Are Safe From Abuse, Neglect, And Injury.			
Never Or Rarely Feels Afraid Or Scared At Home	80	82	-2
Never Or Rarely Feels Afraid Or Scared In Neighborhood	84	83	1
Never Or Rarely Feels Afraid Or Scared At Work, Day Program Or Regular Activity	88	86	2
Person Has Someone To Go To For Help If Ever Afraid	94	93	1

Source: http://www.nationalcoreindicators.org/upload/state-reports/2013-14_ACS_New_York_State_Report.pdf