Dane County Self-Directed Supports

System Evaluation & Management Audit

Final Report

July 2006

E jj Olson & Associates
Health Care & Human Services Consultants

Wipfli LLP
Business Experts…Right from the start.

Dane County Self-Directed Supports
System Evaluation and Management Audit

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Executive Summary

Dane County Self-Directed Supports
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Executive Summary

During 2005-2006, the Dane County Self-Directed Supports System for adults with disabilities, in conjunction with an advisory board composed of key stakeholders, worked with the health care and human services consulting firm E jj Olson & Associates, and the accounting firm Wipfli LLP to conduct a system evaluation and management audit. The effort was initiated to provide an objective examination of program processes and controls, generate on-going outcome measures for each type of service within the SDS System, and provide recommendations to increase efficiency and System-wide service quality.

Methodology

The methodology included an examination of the demographics of adults with disabilities in Dane County, an overview of services provided within the SDS System, an analysis of consumer utilization and cost trends, and an audit of provider financial records and procedures to determine program compliance. Additionally, the consultants conducted interviews with key stakeholders, as well as an extensive survey of provider agencies to identify strengths and weaknesses within the SDS System. Finally, a half-day workgroup was held in order to identify potential outcomes and indicators for the SDS, which included members of the advisory board, consumers, Dane County Human Services Department staff, elected officials, and representatives from several provider agencies.

Demographic Profile

In order to assess the overall demographic profile for adults with disabilities in Dane County, the consultants looked at the following factors: overall population trends and projections, population trends and projections for adults with disabilities, and trends and projections for adults with developmental disabilities. Cross comparisons were made for different age groups for each of these factors to determine the impacts of an aging population on the future of the SDS System.

Findings

- Dane County has experienced 46.9% population growth between 1970 and 2000, from 290,272 to 426,526 and is expected to increase another 36% by the year 2030, to 579,976.

- Older adults age 65 years and older are predicted to increase by 158% from 39,869 in 2000 to more than 103,000 by 2030.

- 12.7% of persons in Dane County, and 15.8% of persons in the State of Wisconsin are affected by some type of disability.

- 34.8% of persons age 65 and older are affected with some form of disability.

- Developmental disabilities affect approximately 1.6% of the total population, nation-wide.

- Estimates for 2005 indicate that 5,600 adults in Dane County live with a developmental disability, and projections for 2030 indicate that this number will grow to 7000.

- The average life expectancy of individuals with developmental disabilities is increasing, and this longevity will require more support services.

System Overview

The consultants reviewed the SDS System components and processes, including: overall system model, payment & allocation process, types of supports, goals for support types, SDS Enrolment process, the process for determining individual rates for consumers, and the SDS payment process.

Findings

- The goal of SDS is to allow people with developmental disabilities to live and fully participate in the community.

- The County allocates a specific dollar amount to an individual consumer based on assessment of their supportive needs and available funding, which the consumer then uses to purchase the services they need.

- Service brokers work with consumers and their families to develop service plans, advocate on their behalf, and negotiate contracts with service providers.

- The network of supports consists of approximately 30 agencies that provide residential and vocational services, including: supported living arrangements, community based work supports, facility based work supports, and day supports.

- To determine the individual rate, the County Developmental Disabilities unit intake worker meets with the consumer and the family to determine the number of service hours needed per day. When this number is established, it is put into the following formula: number of hours X 365 days in a year X the rate of direct care + 35% indirect service rate. If the consumer is in a paired working/living arrangement with another consumer, the formula is: (number of hours divided by 2) X 365 days in a year X the rate of direct care + 49% indirect cost rate. After this base rate is set, the worker may adjust the individual's final rate based on comparisons with the rates of other consumers with similar needs.

- After approving an Individual Financial Plan (IFP), the county submits it to Fiscal Assistance, who then creates and manages a customer account and make payments to the appropriate providers.

System Utilization

The consultants examined System Utilization trends for the period from January 2000 through July 2005, based on the database for adults with disabilities, which was provided by the Dane County Department of Human Services. Additionally, the consultants examined demographic factors including age, race, gender, and Level of Care.

Findings

- SDS was piloted in 1998, when 135 participants were voluntarily transferred from the Purchase of Service (POS) System of community-based contracts to the SDS Model.

- The numbers of consumers transferring to SDS has increased every year, with the peak being 2003-04 with 652 transfers.

- As of July 2005, the SDS System had 1,140 consumers.

- The average current age of an SDS consumer is 43 years, and the range is from 18 to 86 years.

- Males have historically outnumbered females, with 663 male consumers being served as opposed to 525 females (as of July 2005).

- 92% of SDS consumers are white, with African American, Asian, Native American, and Philippine comprising the remaining 8%.

- SDS recognizes five different Levels of Care Codes, which are: BI, DD1A, DD1B, DD2, and DD3. Descriptions of these codes can be found on page 20 of the report. DD2, which denotes moderate disability, comprises 625 consumers, more than twice that of any other classification.

- Certain high needs consumers remain outside of the SDS System due to certain behavioral challenges. There are currently 57 such consumers.

System Cost Analysis

In order to assess overall costs for Services for Adults with Disabilities, the consultants examined the following factors: recent cost trends, Dane County's DD services vs. other Wisconsin counties, costs associated with Level of Care categories, costs associated with an aging consumer base, market forces, and factors mitigating costs. Additionally, funding levels were projected for current consumer demand and consumer demand in 20 years. The consultants also profiled projected trends in federal, state, and local funding.

In assessing const trends and projections, the consultants used costs for the entire Adult System, rather than only SDS costs, due to the large number of consumer overlap between the POS and SDS Systems. In comparisons with other counties, it was necessary to use costs for the entire DD System (adults and children), as the specific budget breakdowns for other counties were not readily available.

Findings

- During the five-year period form 2000-04, Dane County's costs for services for Adults with Disabilities have risen 22%, while number of consumers being served has increased only 12.5%, yielding a per consumer increase of 10.6%.

- The rate of year-to-year increase in average consumer costs has steadily decreased over this period, going from a 5.44% increase from 2000 to 2001, to a -0.88% decrease from 2003 to 2004. These trends indicate that while costs continue to rise, services are being provided in a more cost effective manner.

- Dane County's SDS System is unique within the State of Wisconsin in terms of consumer choice and participation. The Wisconsin Developmental Disabilities Council calls it "the model for the entire state."

- Dane County's total per-capita cost for services for Developmental Disabilities are $164.44, which is nearly twice that of any of the other four largest counties in the state. It should be noted that 21% of these costs come from the Dane County's tax levy, while the remaining 79% comes from outside revenue sources.

- Dane County's total budget for Developmental Disabilities is $74,584,924. This is second in the state only to Milwaukee County, at $77,231,952.

- Dane County's waiting list for services was at 329 consumers as of April 2006, which is slightly better per capita than other comparable counties in the State.

- There does not appear to be a direct correlation between age and residential costs, according to available data. This is likely due to the coverage of addition medical costs associated with older adults with disabilities by funding sources other than SDS.

- There does appear to be an inverse relationship between vocational services and age, as older adults with disabilities have a reduced need for these services.

- The total cost to meet the current demand for services for **adults** with disabilities is $83,743,165, if one added those individuals currently on the waiting list. This number is determined by the current average cost per consumer ($56,283) X the current number of consumers on the waiting list (329), + the current adult budget ($65,226,058).

- If projected out at the rate of growth experienced between 2000-2004, the average cost per consumer will be $84,207 by the year 2030.

- Federal and State budget projections indicate further funding cuts in the future, which will negatively impact SDS.

Provider Audit

During January 2006, the accounting firm of Wipfli LLP performed an accounting review of the Dane County Self Directed Supports System's billing and reimbursement procedures and reviewed a random sample of 20 consumer plans, incorporating a cross section of clients receiving various types and volumes of services. The review of program compliance included: 1) Perform an accounting review of billing and reimbursement; 2) Audit a sample of client plans for consistency in documentation; 3) Determine if reimbursement is consistent with services received; 4) Determine if funds are being spent according to individual plans. 5) Assess the current formula for determining the Individual Rate. The items reviewed for each consumer included the Individual Service Plan (ISP), Individual Financial Plan (IFP), and the billing vouchers relating to the services received by the consumer. In addition, Dane County SDS provided a printout summary of all checks paid, by client, for SDS services received, and case notes as completed by the brokers.

Findings

- Based on the sample selected, Wipfli found no instances of inconsistencies between the ISP, IFP and billing vouchers.

- It appears that there is sufficient evidence to prove that the system currently in place is adequate and accurately accounts for all services being provided.

- In addition, it appears that the system of reimbursing providers for their services is sufficient.

- Based on the sample, it appears that there are sufficient controls in place to assure proper reimbursement. Vouchers require signatures by either the client or the clients' legal guardian, as well as by the broker and the provider of services.

- The process for determining the Individual Base Rate appears to be reasonable and sound, however, no detailed information was provided with regard to final cost adjustments.

Key Stakeholder Interviews & Provider Survey

In order to gauge the strengths and weaknesses of the SDS system from a variety of perspectives, the consultants conducted an extensive survey of brokers, residential provider agencies, and vocational provider agencies. In addition, interviews were conducted with other key stakeholders within the System, including consumers, DHS staff, and elected officials. These sections offer a wide range of opinions, addressing issues such as service quality, System oversight, cost effectiveness, and communication.

Program Outcomes

In January of 2006, the consultants conducted a workgroup consisting of 40 stakeholders, including County staff, elected officials, service providers, and consumers and their families. The purpose of this meeting was to develop measurable outcomes for the three primary areas of support within the SDS System: residential supports, vocational supports, and broker supports. This group was trained by the consultants based on the "Logic Model" technique, and then split into smaller discussion groups to generate ideas for potential outcomes.

Findings

- Relying heavily on input from this workgroup, along with regular feedback from the advisory committee and studies of best practice models, the consultants have developed a set of initial, intermediate, and long-term outcomes for these three service areas. These outcomes are displayed in the *System Outcomes* section of this report.

Recommendations

The recommendations developed by the consultants focus on five primary areas: Cost Effectiveness & Efficiency, Quality Assurance, Data Collection & Information Systems, Communication within the SDS System, and System Oversight. Further commentary can be found in the *Recommendation*s section of the report.

Cost Effectiveness & Efficiency

- *Track unit hours for indirect service hours as well as direct service hours to more accurately measure total units of service.*
- *Utilize annual audit information to determine if the current rates of indirect services are accurate.*
- *Explore the viability and potential cost reductions of more consolidated consumer living arrangements.*
- *Non-profit provider agencies should explore earned income/business partnerships to generate additional revenue and reduce reliance on SDS funding.*

- *Explore the viability of allowing non-profit agencies within the SDS System to carry over a set amount of financial reserves from year to year.*
- *Provider agencies should explore the option of joining existing insurance pools to reduce employee insurance costs and increase efficiencies.*
- *Provider agencies should take advantage of the centralized training and consulting offered through the Waisman Center.*
- *The County should assist provider agencies in consolidating administrative services to increase overall cost effectiveness and efficiency.*
- *Develop limited fee-for-service arrangements to generate revenue and reduce waiting list.*
- *Promote incentives to consumers for whom a family member or family friend agrees to act as their broker without pay or at a reduced rate, within the CIP funding guidelines.*

Quality Assurance

- *Implement the standardized outcome measures recommended in this report for all provider agencies. These outcome measures should be broken down by service group and phased in, starting with Residential Providers.*
- *Implement comprehensive survey tools for consumers that address each of the three primary service areas: vocational, residential, and broker services.*
- *Develop an annual "consumer report" manual for consumers and their families/guardians to help individuals make decisions about what direct service providers would be most appropriate to address their needs.*
- *Periodically conduct an audit of service providers, similar to the one conducted by Wipfli for this report, to determine if services are appropriate to the needs of individual consumers.*

Data Collection & Information Systems

- *Expand the current SDS database to include more comprehensive data associated with provider costs and service quality.*
- *Add an additional column to the spreadsheet for tracking unit rates.*
- *Stratify cost data to assure that consumers with similar levels of service needs are receiving congruous levels of funding for services.*

Communication within the SDS System

- *The County should clarify roles of stakeholders within the SDS System.*
- *Dane County should provide more direct feedback to provider agencies.*

System Oversight

- *Reevaluate unit costs again after July 2007.*
- *Reevaluate provider, residential, and broker outcomes and indicators after July 2007.*
- *Reevaluate specific efficiency and cost effectiveness standards for provider agencies on a yearly basis.*
- *Enforce the current termination, suspension, and modification policies to address agencies that consistently do not meet Dane County's standards for cost effectiveness and service quality.*

Dane County Self-Directed Supports
System Evaluation & Management Audit

Introduction

Introduction

During June 2005 – July 2006, the health care and human services consulting firm of E jj Olson & Associates and the accounting firm of Wipfli LLP worked with a community-based advisory committee and the Dane County Board of Supervisors to conduct a program evaluation and management audit of the Self-Directed Supports System for persons with developmental disabilities in the County. The effort was initiated to better understand the current range of services provided under contract with the county, assess the status of current caseloads, profile the strengths and weaknesses of the system, project the resources needed to adequately meet the demand for services in Dane County through the next twenty years, develop outcome measures for the primary services provided through the program, and identify any efficiencies that might be realized in the current system.

The system evaluation and management audit process is an important function that provides a mechanism to review administrative and operational processes, and ultimately contributes to process improvement. It is a process that is conducted periodically to ensure the ongoing appropriateness of program components and activities.

During the twelve-month program evaluation and management audit process, the consultants reviewed an innovative program that is unique in the State of Wisconsin. The Self-Directed Supports system in Dane County sets the standard in terms of the quality and comprehensiveness of the community supports that are available. The program is widely recognized as a best practice nationally, and reportedly attracts clients from throughout the South Central region of the state.

The consultants wish to thank Mr. Dan Rossiter and the Dane County Human Services Department for providing Wipfli and E jj Olson & Associates with the necessary information to perform this analysis. His department provided the SDS database for 2000-2004, flowcharts of how the program is applied, tables used to determine base rates for service, two months summaries of service units performed, system costs and utilization data, as well as candid answers to all questions.

Methodology

The methodology to conduct the program evaluation and management audit included an examination of the demographics of developmental disability in Dane County, a survey of Self-Directed Supports provider agencies to gather their input regarding the strengths and issues of the current system, a review of Self-Directed Supports System utilization and costs during 2001-04, an audit of client service plans versus program payment transactions, interviews with key stakeholders within the SDS System, and a half-day outcomes development session with individuals representative of all facets of the current system.

This process has affirmed the ongoing commitment by the county to meet the needs of persons with developmental disabilities in a compassionate and fiscally responsible manner. This is a program that, while strong and widely supported, can be improved with the addition of processes to monitor and enhance accountability and quality of service. The recommendations that have been developed provide the framework for these improvements. However, it should be understood that implementation cannot be accomplished unilaterally by the County. Ultimately, the rich history of service and partnership represented by this and other programs should serve as the inspiration for all stakeholders to come together to improve the Self-Directed Supports System in Dane County.

Dane County Self-Directed Supports
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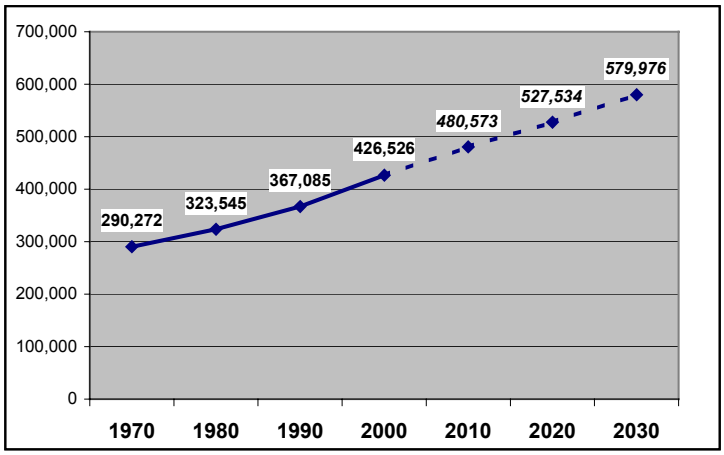
Demographic Profile

Demographics of Disability in Dane County

Dane County has seen steady population growth during the past thirty years, with the population increasing 46.9% during 1970–2000 from 290,272 to 426,526. Projections developed by the Wisconsin Department of Administration indicate continued growth in Dane County through the next thirty years. The population in the county is expected to increase 36.0% to number 579,976 by the year 2030. Dane County is expected to be third among the ten fastest growing counties in Wisconsin through the next three decades, behind only St. Croix and Calumet Counties, and will far exceed projected growth in the state of 19.6% during the same period.

Population Dane County, WI
Actual 1970-2000, Projected 2010-2030



Source: US Bureau of the Census, 1970,1980, & 1990 Census, Census 2000. Projections developed by Demographic Services Center, Wisconsin Department of Administration, January 2004.

The most significant growth in the county will be seen among the population of older adults; whose numbers will more than double during coming years. The population of persons age 65 years and older is predicted to increase 158.3% from 39,869 during 2000 to more than 103,000 by 2030 when they will comprise 17.8% of all persons in the county. The most significant growth will be seen among the 65-74 and 75-84 year age cohorts. By 2030, the population age 65-74 years in the county is predicted to increase 167.4% to number more than 54,000, while the population age 75-84 years is predicted to increase 158.7% to number nearly 37,000. The number of persons of advanced age in Dane County (85+) will more than double as well, increasing 123.7% from 5,403 to more than 12,000.

Dane County, WI Population by Age - Actual 2000, Projected 2005 - 2030

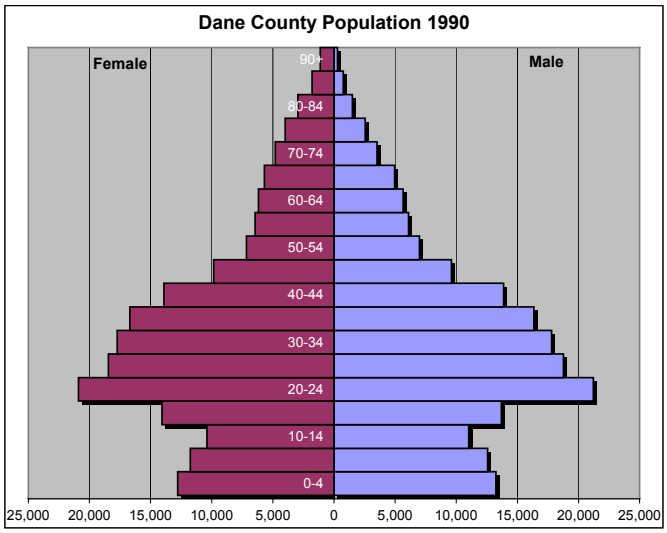
	2000		2005		2010		2015		2020		2025		2030	
	Number	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Total	426,526	100.0%	455,927	100.0%	480,573	100.0%	506,315	100.0%	527,534	100.0%	554,848	100.0%	579,976	100.0%
18+	330,271	77.4%	356,276	78.1%	377,847	78.6%	398,441	78.7%	411,950	78.1%	430,650	77.6%	447,894	77.2%
60+	52,445	12.3%	59,977	13.2%	73,280	15.2%	89,861	17.7%	106,197	20.1%	121,375	21.9%	132,009	22.8%
65+	39,869	9.3%	42,745	9.4%	48,854	10.2%	60,575	12.0%	75,815	14.4%	90,445	16.3%	103,021	17.8%
0 to 9 years	52,511	12.3%	54,764	12.0%	58,064	12.1%	61,964	12.2%	67,171	12.7%	71,844	12.9%	75,734	13.1%
10 to 17 years	43,744	10.3%	44,887	9.8%	44,662	9.3%	45,910	9.1%	48,413	9.2%	52,354	9.4%	56,348	9.7%
18 to 24 years	60,887	14.3%	65,017	14.3%	66,363	13.8%	65,572	13.0%	64,644	12.3%	68,348	12.3%	71,759	12.4%
25 to 34 years	68,386	16.0%	68,909	15.1%	73,100	15.2%	76,132	15.0%	76,942	14.6%	75,483	13.6%	75,826	13.1%
35 to 44 years	70,108	16.4%	68,910	15.1%	64,866	13.5%	67,683	13.4%	68,324	13.0%	71,631	12.9%	72,284	12.5%
45 to 54 years	60,220	14.1%	67,409	14.8%	68,952	14.3%	66,915	13.2%	63,092	12.0%	63,049	11.4%	66,821	11.5%
55 to 59 years	18,225	4.3%	26,054	5.7%	31,286	6.5%	32,278	6.4%	32,751	6.2%	30,764	5.5%	29,195	5.0%
60 to 64 years	12,576	2.9%	17,232	3.8%	24,426	5.1%	29,286	5.8%	30,382	5.8%	30,930	5.6%	28,988	5.0%
65 to 74 years	20,211	4.7%	21,179	4.6%	26,168	5.4%	36,453	7.2%	47,128	8.9%	52,582	9.5%	54,052	9.3%
75 to 84 years	14,255	3.3%	15,184	3.3%	15,205	3.2%	15,968	3.2%	20,089	3.8%	28,413	5.1%	36,882	6.4%
85+ years	5,403	1.3%	6,382	1.4%	7,481	1.6%	8,154	1.6%	8,598	1.6%	9,450	1.7%	12,087	2.1%

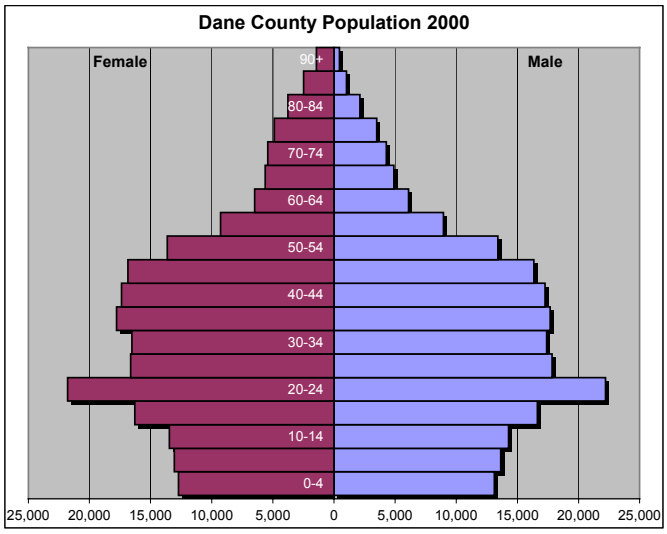
Source: Table DP-1, US Bureau of the Census, Census 2000. Final Population Projections for Wisconsin Counties by Age: 2000-2030. WI Department of Administration, January 2004.

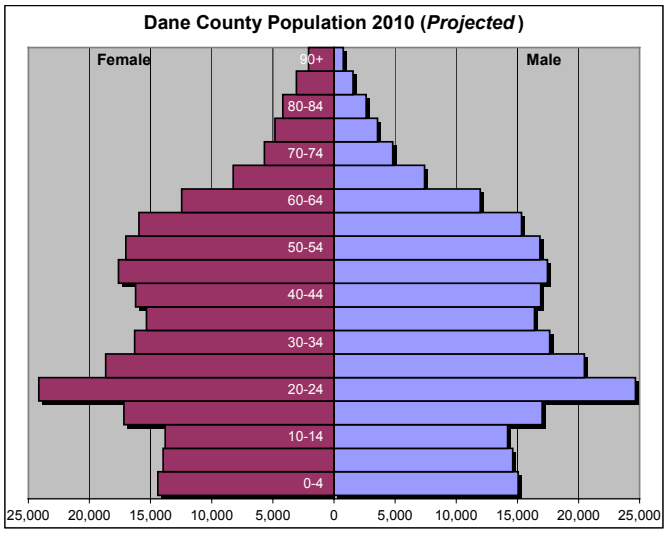
Dane County Population by Age and Gender 1990-2030

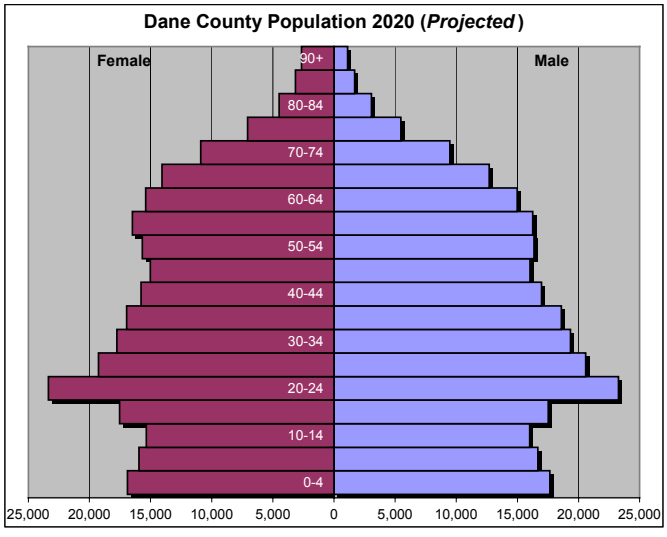
Actual 1990 - 2000
Projected 2010 - 2030

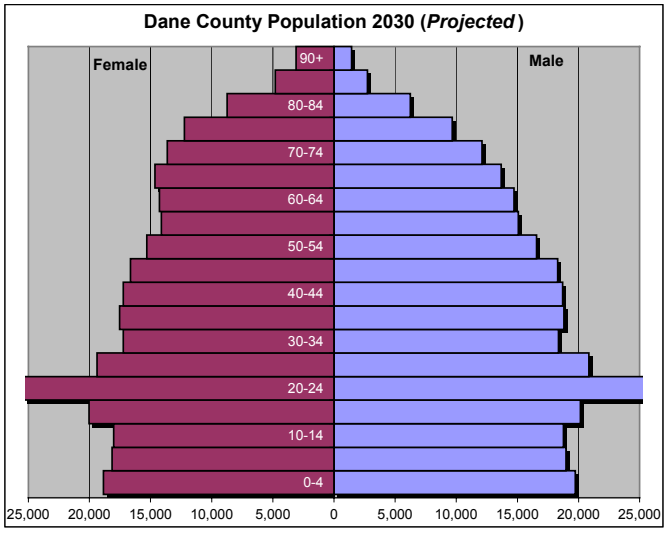
Final Population Projections for Wisconsin Counties by Age and Sex: 2000-2030, Prepared by Demographic Services Center, Wisconsin Department of Administration, January 2004.











Demographic Focus: People with Disabilities

Under the Americans with Disabilities Act (ADA), disability is defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual. When the ADA was passed in 1990, disabilities affected nearly one in seven Americans. Today, disabilities affect nearly one in five.

Information on disability is collected during each census, with the latest data collected during Census 2000. As a result of discussion with the disability and policy research communities, Census 2000 questions on disability were substantially different from those asked during 1990. Due to the divergent datasets, making comparisons between the two years is difficult, and is not recommended by the US Census Bureau. The following focuses on disability data gathered during Census 2000.

Rate of Disability by Age

More than one in ten persons in Dane County (age 5+) or nearly 51,000 individuals lives with a disability. Disabilities affect 12.7% of all persons in Dane County versus 15.8% of all persons in Wisconsin. The highest rates of disability in the county are among persons age 65 years and older, with more than one in three (34.8%) having a disabling condition. Some 13,144 older adults, or 34.8% of all persons age 65 years and older lived with a disability (versus 36.5% in WI). Among persons age 5-20 years, some 7,643 individuals with disabilities or 7.9% of all persons within the age cohort lived with a disability (comparable to 7.9% in WI), while 30,185 individuals age 21-64 years or 11.5% of all persons within the age cohort lived with a disability (versus 14.9% in WI).

Number of Persons by Age and Type of Disability 2000
Civilian Noninstitutionalized Population Age 5+ Years

	Dane County		WI State	
	Number	Percent	Number	Percent
Population Age 5+ Years	400,708	100%	5,021,335	100%
w/disability	50,972	12.7%	790,917	15.8%
By Broad Age Group				
Population Age 5-20 yrs	96,445	100%	1,258,268	100%
w/disability	7,643	7.9%	98,981	7.9%
Population Age 21-64 yrs	261,757	100%	3,018,794	100%
w/disablity	30,185	11.5%	449,699	14.9%
Population Age 65+ yrs	37,726	100%	662,813	100%
w/disability	13,144	34.8%	242,237	36.5%
Table DP-2, U.S. Bureau of the Census, Census 2000.				
By Type of Disability				
Sensory Disability	9,358	2.4%	152,506	3.0%
Physical Disability	20,113	5.0%	338,728	6.7%
Mental Disability	15,642	3.9%	209,288	4.2%
Self Care Disability	6,432	1.6%	103,989	2.1%
Employment Disability	19,853	6.6%	309,567	9.0%
Go Outside Home Disability	15,758	4.6%	262,479	6.3%

Table P41, SF3 CD-ROM, U.S. Bureau of the Census - Prepared by Demographic Services Center, WI Department of Administration.

*Rate of Disability by Type**

Employment and physical disabilities are the most prevalent types of disability in the county, affecting 6.6% and 5.0% of the population, respectively. Mental disabilities affect 3.9% of all persons, while sensory disabilities affect 2.4%. During 2000, 1.6% of the population had difficulty dressing, bathing, or ambulating due to a disabling condition, while 4.6% of persons had difficulty going outside the home to shop or visit a doctor's office. It should be noted that although disability affects a significant proportion of the population in the County, the rates of disability tend to be lower than those in the state for all disability types. This is due primarily to the presence in Dane County of a younger population overall. The median age of all persons in the county at 33.2 years is significantly below that of all persons in the state at 36.0 years.

*SENSORY DISABILITY - Blindness, deafness, or a severe vision or hearing impairment; PHYSICAL DISABILITY - A substantial limitation in the ability to perform basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying; MENTAL DISABILITY - Difficulty learning, remembering, or concentrating; SELF-CARE DISABILITY - Difficulty dressing, bathing, or getting around inside the home; GO OUTSIDE HOME DISABILITY - Dificulty going outside the home alone to shop or visit a doctor's office (based on population age 16+ years); and EMPLOYMENT DISABILITY - Difficulty working at a job or business (based on population age 16-64 years).

Disability Population Projections 2000-2030

E jj Olson & Associates developed projections of the population of persons with disabilities in Dane County by projecting forward year 2000 age based rates of disability through the year 2030. Projections indicate both the rate and population of persons with disabilities in the county will increase steadily through the next thirty years. The number of people with disabilities in the county (age 5+) is projected to increase 60.4% during 2000-2030 from 50,972 to 81,734; nearly double the rate of growth in the general population. As a result, the rate of disability among the general population in the county is projected to increase by 2.4 percentage points during the course of the next thirty years, growing from 12.7% to 15.1%.

Dane County, WI
Projected Population of Persons with Disabilites by Age, 2000-2030
Civilian Noninstitutionalized Population Age 5+ Years

	2000		2005		2010		2015		2020		2025		2030	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Population Age 5+ Years	400,708	100%	427,875	100%	451,110	100%	470,914	100%	492,979	100%	518,165	100%	541,378	100%
Age 5+ w /disability	50,972	12.7%	55,576	12.9%	59,589	13.2%	64,533	13.7%	70,409	14.3%	76,421	14.7%	81,734	15.1%
By Broad Age Group														
Population Age 5-20 yrs	96,445	100%	99,696	100%	101,975	100%	103,774	100%	109,694	100%	117,844	100%	125,804	100%
Age 5-20 w /disability	7,643	7.9%	7,876	7.9%	8,056	7.9%	8,198	7.9%	8,666	7.9%	9,310	7.9%	9,939	7.9%
Population Age 21-64 yrs	261,757	100%	285,434	100%	300,281	100%	306,565	100%	307,470	100%	309,876	100%	312,553	100%
Age 21-64 w /disablity	30,185	11.5%	32,825	11.5%	34,532	11.5%	35,255	11.5%	35,359	11.5%	35,636	11.5%	35,944	11.5%
Population Age 65+ yrs	37,726	100%	42,745	100%	48,854	100%	60,575	100%	75,815	100%	90,445	100%	103,021	100%
Age 65+ w /disability	13,144	34.8%	14,875	34.8%	17,001	34.8%	21,080	34.8%	26,384	34.8%	31,475	34.8%	35,851	34.8%

Table DP-2, U.S. Bureau of the Census, Census 2000. Broad age group population projections 2005-2030 prepared by Demographic Services Center, Wisconsin Department of Administration, August 2004. Disability population projections 2005-2030 developed by E jj Olson & Associates, August 2004.

Increases in the number of people with disabilities in the County will be driven in large part by projected increases in the population of older adults, whose rate of disability at 34.8% exceeds that for all other ages. The number of older adults with disabilities in Dane County is projected to more than double during the next three decades, increasing 172.8% from 13,144 during 2000 to 35,851 during the year 2030.

Demographic Focus: **Developmental Disabilities**

Developmental disabilities are severe, life-long disabilities attributable to mental and physical impairments that manifest in the individual prior to twenty-two years of age. Common causes or types of developmental disability include mental retardation, autism, cerebral palsy and/or epilepsy. As defined by the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law 106-402, the term "Developmental Disability" means a severe, chronic disability of an individual that:

1. *is attributable to mental or physical impairment or combination of mental and physical impairments;*
2. *is manifested before the individual attains the aged of 22;*
3. *is likely to continue indefinitely;*
4. *results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive, and expressive living, and economic self-sufficiency; and*
5. *reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized support, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.*

In spite of federal legislation, each state continues to have its own legal definition of developmental disability, which it uses as the basis for determining individual eligibility for publicly funded supports. In Wisconsin, State Statutes, Section 51.01 (5)(a), defines "Developmental Disability" as:

"a disability attributable to brain injury, cerebral palsy, epilepsy, Prader-Willi syndrome, autism, mental retardation, or another neurological condition closely related to mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual ...."

Common Causes/Types of Developmental Disability

Mental Retardation – refers to noticeable limitations in functioning related to below average intelligence typically caused by injury, disease, and/or genetic and environmental factors. Persons with mental retardation learn more slowly than others and may need assistance with self-care, vocational, and academic activities.

Autism – usually appears during the first three years of life, and impacts the normal development of the brain in the areas of social interaction and communication skills. Children and adults with autism typically have difficulties in verbal and non-verbal communication, social interactions, and leisure or play activities.

Cerebral Palsy (CP) – refers to a group of non-progressive motor (muscle) disabilities that arise due to injury to the developing brain before or during birth or during the first year of life. Persons with cerebral palsy may find it difficult to talk, see, hear, sit or swallow. Despite significant motor impairment, many people with cerebral palsy have normal intelligence.

Epilepsy – is a condition of the nervous system that heightens the risk of seizure in the individual, causing a change in sensation, awareness, or behavior brought about by a brief electrical disturbance in the brain. Seizures may manifest as momentary disruptions of the senses, short periods of unconsciousness or staring spells, and/or convulsions.

The literature on disabilities suggests a number of variables including geographic, demographic, and socio-economic factors impact on the prevalence of developmental disability in specific populations. Due in part to this variability, as well as the differing definitions of developmental disability used by researchers and in drafting public policy, estimates of prevalence in the general population have ranged from approximately 1.0% to as much as 2.5%. The widely accepted and cited prevalence, which is often attributed to Gollay and Associates (1988), indicates developmental disability affects 1.8% of the general population. More recent studies indicate individuals with developmental disabilities comprise somewhere between 1.13% (Larson, Lakin, Anderson, Kwak, Lee, and Anderson, 2001) and 1.6% (APA, 1990) of the non-institutionalized population in the United States, a general range recognized under federal legislation in the Developmental Disabilities Act of 2000, which acknowledges a prevalence of from 1.2% to 1.65% of the United States population (Public Law 106-402, DD Act and Bill of Rights Act of 2000, Sect.101(a)(1)).

Aging with a disability is one of the most important new developments in long term care, and represents an emerging area with significant demographic implications. Until recently, individuals with a disability rarely enjoyed the same life expectancy as their peers without. Secondary medical conditions such as respiratory illness, renal failure, accidents, infections, and depression, coupled with a general lack of adequate primary medical care, prevented most persons from experiencing their true life expectancy. However, ongoing advances in medicine and rehabilitation have made the expectation of living to late life fairly reasonable for most persons, even those with a significant disability. Still, it should be noted that severe functional impairment continues to be a strong predictor for early mortality (Hoffman, 2000).

Average life expectancy for persons with developmental disabilities has continued to increase, but still lags behind that for the general population. In the early 1990's, persons with mental retardation evidenced an average life expectancy of 66 years, versus 70 years for all persons (Cook, 2002). Today, adults with developmental disability have an average life expectancy of 67 years for women and 63 years for men, versus 79.5 years and 73 years for women and men in the general population, respectively (White-Scott, 2003). Individuals with more severe disabilities

and Down's Syndrome tend to have slightly shorter life expectancy at approximately 57 years for women and 53 years for men (Janicki, Dalton, Henderson, & Davidson, 1999).

E jj Olson & Associates has developed estimates of the current and projected population of persons with developmental disabilities in Dane County by projecting forward prevalence in the general population of 1.6% through the year 2030. In projecting the population of older adults with developmental disability (age 65+) in the county through the next thirty-years, estimates based on a standard prevalence of 1.6% were adjusted down 0.15 to account for the decreased life expectancy generally evidenced in this population.

Dane County, WI
Projected Population of Persons with Developmental Disability by Age, 2000-2030*

	2000		2005		2010		2015		2020		2025		2030	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Population All Ages	426,526	100.0%	455,927	100.0%	480,573	100.0%	506,315	100.0%	527,534	100.0%	554,848	100.0%	579,976	100.0%
All Ages w/DD	6,729	1.6%	7,192	1.6%	7,572	1.6%	7,956	1.6%	8,259	1.6%	8,661	1.6%	9,032	1.6%
Population Age 18+ Years	330,271	100.0%	356,276	100.0%	377,847	100.0%	398,441	100.0%	411,950	100.0%	430,650	100.0%	447,894	100.0%
Age 18+ w/DD	5,189	1.6%	5,598	1.6%	5,928	1.6%	6,230	1.6%	6,409	1.6%	6,673	1.5%	6,919	1.5%
By Broad Age														
Age 0-17 w/DD	1,540	22.9%	1,594	22.2%	1,644	21.7%	1,726	21.7%	1,849	22.4%	1,987	22.9%	2,113	23.4%
Age 18-24 w/DD	974	14.5%	1,040	14.5%	1,062	14.0%	1,049	13.2%	1,034	12.5%	1,094	12.6%	1,148	12.7%
Age 25-44 w/DD	2,216	32.9%	2,205	30.7%	2,207	29.2%	2,301	28.9%	2,324	28.1%	2,354	27.2%	2,370	26.2%
Age 45-64 w/DD	1,456	21.6%	1,771	24.6%	1,995	26.3%	2,056	25.8%	2,020	24.5%	1,996	23.0%	2,000	22.1%
Age 65-84 w/DD	469	7.0%	495	6.9%	563	7.4%	713	9.0%	914	11.1%	1,102	12.7%	1,237	13.7%
Age 85+ w/DD	73	1.1%	87	1.2%	102	1.3%	111	1.4%	117	1.4%	129	1.5%	164	1.8%

*Assumes a prevalence of developmental disability in the general population of 1.6% of all persons. Disability population projections age 65+ adjusted down .85 due to decreased life expectancy evidenced in DD Population.

Source: Table DP-1, U.S. Bureau of the Census, Census 2000. Final Population Projections for Wisconsin Counties by Age: 2000-2030, Demographic Services Center, WI Department of Administration, January 2004. Developmental disability population projections 2000-2030 developed by E jj Olson & Associates, August 2005.

Estimates for 2005 indicate that more than 7,000 individuals in Dane County currently live with a developmental disability, with some 5,600 of these being adults over the age of 18 years. Projections indicate the population of persons with developmental disabilities in the county will increase steadily in relation to projected increases in the general population through the next 30 years, when it is estimated that more than 9,000 people with developmental disability, including approximately 7,000 adults with the diagnosis, will reside in the county during 2030.

During 2004, Dane County was responsible for 94 individuals with developmental disabilities in institutions, including fifty individuals in state centers and forty-four in ICFMR and other nursing homes. The county works on an ongoing and individualized basis to relocate residents of state centers and other institutions to the community, with the establishment of a package of financial and residential resources consistent with the need and sufficient to support each individual on a long-term basis.

Dane County, WI
Population of Persons with Developmental Disability in Institutions 2000-05

Year	NWC	CWC	SWC	Other ICFMR	Nursing Homes*	Mental Health Institutes	Child Caring Institutions
2000	2	40	14	41	Not Available	0	1
2001	2	39	15	23	24	0	1
2002	2	37	16	23	26	1	1
2003	1	33	16	21	25	1	1
2004	1	33	16	23	21	0	0
2005**	0	29	16	15	3	0	0

*Includes Brain Injury Rehab Centers

** Reduction in ICF & Nursing Home population due in part to reclassification of some individuals as aging

Source: Wisconsin Council on Developmental Disabilities, Dane County DD Data Form - 2004

During 2005, the number of persons with developmental disabilities in institutions was reduced to 63, although it should be noted that this decrease was due in part to the reclassification of some individuals as aging. Nevertheless, institutional care continues to be among the last in a list of alternatives available to the County. Community-based supports continue to be the preferred choice.

Taken together, the information indicates that demand within the Self Directed Supports System will continue to increase into the future. Projections indicate the number of adults with developmental disabilities in the county will increase from an estimated 5,600 during 2005 to more than 7,000 during 2030. It should be acknowledged that these estimates are based on projected increases in the general population of the County, and thus fail to take into account the attraction of the county's resources to families and individuals with complex medical and mental health needs. A body of anecdotal evidence in the human services community points to a net in-migration of individuals seeking to take advantage of the high quality health and human services programs in the county, widely acknowledged as a national best practice model. To date, the volume and rate of this in-migration of service seeking individuals is a factor that has yet to be quantified. Nevertheless, it is a factor that demands consideration when evaluating ongoing system demand.

Of further significance to the County going forward will be the increasing issue of aging and disability. As life expectancy for persons with developmental disabilities continues to advance, increasing client longevity will require that system resources remain tied to consumers longer. Additionally, the County will increasingly be faced with the prospect of caring for individuals that manifest not only the impairments associated with developmental disability, but with the physical and mental infirmities of aging as well.

References

American Psychiatric Association (1990). Report of the Task Force on Psychiatric Services to Adult Mentally Retarded and Developmentally Disabled Persons. American Psychiatric Association, Washington, DC.

Cook, D. (2002). Promoting Healthy Care for Adults and Elders with Developmental Disabilities. University Center for Excellence in Developmental Disabilities (UCEDD). https://depts.washington.edu/aedd/dd_aging_text.html.

Hoffman, E. (2000). Life Expectancy in persons with severe developmental disability. Developmental and Behavioral News. American Academy of Pediatrics, Section on Developmental and Behavioral Pediatrics. Fall 2000; 9(1): 8-9.

Janicki, M., Dalton, A., Henderson, C., & Davidson, P. (1999). Mortality and Morbidity among Older Adults with Intellectual Disability: Health Services Considerations. Disability and Rehabilitation. 21(5/6): 284-294.

Larson, SA, Lakin, KC, Anderson, L, Kwak, N, Lee, JH, Anderson, D (2001). Prevalence of mental retardation and developmental disabilities: Estimates from the 1994/1995 National Health Interview Survey Disability Supplements. American Journal on Mental Retardation. May; 106(3):231-52.

White-Scott, S. (2003). Developmental Disabilities: Inside Looking Out. Paper presented at Pollution, Toxic Chemicals and Mental Retardation: A National Summit, Wingspread Conference Center, Racine, WI. American Association on Mental Retardation. July 22-24, 2003.

Dane County Self-Directed Supports
System Evaluation & Management Audit

System Overview

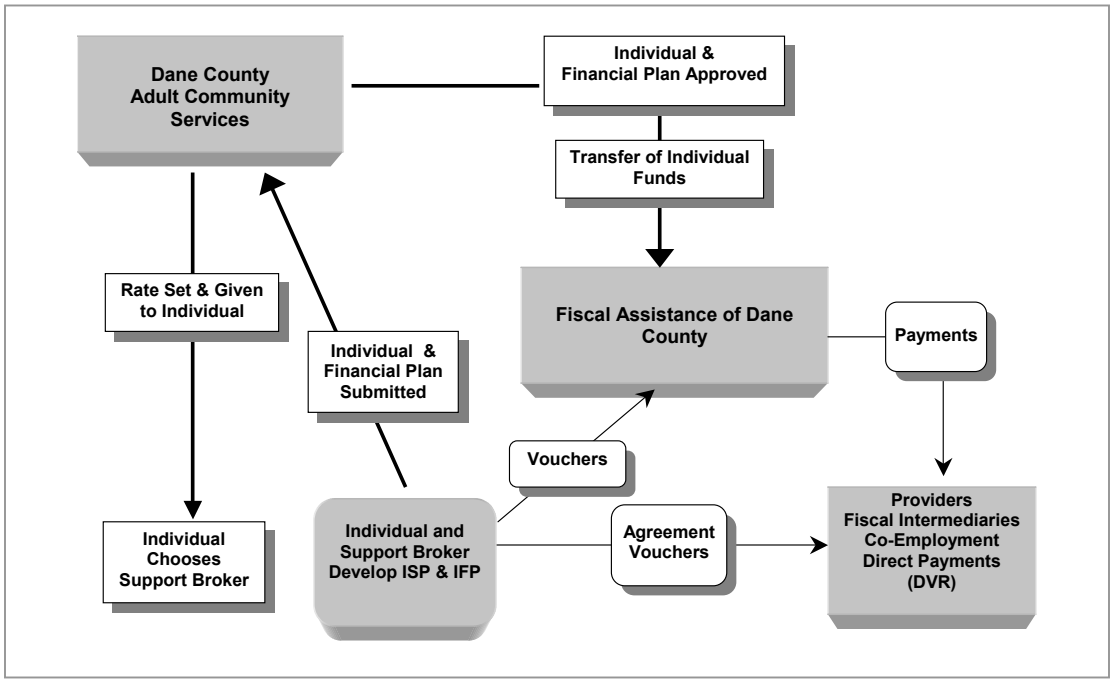
Self-Directed Supports System Overview

Dane County provides services to persons with developmental disabilities (DD services) through the Adult Community Services Division (ACS) of the Department of Human Services. These services are provided for people who have substantial disabilities due to mental retardation, cerebral palsy, epilepsy, autism, Prader-Willi Syndrome, head injuries, or other neurological disorders and who are residents of Dane County. State statute designates the counties as the providers of these services; however, the county's liability is limited to available funding.

The goal of the Dane County DD Services System is to help people live and fully participate in the community. Adult services include supported living arrangements, employment services, case management to help coordinate services, and other support services such as transportation, counseling, communication aids, mobility training, and respite care. Services are individualized, based on the nature and extent of an individual's disability and their individual/family preferences for service. These services are funded through a combination of county general-purpose revenue (GPR) and other state and federal sources including the Medical Assistance waiver programs generally called the Community Integration Program (CIP) and the State's Community Options Program (COP). The typical individual's support package is funded by 60% outside funding and 40% county general-purpose funds (although individual case costs and funding arrangements vary).

The Self-Directed Supports (SDS) system itself is actually a payment system whereby the County allocates a specific dollar amount to an individual consumer based on an assessment of their supportive needs. Consumers then use these funds to purchase the services and supports they desire from within a pool of residential and vocational providers. A fiscal intermediary, Fiscal Assistance of Dane County, is positioned between the County and service providers, and manages the voucher and payment process.

Self-Directed Supports Allocation & Payment Process Overview



System Services and Supports

Developmental disability services and supports for adults in Dane County are provided by approximately thirty agencies and include supported living arrangements, community based work supports, facility based work supports, and day services.

Service Brokers

Service Brokers function as the key advocate for consumers within the SDS System. They assist consumers in the purchasing process, work with consumers to develop service plans, and negotiate contracts for services with providers. Consumers are able to select the broker of their choice in a variety of ways, including individual interviews and broker fairs.

The change of the old Purchase of Service (POS) System of case management to the broker-based SDS System satisfies the Medicaid Waiver requirements against conflicts of interest in case management. The Conflict of Interest Policy states that case management must be provided by a party that does not have the potential to benefit from a particular decision, outcome, or expenditure. Dane County has preemptively addressed this requirement by adopting the current SDS system.

Supported Living Arrangements -

Self-Directed Supported Living includes the provision of a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community. This will include live-in, live-near, come-in and shift staff support, depending upon consumer need and choice. These supports include personal and household services.

Personal services can include:

- Assistance with activities of daily living such as eating, bathing, grooming, personal hygiene, dressing, exercising, transferring and ambulating;
- Assistance in the use of adaptive equipment, mobility and communication aids;
- Accompaniment of a participant to community activities;
- Assistance with medications that are ordinarily self-administered;
- Attendant care, including supervision and monitoring of participants in their homes, during transportation (if not done by the transportation provider) and in community settings; reporting of observed changes in the participant's condition and needs; and
- Extension of therapy services, or activities by the direct care worker that assist the participant with a PT or OT treatment plan. These include assistance with exercise routines, range of motion exercises, standing by during therapies for safety reasons, having the direct care worker read the therapist's directions, helping the participant remember and follow the steps of the exercise plan or hands on assistance with equipment/devices used in the therapy routine.

Household services can include:

- Performance of household tasks and home maintenance activities, such as meal preparation, shopping, laundry, house cleaning, simple home repairs, snow shoveling, lawn mowing and running errands, as well as assistance with packing and general house cleaning when a participant moves.

Goals for Supported Living Arrangements:
Objectives are to provide individualized support that will assist consumers in developing daily living skills, enhance consumers' participation in the community as valued members, and enable consumers to live in the least restrictive settings.

Community Based Work Supports
The primary focus of Self-Directed Community-Based Work Supports is the provision of assistance to facilitate the employment of a participant in an integrated work setting or to develop other forms of income generation. Includes job development aimed at developing a position in a community job, carving out a portion of an already existing position, participating in volunteer activities, and/or developing self-employment opportunities. Participants using this service may need ongoing support to maintain employment or income. Participants may need assistance in transportation, bridging time between jobs, and assistance on the job during non-paid activities (lunch, break, etc.) Specific services include vocational/ job-related assessment, job development, referral, on-the-job support and coaching, education or training and transportation. Other support services including services not specifically related to job skill training may also be provided based on the needs of the specific participant served.

Goals for Community Based Work Supports:
Develop and support daytime and work-related activities that have meaning to the individual. Work/daytime activities should be accomplished as much as possible in integrated, naturally-occurring settings and should be consistent with consumer skills, interests, and choices.

Provide supports in such a way as to maximize the potential for personal growth, enhance independence, and widen connections with the community

Provide services in a consistent and comprehensive manner to enable consumers to maintain employment and/or to maintain and enhance their community skills

Facility Based Work Supports -
Self-Directed Facility-Based Work Supports are the provision of supports to teach an individual the skills necessary to succeed in employment. Supports occur over a defined period of time and involve training and the provision of opportunities for experiences that enhance basic work-related skills. Training is intended to teach an individual the concepts necessary to effectively perform a job in the community and may include following directions, attending to tasks, task completion, appropriate responses to supervisors/co-workers, attendance/punctuality, problem solving, safety and mobility training.

Goals for Facility Based Work Supports:

- Increase independent vocational performance.
- Develop skills in performing activities of daily and community living in order to enhance emotional, personal and social development.
- Develop and support daytime and work-related activities that have meaning to the individual. Work/daytime activities should be accomplished as much as possible in integrated, naturally occurring settings and should be consistent with consumer skills, interests, and choices.
- Provide supports in such a way as to maximize the potential for personal growth, enhance independence, and widen connections with the community
- Provide services in a consistent and comprehensive manner to enable consumers to maintain employment and/or to maintain and enhance their community skills

Day Supports

Self-Directed Day Supports are the provision of regularly scheduled, recurring activities for a defined period occurring for a number of days during a typical week to develop a participant's social skills and to promote community integration. Supports are typically provided four or more hours per day, up to five days per week outside of the person's home. Supports may occur in a single physical environment or in multiple environments, including the community. Services may also include adults who may need protection or who need assistance with activities of daily living and leisure time needs. Day support provides participants the opportunity to interact and to share a social experience with peers in a safe environment. Services provided may include personal care, assistance with monitoring medication and managing medical conditions. Often, these supports are designed around the needs of individuals who are approaching retirement.

Goals for Day Supports:

- Develop skills in performing activities of daily and community living in order to enhance emotional, personal and social development.
- Develop and support daytime activities that have meaning to the individual. Daytime activities should be accomplished as much as possible in integrated, naturally occurring settings and should be consistent with consumer skills, interests, and choices.
- Provide supports in such a way as to maximize the potential for personal growth, enhance independence, and widen connections with the community
- Provide services in a consistent and comprehensive manner to enable consumers to maintain and enhance their community skills

Existing Performance Indicators for Self-Directed Supports Programs -

Primary program goals of Self Directed Supports programs in the county include:
1) Preventing institutionalization (nursing home, State DD Center, hospitalization, etc.), and
2) Providing service in the least restrictive environment consistent with available funding sources.

Indicators:
Measurable objective: Number of consumers leaving this program to a more restrictive environment.
Measurable objective: Number of consumers moving into a less restrictive environment
Measurable objective: Number of institutional days/ by consumer.

The Self Directed Supports Enrollment Process

The County Department of Human Services manages enrollment in the SDS System. Consumers initially apply for participation in the program with the SDS Coordinator, who makes a determination of system capacity. Assuming adequate system capacity exists, county intake workers perform a support needs assessment and the individual rate is set based on this assessment. In the absence of adequate system capacity, the individual application is put on a waiting list pending future capacity review. Further discussion of the nature of this waiting list is provided in the *System Cost Analysis* section of this report.

Each person receiving support from the system is assigned an Individual Rate based on his/her need for support within a calendar year. Individual Rates are set for both the residential service needs and the vocational service needs of the person. This rate setting process involves a structured interview and assessment involving the Developmental Disabilities Intake Unit and the person with a disability, the individual's family, and/or the person's advocate. Factors such as

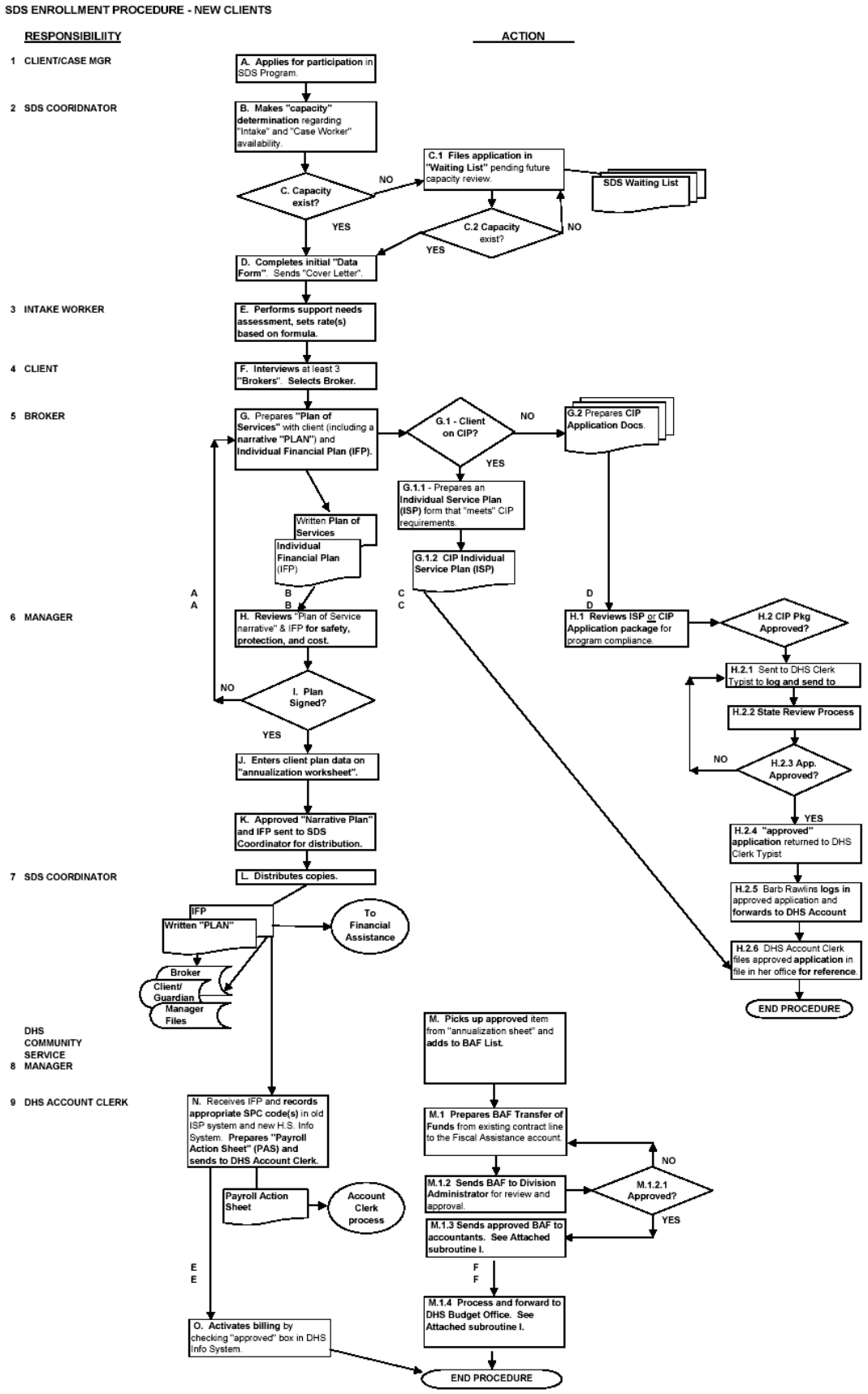
whether the individual can evacuate a residence without assistance in an emergency, is able to safely answer the door, or is prone to seizures, are taken into consideration. In addition, it must be determined if the individual will be provided supports on a one-on-one basis or if he/she will be paired with another individual to receive supports together. Dane County attempts to place individuals in paired relationships whenever possible, as these arrangements reduce direct costs, thus reducing the Individual Rate.

The Individual Residential Rate formula is based on the number of hours of support/supervision an individual will need during a 24-hour period. Through this process, a determination is made of the number of hours the person with the disability may be safely left alone without supervision. From this is established a preliminary residential rate based on the number of hours the individual will need support. For an individual living alone, this formula = the number of support hours needed x 365 days in the year x the direct care rate (currently $13.48 per hour). A 35% indirect cost is then added to this preliminary rate to yield the actual base rate. For individuals living in paired arrangements, the formula is the same, except the number of support hours is divided by two. For these individuals, a 49% indirect cost is then added to yield the actual base rate.

The process of setting an Individual Vocational Rate begins with the completion of a *Vocational Profile* that looks at the individual's job preferences; work history; vocational characteristics – academic skills, communication, attention span, motor skills, strength/endurance, social skills, etc. – and transportation needs. This is supplemented with the *Vocational Support Worksheet* and *Projected Employment and Support at Graduation* worksheet that examine the current and projected direct support staff hours the individual needs to maintain employment. Through this process, a determination is made of the number of hours the person with the disability may be left alone on the job without supervision and whether the individual requires one-on-one support in the workplace. From this the preliminary vocational rate is established – number of hours needing support x 365 days in the year x $13.48 + 35% indirect costs for individuals needing one-on-one support, and number of support hours x 365 days in the year x $13.48 + 49% indirect service costs for individuals paired with another individual for supports.

This rate is only the starting point for each individual, however. For each client, once the base rate is established, the intake workers then utilize their historical experience and comparative data to create add-ons based on the additional needs of the individual clients, thus arriving at the final individualized rates. These rates are reviewed on an annual basis and may also be adjusted throughout the year through a review process that is typically initiated by the Support Broker. The rates are dynamic in that as the circumstances of the individual change, the rate is adjusted. For example, a residential rate may be adjusted downward when an individual goes from living alone to having a roommate. The rate may be adjusted upward if the individual has additional physical needs that require more support in order for the person to continue to live in the community. A more detailed analysis of what constitutes these costs is provided in the *Provider Audit* section of this report.

After interviewing and selecting a broker, consumers then work with the broker to prepare an Individual Service Plan (ISP), a narrative document outlining the consumer's service goals, and an Individual Financial Plan (IFP), a formatted template indicating specific services and dollar amounts. These are reviewed by the county to ensure compliance with the safety needs of the consumer and the total dollar amount allocated by the county. Following approval, the IFP is submitted to Fiscal Assistance and to the SDS Payroll Manager with the county. Billing is then activated in the Human Services information system.


SDS ENROLLMENT PROCEDURE - NEW CLIENTS
RESPONSIBILIITY
ACTION
1 CLIENT/CASE MGR
A. Applies for participation in SDS Program.
2 SDS COORIDNATOR
B. Makes "capacity" determination regarding "Intake" and "Case Worker" availability.
C. Capacity exist?
NO
YES
C.1 Files application in "Waiting List" pending future capacity review.
SDS Waiting List
C.2 Capacity exist?
NO
YES
D. Completes initial "Data Form". Sends "Cover Letter".
3 INTAKE WORKER
E. Performs support needs assessment, sets rate(s) based on formula.
4 CLIENT
F. Interviews at least 3 "Brokers". Selects Broker.
5 BROKER
G. Prepares "Plan of Services" with client (including a narrative "PLAN") and Individual Financial Plan (IFP).
G.1 - Client on CIP?
NO
YES
G.2 Prepares CIP Application Docs.
G.1.1 - Prepares an Individual Service Plan (ISP) form that "meets" CIP requirements.
G.1.2 CIP Individual Service Plan (ISP)
Written Plan of Services
Individual Financial Plan (IFP)
A
A
B
B
C
C
D
D
6 MANAGER
H. Reviews "Plan of Service narrative" & IFP for safety, protection, and cost.
H.1 Reviews ISP or CIP Application package for program compliance.
H.2 CIP Pkg Approved?
H.2.1 Sent to DHS Clerk Typist to log and send to
H.2.2 State Review Process
H.2.3 App. Approved?
NO
YES
H.2.4 "approved" application returned to DHS Clerk Typist
H.2.5 Barb Rawlins logs in approved application and forwards to DHS Account
H.2.6 DHS Account Clerk files approved application in file in her office for reference.
END PROCEDURE
I. Plan Signed?
NO
YES
J. Enters client plan data on "annualization worksheet".
K. Approved "Narrative Plan" and IFP sent to SDS Coordinator for distribution.
7 SDS COORDINATOR
L. Distributes copies.
IFP Written "PLAN"
To Financial Assistance
Broker
Client/ Guardian
Manager Files
DHS COMMUNITY SERVICE
8 MANAGER
M. Picks up approved item from "annualization sheet" and adds to BAF List.
9 DHS ACCOUNT CLERK
N. Receives IFP and records appropriate SPC code(s) in old ISP system and new H.S. Info System. Prepares "Payroll Action Sheet" (PAS) and sends to DHS Account Clerk.
M.1 Prepares BAF Transfer of Funds from existing contract line to the Fiscal Assistance account.
M.1.2 Sends BAF to Division Administrator for review and approval.
M.1.2.1 Approved?
NO
YES
M.1.3 Sends approved BAF to accountants. See Attached subroutine I.
Payroll Action Sheet
Account Clerk process
E
E
F
F
M.1.4 Process and forward to DHS Budget Office. See Attached subroutine I.
O. Activates billing by checking "approved" box in DHS Info System.
END PROCEDURE

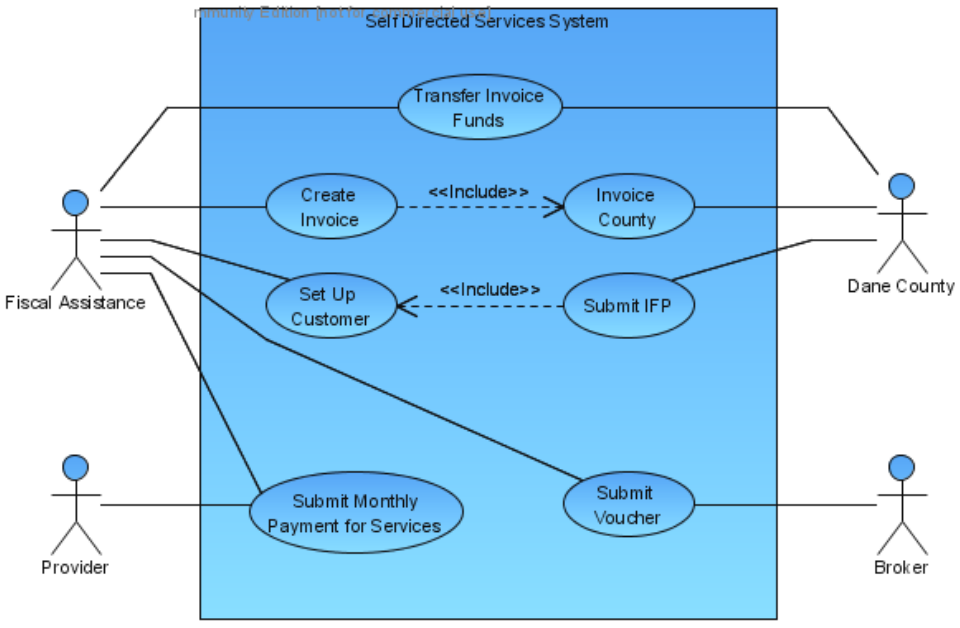
The Self-Directed Supports Payment Process

The primary actors in the Self-Directed Supports payment process include the County, Fiscal Assistance, Providers of services, and Service Brokers. After approving an Individual Financial Plan (IFP), the county submits it to Fiscal Assistance. Fiscal Assistance then establishes a customer account based on the information included in the IFP and creates an invoice for one-twelfth the customer annual rate, which is submitted by Fiscal Assistance to the county. The county then transfers the invoice amount to Fiscal Assistance.

After working with the consumer and service providers to assemble a package of supports, a voucher document indicating the amount and duration of payments is submitted by the broker to Fiscal Assistance for each agency that will provide services to the individual. Fiscal Assistance has recently developed an integrated electronic IFP/Voucher document (MS Excel based) to assist in the ease and timeliness of the voucher development and submission process. After receiving the voucher, Fiscal Assistance then pays provider agencies each month for the agreed upon amount. All financial transactions between the county and Fiscal Assistance and between Fiscal Assistance and providers are conducted as electronic transfers. Each year, funds that aren't used by a particular client are returned to the County to be used for the admission of new consumers to the Self Directed Supports system.

Control: Each month, Fiscal Assistance compares the report of monthly payments with actual expenditures and expected payments indicated by the IFP accounts. When the monthly checks are prepared for payment to providers of services, they are matched against vouchers to ensure proper payment. Fiscal Assistance posts web based payment reports to their site on the 20th of each month. These can be reviewed by authorized users including the county, brokers, and providers at their website, www.fiscalassistance.org.

Self Directed Supports Payment Process



The County contracts with Fiscal Assistance and the seven service broker agencies under an annual flat rate contract. Fiscal Assistance has only one other customer, a limited scope Medicare related payment program. The broker contract calls for broker agencies to service a certain capacity, or number of clients. Should a broker not meet capacity, they could have their payment by the county reduced. Therefore, it is in their best interest to have satisfied clients who will stay with them. While the consumer has the option to interview a number of potential brokers, applicants are typically pointed to a particular broker by the county based on a variety of factors such as location, etc.

Brokers are required to meet periodically with their clients to review the progress of their plan of care and financial plan. In addition, they are responsible for filing an annual report to the county for each client with an update on their progress. Finally, brokers are required to develop a wrap up report once a client is discharged from the SDS System, which generally happens only in the case of relocation out of Dane County or upon death.

Dane County Self-Directed Supports
System Evaluation & Management Audit

System Utilization

Self-Directed Supports System Utilization

The consultants examined Self-directed Supports program utilization trends for the period January 2000 through July 2005. The examination included a review of demographic characteristics and historical transactions for 1,201 clients during the nearly six-year period. The source of the information was the SDS Database, a Microsoft Access relational database developed internally by the Department of Human Services, which consolidated three major, separately maintained datasets pertinent to Self-Directed Supports program operations. These include the County information system in which basic client information is stored; the fiscal assistance database holding Self-Directed Supports payment and transaction data; and the EDS data system holding Medicaid eligible personal care services information. Data was extracted from each of the three datasets and consolidated by Department of Human Services information systems staff during August 2005.

Program Enrollment

Self-Directed Supports enrollment as of July 2005 included 1,140 active cases, 48 inactive or closed cases, and one individual waiting for service (wait list). The program was originally piloted during 1998-99 when 135 participants were transferred from the Purchase of Service (POS) System of community-based contracts to the Self-directed Supports model. Following the gradual transfer of additional consumers to the program during the next three years, SDS enrollment peaked during 2003-04 when 652 participants were converted to the payment system during the two-year period. Forty-eight individuals have transferred out of the system during the eight-years the program has been in operation. Cases may be closed due to a number of reasons including voluntary relocation to an out-of-county residence, transfer to an institutional setting (e.g. nursing home, state center, judicially mandated incarceration), or death.

Dane County, WI
Self-Directed Supports System Enrollment Trends 1998 – July 2005

	Enrollment	Closures	Net Active Caseload
Prior to 2000 –	135	2	133
2000 -	98	7	224
2001 -	96	1	319
2002 -	167	8	478
2003 -	260	7	731
2004 -	392	13	1,110
2005* -	40	10	1,140

*Through July 2005
Source: SDS Database August 2005, Dane County Department of Human Services

Consumer Demographics

The average age of current program participants is 43 years, while ages overall range from 11 to 86 years. The majority (83.3%) of participants are between 25 and 64 years of age, with those age 18-24 years and 65 years and older comprising 10.5% and 6.2%, respectively. The age distribution of Self-directed consumers is relatively consistent when examined across both active cases and historical enrollment. Of note is the advanced age of a number of program participants. The active caseload includes seventy-five individuals age 65 and older, with two individuals age 85 and 86 years.

Dane County, WI
Self Directed Services Program Participants by Age and Case Status, July 2005

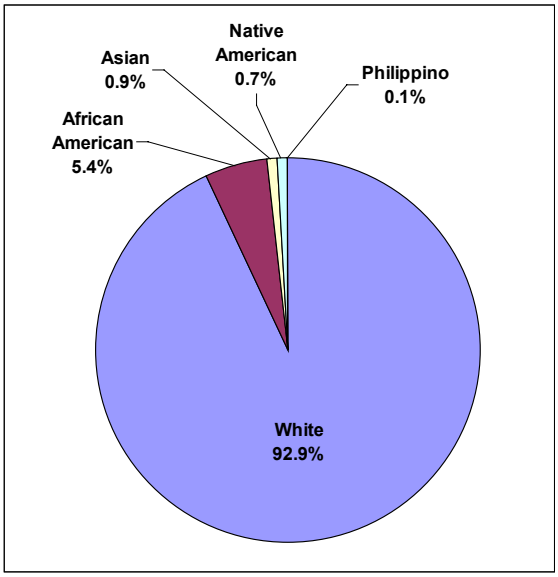
	Active		Closed*		Wait List		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
SDS Participants All Ages	1,140	100.0%	48	100.0%	1	100.0%	1,189	100.0%
By Broad Age Group								
Age 0-17 w /DD	1	0.1%	0	0.0%	0	0.0%	1	0.1%
Age 18-24 w /DD	120	10.5%	6	12.5%	0	0.0%	126	10.6%
Age 25-44 w /DD	508	44.6%	18	37.5%	0	0.0%	526	44.2%
Age 45-64 w /DD	441	38.7%	19	39.6%	1	100.0%	461	38.8%
Age 65-84 w /DD	68	6.0%	5	10.4%	0	0.0%	73	6.1%
Age 85+ w /DD	2	0.2%	0	0.0%	0	0.0%	2	0.2%

*Age at date of w ithdraw al from the program
Source: SDS Database August 2005, Dane County Department of Human Services.

Historically, program participation by males has exceeded that by females. Over the course of the roughly six-year period of study a total of 663 males have been served by the program, versus 525 females. This trend continues among active cases, with the current caseload including 639 male and 501 female participants.

The primary race of the majority of program participants is White (92.9%), with persons of color collectively comprising less than 10% of all those enrolled. Participation by racial and ethnic minorities includes, in descending order, African American (5.4%), Asian (0.9%), Native American (0.7%), and Philippine (0.1%). This distribution is relatively consistent when examined across both active and closed cases, and when viewed in terms of historical enrollment.

Dane County, WI
Self Directed Services Program Participants by Race



ource: Self Directed Services Database August 2005, Dane County Department of Human Services

Level of Care (LOC)

The levels of care evidenced among the current active caseload indicate what are in some cases the significant needs of consumers. Although the majority have only mild to moderate cognitive disabilities and are relatively healthy, a significant number present with profound disabilities, involved behaviors, and fragile or unstable health status. Some 625 individuals are eligible at the DD2 level of care, 233 at the DD3 level; 72 at the DD1B level, and 54 are eligible at the most profoundly disabled DD1A level. Brain injury (BI) affects 42 consumers who currently active in the system.

- Level of Care Description -

Brain Injury (BI) – head trauma resulting in impairment of cognitive abilities or physical functioning and/or a disturbance of behavioral or emotional functioning.

DD1A - profound or severe retardation, unstable health or health that requires continuous monitoring and complex procedures. Usually exhibits behavior appropriate to developmental levels.

DD1B - profound or severe retardation, relatively stable health, frequent challenging or undesirable behavior such as aggression, property destruction, stool smearing, rectal digging, stripping, etc.

DD2 - moderate retardation, relatively stable health, occasional challenging or undesirable behavior such as aggression, property destruction, stool smearing, rectal digging, stripping, etc.

DD3 - mild retardation, stable health, appropriate social behavior at most times.

The level of care required by consumers participating in the Self-Directed Supports program is evaluated annually by the County, and may be adjusted based on changes in physical or behavioral status or health condition. Department of Human Services staff indicate that any changes to the indicated level of care are more likely to reflect a move to higher rather than lower levels of care over time. This is generally confirmed by an examination of LOC trends during the course of the program. Among the 147 consumers whose level of care requirement has changed, fully 86 (58.5%) have moved to a higher level of care than initially indicated in earlier assessments. The majority of this movement is accounted for by a change in status from an initial assessment of a DD3 level of care to the DD2 or DD1B levels, as well as movement from an initial assessment of a DD2 level of care to the DD1B and DD1A levels.

Some of the highest needs consumers remain outside of the SDS System. This is a sub-group of consumers that typically presents significant socio-legal behavioral challenges. Of the 1,140 active cases in the system, fifty-seven are classified as "non-SDS", meaning the consumers' supports are County-directed.

The involvement of non-SDS consumers has increased during the course of the past six years, with peak enrollment occurring during 2002-03, when thirty-nine were enrolled in the program during the two-year period. The continuing role of the county as the case manager for these individuals is evaluated on a month-by-month basis.

- SDS Versus Non-SDS Consumers -

Within the Self-Directed Supports payment system, there are actually two major groups of consumers; those whose services are Self-directed and those whose services are county-directed. Self-directed consumers comprise the majority of program participants, and typically play a significant role in working with their guardians and service brokers to make choices about the services they receive.

County-directed consumers are typically individuals who present significant behavioral challenges that often result in legal problems. The status of this group of consumers is indicated as "non-SDS" in the county information system, although their services continue to be assembled and paid through the Self-directed Supports system. The continuing role of the county as the support broker for these individuals is evaluated on a month-by-month basis.

Dane County Self-Directed Supports
System Evaluation & Management Audit

System Cost Analysis

System Cost Analysis

The section focuses on funding of the SDS System as a whole. It examines factors that impact costs within the system and how the SDS system compares with other county systems in Wisconsin. It addresses the following issues:

- Recent cost trends
- Dane County's services for adults with disabilities in comparison to other counties within the state in terms of service quality, costs, DD Center placements, provider salaries, and waiting lists.
- Costs associated with different Level of Care classifications
- Costs associated with an aging consumer base
- Market forces, such as housing and wages
- Factors mitigating costs: transition to community settings, outside revenue, and cost saving measures.
- Funding levels necessary to meet current demand
- Funding levels necessary to meet the demand for DD services in Dane County during the next 20 years.
- Projected trends in federal, state, and local funding sources

Recent Cost Trends

In order to assess recent cost trends for services for adults with disabilities in Dane County, the consultants analyzed consumer cost data from 2000-2004, which was provided by the Health and Human Services Department. These databases include cost data for the overall Adult DD System, which includes both the SDS and POS Systems. It was not until 2006 that the County required that all adults with disabilities convert to the SDS system, so many consumers transferred from POS to SDS during this period, and many have received services from both systems. Therefore, it would be misleading to analyze increased costs to only the SDS System. It is more accurate to look at cost trends within the larger framework of the overall Adult DD System.

Total Consumer Cost 2000-04

Year	Consumers served	Total costs	Cost per consumer
2000	1028	$52,289,753	$50,866
2001	1061	$56,902,795	$53,631
2002	1099	$61,563,123	$56,017
2003	1137	$64,565,307	$56,786
2004	1157	$65,119,651	$56,283

SOURCE: DANE COUNTY DHS

Average Consumer Costs 2000-04

Year	Average cost per consumer	Difference from previous year	% Change from previous year
2000	$50,866	X	X
2001	$53,631	$2,766.00	5.44%
2002	$56,017	$2,386.00	4.45%
2003	$56,786	$768.00	-1.37%
2004	$56,283	($503.00)	-0.88%

SOURCE: DANE COUNTY DHS

Both overall costs and per-consumer costs for Adults with Disabilities have been rising. From 2000 until 2004, consumer numbers grew by 12.5% while overall costs grew by 22%, yielding total per-consumer increase of 10.6%. Some of the specific factors driving theses costs, as well as factors mitigating these costs, will be discussed later in this section.

Most of the increases over this period, however, occurred within the first two years. While overall costs have been growing for adult services, the year-to-year increase for per-consumer costs has lessened in each successive year, until 2004 when there was actually a decrease from the previous year. These reduced per-consumer costs for the Adult System are consistent with data from the County that indicates yearly reductions in daily waiver costs for this five-year period. These changes are very significant, as the majority of Adult DD consumer services are covered under the DD Waiver. These trends indicate that although Adult System costs have been rising, the County has shown increased cost-effectiveness on a per-consumer basis.

DD Waiver Costs: Average Cost Per Person Per Day

Year	CIP IA	%	CIPIB	%	BIW	%
2000	$288.51	X	$156.52	X	$258.61	X
2001	$306.45	5.9%	$158.09	1.0%	$253.44	-2.0%
2002	$314.12	2.4%	$158.98	0.6%	$282.08	10.2%
2003	$301.99	-4.0%	$163.29	2.6%	$266.09	-6.0%
2004	$286.75	-5.3%	$155.19	-5.2%	$232.75	-14.3%

SOURCE: DANE COUNTY DHS

Comparisons with other Wisconsin Counties

Services

Dane County is a leader in providing comprehensive, self-directed services (residential, vocational, case management, transportation, social/recreational/community involvement) to each individual within the system. So much so that the Wisconsin Developmental Disabilities Council calls Dane County the "model for the entire state." The reason for this distinction is Dane County's commitment to person-centered planning and self-directed services.

In order to provide some larger perspective, the consultants compared Dane County with other counties across the state, using information provided by the Wisconsin Developmental Disabilities Council and the Bureau of Labor Statistics. The primary focus is on comparisons between Dane County and Waukesha and Brown Counties, which are most similar to Dane in terms of population size and demographics.

Dane County's SDS System is well ahead of other similar counties in the state in terms of self directed services and least restrictive placements. The DD Council's report states that Dane County has the only system of its kind in the state. Both Waukesha and Brown County have more traditional case manager directed purchase of service systems. Waukesha County has been exploring the possibilities of this type of system, but they have concerns about perceived loss of accountability by service providers and potentially higher costs. They do, however, support the philosophical intent of this type of system. Brown County is not considering any major changes with their DD system, but they do report that they have achieved an increase in consumer choice and community placements within the last several years. As the table below shows, Dane County has a much larger proportion of supported living placements and considerably fewer CBRF placements. This difference can be largely attributed to the uniqueness of SDS System.

Residential settings and Supports by County

Type of Support	Dane		Brown		Waukesha	
	# Consumers	% Total	# Consumers	% Total	# Consumers	% Total
Natural Family/Paid In-Home Supports	260	22.3%	153	23.1%	56	15.6%
Supported Living	825	70.8%	95	14.3%	11	3.1%
Other Apartment Living	0	0.0%	164	24.7%	66	18.4%
Adult Family Homes	78	6.7%	156	23.5%	112	31.2%
CBRF	2	0.2%	95	14.3%	114	31.8%
Totals	1165	100.0%	663	100.0%	359	100.0%

SOURCE: WISCONSIN DEVELOPMENTAL DISABILITIES COUNCIL

Overall Costs

The previous cost trend analysis dealt with costs only for the Adult DD System. The following cost comparisons with other counties contain data from the total DD System (adults and children), as cost breakdowns were not readily available for the other counties.

Dane County's 2005 total budget for Developmental Disabilities was $74,584,924. With a total population of 453,582, this budget yields a per-capita cost of $164.44. This ranks Dane County as the 2nd highest total DD budget and the 6th highest per-capita cost among Wisconsin counties. It should be noted that these costs represent the total budget, of which 21% comes from the Dane County tax levy, and 79% is comprised of outside revenue.

This high ranking is very significant for such a populous county. Dane County is substantially ahead of the other large counties, as the next highest ranking among large counties is 47th. Dane County's spending per-capita is well above any of the other four counties listed, as well as the state average. Most notably, Dane County spends nearly twice as much as the two counties with which Dane County is most similar in population and demographics, Waukesha County and Brown County. Similarly, Dane County has less than half the population of Milwaukee County, but its total budget is only $2,647,028 less than Milwaukee County's.[1] Clearly, Dane County is investing more resources in providing services for persons with disabilities than these other large counties.

DD Budget Comparisons by County

County	County Pop.	Total DD Budget	Budget Per Capita	Rank
Milwaukee	928,018	$77,231,952	$83.22	58
Dane	453,582	$74,584,924	$164.44	6
Waukesha	377,193	$32,687,203	$86.66	53
Brown	237,166	$22,627,680	$95.41	47
Racine	194,188	$13,882,662	$71.49	61
State Avg	72,442	$7,908,027	$109.16	X

SOURCE: WISCONSIN DD COUNCIL

DD Center Placements

The consultants compared counties based on numbers of consumers in DD Centers. Dane County currently ranks 47th among 72 Wisconsin counties in total number of residents placed in state DD centers, with a total of 47 placements. Given Dane County's current population of 453,582, this equates to 1.036 placements per 10,000 people. In comparison, Waukesha has

[1] Please note that in Milwaukee County, consumers over the age of 60 are included in the Department of Aging budget, not the DD budget.

1.034 placements per 10,000 people (39 total placements), and Brown County has 0.464 placements per 10,000 people (11 total placements). Dane County is slightly below the state average of 1.129 placements per 10,000 people.

This relatively high number of DD center placements seems unusual given Dane County's commitment to least restrictive placements. One contributing factor for this high number was the closing of Lake Shore Manor, an Intermediate Care facility. When this center closed, many of the residents became Dane County residents, regardless of their previous county of residence. Some were then placed in DD centers as Dane County placements. Similarly, many Central Wisconsin Center residents have been placed in other facilities around the state, and Dane County was considered the placing county, regardless of the county of origin. When these residents were returned to the CWC, they remained Dane County residents.

It should also be noted that the number of DD Center placements has been steadily decreasing over the last several years. In 2000, there were 57 DD Center placements, compared to 47 in 2005, which is an 18% decrease over five years.

Provider Salaries

In 2006, the average wage for SDS front-line direct care staff was $11.00 per hour as reported by Dane County. This is slightly higher than Waukesha County, where Basic Supportive Home Care staff make between $8.50 to $10.50 per hour. The consultants requested this information from Brown County as well, but it was not provided.

The consultants also analyzed reports from the Bureau of Labor Statistics (BLS) in order to compare Dane County with Waukesha and Brown County in terms of average direct care hourly wage. Therefore, in order to provide some basis for comparison, the consultants used the BLS statistics for the *Health Care Support Occupations*, and *Community & Social Service Occupations* categories.[2] These two categories most closely encompass the range of services provided by SDS. Dane County has slightly higher wages for the category of *Health Care Support Occupations*, with an average hourly wage of $12.71, compared to Brown County at $12.22, and Waukesha at $12.00. For *Community & Social Services Occupations*, Dane County was significantly higher, with an average hourly wage of $20.58, compared to $18.64 and $18.62 for Waukesha and Brown, respectively. While these figures do not directly represent the wages paid to direct care staff, but they do show that Dane County pays higher wages for this range of services than these other counties.

Waiting Lists

The high costs of services have placed strains on the overall DD budget. Ultimately, the County cannot afford to meet the needs of all adults with disabilities within the County. This has necessitated the development of a waiting list for services for adults with disabilities.

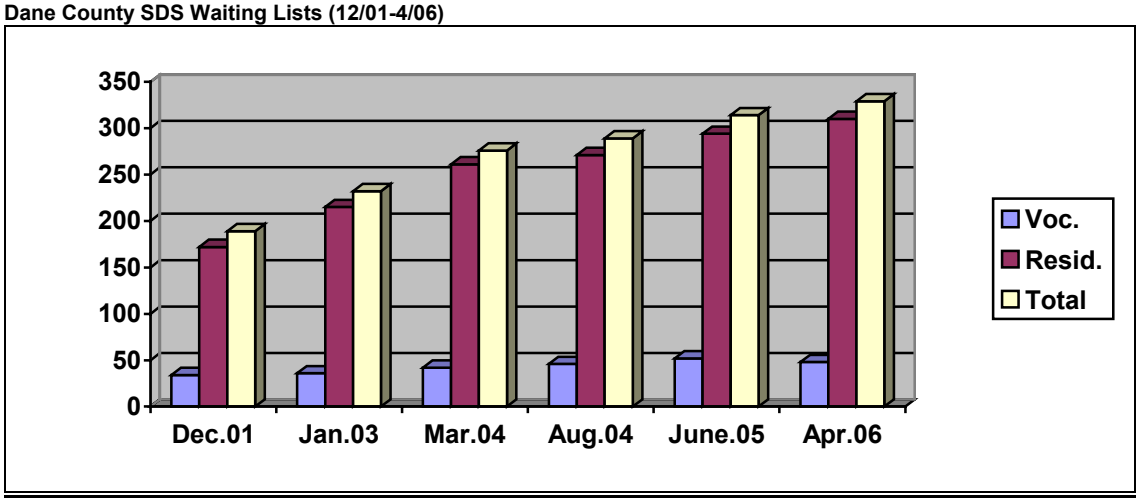
When a consumer graduates from high school, he or she is provided with a broker as required by the Medical Assistance Waiver. Typically, the consumer is also provided with a vocational service provider at this time, although he or she could be put on a waiting list depending on availability. Most consumers will go onto the waiting list for residential services at this point, unless they meet the criteria for a person in crisis.

[2] The BLS does not provide these statistics for every county, but does provide them for metropolitan area. The figures used in this report represent the Madison, Green Bay, and Milwaukee/Waukesha metropolitan areas.

Typically, consumers are taken off of the residential waiting list and brought into the system due to that individual being in a crisis situation. **Appendix I** details Dane County's criteria for what constitutes an individual in crisis or need of continuity. In general, people with the most critical needs are prioritized for services, as they are the most likely to experience a crisis in their lives and the least likely to be able to resolve the crisis without ongoing public support. As a result of these criteria, the vast majority of consumers coming into the system are those with the highest needs. This means higher overall costs and higher average costs per consumer.

Waiting lists for services are not a new development in Dane County, as they have existed for specific services well before the conversion to the SDS system. The total waiting list has been consistently growing, however, and, as of April 2006, the waiting list was at 329 people. The consultants have received waiting list data from the County going back to December of 2001. These figures show a 74% increase in the total waiting list during this period, with an 80% increase for residential services and a 41% increase for vocational services.

Dane County SDS Waiting Lists (12/01-4/06)



SOURCE: DANE COUNTY DHS

Dane County's waiting list is an issue because it shows that not all consumers' needs are being met. A waiting list of this size, however, is certainly not an anomaly within the state. Dane County's waiting list is similar in size to the waiting lists in both Waukesha (319) and Brown (350) counties. When adjusting for county population, however, Dane County fares better than Brown or Waukesha Counties, in terms of number of people on the waiting list per 10,000. Dane County currently has a population of 453,582 and the SDS System has a waiting list (as of April 2006) of 329 consumers, which equals approximately 7.3 people on the waiting list per 10,000. By comparison, Waukesha County has a population of 377,193 and a waiting list of 319 people, which equals 8.5 per 10,000. Brown County has a population of 237,166 and a waiting list of 350 people, which equals 14.8 people per 10,000.

Dane County also outperforms the other two counties in terms of meeting current consumer demand. Dane County serves a greater percentage of individuals that have been identified as needing services than either Brown or Waukesha County. The total population of individuals needing service was calculated by adding the number of individuals currently being served and the number of individuals on the waiting list. The percentage is the number currently being served out of this total population.

Percentage of Individuals Being Served by County

County	Currently Served	Waiting List	Total Population	% Served
Dane	1165	329	1494	78.0%
Brown	663	350	1013	65.4%
Waukesha	359	319	678	52.9%

SOURCE: WISCONSIN DD COUNCIL

Clearly Dane County is not alone in struggling with growing waiting lists, but has managed them comparatively well. All counties across the state appear to be under similar financial pressures, and waiting lists are an unfortunate byproduct of this trend.

Levels of Care

All SDS consumers covered under the Medicaid Waiver (about 91%) are assigned a specific level of care code. Level of care has been used by the county as a predictor of the number of support hours that would be required for patients in a nursing home setting. This estimate then serves as the basis for the level of financial support assigned by the county to each individual for physical supports. A complete description of the level of care codes is provided in the *System Utilization* section of this report.

Client Average Annual Cost by Level of Care (2000-04)

Level of Care (LOC)	Average
Brain Injury	$77,278
DD1A	$51,476
DD1B	$74,193
DD2	$50,249
DD3	$26,226
LOC not indicated	$10,960
Average	$48,397

SOURCE: DANE COUNTY SDS DATABASE

On average, higher levels of care are associated with higher costs. There are limits to the Level of Care Codes as a predictor of costs, however. For example, they are not a useful predictor for costs associated with other supports, such as behavioral supports. In addition, the assigned level of care for an individual is not static, and can change over time as an individual ages within the system. The Levels of Care Codes are useful, however, as an overview of the spectrum of costs among consumers. As a result of the waiting list, new consumers coming into the system will typically be those with higher needs, and will therefore most likely be categorized into a higher Level of Care. These averages would seem to indicate that as the numbers of consumers in the higher Level of Care categories increase, so will the overall costs.

Aging Consumer Population

One aspect of providing quality services to adults with disabilities is that consumers live longer and healthier lives. Therefore, it is essential to look at how an aging consumer population will impact costs in the SDS System. Population projections for the county, including projections for age and disabilities, were discussed in the *Demographic Profile* section of this report, and therefore will not be restated here. This section will look at the costs associated with different age groups over the period from 2000–2004 to determine what differences in costs exist for older consumers as opposed to younger consumers within the SDS System. These differences could have very significant impacts on the future system costs.

The consultants looked at the cost breakdown by 10-year age groupings for the period between 2000 and 2004, both for the five-year period as a whole, and for each individual year. The results of this analysis show that within the Adult System, higher costs do not directly correlate with higher age groups. While costs are appreciably lower for the youngest two age groups, they rise

dramatically for the 30-39 age group and then plateau. The highest age group, (80 +) is actually lower than the five groups below.

Total Cost by Age (2000-04)

Age Group	Consumers	Total costs	Avg. costs
80 + above	12	$3,033,173	$252,764
70-79	45	$12,973,397	$288,298
60-69	111	$31,216,389	$281,229
50-59	246	$66,339,470	$269,673
40-49	313	$85,068,694	$271,785
30-39	235	$68,896,242	$293,175
20-29	232	$36,218,731	$156,115
Total	1194	$303,746,095	$254,394

SOURCE: DANE COUNTY HSD

Total Cost by age: Year-by-Year

2000

Age Group	Consumers	Total costs	Avg costs
80 + above	2	$48,008	$24,004
70-79	27	$1,344,977	$49,814
60-69	50	$2,692,515	$53,850
50-59	174	$9,252,997	$53,178
40-49	282	$14,775,389	$52,395
30-39	269	$13,724,439	$51,020
20-29	224	$10,451,428	$46,658
total	1028	$52,289,752	$50,866

2001

Age Group	Consumers	Total costs	Avg costs
80 + above	4	$264,670	$66,168
70-79	29	$1,630,701	$56,231
60-69	55	$3,011,969	$54,763
50-59	188	$10,250,596	$54,524
40-49	291	$15,914,808	$54,690
30-39	259	$14,452,656	$55,802
20-29	235	$11,377,395	$48,414
Total	1061	$56,902,795	$53,631

2002

Age Group	Consumers	Total costs	Avg costs
80 + above	4	$288,228	$72,057
70-79	33	$1,822,221	$55,219
60-69	65	$3,898,138	$59,971
50-59	200	$11,475,113	$57,376
40-49	300	$16,934,398	$56,448
30-39	253	$15,271,043	$60,360
20-29	244	$11,873,984	$48,664
Total	1099	$61,563,123	$56,017

2003

Age Group	Consumers	Total costs	Avg costs
80 + above	6	$380,265	$63,377
70-79	34	$1,939,008	$57,030
60-69	78	$4,740,513	$60,776
50-59	200	$11,381,578	$56,908
40-49	312	$18,155,282	$58,190
30-39	244	$15,733,868	$64,483
20-29	263	$12,234,793	$46,520
Total	1137	$64,565,308	$56,786

2004

Age Group	Consumers	Total costs	Avg costs
80 + above	8	$445,868	$55,733
70-79	36	$2,136,470	$59,346
60-69	81	$4,992,265	$61,633
50-59	215	$12,133,897	$56,437
40-49	319	$18,578,958	$58,241
30-39	231	$14,821,996	$64,164
20-29	267	$12,010,197	$44,982
Total	1157	$65,119,651	$56,283

SOURCE: DANE COUNTY DHS

The absence of a direct relationship between increasing age and costs is contrary to the consultants' expectations; as costs for older adults in society as a whole are higher, it would seem logical that the same pattern would exist within the SDS system. One explanation for this discrepancy is that not all costs associated with older adults within the system are included within the available data. Many of the highest costs associated with older adults, such as nursing home care or adult family home care, are not covered under the Adult DD System. Therefore, the costs for those older adults who need the most extensive and costly care would not be reflected in this data. This helps to explain the absence of a correlation between age and residential costs.

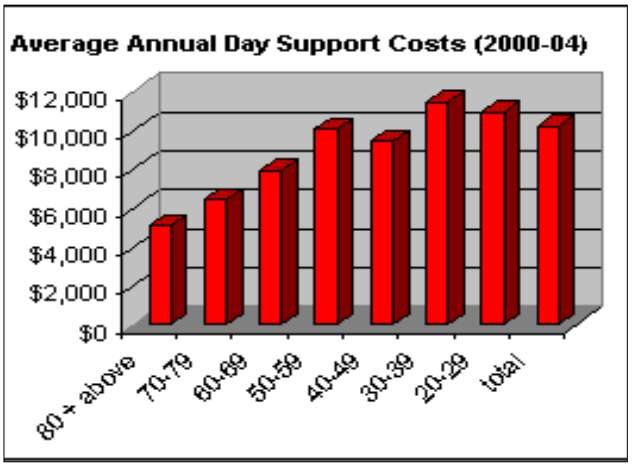
These costs were also separated into Residential and Day support services. Residential costs showed no direct correlation with age, while costs for day supports show an inverse relationship with age. The lack of a correlation between residential costs and age are consistent with the findings for overall costs. Conversely, the SDS System does cover costs for day supports, but the need for these services are generally reduced as consumers age, explaining the inverse relationship.

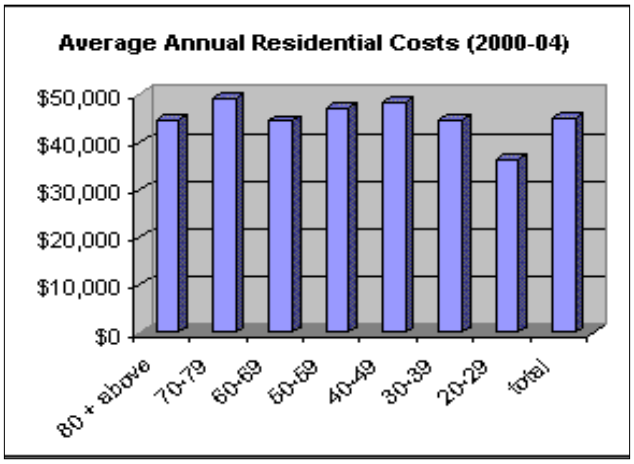
Day Support Costs by Age (2000-04)

Age Group	Consumers	Total costs	Avg costs
80 + above	19	$96,602	$5,084
70-79	69	$445,672	$6,459
60-69	160	$1,273,435	$7,959
50-59	417	$4,216,004	$10,110
40-49	568	$5,395,336	$9,499
30-39	651	$7,494,116	$11,512
20-29	504	$5,535,674	$10,983
Total	2388	$24,456,839	$10,242

Residential Costs by Age (2000-04)

Age Group	Consumers	Total costs	Avg costs
80 + above	10	$447,929	$44,793
70-79	63	$3,114,176	$49,431
60-69	125	$5,568,596	$44,549
50-59	309	$14,632,664	$47,355
40-49	409	$19,806,781	$48,427
30-39	397	$17,756,933	$44,728
20-29	239	$8,716,988	$36,473
Total	1552	$70,044,067	$45,131





In summary, this has been a transitional period as consumers move from the POS System to the SDS System, and there are year-to-year fluctuations among the age groups. For some years, the costs do increase according to age, and for other years they do not. Ultimately, however, it is not possible to conclusively say from this data that overall costs for the SDS System will rise with an aging population. More likely, additional costs to support these individuals are spread out among other funding sources for adults with disabilities and older adults.

Market Factors

Finally, economic factors in the larger market often drive system costs as well as costs for individual providers. Dane County has effectively and voluntarily increased the ongoing cost of care through living wage and wage compression initiatives. The Living Wage Ordinance, which took affect in 2000, requires that the County pay hourly wages equal to 100% of the poverty level for a family of four. This figure is updated annually, based on the poverty guidelines published by the U.S. Department of Human Services. At $9.07 per hour in 2005 and $9.31 per hour in 2006, the minimum starting living wage in the county is 59% higher than the state standard of $5.70 per hour during 2005 and $6.50 per hour during 2006. This living wage adjustment plays a key role in determining the budgets for provider agencies in the SDS system.

Dane County CPI vs. Living Wage
% Increase from Previous Year

Year	CPI	Living Wage
2001	2.8%	2.1%
2002	1.6%	3.4%
2003	2.3%	2.4%
2004	2.7%	1.7%
2005	4.0%	2.4%
Total	13.4%	12.0%

SOURCE: WISCONSIN DD COUNCIL

In the survey conducted by the consultants, many providers expressed concerns that the County does not increase wages commensurate with inflation, but that they are expected to provide the same services year to year. The cost of inflation, as measured by the Consumer Price Index (CPI), has increased 13.4% from 2001-2005, while Dane County's Cost of Living Wage Adjustment has increased only 12% for the same period. As discussed earlier in this report, living wage is only part of what determines the overall funding rate. Likewise, inflation represents only part of the cost pressures on provider agencies. This comparison, however, does provide a useful tool to illustrate what efforts the County has made to address provider costs.

Another financial stressor for provider agencies is the rising cost of employee benefits. A large part of these benefit costs are related to providing health insurance for employees. The Bureau of Labor Statistics (BLS) reports that employer health insurance increases of 10.5% between 2001 and 2002, 9.8% between 2002 and 2003, and 9.3% between 2003 and 2004. These increases outpaced inflation, as measured by the Consumer Price Index, which grew by 1.6%, 2.3%, and 2.7% respectively during these years.

As reported in the Individualized Base Rate Chart, included in the *Provider Audit* section of this report, the County adds an additional 22.5% to the average employee wage to cover employee benefits. According to the BLS, Private Industry employers nation wide paid an average of 29% for employee benefits in 2005.

These costs create pressure on provider agencies to offer competitive salaries in order to maintain a stable employee base. If agencies cannot afford the cost of benefits, they may be forced to either freeze salaries or reduce the number of full time staff in favor of part-time positions that do not include benefits. These adjustments, in turn, create high turnover. This high turnover reduces the effectiveness of staff, and requires administrators to spend more time hiring, training, and supervising inexperienced staff. These administrative costs help to drive overhead and indirect costs higher, and create a financial strain on the entire system.

The cost of housing is a contributor as well. Between 1990 and 2000, the median monthly rental rate in the county increased 52% and continues to rise. In spite of the advantages of privacy, choice and increased opportunity for success, the County's residential apartment living model is more costly than adult family home and group home models used by other counties. Additionally, SSI rates, which are the same throughout Wisconsin, do not reflect the high cost of housing in Dane County versus other areas in the state, requiring the County to cover the difference between the level of subsidy and the actual residential cost.

Factors Mitigating Cost

Dane County has demonstrated that people with substantial needs can be successfully and appropriately served in the community. Community care has been embraced as the standard for a least restrictive setting. At the behest of the state, the County has been successful in moving people with significant needs out of costly institutional settings such as nursing homes, ICF-MRs and DD Centers, and into the community. The result has been annual increases in the numbers of individuals to be served in community settings. Unfortunately, the reimbursement received by the

County for community care is often inadequate to cover actual costs. In spite of this, the County works steadfastly to avoid moving people into institutional settings when their health or behavioral needs increase, and thus the cost of their care increases.

Dane County has aggressively pursued outside revenue from the state to offset program expenditures. While the State of Wisconsin has encouraged Dane County to develop comprehensive services, it has also assisted the county in capturing additional outside revenue to support their delivery. Overall, the SDS system is funded through an approximate distribution of roughly 21% local tax levy and 79% outside revenue.

In addition to pursuing other revenue, cost savings measures have been implemented within the developmental disability system itself. The Sound Response/Safe at Home program uses electronic monitoring to reduce direct care staffing costs, while the DD crisis home maintained by the county has helped to avoid high cost placements at the Mendota Mental Health Institute. In addition, the County has taken measures to place as many consumers as possible with a residential match to reduce residential costs. Two–person residential arrangements allow the county to divide direct service costs in half. These measures have served to control costs associated with ongoing residential support and temporary institutional placement.

Finally, it should be noted that even though these expenditures represent a liability for the County, the funds that are expended are not lost to the community. Because the majority of service providers are local entities, the bulk of the expenditures remain in the community serving to stimulate and enhance the local economy.

Identify funding levels necessary to meet current demand

For purpose of this analysis, current demand is defined as those individuals in need of SDS services, but unable to receive them due to the program being at capacity. This necessitates their placement on a waiting list maintained and monitored by SDS staff. As of April 2006, there were 329 people on the waiting list to enter the SDS program.

The average adult consumer cost Dane County $56,283 in the year 2004, the last year for which the consultants had accurate data. This figure was applied to all consumers on the current waiting list, totaling $18,517,107. When this figure is added to the 2004 total dollars spent for active clients, ($65,226,058) the total amount to meet current demand comes to $83,743,165. This assumes that all residents would come in at the average acuity of those already in the program, and does not account for inflation to 2006 dollars.

Due to Dane County's criteria for removal from the waiting list, however, it is likely that the consumers with the highest level of need are already being served by the System, and cost for those remaining on the waiting list would be lower. It is not possible to determine these costs at this time, however, so the consultants used only the available data.

Identify funding levels necessary to meet demand during the next 20 years

The consultants have developed two potential models to project demand for the SDS System in the coming years. These models are based on the data received from Dane County and demographic data from the U.S. Census. Neither of these models take into account potential policy or procedural changes that may occur as a result of this report or other external factors, as these are not quantifiable.

Model #1

The first model looks at the growth the Adult DD System has experienced within the last five years in terms of both numbers of consumers and costs, and projects these levels out until the year 2030. Review of the SDS database in total showed a 12.5% increase in consumers served within the Adult DD System, while payments for those services rose 22% between 2000 and 2004. The cost per consumers served, on average, rose from $50,866 in 2000 to $56,283 in 2004, a 10.6% increase. Based on these trends, the following table shows what the total consumer population and total costs will be in five-year increments projecting up until 2030.

Projected Costs based on 2000-2004 trends

Year	Clients served	Total $ Spent	$$ Per Client
2010	1301	$79,216,365	$60,886
2015	1464	$96,643,965	$66,027
2020	1647	$117,905,637	$71,603
2025	1852	$143,844,877	$77,650
2030	2084	$175,490,750	$84,207

SOURCE: DANE COUNTY DHS

These projections clearly illustrate the amazing growth that the system has been experiencing recently and the need for some changes in order to insure long-term sustainability within the system.

Model #2

This model is based on the population and growth projections described in the demographics section of this report. The projections of the resources that will be needed to sustain the program at current levels through the next twenty years (not including the addition of clients on the waiting list) indicates program costs will total $82.4 million during 2010 and $119.8 million during 2020. The projection is based on a number of assumptions, including predicted increases in the population of adults with developmental disabilities in the county to number 5,928 individuals during 2010 and 6,409 individuals through the year 2020, (please refer to *Demographics Profile* section of this report), steady state utilization (approximately 207.2 per 1000 age 18+) and per client costs ($56,229) comparable to those during 2004, and an inflation rate of 3% per year projected forward. It is estimated that during 2010 approximately 1,228 adults with developmental disabilities will require services at a cost of $67,140 per client. During 2020 approximately 1,328 adults with developmental disabilities will require services at a cost of $90,231 per client.

Projected Funding Source Trends

The Dane County Self-Directed System receives funding from a variety of sources. Approximately 21% of the funds are provided by Dane County. The remaining funds come from a mix of state and federal programs. The largest portion of this outside money comes from Medicaid Home and Community Based Waivers, particularly the CIP-1B program.

Dane County is very proud of its services for adults with disabilities. The SDS system is considered to be a model of self-determination and person-centered planning. However, this system has been squeezed in recent years by state and federal funding cuts. Medical Assistance Programs have not kept up with inflation and Dane County has been forced to make up the difference to maintain its high level of services. Already, Dane County contributes nearly twice the state average for services to adults with disabilities, and this trend is likely to continue in the future.

Federal and State Budget Projections

Programs for adults with disabilities nation-wide face long-term budgetary problems associated with three primary factors:

1. Rising health care costs in both the public and private sector.
2. Increasing numbers of older adults and the needs associated with this population.
3. Lost revenue due to state and federal policies.

These factors are placing a tremendous strain on all of the entitlement programs and driving up costs. According to The Congressional Budget Office, the combined costs of Medicare, Medicaid, and Social Security will continue to steadily rise for the next several decades. In 2005, these programs represented just over 8% of the Gross Domestic Product (GDP). Due to large projected numbers of baby boomers that will be retiring and utilizing their benefits in the coming years, this figure is expected to increase dramatically. By 2025, it is estimated that the combined costs of these programs will represent over 13% of the GDP, and by 2050 that figure would inflate to almost 19% of the GDP. In addition, the 2007 budget proposes making permanent the federal tax cuts that were enacted between 2001 and 2003. The Center on Budget and Policy Priorities estimates that these proposed tax cuts will cost $285 billion over five years and $1.7 over ten years. These competing trends of less revenue and increased demand are felt at all levels of government. For the Dane County SDS System, the effects of these forces on Medicaid will have the most profound impact on future funding.

To address these trends, the current Presidential Administration has put forth several legislative and regulatory proposals that would reduce net federal Medicaid funding by $14 billion over the next five years and $35.5 billion over the next ten years. The Center on Budget and Policy Priorities estimates that nearly four-fifths of these Medicaid savings proposals would reduce federal expenses by shifting costs directly to the states. This cost shift is the result of the federal government limiting what expenses they are willing to match, thereby forcing the states to cover the difference, reduce services, or pass the costs on to counties.

Wisconsin Medicaid currently receives 60% of its funding from the federal government. The Wisconsin Council on Children and Families estimates that Federal budget reduction policies cost Wisconsin a net $2.4 million between 2002 and 2005. With the proposals in the 2007 budget, it appears this trend will continue. These policies will likely have a trickle down effect, forcing the state to pass these costs on to the counties.

Other Issues

The recent approval by the State Senate to expand the Family Care Initiative could have a major impact on the Dane County SDS System. This system is designed to help move people out of institutions into less restrictive, and less expensive settings. These efforts toward regionalization of services could place an additional burden on Dane County by diverting Medicare funds to help to provide services for neighboring counties. Given the lower populations and rural character of the surrounding counties, Dane County will likely still have the greatest need for these funds in its region. State statutes require that counties provide services for residents with developmental disabilities, and many policy makers in Dane County are concerned that the county will end up having to cover expenses for consumers who fall through the cracks of the regional system.

Findings

The overall objective of this section was to evaluate the funding of services provided by the self-directed services program. In the course of doing so, several facts emerged which need mentioning:

- Overall costs for Services for Adults with Disabilities have been rising over the past five years, but average costs per consumer have been increasing at a much lower rate, and have now begun to decrease. This indicates increased cost-effectiveness by the County in provision of services.
- Dane County spends significantly more per capita than other counties in the state on services for adults with disabilities.
- A waiting list for services has continued to grow and has reached substantial proportions, indicating a large number of consumers' needs are not being met. This waiting list is comparatively smaller, however, than waiting lists in similar counties.
- There did not appear to be a direct relationship between age and cost, at least not specifically for the SDS System. This is likely due to the fact that costs are transferred to other systems or funding sources, such as Medicare, for older adults with disabilities.
- There did appear to be an inverse relationship within the SDS System between age and costs for supported work services.
- Federal and State budget projections indicate further funding cuts in the future, which will impact the SDS System.

Faced with increasing funding restraints and continued pressure to serve the entire qualifying population, SDS must find a way to serve the population in a cost effective manner. The impetus in the future has to be placed on generating new efficiencies and additional revenue sources. The recommendation section of this report will address several potential ways the county can address these findings in a fiscally responsible manner.

References

Wisconsin Council on Developmental Disabilities. (2005). WCDD *DD-Data Report by County*

Wisconsin Economic Summit IV. (2003). *The Health Care Cost Crisis in Wisconsin: An economic Development Prognosis*.

Forster, Stacy. (2006, April 19). Concerns Linger About Expanding Family Care Program. *The Milwaukee Journal Sentinel,* pp. B1, B4.

Pear, Robert. (2006, January 30). Budget to Hurt Poor People on Medicaid, Report Says. *The New York Times*, p. A14.

Bush Spending Plan Cuts Social Programs. (2006, February 6). *The New York Times, Associated Press.*

Center on Budget and Policy Priorities. (2004) *Federal Policies Worsen Wisconsin's State and Local Budgets and Hurt Wisconsin Families.* Washington, DC.

Kogan, Richard and Robert Greenstein. (2006) *Proposed Cap Would Require Deep Cuts in Entitlement Programs.* Center on Budget and Policy Priorities. Washington, DC.

Schneider, Andy, Ku Leighton, and Judith Solomon. (2006) *The Administration's Medicaid Proposals Would Shift Federal Costs to States.* Center on Budget and Policy Priorities. Washington, DC.

Dane County Self-Directed Supports
System Evaluation & Management Audit

Provider Audit

SDS Provider Audit

During January 2006, the accounting firm of Wipfli LLP performed an accounting review of the Dane County Self Directed Supports System's billing and reimbursement procedures and reviewed a selected sample of client plans for consistency in documentation. The points of the project methodology encompassed by Wipfli's review of program compliance included:

- Perform an accounting review of billing and reimbursement procedures
- Audit a sample of client plans for consistency in documentation
- Determine if reimbursement is consistent with services received
- Determine if funds are being spent according to individual plans
- Assess the current formula for determining the individualized rate

Audit Sample

Wipfli selected a sample of 20 client files from the Dane County SDS's database for the year 2004. The sample was selected at random and incorporated a cross section of clients receiving various types and volumes of services from a multitude of providers. It appears that the sample was a fair representation of the population of clients that Dane County SDS serves, based upon the wide cross-section of types and volumes of services that were represented. A complete list of the entire audit sample is provided in **Appendix II.**

Review of Billing, Reimbursement, and Documentation

The items reviewed for each client in the sample included the Individual Service Plan (ISP), Individual Financial Plan (IFP), and the billing vouchers relating to the services received by the client. In addition, Dane County SDS also provided a printout summary of all checks paid, by client, for SDS services received. In reviewing these documents, the consultants were looking for assurance that there was consistency between the ISP, IFP and billing vouchers, as well as whether funds were spent according to the individual clients' plans.

The review of the ISPs included identifying who the individual broker was, what services the client was receiving through SDS funding, and who was the provider of these services. In addition, case notes provided by the brokers were scanned to assure that adequate documentation was there to support the services provided to the client, and that the goal of the SDS program to improve the quality of life for Dane County residents with disabilities is being met.

The review of the IFPs included verifying that the services for which funding was being provided matched those identified in the clients' ISPs. In addition, the calculated monthly allocation of funds was traced to the clients' individual summary of payments, to assure that the providers of service were being paid according to the ISP. Finally, the consultants reviewed whether the entire allocation of funds was used up during the calendar year, and if not, how the excess funds were returned or spent.

The review of the Billing Vouchers included verifying that the amounts being requested for reimbursement by the providers matched the amounts set forth in the IFP. In addition, the vouchers were reviewed to make sure that documents contained adequate authorization. Finally, the consultants traced the providers' request for reimbursement via the vouchers back to the IFP and ISP to verify that the correct providers were paid.

Findings and Conclusions

Based on the sample selected, we found no instances of inconsistencies between the ISPs, IFPs and billing vouchers. Based on the sample, it appears that there is sufficient evidence to prove that the system currently in place is adequate and accurately accounts for all services being provided. Based on the sample, it appears that the system of reimbursing providers for their services is sufficient and that there are sufficient controls in place to assure proper reimbursement. Vouchers require signatures by either the client or the client's legal guardian, as well as by the broker and the provider of services.

For the sample selected, funds appear to be accurately paid according to the individuals ISPs and IFPs. There were cases noted in which not all of the client's available funds were spent. It was found that if the surplus funds were less than $100, they were carried over to the following year. If the surplus was over $100, however, the funds were returned back to the County in most cases. There was one instance in which the surplus funds were used to purchase a specific item for the client. It was found that this is allowable providing the item purchased relates directly to the clients disability, and that the amount of the expense did not exceed the surplus funds available.

The consultants also reviewed the case notes as completed by the brokers. The brokers keep very detailed notes relating to the services being provided as well as documenting all contacts with the clients. There was consistent quality in documentation among broker agencies.

Determine if reimbursement is consistent with services received

Prior to January 1, 2006, providers reported "days of service" to SDS.[1] It is the consultants' understanding that the unit "days of service" reflected specific days in which direct service was delivered. The numbers of "days of service" were not used to determine provider rates, but did provide a barometer regarding service utilization. It indicated how many days a client received service but showed no detail as to how much actual time was being spent with the client. There were no specific records, so a particular service, for example, could have lasted two minutes or two hours. The unit "days of service" did not accurately describe what services were being purchased and for what cost, making it difficult to evaluate the different rates being paid to providers for their services. This creates confusion when trying to compare two providers that are essentially providing the same services but are being paid differently.

Effective January 1, 2006, SDS requires its providers, on a monthly basis, to report the number of hours of direct service, in the form of units, rather than days of service. A unit is described as "staff /client hour," and is defined as the amount of time spent face to face with a consumer(s). If a staff is supporting more than one consumer during an hour, the unit is divided between the number of consumers being supported. For example, if a staff is providing one hour of equal support to two consumers, the staff would report 1/2 hour for each consumer.

[1] Traditionally, the Medicaid Waiver programs (CIP 1A, CIP 1B, Brain Injury Waiver) have required units of service reporting. Reporting to the nearest 1/4th of an hour was required for standard program categories including, but not limited to, case management, home care, chore service, day services, sheltered, employment, and supported employment. Transportation services were reported as one-way trips, while group home and adult family home services were reported by the day. Every consumer, for each day, had units of service reported for whatever services the consumer received on that day. For nearly two decades, Dane County met this requirement by tracking units of service. At the request of the WDHFS, the federal Center for Medicaid/Medicare Services (CMS) approved "Self Directed Services" as its own Medicaid Waiver reporting category about five years ago. The defined unit of service was "one SDS day" regardless of the number of different services a consumer received. Dane County implemented the "one SDS day" unit of service in 2001 as it met the state and federal requirements and was an administrative efficiency. In 2005, when the transition to SDS services was completed, Dane County began to seriously regret the loss of detailed units of service and, for 2006, reinstituted the requirement that units of services be reported for each separate service.

This change in methodology provides a more measurable statistic with which to evaluate both level and cost of service. Analyzing the various rates paid for services should yield some meaningful comparisons in the future.

Because the consultants were analyzing data prior to the change in reporting, it was not possible to completely test whether reimbursement was consistent with the services received. To accomplish this, it was necessary to have a measurable statistic such as hours of service or units provided in order to calculate a cost per hour or unit for each service. SDS staff provided a schedule detailing the number of units, which represent hours of direct service, for each provider during the months of January and February 2006. These figures were annualized and divided into the each provider's total 2006 budget, yielding a projected cost per unit of service for each provider. A complete list of the unit rate data is illustrated in **Appendix III.** [2]

Summary of Unit Rate Data

Provider Group	Max Rate	Min Rate	Average	Range
Brokers	$65.19	$43.26	$52.08	$21.93
Residential	$26.01	$16.42	$21.47	$9.59
Vocational	$44.39	$21.72	$30.02	$22.67

SOURCE: DANE COUNTY DHS

Findings and Conclusions

Based on our review of this data, it appears that there is a wide variance between unit costs in each provider category. These findings do not necessarily show, however, that one provider may be more or less efficient than another at providing the same service. As these units measure only direct services, they do not take into account the services that are vital to consumers, but do not fit into the technical definition of "direct services" for Dane County. Some of these indirect costs are detailed later in this report. Also, with only two months of data, it is not possible to determine whether the data given for those two months is a fair representation of normal volume for each provider. Variances in unit rates can also result from differences in the cost structure at each provider, levels of productivity, and travel costs. Furthermore, each provider targets specific populations with their own specific needs. This can dramatically affect budgets, as higher levels of care require higher costs. Finally, there may some inaccuracies in this data due to human error, as this recording system is new to providers.

Due to these factors, it is not possible to definitively conclude that reimbursement is consistent among the providers of the services. Once a larger sample of data is available, it would be prudent to review this data to ensure that consistency exists among providers of like services. The consultants estimate that after 12 months of compiling this unit rate data, the County should be able to make some accurate judgments about the range of unit costs for services.

Assess the current formula for determining the Individualized Rate

An overview of the rate setting formula is provided in the *System Overview* section of this report. This audit, however, will briefly recap this formula for the purpose of more closely analyzing the costs involved.

The individualized rate is determined each year by a number of factors. First, the County determines a direct care rate for providers. This rate is the combination of the average provider

[2] The data presented in Appendix III is intended to demonstrate the format in which unit data will be recorded. Because only two-months worth of data exists, these numbers do not accurately reflect what the final unit rates will be for each agency. Therefore, agency names have been withheld from the list.

rate, which in this year was $11.00, and cost for fringe benefits, which are 22.5% of the average county wage, at $2.48. Added together, these yield a direct care rate of $13.48. This rate is then multiplied by the number of support hours needed each day for each consumer, and then multiplied by 365 to determine the base rate for the year. For arrangements where two consumers share a paired living or working arrangement, the number of direct support hours is divided by two.

After this base rate is established, indirect costs are added for each consumer at a rate of are 35% for consumers living alone and 49% for consumers in paired arrangements with other consumers. The administrative costs in this year averaged at 11.5%, and the remaining indirect costs total 23.5% for consumers living alone and 37.5% in paired living or working arrangements. These costs are added to the direct care rate to establish the individualized base rate for each client.

SDS Individualized Rate Chart

Assumes 2 individuals living/working together

Maximum hours left alone per day	Balance of time needing support	Divided by 2 persons	Times 365 days	Times Direct Care Rate @ 13.475	Plus overhead @37.5%	Plus Admin @ 11.5%	Total Rate
0	24	12	4,380.0	$ 59,021	$ 41,426	$ 13,052	$ 113,499
1	23	11.5	4,197.5	$ 56,561	$ 39,700	$ 12,509	$ 108,770
2	22	11	4,015.0	$ 54,102	$ 37,974	$ 11,965	$ 104,041
3	21	10.5	3,832.5	$ 51,643	$ 36,248	$ 11,421	$ 99,312
4	20	10	3,650.0	$ 49,184	$ 34,522	$ 10,877	$ 94,583
5	19	9.5	3,467.5	$ 46,725	$ 32,796	$ 10,333	$ 89,854
6	18	9	3,285.0	$ 44,265	$ 31,070	$ 9,789	$ 85,125
7	17	8.5	3,102.5	$ 41,806	$ 29,344	$ 9,245	$ 80,395
8	16	8	2,920.0	$ 39,347	$ 27,618	$ 8,702	$ 75,666
9	15	7.5	2,737.5	$ 36,888	$ 25,892	$ 8,158	$ 70,937
10	14	7	2,555.0	$ 34,429	$ 24,165	$ 7,614	$ 66,208
11	13	6.5	2,372.5	$ 31,969	$ 22,439	$ 7,070	$ 61,479
12	12	6	2,190.0	$ 29,510	$ 20,713	$ 6,526	$ 56,750
13	11	5.5	2,007.5	$ 27,051	$ 18,987	$ 5,982	$ 52,021
14	10	5	1,825.0	$ 24,592	$ 17,261	$ 5,439	$ 47,291
15	9	4.5	1,642.5	$ 22,133	$ 15,535	$ 4,895	$ 42,562
16	8	4	1,460.0	$ 19,674	$ 13,809	$ 4,351	$ 37,833
17	7	3.5	1,277.5	$ 17,214	$ 12,083	$ 3,807	$ 33,104
18	6	3	1,095.0	$ 14,755	$ 10,357	$ 3,263	$ 28,375
19	5	2.5	912.5	$ 12,296	$ 8,631	$ 2,719	$ 23,646
20	4	2	730.0	$ 9,837	$ 6,904	$ 2,175	$ 18,917
21	3	1.5	547.5	$ 7,378	$ 5,178	$ 1,632	$ 14,187
22	2	1	365.0	$ 4,918	$ 3,452	$ 1,088	$ 9,458
23	1	0.5	182.5	$ 2,459	$ 1,726	$ 544	$ 4,729
24	0	0	0.0	$ -	$ -	$ -	$ -

Indirect cost rate: 37.5% **Admin % 11.5%**

If lives alone or requires 1:1 support.

Maximum hours left alone per day	Balance of time needing support	1:1 support	Times 365 days	Times Direct Care Rate @ 13.475	Plus overhead @23.5%	Admin @ 11.5%	Total Rate
0	24	24	8,760.0	$ 118,041	$ 42,672	$ 20,884	$ 181,596
1	23	23	8,395.0	$ 113,123	$ 40,894	$ 20,013	$ 174,030
2	22	22	8,030.0	$ 108,204	$ 39,116	$ 19,143	$ 166,463
3	21	21	7,665.0	$ 103,286	$ 37,338	$ 18,273	$ 158,897
4	20	20	7,300.0	$ 98,368	$ 35,560	$ 17,403	$ 151,330
5	19	19	6,935.0	$ 93,449	$ 33,782	$ 16,533	$ 143,764
6	18	18	6,570.0	$ 88,531	$ 32,004	$ 15,663	$ 136,197
7	17	17	6,205.0	$ 83,612	$ 30,226	$ 14,793	$ 128,631
8	16	16	5,840.0	$ 78,694	$ 28,448	$ 13,922	$ 121,064
9	15	15	5,475.0	$ 73,776	$ 26,670	$ 13,052	$ 113,498
10	14	14	5,110.0	$ 68,857	$ 24,892	$ 12,182	$ 105,931
11	13	13	4,745.0	$ 63,939	$ 23,114	$ 11,312	$ 98,365
12	12	12	4,380.0	$ 59,021	$ 21,336	$ 10,442	$ 90,798
13	11	11	4,015.0	$ 54,102	$ 19,558	$ 9,572	$ 83,232
14	10	10	3,650.0	$ 49,184	$ 17,780	$ 8,701	$ 75,665
15	9	9	3,285.0	$ 44,265	$ 16,002	$ 7,831	$ 68,099
16	8	8	2,920.0	$ 39,347	$ 14,224	$ 6,961	$ 60,532
17	7	7	2,555.0	$ 34,429	$ 12,446	$ 6,091	$ 52,966
18	6	6	2,190.0	$ 29,510	$ 10,668	$ 5,221	$ 45,399
19	5	5	1,825.0	$ 24,592	$ 8,890	$ 4,351	$ 37,833
20	4	4	1,460.0	$ 19,674	$ 7,112	$ 3,481	$ 30,266
21	3	3	1,095.0	$ 14,755	$ 5,334	$ 2,610	$ 22,700
22	2	2	730.0	$ 9,837	$ 3,556	$ 1,740	$ 15,133
23	1	1	365.0	$ 4,918	$ 1,778	$ 870	$ 7,567
24	0	0	0.0	$ -	$ -	$ -	$ -
Overhead Rate =		**23.5%**			**Admin %**	**11.5%**	

Average Wage/Benefit

Average Wage	$ 11.00	Minimum rate by Co. Ordinance is $9.31
Fringe @ 22.5%	$ 2.48	
Total	$ 13.48	

SOURCE: DANE COUNTY DHS

The percentages of indirect costs remain constant from year to year. Funding adjustments are made through wage ordinance increases, inflation, funding shortfalls, and other factors. The County does distribute a Consumer Cost Survey annually to each of the SDS provider agencies**.** The results of this survey were used to set the original percentages of indirect costs and provide annual updates regarding the breakdown of provider costs.

The indirect cost category is very broad, and includes vital support activities as well as travel expenses, training expenses, and administrative costs. The county caps the administrative portion of these indirect costs at 15%, which remain constant for individuals whether they receive one-on-one supports or if they are paired with another individual. The remaining indirect costs are 14% higher for individuals in paired arrangements, however, due to the increased demands on staff created by caring for two people as opposed to one. Despite the higher indirect costs, it is still more cost-effective to place individuals in shared support arrangements, as it allows the county to divide direct care costs in half.

Indirect Support Activities

General
Team meetings
Supervision of direct support workers, performance evaluations
Staff travel time to consumers homes, appointments, etc.
Communications with guardians and families: ranges from infrequent to daily.
Communication with other service providers

Support for Daily Living Tasks
Arrange meetings with applicants and new hires and people supported.
Train new staff: much training is done on an indirect basis, along with direct training time with person supported.
Schedule staff to work, find emergency and fill-in support workers.
Write individual job descriptions and support routines.
Find specific products needed; on-line research, ordering, shopping for specialty items such as: latex-free clothing
Locate adaptive equipment such as eating utensils, dressing or bathing aids, etc.
General shopping for people unable to do so for themselves.

Support for Housing Concerns
Housing: locate housing: calls to landlords, affordable housing organizations
View apartments to screen for accessibility, neighborhood, etc.
Communicate with landlords re: leases, maintenance issues, accessibility modifications,
Arrange for renter's insurance, etc.
Find funding for modifications: Project Home, etc.
Packing and moving; gathering boxes. Unpacking
Section 8 – recertification paperwork, inspections, etc.
Communicate with neighbors
For homeowners: Assist with arranging for repairs and maintenance
Cleaning, organizing and maintaining households for people unable to do so
Arrange and manage utilities, energy assistance, etc.
Assist with pet care when person is unable to do so

Support for Medical Needs
Medical: Set appointments; communicate questions/health concerns/changes to medical providers.
Facilitate good communication between medical providers.
Communicate info from medical providers/appointments to others including family, guardians and Brokers, as needed.
Arrange for prescription/medication management. Train support staff in proper procedures
Arrange for receipt of disposable medical supplies
Arrange for receipt of and repair of durable medical equipment: contact with vendors, set appointments, etc.
Train staff in proper use of equipment.
Arrange for home health care needed
Arrange for MAPC services as needed, complete daily and monthly paperwork, arrange for RN visits.
Medicare Part D! Understand it, determine plan coverage's for each individual, sign up, etc.
Manage dietary needs

Support for Meaningful Community Activities
Arrange for community activities: research possibilities, visit sites to determine accessibility for consumer as necessary, register for classes, events, etc.
Arrange social interactions with friends and family

Support for Mobility and Transportation Needs
Mobility/Transportation: Arrange transport services
Schedule and confirm Metro Plus rides
Monitor provision of rides, address problems when they arise
Apply for Para-Transit services
Support for Individual and Community Safety
Legal: Contacts as necessary with the criminal justice system for both crime victims and offenders

Contacts with probation, with legal representation, etc.
Communication Technology: Arrange appointments/trouble-shoot/plan/ train support staff in use of equipment and technology.
Arrange for emergency access to services; maintain emergency information, procedures, answering services, etc.
Arrange for and maintain safety equipment in people's homes: this may include Sound Response, etc.
General and on-going staff training: Re-train annually re: BBP, Abuse and Neglect, etc.
Communicate concerns and changes to other service providers, Broker, etc.
One change may necessitate multiple phone calls or e-mails to inform the support "team".

Support for Community Employment
Job Development - Individual contacts and networking
Job Carve Out - parsing out various employment-related activities to create single job opening
Research and Development of Self Employment options
Checking in with employers to assure adequate job performance or need for improvement
Arrange, coordinate, monitor individual transportation to work.
Staff travel time to work places where coaching or spot check is required
Coordination of Holiday and Vacation scheduling with employers
Facilitate participation in workplace social events
Develop workplace accommodations, adaptive equipment
Coordinate / arrange alternate activities when individual is unable to work

Support for Facility Based Employment and Day Activities
Work station set-up/tear down
Develop necessary jig & fixtures
Time and motion studies
Product quality control
Shipping and receiving
Inventory control

Financial
All Representative Payee responsibilities: communication with Social Security Administration, Bank, guardian, re: income, expenses, wage changes, etc.
Develop and manage PASS plans, etc.
Funeral pre-planning and time-of-need planning
Manage checking accounts, pay bills, reconcile bank accounts, etc.
Annual tax filing

Record Keeping
Daily logs
Annual service narrative summaries
Units of service

Administrative Tasks (limited to 15% of total budget)
Development and monitoring the support rate to assure it is adequate for the needs of the client.
Audit
Systems meetings
Board meetings
Maintaining compliance with DCHS contract
Business insurance
Business safety plan
Program evaluation
Program planning
Budget planning, tracking and development
Program and fiscal reporting
Management (Supervision of program managers, supervisors, accounting, human resource and administrative support staff) & Evaluation
Data and information technology system development and management
Data tracking and client record keeping
Sub-contracting, including contract negotiations and contract management
Accounting
Personnel Administration (human resource functions of staff recruiting and hiring)
Billing and third party collections
Agency-wide public relations
Brochure, web-site and publication development
Strategic planning

Findings and Conclusions

Based on the information reviewed in this audit, Dane County's method for determining the Individualized Base Rate appears to be reasonable and sound. The balance of the rate setting portion relies on the judgments of the individual intake workers. Individual rates are compared to other consumers with similar needs and service plans, and adjusted accordingly. This final adjustment, however, is somewhat subjective in nature. The Consultants were not provided with any aggregate data related to the breakdown of individual cost adjustments, and therefore were unable to determine any averages for these additional costs. Therefore, the consultants were unable to determine if the finalized rates are appropriate to the services being provided.

Dane County Self-Directed Supports
System Evaluation & Management Audit

SDS Provider Survey

SDS Provider Agency Survey Results

The SDS Provider Agency Questionnaire was distributed during October 2005 to thirty-six agencies providing Self-Directed Supports in Dane County. A fourteen-question survey was distributed as an electronic form via email to twenty-nine providers of residential, vocational, and day services. An abbreviated eight-question version of the survey was distributed in similar fashion to seven providers of support brokerage services.

Agency representatives were asked to provide information about the services provided by their agency, methods used to estimate and control costs, measures used to determine service quality, system strengths and weaknesses, and any suggestions to enhance the existing system. Reminder notices were emailed at both one and two-weeks post distribution. Phone contact was initiated in the case of non-compliance with the targeted return date of November 11, 2005. Completed questionnaires were ultimately returned via email, postal mail, and fax by thirty-six agencies representing a response rate of 100.0%.

Survey Response

Number of responding agencies: 36 (100.0% of all agencies surveyed)
Service providers: 29 (80.6% of all agencies responding)
Support broker agencies: 7 (19.4% of all agencies responding)

Responding agencies include:

Service Providers

- Advance Employment Inc.
- Catholic Charities Supportive Living Program
- Community Living Connections Inc.
- Community Work Services Inc.
- Create-Ability Inc.
- Creative Community Living Services Inc.
- Dreamweavers Inc.
- Dungarvin WI Inc.
- Encore Studio for the Performing Arts Inc.
- Goodwill Industries of South Central Wisconsin Inc.
- Integrity Residential Services
- Lutheran Social Services of Wisconsin & Upper Michigan Inc.
- Madison Area Rehabilitation Centers (MARC)
- Mobility Training & Independent Living Program Inc.
- Neighborhood Connections
- Options in Community Living
- Partners in Community Living, Inc.
- Pathways of Wisconsin Inc.
- REM WI – Dane County
- Rise Up Inc.
- St. Coletta of WI – Madison
- TJS Placements LLC
- Valley Packaging Industries
- WORC Inc.
- Work Plus Inc.
- Working Partnerships
- The Good Life Inc.
- Integrated Community Work (ICW)
- Community Support Network, Inc.

Support Broker Agencies

- ARC - Wisconsin
- Avenues to Community Inc.
- Catholic Charities – Brokers
- Progressive Community Services
- Teamwork Associates inc.
- TJ's Support Brokerage Firm Inc.
- UCP of Greater Dane County

Summary Discussion of Results

Survey respondents are representative of twenty-nine agencies providing Self-Directed Supports through individual agreements with consumers, and seven support broker agencies providing service under county contract. The majority of responding agencies (80.6%) are non-profit providers. A little over half of responding agencies (63.9%) indicate additional funding is generated through sources other than SDS agreements/contracts. However, county Self-Directed Supports related revenues comprise the vast majority of program funding.

Nearly three-quarters of service providers (72.4%) indicate costs are estimated at multiple points in time during the development of individual agreements with consumers, with more than half (62.1%) indicating the process is performed before, during, and after the development of an agreement. Agencies tend to follow a client-centered method to estimate individual agreement rates, with each provider assessing the level of individual client needs and goals, and translating these into a number of support hours and an individual budget.

Agencies generally monitor service utilization by tracking staff time, with many performing monthly comparisons to determine any differences between the projected and actual number of hours of support needed by an individual. Generally agencies will renegotiate rates only when a client consistently needs more or less support than originally projected, or in the case of major changes in health, working condition, or housing status (e.g., the addition or loss of a housemate). In cases where fewer services are being used than first projected, the difference in cost may either be absorbed or reduced, alternative services may be offered, or funds may be redirected to a more appropriate client service. In cases where more services are being used than first projected, if the increase is nominal and/or short-term, the costs are absorbed. If the change is significant and/or long-term, an attempt is made to meet the needs within the constraints of the existing contract by adjusting the program.

Agencies vary widely in terms of the methods used to measure service quality. A number of providers use quality assurance surveys, which are administered to customers and other stakeholders on a regular basis. One unique approach to quality assurance includes the use by one provider of an anonymous comment phone line allowing concerned persons to express any problems or suggestions. More than three-quarters of respondents (77.8%) indicate they seek outside evaluation of their quality measures. Outcomes and indicators in their traditional form are used by relatively few agencies, with those that are in place generally following the United Way model.

Many respondents indicate they are happy with current training offerings and see the benefit they provide. Although, a number express frustration that budget cuts leave them with few resources and little time to allocate to training activities. Additional training topics suggested by respondents include education sessions for guardians and family members about the SDS system, conflict resolution training, technology and computer related training, and meaningful outcome measurement.

Respondents were candid in their discussion of system issues and how the system might be improved. The greatest concern is the continuing funding cuts that have been enacted within the system and the impact this has had in terms of the associated issues of staff turnover and service quality. In general, there is the widespread feeling among providers that they are now doing more for less. Many identify the often conflicting fiscal and administrative constraints under which they operate in Dane County as a major source of frustration. The inability to carry-over funds from year to year is seen in some cases to be counterproductive to the health of the provider

system itself. Many would like to see this changed, with the recognition of a three-month reserve fund.

Administrative caps are generally viewed with disdain as well. One provider in particular found it ironic that the County advocates for reduced administrative overhead, while maintaining one of the most complicated financial accountability systems in the region. Still another echoed the feeling of a number of respondents when commenting that the processes required by the system (i.e. accountability activities, reporting, negotiating agreements, etc.) actually shifts resources away from programs and toward program administration.

One opportunity for cost savings identified by respondents includes the exploration of insurance pools to combat escalating premiums. Another suggested streamlining the voucher system with either email vouchers or some other ecommerce type solution. Finally, increased funding for wage compression was suggested as a method to increase staff retention and reduce costs associated with staff turnover (i.e. recruiting, hiring, training).

Overall, responses varied depending on the individual agencies surveyed. On questions #12 and #13, however, which deal with what the County can do to help agencies provide more effective services and to improve the efficiency of the SDS System as a whole, the responses primarily broke down along broker/direct-service provider lines. The two groups seem to view one another as responsible for creating obstacles and inefficiencies within the system. Several brokers indicated that they feel a lack of cooperation and consistency on the part of the direct-service providers, while many direct-service providers indicated that the role of the brokers is unclear and they lack county oversight. These contradictory viewpoints seem to indicate a lack of communication among the key players within the system.

Despite these divergent viewpoints, respondents generally reiterated their support for the system, its philosophy, and the benefit it provides to individuals and families. However, many make it clear that a unit rate approach and additional oversight will not solve what they perceive to be a funding issue. What is clear is that there is some frustration on the part of the provider community. At the same time there exists a willingness to work with the County to make improvements that will benefit all involved.

Discussion of Results by Survey Question & Response

Q1. Is your agency a for-profit, non-profit, or some other type of entity?

Of thirty-six agencies responding, 29 (80.6%) are non-profit entities. Seven (19.4%) are for-profit providers.

Q2. What are the contracted services that are provided by your agency under Self-Directed Supports agreements?

Of thirty-six agencies responding, eleven (30.6%) indicate they provide more than one service or support under Self-Directed Supports agreements. Five agencies (13.9%) provide both residential supports as well as vocational and/or day services. Four agencies (11.1%) provide a combination of vocational and day services. One agency provides both residential supports and support broker related services. Services mentioned as "Other" include self-employment opportunities, in-home supports, and specialty residential units for persons with challenging behaviors and mobility limitations.

Service/Support Provided (N = 36 Agencies)	Number of Agencies
Community Based Work	15 (41.7%)
Day Services	7 (19.4%)
Facility Based Work	3 (8.3%)
Residential Supports	16 (44.4%)
Support Broker	7 (19.4%)
Other	4 (11.1%)
Agencies providing a single service/support under SDS agreements	25 (69.4%)
Agencies providing more than one service/support under SDS agreements	11 (30.6%)

Q3. What other sources of revenue (if any) does your agency have to offset the cost of the services you provide under Self-Directed Supports agreements?

The majority of providers indicate Self-Directed Supports contracts and agreements are not the only source of funding for program funding. Twenty-three agencies (63.9%) indicate additional funding is generated through other sources. These include other contracts with Dane County, private pay and private donations, and other federal and community grants. In spite of these additional sources, respondents indicate Self-Directed Supports contracts and agreements continue to comprise the bulk of program funding, totaling anywhere from 40% to 99% of program dollars. Revenue sources cited by respondents as "Other" include contracts with other counties, the Department of Vocational Rehabilitation, the Department of Health and Family Services, the United Way, as well as other agencies and schools districts. One respondent in particular wanted to make it clear that the agency's other revenue sources do not offset SDS costs. Rather, the agency supplements insufficient SDS funding with other revenues.

Additional Sources of Revenue (N = 36 Agencies)	Number of Agencies
Other Dane County Contracts	5 (13.9%)
Federal & Community Grants	4 (11.1%)
Private Pay	7 (19.4%)
Private Donations	11 (30.6%)
Other	13 (36.1%)
Agencies with no additional sources of revenue	13 (36.1%)
Agencies with one or more additional sources of revenue	23 (63.9%)

Q4. At what point does your agency estimate costs for implementing an individual Self-Directed Supports agreement (before, during, or after the development of the agreement)?

Nearly three-quarters of providers (72.4%) indicate costs are estimated at multiple points in time, with more than half (62.1%) indicating the process is performed before, during, and after the development of an individual services agreement. One agency did not respond to the question.

When Costs are Estimated (N = 29 Agencies)	Number of Agencies
Before	5 (17.2%)
During	1 (3.4%)
After	1 (3.4%)
Before & During	3 (10.3%)
Before, During, & After	18 (62.1%)
No answer provided	*1 (3.4%)*
Agencies estimating costs at one point in time	7 (24.1%)
Agencies estimating costs at two or more points in time	21 (72.4%)

Q5. What tools or methods are used to estimate/bid individual agreement rates? What are the variables you need to consider?

In general, agencies follow a client-centered method to estimate individual agreement rates: they assess the level of individual client needs and goals, translate that into a number of support hours, and then build an individual budget.

Through conversations with the individual client, family, guardian, support broker, and any other concerned entity, agencies project the number of support hours an individual is likely to use. Variables considered include the client's daily routine, health care needs, level of living skills, and mobility. This assessment is then used to determine the type of staff and services needed, which varies widely from intensive 24-hour care to job development. Transportation needs are factored in as well.

The cost per hour of a particular service is used to develop an individual budget. Agencies generally adjust the rates of services annually to reflect changing budget constraints. For example:

> *"Jane needs job coaching support. She will probably use 10 hours of job coaching and transportation per week. This translates into 10 hours/week x 52 weeks x $29/hr = $15,080. She also receives 1 hour of counselor support per week, which translates into 1 x 52 x 29 = $1,508. Time and mileage are factored in because she needs a ride to and from work: 10 miles x 2 rides (one each way) x 5 days x $.40/mi = $40." Her estimated yearly rate for job coaching support would be $16,578.*

Additionally, agencies factor in set costs such as liability insurance, office rent, maintenance, and administrative costs that are generally shared by all individuals using services.

Q6. Describe any methods used by your agency to monitor service utilization (i.e., the units of service provided).

Agencies generally monitor service utilization by tracking staff time. Once an individual client and the agency agree upon a contract and rate for services, the agency develops an individualized schedule that breaks up the hours of projected support into staff shifts. Staff members then keep

logs and timesheets to record actual hours of support provided to each client, documented in 15-minute increments. Many agencies perform monthly comparisons to determine if there are any discrepancies between the projected and actual number of hours of support.

Although agencies monitor overall service utilization in similar ways, they vary widely in terms of how and when they adjust services to account for changes in client needs and goals. Some use monthly reports and adjust schedules when a client experiences a major change in needed support. Others will immediately adjust schedules once a major change occurs.

In addition to monitoring staff time, a few agencies indicate that outcome measures are used to monitor progress towards reaching individual goals, maintaining or enhancing independence, and ensuring customer satisfaction.

Q7. How do you determine when to renegotiate self-directed service agreements?

"There are many types of scenarios that could bring this need to light, however all have to do with a change in service needs." This quote sums up how the vast majority of agencies determine when Self-Directed Supports need to be renegotiated. Generally agencies will only renegotiate when a client consistently needs more or less support than originally projected or when a major change or crisis occurs such as a new health concern, a job change, or a change in housing status (e.g., the addition or loss of a housemate).

One agency noted that they sometimes consider renegotiation when brokers, guardians, or coordinators have concerns about the level of support provided. Another agency candidly reported that it pays little attention to the individual rate. The nature of the population served means that supportive needs change on a consistent basis. Again, cost shifting is mentioned as a necessary practice in this service environment. Pooling everyone's money and then shifting it fluidly from individual to individual "has allowed the agency to honor its long term commitment to the people we support and their families...in each individual's best interest."

Q8. What actions are taken, if any, when it is discovered that there are (a) fewer services being used than first planned?

This particular problem seems to be rare, as agencies report that the majority of clients tend to need more services rather than fewer. However, agencies confronted with this situation agree that it is important to find out why the discrepancy exists. Nominal changes in service level are usually absorbed. If the client has become more independent, agencies generally decrease the budget allocated to the individual, inform the broker and the county, and then reimburse other entities, if applicable. In other cases, the budget is not decreased because appropriate alternative services are offered. Agencies that do not provide residential support will sometimes transfer funds to a residential agency if the money could be better utilized there.

What actions are taken, if any, when it is discovered that there are (b) more services being used than first planned?

If the increase is nominal and/or short-term, agencies generally are able to absorb the costs. If the change is drastic and/or long-term, an attempt is usually made to adjust an individual's program to meet the needs within the constraints of the existing contract. This adjustment may include the elimination of individualized services in favor of services provided in a group setting, as well as considering the possibility of adding a roommate or another less costly living situation. If the additional services that are needed do not fit within the existing budget, agencies generally

request additional funds and/or revise the rate. Cost shifting across the service population seems to be common. A number of agencies expect that an increase in services for one individual will be offset by a decrease in services for another.

Q9. How does your agency measure the quality of the services provided? In your answer, consider quality indicators specific to the type of service(s) provided.

Agencies vary widely in terms of the methods used to measure service quality. Many agencies indicate that they seek to develop relationships with their customers that allow for ongoing dialogue on the subject. This conversation can either be formal, as in the case of team meetings and scheduled forums, or as is most common, informal, as in the case of ongoing dialogue and feedback from customers allowing providers to adjust their services in a fluid manner.

A number of providers use quality assurance surveys, which they administer to their customers on a regular basis. Those surveyed might include clients, employees, guardians and family members, service brokers, vocational providers, staff, and funding sources. Surveys are usually conducted bi-annually or annually, and generally appear to measure quality in terms of the level of service satisfaction. A unique quality assurance method used by one agency includes an anonymous comment phone line allowing concerned persons to express any problems or suggestions. Another agency indicates it has begun a comprehensive quality assurance program with a dedicated coordinator working with regional committees organized to address specific subjects relating to service quality.

Outcomes and indicators in their traditional form are used by relatively few agencies. In a number of cases respondents provided what they indicate to be their "outcomes", but these appear more to be tools designed to gather data that might relate to indicators. The outcomes that are in place generally follow the United Way model, and relate primarily to community integration, vocational goals, and the level of satisfaction with services. Typical indicators include the number of individuals placed in jobs, the level of job satisfaction, and the number of individuals who participated in social and/or community activities. Agencies indicate the data supporting these measures is collected on a regular basis (e.g., monthly, quarterly, annually).

Is there outside evaluation of these measures? (Yes/No) Comments.

Of thirty-six agencies responding, twenty-eight (77.8%) seek outside evaluation of their measures of quality and do so in a variety of ways. Some hire agencies to conduct reviews, while others administer their own surveys to gain feedback from sources external to the organization including brokers, guardians, family members, and clients. Other methods to gather external input involve team meetings with appropriate combinations of brokers, guardians, family members, consultants, clients, and county representatives. A number of agencies point to their accreditation status (CARF, COA, etc.) as an indication of the quality inherent in their programs. Many among the eight agencies (22.2%) indicating that they do not seek outside evaluation cite cost as the limiting factor.

Q10. Does your agency use outcomes and indicators to evaluate the success of service(s) provided through Self-Directed Supports agreements?

Of thirty-six agencies responding, twenty-seven (75.0%) indicate they use outcomes and indicators to evaluate the success of their services. However, as stated previously, outcomes and indicators in their traditional form seem to be used by relatively few agencies. Some agencies develop client-specific outcomes and indicators, and so they are "difficult to enumerate." Others

use informal measures, and one respondent simply stated that it "doesn't know." What many reference as outcomes actually appears to be data relating to indicators. Whether these are then translated to outcomes is unknown. In spite of some apparent confusion, a number of examples were provided that bear further review as the outcomes development process goes forward.

Q11. What additional training opportunities do you need?

Many respondents indicate they are happy with current training offerings and see the benefit they provide. In the words of one respondent, "staff who attend general and specific training events on a regular basis tend to provide better quality services." At the same time, a number of others express frustration that budget cuts leave them with few resources and little time to allocate to training activities. In addition to existing opportunities, respondents suggest topics such as:

- Clarifying roles for guardians, brokers, managers, and interested staff or family
- Education for guardians and family members about the SDS system
- Conflict resolution
- Meeting facilitation skills and techniques
- Education about financial services/resources
- Technology training, especially MS Office applications
- Computer maintenance and computer security practices
- In-depth education about meaningful outcome measures
- CPR, etc. specific to helping adults with disabilities

Q12. How can the County help your agency more effectively provide high quality Self-Directed Supports?

The greatest concern among respondents is the continuing funding cuts that have been enacted within the system. As one respondent put it, "the recent expectation that the same can be done for less, year after year, is simply not sustainable." Budget cuts force agencies to group clients in order to share staff and other resources, decrease support, and eliminate positions. Furthermore, many are finding it difficult to attract and retain quality staff as wages and benefits decrease. This is especially distressing to long-term providers, as "lifespan services require lifespan relationships." One for-profit provider indicated that if budget cuts continue, the organization would likely be forced to examine whether remaining in Dane County is a viable option.

Other widespread concerns include the role of brokers, paperwork/bureaucracy, quality control, and the lack of recognition for quality services. A number of direct service providers feel the role of the broker needs to be more clearly defined, and see a need for greater accountability for the brokers. Brokers, on the other hand express concerns about inconsistencies in the quality of services from direct service providers. It should be noted that this apparent tension between service providers and the broker community indicates to many that support brokers are successfully fulfilling their role in advocating for services on behalf of their clients. Respondents also desire less paperwork. The general feeling is that resources spent completing paperwork could be better spent providing services. Many desire more autonomy in allocating resources and additional recognition for providing quality services.

Specific suggestions include: encourage County managers to provide more direct feedback to agency directors; include agencies in yearly CIP reviews; continue promoting values of self-determination with providers, families, schools, etc.; produce Consumer Reports so that consumers can be more educated when they select service providers; have the County take the lead in determining "preferred providers;" create a single point of contact at the county for

contract information; and develop an integrated, secure, and accessible database of client, contract, and funding information to promote an efficient workflow.

Q13. What can the County do to improve the financial efficiency of the Self-Directed Supports system, while maintaining client choice and high quality services?

There is a widespread feeling among providers that they are doing more for less, as well as a collective sense that micromanagement by the County only serves to increase costs and prevents them the flexibility to meet their own unique business needs. Respondents indicated that the SDS model and the processes it requires actually shifts resources away from programs and toward program administration. In one case it was identified that overall system overhead is driven by the large number of system providers, with administrative functions and costs duplicated among agencies. One provider identified the duplication that SDS creates within one agency, with SDS agreements administered separately from other similar county contracted services. Many would like to see administrative caps removed and an acknowledgment by the County of the fluidity of these costs from year to year.

Certain fiscal policies are seen to be counterproductive to the health of the provider system, and thus to the SDS system overall. While for-profit providers may carry-over a reserve of 4% from year to year, non-profits, which comprise the majority of system providers, are prevented from doing the same, forcing them to operate on very lean margins with little or no cushion. Many would like to see this changed, with the recognition of a three-month reserve fund. In other cases, agencies that under spend their budgets and return money to the County are then "penalized" during the following year when individual rates are reduced and the agency receives a lesser amount. One agency related that costs overall have been reduced during the year due to a number of vacant management staff positions. The overworked administrators will see a reduction in funding for programs as a result.

A few areas were identified specifically for potential savings. A number of respondents indicate that increasing overhead is driven in part by rising insurance costs, and would like to see further exploration of insurance pools to combat escalating premiums. Some brokers expressed concern over perceived duplication of broker related services within the direct service agencies, which they feel drives up overhead costs unnecessarily. More than one respondent identified the inefficient nature of the SDS payment process itself, and suggest streamlining the voucher system with either email vouchers or some other ecommerce type solution. Finally, increased funding for wage compression was suggested as a method to increase staff retention and reduce costs associated with staff turnover (i.e. recruiting, hiring, training).

Q14. Open-ended – Please provide any other comments you feel are pertinent to the current review of the Self-Directed Supports system…

Respondents are generally supportive of the system, its philosophy, and the benefit it provides to individuals and families, but reiterate the major issues of decreased funding, budgeting constraints imposed by the County, low wages and staff turnover, and the inefficiencies inherent in the system. A number of respondents make it clear that a unit rate approach is not what is wanted or needed. In their view the unique needs of clients make this problematic. Agencies seemed split as to whether or not additional county oversight is needed. Many brokers felt that it was necessary, whereas many of the direct service providers felt that oversight was already too stringent. In fact, some indicate they would like to see the County release some of the control so that, in their view, the system would more closely reflect a free market in which choice would be enhanced. What is clear is that there is some frustration on the part of the provider community.

However, there is also a willingness to work with the County to improve the system if the solution can be beneficial for all involved.

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Key Stakeholder Interviews

Key Stakeholder Interviews

The purpose of the Key Informant Interviews is to provide a sampling of the diverse opinions of key stakeholders at different levels within the Self-Directed Supports System. These interviews render a more qualitative understanding of the current issues facing the System than a survey can provide. The consultants spoke with parents and/or guardians of consumers, as well as elected officials, members of the Advisory Board, and others involved in the direction of SDS policies. No additional interviews were conducted with provider agencies, as they were already extensively surveyed, the results of which are detailed in a separate section of this report. **The issues presented in this section are summaries of all of the interviews, and are not taken verbatim from any one respondent's comments.**

Consumer Interview Responses

Guardians and family members of SDS consumers identified the following issues as being areas of interest or concern to the system:

- Generally, guardians felt that services met their consumer's current needs, but that services could be improved. It was commented that brokers and the direct service providers generally made themselves available to address issues as they arise.

- Guardians were generally pleased that both the consumer and family were involved in the planning process. Prior to the SDS System, many guardians felt that the case managers made decisions and consumers had little input. They like having one person that they can go to for any issues that arise.

- More care needs to be taken when matching roommates to ensure compatibility. Some guardians have had negative experiences with unsuitable roommates, and the consumers had to be moved. These experiences were extremely traumatic for the consumers.

- Guardians expressed concern about waiting lists. These concerns addressed both how the waiting lists will affect the individual consumers and what impact they have on the equity of the system as a whole. Guardians noted that they realize that the waiting lists exist because the System is under financial constraints.

- Financial cutbacks have affected the services that consumers currently receive, and guardians are worried about what services will be available in the future.

- Consumers should have the ability to opt out of broker services if they have a family member or friend who was willing to fill that role, or if they just did not feel a broker was necessary. Those funds could then be used for other services or to bring other consumers into the system. ***Consultant note: Medical Assistance rules requires that all consumers hire a broker, but one broker agency, TJ's, does allow for consumers to hire family members or friends as brokers.**

- There are inconsistencies in the professional capabilities and quality of staff within provider agencies. High staff turnover and inconsistencies in training were mentioned as possible causes for this problem. It was mentioned that the County should require that new provider staff attend system-wide training sessions to help them understand how to make the most of available resources and understand the scope of their responsibilities.

***Consultant note: system wide trainings are available to provider agencies through the Waisman Center, but are not required.**

- The system-wide quality of provider agencies is inconsistent in terms of quality and efficiency, and better quality control measures are needed. Guardians would like to see more effective evaluation of provider agencies by the County. Most importantly, they would like to see agencies that are consistently not providing efficient, quality service be removed from the SDS System.

- Provider evaluations should be made public so guardians can make more informed decisions about which agencies to hire for their consumers. It was suggested that the County produce a consumer directory that profiles and evaluates each provider agency.

- Guardians should be given the opportunity to evaluate providers as part of an oversight panel that would include people at all levels within the system. ***Consultant note: This already exists in the form of the Quality Assurance Board**.

- The roles and responsibilities of the brokers need to be better clarified: where responsibilities begin and end, whether there are advocates within the system other than brokers, and what the role of a broker is when a family member has been actively involved in setting up services. Guardians did not have a clear understanding of these concepts.

- Rising health insurance costs for employees were identified as one major issue for provider agencies. A suggestion was that the County could play a role in organizing the provider agencies for better bargaining power. Some type of a coordinated effort to pool insurance costs should lead to reduced costs for each provider agency and for the system as a whole.

Interview Questions for Consumers

1. What services do you currently use within the SDS system? Are they the same services recommended in your individual service plan?
2. Do you feel that these services meet your current needs?
3. In what ways have Dane County Self-Directed Services been helpful in developing and providing support services for you?
4. List any specific examples of problems that you have encountered while using Dane County Self-Directed Services.
5. What suggestions do you have for increasing the effectiveness of Dane County Self-Directed Services?

Policy-Maker Interview Responses

- Policy makers identified the client-centered approach as a major strength of the SDS System. This approach allows for maximum choice for the consumers and their families, by involving them in the decision-making process.

- It was mentioned that the SDS System allows consumers to develop plans within a pre-set dollar amount, and also allows for less expensive non-traditional approaches based on consumer/family direction. County case managers are provided with exact costs of

services for individuals rather than having to average costs. This information makes it easier to make specific decisions for each individual, rather than generalized decisions around provider cost averages.

- Cost management was mentioned as a weakness of the SDS System. The System relies on basic market economy principles of consumer choice, but this reliance has been diluted due to flattening of funding. In addition, consumer choice at times can lead to consumers paying more for services they want rather than purchasing only what they need. The County is fiscally responsible for the impact of these decisions made by individuals/families, as additional expenses weaken the System as a whole. Because of these issues, there is concern among policy makers regarding the sustainability of the System.

- Many policy makers feel that there is a lack of information surrounding SDS services. They, along with the public, are not well informed about how SDS works.

- An important issue facing the system is how to reduce cost while maintaining safety and avoiding significant compromises to service quality. The County should review cost saving measures implemented by other counties to determine if any of those measures might be successful in Dane County.

- A commonly cited limitation regarding the oversight of the SDS System regards staffing and information management resources. Multiple providers and services make oversight complex and challenging, especially because there are so many providers in the SDS system. It was noted that it is becoming increasingly difficult to perform quality assessments of the County's many provider agencies.

- It was noted by some policy makers that oversight of the SDS System, despite its limitations, is better than it was with the POS System.

- Policy makers made several comments regarding data collection within the system:
  - Dane County should be collecting data regarding cost information relative to resources provided by brokers. Services and their costs should be broken down per a consistent unit. ***Consultant note: units of service are being tracked as of 1/1/06.**
  - Determine and monitor the difference between broker recommendations for services and actual services being provided.
  - Brokers need the tools to be able to provide data to the county regarding the quality of consumer services.
  - Data collection must be consistent System-wide.
  - Consistent outcomes and indicators need to be implemented for SDS and the entire DD System.
  - Provider agencies need to provide more accurate and consistent safety information.
  - The County needs data regarding gaps in service to be able to address these issues.
  - The County needs accurate and up to date information to recommend program efficiencies.

- It was mentioned that the County should reconsider the possibility of some type of co-op/congregate living arrangements. As a major cost to the SDS system is consumer

housing, the County needs more creative options between one and two person apartment placements and institutional placements. The System will be more cost-effective if the County can do more to combine consumer residential costs.

- Expand indirect services, such as Sound Response, because they provide cost effective and cost efficient alternatives to direct staff.

- Parents of adult DD consumers should be provided with more support and assistance to keep consumers at home.

- Because consumer/family choice is at the core of SDS, they and the market should dictate the types of direct services and supports provided, given that they fall within the rules previously set by MA, the State, and County.

- It was mentioned that Dane County needs to do more to evaluate the consistency of the quality of services that are being provided among various agencies. The county should establish standards for efficiency and require its funded agencies to meet those standards. In the future, the county should consider funding agencies based on whether or not they can meet these standards.

Questions for Key Policy Makers

1. What do you feel are the strengths of the Dane County Self-Directed Services System? What are the weaknesses?
2. What do you feel are the main issues currently facing the Dane County Self-Directed Services System?
3. Do you feel that Dane county maintains effective oversight of the Self-Directed Services System? In what ways could it be improved?
4. What data do you think Dane County should be collecting from the brokers and service providers within the SDS System?
5. What (if any) should be made in the current array of services provided by the Dane County Self-Directed Services System?
6. How could Self-Directed Services be delivered in a more efficient and/or cost-effective manner?

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System Outcomes

Self-Directed Supports System Outcomes

Outcomes for Self-Directed Supports System in Dane County were developed with input from a 41 person ad-hoc coalition of stakeholders inclusive of County board members, county staff, service providers, consumers, and family members. Measures were developed for the primary areas of service and support addressed by the SDS System: a) Residential Supports, b) Vocational Supports, and c) Broker Supports. Initial products were developed during a large group, half-day session held at the Warner Park Pavilion on January 18, 2006.

During the session, participants were introduced to performance measurement, outcomes, indicators, and "Logic Model" with a didactic lecture and presentation conducted by the consultant. Participants then broke out into small workgroups of approximately 10-15 individuals to identify program inputs, activities, and outcomes as well as the expected outcomes or benefits for the consumer. These were then shared with the larger group at the end of the session for general comment and review. The products of the half-day session were later aggregated and refined by the consultant to create the final collection of program outcomes, indicators, and data sources for residential, vocational, and broker supports.

Performance Measures: A Conceptual Framework

Though the concept may be new to many, performance measures have actually been used by both business and government for many years, having evolved from early management approaches developed by Edward Deming and Peter Drucker into a variety of techniques for managing organizational performance. At the federal level, the Government Performance and Results Act of 1993 produced much activity around identifying results for governmental agencies. Using the "Logic Model" technique, agencies identify their personnel and budget resources (inputs), activities, outputs, outcomes and measures. Today, all federal agencies report performance information as part of the federal budget process. This general approach has been adopted by many state and local government agencies, as well.

The two major entities of performance measurement systems are outcomes and indicators. *Outcomes* are the results or impacts achieved as a result of service or program activities, and are generally separated into three groups: initial, intermediate, and long-term. They include the anticipated or actual effects of program activities, and are comprised of the changes or improvements in a target population being served. Outcomes answer the questions, "So what?" and "What difference does the program or service make in people's lives?" Some examples might include increased knowledge or functioning of program participants.

Indicators are an explicit measure of the expected effects or results. They tell to what extent service or program activities have been successful in achieving, or contributing to, the expected outcome. Indicators answer the question, "What was actually accomplished, how well, and how often?" An example might include the change in pre and post test scores of participants in an educational session. Two things to keep in mind when developing indicators:

- Indicators must be specific and clear enough to allow for measurement by someone not intimately involved in the development or management of the actual program. They must also be reasonably attainable, given the design of the program and whatever constraints may exist.
- Indicators may describe not only an exact result expected, but may also describe degrees or gradations of achievement, and thus may be measured incrementally.

Typically, targets are established for indicators to promote general improvement across a service population (i.e. *85%* of participants will show an increase between pre and post test scores). Baseline data for these target values may be gathered during an initial testing phase, or may be established based on general stakeholder consensus and then adjusted according to observed performance. It has been suggested that targets should be used to guide and encourage performance improvement, rather than as a means to measure performance for accountability purposes (Pathfinder Project - Building Block 2, 2003). Whatever the intent may be, outcomes and indicators together comprise the foundation of a performance measurement program.

Developing Performance Measures

The first step in developing performance measures includes the identification of a group of outcomes that are aligned with the program mission or goal and are tangibly linked to program outputs. Outcomes should be meaningful, measurable, and strongly attributable to program activities and the services provided (Pathfinder Project – Building Block 1, 2003).

When developing measures of performance across a specific service population, one must consider the customer base as well as the program model. Each must be consistent with expectations regarding the accomplishments that are possible, as well as measurable effects. In the area of long-term care, consideration should be given to the sustainability of outcomes that will be monitored regularly among a relatively static population for an extended period of time. While *increasing* the involvement of consumers in the community is an achievable goal, as an outcome it may not be sustainable once some upper limit is reached and subsequent increases are no linger realized or possible. *Ensuring* involvement in the community is more likely sustainable both in terms of being an ongoing goal and as a program outcome that could be measured and monitored over an extended period of time.

An additional important principle in developing performance measures is the necessity for group consensus. Engaging stakeholders in an inclusive process that promotes input by all concerned serves to create a sense of ownership that will ultimately enhance system success.

Implementing a Performance Measurement Program

Brown, et al (2001) discuss the requirements associated with implementing an outcomes management program for a specific service population. Among these are the need for reliable, valid, and easy to use outcome measures; the need for economic and user friendly technology to capture data; the need for reports and other decision-support tools designed to foster improvement in outcomes over time and aid in effectively allocating resources; and the need for buy-in and participation by stakeholders to systematically improve outcomes.

The benefit of implementing an outcomes based program of performance measurement can be seen in terms of the impact and cost effectiveness of services provided. Studies in clinical settings have shown that outcomes driven decision support systems make it possible to focus resources and improve results without increasing the overall cost of care (Brown et al, 2001).

Outcome Development Workgroup Participants

Attendee	Agency
Duncan McNelly	Arc-Wisconsin
Betsy Shiraga	Community Work Services
Kathleen Scoepp	Work Plus
Kate Mace	REM Wisconsin
Olwen Hansen-Blake	REM Wisconsin
Amy Melton-White	Rise Up
Kathy Stellrecht	Catholic Charities
Amanda Rogers	Dane County Human Services
Kelsy Schoenhaar	Encore Studio for the Performing Arts
Jean Robertson	Dungarvin
Maureen Quinlan	Neighborhood Connections
Mickey Roiland	Dane County Human Services
Diana Shinall	TJ Support Brokerage Firm
Pat Wilson	TJ Support Brokerage Firm
Wendy Hecht	Teamwork Associates
Eileen Bruskewitz	Dane County Board
Janet Estervig	WORC
Laurine Lusk	Long Term Support Committee
Fran Genter	Dane County Human Services
Richard Hintz	CCLS
Kim Turner	Options in Community Living
Keith Yelinek	ARC Dane County
Ron Johnson	ARC Dane County
Ken Hobbs	ARC Dane County
Sharlene VanGalder	TJS Placements
Brenda Oakes	MT&ILP
Joan Fischer	MT&ILP
Deb Rogan	Pathways of Wisconsin
Barb Caswell	Goodwill
Lori Mettel	Create-Ability
Joan Callan	Create-Ability
Linda Branson	St. Coletta
Mario Dealca	St. Coletta
Carrie Bublitz-Cardarella	Community Living Connections
Richard Berling	MARC
Board Prez.	MARC
Kellie	TJ's Placements
Andrea	TJ's Placements
Jessica Mathews	REM Wisconsin
Heather Schaller	Dreamweavers
Alexa Butzbaugh	Progressive Community Services

References

Brown, G.S. PhD; Burlingame, G.M. PhD; Lambert, M.J. PhD; Jones, E. PhD; Vaccaro, J. MD (2001). Pushing the quality envelope: A new outcomes management system. Psychiatric Services 52:925-934. American Psychiatric Association, Arlington, VA.

The Pathfinder Project (2003). *Guidance on Outcome Focused Management, Building Block 1: Identifying Outcomes*. New Zealand State Service Commission and Treasury, Wellington, NZ.

The Pathfinder Project (2003). *Guidance on Outcome Focused Management, Building Block 2: Outcome Indicators*. New Zealand State Service Commission and Treasury, Wellington, NZ.

Workgroup Products

The following represent workgroup products generated during the half-day outcomes development session held January 18, 2006.

SDS Residential Supports Logic Model

INPUTS	ACTIVITIES	OUTPUTS	INITIAL OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Money Staff Housing supply	Developing a support plan – collaborative developed	Support plan Number of training sessions on residential options	Link people with safe, sanitary affordable housing Increased awareness *(of residential options?)*	Individuals receive needed supports	Individuals experience continued personal growth People are living in a safe, stable physical environment that is appropriately accessible People are safe People have choice People have quality health and dental care People are treated with dignity and respect People's support systems are sustainable People have access to community

SDS Residential Supports Logic Model

INDICATORS	DATA SOURCES	NOTES:
Number or percent of people moving during the year Self-assessment of safety of environment Number of critical incidents related to home environment Risk assessment in place Safety plans in place All clients have (blank) year plan	Incident report system Satisfaction survey	

SDS Vocational Supports Logic Model

INPUTS	ACTIVITIES	OUTPUTS	INITIAL OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
			Savings from SDS system People are being supported as many hours as desired People choose where they work People work the number of hours as desired People work in an area that interests them. Families, guardians, and consumers know the choices of vocational providers Needs are accurately defined for each consumer with the measurement of "high-med-low" needs with matching funding	Stability of the DD system Consumer will understand own realistic vocational goals Consumers earn a "reasonable" wage that allows them to live a satisfied life People will develop social relationships Consumers feel empowered to make choices and hold the provider accountable Actual funding matches needs	Participants achieve their employment goals Enhance each person's goals for their maximum potential Consumer satisfaction Consumer needs being met Consumer has choices for services to meet their needs Participants will know the cost of their services Non-disabled community members will know and view people with disabilities as part of their community People with disabilities contribute to their community People are drawn into the disability services field as a career choice People recognize and value the work done in the field of disability services No waiting list for vocational services Consumers don't lose a job based on lack of funding

SDS Vocational Supports Logic Model

INDICATORS	DATA SOURCES	NOTES:
Number of hours working	Use data already given to county staff to assess and measure the impact of SDS (i.e. consumer empowerment, consumer choice, cost savings, consumer direction)	Have measurements that reflect how the SDS system is working for the consumers Reporting to consumers and their team on service outcomes Reduce amount of paperwork Unable to keep reserves from any cost savings within individual budgets Cost of data – units of service Funding for an individual consumer doesn't always match needs Pairing in employment has reduced choices Need for a report card on how the SDS system is doing Protection/safety Satisfaction Needs being met Choices and options Match consumer needs with provider Health Income Independent At their vocational goal Volunteer → paid New job, earn more money

SDS Broker Supports Logic Model

INPUTS	ACTIVITIES	OUTPUTS	INITIAL OUTCOMES	INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Training Staff Money Office Ideas and thoughts from consumers, family members, and others Data (i.e. medical, financial, educational, behavioral, social history, support structure, transportation)	Communication (phone, email) Transportation Providing resources Assessment and planning Obtaining, maintaining, and allocating funding Spending time with clients Quality assurance monitoring Health and safety Communication with team Team meetings	CIP and MA paperwork Plans of support with safety plan Agreements and vouchers Min CIP and MA standards Agency census / units met Response to client, guardian, and provider concerns Every client has active person centered plan that has client input on residence, work, medical health and safety and any other goals	Clients access desired services Clients have information needed to make informed choices Team participates in planning Client purchases cost-effective services People are educated about service dollars and how and where they can be spent People are educated about safe practices Person and team give input and design a person centered plan	Clients trust their broker Team has timely access to the broker Team knows roles/steps in crisis Broker accesses, identifies, recruits, and coordinates new resources as needed Client receives services as specified in fiscal / individual plan Broker facilitates, resolves, initiates, advocates for needed and timely changes to meet client needs and assure quality People interview and/or explore a variety of service options People are aware of lifestyle choices and their potential consequences A plan is developed A cohesive team regularly reviews and communicates with each other and makes changes as necessary	Client receives quality services Client receives client-centered quality services People choose the support wanted and needed within their budget People practice lifestyle of choice with knowledge of potential consequences People are actively living and evolving a support plan they developed

SDS Broker Supports Logic Model

INDICATORS	DATA SOURCES	NOTES:
All clients have a person-centered plan with involvement of person, family, and team All plans reviewed annually (interviews, data, plan itself) Client doing well medically and behaviorally People with disabilities, their guardians, and the people important to them are involved in developing the person centered plan Supports are found within the individual rate Reduction in critical incidents within the system Regular communication is documented	Need a plan evaluation tool Anonymous client surveys Client focus groups Observation and quality assurance surveys	**Potential outcomes -** Life-long learner Meaningful daytime activity Income production Employment/income producing activity Healthy and safe Living where they want to live Supportive environment Community based environment Meaningful relationships with others (family, friends, employer) Recreation Access to informed choices Collaboration system-wide Team building → trust Person-centered work expectations Comparable dollars for comparable service System responsive to stakeholder surveys **Broker Characteristics –** Timeliness / responsiveness (needs change) Knowledgeable Open to new ideas Effective gatekeeper Model and encourage self advocacy Crisis response

Final System Outcomes

The following framework for Self-Directed Supports outcomes, indicators, and data sources was developed by the consultants based on the products of the workgroups, feedback from stakeholders within the SDS System, and a review of national best practices in outcomes for developmental disability services.

SDS Residential Supports Outcomes

RESIDENTIAL SUPPORTS OUTCOMES	RESIDENTIAL SUPPORTS INDICATORS	RESIDENTIAL SUPPORTS DATA SOURCES
INITIAL: 1. People are treated with dignity and respect 2. People are made aware of the options available to them within their chosen residential setting. 3. People are connected with safe, sanitary, stable, and affordable housing 4. Racial and ethnic minorities have equal access to residential services and supports. 5. County residents who need SDS are accessing services.	1. The % of consumers that report that they feel respected in their residential setting. 2. Realistic, appropriate residential options are provided to the consumer during the development of the Person Centered Plan. 3. The % of consumers placed in community residential settings. 4. Minorities are served in a proportion comparable to their proportion of the overall population. 5. The proportion of adults 18+ who receive services compared to estimated number of adults with DD in Dane County.	1. Consumer self-report survey 2. Residential provider case notes 3. a. SDS database b. County/provider incident report 4. US census data/ SDS database 5. SDS waiting list/ census data projections
INTERMEDIATE: 1. People are safe from abuse, neglect, and injury. 2. People have access to community activities. 3. People's health and dental care needs are arranged for them. 4. Individuals' residential needs are being met.	1. Number of residential incident reports per provider during the year as proportion of total number of consumers. 2. The number and % of SDS consumers that are actively participating in social events or other activities in the community. 3. The % of SDS consumers that have had a routine physical exam during the past year/dental exam during past six months. 4. The % of consumers that report that their residential needs are being met.	1. SDS database 2. Consumer self-report survey 3. Broker case notes 4. Consumer self-report survey
LONG-TERM: 1. People's support systems are sustainable 2. Consumers remain in least restrictive living environment. 3. People sustain community involvement from year to year. 4. SDS system is able to accommodate changes in individuals' needs over the long term. 5. Enhance consumer life-long learning opportunities regarding making viable life choices.	1. The number and % of consumers who are able to maintain the same level of service from year to year. 2. The number and % of consumers not admitted to an institutional setting during the year. 3. The number and % of repeat consumers per provider. 4. Needs are addressed in Annual Reviews and by requests for individual rate increases. 5. Issues discussed in Person Centered Plan, when relevant.	1. Annual review/SDS database 2. Broker Records and SDS database 3. Provider records/SDS database 4. Annual reviews/ self-report survey/records of requests for individual funds. 5. Case notes from development of Person Centered Plan.

SDS Vocational Supports Outcomes

VOCATIONAL SUPPORTS OUTCOMES	VOCATIONAL SUPPORTS INDICATORS	VOCATIONAL SUPPORTS DATA SOURCES
INITIAL: 1. Realistic vocational goals and needs are accurately defined 2. People are made aware of the options available to them within their chosen vocational service provider. 3. People have choice in where they work. 4. Racial and ethnic minorities have equal access to residential services and supports.	1. The % of ISP's developed with consumer/ family input. 2. a. The number of vocational options presented to consumer during development of Person Centered Plan. b. The % of consumers indicating they are aware of their vocational options. 3. The % of consumers indicating they work at the location of their choice. 4. Minorities are served in a proportion comparable to their proportion of the overall population.	1. Vocational profile/ case notes for development of the Person Centered Plan. 2. Vocational service provider case notes 3. Consumer self-report survey 4. US census data/ SDS database
INTERMEDIATE: 1. People are safe from abuse, neglect and injury 2. People earn a reasonable wage 3. People work the number of hours they desire 4. People are satisfied with the work they do.	1. Number of vocational incidents during the year as a proportion of total number of consumers. 2. The % of consumers earning minimum wage or higher. 3. The % of consumers where provider wage report matches requested number of hours in Person Centered Plan. 4. The % Consumers indicating satisfaction with their work.	1. Provider wage report 2. Provider wage report/Annual review 3. Annual review 4. Consumer self-report survey
LONG-TERM: 1. People realize their maximum vocational potential 2. People contribute to their community 3. People achieve their employment goals	1. a. The % Consumers earning at or above minimum wage. b. The % Consumers continuously employed during the previous year. 2. The % Consumers engaged in community-integrated employment. 3. The % Consumers engaged in day/work program per their Person Centered Plan.	1. a. Provider wage report b. SDS database 2. SDS Database/Annual review 3. Annual review

SDS Broker Supports Outcomes

BROKER SUPPORTS OUTCOMES	BROKER SUPPORTS INDICATORS	BROKER SUPPORTS DATA SOURCES
INITIAL: 1. People have the information they need to make informed choices. 2. People are aware of the services and supports available to them. 3. People are involved in developing a cost-effective financial plan that meets their needs. 4. Racial and ethnic minorities have equal access to residential services and supports 5. Brokers are accessible and responsive to the consumer.	1. The % of consumers/guardians that indicate their broker provides them with the information they need. 2. a. The number of residential, vocational, and other options presented by broker during development of the Person Centered Plan. b. The % of consumers that indicate that they are aware of the supports that are available to them. 3. a. The % of Person Centered Plans developed with consumer input 4. Minorities are served in a proportion comparable to their proportion of the overall population. 5. The % of consumers indicating that their broker was accessible and responsive to their input.	1. Consumer self-report survey 2. a. Broker Case notes b. Consumer self-report survey 3. Annual review 4. US census data/ SDS database 5. Consumer self-report survey
INTERMEDIATE: 1. People are safe from abuse, injury, and neglect. 2. People receive services as specified in their Person Centered Plan. 3. People are able to choose the supports that are wanted and needed within their budget.	1. Number of total incident reports during the year as a proportion of the total number of consumers. 2. The % Consistency between sampled Person Centered Plans and actual services received 3. The % of service/support packages are assembled within the individual budget specified by the county	1. SDS database 2. Sample audit of completed Person Centered Plans versus actual Fiscal Assistance reimbursements 3. Annual reviews
LONG-TERM: 1. People are actively living and evolving a support plan that they have helped to develop. 2. People are satisfied with the services they receive year after year. 3. People have a long-term, trusting relationship with their broker. 4. People are living as independently as possible and have maximized their life options.	1. a. The % of Person Centered Plans that match actual financial reimbursements. 2. The % of consumers indicating satisfaction with broker services. 3. a. The number and % of consumers requesting a change in broker or switching brokers each year. 4. The % of consumers reporting that they feel they are living as independently as possible and are maximizing their options within the individual budget specified by the county.	1. a. Sample audit of completed Person Centered Plans / SDS database 2. Consumer self-report survey 3. Provider records 4. Consumer self-report survey

Dane County Self-Directed Supports
System Evaluation & Management Audit

Recommendations

Recommendations

The following recommendations have been developed to address the issues identified during the evaluation and management audit of the Dane County Self-Directed Supports System. Recommendations focus on improving administrative and operational processes with the addition of mechanisms to enhance cost effectiveness & efficiency, quality assurance, data collection, communication, and oversight within the System. It is the hopeful expectation of the consultants that the management staff at the Dane County DHS, in conjunction with the Health and Human Needs Committee and the Dane County Board, will take a leadership role in working with the DHS staff, provider agencies, and consumers and their families to consider the following recommendations. References to County in this section refer to DHS.

Cost Effectiveness & Efficiency

Recommendation: Track unit hours for indirect service hours as well as direct service hours to more accurately measure total units of service.

Effective 2006, the County has returned to a unit-based system for reporting direct services (a unit definition is provided on p.36 of the *Provider Audit*). Several of the provider agencies have noted that these units do not encompass the full range of services that they provide, because they do not account for indirect services. Tracking units for indirect services will more accurately gauge total service costs and streamline the budgeting process. The County Intake Worker would then only have to add administrative costs, along with individual add-ons.

- The County should develop a uniform tracking tool that includes specific codes for worker functions, and provide training for agency staff on how to complete the required paperwork.

Recommendation: Utilize annual audit information to determine if the current rates of indirect services are accurate.

Indirect services are a broad category, encompassing all costs that are not direct services. A detailed list of activities that are categorized as indirect services is provided on page 40 of the *SDS Provider Audit*. The indirect service rates are currently at 35% for individuals living alone, and 49% for two individuals living together. These rates are not adjusted from year to year, but remain constant. Currently, the DHS requires an annual audit for agencies receiving more than $25,000 in County funds per year.

- A sample of these audits should be analyzed on a yearly basis to provide some insight into whether these percentages are accurate or need to be adjusted.

Recommendation: Explore the viability and potential cost reductions of more consolidated consumer living arrangements.

The County has realized savings in direct care costs in situations where two consumers live together. There does not appear to be many options utilized beyond these one and two-bed arrangements, however. The County should explore what efficiencies can be generated by

utilizing living arrangements such as clustered community living, group homes, congregate living facilities, or housing cooperatives.

- The County must ensure that any such facilities maintain the ideals of the SDS System and offer these settings as consumer choice options.

Recommendation: Non-profit provider agencies should explore earned income/business partnerships to generate additional revenue and reduce reliance on SDS funding.

According to the consultants' survey, currently about 80% of the provider agencies are non-profits, and 63% of those agencies do generate some revenue outside of the SDS System. Most reported, however, that SDS contracts constitute the vast majority of program funding. Best practice models showed that non-profit agencies that were able to develop partnerships with for-profit agencies or consolidate services with other non-profits were in many cases able to generate additional revenue and improve financial stability. More financially independent provider agencies would, in turn, strengthen the SDS System overall.

Recommendation: Explore the viability of allowing non-profit agencies within the SDS System to carry over a set amount of financial reserves from year to year.

Allowing some carry-over for these agencies will help them to become more financially stable and independent.

Recommendation: Provider agencies should explore the option of joining existing insurance pools to reduce employee insurance costs and increase efficiencies.

According to the provider survey, most agencies appear to be struggling with high insurance costs for employees. The firm of Mortenson, Matzelle & Meldrum currently operates an insurance pool that is available to providers if they fit the established criteria. Provider agencies that are struggling with this issue should determine if they meet these criteria and explore joining this pool. **Consultant note: The County has previously pursued a System-wide insurance pool discussion with Mortenson, Matzelle & Meldrum, but the parties involved could not agree on terms.*

Recommendation: Provider agencies should utilize the centralized training and consulting services offered through the Waisman Center.

Provider agencies should evaluate their training and service needs and access Waisman Center services and resources as much as possible. This will increase efficiencies and reduce indirect and administrative costs associated with duplicating trainings or services within each agency.

Recommendation: The County should assist provider agencies in consolidating administrative services to increase overall cost effectiveness and efficiency.

Combining administrative activities will reduce costs for agencies that are providing similar services.

- The County should provide consultation to all agencies interested in pursuing such efficiencies.

Recommendation: Develop limited fee-for-service arrangements to generate revenue and reduce waiting list.

The County currently gives individuals requesting services from the Adult Community Services System three choices regarding funding:

- ✓ Enroll in the Community Options Program & Medicaid Waiver programs;
- ✓ Decline all services that exceed $1,000 per month, for individuals living in the home of a parent/family member or $650 per month for individuals in a supported living arrangement funded through the County; or,
- ✓ Pay the Federal Share of the cost of all services to the County.

While the County's Long-Term Support Committee has approved this procedure,

- The County Board should adopt this rule as an official policy for the Developmental Disabilities System. Whatever efficiencies can be generated by this policy could conceivably offset the costs for several more individuals on the waiting list to receive services.

Recommendation: Promote incentives to consumers for whom a family member or family friend agrees to act as their broker without pay or at a reduced rate, within CIP funding guidelines.

It is required in the CIP funding rules that all consumers have a qualified service broker. However, TJ's Support Brokerage Firm, Inc. provides training for friends and family members of consumers to become brokers for one specific consumer. Typically, these brokers are paid a salary of $2200 per year, but do have the option of declining compensation.

- The County should promote this option to prospective brokers as a means of providing better services to the consumer.

Quality Assurance

Recommendation: Implement the standardized outcome measures recommended in this report for all provider agencies.

Dane County DHS management should utilize the outcome measures provided in this report for each of the three provider groups; vocational, residential, and broker services. These outcomes,

which were developed in an outcome training session and in subsequent meetings with key stakeholders, will provide a standardized framework with which to analyze all provider agencies in a consistent manner.

- The consultants reinforce and strongly endorse DHS's intent to pilot the residential outcomes and indicators by the end of 2006.

- The consultants also strongly recommend that the DHS continue this effort of implementing both broker and vocational outcomes and indicators during the year 2007.

- Implementation of these outcomes will require some changes in data collection, which are detailed in the *Data Collection and Information Systems* section of these recommendations.

The provider survey conducted by the consultants indicates that 75% of provider agencies already use some type of outcomes and indicators to evaluate the success of their services. This existing familiarity with outcomes by providers should ease the implementation of these important recommendations.

Recommendation: Implement comprehensive survey tools for consumers that address each of the three primary service areas: vocational, residential, and broker services.

It is the consultants' understanding that DHS is currently considering four different consumer survey formats, and plans to pilot the vocational consumer survey by the end of 2006. After reviewing the four proposed formats, the consultants have determined that any of these formats would be an effective means of gauging consumer feedback.

- DHS should select one of the proposed consumer survey formats and implement the survey for the vocational providers within the year 2006.

- DHS should implement the agreed-upon consumer surveys for brokers and residential providers within the year 2007.

These surveys will provide quantifiable data that will allow the DHS to gauge system-wide satisfaction with services, make year-to-year comparisons, assess trends, and make comparisons between provider agencies to improve overall quality of services.

Recommendation: Develop an annual "consumer report" manual for consumers and their families/guardians to help individuals make decisions about which direct service providers would be most appropriate to address their needs.

Several of the guardians that the consultants interviewed felt that they did not know enough about the residential and vocational provider agencies prior to making a decision, despite the assistance of their support broker.

- The County should develop a "consumer report" type of guide to distribute to consumers and their families. This report could be a combination of objective data, such as number of incident reports for a given provider, and subjective testimonials from current

consumers of each provider. This information should be compiled in an annual or semiannual report that would be available directly to the consumers and their families, either on-line or in print, or both.

Recommendation: Periodically conduct an audit of service providers, similar to the one conducted by Wipfli LLD for this report, to determine if services are appropriate to the needs of individual consumers.

- The County should audit a random sample of Person-Centered Plans to assess consistency between the individualized financial plan, the individualized service plans, services received, and billing vouchers. This will help the County to identify which providers are consistently achieving their desired outcomes and which are not.

Data Collection & Information Systems

Recommendation: Expand the current SDS database to include more comprehensive data associated with provider costs and service quality.

The SDS database should include all information that will be necessary for DHS management staff, the Quality Assurance Board, and any other appropriate evaluating body to make accurate annual evaluations of provider agencies. In addition to the current cost data, it should include data related to survey responses, incident reports, and performance outcomes to allow the County to make qualitative decisions about the performance of each provider.

- The Health & Human Needs Committee of the County Board should clarify standards relative to the data that must be reported by provider, and establish one central location for the collection of data in order to streamline the process.

- In addition, data collection methods should be uniform among all agencies. An audit of data collection practices among brokers and providers may be useful in determining the best model for the SDS system as a whole.

Recommendation: Add an additional column to the spreadsheet for tracking unit rates (see Appendix C in the SDS Fiscal Review Section).

A column reflecting the total expected volume of each provider would be useful in monitoring actual hours incurred against the County's expectations for that provider. This will provide the county with a tool to monitor utilization and help gauge future expenses.

- Add this additional column to the spreadsheet for tracking unit rates.

Recommendation: Stratify cost data to assure that consumers with similar levels of service needs are receiving congruous levels of funding for services.

An example of this would be to group consumers into categories based on a set cost interval, possibly five or ten thousand-dollar increments. This cost data can then be combined with data

tracking units of service. Organizing the database in this way would provide a useful method of comparison to assure that consumers are getting the same level of service for similar dollars across the system.

Communication within the SDS System

Recommendation: The County should clarify roles of stakeholders within the SDS System.

In the survey conducted by the consultants, many of the direct service providers commented that they do not clearly understand the role and responsibility of the brokers. Conversely, many brokers expressed frustration that many providers did not necessarily follow consumers' Person-Centered Plans. In addition, different County case managers had different expectations of the brokers and responded differently to broker requests. These comments clearly point to a need for improved understanding of roles and responsibilities among the stakeholders within the SDS System.

- The County should take the lead to ensure that these issues are addressed in order to improve System-wide communication. In order to accomplish this, the county should facilitate a training session or a series of training sessions of all interested participants, to define the roles of all parties.

Recommendation: Dane County should provide more direct feedback to provider agencies.

Many of the provider agencies surveyed stated that they do not receive feedback from the county regarding the data that they submit.

- If possible, the County should move towards the distribution of a brief summary report to all provider agencies summarizing results for the System as a whole to give individual agencies a broader understanding of what developments are taking place system-wide, and chair quarterly meetings to discuss issues regarding the SDS System.

System Oversight

Recommendation: Reevaluate unit costs again after July of 2007.

At the time of this report, the consultants had only two months' worth of unit rate data for analysis, as the system had just been implemented. This limited timeframe does not account for numerous potential fluctuations that could occur throughout the year, as well as potential human error associated with the transition to the new system.

- Using twelve months of data, the County should make an accurate judgment regarding the range of unit rates and adjust the rates accordingly.

Recommendation: Revaluate provider, residential, and broker outcomes and indicators after July 2007.

- Based upon their effectiveness and relevance during the operational phase of 2006 and 2007, DHS should adjust the outcomes and indicators, if necessary, to address consumer and system needs in the most accurate manner possible.

Recommendation: Reevaluate specific efficiency and cost effectiveness standards for provider agencies on a yearly basis.

The County currently has the following review policies in place to gauge providers' fiscal performance: annual budgets, annual audits, contract compliance reviews, and quarterly expense reports. It does not appear, however, that specific standards exist regarding what results the County expects with regard to these review measures. If the County implements the consultant recommendations with respect to provider audits and data collection, they should have, within twelve months, more accurate and revealing unit-based data for each agency.

- Reevaluate specific efficiency and cost effectiveness standards for provider agencies on a yearly basis.

Recommendation: Enforce the current termination, suspension, and modification policies to address agencies that consistently do not meet Dane County's standards for cost effectiveness and service quality.

Given the realities of reduced federal, state, and local funding, the SDS System cannot support agencies that are consistently unable to meet established standards for efficiency and cost effectiveness.

- The County must enforce across all agencies system-wide, the current termination, suspension, and modification policies, in order to reinforce the viability and cost effectiveness of the SDS programming. These policies must be written into the contracts of each provider agency.

References

Dobkin, Leah. *Generating Revenue for Consumer-Directed Programs (Not Just Raising Funds).* From http: // ww.consumerdirection.org.

Dane County Self-Directed Supports
System Evaluation & Management Audit

Appendix I

Dane County Criteria for Providing Assistance to Individuals in Crisis or in Need of Continuity

APPENDIX I

SOURCE: DANE COUNTY DHHS

KATHLEEN FALK
DANE COUNTY EXECUTIVE

Dane County
Department of Human Services
Division of Adult Community Services

Director – Lynn Green
Division Administrator – Fran Genter

Developmental Disability Programs

Criteria for Providing Support to Individuals in Crisis or in Need of Continuity

CURRENTLY RECEIVING SERVICES

For people who are currently receiving services, increased funding might be provided in the following situations:

- Inability of primary caretaker (physical incapacitation, etc.) to continue providing necessary support and where no other caregiver is available.
- Substantiated reports of abuse or neglect requiring short-term or long-term interventions.
- Impending risk for abuse or neglect (substantiated threats or based on situational assessment).
- Consumer presents high medical needs that cannot be fully addressed by caregivers.
- Consumer presents significant behavioral challenges, putting self or caregivers at risk.

REQUESTING A NEW SERVICE

For people who are requesting a new service, increased funding might be provided in the following situations:

1. Death of the primary caregiver, where no other caregiver is available.
2. Substantiated reports of abuse or neglect requiring short-term or long-term interventions.
3. Inability of primary caretaker (physical incapacitation, etc.) to continue providing necessary support and where no other caregiver is available.
4. Where a caregiver is available but the caregiver would experience significant disruption in his or her life and/or would lose his/her employment in order to provide the necessary support.
5. Consumer is terminally ill, where death is imminent.
6. Impending risk for abuse or neglect (substantiated threats or based on situational assessment).
7. Consumer presents high medical needs that cannot be fully addressed by family or caregivers.
8. Consumer presents significant behavioral challenges, putting family members or caregivers at risk.
9. Risk for out-of-home placement (children) or risk of institutionalization (children & adults).
10. Potential reunification with family from out-of home placement (children in foster care or child-caring institutions).
11. Court ordered placements

CONTINUATION OF SERVICES

For people who are requesting a continuation of services, the following situations may constitute a need for continuity:

A. Children transitioning from County-funded children's services (Foster Care, mandated Case Management, Respite, Children Come First) to Adult Developmental Disability Services

(continued on next page)

1202 Northport Drive, Madison, WI 53704 * (608) 242-6200 * FAX (608) 242-6531 * TDD (608) 242-6279

CONTINUATION OF SERVICES (cont.)

B. Young adults who currently receive developmental disability residential services and who require daytime support upon leaving high school.
C. The closing or downsizing of institutions where Dane County residents will be displaced and where no other alternatives are available.
D. Individuals currently receiving services who have an increased support need due to medical (infirmaries of aging, etc.), psychological (onset of Alzheimer's, etc.), or challenging behavioral issues and who, without additional support, would be at risk of physical harm, institutionalization, or involvement in the legal system.
E. Children transitioning from other funded services (school systems, graduates in supported employment, Division of Vocational Rehabilitation, etc.)
F. Adults and children with acquired brain injuries where the County is required to commit to providing long-term community care prior to intake into an inpatient rehabilitation program.
G. Adults who have left the County, while receiving services and return within 6 months.

What are the criteria for approving different models of support?

- Consumer presents high medical needs that cannot be fully addressed in current support arrangement.
- Consumer presents significant behavioral challenges that cannot be fully addressed in current support arrangement.
- Consumer is requesting a change in model of support, where no immediate danger is ascertained

If model of support is to be changed, it must be cost-neutral.

***In all cases, the provision of support is dependent upon the availability of funds.**

Dane County Self-Directed Supports
System Evaluation & Management Audit

Appendix II

Provider Audit Spreadsheet

APPENDIX II - SDS PROVIDER AUDIT SPREADSHEET

SOURCE: DANE COUNTY DHHS

		Review Individual Service Plan			Review Individual Financial Plan			Review of Billing Vouchers					
	Services Received	Broker	Provider of Services	Broker Notes Support Monitoring of Condition and Changes	Services Provided Match ISP?	IFP Amount	Billed Amount	Voucher Amount Matches IFP	Does the Voucher Contain Approval Signatures?	Provider of Service Matches ISP	Were Total Allocated Funds Used Up?	Were Funds Spent According to Plan?	Is There Consistency Between the ISP, IFP & Billing Voucher?
49841	Personal Care	ARC of Wisconsin	Partners In Community Living (personal)	Yes, comments found in annual notes referring to clients condition, and lack of changes needed or concerns	Yes	43416	43416	yes	yes	yes	yes, and surplus funds were returned	yes	yes
49841	Personal Care	ARC of Wisconsin	WORC (work/educ/day support)	see above	Yes	12400	12400	yes	yes	yes	no, surplus funds were returned	yes	yes
123588	Personal Care	Catholic Charities	REM Wisconsin (personal)	see above	Yes	67313	67313	yes	yes	yes	yes, no surplus	yes	yes
123588	Day Care	Catholic Charities	Pathways of Wisconsin (ADC)	see above	Yes	6530	6530	yes	yes	yes	yes, no surplus	yes	yes
159459	Work/Educ	Avenues to Community	MARC East (work/educ/day support)	see above	Yes	2215	2215	yes	yes	yes	yes, no surplus	yes	yes
245704	Work/Educ	Avenues to Community	MARC East (work/educ/day support)	see above	Yes	11903	11903	yes	yes	yes	yes, no surplus	yes	yes
245704	Personal Care	Avenues to Community	Dungarvin (personal)	see above	Yes	89404	89404	yes	yes	yes	yes, no surplus	yes	yes
246835	Personal Care	Cindy Kernan, Dane Co DHS	Dungarvin (personal)	see above	Yes	161012	161012	yes	yes	yes	no, excess funds were used to rebuild wheelchair ramp in clients home	yes	yes
246835	Work/Educ	Cindy Kernan, Dane Co DHS	Encore Studio (work/educ/day support)	see above	Yes	19678	19678	yes	yes	yes	no, excess funds were used to rebuild wheelchair ramp in clients home	yes	yes
247072	Personal Care	Teamwork Associates	Options (personal)	see above	Yes	29352	29352	yes	yes	yes	no, surplus funds were returned	yes	yes

SOURCE: DANE COUNTY DHHS

	Review Individual Service Plan				Review Individual Financial Plan			Review of Billing Vouchers					
	Services Received	Broker	Provider of Services	Broker Notes Support Monitoring of Condition and Changes	Services Provided Match ISP?	IFP Amount	Billed Amount	Voucher Amount Matches IFP	Does the Voucher Contain Approval Signatures?	Provider of Service Matches ISP	Were Total Allocated Funds Used Up?	Were Funds Spent According to Plan?	Is There Consistency Between the ISP, IFP & Billing Voucher?
247072	Work/Educ	Teamwork Associates	Bauer, Daun (work/educ/day support)	see above	Yes	9113	9113	yes	yes	yes	no, surplus funds were returned	yes	yes
248930	Personal Care	Avenues to Community	REM Wisconsin (personal)	see above	Yes	67996	67996	yes	yes	yes	yes, no surplus	yes	yes
248930	Work/Educ	Avenues to Community	MARC South (work/educ/day support)	see above	Yes	11351	11351	yes	yes	yes	yes, no surplus	yes	yes
249706	Personal Care	TJ's Support Brokerage Firm	Dungarvin (personal)	see above	Yes	59011	59011	yes	yes	yes	no, no return	yes	yes
249706	Personal Care	TJ's Support Brokerage Firm	TJ's Support Brokerage Firm	see above	Yes	2419	2419	yes	yes	yes	no, no return	yes	yes
249706	Work/Educ	TJ's Support Brokerage Firm	MARC West (work/educ/day support)	see above	Yes	7826	7826	yes	yes	yes	no, no return	yes	yes
250191	Personal Care	Community Living Connections	Community Living Connections	see above	Yes	2643	2643	yes	yes	yes	yes, no surplus	yes	yes
250191	Work/Educ	Community Living Connections	MARC East (work/educ/day support)	see above	Yes	690	690	yes	yes	yes	yes, no surplus	yes	yes
251579	Personal Care	TJ's Support Brokerage Firm	REM Wisconsin (personal)	see above	no formal ISP	84307	84307	yes	yes	yes	yes, no surplus	yes	yes
251579	Personal Care	TJ's Support Brokerage Firm	TJ's Support Brokerage Firm	see above	no formal ISP	3112	3112	yes	yes	yes	yes, no surplus	yes	yes
251579	Day Care	TJ's Support Brokerage Firm	Elder Care Day Center (ADC)	see above	no formal ISP	5802	5802	yes	yes	yes	yes, no surplus	yes	yes
253161	Personal Care	Teamwork Associates	Options (personal)	see above	Yes	65949	65949	yes	yes	yes	yes, no surplus	yes	yes
253161	Work/Educ	Teamwork Associates	MARC- Res (work/educ/ADC)	see above	Yes	24078	24078	yes	yes	yes	yes, no surplus	yes	yes
254664	Personal Care	The ARC - WI Disability Assoc.	REM Wisconsin (personal)	see above	Yes	43503	43503	yes	yes	yes	yes, no surplus	yes	yes
254664	Work/Educ	The ARC - WI Disability Assoc.	Channels (Supported Employment)	see above	Yes	16914	16914	yes	yes	yes	yes, no surplus	yes	yes
255133	Personal Care	UCP of Dane CO.	TJ's Support Brokerage Firm	see above	Yes	1000	1000	yes	yes	yes	yes, no surplus	yes	yes

SOURCE: DANE COUNTY DHHS

	Review Individual Service Plan				Review Individual Financial Plan			Review of Billing Vouchers					
	Services Received	Broker	Provider of Services	Broker Notes Support Monitoring of Condition and Changes	Services Provided Match ISP?	IFP Amount	Billed Amount	Voucher Amount Matches IFP	Does the Voucher Contain Approval Signatures?	Provider of Service Matches ISP	Were Total Allocated Funds Used Up?	Were Funds Spent According to Plan?	Is There Consistency Between the ISP, IFP & Billing Voucher?
255133	Work/Educ	UCP of Dane CO.	CWS (Supported Employment)	see above	Yes	8299	8299	yes	yes	yes	yes, no surplus	yes	yes
255679	Personal Care	Avenues to Community	Create-Ability (personal)	see above	Yes	89618	89618	yes	yes	yes	no, no return	yes	yes
255679	Work/Educ	Avenues to Community	MARC- South (work/educ/ADC)	see above	Yes	9878	9878	yes	yes	yes	no, no return	yes	yes
261610	Work/Educ	ARC of Wisconsin	MARC- Res (Fac Based Employ)	see above	Yes	7881	7881	yes	yes	yes	yes, no surplus	yes	yes
261610	Work/Educ	ARC of Wisconsin	MARC- South (work/educ/ADC)	see above	Yes	27589	27589	yes	yes	yes	yes, no surplus	yes	yes
264432	Personal Care	Cindy Kernan, Dane Co DHS	Dungarvin (personal)	see above	Yes	80976	80976	yes	yes	yes	yes, no surplus	yes	yes
264432	Work/Educ	Cindy Kernan, Dane Co DHS	Goodwill (work/educ/ADC)	see above	Yes	21828	21828	yes	yes	yes	yes, no surplus	yes	yes
269852	Work/Educ	ARC of Wisconsin	ICW (supported employment)	see above	Yes	31758	31758	yes	yes	yes	yes, no surplus	yes	yes
335455	Work/Educ	Avenues to Community	WORC (work/educ/day support)	see above	Yes	5726	5726	yes	yes	yes	yes, no surplus	yes	yes
418475	Work/Educ	TJ's Support Brokerage Firm	Goodwill (work/educ/ADC)	see above	Yes	7964	7964	yes	yes	yes	yes, no surplus	yes	yes
418475	Personal Care	TJ's Support Brokerage Firm	TJ's Support Brokerage Firm	see above	Yes	2568	2568	yes	yes	yes	yes, no surplus	yes	yes
418475	Work/Educ	TJ's Support Brokerage Firm	MARC- Mt. Horeb (Fac Based Employ)	see above	Yes	18928	18928	yes	yes	yes	yes, no surplus	yes	yes
418475	Personal Care	TJ's Support Brokerage Firm	SWD Services/Dungarvin (personal)	see above	Yes	69954	69954	yes	yes	yes	yes, no surplus	yes	yes
676564	Personal Care	TJ's Support Brokerage Firm	Create-Ability (personal)	see above	Yes	41284	41284	yes	yes	yes	yes, no surplus	yes	yes
676564	Personal Care	TJ's Support Brokerage Firm	TJ's Support Brokerage Firm	see above	Yes	2000	2000	yes	yes	yes	yes, no surplus	yes	yes
676564	Other	TJ's Support Brokerage Firm	Meriter Lifeline	see above	Yes	488	488	yes	yes	yes	yes, no surplus	yes	yes

Dane County Self-Directed Supports
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Appendix III

Unit Rate Spreadsheet

APPENDIX III

PROVIDER UNIT RATES

SOURCE: DANE COUNTY DHHS

BROKERS

Provider	Jan Units	Feb Units	total	Projected	06 Budget	Unit Rate
Provider 1	793.50	808.00	1,601.50	9,609.00	$ 415,690	$ 43.26
Provider 2	621.50	511.50	1,133.00	6,798.00	$ 302,897	$ 44.56
Provider 3	902.75	729.25	1,632.00	9,792.00	$ 448,466	$ 45.80
Provider 4	1,130.00	1,004.25	2,134.25	12,805.50	$ 634,983	$ 49.59
Provider 5	810.50	764.50	1,575.00	9,450.00	$ 507,870	$ 53.74
Provider 6	997.25	894.00	1,891.25	11,347.50	$ 708,440	$ 62.43
Provider 7	268.25		268.25	3,219.00	$ 209,832	$ 65.19

RESIDENTIAL SERVICES

Provider	Jan Units	Feb Units	total	Projected	06 Budget	Unit Rate
Provider 1	10,097.04		10,097.04	121,164.48	$ 1,990,120	$ 16.42
Provider 2	921.00	836.50	1,757.50	10,545.00	$ 182,699	$ 17.33
Provider 3	4,870.30	4,480.75	9,351.05	56,106.30	$ 994,351	$ 17.72
Provider 4	2,813.00	2,697.00	5,510.00	33,060.00	$ 600,227	$ 18.16
Provider 5	4,185.00	3,710.00	7,895.00	47,370.00	$ 904,431	$ 19.09
Provider 6	20,689.79	21,211.15	41,900.94	251,405.64	$ 5,046,892	$ 20.07
Provider 7	8,231.75		8,231.75	98,781.00	$ 2,023,967	$ 20.49
Provider 8	14,456.81	10,087.27	24,544.08	147,264.48	$ 3,258,471	$ 22.13
Provider 9	12,163.40	10,852.00	23,015.40	138,092.40	$ 3,056,336	$ 22.13
Provider 10	40,278.50	36,805.50	77,084.00	462,504.00	$ 10,782,029	$ 23.31
Provider 11	1,545.00	1,417.00	2,962.00	17,772.00	$ 420,172	$ 23.64
Provider 12	7,483.00	6,965.25	14,448.25	86,689.50	$ 2,121,202	$ 24.47
Provider 13	5,472.25	4,959.50	10,431.75	62,590.50	$ 1,589,055	$ 25.39
Provider 14	8,397.50	8,219.75	16,617.25	99,703.50	$ 2,565,937	$ 25.74
Provider 15	1,546.90	1,390.60	2,937.50	17,625.00	$ 458,443	$ 26.01

VOCATIONAL SERVICES

Provider	Jan Units	Feb Units	total	Projected	06 Budget	Unit Rate
Provider 1	611.50	622.00	1,233.50	7,401.00	$ 160,774	$ 21.72
Provider 2	1,848.25	1,717.00	3,565.25	21,391.50	$ 483,206	$ 22.59
Provider 3	2,283.00	2,103.25	4,386.25	26,317.50	$ 616,369	$ 23.42
Provider 4	2,665.75	2,401.25	5,067.00	30,402.00	$ 781,187	$ 25.70
Provider 5	2,084.00	2,100.00	4,184.00	25,104.00	$ 670,778	$ 26.72
Provider 6	2,357.75	2,346.00	4,703.75	28,222.50	$ 824,827	$ 29.23
Provider 7	1,279.50	1,379.75	2,659.25	15,955.50	$ 476,991	$ 29.90
Provider 8	1,196.75	715.00	1,911.75	11,470.50	$ 372,562	$ 32.48
Provider 9	1,343.50	1,715.75	3,059.25	18,355.50	$ 625,888	$ 34.10
Provider 10	1,507.25	1,509.00	3,016.25	18,097.50	$ 619,752	$ 34.25
Provider 11	3,595.50	3,568.50	7,164.00	42,984.00	$ 1,537,019	$ 35.76
Provider 12	2,327.50	1,962.75	4,290.25	25,741.50	$ 1,142,729	$ 44.39