COALITION FOR WHOLE PERSON SUPPORTS, ADVISORY GROUP - RESPONSES TO THE PACE MODEL WEBINAR PRESENTATION
JANUARY 2025

Question 1: **How does the model meet the goals of whole person supports?**	The goal is certainly tailored for the individual and creating a life plan that allows for change and modification as needed.
	Its holistic, person-centered framework could also benefit those with ID/DD. I'm particularly drawn to how the model emphasizes delivering high-quality care to improve quality of life, backed by strong coordination and interdisciplinary teamwork. The close collaboration among healthcare and service professionals reduces gaps in care, encourages proactive health monitoring, and ensures more seamless transitions across different levels of support. Assuming this model can be adapted to serve the ID/DD population, it holds promise for providing comprehensive, whole-person care that integrates specialized interventions within a unified system.
	Impressive work they are doing and doing as a faith community. Although nothing is perfect, what they are doing what I would want from my family members beyond self-directed or possibly as a part of self-directed. I feel they are or at least close to meeting the goals of whole person supports.
	Comprehensive with an interdisciplinary team that works closely with the person on a broad range of needs – particularly for those with complex medical needs.
	It provides combination of a medical and social aging/disability model of care based however on a medical IDT team approach which from the presentation would benefit on more inclusion/presence of the individual at the IDT level.
Question 2: **What are the positive attributes of the model?**	The rate PMPM allows for flexibility and providing the right supports. That health and long-term care are included in the rate provides us an example of how managed care could work for our population
	One of the model's most compelling attributes is its "community main center" concept, which significantly broadens the options for individuals with ID/DD who require high-level care—an area where choices are often limited. This approach is particularly promising for younger adults aging out of the DOE system who may not be well-suited to a traditional group home environment, as it integrates them into a supportive community setting, offering a viable alternative especially beneficial for those with complex care needs within the ID/DD population. Notable attributes include consolidating most services under one administrative umbrella, which can be beneficial for some participants by sparing them from juggling multiple agencies or navigating complicated referrals. Also, regular interdisciplinary assessments enable the early detection of health or behavioral issues, helping to prevent more serious complications and reduce costly hospitalizations. Together, these

	features create a comprehensive and integrated support system that improves participants' quality of care and overall quality of life, ensuring they remain actively connected to their communities.
	How individualized it is. OPWDD promotes choice but in the real world, no one has choice to do whatever, whenever, etc. because there are rules, laws and consequences. How do they manage differences in wants, needs, etc.? Due to the size, there is better knowledge of the people they serve as well as the opportunity for support people to interact more with them.
	Integrated care/support, intense care oversight by the interdisciplinary team is great for folks with complex medical needs, payment model is incentivized to promote positive outcomes, enrollees express great satisfaction with the program, a really great model for people with complex medical needs
	It takes into account the chronological age of the individual and allows for more choice in voluntary involvement of the individual in activities and services. There is more flexibility in the service model.
<u>Question 3:</u> **What are the drawbacks of the model?**	I think bringing this model to scale is a barrier. Whatever model is created for our folks, it will need to meet the needs of all the individuals in the system
	A key drawback of adapting the PACE model for individuals with ID/DD is that this population spans a broad range of abilities, health conditions, and support needs. Making it difficult for one model to address them all effectively. Providing highly specialized services—such as behavioral therapy, communication supports, specialized feeding, and other complex medical interventions—can be highly resource-intensive. Recruiting and retaining the necessary professionals, especially in under-resourced areas, presents an additional challenge. While the PACE model offers theoretical flexibility, implementing it in practice may require substantial financial and organizational support. I also think that the model typically operates as a “one-stop shop,” participants may have fewer options if they wish to access or choose services beyond its network.
	How are they different from supports and services from a "planned community", such as Springbrook in NYS?... The Larch Community was or is it still around? I think that was shared living. In some parts of the USA there are "gated community" where "outside community" does come in for different opportunities such as stores, etc.
	Seems to rely on segregated service (doesn’t focus on integration within the general community), heavily based on medical model of care, difficult to expand to larger populations, heavily regulated (both federal and state direct oversight – yikes!), doesn’t seem to address the support that would be provided to those with I/DD & severe mental illness or behavior support needs, designed for the senior population (not really designed for younger folks), I don’t believe it includes supported housing

	beyond providing PCA/HHA services. Limits choice in terms of providers (I believe the enrollee must agree to use the specific provider team that are part of the PACE)
	The model could be viewed as not integrative enough within the larger community. It seems to me that there would be more of a tendency to stratification and isolation due to severity of the individual's condition particularly within the program's social components than what was alluded to during the presentation.
<u>Question 4:</u> **How would you modify this specific model?**	I really think there is a strong need to work through the fiscal piece for folks that are in certified settings as well as folks with complex needs
	To ensure financial sustainability and access to necessary services, payment models should be adjusted to reflect the higher costs associated with providing care to individuals with ID/DD. This adjustment is needed to maintain adequate resources and ensure comprehensive care. Additionally, while the traditional PACE model relies heavily on adult day health centers, this may not always be the most effective service delivery method for individuals with ID/DD. Alternative approaches, such as community-based services or more flexible, individualized care plans, should be considered to better meet the unique needs of this population and promote a more inclusive and supportive care environment.
	Size limitations probably is a barrier to some, but Archcare seems to be financially stable that might encourage others to try it. How do they deal with direct care storage that other agencies state as a reason to decrease services?
	I do like the concept of integrating various disciplines within a single payment mechanism. For the IDD population, I think integrating a habilitation component (including supported non-certified housing programming) with a focused/purposeful aim to maximize independence and use a technology first approach would be great. Such a model would incorporate not just the medical, but habilitation, mental health – even substance abuse. Day time activity should not be limited to a site-based day program, but to employment/volunteering, recreational programs, etc.
	I think this is a good model, but the number of people served is limited. I would like to know the per person capitated rate and see if it is competitive with OPWDD rates for services. Also not sure how seeing medical practitioners for specialty care costs are factored in this essentially primary care approach.
<u>Question 5:</u> **Do you have any other general recommendations?**	No, however, this program certainly displays the possibility for system change at OPWDD
	The PACE model, which has been used successfully with older adults with dementia, offers a theoretical framework that can be adapted to meet the needs of individuals with ID/DD. However, moving from theory

	to practice will require careful testing and adjustments to ensure it works in the real world. A pilot program would be a valuable way to evaluate how the model functions and addresses the unique needs of this population.
	I remember when there were several pilot programs besides self-determination (maybe it was CSS then). Those programs didn't go far, and CSS continued and eventually was renamed self-directed. As someone who started with SD 20 years ago, it has been interesting to see the changes over time with it. I know that when I am gone, for my family members SD will most likely end for them. Could SD buy into parts of this model? Also, the homes that SO have vacated are just sitting there empty, why can't those homes be repurposed since the state owns them? They won't be livable if left empty to long.
	It's possible this type of model will work best when there are various types of designs to meet different age/peer groups (e.g. children, young adults, middle age, seniors).
	I would love to see some pilot funding for more inclusion of IDD into the model. I think if the model were only for IDD individuals, it might not pass the most integrative setting standard of care such as required under Olmstead decision.