

Indiana Family and Social Services Administration

Long Term Care Transformation Stakeholder Workgroup

Meeting 4
January 8, 2018

Members and observers - please sign-in!





Welcome

- Round-robin of core members and observers



Agenda Overview

- Review ground rules, roles and responsibilities, timeline, and December 4 Workgroup and Planning Meetings
- Case Management Conflict of Interest
- A&D Services
- Review Case Management
- Review of Supported Services
- Next Steps and Wrap-Up

Proposed Workgroup Ground Rules



1. Show up on time, come prepared, and leave your “hat” at the door.
2. Listen attentively to others and don’t interrupt or have side conversations. Treat all meeting participants with the same respect you would want from them.
3. Share your unique perspectives and experiences. If you disagree, try to offer a solution.
4. Seek first to understand, then to be understood.
5. Value learning from others. You can respect another person’s point of view without agreeing. Respectfully challenge ideas, not people.
6. Stay open to new ways of doing things and watch/listen for the future to emerge.
7. Stay on point and on time. Keep comments brief and to the point.
8. Attend in person; do not send substitutes if at all possible.
9. If you raise an issue that is not part of the current discussion, we will place it in the “parking lot” for a future discussion.



Roles and Responsibilities

Division of Aging

- Develop Workgroup meeting agendas and materials
- Communicate with Workgroup members
- Facilitate discussions and keep group focused on session topics and questions
- Compile minutes including the tracking of action items and/or items in the “parking lot”
- Post agendas, materials, and minutes to the FSSA Long-Term Care Transformation website

Workgroup Members

- Review materials in advance of each meeting.
- Provide verbal input on redesign program elements.
- Exchange ideas, innovations, strategies and solutions.
- Follow workgroup ground rules (see above).
- Review meeting minutes for accuracy before posting.

Timeline



Meeting #	Date	Location
Meeting #1	October 2, 2017 ✓	Conference Room C
Meeting #2	November 6, 2017 ✓	Conference Room 1+2
Meeting #3	December 4, 2017 ✓	Conference Room C
Meeting #4	January 8, 2018	Conference Room C
Meeting #5	February 5, 2018	Conference Room C



December Stakeholder Workgroup Overview

1. Person-Centered Foundations
2. CMS White Paper Review
3. Congregate Settings Planning Meeting
4. Case Management Planning Meeting



A&D Services



A&D Services

- Services Provided under Current A&D Waiver
 - Waiver renewal
- Services Provided under Current TBI Waiver
 - Included in A&D Waiver
 - Not included in A&D Waiver
- Group Discussion



Conflict of Interest



CMS on Conflict of Interest

- COI defined as a “real or seeming incompatibility between one’s private interests and one’s public or fiduciary duties”
- CMS goals:
 - Prevent unfair competitive advantage
 - Prevent existence of conflicting roles that might bias performance
- Requires implementing COI mitigation strategies



Sources of Conflict

Conflict of Interest (COI) may arise when an entity helping an individual gain access to services also provides direct services to that individual. There is potential for COI in:

- Honoring free choice
- Overseeing quality and outcomes
- Fiduciary relationships



Potential Consequences of Conflict of Interest

Indiana NCI Survey Results:

- 63% of people said their case manager talked to them about services that might help with unmet needs and goals
- 72% said that they can choose or change what kind of services they get and determine how often and when they get them
- 82% said that they can choose or change who provides their services if they want to
- 86% said that they can chose or can change case manager/service coordinator



Requirements for Conflict

- 2014 Final Rule Requirements:
 - Entities separate case management from providing direct services
 - Direct service providers cannot determine financial or functional eligibility
 - Case managers cannot be related/married to the individual, be financially responsible or make health-related decisions for them, and/or benefit financially from providing services to them



Addressing & Resolving Conflict

The State must (at minimum):

- Demonstrate that the only willing and qualified case manager is also a direct service provider (this is the only exception to conflict requirements)
- Provide full disclosure, assuring individuals that they are supported in exercising free choice
- Describe individual dispute resolution processes
- Assure that entities separate case management from service delivery functions
- Assure that entities provide case management and services only with approval of State
- Provide direct oversight and periodic evaluation of safeguards



Review of Case Management



Case Management Definition

Case management means a comprehensive service including, but not limited to, the following:

- Ongoing engagement to conduct an assessment with an individual to identify:
 - Strengths
 - Preferences
 - Goals and desired outcomes for the future
 - Functional **abilities and** needs
 - Clinical support needs
 - Need for in-home and community services
 - **Current social supports (building on existing supports)**
- Supporting participants in the development of a person-centered **support** plan, which provides guidance on supporting the person to achieve their goals and desired outcomes



Case Management Definition (cont.)

Case management means a comprehensive service including, but not limited to, the following:

- Monitoring service delivery to participants to ensure services are helping the individual towards their identified goals and desired outcomes
- Provide ongoing advocacy and options counseling to integrate health and supportive services for participants through an ongoing relationship
- Monitor the **support** plan to ensure the quality of long term services and supports (LTSS) for participants
- Reassessing participant support plans at least every ninety (90) days or more often if needed to determine the continuing need and effectiveness of services
- Reporting and following-up on incidents affecting health and safety



Service Requirements

1. Comprehensive assessment, such as a comprehensive caregiver assessment, falls risk assessment, etc.
2. Periodic reassessment
3. Ongoing development of a person centered support plan in consultation with the individual and whoever else the individual wishes to be involved, at a time and place convenient to the individual.
 - Involve informal caregivers if the person does not object to the involvement of such caregivers
 - The extent of the involvement of caregivers in the provision of assistance will be documented in the person-centered support plan
 - The case manager shall develop a back-up or emergency plan with the individual in the event that formal and informal caregivers are unable or unavailable to provide supports.
 - Identify services to be included in support plan, regardless of funding source
4. Referral and related activities to help the individual access needed services



Service Requirements (cont.)

5. Provide linkage, support and advocacy
 - Assist with maintenance of eligibility for Medicaid and other supports
 - Advocate for individuals' unmet needs and empower them to access needed services and supports
 - Support caregivers through connection to resources and education
6. Facilitate community integration as desired
 - Support individuals in developing their network of support in their community
 - Support individuals in making valued contributions to their community
7. Coordinate services and supports during all transitions (hospital to home, institutions to community, etc.) whenever possible
8. Coordinate and collaborate with health care **providers and health care coordinator when applicable** in order to integrate with health care
9. Monitoring and follow up activities, **including direct communication and coordination with providers of in-home services**
10. Incident reporting



Case Management Performance and Outcome Measures

1. Timeframes for service provision, as outlined in IAC 455 2.1-8-1
2. Documentation standards, as outlined in DA HCBS Provider Reference Manual
3. Satisfaction and person-centeredness measures
 - Individuals express they have control of and/or input into their plan of care
 - Care plans goals reflect individual preferences for a variety of life domains
 - Increased community engagement
 - Increased quality of life
 - Decrease in caregiver burden
 - Individual preferences for care during advanced serious illness are supported



Case Management Performance and Outcome Measures (cont.)

4. Healthcare utilization measures
 - Decreased use of emergency room
 - Decreased days in hospital
 - Decreased days in a skilled nursing facility
 - Decreased 30-day readmission rate
 - Increased identification of behavioral health needs
 - Decreased adverse events related to medication non-compliance/interactions
 - Decreased adverse events related to falls
 - **Number of days at home/assisted living (in community setting)**

Care Management Provider Responsibilities



- Complete the State's required case manager orientation training before providing case management services.
- Complete training to meet case management core competencies:
 - Active listening and engagement
 - Facilitation of person centered assessment and planning processes
 - Knowledge of system processes and service options, including integration with health care and social services
 - Identification of service and support options to meet identified needs consistent with a person's desired outcomes
 - Culturally sensitive knowledge
 - Population-specific knowledge, including aging and disability competency training (e.g. what is typical and atypical)
 - Facilitation of active engagement in community life, including making contributions and building relationships
 - Advocacy and protection of individual's rights
 - Conflict resolution and mediation
 - De-escalation through evaluation of the individual and the environment



Provider Responsibilities (cont.)

- Complete training on:
 - Community resources and supports including both private and public pay options
 - Philosophy and importance of person-centeredness, self-determination and independent living
 - Developing person-centered support plans that incorporate all types of services and supports, regardless of funding source
 - Supporting families and caregivers
 - **Consumer direction (not CDAC)**



Provider Responsibilities (cont.)

- Case managers must complete a minimum of 20 hours of training per calendar year on topics related to case management services and supports. Hours will be pro-rated for the 1st year for newly-hired case managers.
- Case management providers have the flexibility to identify training topics relevant to the individuals supported by the case managers, including safety training for case managers providing services in individual's homes.
- Of the 20 hours required per calendar year, case managers must complete training on each of the following topics:
 - Level of care
 - Incident reporting
 - Case management service definition
 - Community resources and supports including both private and public pay options
 - Supporting families and caregivers
 - **Supporting individual choice and empowerment (initial and annual)**
 - **Cultural competency (initial and annual)**
 - **Supported decision making (initial and annual)**



Provider Responsibilities (cont.)

- Identify provider compliance issues (e.g. HCBS Setting Rule Compliance)
- Ensure that case managers, at a minimum:
 - Follow up on identified issues
 - Immediately address critical issues
 - Address any concerns with services or outcomes
 - File and follow up on incident reports
 - Coordinate services
 - Share information on the participant's well-being as required by the participant's person-centered support plan
 - Collaborate with the participant's other providers
 - Collaborate with other authorized entities



Provider Requirements (cont.)

Ensure that assessments, person centered support plans, case notes, level of care reviews, and other actions are data entered in DA's case management system within seven (7) calendar days of the action.

- A case manager must document in the case management system:
 - Contacts regarding the participant and their services. These would include, but not be limited to, contacts with:
 - Participant or a legal representative
 - Participant's providers
 - Potential providers
 - Individuals the participant has identified as part of the person centered planning process
 - Any issues which must be reported, including, but not limited to:
 - unusual incidents affecting the participant's health and welfare
 - Resolutions of issues and incidents



Provider Requirements (cont.)

- At a minimum of every ninety (90) days, the case manager, using the DA's monitoring tool, must review service deliverables as determined by the person-centered **support** plan, to determine if participant's assessed needs are being addressed and assess whether the participant is satisfied that the services meet their needs and goals.
 - The case manager must conduct the first face-to-face assessment with the participant in the home
 - The case manager must conduct at least two of the four required 90-day assessments in the home



Review of Supportive Services



Definitions

- **Provider**
An entity paid to deliver HCBS services to eligible participants, including Area Agencies on Aging and their grantees
- **Provider owned or controlled settings**
Setting that is owned, controlled, or operated by a provider that is paid to deliver services and supports to persons eligible for HCBS
- **Provider owned or controlled residential settings**
Residential setting that is owned, controlled, or operated by a provider that is paid to deliver services and supports to persons eligible for HCBS



Room and Board

- Provision of:
 - Two nutritionally balanced meals a day plus snacks; and
 - Housing accommodations for rent or purchase, including costs of building maintenance, upkeep, and improvement
- Any Medicaid per diem does not include payment for room and board
- Providers must cover the minimum definition of room and board within the current maximum Federal Supplemental Security Income (SSI) after ensuring that the participants retain the PNA
- Participants are responsible for paying room and board directly to the provider
- Participants or their families may elect to pay more for a larger unit or other enhancements not covered under the minimum room and board definition (as described in bullet one above)



Supported Services

- Supported services are health-related and supportive services that support full access to and inclusion in the greater community and are customized to meet **align with the** needs and preferences of persons who reside within a housing with services establishment
- Services can be offered or provided directly by the housing establishment or by another provider



Supported Services in Provider-Owned or Controlled Settings

- **Health related services** for the purposes of preventing disease and promoting, maintaining, or restoring health. Health-related services can include, but are not limited to:
 - Attendant care services
 - Health monitoring
 - Medication oversight as permitted under state law



Supported Services in Provider-Owned or Controlled Settings (cont.)

- Supportive services meet scheduled and unscheduled needs **consistent with individual** preferences, and provides supervision, safety, and security. Supportive services can include, but are not limited to:
 - Homemaker services, including laundry and housekeeping services
 - Preparing, serving, and cleaning up after meals
 - 24-hour on-site response capability to meet unanticipated and unscheduled resident needs and to provide supervision, safety and security
 - Arranging transportation for medically necessary appointments and to other needed services to meet health needs
 - Providing and/or arranging transportation for community activities that are therapeutic in nature or assist with maintaining network of supports in the community
 - Personal emergency response system
 - Participant-focused activities appropriate to the needs, preferences, age, and condition of the individual resident
 - Assistance with correspondence and bill-paying, if requested by the resident.



Supported Services in Provider-Owned or Controlled Settings

- Supported services in provider-owned or controlled settings must provide individuals with the following basic services, consistent with the needs and preferences identified in the person-centered support plan and service agreement:
 - Health-related services in accordance with the person-centered support plan
 - Housekeeping services to provide a safe, clean and comfortable environment for each individual, including personal living quarters and all other common areas of the building
 - Laundry services to keep the individual’s clothing clean and in good repair, and laundering towels, washcloths, bed linens on a weekly basis or more often as necessary to maintain cleanliness
 - Meals in accordance with the definition of “board” in 455 IAC 2.1
 - Access to nutritious snacks on a scheduled and unscheduled basis
 - **Facilitate inclusion in** daily activities consistent with the needs, preferences, age, and condition of the individual
 - Providing and/or arranging transportation for community activities (such as shopping for groceries or snacks) in accordance with the person-centered support plan
 - Arranging transportation for medically necessary appointments and to other needed services to meet health needs in accordance with the person-centered support plan



Supported Services in Provider-Owned or Controlled Settings

- Participants' assessed need determines the additional payment provided for a higher intensity of supports
- Participants may elect to pay more for service enhancements not covered by Medicaid



Supported Services in Provider-Owned or Controlled Settings Supporting Individuals with Dementia or Cognitive Impairment

- An individualized evaluation of each individual's:
 - Past and current interests
 - Current abilities and skills
 - Emotional and social needs and patterns
 - Physical abilities and limitations
 - Adaptations necessary for the individual to participate
 - Identification of activities for behavioral interventions
- An individualized activity plan developed for each individual based on their activity evaluation that includes both structured and non-structured activities a minimum of three times within a 24-hour period, seven days per week



Supported Services in Provider-Owned or Controlled Settings Supporting Individuals with Dementia or Cognitive Impairment

Provide on a daily basis:

- Meaningful person directed activities that promote or help sustain the physical and emotional well-being of residents
- Offer opportunities for activities that accommodate variations in a resident's mood, energy and preferences



Supported Services in Provider-Owned or Controlled Settings Supporting Individuals with Dementia or Cognitive Impairment (cont.)

Provide on a daily basis:

- Opportunities for individuals to be outdoors, weather permitting, with appropriate and sufficient supervision
- Service modifications to meet the needs of the population such as:
 - Making appropriate activities available at different times of day based upon individual schedules and interests
 - Providing visual contrast between plates, eating utensils, and the table to maximize the independence of each resident
 - Providing adaptive eating utensils for those residents who have been evaluated as needing them to maintain their eating skills



Provider Certification

Providers must provide copies of the following:

- Setting floor plan
- Corporate, partnership, and ownership structure;
- Staffing plan
- Documentation in support of compliance with fire prevention and building rule commission
- Documentation in support of compliance with state sanitary code certificates and permits
- Completed supported services in provider-owned, congregate setting self-survey

Providers must complete an on-site survey within 30 days to ensure compliance and assess experience of consumers

- An on-site survey will be required for each three year HCBS provider renewal process
- DA staff maintain the flexibility to waive the on-site requirement based on successful provider performance during the previous certification period



Provider Certification (cont.)

Provide a copy of the residency agreement that addresses eviction procedures and is consistent with or comparable to applicable State and local landlord tenant laws. The residency agreement must:

- Designate a specific physical place that is owned, rented or occupied by the individual receiving services
- Ensure the individual has all the same rights, responsibilities, and protections from eviction as tenants under the Indiana Residential landlord-tenant statute
- Provide the individual notice of an intent not to renew the residency agreement, other than in an emergency, in accordance with the following notification periods:
 - If residency agreement is a month to month agreement, the agreement must contain automatic renewal language and a 45-day written notice of an intent not to renew.
 - If residency agreement is for a time period longer than month to month, the provider must give the individual at least 60 days to review any renewal agreement and a 30-day written notice of an intent not to renew.
- Provide for a set rent payment for the duration of the residency agreement



Provider Certification (cont.)

Ensure units have:

- A minimum of 220 square feet of living space including closets, excluding the bathroom. Residential settings limited to serving four (4) or fewer participants are exempted from this requirement
- Privacy in sleeping or living unit



Provider Certification (cont.)

Ensure units have access to the following in accordance with the participant's person-centered service plan:

- A bedroom or sleeping area in the case of a studio apartment;
- A private bathroom with toilet, sink, and shower;
- A living area
- A kitchen area that contains
 - a refrigerator
 - a food preparation area
 - a sink
 - a microwave or stovetop for hot food preparation



Provider Certification (cont.)

- Ensure units have access to the following in accordance with the participant's person-centered service plan:
 - The ability to control the temperature of their living unit.
 - Residential settings with certification prior to the effective date of this rule may receive an exception to the requirement to have a sink in the kitchen area. All other environmental design specifications are required.
 - Residential settings limited to serving four (4) or fewer participants are exempt from this clause.
- Develop, implement, and disclose to potential and current residents its pet policy, if pets are permitted in the setting



Provider Requirements for Provider-Owned or Controlled Settings Supporting Individuals with Dementia or Cognitive Impairment

Implement policies and procedures to assess and reduce the risk of potential hazards in the physical environment related to the special characteristics of the population. These policies and procedures must include:

- An annual written statement describing in detail how the physical characteristics of the setting have been or will be modified to promote the safety of individuals
- Procedures for addressing unsafe behaviors such as wandering, and verbally or physically aggressive behavior
- Procedures governing the transition of individuals moving in or out of the setting



Provider Requirements for Provider-Owned or Controlled Settings Supporting Individuals with Dementia or Cognitive Impairment (cont.)

- Provide an orientation and training for staff that includes information on current standards of practice and care for dementia and cognitive impairments, including a basic overview of the disease process, communication skills, emergency and evacuation procedures specific to the population, and behavioral management.
 - All staff working in the setting must complete at least two hours of dementia-specific orientation
 - All managers and service coordinators must complete an additional two hours of training devoted to dementia-specific topics



Provider Requirements for Provider-Owned or Controlled Settings Supporting Individuals with Dementia or Cognitive Impairment (cont.)

- All direct care staff must complete an additional eight hours of training on the specialized needs of the population, which may include on-the-job shadowing of more experienced employees within the first five days of employment following orientation. Topics can include, but are not limited to:
 - Promoting resident dignity, independence, individuality, privacy and choice
 - Planning and facilitating appropriate activities
 - Creating a therapeutic environment
 - Reducing safety risks
 - Dealing with difficult behaviors
 - How to partner with families and the community



Provider Requirements for Provider-Owned or Controlled Settings Supporting Individuals with Dementia or Cognitive Impairment (cont.)

- Ongoing in-service education and training on dementia/cognitive impairment topics
 - All staff working in the setting must annually complete at least two hours of refresher training on dementia/cognitive impairment topics
 - All managers and service coordinators must annually complete an additional two hours of continuing education regarding dementia care
 - All direct care staff must annually complete an additional six hours of in-service education regarding dementia and other cognitive impairments



Next Steps and Wrap-Up

- *Review minutes from today's meeting*
- *Next meeting: February 5, 2018*
- *Questions or Comments:*
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