Indiana Family and Social Services Administration

Long Term Care Transformation Stakeholder Workgroup

Meeting 2

November 6, 2017

Members and observers - please sign-in!

Welcome and Introductions!

- Round-robin of core members and observers

Agenda Overview

- Review ground rules, roles and responsibilities, timeline, and October 2 Workgroup
- HEA 1493 Report
- Moving to Action and Parameters of Initial Design
- Discussion Topics
  - Case Management
  - Supported Services in a Residential Congregate Setting
  - Secure Memory Care in Nursing Facilities vs Assisted Living
  - Person-Centered Foundations
- 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

October Stakeholder Workgroup Overview

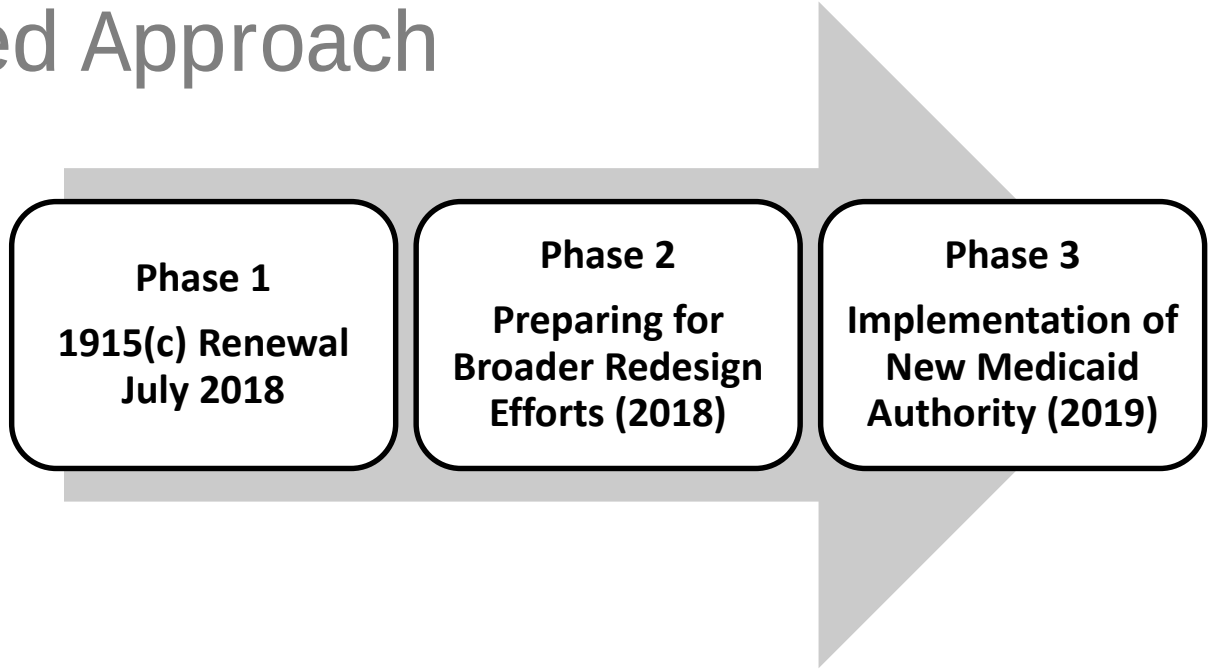
1. Availability of HCBS options related to housing and supports and
2. Availability of HCBS options related to access
3. Supporting unpaid caregivers
4. Mitigating workforce challenges
5. Reducing fragmentation within and across programs
6. Informed decision making/person centered delivery

HEA 1493 Report

Review Commitments

Moving to Action

Phased Approach



Parameters of Initial Design

- Target population
- TBI Waiver participants
  - A&D Waiver
  - CIH Waiver
- CMS HCBS Settings Rule
- Build on what already exists
- **Person-Centered Foundation**

Case Management:

What do you expect from an HCBS Waiver Case Manager?

How does that differ from A&D's current Case Management Definition?

Case Management Examples and Ideas

- Literature points to five possible roles or functions for case management: administration, crisis management, empowerment, individual advocacy, and system advocacy
- Coordination models: e.g. brokerage; clinical; strengths-based; intensive
- Directing persons to needed services, coordinating payment, empowering people to manage their own services and engaging and supporting informal caregivers (MN)
- Coordination across disabilities to ensure consistent policies and procedures (WA is focused on coordinating the system to break down "silos" not only across disability groups)
- Standards for Outcomes (satisfaction, quality of life) and Performance (frequency of plan reviews, number of face to face visits)

Case Management Examples and Ideas

- Connection to information and referral
- Support transition between settings
- Increased self-determination (mostly I/DD oriented – OR, NJ, MD, VT, NH, WI)
- Choice of case manager (MN)
- Tiered approach
  - OH: Individuals are stratified by risk; higher risk individuals have case managers with smaller case loads
  - NJ: Program CM for structured service programs vs. Primary CM for more vulnerable needs
- Caseload limit (National average: Up to 50*; Indiana ranges from 55-100)
- Time frames for assessment and reassessment:
  - VA: Face-to-face meetings every month, one must be in the home
- Incentives for high quality case management

*Based on caseload per week in home care settings: http://www.tcshealthcare.com/index.php?q=Trend-Report-7

Indiana A&D Waiver - Ideas for Integrated Medical and Social Care (Dr. Steve Counsell)

Case Manager Roles & Responsibilities

a) Send summary of service plan to PCP with contact information

b) Send quarterly and annual visit updates to PCP

c) Increase involvement in care transitions from hospital/SNF to home and coordinate with hospital and PCP office staff

d) Routinely contact home health agency PA services for updates, document status in case management notes, and include in updates to PCP.

e) Oversee PA services provided by home health agency including approval process.

f) Co-locate office of CM or Options Counselor in hospital or physician practice to facilitate collaboration and communication.

Indiana A&D Waiver - Ideas for Integrated Medical and Social Care (cont.)

Nurse Healthcare Coordination

a) Identify triggers in interRAI assessment for Healthcare Coordination (HC) nurse assessment and medical coordination.

b) HC nurse responsible for oversight and coordination of PA services.

c) Shared service plan development and periodic "huddles" by HC nurse with case managers on shared clients.

d) HC nurse is responsible for liaison and status updates with PCP

e) Engage HC nurse with waiver client to help with transitional care at time of discharge home from hospital/SNF

f) Co-locate office of HC nurse in AAAs with case managers

g) Allow Healthcare Coordination service to be provided by nurse employed by a physician group, hospital/health system, and health plan.

Indiana A&D Waiver - Ideas for Integrated Medical and Social Care (cont.)

PCP, Hospital/Health System, and Medicare Advantage Health Plan

a) Identify shared clients between AAA waiver CMs and PCP, hospital/health plan, for increased communication and coordination

b) Collaborate in care of waiver clients including having an identified AAA CM Liaison assigned to PCP, hospital/health plan for coordination of care, especially care transitions from hospital/SNF to home

c) AAA collaborate with PCP caring for large numbers of waiver clients, including providing a list of shared clients, arranging monthly care conferences with office staff, and coordination of transitions

d) PCPs, hospital/health plan provide salary support for AAA CM and co-locate CM with practice or hospital staff.

e) Provide PCP payment for team conference with AAA CM to discuss waiver clients.

f) Collaborate with hospital or MA plan care transitions program to prevent 30-day hospital readmissions of waiver clients.

g) Develop outreach strategy to engage with physician groups and health systems

h) Geriatrician, mental health specialist, and pharmacist to support CM and Healthcare Coordination nurse in care management of waiver clients.

Case Management Round Table Activity

- Service Definition and Activities
- Standards and Training
- Timeframes and Caseloads

Case Management Round Table Activity

Themes from Group Activity

If you could only add 2-3 changes to the current definition and activities, what would they be?

- Tiered case management system based upon need
- Importance of longevity and stability of case management relationship
  - Concerns with reimbursement rates, how do we reduce turnover;
  - Macro-system issues are more important than day to day of case management role
  - Case managers need knowledge to go into homes (lack of medical knowledge).
  - Do consumers know that they can request a different case manager? Can people have choice of no case manager?
- Case managers may not be providing sufficient education for informed decision making
- Tiered – minimal tier may not need quarterly face-to-face assessment?

Case Management Round Table Activity

Themes from Group Activity

Training and Standards

- Continuity of options counseling throughout their life, ensuring options counselor involved in all the steps (knowledge and skillset are often separate from case management)
- Training to empower consumer to be as independent as possible in least restrictive setting (focused care plan) – advocacy; less medical model more social side
- Technology – how technology can be brought into home
- Provider fairs to ensure case managers are aware of all providers, new resources, technology (some regions still have provider fairs, not required in contract)
- Retain flexibility of training to address localized issues
- Disability culture, aging culture

Case Management Round Table Activity

Themes from Group Activity

Timeframes and Caseloads

- Keep timeframes
- Weight caseloads to support tiering
- Tiering based on strengths of case managers
- Look more at outcomes – connecting highly trained case managers to individuals
  - For backup purposes, training and knowledge for all
  - Specialization may be challenging with geographic regions
  - Specialization may cause burn-out – some case managers may need some diversity
- Increase flexibility of what case manager can do instead of narrow windows of time for reassessment
- Difference between entry into system vs. ongoing (more stringent timeframes upon entry and more flexibility to be person-centered)
- Timeframes within control

Supported Services Across Settings

What does this look like?

What services are included?

How could DA phase in this approach?

Examples of Available Settings

Provider-Owned Congregate Settings	Participant-Controlled Subsidized Settings	Participant-Owned or Family-Owned Settings
Assisted Living	Public Housing, Section 811	Family Home
Adult Family Care	Permanent Supportive Housing	Independent Apartment

Supported Services in a Provider-Owned Congregate Setting

- Parameters of Redesign
  - Phased approach: focus on services this month, service delivery next month
  - Building on Assisted Living Workgroup (Nov 2016 – Jan 2017)
  - DA drafted a new provider rule (455 IAC 2.1)

Supported Services in a Provider-Owned Congregate Setting: Full Group Discussion

- Thinking about the concept of "supported services" with housing, what types of services could be included in this menu of services?
  - Would the "supported services" menu be the same for everyone or could individuals customize their menu of services?
- Are there features of supported services that you feel DA should pursue such as revising the definition of room and board or allowing supported services to be applied to different settings?

Secure Memory Care in Nursing Facilities vs Assisted Living:

What are the characteristics that a "community" setting must have?

Secure Memory Care State Examples

- Washington
- Oregon
- Illinois
- New York
- Massachusetts

Services and Service Planning

- Provide daily activities consistent with the functional abilities, interests, habits and preferences of the individual residents (WA, NY, MA)
- Provide access to independent, self-directed activities, individual activities, or group activities (WA, NY)
- Person-centered service planning
  - Make reasonable attempts to identify the customary routines of each resident and the resident's preferences in how services may be delivered (OR)
  - Individualized plan and activity assessment based on past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities, behavioral interventions (OR, NY)
  - Offer opportunities for activities that accommodate variations in a resident's mood, energy and preferences (e.g. individuals up at night must have access to staff support, food and appropriate activities) (WA)

Training

- Initial dementia-specific orientation and training for all staff (ranges from 2-16 hours) – IL, MA
- At least 2 hours/year of continuing education for all staff on dementia/cognitive impairment topics (MA)
- Continuing education requirements for direct care staff related to dementia, including Alzheimer's disease (ranges from 6-12 hours) (WA, IL, MA)
  - Some states specify topics for dementia-specific training (WA, IL)
- Additional training requirements for managers and service coordinators (IL, MA)

Partner Sharing Activity

Imagine that your family had a discussion with you and they want you to consider moving into an assisted living facility due to increasing memory problems and possible onset of dementia. What would you tell your family are the most important elements of a potential new home for you?

Instructions:

- Find a partner with a nametag sticker different from yours
- Decide which partner will share first. That partner will describe elements that are most important to him or her in the following areas and must be present in a new home, as well as in the provision of services
  - Physical environment and location
  - Possessions
  - People who are present (or absent)
  - Daily routines
  - Status and control
- After 5 minutes, switch partners and the other partner will share
- Remember, help your partner think about his or her own life, and not what others would want or what restrictions might currently be in place within existing services

Secure Memory Care Activity

Themes from Partner Sharing Activity	Provider Viewpoint (Risks, Mitigation)
Control of schedule (e.g. eating when I choose even if middle of the night)	Liability – responsible to family Cater to majority of individual's preferences
Pets/no pets (may not be allowed in NF)	Safety, allergies Small pets allowed for an additional fee
Quiet vs. constant socialization	Need for 1:1 supervision
Security – external and internal	Liability
Knowing individual as a person – life history	Gathering and documenting data Use of technology (Oasis)
Keep car/drive, Uber (may be harder in NF)	
Community options (e.g. hiking, kayaking), transportation to activities	Staffing
Dietary interests (comparable to NF)	Cost of food/groceries
Proximity to family/friends versus far away	
Want to bring my favorite things with me (e.g. favorite chair, blankets, pictures)	

Next Steps and Wrap-Up

- *Review minutes from today's meeting*
- *Next meeting: December 4, 2017*
- *Questions or Comments:*
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