



# Indiana Long Term Care Transformation Stakeholder Workgroup

## Meeting 5 Minutes

Monday, February 5, 2018, 9:00 am – 1:00 pm

**In Attendance:**

Core Members

First Name	Last Name	Organization
Joanne	Burke	Commission on Aging
Liz	Carroll	Indiana Assisted Living Association
Zach	Cattell	Indiana Health Care Association
Steve	Counsel	Indiana Division on Aging
Erin	Davis	Case Manager Representative (SWIRCA)
Johanna	Hensley	Adult Day Service Provider
Laura	Holscher	ADRC Representative
Melissa	Keyes	Indiana Disability Rights
Kristen	LaEace	Indiana Associations of Area Agencies on Aging
Ambre	Marr	AARP Indiana
Amber	O'Haver	Indiana Council on Independent Living
Monica	Peterson	Family Caregiver Representative
Debbie	Pierson	Indiana Division on Aging
Yonda	Snyder	Indiana Division on Aging
Jennifer	Trowbridge	Caregiver Homes

Observers

First Name	Last Name	Organization
Dani	Deckard	Divison of Aging
Emily	Cook	Division of Aging
Terry	Miller	HOPE
Michael	Bolling	Gardant
Kelsie	Duggan	OGC
James	Budden	Division of Aging
Jesse	Wyatt	Division of Aging
Amy	Rapp	Division of Aging
Jennifer	Crosbie	Seniorlink/Caregiver Homes
Chris	Myers	AAA 10
Michael	Sullivan	Alzheimer's Association
Sean	Nelson	Silver Birch Living
Rachel	Fugate	OMPP
Rick	Banas	Gardant
Murray	Moorthy	IPMG

Facilitators

First Name	Last Name	Organization
Erika	Robbins	The Lewin Group



First Name	Last Name	Organization
Kristen	Vangeloff	The Lewin Group

## Welcome, Re-Cap of January Meeting and Review of Workgroup Ground Rules, Responsibilities, and Timeline – Erika Robbins (The Lewin Group)

### Follow-Up on Commitments from January Meeting

- Erin Davis: I talked with my coworkers about removing Sociology as a Major option. The overall consensus is that we would like to keep it in. It opens up a lot more possibilities for staff.
  - Kristen LaFace: Same here, I've heard that from other AAAs as well. They hope that the new training regimen would allay some of the training concerns.
- Laura Holscher: How are we going to track the 65 max case load
  - DA: We've been working with the data and analytics team about how to report that and enable an automatic warning if a case managers are assigned to many cases.
  - Dr. Counsel: Do case managers have a choice in their clients and a choice in the diversity of their clients under various programs?
    - DA: It varies agency to agency. Right now, we're just addressing the cap on the number of consumers.
- Amber O'Haver: Following up on self-advocacy and empowerment—We talked about the case management definition and the service requirements, and we talked about adding language. I dug into a couple other states for disability across the board—not just aging. In Minnesota and a couple tether states, they looked at investing funds to develop empowerment and advocacy competencies. Strengthening their voice has shown results that have reduced rates of abuse and neglect. They can advocate for themselves. I would add “developing empowerment and advocacy capacity” as part of the comprehensive packet of services. Service requirements could be to coordinate supports for individuals to participant in community and political activism. This would definitely engage a person with their community. Not everyone wants to get into political activism, but developing their skill set and their ability to use their voice is meaningful. I found some training materials already created. There are lots of them. I can create a list. There is a leadership training that is already offered here in Indiana. It was started in Minnesota. There are lots of tool kits and self-advocacy trainings that the case managers could share.
  - Dr. Counsel: It could also be a tremendous tool for caregivers and on the medical side. Empower people to ask questions of their doctors.
  - Amber O'Haver: There was check list for the quality of care that they receive.
  - Erin Davis: I like the idea and it is definitely needed. I would like to learn more.
  - Erika Robbins: Do you see this working better for some populations? Does it need to be flexible?
  - Monica Peterson: I like it—my mom was actively engaged and was involved as long as she could be. It is also good from the side where the caregivers are not good caregivers. Give people the ability to speak for themselves right from the beginning.
  - Amber O'Haver: Another article I came across about “meeting people where they are” and how case managers can empower clients to meet their goals. Seniors can



sometimes be resistant to change—how do you motivate them to speak up for themselves? It is generational and cultural, and depends on personality.

- Erika Robbins: Perhaps if there were some expectation, then at least case managers would have the tools.
- Kristen LaEace: A while ago we talked about developing participant rights and responsibilities – the participant rule.
- DA: Yes, the participant rule.
- Erika Robbins: It fits nicely into person centered planning and thinking. You really need people that live it every day to be the advocates.
- Amber O’Haver: The most success was when peers were leading the training.
- Erika Robbins: They’ve found that on the MFP side too—the peer piece is so important. Empowering people in any environment and any setting.

## Transportation Discussion

Erika Robbins gave an overview of the stakeholder survey feedback on transportation (slide 10), medical and non-medical transportation (slides 11-13), and state examples (slide 14).

Group discussion:

- Laura Holscher: You can’t choose this transportation on the waiver, it doesn’t show up on the pick list. It isn’t currently a choice. It is easier to use your attendant care for this—you already know you’re attendant care person. It is just easier to use it under attendant care escort.
- Erin Davis: The service disappears from the pick list once you select a county and waiver. The CCB is unclear. There is no definition. I’ve tried reaching out to providers to see if they knew if there were on the pick list—I got no response.
- Erika Robbins: Why do you think those challenges from the survey exist? Do you think that they are real?
  - Erin: Yes, very much. Attendant care won’t cover all the transportation needs, maybe only during the week or just on the weekend. Rural areas especially can take a long time to get to appointments. Public transportation is unreliable and not timely.
- Erika Robbins: What are some of the fixes that could improve access?
  - Dr. Counsel: Some health plans are starting to contract with uber or lyft.
  - Kristen LaEace: Yes, some CBOs are doing the same thing. The rate is an issue in some areas.
  - Laura Holscher: A couple providers I talked to didn’t think it was worth the cost to be a non-medical transportation provider.
  - Erika Robbins: There is a lack of specificity—is the rate for one trip or ten?
  - Debbie Pierson: The lack of specificity may help providers. It is just supposed to follow a written service plan. The case manager would negotiate that and document it in the service plan. \$233 a month for unassisted, \$452 for assisted.
  - Dr. Burke: There is a county that doesn’t have any Medicaid transportation providers. They are a little worried about how the money flows. They don’t want to get involved with the state and jump through all the hoops.



- Amber O’Haver: What kind of liability do providers have? I hear that it is too much liability and too many hoops.
  - Debbie Pierson: I’m not sure what it is off the top of my head.
- Liz Carroll: In other states, it is within the per diem.
- Johanna Hensley: Insurance is expensive and we even use a carrier that specializes in non-profits and adult day.
- Zach Cattell: Commercial clients are severely impacted by any small speeding infraction.
- Amber O’Haver: That’s what is so great about uber and lyft. Lyft especially. They have to cover the insurance and they can’t turn away anyone with a chair or service dog.
- Melissa Keyes: Legally they can’t, but we hear about drivers not being educated on rights.
- Debbie Pierson: There is an obligation there to make sure that providers do have the appropriate regulations when transporting vulnerable populations. We have to find the balance between regulations on providers vs protecting the populations we serve.
- Kristen LaEace: For uber and lyft, the individual drivers have to be covered by insurance. It would be difficult under Medicaid to get the payments working. It might be easier under self-direction or cash and counseling.
- Dr. Counsel: Medicare Advantage plans have it.
- Debbie Pierson: Using informal supports and connecting people to volunteers that can drive—there are some innovated things going on in other states. I think Kristen shared something recently on this.
- Erin Davis: My grandmother in MA was part of a volunteer ride sharing activity that works very well.
- Kristen LaEace: In the CHOICE and Commission on Aging packets—over the last year, I Have shared 2-3 articles about groups using uber and lyft.
- Debbie Pierson: In a rural California community, they have a co-op where you can bank hours of volunteer time that they can then draw from later. It’s a whole movement in community development.
- Erika Robbins: States that regionally base it have more success because they can figure out what their specific needs are, rather than coming from the state down. I was curious about the county by county problem?
  - Amber O’Haver: The provider won’t cross the country line.
  - Debbie Pierson: It has to do with how they get their grants.
  - Kristen LaEace: Rural transportation money or whatever bucket of money they get comes with these rules. SARCOA got a federal grant that allowed them to coordinated regionally. Each transportation provider has their allotted area. If the ride is being provided by a public transit system, they are limited to their planning area. An individual provider wouldn’t have that same barrier. But there isn’t a supply of those providers.
- Laura Holscher: We have one that came about to provide transportation to their adult day service clients. Those are their priority. They are struggling to find drivers that can pass. They approached me about sharing the meals drivers.
- Kristen LaEace: On the state plan side, that would be more consistent use.
- Erika Robbins: In MA they tried to build rates that align with state plan and waiver in order to expand their options. Are there tweaks that DA should consider?



- Dr. Burke: It seems like there should be some flexibility. There are differences between geographical areas and the different counties. One size won't fit all if it is rigid—not only about rates, but think about what is possible in these different areas. In some places, there is no public transportation, no Medicaid providers. It is nice to think about volunteers, but there are problems there too—these areas are very conservative and don't want to get involved with government.
- Amber O'Haver: How are providers and drivers marketed to?
  - Erin Davis: Yes, for the assisted you can't even add it on the CCB because it isn't on the pick list. And the ones that are—the providers never responded. The providers need to be made aware.
  - Debbie Pierson: We think part of the problem is that some counties have no providers.
- Amber O'Haver: It would be so great to be able to reimburse friends. If there was some flexibility and a budget amount. They would be much more likely to utilize transport.
- Dr. Counsel: Is the current system flexible, but just not being used? Doesn't it need more specificity on the number of trips?
  - Debbie Pierson: I think the lack on specifics was intended to make it flexible. In theory, the providers would take people with a variety of needs so that it balanced out (2 trips for some vs 10 trips for others).
  - Erin Davis: If there was a ticket system where they turn in their tickets. If you had a "TRIP Ticket program," but have the AAA be the contracted provider, maybe it would take away some of the liability issues. Right now there is a "TRIP Ticket program" under Title III in existence where tickets have a monetary value and are turned in to providers which the providers then turn in to the AAAs to get reimbursed.
  - Laura Holscher: In some really rural areas, it is really hard to convince people to make the trip. So maybe paying for the tickets that can be paid to a friend or relative?
  - Debbie Pierson: For pest control and nutrition, we sort of do this. But there are issues when the case manager is independent and not comfortable with using the AAA as the contractor. Some AAAs have refused to serve clients that aren't theirs.
  - Observer: Medicaid pays it as a range (5-10, 10-15, etc.).
  - Debbie Pierson: What Medicaid does or does not hear is a bit masked because people are using attendant care for something it wasn't intended for.
- Erika: Should attendant care include it more deliberately?
  - Debbie Pierson: We've talked to those providers that are transporting under attendant care, but they don't want to sign up to be transportation providers—liability and other issues.
  - Dr. Counsel: If they sign up as a transportation provider, can they limit to just their clients under attendant care?
  - Erika Robbins: Other states use the financial management service provider as a conduit to pay uber or lyft. They process it like a good or service. Similar to a consumer-directed third party administrator.
  - Dr. Burke: That flexibility across the state would be great. There are more rural states than Indiana – what do they do? And these rural areas are older too. This is critical.
  - Dr. Counsel: On the health care side I see this too. It is best to have someone to do curbside to curbside—we need people to help with steps and walkers.



- Laura Holscher: Yes, with the attendant care or using a friend for neighbor, they are likely to help them get into the house.
- Amber O’Haver: Yes, it is the drivers that are unfamiliar with the person and that there is an issue with pick up and drop off.
- Yonda Snyder: This is an issue that transcends Medicaid. We’ve identified transportation as a focus area on our state plan on aging. We are looking at how DA starts to facilitate this in our communities. It is in the four year plan.
- Erika Robbins: Do you know who to talk to in your communities about transportation? The CILs do it in some states.
  - Amber O’Haver: No they are not doing it here. But there are other organizations that do that. Alliance for Health Promotion—they have a whole transit and disability network, Health by Design.
  - Erika Robbins: You have to have a very focused, multi-prong strategy. I think this conversation has brought up some ideas for research. Advocacy and building it out in the local communities is really important. Models that would work.
  - Ambre Marr: We have not seen Health by Design solve the problem. It takes a lot—can’t rely on that solely. How do you have agency input from agencies that are tasked with so many other things? The capacity is so hard. We ran into this when we were building the coalition for transportation in Marion county. While we would love to have interagency cooperation—people look toward the agency that is providing the money. Transpiration is such a huge need. Individuals that come to our conference say that it is a provider shortage, there isn’t an option at the AAAs. What is the actual issue? I think it does come down to rates and reimbursement, but I don’t have the data.
  - Amber O’Haver: We need a web within the states, community partners. We need to come together to solve problems.
  - Erika Robbins: We need the advocacy at the local level to be the voice.
  - Kristen LaEace: If the reimbursement rate were high enough, there would be plenty of providers. Need to account for the liability hassle.
  - Dr. Burke: How do we get local providers interested in showing up? We do that with money and by making it less burdensome on them. What about the school buses that sit there idle for most of the day?
  - Debbie Pierson: We had an intern look at school buses—there was no administrative or legal barrier that would prevent the use of school buses to provide transportation.
  - Monica Peterson: Is there anyone looking into for-profit transportation and see if they can do it as part of their charitable contributions—tax breaks? They have to do a certain amount of charitable contributions. It looks good for them.
  - Dr. Counsel: What about other states?
    - Erika: All states struggle with this, especially rural states. States that are farther ahead have more alignment between state plan and waiver and have regional methods. And agencies band together—not aging vs disability. An allied coalition.
  - Erin Davis: Even the entities that are available, if they have maintenance issues then the entire route is down.



- Ambre Marr: It has been a struggle to get people to talk about improving transportation—if they money isn't there, they don't want to pay more taxes.
- Yonda Snyder: Indiana's culture is not built around public transportation.
- Ambre Marr: My part of Indianapolis is on an hour loop for public transportation. If I miss one bus, I'm waiting outside for an hour to get the next one.
- Erin Davis: This is where cash and counseling would work. Shift the focus away from attendant care being a band aid.
- Debbie Pierson: This seems to be an opportunity to come back to having a supported services package and then the consumer can go and decide what they need to buy.
- Amber O'Haver: It puts the control with the consumer.
- Debbie Pierson: Yes, but with the counseling piece and the case management to guide you through the Person Centered Planning process. People don't always know what they can buy, how to put together a plan.
- Ambre Marr: Would they be able to use that money how they choose?
- Debbie Pierson: Yes, that's my understanding. There aren't a lot of cash and counseling models around. CMS is open to it and open to experimental proposals right now. It can help the state have some predictability in cost too. It is a determined pot of money and the state knows exactly how much it will cost for the month. Medicaid making that ideal case management piece available is critical. And that's the piece that people would never buy for themselves. That is the piece that we need to provide.

Erika Robbins provided research and information on Non-Emergency Medical (slides 18 and 19)

- Erin Davis: Sometimes people can get approved for additional trips through the PA – over 20 trips. It is acknowledged in the service plan to use Medicaid cab to get to doctor's appointments.
- Dr. Burke: It is more than 25 miles to certain health systems, especially in rural areas.
- Erika Robbins: We aren't sure how this is accessed if the person's needs are more than 15 miles.
  - Laura Holscher: They have to find another way.
- Erika Robbins: Is there a way to have the waiver wrap around or add on?
  - Kristen LaFace: I feel like we're doing the same thing with attendant care by asking this question. It is just a band aid. This is the problem with Medicaid—how often have they been talking about this.
  - Debbie Pierson: They have been talking about this a lot –they are getting a new contractor in May that will coordinate with all the sub-contractors. Many states do the coordination like this. In theory, it should eliminate some of the fragmentation.

## Dementia and Cognitive Impairment within HCBS

Erika Robbins reviewed findings around Dementia and Cognitive Impairment (slides 22-24)

- Dr. Counsel: The worse your cognitive impairment, the more other medical conditions a person is likely to have. You need the holistic approach to care for people. It isn't like if you have heart failure and that's all you've got.





- Monica Peterson: A lot of times the caregivers themselves are not well. Even if they are well, they have diminished health because of the caregiving that they provide. The caregiver needs to take care of themselves in order to keep caregiving.
- Jennifer Trowbridge: Serious coaching is needed for caregivers who provide care to people with dementia. We just implemented a new pilot program based on this need.
- Monica Peterson: I was in a situation where I sought out training, but a lot of people don't know that it is there. We needed it for my mother's complex medical complications. The training really helped.

Erika Robbins directed attention to the State Alzheimer's Disease Plans handout in the packets and covered the information on slides 25-28.

- Erika Robbins: There is a component in the waiver that should be Alzheimer's focused. How can we embed this in a future waiver?
- Kristen LaEace: What does in-home look like? Do they just bring someone in to provide care?
- Erika Robbins: Yes, think of it like how babysitting is done in the home.
- Debbie Pierson: On the waiver, there is home health and nursing respite—have to make sure that it doesn't duplicate state plan.
- Dr. Counsel: I know a couple that took on the wife's parents and they feel trapped—they can't go anywhere, the parents need almost 24 hour supervision. Would something like this kick in? If they are on the waiver?
  - Erin Davis: Right now the NF is the option is someone needs respite for a full weekend (full 48 hours) unless they can come up with it through formal and informal supports.
  - Dr. Counsel: It can be very disorienting going into a facility.
  - Debbie Pierson: They could use all of their hours to do a week for a vacation, but that would take up a lot of their hours.
- Erika Robbins: It is state-funded in WV and CT, which is interesting. It has to be a priority.
- Dr. Burke: An older person gets an assessment by a physician and gets a diagnosis. Medicare treatment protocol for a diagnosis of some type—what protocol is followed?
  - Dr. Counsel: Medicare would cover the lab tests and appointment, head scan if they need it. But it wouldn't cover any caregiver needs. We need more of our community based services tied in with the medical care. Flag the caregivers for attention.
  - Erin Davis: The Alzheimer's Association is trying to get into medical offices to make sure folks are aware of what is available.
  - Dr. Counsel: We need a better connection between the care manager and physicians to work together.
  - Dr. Burke: Yes, the health coordination.
  - Erin Davis: It would be nice if there was a service part of the support plan that focused on the caregivers so that caregivers feel like they can get to the trainings and get those opportunities. We send a couple people to the two day conference in our area and made sure that there was coverage.
  - Kristen LaEace: What are we trying to do?
    - Debbie Pierson: There are things in the 1493 report, caregiver support for less than NF LOC—caregiver support is a pillar.





- Liz Carroll: We have folks in the room from Illinois that know what they are doing in dementia service. Can they speak about it?
  - Observer (Gardant Representative): In Illinois as part of the Supported Living Program (Medicaid waiver for elderly in AL), there is a higher reimbursement rate for serving dementia and special memory care. We have one community in South Illinois that is interconnected with the AL Medicaid Waiver standard program. The couple lives in the AL—the husband in the regular AL and the wife lives in the memory care side. They both get the services that they need and he is able to visit her without having to walk outside. He has his own apartment and gets the services that he needs. The state is looking at expanding this.
  - Liz Carroll: Is there respite?
    - Observer (Gardant Representative): Not at this point in time. I remember talking to one person who said that their ability to bring my wife into the respite program a couple times a week is what keeps me going. Otherwise I have to sit with her 24/7.
    - Observer (Michael Bolling, Gardant): We offer respite care, but the time it takes to get through the whole Medicaid set up—it is pretty strenuous for someone who just wants some intermittent respite. It can take up to 90 days.
  - Liz Carroll: What about the option of having respite in an AL rather than a nursing home? They might feel more comfortable in an apartment with 24 hour staffing and then wouldn't have to go through as strenuous of a process. Or maybe the cash and counseling model?
- Johanna Hensley: We do a lot of dementia care training. Most is in house. Well over 50% of our clients have some dementia or Alzheimer's. Probably close to 80%. We have a variety of payers, CHOICE, Medicaid, private pay, some LTC insurance. We have a lot of participants that are on the Medicaid waiver. We strongly encourage them to get on the waiver if they are eligible. Adult Day takes care of a lot of support, but there are quite a few cases where it would be helpful to have some more support for families.
- Erika Robbins: is the adult day used to help the sandwich generation caregivers and maybe the older caregiver to get the respite?
- Johanna Hensley: It is a mix, but I would say the majority have a spouse caregiver that is older too. We have spouses that just don't get it—they don't understand that they aren't doing it on purpose.
- Dr. Counsel: Attending to the caregiver can so much improve those on the waiver. And caregiver strain is the leading cause of nursing home placement. A lot of it may be more of a medical respite rather than social support.
- Kristen LaFace: Does respite cover caregiver training? Does that need to be clarified? I know some groups around the state that are starting to specialize in Alzheimer's training that are evidence based.
- Erika Robbins: When you run up against the families that don't understand, what do you do?
  - Johanna Hensley: We coach them. We have caregivers come in that are completely frustrated because mom is wearing the same outfit every day. We help them with the basics and we help them choose their battles.



- Dr. Counsel: Some component of that should be the waiver care management. They should have that knowledge and skill.
- Laura Holscher: That is intense case management—when we talked about the different levels of case management. We have found that is how we primarily spend our Title III E money—coaching around dementia. It teaches the caregiver how to use their respite. They feel bad about using it. Historically, the utilization has been really low. Counseling and coaching has made a difference. It takes a lot of time. Caregivers don't want to lie to their loved ones, but then they are causing them to relive their grief over and over again.
  - Johanna Hensley: We call it entering their reality.
- Dr. Counsel: We need to bring the bar up because it is so common.
- Monica Peterson: I like what Laura said about more intense care on the care management side. If the care manager can start on the entry level and build up the willingness to learn. They need it before the illness progresses. Tell them what is going to happen and when they will need help. The respite is a little scary for their loved ones.
- Erin Davis: Or if they have a provider that worked really well and then they leave—they don't adapt well to another provider.
- Johanna Hensley: There are a lot of different levels of adult day. Caregivers ask me if they can still come to adult day if they are on respite. Well sure, but Medicaid won't pay for it. We don't want them to get out of their routine though, because it is extremely important. We try to work with them to figure something out.
- Erika Robbins: Are there models where respite is hourly rather than daily to help accommodate?
  - Kristen LaFace: Is this something we could take to Medicaid in order for them to be dementia capable?
  - Erika Robbins: But the services you want to wrap around are waiver.
  - Debbie Pierson: Once you go into a nursing home, then you are in an institution and not HCBS anymore.
- Amber O'Haver: You want things to stay consistent and you want them to stay in their home.
- Dr. Burke: How wide spread are day services throughout the state? Can we incentivize that?
- Yonda Snyder: We put that in the 1493 report as a service we want to see expanded. We don't know yet what the barriers are to the establishment of more adult day. We've had several open in the last couple of weeks.
- Johanna Hensley: We've tried all kinds of marketing. Unless you are in a place that you need it, it is one of those commercials that goes in one ear and out the other.
- Dr. Burke: We got so used to defaulting to nursing home care.
- Amber O'Haver: There is a culture shift.
- Yonda Snyder: There is a chicken and egg thing going on. What comes first, the demand or the providers? How can we help match that up?
- Dr. Burke: The VA system is a pretty big player in this.
- Kristen LaFace: What is the distribution in adult day between non-profit and for profit?
  - Debbie Pierson: More are for profit.
  - Johanna Hensley: Ours is non-profit, but we are one of the longest running.
- Erin Davis: Can days of respite at home be covered like attendant care—like a package of days that can be utilized? Coverage across hours with a higher rate?



- Dr. Burke: I've been working with the Purdue Extension and their Healthy Communities—we're trying to get them to work on older adults. They do family caregiver training, but they aren't hooked up with the right partners, like the AAAs.
- Erika Robbins: Does anyone have any other interesting ideas from the Alzheimer's handout?
  - Kristen LaEace: Florida talked about creating an Alzheimer's specialized adult day license. I guess we already have our own levels.
  - Erika Robbins: It is important that it is culturally competent care.
  - Kristen LaEace: A number of states are tying into the Dementia Friendly Communities initiative. Are you doing anything on the state plan about Dementia Friendly Communities?
    - Debbie Pierson: It is on the list of goals.
    - Yonda Snyder: We haven't fully fleshed out the specific objectives and strategies yet.
- Amber O'Haver: Financial incentives to keep loved ones at home—it is unusual compared to everything else that I've seen.
- Kristen LaEace: I know you are looking at putting things in A&D waiver, but what about a specialized Alzheimer's waiver? For this respite service, we want them to go into a NF briefly for respite, but still be HCBS. Can CMS approved this specifically for a dementia waiver?
  - Yonda Snyder: The trend is moving away from specialized waivers towards more integration. But there are conversations that we can have at the state for flexibility.
  - Erika Robbins: There are ways to construct services for people with dementia.
  - Debbie Pierson: There could be specialized services for people with dementia to facilitate community integration.
  - Erika Robbins: In Washington state, they added it to the nursing home benefit which benefits them by getting the community inclusion benefits.
- Erin Davis: Knowing what is out there and what is available is important.
- Kristen LaEace: In Washington they talk about telehealth and web based resources. This could be great for caregiver coaching—see what the behavior is without having to be in the home.
- Jennifer Trowbridge: Is there something that could be offered to support the spouses if they aren't using the adult day services?
- Observer: I know that Delaware is working on expanding respite. For Structured Family Care—add the spouse component to keep the caregivers going.

## Outcomes and Quality Discussion

Erika Robbins went over Quality from a Federal perspective on the 1915c waivers (slides 31-36). She explained that ACL is looking at Days at Home (slide 33) at the national level as it creates another measure besides diversion and transition. CMS is looking at healthy days at home as an expansion of the concept of community tenure, similar to days at home. It has a broader applicability.

- Liz Carroll: How do you establish a baseline for the expectation of how many days should be at home?
- Dr. Counsel: I think you might look over time for trends—see which way the state is going.



- Erika Robbins: What other Quality Measures could be included in DA's Waivers? What is missing from Indiana's list?
- Debbie Pierson: We have the NCI-AD that we started three years ago that replaced what was the Participant Experience Survey with just a sample of the waiver population. NCI expanded to include non-waiver and NF, but still just a sample. We do compliance interviews by a third party who talks to the participant, talks to providers, looks at records, does corrective action plans. We rely very heavily on the 90 day reviews by the case managers for the data that we give to CMS. Another one is our provider certification and enrollment process. There is a fairly robust process that we go through on their policy and procedures. We do provider compliance reviews every three years on unlicensed providers. ISDH does the review of licensed providers, but we probably should do more. We are overhauling that process to be more outcomes driven. We pull employee and consumer charts. Medicaid through FSSA audit, does oversight and monitoring, and then incident reporting, which is fairly robust compared to other states. It is fully automated and online. We know there are empty points. We have finite resources and capacity. What can we streamline and simplify?
  - Dr. Burke: Is this more of a summative assessment?
  - Debbie Pierson: It is a similar thing to the days at home—there is a log. We have a lot of leading indicators—providers are doing this, case manager are doing this. We can go in and fix, but we don't really have the outcomes.
  - Kristen LaEace: With the revamp of the provider system, are you also looking at general network adequacy?
  - Debbie Pierson: There are some important measures in there that we don't currently track—like utilization rates. We are working on getting to the point where we can look at trending and geographical variance and can be more deliberate in provider recruitment.
  - Dr. Counsel: Is the same cut out used, 86% and you're good?
  - Debbie Pierson: Yes, that's the CMS threshold. And that's a disincentive to put in anything new and interesting. We don't want to look bad.
  - Yonda Snyder: There are challenges—we want to be innovative, but there are challenges.
  - Dr. Burke: Is the purpose more than just giving a report that is acceptable to CMS? That doesn't necessarily have to be part of what you send to DC. We can have more than what we send to hold ourselves accountable.

Kristen Vangeloff described the logic model approach to developing robust HCBS outcomes by looking at inputs, activities, and outputs that go towards short, intermediate, and long term outcomes. The stakeholders and observers then participated in a logic model exercise for the components of Indiana's HCBS system.

### Next Steps for a Stakeholder Advisory Group

- Erika Robbins: Thinking back on these LTC Stakeholder Workgroup meeting, what do you think worked well and what could have been done better?
  - Jennifer Trowbridge: We need attachments with more lead time in order to prepare better.
  - Kristen LaEace: I would read stuff ahead of time if it were available.



- Laura Holscher: I would have liked to know more about the logic model in advance – I know it was in the slide deck, but I would have liked to have known the specifics about the logic model.
- Erika Robbins: Did you like coming together in-person?
  - General consensus was that in-person is preferred.
  - Monica Peterson: I would like the option to dial-in on days that I couldn't make it in-person.
- Erika: Were the right people here?
  - Amber O'Haver: More people with disabilities and some elderly representatives would be good.
  - Monica Peterson: I would say more diversity and somebody from the faith based community.
  - Dr. Burke: It may be hard to get down to this in-person meeting. We might be able to have some input from people receiving services by using technology—skype them in. Case managers could set that up. Give them an option to bring things up and respond to questions.
  - Amber O'Haver: Maybe bring some people here for one of the meetings.
  - Dr. Counsel: Yes, like transportation providers
  - Kristen LaEace: We had a lot of Medicaid policy questions. It might have been good to have someone from OMPP be more engaged.
  - Amber Marr: There are a lot more people that have to come together for change—those people were not in this room.
  - Laura Holscher: It is hard to manage a group this big and you've done a good job!
- Erika Robbins: What about timing?
  - Monica Peterson: I would prefer every other month.
  - Amber O'Haver: There is so much content, you have to meet at least once a month.
- Erika Robbins: What do you see as your role in an ongoing advisory group?
  - Monica Peterson: We want to continue in this, but be more focused on how this impacts caregivers.
  - Zach Cattell: I would like more recaps in case you missed something. We need more next steps—we can be given assignments.
  - Amber O'Haver: We could do assignments if we met every other month.
  - Kristen LaEace: It seemed like there were some specific products that DA is working towards (renewal, service definitions). When we have time to focus down, we were productive in that. We could see that feedback reflected and that was appreciated.
- Yonda Snyder: Thanks to all the stakeholders and observers for your participation.
- Debbie Pierson: It has been our intention to start up an advisory group that is ongoing with a diverse group of stakeholders. Once this group got going, we thought that this is probably it. We'll figure out a schedule, technology, who else to invite. And we'll work on figuring out how to get Lewin-level help for future groups.
  - Zach Cattell: I would bring the group together at least quarterly.
  - Amber O'Haver: Offer us a reasonable accommodation.
  - Monica Peterson: Maybe you can look at partners in the community for hosting that is easier to get to.



- Debbie Pierson: Some groups do rotate where the meetings are held.
- Dr. Burke: I appreciate the Division of Aging stepping out and talking to the Commission on Aging. The issues we are discussing aren't going to go away. The broader the engagement and input, the better. Let's keep reaching out. This is new. We've got huge issues we are facing. We can do it, but it's not going to be fixed at the end of this meeting. I appreciate your willingness to reach out. We're a bit behind in this state.