



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Benefits Collaborative Meeting: EPSDT Personal Care

Monday, January 13, 2014

10:00 a.m. – Noon

Department of Health Care Policy

225 E 16th Ave, Denver

First Floor Conference Room (moved to Basement Conference Room)

Notes

Facilitators:

- Kimberley Smith, Benefits Collaborative Manager, Department of Health Care Policy & Financing (HCPF)
- Meredith Henry, Children's Policy Specialist, HCPF
- Guinevere Blodgett, Home Health Specialist, HCPF
- Dr. Judy Zerzan, Chief Medical Officer, HCPF (on phone)

Welcome

Kimberley Smith, Benefits Collaborative Coordinator with the Department of Health Care Policy & Financing (Department) began by discussing some phone technology issues and then invited participants to introduce themselves.

Kimberley then reviewed the ground rules for this and future Benefits Collaborative meetings, they include:

- Tough on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/vibrate
- On the phone: Please mute your line
- Please introduce yourself when asking a question or making a comment

Kimberley provided her contact information Kimberley.smith@state.co.us 303-866-3977, to which participants can address their future questions and suggestions. She also reminded participants that the call is recorded and that the recording and this transcription are both posted to the Benefits Collaborative web site.

Benefits Collaborative Overview

Kimberley then briefly reviewed the concept of a Benefits Collaborative. She explained that the purpose of the Benefits Collaborative is to create a benefit coverage standard, which is the term the Department uses to refer to a benefit policy. She explained that The Benefits Collaborative is a process, not just a meeting or series of collaborative meetings; it begins with the drafting of a policy and becomes standard practice once the Medicaid Director signs it, after much public input.

Frame for Today's Discussion

Kimberley provided a quick overview of recent happenings within the Personal Attendant Tool (PAT) Stakeholder Feedback Meetings (which Kimberley referred to as the "Home Health Meetings"), last held on January, 2nd.

The Department is developing a temporary Personal Care Standard, so that there is something in place shortly after the PAT is implemented, to limit possible gaps in service. The Department collected feedback on the temporary standard at the PAT Stakeholder Meeting on January 2nd. As she did on January 2nd, Kimberley informed the group that CMS did not give the Department a timeline by when the Department needs to provide personal care but we recognize that time is of the essence. She then repeated that the Department also recognizes that robust stakeholder input is key to the success of any long-term personal care policy solution.

Today's meeting, and a second meeting on February 10th, are set up so that stakeholders can work through the draft standard in a more considered fashion, gather many more points of view and arrive at a standard that will work in the long-term.

In this process, participants will look at the EPSDT Personal Care Standard and also the associated Personal Care Assessment Toll (PCAT). Today, the focus is on the standard.

Kimberley noted that no changes had yet been made to the draft policy since the January 2nd meeting – due to lack of time – but that all questions and suggestions were captured and changes will be made between the first and second Benefits Collaborative meeting; she gave several examples to demonstrate that participants had been heard.

Draft Coverage Standard Discussion

Kimberley began by reviewing – for those who were not part of the January 2nd meeting – some of the various comments made in that meeting with respect to pages 1-4 of the standard. Discussion on January 2nd included – but was not limited to – the following topics:

- The standard addresses four of six activities of daily living (ADLs).
- The Department is working with CMS on exactly how to define Medical Necessity for this particular benefit – no word yet on when CMS will provide follow-up.
- Personal Care Services shall be provided in writing by a provider as part of a client’s written care program and there is need to identify how this will actually work in practice.
- Current rules don’t allow a personal care worker to be providing services when a skilled care worker is also there providing a skilled transfer; currently the draft allows for this and this discrepancy will have to be reconciled.
 - The Department’s intent is not to have two people in the home at all times, but to have one person in the home based on what the needed skill level is. That said, there may be situations where there could be two workers in the home at the same time... such as instances when a skilled worker comes in to bathe the client, but there is a personal care worker there all day to help with unskilled tasks. This is an area to work through.

COMMENT – Gary Montrose with Colorado Long-term Assistance Providers (CLASP) repeated the request he first made on January 2nd that the Department work with CLASP to ensure that the policy does not prohibit the execution of a grant funded pilot currently in the planning phases. The pilot in question would allow a personal care attendant, a professional from a home health agency who specializes in Long-term Services and Supports (LTSS) Community Based Services worker and a nurse practitioner to meet simultaneously in a person’s home to provide care coordination services. The idea is to test and promote the person-centered medical home model within in a person’s home. Gary made the request that, if the Department is not yet ready to write a general rule than, at the least, grant an exception so that the pilot can get off of the ground. The Independence Center in Colorado Springs, along with their associated Regional Care Collaborative Organization will be involved in the pilot.

RESPONSE – Kimberley confirmed that the Department has made a note to connect with Gary on this issue and thanked him for his comment.

COMMENT – David Bolin with Accent on Independence stated that he cannot stress enough that the language as currently written in the last paragraph of page four necessitates that the Department look at the Conditions of Participation for Medicare for a home health agency and Colorado state rules on governing – which state that you cannot have two providers in at the same time. Personal care rules say that Certified Nurses Aids (CNAs) cannot be in a home within two and a half hours of a personal care attendant. There will have to be rule changes in that area in order for skilled agencies to be interested in this program.

It is very important that things be done in the right way. Program Integrity needs to be involved, as does the Colorado Department of Public Health and Environment (CDPHE) because agencies get surveyed on exactly these types of things and CMS could put a condition on a skilled home health agency.

COMMENT – George Lyford with the Colorado Center on Law and Policy (CCLP) commented on the current drafted policy which states the client must demonstrate a need in at least four areas of activities of daily living (ADLs). He believes this is contrary to the intent of EPSDT, which requires that all medically necessary services be provided. He provided the following example: if a client were to demonstrate needed assistance with 3 ADLs (dressing, feeding and ambulation) this standard would say they are not medically necessary because the client doesn't demonstrate need in a fourth area. Whereas, if that same client were able to demonstrate a need in toileting, then all four areas would qualify as medically necessary.

George appreciates that the Department has reached out to CMS for guidance on this; to the extent that guidance is not forthcoming, George encourages the Department to rethink this fourth area and make it one area. He invites discussion around potential ways to combine services so that there aren't unnecessary visits but that makes sense for the client.

COMMENT – David Bolin with Accent on Independence brought the group's attention to the bottom of page three, where it states "documentation of each billed visit shall include the location where services were provided." He asked if this statement is inclusive of services provided in the community, as per CMS requirement that don't allow Home Health to be limited to the home.

RESPONSE – Guinevere Blodgett confirmed that services cannot be limited to the home and will be provided in the least restrictive environment.

David suggested adding language to this effect because CMS has given guidance to all 50 states stating that services cannot be limited to the home but, as yet, he has not seen this directive implemented in Colorado.

Guinevere directed the group's attention to page two, where it states "Personal Care Services are provided in a client's place of residence or outside a client's place of residence, when activities of daily living take the client outside of their residence.

David noted that this takes care of this standard but should be included in other Home Health standards. If you have it in one but not another it causes confusion.

COMMENT – Gary Montrose with CLASP made a general comment that, where applicable, each of his comments hold true for all Home Health standards, not just the EPSDT Personal Care Standard.

Gary then asked for a definition of what is meant on page three, under General Requirements, where it states in the second to last bullet “provided on an intermittent basis”. How might this effect people with a chronic condition that is not going to be resolved over time?

RESPONSE – Dr. Zerzan first noted that the scope of this discussion is limited to the EPSDT Personal Care benefit. She acknowledged the desire expressed that services be provided in the community as part of other benefits but that discussion is happening elsewhere.

To the “intermittent” comment. We have received this feedback previously and it’s on our list of things to change. By “intermittent” we mean it is not continuous (i.e. 24 hours a day – which would probably require private duty nursing). It does not mean “intermittent” as in “you only get it for a month.”

Gary responded that his organization would be interested in something along the lines of medical necessity. It could be that, in an acute crisis, a client may need services every other day for a week or a month (in order to prevent, for example, skin lesions leading to a \$100,000 medical problem), it could be that they just need a visit once a month for a year. His organization is trying to do the most with the least resources, so setting the language up in a way that allows our organization to do its job would be helpful.

Dr. Zerzan understands and is open to looking at how to word this differently.

George Lyford with CCLP noted that, in the Definitions Section, “intermittent” is defined as having a “distinct start time and stop time and is task oriented”.

Kimberley noted several heads in the room nodding in agreement to the definition as written.

COMMENT – George Lyford also noted that, throughout the document, the term “non-medical” is used and, as he has suggested previously, he would like that changed to “personal care services”, so that there is no confusion with the fact that clients must still meet a medical necessity standard.

RESPONSE – Dr. Zerzan agreed and noted that the Department is working on a list of responses to the letter George provided in December.

Kimberley invited the group to review the Activities of Daily Living section of the draft standard, beginning on page five with Ambulation and Locomotion. She invited general comment. Guinevere added that globally, where these tasks are concerned, the Department to the personal care information from the Colorado Department of Public Health and Environment (CDPHE) Chapter 26 – what they refer to as “non-medical care”.

COMMENT – Jeannette Jansson with the Department asked that, instead of using the term “as ordered by a qualified physician” we use the term “provider”, since Medicaid reimburses various provider types. This would allow for language consistency throughout the document.

RESPONSE – David Bolin with Accent on Independence stated that it does need to say “physician” because the Conditions of Participation for Medicare agencies require that all doctor’s orders to be signed by a medical doctor and not by a PA or nurse practitioner. He believes it is important to be clear on this so that we don’t generate questions. He noted that Guinevere was nodding in agreement.

Gary Montrose with CLASP offered another take on this. He appreciates Jeannette’s comment that non-medical providers are doing a lot of the work on a regular basis within the scope of this standard. He asked if part of the preamble could include language that states physicians are responsible for writing the orders and other providers are able to deliver the services.

David stated that, in terms of the Class A licensed Medicare agencies, the doctor has to write the orders. He again emphasized his desire that we create language that is consistent with the requirements that an agency has to follow.

Bill Heller with the Department suggested that the language be changed to read something like the following, “as ordered by the qualified physician and performed by a provider (under the orders of a physician)”. Guinevere agreed.

COMMENT – Shannon (on the phone) noted that, with regard to the personal attendant benefit and PAT tool, supporting documentation is provided from occupational and speech therapists, etc. She asked would we not want to require supporting documentation from these types of providers for this benefit as well, which doctors would sign off on. What kind of process does the Department envision?

RESPONSE – Guinevere noted that, on page twenty, the prior authorization requirements are addressed.

David Bolin with Accent on Independence noted that the language there requires that “sufficient” documentation be submitted.

COMMENT – George Lyford with CCLP asked if the Department believes that the language on page five, which states “as ordered by the qualified physician on the plan of care” is limiting.

RESPONSE – David Bolin did not believe it was limiting but believes adding the word “provider” does limit it.

COMMENT – David Bolin repeated his concern that the mention of two providers possibly providing services at the same time (this time on page five) is counter to current rule. He noted that language similar to this language, which states “A PC provider may assist... another care provider, caregiver or family member who is competent in providing skill aspect of care” appears throughout the document. Family member is not a problem but other caregivers are in violation of Medicaid rules.

RESPONSE – Kimberley noted that the suggestions that the Department decides to implement will be made to the entirety of the document and that the Department will then invite Benefits Collaborative participants to be a “seventh set of eyes” to make sure those changes have been applied consistently.

Guinevere asked where this stipulation is in rule, because the Home Health Regulation does allow two care givers to be in the home at the same time. Is this stipulation specific to personal care? If so, Guinevere would answer that EPSDT is a little different.

David replied that, until the policy is clearly spelled out by DPHE agencies will not risk changing their practices for fear they will be going afoul of rule. For example, while the Department has stated that Class B agencies will be allowed to bill as Class A agencies with regard to this benefit, this is currently nowhere in rule. David is not sure you can provider services under one Medicaid number and bill under another. Regardless, presently personal care rules state that you cannot have a skilled provider and a personal care provider provide services at the same time.

Guinevere noted that she was not aware of this and thanked David for the input.

George clarified that, to the extent that the person the personal care provider is assisting a CNA or home health provider, those rules are implicated.

Dr. Zerzan noted that we will need to look at this and Kimberley identified it as a point of research.

Kimberley then invited the group to comment on page six, Bathing and Showering.

COMMENT – David Bolin with Accent on Independence noted that many children will require bathing more than one time per day because of the nature of their disability, perhaps due to toileting, for example. He also asked to what the asterix under Usual Frequency of Task refers.

RESPONSE – Several Department staff directed the group to page 19, where Usual Frequency of Task is defined. Dr. Zerzan noted that George has brought this up previously and the Department will likely be adding the definition to the beginning and the end of the document.

David noted he likes the idea of putting it at the beginning, rather than on page 19.

Shannon (on phone) stated that she believes it is spelled out well down at the bottom of page 6 under Special Considerations, where it begins “additional baths may be warranted...”

George Lyford noted that this “Special Considerations” language is not in every chart where there is an asterix.

Kimberley noted that the Department will work through this issue.

COMMENT – George Lyford asked an open question to the providers in the room and on the phone. Under the Factors that Make Task Skilled section, all the factors describe what the child is capable of doing rather than what the child needs. Perhaps additional language is warranted here that would help guide providers to understand when and how the services are medically necessary. He asked for comment.

RESPONSE – David Bolin with Accent on Independence stated that the first question most providers ask themselves first is “is it skilled (is a CNA needed?)” because agencies want to make sure that personal care providers are not exceeding the scope of their practice.

David acknowledged George’s point, that it might be helpful to define how/when it is medically necessary.

George just wants to make sure providers have the guidance they need.

No other providers spoke to this question.

David suggested that it is a fruitful exercise to look at it from George’s non-provider perspective and add language that helps people to determine if something is medically necessary.

The group moved to page 7, Dressing. Hearing no comment, the group then moved on to page 8, Feeding.

COMMENT – Shannon (on phone) noted that the page mentions “bite size” but not “prepping special diets”, which is part of feeding and of particular relevance to her experience.

RESPONSE – Jeanette asked Shannon if she was suggesting that that requires some additional skill level.

Shannon noted that “special diets” was taken out of skilled care when the PAT was created and so, perhaps, it belongs here. She is not referring to specific provider types. If we are going to talk about special diets, there is more to them than the “tube feeding” mentioned on page 8.

Michelle Miller with the Department stepped in and asked Shannon if she was referring to the Part of the PAT that speaks to, for example, Ketogenics and specifically describes what makes this service personal care. Michelle wonders if the same language should be included in the Personal Care Standard.

Shannon agreed. She thinks it a good idea, to be clear, that if someone doesn’t fall under “Feeding” in the PAT they may fall under “Feeding” in the PCAT – and to use the same language in both tools.

Kimberley took this opportunity to explain to participants that any unanswered questions and all suggestions made will be tracked in the Listening Log posted online and that each question/suggestion will receive a response from the Department. She encouraged participants to check the log periodically, as responses are added.

COMMENT – Sam Murillo with Family Voices Colorado pointed to the Factors that Make Task Skilled section, where it states “Oral feeding is skilled only when the client is unable to communicate verbally, non-verbally or through other means, the client is unable to be positioned upright, the client is on a modified texture diet or when the client has a chewing and/or swallowing problem”. Sam brought up the example of someone he knew who could make noises – the meaning of which were not always understood by his caregivers– would that be considered “non-verbal” as defined here? Also, this person could not be positioned upright enough to prevent him from aspirating – he ultimately died because he aspirated.

Although Sam cannot readily picture the language that should be in this section he wonders if language exists that would indicate, for example, that “squawking” is OK. If someone with Huntington’s, for example, has swallowing issues, and those are adequately documented somewhere else or does more need to be done to address these nuances here?

RESPONSE – Guinevere responded that the key is “meaningful communication.” There are individuals who can meaningfully communicate non-verbally. The fact that a person aspirates would qualify them as needing skilled care, as would not being able to put them upright.

Sam stated that the flexibility in the definition is important. Several people nodded in agreement.

Kimberley stated that the Department can look at how we might reword this but also invited participants to email suggested language.

Dr. Zerzan stated that some of the other documented swallowing issue take the above into account because we don’t want to exhaustively list every condition in here.

The group moved on to page 9, Homemaking.

COMMENT – Shannon (on phone) noted, under Usual Frequency of Tasks, it states “Only areas in which the client is the primary user may be cleaned, such as bedroom and bathroom.” However, under Factors that Make Tasks Personal Care it states “a provider may provide housekeeping services, such as dusting, vacuuming, mopping, and cleaning the bathroom and kitchen areas, meal preparation, dishwashing....” Shannon stated that dishwashing, for example, is not generally done in areas “only used by the client.”

RESPONSE – George Lyford with CCLP stated that, likewise, if a child soils clothing the personal care tasks that take place in the laundry room should be under the scope of this definition.

The group moved on to page 10, Hair Care and Grooming and then Mouth Care on page 11.

COMMENT – Jeannette Jansson with the Department suggested that the same patient-centered language be kept throughout the document, including the Hair Care and Grooming section – which stipulates that the service may be performed when the client needs it.

RESPONSE – Guinevere noted that the Special Considerations box seems to be cut off accidentally in both Hygiene sections.

The group moved on to page 12, Nail Care and Shaving.

COMMENT – Sam Murillo with Family Voices asked what the difference is between “PC” and “PCP” in the last row under Nail Care on page 12.

RESPONSE – PCP means Personal Care Provider. It should state PCP twice for consistency.

Sam noted that a lot of knowledgeable people, even within the context of this document, might think PCP refers to their Primary Care Provider.

The group moved on to Skin Care on page 13. Kimberley noted that the same PCP issue just identified repeats itself here and she stated that the Department will correct this issue throughout the entire document.

COMMENT – Sam Murillo with Family Voices pointed to to the first row on page 13, where it states “applying lotion or other skin care product and only when it is not completed in conjunction with bathing or toileting...” He noted that sometimes applying lotion is best done right after bathing.

RESPONSE – Guinevere explained the thought is that lotion application after bathing is included in the bathing task. This would refer to skin care needs outside of those tasks.

The group moved on to the Mobility sections, which continue from page 13 through page 16.

COMMENT – Guinevere noted that, on page 14, under Special Considerations, the Department forgot to remove the word “skilled” from the statement “visits must be coordinated to ensure that effective scheduling is utilized for skilled intermittent visits.” The second “skilled” also needs to be removed.

COMMENT – Ryan Zieger (on phone) asked if it is within the scope of practice for a personal care provider to do transfers with a Hoyer lift?

RESPONSE – Guinevere answered only if they are with a person who is competent in providing that lift with the Hoyer; they cannot do it by themselves.

COMMENT – Shannon (on phone) pointed to the Special Considerations section at the top of page 16, where it states “a second person may be used when required to safely transfer the client. She noted it doesn’t specify who that second person should be.

COMMENT – Ryan Zieger (on phone) pointed back to page 15, under Factors that Make the Task Personal Care. It seems to him that, as worded, it states that services must be provided in conjunction with a family member who is trained OR when the personal care provider is deemed competent. He asked if this is the case (one or the other).

RESPONSE – Guinevere stated it is an “and” not an “or”. She then amended her statement and noted that it does indeed say “or when the PCP is deemed competent”. She offered to review the Chapter 26 language and, if this is the case, it would be allowed. She will then let Kimberley know.

COMMENT – Sam Murillo with Family Voices pointed to a grammatical error on page 14, under Factors that Make a Task Personal Care. Guinevere agreed that “positions” should be changed to “position”.

The group then moved on to the Protective Oversight section.

COMMENT – Shannon (on phone) pointed to the first row, where it states “monitoring a client to reduce or minimize the likelihood of injure or harm due to the nature of the client’s injury...” She wonders if language should be added so that it reads “injure or harm to self or others...” She asked the group for thoughts.

COMMENT – George Lyford with CCLP asked how “protective oversight” is currently defined in the nursing home context. He also asked if we should think about the differences in populations between children that may be good candidates for these types of services and adults in nursing care. If any part of this definition came from the nursing home context, how can we ensure that the definition is appropriate to this population?

He noted that his questions also try to get at Shannon’s earlier point that some clients with behavioral limitations may include protecting them from harming others and themselves. This fact may call into question the limitation that these services only be provided in the course of providing another personal care service. If so, should we then have that discussion?

George summarized by stating this may be a point of further research. Where did this definition come from? How do other states handle it? I would like to hear from some pediatric behavioral health providers.

RESPONSE – Jeanette with the Department sought some clarification.

George explained that he is not stating 24 hour protective oversight is needed but that he would like to know more from, for example, pediatric behavioral health providers about what the needs may be (for example, oversight in the hours in which parents are commuting home from work).

Shannon agreed that a deeper conversation around protective oversight is warranted.

Kimberley identified this as a Parking Lot item for further discussion on February 10th.

The group moved on to Toileting on pages 17, 18 and 19.

COMMENT – Ryan Zieger (on phone) asked if, earlier in the conversation, the group addressed the frequency of dressing, which currently says “up to two times a day.” His question is why dressing would and bowel care not be inline?

RESPONSE – Kimberley pointed to the Usual Frequency of Task asterisk on page 19, which states “some clients will need these tasks performed more or less frequently than is defined in the task.”

Guinevere explained that the language in the Bowel Care and Bladder Care sections is a little more generalized because the Department did research into typical frequency and there is none for bowel and bladder.

COMMENT – Sam Murillo with Family Voices built off of the comment above. He asked if, with regards to the repositioning language on page 14 (which currently is allowed “every 2 to 4 hours”), the language could be made more general. He noted that some clients need to be repositioned every half hour regardless of bowel movements.

RESPONSE – Guinevere explained that there is an established usual frequency for this. It is 2 to 4 hours. However, some clients do need repositioning more frequently than this and this would be allowed for in the Usual Frequency of Task definition discussed above.

Kimberley noted that it may be worthwhile to add some sentences leading up to the tables that start on page 5 that states something to the effect of “as you read

through the following table keep these things in mind, including: [insert Usual Frequency of Tasks exception]...”

Jeannette Jansson with the Department noted that, in this particular instance, it is two separate things. It says “*in addition* to activities of daily living.” So, Sam is talking about moving a patient or client when they need to be moved related to a task vs. the task being moving the patient.

Sam noted that sometimes, when families are reading the Special Considerations, they have already forgotten that there is an asterisk earlier on the page and, not seeing something in the special consideration section, they wonder why it isn’t a special consideration.

COMMENT – Sam Murillo with Family Voices then pointed to page 17, and stated that “skin breakdown” is not consistent. At the top of the page it is one word, at the bottom it is two words.

The group concluded discussion of the ADL Tables and briefly discussed the Limitation section.

COMMENT – Helen Stephens (on phone) asked if there is further explanation on the first point under Limitations, with regard to “the legal responsible adult” provision. She asked if an older sister, who is not a guardian, but above the age of 18, is eligible to provide personal care services.

RESPONSE – Guinevere noted that, in this instance, so long as the sister is not legally responsible for the client, she can provide care.

COMMENT – George Lyford with CCLP commented on the seventh point under Limitations. He stated that this limitation does not seem to comply with his understanding of how CNAs will be reimbursed for administering unskilled tasks that are related to a skilled task. His understanding is that, even though those services may be inherently a personal care task, they will be reimbursed at the CNA rate. This limitation seems to provide a blanket general rule that this can never happen. So there is some contradiction here. He asked if his understanding of how CNAs are reimbursed is correct and, if so, can the language in number seven be amended.

RESPONSE – Guinevere responded by explaining that this is a personal care benefit so, with regards to personal care, a CNA would get reimbursed for personal care. Under the auspices of Home Health a CNA cannot just go out to do personal care and, if they were to do so, they would be reimbursed at the personal care rate. If, on the other hand, a CNA visit includes skilled and unskilled tasks, that visit is billed at the CNA rate.

George pointed out that point seven states a personal care provider can be a CNA.

Guinevere agreed. Someone who is a CNA can choose to provide personal care, and only personal care, to a client but, in that instance, they are not acting as a CNA, they are acting as a personal care provider – and will be reimbursed accordingly.

George thanked Guinevere for clarifying that and suggested that, where the Department refers to personal care services it clarifies that it is referring to personal care services that can only be billed as personal care services.

COMMENT – David Bolin with Accent on Independence referred back to the first point. Are personal care providers who are relatives of the client going to be limited to providing 444 hours per year or less of care – as is currently the case for waivers?

RESPONSE – Guinevere stated that she was unsure of whether or not the Department has considered this and the Department will look into it further.

Sam Murillo with Family Voices noted he spoke to two families last week who stated that this benefit would not work for them if their family care givers were going to experience a reduction in hours.

COMMENT – Sam Murillo commented on the fourth point, where it states “physical behavioral interventions such as restraints shall not be used.” He recognized that it is impractical to offer here an exhaustive list of all the interventions that cannot be used but he wonders why restraints needs to be singled out here. He further stated that “physical behavioral intervention” implies restraint and that, if an example is needed, tapping someone on the shoulder would be an example of non-restraint, but may not be the appropriate example to use.

RESPONSE – Jeanette with the Department noted that, restraints are only ever used by skilled providers and suggested that, perhaps, given that they are only used by skilled providers we need not mention restraints in a personal care benefit.

Kimberley added that perhaps, instead, we should give an example of a personal care physical behavioral intervention that is not allowed.

Dr. Zerzan was careful to point out that we want to make sure we don’t put something in this standard that might construe personal care providers can’t touch people; touching people is part of care. It may be that one person responds poorly to shoulder tapping and redirecting but another does not.

Dr. Zerzan's best guess is that "restraints" were listed here as yet another reminder that they are not allowed under any circumstances but, given that they are a skilled task, perhaps they don't belong here. The group will discuss.

Dr. Zerzan further stated that, if someone is extremely sensitive to touch, that should probably go in the Plan of Care as guidance to the personal care worker.

David Bolin suggested that, instead of saying "such as restraints" the text say "including restraints".

Kimberley agreed that this would be one way to do it, if the Department decides to keep restraints in there. Guinevere offered another solution – to add additional examples.

Before moving the group on to the Personal Care Provider Supervision section, Kimberley explained that the next Benefits Collaborative meeting is on February 10th and it will begin with discussion of the few sections that the group did not have a chance to discuss in detail today. On February 10th the group will also review the PCAT tool. Kimberley will send an email to the group if this plan changes. That email will also include links to the Benefits Collaborative web site, where the Listening Log and meeting minutes from today's call may be accessed.

COMMENT – Ryan Zieger (on phone) asked why "clinical director" and "registered nurse" appear in the language of this section. He noted that, in Chapter 26 (from which a lot of the draft benefit coverage standard language was pulled) it just says "qualified provider".

RESPONSE – The Department will look at this.

COMMENT – Sam Murillo with Family Voices pointed just below that to where it discussed "problem resolution". He asked what the problem resolution would look like. For example, would this be a written document provided to a nurse from a therapist?

RESPONSE – Guinevere imagined – and noted it would require further research – that it would involve the client calling the agency and saying that their personal care worker is not giving them their bath in the right manner, which would then warrant a nurse going out and watching the personal care worker performing that task.

David Bolin noted it could be personality problems. It's just problem resolution.

Dr. Zerzan suggested explaining this in the definitions section.

COMMENT – Sam Murillo also pointed out a grammatical error on the page, where it states "all personal care staff shall have a completed *an* up to date personnel file."

Meeting adjourned at 12:02.