



Colorado
Cross-Disability
Coalition

DISABILITY COMMUNITY PRESENTATION TO THE JOINT BUDGET COMMITTEE

January 3, 2012

200 East 14th Avenue Denver, CO 80203

5:00-5:20 P.M.

Presenters:

Julie Reiskin Introduction and Overview

Chanda Hinton Highlights of Work Completed by the Committee during 2012

Josh Winkler Data: The Need to Make Data Based Decisions, What Data Exists?

Linda Skaflen Expansion of CDASS/ Implementation of HB 05-1243

Julie Farrar How CDASS Fits into the Big Picture

Linda Andre A Personal Perspective

Julie Reiskin Summary

These presenters represent a broad based, statewide community of people with disabilities and our allies.

Requests:

1. Continue your strong support for CDASS so that we can continue to be fully included in our communities.
2. Request HCPF to view the PDPPC (Participant Directed Programs Policy Collaborative) as a model for successful stakeholder engagement. This should include a request that HCPF continue to honor their promise that no policy on consumer direction is considered unless fully vetted by this group. This model and philosophy should apply to all health and human services committees. If this model were employed with the Long Term Care Advisory Committee and the Community Living Advisory Group there would be improved outcomes and community support. This model assures that when the government agency makes the effort to assure quality stakeholder engagement that participants are active and assist with the work. This model has led to responsible and collaborative decision making on all sides.
3. Assure that CDASS and IHSS are included in the proposed provider rate increase that is planned for other HCBS and/or state plan services. Our workers have suffered cuts along with everyone else.
4. Ask HCPF to continue to work with us to provide meaningful data so that we can assist with making data driven cost effective decisions.
5. Require HCPF and CDHS to provide a specific time line and work plan by March 01, 2013 for implementation of the CDASS option for homemaker and personal care into the DD SLS and CES waivers by July 01, 2013.
6. Require HCPF and CDHS to provide a specific time line and work plan by August 15th for implementation of the CDASS option for homemaker, personal care and health maintenance to all other waivers (including adding Health Maintenance to the DD waivers) by no later than October 01, 2013.
7. Require HCPF to offer the consumer directed delivery model for all waiver services at the time of each waiver renewal unless the LTCAC and the PDPPC concur that a specific service type would not be conducive to this delivery model.

Julie Reiskin Testimony

Senator Steadman, Representative Gerou and members of the JBC. Thank you so much for taking the time again to listen to us about Consumer Directed Attendant Support Services commonly known as CDASS. My name is Julie Reiskin, I am the ED of CCDC, which you know is Colorado's only statewide disability rights organization that is run by and for people with all types of disabilities. I am also a Medicaid LTC client and use CDASS.

CDASS is a service delivery option that allows people with disabilities who require LTSS to directly manage those services. After a training, and verification from a physician of our capacity, clients are allowed to hire, supervise, schedule, and manage all aspects of our in home care. We are allocated the same amount of money that would be allocated if we used traditional agency based services and funds are provided to a fiscal management service contracted by the state. Our allocations are reduced to cover all administrative costs of the FMS and we pay the employer share of taxes. Within that budget we are allowed to set rates, set our own schedule and hire our own workers. Clients unable to manage their care directly can appoint an unpaid authorized representative, such as a family member, friend or even someone from a faith based or other community. In that case the representative must complete training and sign a contract. In addition to the obvious benefits of having choice over who comes in our homes and has access to every personal aspect of our lives, CDASS allows us the flexibility to work, parent, and receive services in the community when needed. CDASS also allows the state to comply with federal requirements that all services in a care plan must be made available. For our more severely disabled clients CDASS is the only option that enables them to staff up completely. Without CDASS we could not maintain compliance with CMS quality requirements, risking our federal funds. CDASS also addresses a big concern of many, which is the lack of supervision while caregivers attend to a very vulnerable population. Because the client or a designated representative is the managing employer, many of the problems such as emotional abuse, theft, and patient abandonment via no shows disappears. While not impossible, most people do not abuse their employer.

CDASS is a service delivery model, not a program. Currently Colorado allows this service delivery model for three services, two waiver services (personal care and homemaker) and one state plan service (long term home health care) and we allow it in three waiver programs. (elderly blind disabled, community mental health and spinal chord injury). We believe it is an effective delivery model for many, but not all, people and is an important part of the long term services and supports continuum that we need to provide for our citizens. We have a handout explaining the three parts of the community based continuum regarding home based services as it stands today. We would like to assure that all models are available to all clients in all waivers. We believe and data shows that this level of choice and ability to move in between models as needs change is the most cost

effective and humane way to manage the long term care needs of our population. Certainly boomers will demand and expect the control allowed in CDASS.

We are not blind to the need to contain costs and address fraud, more than anyone we suffer when this does not happen. We implemented strict standards this year to prevent over expenditures by clients and applaud the recent prosecution of a woman who was cheating the program. We have no tolerance for fraud because we see the needs every day and know resources are limited.

Last year we asked you to help encourage HCPF to form a partnership with our community to address problems that had arisen regarding administration of the program—your handouts include the same handout we gave you last year color coded, green are areas we have resolved, yellow means we have raised it and proposed a solution and while waiting for feedback are working on it with HCPF and red means we have not made progress. No color code means that the issue has not been raised. We want to thank you for your support of us—and we want to thank HCPF for making the commitment to work with us as true partners. Once that happened we made substantial progress. We are pleased with the hires HCPF has made to run this program, Bonnie Silva as an overall waiver manager and Candie Dalton to manage this option are both individuals who have already demonstrated that they have the desires and skills to manage and expand this essential program. We do not ask without being willing to do the work, and we have all worked many hours with HCPF over the past year and things are much better. We still have work to do and are here again to ask for your support and guidance on assuring that this program continue on the path we have, and the law passed by your colleagues in 2005 requiring full implementation of this model in all waiver programs and the state plan be implemented.

Chanda Hinton is the co-chair of the committee that works with HCPF will give you an overview of our progress, Josh Winkler will follow and talk about what data we have received and how data must play into our decisions. Linda Skaflen will then talk about the need to expand this program, starting with the DD waivers where changes will have an immediate benefit for many clients hurt by other cuts and changes in the SLS program, and Julie Farrar will discuss how this fits into health care reform. Linda Andre will close with personal accounts of this program as a client and as one who volunteers to help others on this program. We are here not as six people, but as representatives of a large community including people of all ages, races, disability types throughout the state.



PRESS RELEASE

Colorado Department of Law
Attorney General John W. Suthers

FOR IMMEDIATE RELEASE

December 18, 2012

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DAUGHTER BILLED MEDICAID FOR HEALTH SERVICES PROVIDED TO DEAD FATHER

DENVER—[Colorado Attorney General John Suthers](#) announced the criminal conviction today of Viola Kwong (52) for felony forgery. Kwong had requested services for her elderly father through a Medicaid program that allows a Medicaid client to direct his or her own home-based, personal healthcare when able. In this case, Kwong's father was too infirm to direct his own care and Medicaid authorized Kwong as his personal representative in obtaining those services. While her father died on July 23, 2010, Kwong continued to submit numerous fraudulent documents to Medicaid reflecting personal healthcare services provided to her father through November 8, 2010.

“This case, and particularly the restitution ordered, represent another significant recovery for Colorado's Medicaid program” said Suthers. “Viola Kwong submitted invoices requesting payment from Medicaid despite the fact that her father had been deceased for four months.”

Kwong entered her plea of guilty today in Denver District Court and was sentenced to pay \$16,000 in criminal restitution and perform 50 hours of public service. She was also placed on supervised probation for four years and will pay all court costs and probation supervision fees. In addition, Kwong agreed to pay a civil penalty of more than \$37,000 to the Colorado Medicaid program to resolve any potential civil liability to the program. The restitution ordered reflects repayment of all money illegally received by Ms. Kwong, as well as a civil penalty.

The case was referred to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General of Colorado by the Program Integrity Unit of the [Colorado Department of Health Care Policy and Financing](#).

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Chanda Hinton Testimony

For nearly 40 years Colorado has been at the forefront of community- based long-term services and supports. As a nation, America is embracing “person-centered thinking” as the service delivery philosophy and model for our nation’s health care system. This is a departure from the traditional model with a physician directing care to a coordinated service model with a team approach. This approach focuses **on the person receiving services** at the center, providing appropriate supports to allow the patient/client/**consumer** to direct their own health care. CDASS is the ultimate example of person-centered thinking that allows people with disabilities to take control of their **choices**, their **care**, and their **lives**.

The Institute on Patient and Family Centered Care is currently working with Health Care Policy and Finance to help the department develop a more person centered customer response approach. Including the following core concepts:

- **Respect and dignity.** Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in health care.

Over the next 15 years, Colorado’s population of residents age 85 and over is expected to increase by 59%. According to the U.S. Bureau of Labor Statistics, Colorado’s need for home health workers is expected to jump 54% by 2014. This means an additional 10,000 home health workers will be needed to meet the Long Term Care needs of Colorado residents. In other words, what we have, first and foremost is a capacity issue. How do we possibly meet the overwhelming Long Term Care needs of a rapidly-growing aging population?

As Julie mentioned, the PDPPC was established to assure partnership regarding decisions about CDASS, but it has also served as a gateway for clients and other proper stakeholders to be involved in all issues of consumer direction within Colorado Medicaid. The PDPPC is made up of clients, SEPS, HCPF staff, etc. Stakeholders do real work such as minutes, fascinating the meetings, tracking attendance and voting. All together we we’ve accomplished many things and I am honored to share these accomplishments with you.

- Through the PDPPC, there were immediate steps taken by Sarah Roberts and the department that stopped the improper allocation cuts. We created a workable spending protocol.
- The PDPPC is properly organized effectively using personnel who have the authority to support appropriate decisions made regarding all consumer direction issues that affect clients. Having the right staff from the department reduces delays in making decisions and implementing policy. We are pleased with new hires at HCPF (Candie Dalton as administrator of consumer directed programs and Bonnie Silva overseeing all waivers. The right personnel is imperative for appropriate management of any program.
- With new access to data on cost and enrollment, we can make decisions based on facts. (Josh Winkler will speak about this)
- The EBD and Community Mental Health Service Waivers, which offers includes CDASS, now includes Medicaid Buy-in For Working Adults with Disabilities. Linda Skaflen will discuss needs to expand this model to other waivers.
- The Fiscal Intermediary Agent of CDASS (PPL) contract revised, which got the department HCPF off Corrective Action Plan which was preventing expansion of CDASS to other waivers.
- Starting in 2013 the restriction of CDASS services "in-home," which was not occurring in practice is removed from the rule.
- The committee has recommended a more rational process for determining allocations.
- The committee will make a recommendation on defining protective oversight as soon as input from CMS is received but no later than February.
- The committee is currently working on appropriate policies regarding crisis management and will then take on respite, and coordination with acute care.

WE ASK YOU VIEW PDPPC AS A MODEL FOR SUCCESSFUL STAKEHOLDER ENGAGEMENT. WE NEED TO CONTINUE THIS ENGAGEMENT AND REQUEST YOUR SUPPORT TO DO SO.

Chanda Hinton
The Chanda Plan Foundation

TRANSPARENCY	ADMIN/MANAGEMENT	LAW
Continuing government staff turnover causes lack of continuity and loss of historical information/evolution of CDASS, requiring too many “do-overs” and inefficiencies.	CDASS allocations are issued annually but – incorrectly - managed monthly by HCPF, creating serious disincentives for cost savings.	Continued failure to implement HB 1243 from 2005 prevents expansion of CDASS to 1.) other waivers and 2.) Medicaid state plan
Lack of inclusion of CDASS clients and family in policy making and implementation breeds poor communications and disrespect in both directions. Transparency and accountability require members from community and staff to preside over all aspects of CDASS.	Protocols are not consistent and do not allow for natural presence of outliers, a minority with higher medical costs who are not served anywhere else in the health care system. There is no practical way to access short term acute care .	Medicaid Buy In is being implemented without CDASS. The requirement for Medicaid Infrastructure Grants (which Colorado received) was that states must implement a buy in that allows for at least 40 hours a week of personal assistance in the community (not limited to home). CDASS is only option to meet this requirement
Collection of data does not follow generally accepted standards, invoking rumor over reality and inappropriate contentious relationships between staff and clients.	Abnormal norms and task-oriented tables are not applied with clients' medical safety in mind.. No allowance for supervision of clients on ventilators or others with severe needs.	Lack of due process has become the norm and serves only to erode the established relationships between Long Term Care case managers and clients. Lack of due process also delays solutions, stimulates crisis and increases admin costs with appeals processing to remedy.
Anecdotal information and secret meetings need to end. Instead, balanced, factual, regular communications need to be implemented for the sake of more effective delivery of medical care to clients with disabilities.	Reduction in training led to lower quality training and less continuity than with original program	Transitioning from nursing home to CDASS needs to be part of the CTS (Community Transition Services) program. High needs or other hard to serve clients cannot get out of nursing facilities because this kind of transition is so difficult and requires a crisis mentality.
Currently a team of three people, only one of whom has any medical credentials, meets and determines who needs what for high cost clients. This team overrides physicians and case managers. They have made statements such as advising a caregiver to leave dirty diapers in the client bathroom to save time and only empty a couple times a week, asking why someone with a g-tube needs tubing cleaned, and asking a parent to document how many times a week her son wears zippered pants.	The CDASS employee application process is too lengthy to be practical for filling positions	The method by which the fiscal agent fees are calculated needs to be reviewed as CMS apparently has concerns with the current model (percentage). This has been known for at least a year.
The state has not analyzed the cost when looking at avoided hospitalization and acute care costs.	There is no way to account for nursing or private duty nursing in the current allocation process.	CDASS compliments Community First Choice and would not be replaced by this model.

FIXED TO CLIENT SATISFACTION

PARTIALLY FIXED

STILL NOT ADDRESSED

Josh Winkler Testimony

As with all of the other areas we are speaking about tonight, we have made progress with the Department of Health Care Policy and Financing (HCPF) on data transparency and distribution since we spoke with you last year. While we continue to hear anecdotal stories about issues with CDASS, as we heard at the December 13, 2012 Department of Human Services briefing to this committee, HCPF is now making decisions based on actual data as best we can tell.

In June 2012 HCPF released a “Long Term Care Databook” at the Long-Term Care Advisory Council (LTCAC) meeting, a document that contained historical client counts and costs for each of the waivers as well as the CDASS service delivery option. While this was a great start, it left a lot to be desired, and with no other service delivery model data to compare to could be yet another cause for false perception.

After repeated requests, and assistance from a couple legislators, HCPF released an update to the Databook with some data for Home Health, Personal Care and Homemaker services delivered by agencies on December 14, 2012. Again, this data has helped us get a clearer picture of costs and client counts for home and community based service delivery in Colorado, but there is still more needed to draw firm conclusions. Initial analysis shows CDASS is on par with agency services in terms of mean average per capita costs, with 2010-2011 CDASS expenditures at \$28,497 per client and 2010-2011 combined Home Health, Personal Care, and Homemaker costs at \$25,405 per client. The higher mean per capita cost of CDASS is likely due to the high needs clients who cannot be fully served by any other service delivery; once HCPF releases the minimum, maximum, and median cost data we’ve requested this should be more apparent.

Last year we mentioned, despite numerous rumors, there had been no convictions related to fraud on CDASS since its inception as a service delivery option. We are pleased to say a recent report in the Denver Post illustrated when there is fraud the system works; a woman who, in 2010, submitted hours worked for her deceased father for more than 4 months after he died was charged and convicted. This was a clear case of fraud that could’ve happened in any Medicaid service, the important thing is that it was identified and resolved.

If we want to discuss cost savings, lets discuss eliminating the Skilled Nursing Facility (SNF) statutory rate increase as Eric Kurtz mentioned in his briefing to you on December 19, 2012. A 6% increase to SNF’s represents 75% of the total CDASS expenditure. We are not here today to discuss the 1999 Olmstead decision and benefits of community based long-term services and supports though, we are here to discuss equality and freedom of choice for every client regardless of age or disability. When one service option receives a rate increase, so should all comparable other options. As we continue to work with HCPF on obtaining and analyzing data on all of the long-term care programs,

we will work with them to adjust policies to keep parity between the service delivery models with maximizing the ratio of client benefits to costs in mind.

Linda Skaflen Testimony

Choice is something many of us take for granted every day. When we make our personal choices our decisions are based on what we need, what we like, & what we want. We know what we can do for ourselves and what we need from others. If it is something we have to pay for, we decide who we want to pay and how much we can pay within our budget.

I just very simply defined person centered planning, self-determination and consumer directed services. These are terms used in the delivery of Long Term Care services and should be a guaranteed focus when those services are designed. All of us want choices in our lives.

The purpose of incorporating CDASS into Colorado statute was to move the option into all of the Medicaid Long Term Care Waivers. In December of 2009 on behalf of a group of Arc's we asked the JBC to motivate the Department of Human Services into implementing the CDASS option in the Supported Living Services Waiver. The JBC did exactly what we requested and was informed by DHS that the option would become a reality in July 2010. It is January 2013 and CDASS has not been implemented in any of the DD waivers.

At the December PDPPC meeting we asked to work with HCPF and DDD to move quickly toward implementation of the CDASS option in the SLS waiver. Personal care and homemaker services are offered in the SLS and CES waivers and there is no fiscal impact, since these waivers have monetary caps. The Health Maintenance service currently has a different type of cost containment as a Medicaid State Plan benefit and it will take some work to incorporate it into the DD waivers.

The following expertise already exists and should allow for easy expansion into all of the waivers.

- Case management through the Single Entry Points have long term experience with CDASS.
- The Fiscal Intermediary already exists and the current entity, PPL, has been operating for several years.
- Training is already developed, evolving as necessary and in use since the beginning of the pilot.
- Safeguards are in place to prevent fiscal mismanagement.
- Supports exist to assist individual participants who are challenged with the management needs of the CDASS option but still want to have choice and control.

We are working with HCPF staff very committed to the CDASS option but I am very concerned about the lack of a defined date for implementation. While my experience is supporting people with intellectual and developmental disabilities, I want to see the expansion of the CDASS option into all the Medicaid waivers.

I am asking you to request HCPF and CDHS provide a specific time line and work plan for the following three tasks:

1. The implementation of the CDASS homemaker and personal care option into the DDD SLS and CES waivers beginning July 1 2013 with the implementation of the health maintenance option by January 2014.
2. The implementation of the full CDASS option into the HCBS-DD waiver no later than July 2014.
3. The implementation of the CDASS homemaker, personal care and health maintenance option into all other Medicaid waivers beginning July 1, 2013.

I hesitate to say this but after 7½ years it is beginning to feel discriminatory when the CDASS option is allowed in a few but not all waivers.

Thank you for your time.

Linda Skaflen
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Definition References

CONSUMER DIRECTION OF SERVICES is applicable across the spectrum of disability and emphasizes the ability of people with disabilities to assess their own needs and make choices about what services would best meet those needs. It makes a statement that consumers can and should have options to choose the personnel or provider entities that deliver their services, manage the delivery of services, and monitor the quality of services. Choice is guaranteed including the choice not to direct and to direct to the extent desired. Program designs should permit individuals to elect the traditional service model if self-direction does not work for them or to direct some of their services but receive others from agency providers. . At maximum participation in consumer direction the participant independently or in conjunction with an authorized representative or their legal guardian, if applicable, will manage and control all aspects of their service delivery including budgeting within their annual allocation.

SELF-DETERMINATION the act or power of making up one's own mind about what to think or do, without outside influence or compulsion

PERSON CENTERED PLANNING identifies opportunities for the individual to develop personal relationships, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve these goals. The purpose is

- *To look at an individual in a different way.*
- *To assist the focus person in gaining control over their own life.*
- *To increase opportunities for participation in the community.*
- *To recognize individual desires, interests, and dreams.*
- *Through team effort, develop a plan to turn dreams into reality.*

STAKEHOLDERS are defined in many different ways and for a variety of purposes. Strong stakeholder engagement is supported when the majority of participants in decision making capacity are Medicaid Waiver participants, family members (including family members that are paid providers) and non-paid Legal Guardians.

Julie Farrar Testimony

For nearly 40 years Colorado has been at the forefront of community- based long-term services and supports. As a nation, America is embracing “person-centered thinking” as the service delivery philosophy and model for our nation’s health care system. This is a departure from the traditional model with a physician directing care to a coordinated service model with a team approach. This approach focuses **on the person receiving services** at the center, providing appropriate supports to allow the patient/client/**consumer** to direct their own health care. CDASS is the ultimate example of person-centered thinking that allows people with disabilities to take control of their **choices**, their **care**, and their **lives**.

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Over the next 15 years, Colorado’s population of residents age 85 and over is expected to increase by 59%. According to the U.S. Bureau of Labor Statistics, Colorado’s need for home health workers is expected to jump 54% by 2014. This means an additional 10,000 home health workers will be needed to meet the Long Term Care needs of Colorado residents. In other words, what we have, first and foremost is a capacity issue. How do we possibly meet the overwhelming Long Term Care needs of a rapidly-growing aging population?

We can achieve the Governor’s mission of providing Cost Effective, Efficient and **yes** Elegant Long Term Care Services. **But** - this rests upon our ability to provide an array of real options for how, where, when and who provides Long Term Care Services. We have an obligation to achieve the Long Term Care Advisory Committee’s Triple Aim of: Positive Consumer Experience **and** Health Outcomes and Effective Policy for Cost-Containment.

The dialogue should no longer be about how to provide services for our disabled, vulnerable, the frail elderly. We should move forward with the intention of creating a sustainable systemic structure

that meets the Long Term Care needs of all of us. We must move forward in embracing the notion that “disability” is not a dirty word, but a natural state of being and an almost inevitable part of the aging process. People are living longer, including those of us with disabilities. Many of us are aging with a disability and most of the people in this room at some point in your lives, will be aging into disability.

We do **NOT** have to be in adversarial relationships with providers including Skilled Nursing Facilities, Community Center Boards and traditional agency models of Long Term Care service delivery. I suggest we find ways of incentivizing everyone to “doing the right thing”.

For instance, re-instating CDASS, Funds for Additional Services. As it was originally designed, half of any money saved went to the state as cost savings and clients were able to utilize the other half to purchase items to enhance independent living or improve health outcomes. For me this meant I was able to have a roll-in shower installed, for a person with an intellectual disability this might mean purchasing an i-pad which could improve communication, enhance employment skills and increase independence.

With your support as leaders in embracing choice and person-centered care, we can expand CDASS into ALL HCBS waivers. Starting today-we can indeed create a sustainable, stable Long Term Care Service delivery system .

Comparison of Current Delivery Models

	CDASS	IHSS	HOME HEALTH AGENCY
Who	Client or AR must find, select and hire attendants. Nurse practice act waived. Employer of record is Fiscal Intermediary Service (FMS) and client/AR is supervisor. Client does all management FMS does payroll services	Clients can hire who they want but agency is employer and has final say. Agency has to do some training with employee hired by client. If client does not have worker in mind agencies are to help clients with hiring.. Nurse practice act partially waived.	Agency responsible for hiring workers and must comply with Nurse Practice Act. A few agencies allow clients to bring in otherwise qualified aides as employees of the agency.
When and Where	Client schedules when and where attendants work based on client needs. Attendants can provide services in the community as needed enabling clients to work.	Clients can do own scheduling if able however agency is responsible for providing backup. If client does not manage care and leaves to agency client may not be able to get care at desired hours. Care only allowed in the home.	Clients must accept schedule that is set up by the agency. The agency is required to provide the visits ordered by the doctor but does not have to comply with a requested time unless there is medical need. Some agencies try to meet client requests but must balance needs of many clients. Care only allowed in the home.
Backup care	Client must plan and have adequate employees to manage own backup.	The agency must assure 24-hour backup care.	If the regular aide is absent, back up may be provided and the agency usually notifies the client of their specific policy about absence, no shows, and cancellations. Personal care and homemaker rarely provide backup.
How Much are workers paid	Client sets rates for services, must stay within budget. Rates cannot go below minimum wage or above \$39.30 per hour. Clients can set higher rates for backup, emergency, holidays, but must not exceed allocation. State prohibits clients from paying for sick or vacations days . No health insurance.	Agency sets rates that are closely aligned with rate paid to the agency by the state. Agency can pay for sick days, holidays, etc., but cannot bill the state for time not worked. Agencies can choose whether or not to provide health or other benefits.	The agency sets the rates for the workers. The State sets the rates paid to agencies to include overhead for such things as benefits for the caregiver and their cost of supervisory visits. Agencies can choose to pay sick or vacation pay but cannot bill the state for time not worked. Agencies can choose whether or not to pay health or other benefits.

	CDASS	IHSS	HOME HEALTH AGENCY
	CDASS	IHSS	HOME HEALTH AGENCY
How Much Does It Cost	Rate reduced 10.75% to cover administrative cost of fiscal intermediary. Nursing and C.N.A services are reimbursed at \$23.38 and personal care and homemaker at \$12.39. The client pays all administrative costs.	Agency receives two rates, one is approximately \$26.20 for health maintenance services (RN/C.N.A) and the homemaker rate is \$13.88 plus travel time.	Agency receives rate based on services, nursing care is \$97.46 for a regular visit, \$86.22 for a brief visit (first of day), \$47.76 for subsequent visits in same day; for C.N.A. it is \$34.66 for the first hour and \$10.36 for any half hour that follows, a second visit would pay the \$34.66 for the first hour of that second visit followed by the extended rate for visits lasting more than one hour. Personal care and homemaker are reimbursed at \$13.88 per hour plus travel time.
How Much Care Is Available	Uniform assessment tool identifies necessary care. SEP does assessment. Client responsible for all staffing.	Uniform assessment tool identifies necessary care. Agency does assessment and sends to SEP for approval. At times care may be limited to available staff if client has not found workers.	Agency uses assessment tool and sends to SEP for approval for long term care, acute care requires no prior approval. For nursing and C.N.A. services doctor signs form ordering amount, duration and scope. Care limited by hours available by agency to provide staff.
Agency Involvement	FMS manages payroll functions & SEP does assessment for appropriateness of services.	The agency is responsible for providing 24-hour backup. Agency also can teach independent living skills. They cannot easily discharge a client but can discharge under certain conditions.	The home health agency has obligations to arrange and provide their services. HHA responsible for quality assurance. Services may be discontinued with a proper 15 day notice and documentation that the agency made some attempt to resolve the problem.
Managing your care	Doctor must verify client can handle own health issues and needs are predictable. Clients must pass test after training. If client cannot manage AR is appointed and they must meet same requirement and pass test.	Client must handle own health issues or can appoint AR. Client can get some assistance from agency with IL skills training but this is considered a self directed program and client or AR has to be able to some self management.	Agency takes responsibility to whatever extent is necessary. Nurse supervises either every 14 days in some cases and every 62 days in other cases. Care is provided per a plan outlined on a form from the doctor.

	CDASS	IHSS	HOME HEALTH AGENCY
	CDASS	IHSS	HOME HEALTH AGENCY
Other	<ul style="list-style-type: none"> • Client or AR. must attend training and write an attendant support management plan. • Only available in EBD, CMH and SCI waivers. • Allowed to hire family members for up to 40 hours a week 	<ul style="list-style-type: none"> • Only available in HCBS-EBD and Children’s HCBS waiver. • Rules silent on family members being hired, at discretion of agency. 	<ul style="list-style-type: none"> • Available to anyone who qualifies for long term home health, HCBS personal care and homemaker. This is contingent on finding an agency that is willing and able to provide services. • For C.N.A. care allowed to hire family members if they take the C.N.A. class but spouses excluded • For personal care family members can only be paid for \$13 per day
Pro's to this model	<ul style="list-style-type: none"> • Flexibility to hire person compatible with client with skill set appropriate for client needs rather than certification • Services can be provided when and where clients need • Worker trained on skills/tasks needed specifically for client • Wage flexibility • Strong health outcomes • Clients with very high care and complex needs (ventilator dependent) receive all of the care on the care • Available statewide, no difference in amount, duration and scope based on locality • Mandatory background check of employees and client gets results 	<ul style="list-style-type: none"> • Flexibility in setting schedule and assisting with hiring own help but backup support of agency for times when attendant not available • Able to hire person with right skill set, not hampered by certification • Provision of Independent Living Skills Training available to increase independence of client. Skills that clients do not possess can be taught by IHSS agency • Worker can have individual training on top of agency training 	<ul style="list-style-type: none"> • For a client that requires medical supervision the availability of a nurse might be helpful • For a client with unpredictable needs, agency can switch client to acute care which requires no prior authorization and only requires a doctor order when the client has an acute episode. This increases the amount of services available as needed and may allow for coordination of acute and long term care. • This only works if agency has ability to be flexible with staffing • Good for clients that are not able to manage people if there is agency willing to staff difficult client. • Some agencies help families who cannot get CDASS by hiring family members as C.N.A.

	CDASS	IHSS	HOME HEALTH AGENCY
<p>Con's to this model Bolded are those that state could remedy and keep fidelity to model</p>	<ul style="list-style-type: none"> • Not available for any children • Not available for BI, DD-HCBS, DD-SLS, or PLWA waivers or state plan • Not appropriate for clients that are unable or unwilling to plan ahead, attend training or manage employees. • Not appropriate for clients whose health care needs vary wildly because client must stay within an allocation and changes cannot occur quickly or frequently. • Clients in need of AR are best served when there is family member or close friend available, AR is unpaid and can be significant time commitment. 	<ul style="list-style-type: none"> • Not available in most waivers or state plan • Cannot use services outside of home • Not available statewide • Agency can choose not to accept a difficult client and can discharge client (though not as easily as HHA) • No flexibility in rates for client needs unless agency agrees. • Clients in need of AR are best served when there is family member or close friend available, AR is unpaid and can be significant time commitment. • Not appropriate for clients whose health care needs vary wildly because client must stay within an allocation and changes cannot occur quickly or frequently. • Not appropriate for clients that are unable or unwilling to plan ahead, attend training or manage employees. 	<ul style="list-style-type: none"> • Cannot use services outside of home • Availability of services varies statewide • Personal care clients cannot hire family members for reasonable rate. • Home health clients who want to hire family members have to have the family member employee take a class that is usually irrelevant to the home care client need. • Cannot choose who does and does not come into your home or have access to all personal information such as bank accounts and prescription medications. If client accuses worker of theft client can be labeled difficult. • Cannot set hours –significant barrier to employment. Agencies must balance the needs of many clients when scheduling. • Workers only provide services written on care plan, one cannot think of every possible task needed. Not conducive to clients who are head of household when other things come up (changing light bulb, etc). Sets up difficult dynamic between worker and end user. • Division between home health, personal care, and homemaker causes services to take longer and be less coordinated or flexible—many clients forced to use two agencies • Focus solely on medical needs, not on life needs. • No incentive for clients to curtail costs • Nurse Practice Act increases cost of care

Linda Chism Andre Testimony

Chairman Steadman and Committee Members,

My name is Linda Chism Andre. My resume is to provide you with some of my work history as well as community involvement. In 1975, one of my first jobs was as treasurer/accountant for the Atlantis Community, Inc., which led to the successful move of several disabled young adults from a LTC facility in Lakewood, CO to the Las Casitas Apartments where they were able to live more independently with attendant services. (Please see attached article.) I want to draw the contrast of where this small independent living movement began, initially funded by a \$20,000 grant, to where we have come today with Consumer Directed Attendant Support Services.

I have been disabled since age 7 with Juvenile Rheumatoid Arthritis. I am now 65 years old. I have worked in a LTC facility, been a patient in one for a brief period of time, and had several clients I have worked with in nursing homes. I have personally and professionally experienced and observed the substandard care provided in this type of facility. I suspect this is the result of several factors; lack of adequate pay of the direct care employees, lack of time they have to adequately meet the patients' needs, and high turnover rate due to poor working conditions. Please take a moment to think of how you would feel if you or your loved one had no other choice but to live in a LTC facility.

I was faced with this dilemma in 2005 when I ran out of funds to pay for my care after my husband died in 1999 and had to apply for Medicaid. I looked at nursing homes and was turned away by all of them because I didn't meet their age requirement or they couldn't meet my needs, saying "I wasn't appropriate" for their type of facility. Thankfully, I was able to receive services through IHSS until I was eligible for CDASS in 2006. I had no family to rely on for help so I hired and trained my employees and am happy to say one of my attendant's has been with me for nine years and another for five. That doesn't mean I didn't have some pretty bad experiences along the way.

I've worked as a Peer Trainer for Accent Intermediary, the first FMS, and the current FMS, Public Partnerships of Colorado for a total of 7 years. I've trained hundreds of clients who are referred to CDASS about the benefits as well as the significant responsibilities that go with the managing of this delivery of care option. I have also served as a volunteer Authorized Representative for a client with MS since 2007. I am also an active member in the monthly meeting of Participant Directed Policy Programs Collaborative(PDPPC) comprised of clients, HCPF staff, SEP Case Managers, staff from DDD and Mental Health. I have also been on the Medical Services Board for the past 3 ½ years, as well as the several other boards. None of these opportunities would have been available to me these things if CDASS didn't exist.

Having the CDASS delivery of care option available to me has meant the difference between being able to remain in my home as a contributing member of society, being able to help others verses

living the rest of my life warehoused with others, with no independence and no choices, my Social Security going to pay for substandard care, accept a small inadequate amount of monthly personal needs funds, with my physical, psychological, or emotional needs not being meant.

You can see the inroads that have been made since the early attendant services offered at Atlantis' Las Casitas Apts. to present day CDASS. CDASS is a long needed alternative to the health and wellbeing of well over 2,000 clients as well as the benefit of employment of well over 4,000 caregiver/attendants. I am one of those CDASS clients.

It's my hope that you understand how important continued funding for this delivery option of care is to me as well as others who are already benefiting from the services, especially for those whose needs cannot be meant in a LTC facility.

Linda M. Chism Andre, LCSW
Professional Fiduciary
Case Management
Guardian

EDUCATION

Master of Social Work, 1981
University of Denver
Major: Treatment (Ego Psychology)

Bachelor of Science (with Honors) 1979
University of Colorado Denver
Major: Rehabilitation Services
Minor: Psychology

LICENSE

Licensed Clinical Social Worker
#989344
May 1989

CERTIFICATIONS/AWARDS

Certificate of Gerontology
Social Services for the Elderly
From
The University of Denver Institute of Gerontology
Graduate School of Social Work

Cum Laude Award
Denver Chapter of the Arthritis Foundation

2012 Mayor's Diversity Award
Denver Commission for People with Disabilities

PROFESSIONAL AFFILIATIONS

National Association of Social Workers
Hearing Officer for Access-A-Ride Appeals Committee
Colorado Fund for People with Disabilities Board Member
Guardianship Alliance of Colorado, Inc. Advisory Board Member
Medical Services Board Member of Health Care Policy & Financing

References Available Upon Request

Professional Profile

Linda M. Chism Andre, LCSW
Professional Fiduciary
7348 W. Cedar Circle
Lakewood, CO. 80226-2020
303.237.9419
chizwhiz@comcast.net

Career Achievements: Licensed Clinical Social Worker with thirty one years of experience in the fields of alcohol/drug addition, medical rehabilitation, professional fiduciary, volunteer and professional guardianship, power of attorney, representative payee, and case management.

Summary of Qualifications

- Administration of a \$50,000 grant for a Denver non-profit organization which included client recruitment, hiring and supervision of employees, training personnel, policy/procedure development, performance standards/evaluation appraisals, all aspects of fiscal management, including monthly payroll, quarterly taxes, and bookkeeping.
- Coordinate and implement psychological assessments, treatment formulation and discharge planning for neurologically/physically impaired clients.
- Coordinate weekly interdisciplinary team conferences with neurologist/psychiatrist.
- Facilitate individual, marital family and group therapy sessions for dual diagnosed and chemically dependent clients.
- Conduct staff in-service education on various psychosocial issues related to chronic illness/disability and the effects on clients and their families.
- Extensive knowledge of eligibility criteria for both state/federal assistance programs, i.e. SSI, SSDI, IHSS, CDASS, HCBS, HCA, AND Spousal Protection.
- Knowledge of private insurance billing and reimbursements, Medicare and Medicaid Supplemental Plans and HMO's, Part D Drug Plans.

Employment History

Private Practice: Court appointed guardianships, case management, and consulting.

Director of Clinical Social Work: Rocky Mountain MS Center, Englewood, CO.

Director of Clinical Social Work: O'Hara Regional Rehabilitation Center, Denver, CO

Clinical Social Worker: Lutheran Medical Center, Wheat Ridge, CO

LINDA CHISM AND GLENN KOPP DISCUSS INDEPENDENT-LIVING IDEA
They are in living room of apartment at the Las Casitas complex.

INDEPENDENCE FROM NURSING HOMES

Atlantis' Handicapped Move to New Life

(Created to meet the development that could give us and stability such project deserves. BARRY F. Evergreen

By PAT AFZAL
Denver Post Staff Writer

On the surface, this Sunday is just a moving day for eight Denver area young men and women.

Underneath, however, the day emerges as a first, precious taste of freedom for them. They are severely handicapped and will move out of nursing homes Sunday into their own apartments and have a crack at independent living.

"Sunday will be, oh . . . like Christmas," says wheelchair-bound Glenn Kopp, co-executive director of the Atlantis Community, Inc. The group is leasing the apartments where the young adults will live.

Linda Chism, Atlantis' treasurer-accountant,

likens the moving experience to "a flower opening up. We don't know how it's going to work out for sure. Things will sort of evolve."

Their excitement seems normal because they're helping others embark on a new experience.

Then they begin to talk about why the independent-living idea got going. And their comments harden into strong indictments against the institutional way of life for the young handicapped.

"You know about civil rights?" Kopp asks a reporter. "Well, a handicapped person in an institution has no civil rights.

"That statement about race, creed and color — well, it doesn't apply to handicapped people. We're left out of it."

Kopp, who was worked in a Denver area nursing home said that when residents there went against the rules, a punishment was to take their electric wheel chairs away. "That's (the chairs) your freedom, you're movement. Without it, you can't get around."

Rule Ridiculed

He ridiculed a rule that said the handicapped had to be in bed by 9 p.m. "Why should a grown man have to go to bed at 9 o'clock?" he asks.

"It's a so very dehumanizing way to live, to say the least," Ms. Chism adds. "You're without privacy. All your dignity is just gone. You're not recognized as a person. You're a patient and that's it."

Nursing homes "like a lot of young people around, tooling around in their wheel

chairs," Kopp says. "It adds an air of something nicer than just a lot of people sitting around."

By the same token, there isn't a lot of willingness to give the young people the freedom they feel and need, Kopp says.

Those who are "lucky enough to have a taste of living normally really get depressed. It can be a very sad thing."

It was soon after Kopp stopped working for the nursing home in Denver that he and a friend — Wade Blank — decided that "there's gotta be a better way to live. There has to be some better options."

They slowly began to attract verbal, but not much monetary, support for their idea. And Atlantis Community, Inc., was born.

Eventually the group wants to build a 140-unit apartment complex for the severely handicapped.

Right now, however, their first project is the seven apartment units in Las Casitas complex on Denver's west side where the eight young people will be moving Sunday. The apartments are on the western edge of a larger apartment complex in the 1200 block of Federal Boulevard.

Credit for helping to make Atlantis' dream a reality goes to Dr. Henry A. Foley, state director of social services, and John Helm of the Denver Housing Authority, Kopp said.

"We went in cold to Dr. Foley, and he got us \$3,000 seed money to apply to a larger grant," Kopp said. The grant, from the Department of Vocational Rehabilitation, made possible almost \$20,000 in renovations at the Las Casitas apart-

ments. Helm told them about the apartment vacancies.

The new tenants will live on welfare and social service payments, and visiting nurses and on-site attendants will help take care of their medical and personal needs. On July 1, six other tenants will move in.

Those slated for the Sunday move are "frightened, understandably," Ms. Chism says. "When you've lived in an nursing home much of your life, you're naturally apprehensive about living on your own."

She said police were worried about the safety of the tenants because the apartments are in a higher-crime area. "But they (police) don't realize that in an institution, you don't own anything for very long because it's stolen," Kopp said.

Meetings Encouraging

Meetings with a tenant union at Las Casitas have been encouraging, he added, and residents already living there have welcomed the idea of their new neighbors.

The problem now is for Atlantis Community to stay alive financially so other young handicapped adults also can experience the freedom of independent living. And there are immediate problems like finding things such as kitchen utensils, bed linen and furniture to make the Las Casitas-like home.

But optimism about the future is apparent.

"When you think of how far we've come in a year," Ms. Chism says, "I'd say there's a lot more to come from Atlantis."

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LINDA CHISM ANDRE