

Participant-Directed Programs Policy Collaborative (PDPPC)
Meeting May 23, 2018
DRAFT MINUTES FOR REVIEW

- Highlighted items indicate follow up is required.
- Bold and italic indicate a group decision.

Executive Summary:

We had several announcements, began to address a better way to deal with transitions of Authorized Representatives, heard about a rate increase and received information about the evaluation process. We were shown and were able to give input about a new Professional Medical Information Page (PMIP) that the department is designing to go along with the new universal assessment tool that they hope to implement in 2020.

John opened the meeting at 1:02 PM and attendance was taken. Voting rights were announced and there was no disagreement.

Minutes: There were no corrections or additions to the April minutes, Kevin moved and Kirk seconded approval of minutes as sent. ***Motion carried unanimously.***

Open Forum Number 1:

- Julie Reiskin announced that a PDPPC member is now in hospice care.
- Gerrie Frohne reported that there is a new national organization called The Alliance for Citizen Directed Support. It is exciting to have a national group to represent what we all believe in. If you google Citizen Directed Support you will find them. They have not thought of a state chapter but Gerrie suggested this and membership is affordable.
- Rhyann Lubitz announced that Katie McGuire is not here because she is doing bridge testing in the actual environment. This is good and reflects progress re SLS.
- Kirk Miller gave an update: There are still issues with case managers not talking about CDASS or IHSS. **Brent shared his number with Kirk and will meet with him to get the details.** Rhyann was taking to Consumer Direct about a mandatory brochure that would explain all services including consumer direction.
- Kady from Consumer Direct announced a new training opportunity. Next month on June 19th at 11 am they are hosting their first lunch and learn. The goal is to try to do skills based training for clients and caregivers to develop skills. This is a way to add more tools and not to replace clients training their workers. It will be in Lowry Conference Center –it is free and lunch is provided. An announcement went out. This is the first and they will do several more and they are open to

topic suggestions. This topic is standard precautions. There is no call in but the training will be taped.

Authorized Representative (AR) Resignation Process: Rhyann said this was on the agenda in response to Robin speaking at the last open forum. It seems to be difficult when an AR wants to resign. Robin said that the individual issue was solved but she thought it needed to be dealt with systemically. Background: CDASS or IHSS clients that need or want support in managing their care are allowed to have an authorized representative manage their care or help them manage their care. An AR must know the client for at least two years and this is a volunteer position. Most ARs are other clients or family caregivers. We began with the question: How does an AR resign? We have no formal process, other than a form that says they should notify a case manager. Julie said that it is easy enough for the AR to resign but the problem is the replacement. Rhyann said that they have seen situations where an AR dies or there is a family dispute situation where no one is talking to each other. When this has happened the FMS, HCPF and Case management come together to prioritize a solution and keep things going. Julie suggested there be a thought about a backup AR. Louise asked if the AR has to let someone know. The answer is yes, but we cannot make them do so. Kirk suggested a backup AR also. Someone suggested that a plan for a AR resignation should be on ASMP. We do not want to create barriers to getting started, but have to think about a plan just in case there is a problem. Robin suggested having a one meeting subcommittee to figure out responsibility? Curt said that this is a training issue as well. Someone asked if it would be responsibility of a Power of Attorney (POA) to go through training. Louise thought modified training would be good for POA and Bonnie agreed and clarified that it has to be modified training not the regular training to make sure a POA that was also an attendant never gets information on the budget. Louise said that there should be written steps about who gets notified first. It should not be the case manager because they do not always get back to you. Maybe someone else should be the first person. There is not a lot of guidance. Linda suggested we put the fix in policy and at least give temporary authority to have people sign time sheets to keep services going. Julie and Rhyann both acknowledged that one cannot force an AR to do a resignation form (or anything else) since they are volunteers. Louise said something should be in writing and that whoever takes the information should fill out a termination form. Kirk asked if the past AR could write down care guidelines if they exist. Rhyann said an AR transition plan should be fleshed out on the website and everywhere. ***We agreed this is not just about rules, or training, or forms but that we need a group to look at training, forms, rules, etc. This is important and Rhyann will send an email to set up a workgroup.***

REINSTATEMENT OF CDASS FOLLOWING HOSPITAL OR REHAB STAY: When someone is not getting HCBS for 30 days or more the federal waiver requires that their HCBS case is closed. This causes people who are in a hospital or nursing home for long period of time have CDASS cut off. This is a problem and delays going home. This is traumatic and makes discharge impossible. Rhyann explained the process: If someone is in a facility or hospital the case manager has to do new assessment and then has to get financial eligibility from the county. She said case managers often advise not to leave until they get services authorized and set up. This is doable in a facility but not a hospital. A case manager has 2 business days to do the assessment. Then there is a problem with the county but this is outside of the PDPPC purview, so we decided to focus on reopening CDASS. We agreed that we need to find out some information:

- What is the timeline in terms of employment law? Can the FMS keep employees active even if HCBS is closed so when it is reopened they are ready and no paperwork is needed?
- Is there always a need to do a new task sheet? Even if someone has greater needs, they could go home with the old allocation and have the case manager do a task sheet the first few days after being at home.
- Can we have a rule where someone who has been on CDASS within a year they do not have to get training (if there are no issues and person is not in the hospital because of problems with care)?
- Can we get some services going immediately even if some paperwork is still in process?
- If someone needs more services after a hospital stay, if they had services unused we could let them use those unused services instead of an increase. If after they used those services they still needed an increase that could be addressed but it would be more cost effective to just let the person use their savings accumulated while they were in the hospital.

Linda said if someone has been on CDASS why should everything be undone when they are in the hospital? She said even if the waiver has to close, why can't CDASS stay open? Heather in Mesa County said that they have had clients experience this problem. She said when someone on the Western Slope is very ill, the clients are transferred out of county for more sophisticated medical care. Trying to negotiate the return home with a client out of county makes it really hard in rural counties. The clients need care the day they leave the hospital or facility. Hospitals do not want to wait for the CDASS process. Hospitals want or need to discharge someone the minute they no longer need the hospital level of care. Curt agreed with Linda and said there are systems issues including the PAR. If this happens during a recertification process, it makes the whole

situation more complicated. In this case a client might miss a notice and is terminated without the client knowing. Result: ***We will talk more about this next month. Rhyann can find out from the FMS if they can suspend rather than terminate so that employee paperwork remains valid. This would allow people to receive services the day they are ready to leave. The training component is easier and we can look needed changed in the rules committee.***

Rate Changes:

We are getting rate increases!!!! Rhyann is working with DXC and FMS vendors on implementation. Increases are:

- SLS CDASS will be 1% across the board.
- IHSS and CDASS (in EBD, CMHS, BI and SCI waivers) will get a 1% across the board to Health Maintenance
- IHSS and CDASS (in EBD, CMHS, BI and SCI waivers) will get 5.25% for personal care and homemaker.
- Direct Service Provider increase for certain SLS CDASS will get a 6.5% increase.

These rates increases apply to IHSS and CDASS. IHSS will be notified via provider bulletin. CDASS is notified here and anywhere else possible. Rhyann says the rates except the SLS 6.5% will be implemented 1/1/19 and the SLS rate increases (6.5%) will be later in 2019. Waiver amendments/CMS approval is needed along with systems changes.

Discussion: Gerrie said it seems discriminatory that DD clients get such a greater increase than other clients. Julie agreed and said we also need to raise the top level of \$39.30. This is even more important if we cannot address the first hour issue where someone needs to get at least an hour of pay for showing up and doing a short visit. If we can only pay a quarter or half hour we need a much higher rate. Also, we have not raised this ceiling in many years. This high rate is important for emergency care and RN visits.

Professional Medical Information Page (PMIP) Review:

Tim Cortez was introduced: They are working on a new assessment tool. There is a procedural change—with new assessment and support planning process. This will probably be in 2020. This is the long term care professional medical information page. A draft copy was sent ahead of the meeting. This form is currently used for assessments and reassessments for functional eligibility. Case managers send it to the primary care doctor. In the future the hope is to do this electronically and have it prepopulated and the doctor just verifies the information to get a better response rate. The doctor could choose to fill out any missing information. HCPF wanted to pull other

forms into this one like the physician attestation form to assure doctors do not have to sign more than one form.

Comments and questions: ** indicates many people agreed

Julie said there was a lot of extraneous information that felt intrusive. Everything is subject to interpretation. Curt, Corrine, and others agreed.**

It was mentioned that it is hard to get these forms back from the doctor. Doing this electronically would help a lot. **

Love idea of one form. **

Suggestion to allow CDASS clients to choose to skip extra information.**

Tim said the hope is to use this form only for the initial assessment to meet targeting criteria (where they often need a diagnosis for some waivers such as the Brain Injury Waiver). After the initial assessment, they hope to disconnect this form from eligibility in the reassessment process. Most of the diagnoses on these forms are permanent. Someone who has a brain injury this year is not going to not have a brain injury the next year. This change would require CMS approval but it would be in line with what other states do.

Louise asked about the health status question and said that if someone was hospitalized or spent time in a facility the doctor or nurse would not know about these things. Would the case manager contact the client to verify that the information on the form is correct? Louise also said in Section 2 when you use the word "require" regarding at home monitoring, doctors look at this a certain way. They see this as a commitment. Julie expressed a concern about at home monitoring and felt doctors might say yes trying to be helpful and but did not want people to feel forced to have some sort of monitoring. Tim said the state would not require monitoring and clients could refuse it. Julie asked for assurance that if the doctor said NO it was not needed that this could not be used to deny eligibility. Louise mentioned on Page 3, the functional information documented during assessment included menses care. How would the assessor know about this during an assessment? She and other pointed out that the doctors do not know what we can and cannot do. Doctors would not know about things like a bowel program. **Tim said that they would look at "requirement" for rewording.** Tim said information would be prepopulated from assessment so doctor just has to sign and return.

There was a discussion about falls. There was a discussion about how the case manager would know about all of the questions and Tim said that this information is

pulled from the assessment. Louise said in order for us to get follow up care, the physicians need to document problems. She said that the Physician needs to identify where follow up is needed and wondered about the role of the case manager. Julie said case managers listed should be the RAE (Regional Accountable Entity) not Long Term Support Services (LTSS) if the follow up is medical care. Julie said that LTSS case managers do not have time to deal with medical issues. **Tim agreed that case manager time is stretched and that it would be appropriate to refer to the RAE.** Gerrie asked if the new assessment will have a requirement to go to the primary care provider. Tim said this is not required. Gerrie said there is a lot of data that is not appropriate. She said that if the information going to a doctor is going to help someone, great, but this should be up to individual if this is person centered planning.

Tim then gave an example of assessment he did when he was a case manager. He went for a quarterly visit and saw a sharp decline of the client in three months following entry into the HCBS waiver. He said there had been multiple falls, and other problems. He saw that the number of medications went from 6 to 13. He got together with the providers and said there was no reason to have more services but there was a need for medication management. He coordinated with the providers and they reduced medication and saved Medicaid dollars. Gerrie said you could just ask the client instead of working around them. **

Kirk said #5 on health status raises concerns about patient and doctor confidentiality. He asked why are they asking about mental health support when this should be confidential. Kirk said unless the state provides better mental health care it should not be there. Tim said under HIPAA they can share among health care providers for coordination. **Tim said he will check because there are new federal restrictions especially about substance abuse.**

Linda said it seems people putting this together were looking at clients in a holistic way, but she has concerns about the amount of mandated sharing and that a lot of this does not relate to LTSS. She said that Tim's example demonstrated good case management and this cannot come from a form. ** She said that we need to rethink the purpose of the form. Is the goal for the form to replace the case management function?

Louise said regarding the example, the case manager should ask the client when did you notice you could not do X? This would have triggered the client to realize that it happened after a fall and then realize that she had started new medications. Tim said the point is to flag the information for the case manager. Louise said this could leave to privacy violations. **Tim said they would go back and re-evaluate the information.**

Alicia wanted to confirm that HCPF would no longer require the form to do functional eligibility. Tim said it would be used for *the initial assessment* to get targeting criteria. After the initial assessment HCPF would not tie the form to eligibility. HCPF would still require the case managers to send the form out and collect the information. It just would not be tied to eligibility. Alicia suggested that it should be drafted better to make sure medical provider would know a signature is needed. This should be bolded and made very clear. With all of the new information the provider could miss that. **

Linda said we needed to focus on what is the true need to know and only ask that information. **

Consumer Directed Care Evaluation: Triwest the organization that was selected to conduct this evaluation reported on their progress. For details about the evaluation please see earlier minutes.

There were three components of the evaluation:

- 1) Key informant interviews
- 2) Survey
- 3) Cost analysis based on claims data

They are in the thick of it, getting analysis completed and reports written.

- Key Informant Interviews: They did 31 interviews with 35 people. They heard positive things about IHSS and CDASS. Client satisfaction is very high. Half of those interviewed were consumers and others are advocates or agency staff. Transitions from agency care to consumer directed are reported as being positive and care is higher quality once it is consumer directed.
- Survey: They sent over 3000 surveys to consumers divided into CDASS participants based on waiver, IHSS, and some to people getting agency care as comparison form. They hoped to get 30% return. They have closed the survey, but are getting stragglers in. Anything received by Friday will be counted. The rate of return has been 25% response for CDASS, 24% for IHSS and 19% for agency clients. Most replied by mail, about 10-15% replied online but a couple did telephone calls. These numbers will go up a little because some responses are not yet entered.
- The cost analysis is underway. Triwest heard in the interviews and from PDPPC about the importance of context within the cost analysis.

Questions/Discussion:

Linda: how do you include health outcomes? Answer: They asked people in surveys and have some proxy health outcomes that they can see in the data. They can look through a 5-year period after client stopped or started CDASS or IHSS.

Valerie: What is ETA for cost analysis? Answer—everything has to be to HCPF and then corrected before June 30th. Triwest hopes to have a high-level summary to us by next meeting. If HCPF has data by the end of fiscal year (June 30th) how long until we can see it? Rhyann hopes to get it through clearance ASAP but is not sure how long it will take. Valerie was interested in getting this to DORA and Rhyann said it will get to everyone at the same time.

Linda: Will we get everything that goes to HCPF and if we do not get everything can we know what is not being shared? Answer: Yes.

Open Forum #2:

- Kathy Estes: She had been on CDASS through 1915i and now is going onto CDASS through SLS and was told she could not have homemaker due to her SPAL not having enough room. She said that the 1915i clients were promised that they would not lose services in the transition but this would cause a loss of homemaker services. **Katie McGuire asked to speak to her directly to resolve this and Kathy agreed.** The transition from 1915i to CDASS/SLS will not result in a loss of services.
- Linda S.: Several people have been involved in the HCPF stakeholder involvement review process and there have been significant kudos to PDPPC about how it is well run it is. Many list PDPPC as the ideal stakeholder committee process.
- John Barry said that next month we will be at Javiation (same place where MS Society has an office).

The meeting adjourned at 3:18 PM.

Respectfully submitted

Julie Reiskin