HCBS SOTA Call Series

Innovative Strategies for Implementing the HCBS Rules in Settings Serving Aging Americans

Wednesday, August 24th 1:30-3:00 p.m. ET

Part Two of a 2-part Series

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Webinar Agenda

- **Welcome & Overview Remarks**
  - Melissa Harris, Sr. Policy Advisor, Disabled and Elderly Health Policy Group, Centers for Medicare & Medicaid Services (CMS)
  - George P. Failla, Jr., Acting Deputy Director, Division of Long-Term Services and Supports, CMS
  - Becky A. Kurtz, Director, Office of Long-Term Care Ombudsman Programs, Administration for Community Living
- **Experts Panel Discussion**
- **Q&A**

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Intent of the HCBS Settings Final Rule[1]: CMS 2249-F and CMS 2296-F

- To ensure that individuals, who are receiving long-term services and supports through home and community based service (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities, have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate.

- To enhance the quality of HCBS and provide protections to participants.

[1]Published in the Federal Register on January 16, 2014, under the title, *"Medicaid Program; State Plan Home and Community-Based Services, 5-year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice (Section 1915(k) of the Act) and Home and Community Based Services (HCBS Waivers (Section 1915(c) of the Act)"*.

HCBS Setting Requirements

Is integrated in and supports access to the greater community

Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources

Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS

Is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting

Ensures an individual's rights of privacy, respect, and freedom from coercion and restraint

Optimizes individual initiative, autonomy, and independence in making life choices

Facilitates individual choice regarding services and supports and who provides them

*****Additional Requirements for Provider-Controlled or Controlled Residential Settings*****

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HCBS Rule Highlights Related to Community Access

- The home and community-based setting requirements establish an outcome-oriented definition that focuses on the nature and quality of individuals' experiences.
- The requirements maximize opportunities for individuals to have access to the benefits of community living and to receive services in the most integrated setting.

HCBS Rule Highlights Related to Community Access (2)

- Additional requirements for provider-owned or controlled home and community-based residential settings include:
  - The individual has a lease or other legally enforceable agreement providing similar protections;
  - The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
  - The individual controls his/her own schedule including access to food at any time;
  - The individual can have visitors at any time; and
  - The setting is physically accessible.

- Any modification to these additional requirements must be supported by a specific assessed need and justified in the person-centered service plan.

Review:
Person-centered Service Plan & the HCBS Rule (1)

- The person-centered service plan must be developed through an individualized planning process.
- The person-centered planning process is driven by the individual.
- Includes people chosen by the beneficiary and/or the beneficiary's representative, which may include a variety of individuals that play a specific role in the beneficiary's life (ie. members of the beneficiary's interdisciplinary team, family members, friends, individuals providing natural supports).
- Provides necessary information and support to the individual to ensure that he or she directs the process to the maximum extent possible.
- Is timely and occurs at times/locations of convenience to the individual, his or her representative and others engaged in the beneficiary's person-centered service planning process.

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Review: Person-centered Service Plan & the HCBS Rule (2)

- Reflects cultural considerations/uses plain language.
- Includes strategies for solving disagreement.
- Offers choices to the individual regarding services and supports the individual receives and from whom.
- Provides method to request updates.
- Reflects what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.

Review: Person-Centered Service Plan & the HCBS Rule (3)

- Identifies the individual's strengths, preferences, needs (clinical and support), and desired outcomes.
- May include whether and what services are self-directed, and includes risks and plans to minimize them.
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
- Signed by all individuals and providers responsible for its implementation and a copy of the person-centered service plan must be provided to the individual, his or her representative, and others chosen by the beneficiary.

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Panel Facilitator

Becky A. Kurtz, Director
Office of LTC Ombudsman Programs
Administration on Community Living

Innovations in HCBS Implementation across Settings focused on Aging Beneficiaries: *Experts Panel & Agenda*

- **Innovations in Assisted Living & Memory Care: A Look at Illinois' Pilot**
  - Kelly Cunningham, Deputy Administrator, Medical Programs, IL Department of Healthcare & Family Services
  - Julie Simpkins and Teresa Wester-Peters, Gardant Management Solutions
- **Promoting Integration & Personal Choice in Adult Day Health Centers**
  - Kristin Ott, Full Life Care (Washington State)
- **The Critical Role of Direct Support Professionals in Facilitating Integrated "Aging in Place" Models**
  - Marla Lahat, Executive Director, Home Care Partners (District of Columbia)
- **Home & Community Based Services that Promote Optimal Independence and Personal Autonomy: Consumers' Perspectives**
  - Dick Weinman (Oregon)
  - Brian LeBlanc (Florida)

Perspectives and opinions of presenters do not necessarily represent official policy of ACL, CMS or any other federal governmental entity.

Innovations in Assisted Living & Memory Care: *A Look at Illinois' Pilot -- State Medicaid Agency Perspective*

- Kelly Cunningham,
  Deputy Administrator,
  Medical Programs,
  IL Department of
  Healthcare & Family
  Services

Innovations in Assisted Living & Memory Care:
A Look at Illinois' Pilot -- Assisted Living Provider Perspective

- Julie Simpkins,
  Gardant Management Solutions

- Teresa Wester-Peters,
  Gardant Management Solutions

- **Supportive Living Program Waiver**
- **Dementia Care Setting**

Kelly Cunningham, Deputy Administrator,
Division of Medical Programs
Department of Health care and Family Services

What is Supportive Living?

- The Supportive Living Program (SLP) is an assisted living model for persons age 65+ or ages 22-64 with a physical disability.
- Residents have individual apartments with lockable entrances, bathroom, kitchen area with refrigerator, sink, stove/microwave and individual heating/cooling controls.
- First building certified in 1999.
- Currently there are 145 providers with 11,800+ apartments.
- On average, 60% of residents are Medicaid eligible.
- During FY16 to-date the program has served 10,100+ Medicaid participants.

Why Start a Dementia Care Setting?

SLP providers, families and Department staff reported SLP participants with moderate symptoms of dementia were transferring to skilled nursing facilities; most often due to their risk for elopement and/or behaviors.

Program Goals (1)

Residents and families wanted to safely remain in a community setting where individuality and independence would be supported and celebrated.

SLP providers wanted to be able to continue to provide services to participants for whom they had been caring.

The State supported these goals and recognized a cost savings benefit due to fewer skilled nursing facility admissions.

Program Goals (2)

From the beginning, all parties involved wanted more than just another "program". The end goal was to offer a well-thought out service option that enabled persons with dementia to have a better quality of life; one where they could receive the support they needed to remain independent and families knew they were safe and stimulated.

Program Development

The State partnered with:

- Greater Illinois Chapter of the Alzheimer’s Association,
- SLP providers,
- Other dementia care providers, and
- Department field staff (Registered Nurses) who monitor the SLP waiver.

Additionally, other dementia programs were reviewed, including onsite visits.

Administrative Rules (1)

Title 89 Ill. Adm. Code, Part 146 Subpart E, was developed specifically for dementia care.

Title 89 Ill. Adm. Code Part 146 Subpart B, contains rules and requirements for conventional SLP, which are also applicable to dementia care settings.

The rule making process included a public notice and comment period prior to adoption.

Administrative Rules (2)

Admission Requirements:

- Age 65+
- Level of care screening (same as conventional SLP)
- Symptoms related to internal pathological changes in the brain. Those symptoms must affect intellectual and social abilities severe enough to interfere with daily functioning, in that it is unsafe for them to reside alone. Examples of diagnoses that could meet this definition include Alzheimer’s disease, dementia, Pick’s disease, brain injury or brain atrophy.

Administrative Rules (3)

Physical Setting:

- No more than 20 apartments per dementia unit. A provider may have more than one unit.
- Cannot be located above the 2nd story (emergency planning purposes).
- At least one common area for every 10 residents.

Administrative Rules (4)

Safety:

- Alarmed, delayed exit doors.
- Secured outdoor common area.
- Resident laundry rooms used with staff oversight.
- A minimum of three wellbeing checks/day instead of one, as required in the conventional SLP setting.
- Staff oversight provided with smoking.

Administrative Rules (5)

Assessments:

- Same initial level of care assessment.
- Same comprehensive resident assessment.
- Kitchen appliance assessment (to assess ability to safely operate).
- Elopement risk assessment (to verify need for safety intervention of secured egress).
- St. Louis University Mental Status (SLUMS) or Montreal Cognitive Assessment (MOCA).
- Expanded quarterly assessment .

Administrative Rules (6)

Staffing:

- One licensed nurse or certified nurse aide (CNA) for every 10 residents.
- Licensed nurse must be available 24 hours/day.
- Additional training specific to dementia. Four hours required within 7 days of hire and 12 hours annually.
- Illinois requires criminal background checks for all SLP employees.

Dementia Care Setting

- Applications were solicited statewide from current and new providers.
- Five applicants were approved.
  - Two in metro Chicago
  - Two in Central Illinois
  - One in Southern Illinois
- First dementia care setting was certified 6/21/11.
- Five sites currently certified with 119 apartments.
- Three sites are physically connected to an operating, conventional SLP provider building.

Program Data

- To-date, approximately 200 waiver participants have received services in the dementia care setting.
- Most residents are female (>80%).
- Average age at admission = 83.
- Over half of participants are admitted from a conventional SLP provider.
- Overall provider compliance has been good. Onsite biannual certification reviews and complaint investigations are completed by the Department.
- Substantial waiting lists.

Program Innovation (1)

Concerning Activity Log

SLP providers helped develop and agreed to implement the use of the Concerning Activity Log. The purpose of the log is to identify new behaviors exhibited by residents that might be a symptom of a larger issue or new need. Walking or pacing that is not accompanied by agitation is not a "concerning activity", however, a pattern of refusing to eat or public toileting would fall into this category.

Program Innovation (2)

Joint Provider Training

- The Department partners with two trade associations to offer joint training for providers and State staff. Training topics include dementia care.
- Training is held twice a year at a Chicago and downstate location each time.
- Dementia topics have included non-pharmacological solutions for behaviors, intimacy and sexuality and supporting persons with dementia.

What Illinois Has Learned (1)

Length of Stay

A positive, unexpected outcome of the SLP dementia care setting is participant length of stay. The Department anticipated short-term stays with discharges to a nursing facility occurring within several months. The average length of stay for residents in the dementia care setting has been found to exceed 15 months. Most residents transfer to a skilled nursing facility.

What Illinois Has Learned (2)

Level of Care

Participants in the dementia care setting have higher level of care scores. Comparison of annual level of care reviews with participants in conventional SLP found not only did they receive more services, but also that the level of service required was greater.

A large difference was seen in the amount of verbal cuing needed for Activities of Daily Living (ADL), including late loss ADLs such as transfer, eating and toileting.

What Illinois Has Learned (3)

- Interviews and observation of participants during onsite bi-annual reviews have found residents have comprehensive, individualized plans of care. They make choices just like other SLP residents, such as decorating their apartments, participating in activities, selecting clothing and interacting with family and friends.
- Anecdotal information gathered by Department staff while completing on-site reviews has revealed families who are very grateful for the program and speak highly of staff.

Future Plans

- Program expansion
- Additional quality data collection, such as:
  - Utilization of verbal cuing for ADLs.
  - Reason for discharge (cognitive, physical, behavioral decline).
  - Short-term nursing home and hospital admissions and reasons (falls, acute conditions).
  - Family satisfaction survey to gain input on program improvements.

Person-Centered Care

Lessons Learned and

Innovative Practices

White Oaks Memory Care

- Open Date: 2012
- # of Apartments: 32
- Number of Persons Served: 138
- Common characteristics
  1. Dementia or significant cognitive impairment
  2. Concerns for personal safety
  3. Previous exit-seeking and wandering behavior
  4. May otherwise require a higher level of care
  5. No longer able to live independently in their home

Know the Person, not the Disease

- Obtain baseline prior to admission
- Fears
- Relationships
- Coping with stress
- Intimacy
- Joy
- Career
- Hobbies and talents
- Sleeping, toileting, and eating preferences
- Resident life story

Reduce Stress Through Consistency, Predictability & Recognition

- Staffing- reduce turnover and improve retention
- Specialized education of staff
- Consistent staff assignments
- Meal times
- Schedule
- Recognizable landmarks
    1. Colors – “I live in peach”
    2. Murals
    3. Memory Box
    4. Name in Large print

Create Meaningful Opportunities to Contribute to and be Part of a Community

- Welcoming committee
- Use talents to enhance quality of life & environment of care
- Host events- art exhibits
- Volunteer opportunities
- Teach classes and be a lifelong learner
- Community partnerships: Park District, Library
- Show gratitude to public servants (police, fire)
- Be informed- sports, politics and news events
- Intergenerational programs- fulfill need to be a caregiver
- Technology- computers, phones

Physical Health and Safety

- Security of environment
- Exercise classes – improve balance and reduce falls
- Hydration – color is important
- Bathing and hygiene
- Psychiatrist and primary care on-site
- Infection control
- Sleep
- Nutrition
- Anticipate changes in behavior vs react to changes in behavior

Contact Information

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Promoting Integration & Personal Choice in Adult Day Health Centers

- **Kristin Ott**
  - **Full Life Care**
  - **Washington State**

Full Life Care

Adult Day Health Programs and Services

"In youth we learn, in age we understand."
~Marie Ebner-Eschenbach

Kristin Ott, MSW, LSWAIC

Who are our clients?

Older Adults

- Acute conditions
- Disabling chronic condition
- Comorbidity

Younger Adults

- Traumatic Brain Injury
- MS
- Developmental Disabilities

Cognitively and/or Functionally not able to care for themselves

Adult Day Health

- Nursing and Rehabilitation
- Social Services
- Behavioral Health
- Case Management
- Keep people in their homes and communities

Care Planning

- Individualized
- Goal setting
- Choice
- Variety
- Evaluation
- Outcomes

Adult Day Services

- Decreases isolation
- Promotes independence
- Support and understanding
- Increases self-esteem
- Community involvement

Bringing Community Together

<u>Alzheimer's Cafes</u>

- Meet in the community
- Socialization
- Peer support

<u>Preschool Projects</u>

- Halloween show
- Craft projects
- Story times

<u>Community Computer Lab</u>

Community Involvement

- Heads Up Art Show
- Community Gardens
- Farmer's Markets
- YMCA
- Seattle Public Library
- Mural project
- Field trips
- Mariners game
- Zoo

Try something new!

The Critical Role of Direct Support Professionals in Facilitating Integrated "Aging in Place" Models

- Marla LaHat
  - Executive Director, Home Care Partners
  - Washington DC

KEY ROLE FOR DIRECT CARE STAFF IN PERSON-CENTERED HOME CARE

Marla Lahat

Home Care Partners

Washington, DC

Key Elements of HCBS Rule

- Individual initiative, autonomy and independence in making life choices must be optimized across all settings.
- The individual drives the person centered planning process.
- Person centered care identifies the individual's strengths, preferences and desired outcomes.

Challenges in Applying Person Centered Care to Home Care

- Home Care services must meet basic needs to assist with ADLs and IADLs.
- Care plans often consist of lists of personal care, light housekeeping and meal preparation tasks that must be performed within a short period of time.

Challenges, continued

- Expectation is that the home care worker will remain busy with tasks for the entire visit.
- Little time is left for engaging client, learning preferences, recognizing and enhancing strengths.
- Administrators, clinical supervisors and state program monitors and surveyors don't always recognize the value of non-traditional home care activities.

Why are the Direct Care Workers so Important?

- Direct care workers are the heart of home care; they ARE the service that is being delivered.
- Direct care workers may be in the home for 4 to 8 hours per visit while nurses, social workers and other health care workers spend an hour or less and visit far less often.

HOW DO WE CREATE A PERSON CENTERED HOME CARE SERVICE?

- Hiring and personnel actions should consider a variety of worker characteristics.
- Training to direct care workers must incorporate person centered care and thinking outside the box.
- Workers need to be “permitted” and encouraged to engage in creative activities that may be outside the usual tasks.
- Philosophy must permeate the entire agency, from the administration through the clinical staff to the direct care workers.
- Government funders need to allocate resources and allow for flexibility.

CHARACTERISTICS

- Home care direct care workers must be skilled in performing tasks to assist with ADLs and IADLs.
- Home care direct care workers must be honest, ethical and dependable.
- Home care direct care workers must be caring, committed and respectful.
- Home care direct care workers must be CREATIVE and FLEXIBLE.

TRAINING

- Training on Person Centered care needs to be interactive and provide many case examples.
- Innovative training topics such as therapeutic engagement and compassionate touch should be incorporated into the curriculum.
- Ongoing refreshers should be provided.

PERMISSION

- Supervisors need to reinforce the expectation that workers respect client choices during field visits.
- Workers should be evaluated on their ability to be flexible and creative.
- Plan of Care/ Task Lists should include non-traditional activities.
- Family members may need to be oriented to the philosophy.

PHILOSOPHY

- Philosophy of person centered care must be incorporated at all levels of staff.
- Administrators must “buy in” to the philosophy in addition to clinical staff and direct care workers.
- Direct Care Workers need to know that their employer is supportive.

FUNDING

- State/ government Surveyors must recognize the flexibility and creativity demonstrated by workers.
- Allow enhancements of traditional task list
- Provide adequate funding to offer flexible schedules that allow time to engage clients and support their preferences
- Recognize that person centered care not only allows choices and greater satisfaction but also can enhance individual functioning.
- Reimbursements to agencies must be adequate to pay workers a living wage, offer good benefits, and provide innovative training.

SUMMARY

- Person centered planning and care must be incorporated at every level of home care with an emphasis on the direct care worker.
- Person centered home care services can be achieved by nurturing a variety of direct care worker characteristics including flexibility and creativity, delivering innovative training, offering support at every level, and providing good pay and benefits through adequate government reimbursements.

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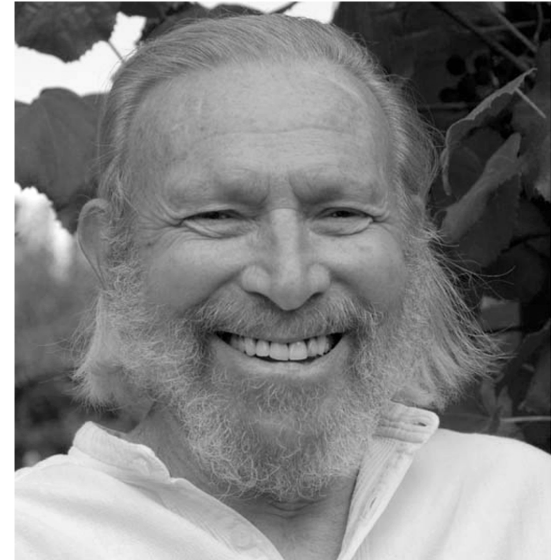
Consumer Perspectives

- **Richard ("Dick") Weinman**
  - **Oregon**



- **Brian LeBlanc**
  - **Florida**

Resources/Links

CMS HCBS Settings Rule Information:
https://www.medicaid.gov/hcbs

Full Life Care: www.fullifecare.org

Home Care Partners: www.homecarepartners.org

Dick Weinman links:

- The Thin Edge of Dignity: http://ltcombudsman.org/assisted-living/training-materials
- AARP Oregon Weinman Blog: http://states.aarp.org/region/Oregon

Facilitated Q&A/Interactive Panel Discussion

- Opportunity for all audience participants to submit questions to panelists, ACL, and CMS.
- Thank you for your time and interest in this topic!