

## **DRAFT HCBS Advisory Workgroup #1 Meeting Minutes**

June 22, 2015, 10:00 a.m. - 4:00 p.m.

Department of Rehabilitation, Room 242, 721 Capitol Mall, Sacramento, CA 95814

### **HCBS Advisory Workgroup Members:**

*Present:* Casandra “Cassie” Eastwood, John Beleutz, Julie Lehmann, Jonathan Istrin, Kristin Ansell, Sherie Abel, Anwar Zoueihid, Allison Lam (proxy for David Nolan), Joe Rodrigues, Mark Kuntz (proxy for Denise Likar)

*Absent:* Denise Likar, Chris Mathias, David Nolan, Mary Jane “Janie” Whitford

### **State Representatives:**

*Present:* Hannah Katch, Rebecca Schupp, Joseph Billingsley, Karli Holkko, Nichole Kessel, Robin Jordan

*Absent:* Aron Smith

### **Proceedings:**

*Meeting commenced at 10:00 a.m. by Hannah Katch*

- Member introduction and brief statement about meeting objectives and agenda
- Rebecca: The number of workgroup meetings could be expanded if the goals have not been met after the scheduled meetings.

### *Workgroup Charter*

- Introduction of draft charter.
- *Purpose/Mission:* To engage experts to provide recommended solutions to the Department of Health Care Services (DHCS) on ways to strengthen ongoing CCT operations; identify opportunities to align CCT with the Home and Community-Based Services (HCBS) Final Rule; enhance the beneficiary experience, health outcomes, and quality of services provided.
  - o Sherie Abel: Is there a clear definition of the Final Rule?
  - o Rebecca in response: There is information on the DHCS website.
  - o Sherie Abel: It would be helpful to have clear categories of beneficiaries regarding individual conditions to aid in development of personalized health care plans.
  - o Jonathan Istrin: So we don't have control over the Final Rule?
  - o Rebecca in response: No, it is a federal regulation but we do have control over how we come into compliance with the rule within the programs.
- *The Role of Workgroup Members:* The HCBS Advisory Workgroup Members were selected based on their knowledge of, and experience with, serving seniors and persons with disabilities, the CCT Demonstration, and/or Home and

Community-Bases Services. We are grateful for your partnering with DHCS to inform and make recommendations on CCT related topics to help with the enhancement of the delivery of CCT services.

- Sherie Abel: What is AMA?
  - Rebecca Schupp in response: It stands for Against Medical Advice
  - Jonathan Istrin: There is an issue of where the right of the consumer ends. An example is in cases where an individual will exercise free choice to commit self-harm. There needs to be a clear boundary between provider and client rights.
  - Rebecca Schupp in response: Beneficiaries have the right to make an informed choice after receiving education and counseling on consequences of going against the providers' recommendation.
  - Jonathan Istrin: When do we have to comply with the regulations?
  - Rebecca Schupp in response: While it is in place now states have 5 years to come into compliance with the regulation. All providers must be compliant by March 2019. There will be a link sent out to better understand the Final Rule.
- *CCT Workgroup #1 Objectives:*
1. Integrating the Social and Medical Models of Care – finding a balance between ensuring the health and safety of consumers while upholding autonomy, independence and self-determination.
  2. Ensuring Person-Centeredness within CCT to better align the Demonstration with the Home and Community-Based Final Rule.
  3. Enhancing the CCT Redesign
- *Outcomes: HCBS Advisory Workgroup #1 will:*
1. Provide a consensus-based philosophy to present to CCT Service Providers that describes California's philosophy on the integration of the Social and Medical Models of Care.
  2. Provide a list of consensus recommendations on ways to integrate the Social and Medical Models of Care in CCT to meet the holistic needs of every individual, including: program-wide standards, flexibilities, gaps, areas of concerns, etc.
  3. Provide recommendations on opportunities to adapt and implement CCT policies, procedures, tools, and resources to strengthen and enhance person-centeredness to better align with CMS' final rule.
  4. Develop clear person-centeredness standards for CCT transitions, and identify measures for determining if CCT transition services are meeting the standards.
  5. Provide a list of recommended strategies for DHCS to present to CCT Service Providers on ways to strengthen the role of the consumer throughout the entire CCT transition process.
  6. Provide a list of recommended strategies or solutions for DHCS to present to CCT Service Providers on ways to improve the delivery and efficacy of CCT.
    - Jonathan Istrin: In LA the housing is maxed out. Is there a way to grandfather in people who have been transitioned from SRO's to meet the final rule?

- Rebecca Schupp in response: This is discussion for a different workgroup and related to the Final Rule, not specifically related to strengthening CCT.
- Sherie Abel: Could there be exceptions where individuals could qualify for the time being until housing is found?
- Sherie Abel: Does CCT have its own definition of person-centeredness?
- Rebecca Schupp in response to Sherie: Not at this time. This issue could be discussed and decided on later in the workgroup meetings. CA is tasked with defining and ensuring person-centeredness throughout all the HCBS programs pursuant to the Final Rule.
- John Beleutz: What process will be used to come to a consensus?
- Rebecca Schupp in response to John: The goal today is to ensure everyone has the same base understanding and the following meeting will focus more on the discussion of social and medical models and the group will provide consensus to make solid recommendations to DHCS.
- John Beleutz: The objectives are broad and the main challenge will be to narrow the priorities and be specific.

### *CCT Demonstration Structure*

- Power Point presentation to provide overview of Olmstead Act and MFP grant as well as the past, present, and future of California's CCT program.
  - John Beleutz: Could we have additional data regarding the transitions including the number and type of each transition.
  - Sherie Abel: CCT programs should be required to provide higher levels of care than in a health care facility due to participants needing to re-acclimate to independence.
  - Rebecca Schupp in response: We agree and this Workgroup can look to recommend adding services that should be made available through CCT.
  - Sherie Abel and Kristin Ansell: There is also a need for training among caregivers as well as supplemental support. This needs to be done prior to transition.
  - Kristin Ansell: There is a great amount of fear in the transitions.
  - Sherie Abel: There is a need to identify and address gaps in CCT services. These include, transportation issues, lack of medical supplies at home, and adequate training for both the beneficiary and caregiver. Someone needs to be there the first day of the transition to aid in the process.
  - Rebecca Schupp in response: There is post-transition training provided currently through CCT but a recommendation may be pre-transition training. A "walk through" prior to transition could be helpful to identify problem areas. The transition structure needs to be strong and reliable with consistent standards.
  - Sherie Abel: Suggest Transitional Case Management and recommends connecting to Section 8 housing opportunities.
  - Julie Lehmann: Section 8 vouchers are not available in Northern California. The waiting lists are closed.

- Anwar Zoueihidr: Is there a way to influence housing and IHSS programs to streamline the application process?
- Rebecca in response: Strengthening CCT and HCBS programs will be discussed in the next workgroup.
- Joseph Billingsley: The state can assist in requesting expedite processes if transitions aren't moving forward.
- Sherie Abel: When looking at the redesign are there additional financial resources available?
- Allison Lam: Is the purpose of the assessment in the redesign to weed people out?
- Rebecca Schupp in response: No, the assessment is to help identify the needs and risks, develop a care plan and how these needs and risks will be met.
- John Beleutz: The common assessment is a good step but the issue is money, the services need to be reimbursed. The combined medical and social models cost more and rates have not changed since 2007.
- Rebecca Schupp in response: Rates are a complex discussion and something that cannot be decided during Workgroup meetings.
- Julie Lehmann: NF's gets a [cost of living adjustment] COLA every year but cost neutrality is based on the number pre COLA. This results in a lower reimbursement than other medical programs and affects ability to attract staff.
- Rebecca Schupp: When recommending changes to the reimbursement structure we need to consider remaining cost neutral to the general fund.
- Cassie Eastwood's response: We need a manual and training for LO's it takes too long for [treatment authorization requests] TARS to get approved.
- Mark Kuntz in response: Monthly calls with nurses to address TAR issues were very useful in this regard.
- Johnathan Istrin: The old approach had more touches because it was less targeted on transitions that have the best chances for success.

### *Public Comment*

- Public Commenter 1: Does the redesign encourage "cherry picking"? There should be clearly defined CMS rules and guiding principles for at what point and when CMS can make the final decision to CCT.
- Public Commenter 2: There is a concern of cost neutrality with funding. In the case with Sherie she was sent home to boxes of unpacked medical equipment that she could not open or assemble herself. Many of these items were lifesaving and not having access to them could create more medical expenses in the future.
- Sherie Abel: Why can't IHO cost neutrality be based on the actual costs of a SNF stay? SNF gets to TAR on top of the daily rate.

### *Finalize Charter for Workgroup #1*

- Charter motioned and finalized, approved without opposition or revision.

## *Introduction to the Medical Model and the Social Model of Care*

- Power Point to introduce both models of care and how they can and should work together.
  - o Julie Lehmann: Successful transitions must include both perspectives.
  - o Joseph Rodrigues: There has been a shift toward person centered care in nursing home (NH) care as well as in long-term care (LTC) institutions.
  - o Allison Lehmann: Historically the focus was on immediate fixes however, there is a huge push towards understanding the complexity of care and of people as more than just a condition.
  - o Mark Kuntz: I use the biopsychosocial model which look at all of the needs of a beneficiary by adopting a bio/mental/social focus.
  - o Sherie Abel: I propose using sub workgroup to flesh out some additional needed details.
  - o Anwar Zoueihid: Social workers and medical staff should work in conjunction with each other.
  - o Consensus is that both models must be utilized for everyone.
  - o Sherie Abel: Are we using the definition of social model of care provided in the power point?
  - o Rebecca Schupp in response: No, we will recommend a CCT specific definition.
  - o Sherie Abel: I propose a sliding scale of funding since some individuals will require more money based on care needs than others.
  - o Julie Lehmann: Could funding be based on a certain amount of money per person instead of an amount of money allotted to each category?
  - o Workgroup consensus: There should be a streamlining and coordination of CCT with other delivery systems, primarily HCBS.

## *Case Studies*

- Three case studies presenting a social model of care, a medical model, and a combined model.
- Case 1. This case was an example of the social model of care.
  - o Sherie Abel: It would be nice if skilled nursing facility (SNF) employees trained the individual to care for themselves prior to transition.
  - o Cassie Eastwood: It appears there was a gap in case management and CCT Lead Organizations (LOs) needed better follow-up.
- Case 2. This model was an example of the medical model of care.
  - o Hannah Katch: The federal government should require the parity of mental health and physical health going forward.
  - o Sherie Abel: I would like to see a checkoff list created that needs to be completed pre transition.
  - o Sherie Abel: Community doctor must be engaged prior to transition and consumers transitioning should see the residence they are transitioning to prior to transition, as well.
- Case 3. This was the ideal case showing a combined social and medical model.

## *Workgroup's Timeline*

- Next workgroup meeting is September 30<sup>th</sup>, same time and location.
- The second meeting will discuss the integration of both the social and medical models of care.
- DHCS will create a list serve for discussion board capabilities.
- Rebecca Schupp: We will provide CCT statistics in the next meeting.

#### *Public Comment*

- Public Commenter 1: The two models are mutually exclusive and CCT should be established as a medical model and social components and standards should be built in.
- Sherie Abel: People get used to what they have in the nursing home in terms of care and supplies. This makes them dependent and they are not used to caring for themselves after transition.

#### *Action Items*

- Meeting minutes will be drafted and distributed to work group members by Wednesday, July 1.
- DHCS will send out the following items:
  - o A list of workgroup members, their affiliations and email contact information.
  - o A link to the CMS HCBS Final Rule.
  - o A link to DHCS' website with information on California's HCBS Statewide Transition.
  - o Data on the number of transitions by provider type and target population.
  - o Agenda and meeting materials for the next Workgroup meeting, September 30, 2015.