

HCBS Advisory Workgroup #1, Meeting 2
DRAFT Meeting Minutes

September 30, 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 "Cassy" Eastwood, John Beleutz, Julie Lehmann, Jonathan Istrin, Anwar Zoueihid, David Nolan, Denise Likar

Call in: Mary Jane "Janie" Whiteford, Kristin Ansell

Absent: Sherie Abel, Chris Mathias

State Representatives:

Present: Hannah Katch, Rebecca Schupp, Joseph Billingsley, Karli Holkko, Nichole Kessel, Joe Rodrigues, Aron Smith

Call in: Robin Jordan

Absent: Jay Harris

Presenters:

In person: Heather Thompson, East Bay Innovations
Katie Gallipeau, East Bay Innovations
Serom Sanftner, East Bay Innovations
Tom Heinz, East Bay Innovations
Pamela Mokler, Care 1st

By phone: Louis Frick, Access to Independence

Proceedings:

Opening

Welcome & Introductions - Meeting commenced at 10:10 a.m. by Hannah Katch

- Welcomed members and guest presenters, and thanked everyone for their time. Shared that the purpose of the workgroup was for DHCS to benefit from the knowledge and experience of the workgroup members.

Review of Action Items from Previous Workgroup - Rebecca Schupp provided a summary of the events of the previous meeting:

- Workgroup #1 charter is final
- Discussed the need for a holistic model of care that includes the strengths of both the medical and social models of care
- Reviewed action items from previous meeting and discussed the emails that went out to workgroup members in response to each item

Review Meeting Agenda - Rebecca Schupp read through meeting agenda and asked if anyone had questions

Review of CCT Reimbursement Structure

Rebecca Schupp summarized the history of reimbursement for CCT services from the beginning of the Demonstration in 2008.

- Before DHCS redesigned the reimbursement structure in 2014, CCT Lead Organizations (LOs) conducted two Preference Interviews with potential CCT Enrollees and completed a Preference Interview Tool (PIT) at each meeting. CCT LOs received \$100/PIT, for a total of \$200/Enrollee.
- As of July 1, 2014, the state eliminated the reimbursement of the PITs and implemented a new structure of payment that authorized an initial 20-hour Treatment Authorization Request (TAR) for transition coordination to “cover” the time and effort associated with gathering a larger amount of information to enroll a Medi-Cal member into CCT.

Joseph Billingsley delivered a PowerPoint slideshow titled, “Overview of CCT Reimbursement Structure” that itemized the services included under the 5 phases of the CCT transition process, and the requirements for reimbursement at each step.

- Slideshow Outline:

Slide 1: Overview of CCT Reimbursement Structure
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Slide 2: Enrollment

20 Hour Treatment Authorization Request (TAR)

- Initial preference interview, face-to-face assessment, care planning with resident, family, legal representative (if applicable) and facility discharge planner, completion of initial transition care plan (ITCP)
- Submit to DHCS: New Enrollee Information Form, CCT Assessment and ITCP

Slide 3: Pre-Transition

100 Hour TAR

- Begin working with the participant to implement the ITCP by securing the necessary long-term services and supports (LTSS), housing, identifying community physician, managed care plan, in-home supportive services (IHSS), waiver services, other appropriate medical and social supports. Prepare the final transition care plan (FTCP)
- Submit to DHCS: FTCP

Slide 4: Transition (1 of 7) - Home Modification

- Environmental adaptations to a participant’s home identified in the care plan, including, but not limited to, grab-bar and ramp installation; modifications to existing doorways and bathrooms; installation and removal of specialized electric and plumbing systems, etc.
- Requires at least 2 bids

Slide 5: Transition (2 of 7) - Household Set-Up

- Household set-up costs are non-recurring expenses for goods and services required by a CCT Participant who is directly responsible for his or her own living expenses.
- Household set-up costs may include, but are not limited to: essential furniture, bedding, towels, toiletries, pots, pans, cooking utensils, basic food staples, etc.

Slide 6: Transition (3 of 7) - Assistive Devices

- Adaptive equipment designed to accommodate a participant’s functional limitations and promote independence, including, but not limited to, lift chairs, stair lifts, diabetic shoes, and adaptations to personal computers.
- The need for items must be documented in the care plan with an explanation of how they would prevent elevation to a higher level of care or return to an inpatient facility.

Slide 7: Transition (4 of 7) - Vehicle Adaptations

- Devices and controls required to enable participants and/or family members and caregivers to transport participants in their own vehicles.
- Must be documented in care plan how these items will sustain participants' independence or physical safety, and allow them to live in their homes. Includes but is not limited to installation and training in the care and use of these items.

Slide 8: Transition (5 of 7) - Habilitation

- Coaching and life skills development on how to build and manage relationships, and other training needed for the participant to learn, improve, or retain adaptive, self-advocacy, or social skills, as identified in the care plan. Ensures success and quality of life in the community

Slide 9: Transition (6 of 7) - Personal Care Services

- Supportive services to assist an individual to remain at home and includes assistance to independent activities of daily living and adult companionship.
- Provided as "gap" services until more formal supports are in place (i.e. IHSS, NF/AH waiver)

Slide 10: Transition (7 of 7) - Family and Informal Caregiver Training

- One-on-one individually tailored sessions to assist caregivers in developing the skills and gaining the knowledge they need to enhance a participant's health, nutrition, and/or financial literacy.
- Examples include, but are not limited to, daily care management, fall prevention, coping skills, emergency response and long-term care planning.
- Only billable by a Home Health Agency

Slide 11: Post-Transition

50 Hour Care Coordination TAR

- Ensure the ongoing safety and sustainability of the transition
- Address any needs and/or concerns that may come up during the 365-day demonstration period, and prior to the completion of demonstration
- Follow-up visits and/or phone calls

Slide 12: Review 20 Hour TAR

Workgroup Exercise: Financial mockup of the 20-hour TAR, including pre-enrollment services and the associated costs

(End of Slideshow)

- Rebecca Schupp opened the floor to questions
- Joe Rodrigues noticed there were hours associated with enrollment and pre-transition, but that there were no hours associated with transition activities
- Rebecca Schupp explained there were no hours for transition activities, but that 50 hours are available post transition for habilitation and targeted case management, based on the beneficiary's HCBS services and qualified housing
- Pam Mokler recommended that LOs communicate with Managed Care Plans prior to enrollment when conducting the assessment
- David Nolan requested the associated dollar amounts
- Rebecca Schupp explained that the original reimbursement was for submitting two completed PITs at \$100 each; and on July 1, 2015, the state changed to a process that authorized 20 hours for

information gathering activities. The question that needs to be examined at this point is if the dollar amount for the 20-hour TAR, \$908.60, is sufficient to cover the associated costs. The 20-hour TAR covers the initial preference interview, face-to-face assessment, care planning, and the completion of the ITCP.

- Karli Holkko shared that the state has been told there are challenges with the rate under the 20-hour TAR, and in response, wanted to spend some time going over the associated costs to determine if changes need to be made
- Denise Likar commented that she had spoken with Joseph and Karli about her budget when she had the necessary financial documents in front of her, but that it would be difficult to provide feedback on associated costs without her budget. Denise also shared that part of the difficulty with the 20-hour TAR is that it doesn't capture costs like fringe, insurance, mileage, support, follow-up, etc. because providers are only allowed to bill for the face-time they had with the client
 - Representatives from different LOs agreed with Denise's assessment of the associated costs and Julie Lehmann noted that the time and cost of travel is not covered, nor is insurance and workers comp. – overhead is roughly 30-40% of an employee's salary
 - Denise Likar said that her staff spend more than 20 hours on the activities associated with the 20-hour TAR, and asked if there is consistency in the ways in which LOs are tracking the time they spend on those activities
- Rebecca Schupp asked how the LOs were able to cover costs with just the PITs
- Jonathan Istrin explained that because the PITs weren't medical his staff could begin to make decisions without a conservator
- Rebecca Schupp asked how they were able to bill for the time after the PIT
- Jonathan Istrin said they were able to bill immediately on the 50 hour TAR
- Rebecca Schupp asked if the 20 hour TAR was sufficient for an RN, excluding overhead
- Denise Likar said in a perfect world it would, but so many factors can affect the process, especially when a lot of follow up is required
- John Beleutz added that the LOs are not compensated for the time they spend on marketing, building relationships with facilities, and finding new enrollees. We need to accept that there should be more revenue than cost to cover overhead
- Julie Lehmann noted that they are not reimbursed for the time that is spent following up on referrals of people who are not transitionable
- David Nolan stated that it should be easier to identify transitionable members via Managed Care Plans
- Denise Likar shared that there is fragmentation across the state and asked what the state is doing to incentivize the SNF
- Hannah Katch asked where the plans weren't able to provide identification support, is it at the SNF?
- Denise responded that there were so many unknowns about working with the plans at this point and plans in CCI counties were most motivated:
 - Who do we talk to? How do we make it happen? Who is responsible for tracking the member?
- Hannah Katch said it will be important to keep this issue at the forefront of our minds, how the CCT LOs and MCPs can work together because this is something we can control
- Denise Likar recommended that DHCS survey LOs on the amount of time they spend on each of the activities included under the 20-hour TAR – recommended that the workgroup review the survey before sending it to the LOs

CCT Transition Process

11:09 am - Karli Holkko presented a short PowerPoint on the CCT Transition Process to set the stage for CCT LO presentations.

- Slideshow Outline:

Slide 1: CCT Transition Process

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Slide 2: Transition Process - Step by Step

The CCT transition process is broken into five stages. Each stage of the process builds upon the preceding stage; and therefore, must be completed in the following order:

- Step 1: Outreach and Targeting
- Step 2: Information Gathering and Enrollment
- Step 3: Implementation
- Step 4: Transition to Community Living
- Step 5: Follow-Up

Slide 3: Step 1: Outreach and Targeting

- CCT Lead Organizations (LO) identify local Medicaid-certified nursing facilities
- LOs meet and develop relationships with facility administrators, and educate facility staff about the CCT demonstration
- LOs identify, develop relationships with, and educate potential CCT participants
- LOs also establish relationships with Managed Care Plans in the service area

Slide 4: Step 1: Outreach and Targeting (continued)

Anticipated Outcomes:

- Increased recognition of, and knowledge about, CCT
- Stronger on-going business relationships between institutional care providers, HCBS organizations, and Managed Care Plans
- Growth of sustainable network of HCBS providers

Slide 5: Step 2: Information Gathering and Enrollment (1 of 4)

- CCT LO Transition Coordinators (TC) conduct initial interview(s)
- If an individual expresses interest in transitioning, the TC provides him/her with a copy of the CCT information packet and thoroughly walks the individual through the contents
- The TC must obtain signed consent from the individual (and/or, if applicable, the individual's Legal Representative)

Slide 6: Step 2: Information Gathering and Enrollment (2 of 4)

- TC collects necessary records and the LO's Registered Nurse (RN) completes the CCT Assessment and determines availability of services in the community for successful transition to community living
- Using Person-Centered Planning techniques, the CCT LO works with the individual, the individual's legal representative (if applicable), friends and family (as requested by the individual), facility discharge planner, and the assigned managed care case manager (as appropriate) to develop the Initial Transition and Care Plan (ITCP) based on the individual's preferences

Slide 7: Step 2: Information Gathering and Enrollment (3 of 4)

- Upon completion of the ITCP, the TC submits the initial 20 hour Treatment Authorization Request (TAR) with attachments to the assigned DHCS Nurse Evaluator (NE) for adjudication
- If the ITCP meets/addresses the needs of the beneficiary, the 20 hour TAR is approved, the resident is enrolled, and LO continues to work with individual.
- DHCS processes immediate approval of 100 hour pre-transition TAR
- If ITCP does not meet/address the needs of the beneficiary, a notice of action (NOA) is issued for deferral of services until additional information is provided.
 - 20 hour TAR is still billable for actual hours spent for enrollment

Slide 8: Step 2: Information Gathering and Enrollment (4 of 4)

Anticipated Outcome(s):

- Individuals enrolled in CCT will be provided comprehensive transition planning services that meet their preference(s), and address their need(s) and risk(s)

Slide 9: Step 3: Implementation

- Once the individual is enrolled in CCT, the transition team begins working with the participant to implement the ITCP by securing the necessary long term services and supports (LTSS) prior to discharge from the facility
- Appropriate medical and social supports are key to a successful transition, and the transition team works to identify current Medi-Cal managed care plan (if applicable) or options for enrollment, secure appropriate and available HCBS waiver program, medical services, and/or demonstration services, community physician, housing, In-Home Supportive Services (IHSS), etc. to meet identified needs and preferences

Slide 10: Step 3: Implementation (continued)

Anticipated Outcome(s):

- Comprehensive transition and care plan is prepared, as directed by the CCT participant
- Robust and on-going communication between members of the transition team and the CCT participant/representative/family

Slide 11: Step 4: Transition to Community Living (1 of 3)

- When all of the health care services and LTSS are in place, the LO:
 - Connects with the participant's community physician and schedules an appointment to ensure continuity of care
 - Secure community physician's signature on the CCT Final Transition and Care Plan (FTCP) to indicate there will be no gaps in care post-transition to the community
 - Submits the home set-up TAR for review and approval
 - Conducts the Quality of Life (QoL) Survey (Baseline)

Slide 12: Step 4: Transition to Community Living (2 of 3)

- On the day of discharge:
 - The TC **must be with the CCT participant to assist with discharge**
 - Services must be in place, including: household set-up, delivery and set-up of equipment, financial arrangements, health care, and other services as needed

- Waiver and/or personal care services may still be in process, in which case, the LO shall provide “gap” services
- The participant must sign the Day of Transition Report to indicate all services and supports are in place or scheduled and adhere to within the FTCP as planned

Slide 13: Step 4: Transition to Community Living (3 of 3)

Anticipated Outcome(s):

- The comprehensive supports and services provided to the participant in the community maintain, if not improve, the individual’s quality of life

Slide 14: Step 5: Follow-Up (1 of 3)

- Post-Transition, CCT LOs continue to collaborate with the participant and other service providers to:
 - Ensure the ongoing safety and sustainability of the transition
 - Address any needs and/or concerns that may come up during the 365-day demonstration period, and prior to the completion of demonstration
 - Remind the participant that the last day of the CCT demonstration is day 365, and that existing services will continue as long as the individual remains eligible for Medi-Cal and/or HCBS

Slide 15: Step 5: Follow-Up (2 of 3)

- Follow-up visits and/or phone calls are required at specific points of the 365-day demonstration period based on the qualified housing arrangement and services they receive
- In the twelfth (12th) month of the 365-day demonstration period, the LO will conduct the second QoL survey (1st follow up)
- Finally, in the twenty-third (23rd) month after the date of transition, the LO will visit the individual to conduct the third QoL survey (2nd follow up)

Slide 16: Step 5: Follow-Up (3 of 3)

Anticipated Outcome(s):

- Safe and sustainable home or community-based living

(End of Slideshow)

Heather Thompson and Katie Gallipeau presented on East Bay Innovations’ transition process

- Slideshow Outline:

Slide 1: Planning for Success

- Presenters: Heather Thompson & Katie Gallipeau, Transition Coordinators

Slide 2: EBI’s Mission

- To arrange and provide personalized support that enables individuals with disabilities to live in their own homes, work in jobs of their choosing, and feel a sense of membership in their community

Slide 3: EBI CCT’s Mission

- EBI CCT’s internal mission is to work in unity in an open, honest, respectful, empathic dynamic by investing in each other and in EBI’s mission to help our clients obtain membership in their community

Slide 4: What Makes EBI Unique?

- Staff come from DD world: start intensive case management and back away
- Staff implements EBI Philosophy
- 1 Transition Coordinator doing TARs, 1 Billing Specialist
- Every staff person has minimum billable thresholds
- Go over Safe Discharge Checklist 2 weeks before discharge

Slide 5: Visual demonstration of a safe discharge checklist

Slide 6: Engaging the Participant

- Introduction with client
- Get to know client's preferences on living situation
- Learn about the client's support network (if applicable)
- Build rapport with our clients

Slide 7: Sean

Slide 8: Engaging the RN

- Multiple Nurse Consultants of various levels of experience
- First introduction is between a TC and a client
 - Send out RN when the person has expressed a definite interest in transitioning
- RN assessment happens within 1 month of a psycho-social assessment with a transition coordinator
- Partnering with a home health agency to increase turn around time

Slide 9: Engaging Community Partners (Housing Authorities, IHSS, SNFs)

- 5 PHA's in Alameda County: City of Alameda, County of Alameda, Berkeley, Oakland and Livermore
- Leveraged our existing relationship that EBI has built with HACA over 20 years
- Use "the carrot" instead of "the stick"
- Ask staff at various partner agencies: what can EBI do to make this task easier for them
- Identify why it benefits their agency to take the time to work with us
- 31 nursing facilities in Alameda County

Slide 10: Engaging the Family

- RIGHT AWAY if:
 - The client wants their family to do their IHSS
 - The facesheet mentions they are conserved or have a DPOA
 - There is doubt this client could manage their own IHSS
- Want to live with family In the first 30 hours:
 - The client casually mentions having a relative or two who are important to them

Slide 11: Engaging the MD

- Review the client's SNF Chart to see any outstanding physician orders
- Rely on the opinion of the SNF doctor, not a future community doctor that does not know them yet
- Identify if the client has any habits, behaviors that could jeopardize continuity of care or make an MD want to stop treating them
 - If so, start identifying and meeting with potential MDs before discharge

Slide 12: Right Before Transition

- IHSS application, push for county to do in-facility assessment
- Home safety evaluation with PT and client (if possible)
- NF/AH waiver application gets submitted as soon as address is secured
- Home mods completed, if possible
 - DME ordered and delivered
- Have a transition coordinator present during delivery
- Have client come to new apartment with DME in place to test the DME
- Start asking clients to start doing various discharge related tasks for themselves. Transition Coordinators “lean in” when necessary
- Start working on interviewing/hiring potential In Home Supportive Service workers
- Identify new primary care provider

Slide 13: Sandy

Slide 14: Day of Transition & 1 Week Following

- Day of Transition Report Form at the facility or at home
- Groceries from Safeway.com (at least 1 week’s worth, until SSI can be increased again)
- Get paper prescriptions and identify a pharmacy located en-route to the new apartment
- Create and provide a resource binder to the client

Slide 15: Managed Care Plans

- Two managed care plans in Alameda County:
 - Alameda Alliance
 - Blue Cross
- Marc

Slide 16: Benefits of the Roll Out

- The 20 Hour TAR in place of the PIT encourages transition coordinator to be more thorough and thoughtful during assessment
- An interdisciplinary team is a GOOD THING
- Increased post-transition hours from 24 to 50 for NF/AH participants

Slide 17: Challenges

- Inadequate rate to cover an in house or consulting nurse
- Challenges in reimbursement for time spent before ITCP
- Redundancy in submitting TAR (20 hrs vs 100 hrs)

Slide 18: Questions?

Slide 19: Thank you for your attention and participation!

(End of Slideshow)

Louis Frick presented on Access to Independence (A2I) and their working relationship with Care 1st Managed Care Plan

1. Introduction to A2I

- What we do differently

- Continue serving consumers regardless of contract
 - Always seeking additional funds
 - Working with property managers, etc.
2. Continuity of Care
- What that means to our organization
 - Focus on institutional residents transitioning to independent living
3. Overview of our organization's transition process
- Highlight how we assist consumers in locating accessible housing
4. Our relationship with Care1st
- How we work with Care1st to ensure continuity of care prior to transition
- (End of Presentation)*

Q & A and Public Comment

Operator opened the line for public comment and questions, there were no questions

~ ~ ~ Meeting Broke for Lunch ~ ~ ~

Maintaining Continuity of Care

David Nolan presented on the Managed Care Plan's role in maintaining the continuity of care

- Slideshow Outline:

Slide 1: California Community Transitions September 30, 2015

Slide 2: Overview

- Role of the Health Plan
- Role of the Local Organization
- Staffing
- Workflow and Process
- Continuity of Care
- Service Options
- Key Objectives and Goals

Slide 3: Role of the Health Plan

- Targeting of members (referral source)
 - MDS 3.0, Section Q
 - SNFist
 - Family (caution)
- Determining appropriateness/safety
 - Member
 - Family
- Lead Case Manager (Transitional Specialist)
 - Sign off on consolidated care plan (medical and social)
 - Oversee transition process

Slide 4: Role of Lead Organization (Silicon Valley ILC)

- Liaison to the CCT (funding)
- Transition Specialist
- Initial interviews to determine appropriateness and safety
- Assist to develop the transition plan (team)
- Develop the service plan in coordination with the health plan case manager
- Quality of life surveys
- Health plan- complex case management

Slide 5: Staffing

- Health Plan: Transition Specialist (RN)
 - Review and approve care plan
 - Liaison to PCP and medical services
 - Identify essential medical services
 - Funded through MMP capitation
- Know
 - Medical Services
 - IHSS
 - CBAS
 - Nursing Facility
 - MSSP

Slide 6: Staffing (cont.)

- LO: Transition Specialist (MSW)
 - Sign off on care plan
 - Liaison to community services
 - Three months ongoing care coordination and management
 - Funded through CCT
 - Caregiver & member training
- Know
 - Housing
 - Community Services

Slide 7: Work Flow / Process

- The vast majority of the work is done by the LO
- Health Plan simply oversees the process
- Health Plan initiates the process
- Health Plan contacts LO
- LO and Health Plan conduct joint assessment and interdisciplinary care team (ICT) meeting with member, family, caregiver, PCP

Slide 8: Work Flow / Process (cont.)

- Health Plan determines medical needs
- LO determines community services
- LO creates matrix/process map for transition
- ICT (member) approves the final transition plan

(End of Slideshow)

Pam Mokler presented on Long Term Services & Supports within Care 1st Managed Care Plan and their working relationships with community transition organizations

- Slideshow Outline:

Slide 1: Health Plan Recommendations to Improve SNF Repatriation Process and CA Community Transitions

Slide 2: Care1st Health Plan

- Care1st was created in 1994 by three medical groups & a disproportionate share hospital dedicated to providing health care services to vulnerable populations through State and Federal government programs
- One of the only Traditional and Safety Net provider-owned Health Maintenance Organizations (HMOs) in California
- Awarded contracts for Medicare and Medi-Cal / Medicaid
- Care1st offers 7,000+ provider networks & serves approximately 700,000 members in California and Arizona
- NCQA Commendable Accreditation. Ranked as a top Medicaid health plan in California by Consumer Reports

Slide 3: Transition of Care Management – Comparison of Custodial Care: Before & After CCI

- Visual demonstration on the transition of care before and after the CCI/Cal MediConnect

Slide 4: Care1st CCT Providers

- Relationships and/or contracts with the following CA Community Transitions (CCT) providers:
- Los Angeles County
 - Libertana
 - The Care Connection
 - Independent Living Center of Southern California (ILCSC)
- San Diego County
 - Libertana

Slide 5: Care1st Results per CCT Provider – Los Angeles

- Total Referrals
 - Libertana: 232
 - TCC: 18
 - ILCSC: 10
- Los Angeles total Referrals: 266
- Completed transitions: 8 (one disenrolled from Care1st)
- Waiting for placement: 14

Slide 6: Care1st Results per CCT Provider – San Diego

- Libertana
 - Referrals: 38
- Completed transitions: 4
 - 2 placed in Orange County Assisted Living Facility
- Waiting placement: 5 (more difficult to find housing in SD)

Slide 7: How Care1st Identifies Potential Candidates for CCT

- Review of MDS Section “Q”
- Case Management Activities, including Interdisciplinary Care Team (ICT) meetings
- LTC Facility visits by Contracted Physician Group, UM Staff and LTSS Department
- CCT referrals direct from SNFs

Slide 8: Care1st Staff Involved in CCT Process

- CCI Medical Director
- Social Workers in both Los Angeles & San Diego work closely with CCT vendors and have bi-weekly Case Conference Calls to discuss potential candidates & where they are in the process
- LTSS Department Team conducts LTC Facility Visits

Slide 9: Communication

- Health Plan & CCT Vendors
- Social Services Department:
 - Social Workers in both Los Angeles & San Diego work closely with CCT vendors and have bi-weekly Case Conference Calls to discuss potential candidates & where they are in the process
- LTSS Department Team
 - Conduct LTC Facility Visits & meet with members 1:1
 - Observe members who appear to be independent & those who ask to move home and/or back to the community
 - Refer potential candidates to Social Services Department

Slide 10: Communication (continued)

- Health Plan & Network Providers
 - Education - conduct trainings re: CCT
 - Request Network Providers to refer potential candidates to Social Services Department
 - Social Workers follow-up with CCT Vendors
- Health Plan & LTC Facility
 - Communicate with LTC facility & Attending Physicians
 - For Medi-Cal Only members with Medicare FFS, we try to contact the Medicare Provider

Slide 11: Housing is Critical to CCT Success

- Develop partnerships with Affordable Housing owners & Property Management companies
- Partner with Housing Authorities to obtain access to Section 8 vouchers
- Partner with organizations providing housing-related activities & services to create “service-enriched” affordable housing
- Partner with Board & Care Homes that accept SSI

Slide 12: CCT Challenges

- Member Choice
 - They control where they want to move
 - Out-of-county – need more time to coordinate from county to county
- Length of time to actually move members. Perhaps financial & clinical eligibility assessments could be completed simultaneously while finding housing.
- Family members oftentimes do not want member to move. We need to provide family caregiver support, i.e., respite, to reduce caregiver burnout, etc.

Slide 13: CCT Challenges (continued)

- Difficulty in coordinating care or repatriating members that have part B only or FFS full duals
- Difficulty in coordinating care or repatriating members that are in LTC facilities that do not have a contract with Care1st. In order to get LTC facilities to work with us to repatriate members, they want to know that we will send them new members (Medicare). Plan would not refer new members with non-contracted LTC facilities.

Slide 14: Thank You!

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Introduction to Principles of Principles of Person Centeredness

Rebecca Schupp begins discussion on Person-Centered-Planning by giving a brief overview on the principles of Person-Centered-Planning:

- Slideshow Outline:

Slide 1: Introduction to the Principles of Person Centered Planning

- HCBS Advisory Workgroup - September 30, 2015

Slide 2: HCBS Final Rule

- In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals.
- Requires that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process.

Slide 3: HCBS Final Rule (continued)

- Minimum requirements for person-centered plans include:
 - Individual goals and preferences.
 - Assist in achieving personally defined outcomes in the most integrated community setting.
 - Ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

Slide 4: Olmstead

- Foundations
 - Strong consumer-professional and family-professional partnerships.
 - People with disabilities must be central participants in planning, developing, and providing services.
 - People are unique and their support needs are unique.
 - Needs should be met in a dignified fashion.
 - Each person, each family, are the experts about their own needs.

- Accountability should be based on consumer satisfaction and measured by positive outcomes.
- All individuals are entitled to a quality life.
- Choice is Job 1.

Slide 5: Olmstead (continued)

- Desired Outcomes:
 - Services should be consumer-driven.
 - Consumer and family education about person-centered planning and control of services, including availability, quality, variety.
 - Should include services that improve the quality of life for people with disabilities.
 - Services should be aimed at developing self-sufficiency in decision-making with support from family and community.
 - Plan should lead to continued reduction in LTC facilities and institutions and toward increased community-based supports.
 - Plan should focus on life-long needs for support.
 - Plan should look at broad spectrum of support needs – not just traditional services.

Slide 6: Administration for Community Living (ACL)

- Person-centered planning is a process directed by the person with long-term services and supports (LTSS) needs. The person-centered planning approach identifies the person’s strengths, goals, preferences, needs (medical and HCBS), and desired outcomes.
- The role of staff, family, and other team members is to enable and assist the person to identify and access a unique mix of paid and unpaid services to meet their needs, and to provide support during planning and implementation.
- When done thoughtfully, person-centered planning creates a space of empowerment—a level playing field—that allows for consideration of personal preferences as well as health and safety needs, without unnecessarily restricting freedoms. The best person-centered planning helps people to live better lives, with support to do the things most important to them.

Slide 7: Administration for Community Living (continued)

- Self-direction standards allow the person maximum control over his or her HCBS including the amount, duration, and scope of services and supports, as well as choice of providers, which may include family or friends.
- Self-direction allows the person to have much greater control over services and supports than would be possible under traditional arrangements.
- Consistent with the philosophy of independent living, self-direction embraces the values of freedom, authority, autonomy, and responsibility to allow the person to fully participate in community life with the necessary supports.

Slide 8: Workgroup Discussion

- Is my organization’s transition process person-centered?
- How does your organization strike a balance between wants and needs?
- How does your organization adhere to person-centeredness when there are limited options?

(End of Slideshow)

- Janie Whiteford shared that the issue of Person-Centered-Planning is near and dear to her heart and she knows that a lot of the consumers don't even know what their role is in the transition planning process, and she stressed the importance of training consumers
- Pam Mokler stated that from a Managed Care perspective, there are a lot of people who do not meet the SNF criteria living in institutions. Pam asked, "What do we do when they choose to stay in the SNF?"
- Rebecca Schupp responded that the responsibility of the CCT LO is to take time to educate consumers of their options, and in that case, ask him or her why they wanted to stay. Sometimes consumers are influenced by others or do not know that their needs can be met in the community
- David Nolan shared that inappropriate placement is a regulation issue for MCPs
- Denise Likar said that she recognizes the difficult spot MCPs are in when faced with de-certifying a SNF resident, it is a lengthy process and it is not easy work

Workgroup Timeline

- Next workgroup meeting is December 4th, same time and location
- The third meeting will focus on Ensuring the CCT Transition Process is Person-Centered
 - DHCS requested recommendations for expert Person-Centered-Planning presenters
- The fourth meeting will be held in March and will focus on Enhancing CCT
 - Where are the gaps?
 - What can be done to improve the program?
 - What actions can the state take to improve/enhance the CCT redesign?

Q&A and Public Comment

Operator opened the line for public comment and questions, there were no questions

Nest Steps and Wrap-up

Action Items:

- Meeting minutes will be drafted and distributed to work group members for review
- DHCS will send a Doodle Poll to find the best date for the March workgroup meeting
- Develop a draft survey to query CCT LOs on the costs of providing CCT services within the 20-hour TAR timeframe for workgroup members to review before sending to LOs
- DHCS will clarify the policy on Vacancies
- Develop a Managed Care matrix to illustrate the types of MCPs across the state, as well as when each plan is responsible for the member (ex. within a SNF?)