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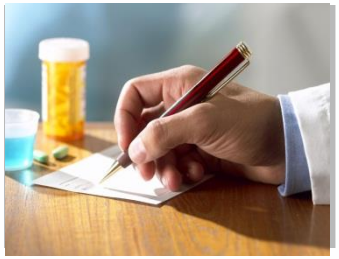
# Progress on State Compliance with the Home and Community Based Settings (HCBS) Final Rule




Division of Long-Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

# Objectives for Today's Session

- Provide a national overview of Statewide Transition Plan (STP) progress over the last year
- Provide an overview of each step on the path to final STP approval and strategies to address each step
- Share preliminary data on milestones and state progress toward implementing STP activities and coming into compliance
- Share promising practices for implementation approaches

# 2014 HCBS Final Rule

- Published January 2014 – Effective March 17, 2014
- Addressed CMS requirements across HCBS provided through:
  - 1915(c) waivers, 1915(i) state plan, 1915(k) Community First Choice, and 1115 Demonstration Waivers
- Some requirements were effective immediately, others were given a transition period in order to allow states sufficient time to come into compliance.
- Guidance issued in May 2017 extended the transition period for settings in existence as of the effective date of the final regulation from March 2019 to March 17, 2022. Extension of the transition period recognized the significant reform efforts underway and is intended to help states ensure compliance activities are collaborative, transparent and timely.
- This session does not cover all aspects of the Final Rule; in today's presentation we will focus specifically on the regulation's impact on home and community-based settings.

# Key Themes

- The regulation is intended to serve as a catalyst for widespread stakeholder engagement on ways to improve how individuals experience daily life
- The rule is not intended to target particular industries or provider types
- Federal financial participation (FFP) is available for the duration of the transition period
- The rule provides support for states and stakeholders making transitions to more inclusive operations
- The rule is designed to enhance choice

# Home and Community-Based Settings Criteria

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

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# Home and Community-Based Settings Criteria (cont.)

The setting options are identified and documented in the person-centered service plan

The setting options are based on the individual's needs, preferences, and, for residential settings, resources available for room and board

Ensures an individual's rights of privacy, dignity, 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

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# Provider-Owned or Controlled Settings: Additional Criteria (1 of 4)

- Unit/dwelling is a specific physical space owned, rented, or occupied under legally enforceable agreement
- Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place, providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law

# Provider-Owned or Controlled Settings: Additional Criteria (2 of 4)

- Each individual has privacy in their sleeping or living unit
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors of their choosing at any time
- Setting is physically accessible to the individual

# Provider-Owned or Controlled Settings: Additional Criteria (3 of 4)

**Modifications of the additional criteria must be:**

- Supported by specific assessed need
- Justified in the person-centered service plan
- Documented in the person-centered service plan

# Provider-Owned or Controlled Settings: Additional Criteria (4 of 4)

**Documentation in the person-centered service plan of modifications of the additional criteria includes:**

- Specific individualized assessed need
- Prior positive interventions and supports including less intrusive methods
- Description of condition proportionate to assessed need
- Ongoing data measuring effectiveness of modification
- Established time limits for periodic review of modifications
- Individual's informed consent
- Assurance that interventions/supports will not cause harm

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# STP Timeline

STP Initial Approval

STP Final Approval

Heightened Scrutiny

STP Plan Implementation

Monitoring

Note that there is often overlap across steps in the process and they may occur concurrently.

# HCBS STPs: Status of STP Review and Implementation Activities

As of August 22, 2018

- 42 States have initial approval: AL, AK, AR, AZ, CA, CO, CT, DC, DE, GA, HI, ID, IN, IA, KY, LA, MD, MI, MN, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, UT, VT, VA, WA, WV, WI, WY
- 9 States have initial and final approval: AK, AR, DC, DE, KY, OK, TN, WA, WY

# Review of the Criteria for Initial Approval

- Identification of all settings subject to the rule in the Statewide Transition Plan (STP);
- Systemic assessment completed, including outcomes;
- Remediation strategies outlined, with timelines, and actively worked on;
- Draft STP widely disseminated for 30-day public comment period; comments responded to, summarized and submitted to CMS.

# Key Elements in the Process for Final Approval

- Summary of completed and validated site-specific assessments, including aggregated outcomes completed;
- Draft remediation strategies with timelines for resolution by the end of the transition period (March 17, 2022);
- Detailed plan for identifying and evaluating those settings presumed to have institutional characteristics.

# Key Elements in the Process for Final Approval, cont.

- Process for communicating with beneficiaries who are currently in settings that cannot or will not come into compliance by March 17, 2022;

- Description of ongoing monitoring and quality assurance to ensure all settings remain in full compliance with the settings criteria;

- Updated version of the STP is posted for minimum 30-day public comment period.

# First Element: Site-Specific Assessments

The first element for final approval includes 3 components:

- State completes comprehensive summary of site-specific assessments for all settings in which HCBS are provided;
- Provides validation of those assessment results, as necessary;
- Includes the aggregate outcomes of those activities.

# Site-Specific Assessments

**Identify:**

- Your state's comprehensive, state-wide approach to assessing compliance;
- All services under all HCBS authorities and all settings in which service (s) are provided;
- Methods used to identify all types of settings in the state

# Site-Specific Assessments, cont.

- Distinguish between settings under the rule:
  - Group settings
  - Individual privately owned home
  - Non-Disability Specific Settings

# Reverse Integration

- Reverse integration is a model of inviting individuals not receiving home and community-based services into a facility-based setting to participate with individuals receiving home and community-based services.
- It is not considered by itself to be a sufficient strategy for complying with the community integration criteria outlined in the settings rule.

# Validation Strategies

- Validity check required for provider self-assessments;
  - Identify how independence of assessments is ensured when a Managed Care Organization (MCO) validates provider self-assessments;
  - Validation strategies varied across states;
  - Describe process for following up with non-responders;
  - More robust validation processes increase success factors in helping settings assure compliance.

# Site-specific Assessments, Validation, and Aggregated Outcomes

- The STP should include a comprehensive summary of completed site-specific assessments of all home and community-based settings, validation of those assessment results, and inclusion of the aggregate outcomes of these activities, including the type and number of settings that:
  - Fully comply;
  - Do not comply but can with modifications;
  - Cannot or will not comply with settings criteria by the end of the transition period;
  - Are presumptively not home and community-based and may be submitted for heightened scrutiny

# Site-specific Assessments, Validation, and Aggregated Outcomes-State Progress

- State-specific examples to consider related to:
  - Identifying the process or methods the state will use to identify all types of home and community-based settings in their state
  - Site-specific assessment process
  - Validation strategies
    - Use of case management entities
    - Licensing and credentialing agencies
    - State agency staff
    - MCOs
    - Other

# Second Element: Remediation Strategies

- The STP should include draft remediation strategies, including milestones and a corresponding timeline for resolving issues that the site-specific settings assessment process and subsequent validation strategies identified by the end of the home and community-based settings transition period (March 17, 2022)

# Remediation Strategies-State Progress

- State-specific strategies to consider:
  - Create a template for corrective action or remediation plan for providers to use in the self-assessment process
  - Develop a process for follow up with settings that require modification
  - Tiered standards

# Settings that are not Home and Community-Based

Settings that are not home and community-based include:

- A Nursing Facility;
- An Institution for Mental Diseases;
- An Intermediate Care Facility for Individuals with Intellectual Disabilities;
- A Hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

# Three Categories of Presumptively Institutional Settings

Settings Presumed NOT to be Home and Community-Based:

Category I: Settings in a publicly or privately operated facility that provides inpatient institutional treatment;

Category II: Settings in a building on the grounds of, or adjacent to, a public institution;

Category III: Settings with the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

# Third Element: Detailed Plan for Identifying and Evaluating Settings Presumed to Have Institutional Characteristics

- The STP must describe the state's heightened scrutiny process which should include:
  - A detailed plan for identifying settings presumed to have institutional characteristics
  - The proposed process for evaluating these settings and
  - Preparing the submission to CMS for review
- The state should clearly lay out its criteria for determining whether a presumptively institutional setting overcomes that presumption.

# Detailed Plan for Identifying and Evaluating Settings Presumed to Have Institutional Characteristics, cont.

- The state should only submit those settings under heightened scrutiny that the state believes will overcome any institutional characteristics and can comply with the federal settings criteria.
- If the state determines it will not submit information on a setting falling into a presumptively institutional category, the presumption stands and the state must describe the process for determining next steps for individuals involved.

# Fourth Element: Process for Communicating with Beneficiaries Who Are Currently in Settings that Cannot or Will Not Come into Compliance by 3/22

- States should include:
  - Reasonable notice and due process for beneficiaries;
  - A timeline and description of the processes for assuring that beneficiaries, through the person-centered planning process, will be given the opportunity, the information and the supports necessary to make an informed choice among options for continued service provision, including locating a compliant provider or utilizing alternate funding

# Process for Communicating with Beneficiaries Who Are Currently in Settings that Cannot or Will Not Come into Compliance by 3/22, cont.

- This description and timeline should specifically explain how the state intends to assure beneficiaries that they will be provided sufficient communication and support, including options among compliant settings, and assurance that there will be no disruption of services. The state should allow ample time prior to any changes in provider in order to afford the beneficiary individually acceptable options for housing, employment or other day services.
- Include an estimate of the number of individuals who may need assistance in this regard;
- Ensure that the entire process adheres to the timelines specified in the STP.

# Communicating with Beneficiaries Who Are Currently in Settings that Cannot or Will Not Come into Compliance-State Progress

- Possible strategies to consider:
  - Compile a user-friendly list of the alternatives available for beneficiaries, either in compliant settings or with another funding stream other than Medicaid-funded home and community-based services
  - Identify the critical services and supports that are in place for beneficiaries prior to implementing any changes in provider

# Fifth Element: Ongoing Monitoring and Quality Assurance to Ensure Settings Remain in Compliance with the Settings Criteria

- Monitoring implementation of remedial action:
  - States need to monitor the implementation of remedial actions to achieve regulatory compliance, both those actions that are the responsibility of the state (state-level) and those that are primarily the responsibility of providers (provider-level).
- Monitoring to ensure ongoing compliance:
  - Once remedial actions have achieved settings compliance, the state will continue to engage in monitoring and oversight activities to ensure ongoing compliance.

# Ongoing Monitoring and Quality Assurance-State Progress

- State-specific strategies to consider:
  - Modification of assessment tools:
    - Evaluation of the status of the home/caregiver relationship
    - Assess participants' experiences regarding choice and access to the community
  - Compile and analyze trends to inform training and technical assistance strategies
  - Publish information related to the monitoring process with proposed corrective actions

# Ongoing Monitoring and Quality – Promising Practices

Based on stakeholder feedback, CMS suggests that states follow the steps below to ensure ongoing setting adherence to regulatory requirements:

- Periodic review of person-centered plans, both across a setting and over time, to ensure plans reflect individual preferences.
- Interviews with individuals, families and providers to ensure fidelity in implementation of person-centered plans.
- Develop a process of communicating with CMS if the state wants to receive Medicaid funding for HCBS in new presumptively institutional settings.

# Sixth Element: Public Comment

- States should provide the opportunity for public comment by widely disseminating the STP for a 30-day public comment period.
  - The state should use two forms of public notice, ensuring that at least one is electronic and one is non-electronic.
- States should summarize and respond to the public comments and include that information in the STP that is submitted for CMS review.

# Milestones and Quarterly Reports

- In order to collect consistent information on the implementation of the STPs, CMS has identified a standard set of milestones to track across states.
- Since each state is different, the milestones should align with timeframes in the state's STP.
- Milestone data provides CMS information on each state's progress, as well as overall trends and progress towards compliance.
- Optional quarterly reports provide states the opportunity to report on their progress towards compliance.

# Milestone Types

The milestones fall into the following categories:

- Systemic Assessment
- Remedial actions to bring state standards into compliance
- Site-specific assessment
- Remedial actions to bring specific settings into compliance
- Heightened scrutiny
- Resolution of Beneficiary Concerns when in a setting that will not be compliant
- Ongoing oversight and monitoring (Quarterly Reports)

# Milestone Types, cont.

- States provide/define their own milestone description and due date.
- States may choose to:
  - add sub-milestones in order to document progress at additional intervals or by particular programs or
  - create additional milestones
- States can request to delay the due date or revise the milestone description.

# State Milestone Data and Quarterly Reports

- CMS requests that states complete the milestones template after receiving initial approval on the STP
- To date 26/51 states (and DC) have submitted the milestones template
- To date 26/26 states have submitted quarterly reports and/or made progress updates on their milestones

# Milestone Progress

- 21/26 states report completing the systemic assessment
- 3/26 states report completing the three (3) milestones related to the remedial actions to bring state standards into compliance
- 11/26 states report completing both milestones related to the site-specific assessment

# Milestone Progress, cont.

- 0/26 states report completing the nine (9) milestones related to the remedial actions to bring specific settings into compliance
- 5/26 states report completing the four (4) milestones related to heightened scrutiny
- 3/26 states report completing the eight (8) milestones related to beneficiaries in non-compliant settings
- 6/26 states have submitted quarterly reports

# Training and Technical Assistance

- Upcoming trainings
- Workshops
- Technical Assistance

# Questions?

# Resources

**Central Office Contact—Division of Long Term Services and Supports:**

- **Ralph Lollar, Director**

  **Ralph.Lollar@cms.hhs.gov**

**HCBS Settings Technical Assistance:**

https://www.medicaid.gov/medicaid/hcbs/technical-assistance/index.html#Settings

# Resources, cont.

HCBS Training and Resources on Medicaid.gov:

**Home & Community Based Settings Requirements Compliance Toolkit**

https://www.medicaid.gov/medicaid/hcbs/guidance/settings/index.html

**Home & Community Based Services Training Series**

https://www.medicaid.gov/medicaid/hcbs/training/index.html

**Statewide Transition Plans**

https://www.medicaid.gov/medicaid/hcbs/transition-plan/index.html

# Public Engagement:
# *Promising State Strategies*

| Promising Practice | State Examples |
|---|---|
| Minimal Requirements: Full Statewide Transition Plan (STP) must be made available to the stakeholders in electronic and non-electronic accessible forms. | All States |
| Provides clear, easily digestible overview of the rule and context of the state's transition process. | Pennsylvania |
| Virtual and in-person orientation sessions and "town-hall" like meetings across state and stakeholders. Focus groups and feedback forums early on to help inform the design of the state's HCBS implementation strategy. | Ohio |
| Establishment of state working groups or committees that included equal representation of stakeholders. | Delaware; Wyoming |
| List of all relevant services, settings, descriptions being captured in the HCBS implementation process. | North Dakota, Iowa |
| Use of multi-media to broadcast and disseminate information, as well as solicit public comments. | South Carolina |
| Provides clear, informative summary of public comments received, including state's responses for how it addressed each comment or category of comments. | Alabama |
| Provided ongoing updated results on validation and remediation of all Medicaid HCBS Settings | Alaska; Oregon |
| Provides ongoing consumer friendly updates on state HCBS website for stakeholders to review feedback from CMS on STP, public comments submitted by stakeholders & state's responses. | Maryland; Idaho |
| Published and allowed public access to all heightened scrutiny evidentiary packages submitted to CMS and/or used external stakeholder advisory group to review and provide feedback on state HS reviews. | Kentucky |
| Developed easy to digest educational materials for consumers and parents/families. Also continue to host stakeholder information sharing and feedback forums, targeting specific stakeholder groups. | Wyoming |

# Highlighting Effective Practices in Assessing Setting Compliance: *State Examples*

| Effective Practice/Strategy | State Examples |
|---|---|
| Provides clear, easy to understand listing of all HCBS authorities and categories of settings across state. | Iowa |
| Developed unique comprehensive assessment tools based on type of setting and target respondent. | Oregon<br>South Carolina |
| Clearly laid out the specific details of the state's approach to the assessment process (including sample sizes). Also discussed how the state addressed any non-respondents. | Arkansas<br>Oregon |
| Summarized assessment results in a digestible manner (based on the main requirements of the rule and additional provider-owned and controlled setting criteria) so as to inform state's strategy on remediation. | Iowa<br>South Dakota |
| Framed the assessment process as an opportunity for setting reflection, presuming there was room for improvement throughout the system. | New Hampshire<br>Tennessee |

# Highlighting Effective Practices in Validating Setting Compliance: *State Examples*

| Effective Practice/Strategy | State Examples |
|---|---|
| State outlines multiple validation strategies that addressed concerns and assured all settings were appropriately verified. Validation process included multiple perspectives, including consumers/beneficiaries, in the process. | District of Columbia<br>Tennessee |
| Implemented sophisticated electronic/online survey tools to collect data from majority of beneficiaries of HCBS system, allowing access to the data and connecting the data back to individual settings/providers to inform necessary remediation steps. | Colorado; North Carolina |
| Conducted 100% onsite visits of settings, relying on existing state infrastructure or creating new process/vehicle. | Multiple States |
| State relied on existing state infrastructure, but laid out solid, comprehensive plan for training key professionals (case managers, auditing team) to assure implementation of the rule with fidelity. | Delaware<br>Tennessee |
| State used effective independent vehicles for validating results and/or relied on the evaluative activities of other federally-funded DD/aging networks. | Michigan; Utah; New Hampshire; Kentucky |
| State clearly differentiated and explained any differences in the validation processes across systems/Medicaid HCBS authorities. | Connecticut<br>Indiana |

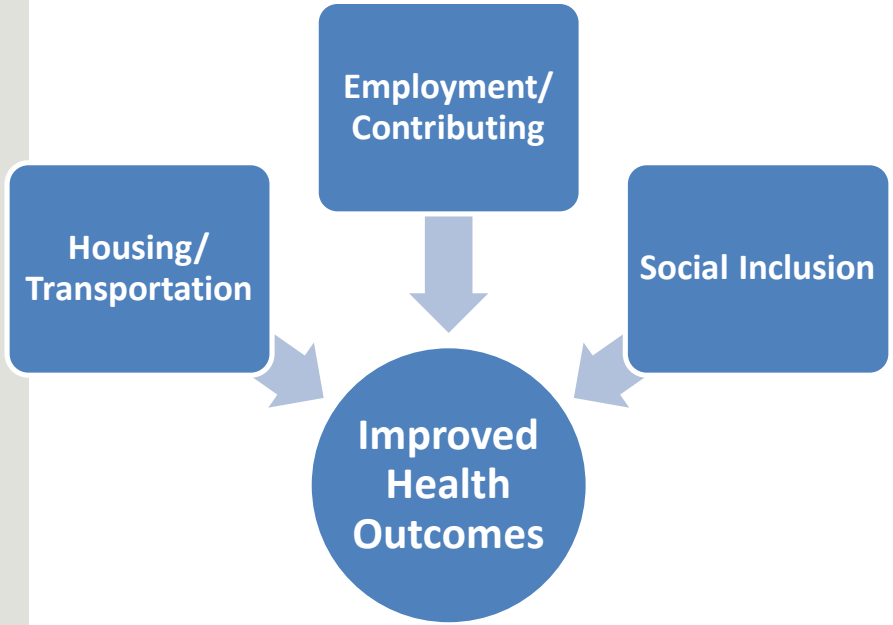
# Highlighting Effective Practices in HCBS Settings Remediation: *State Examples*

| Effective Practice/Strategy | State Examples |
|---|---|
| State simultaneously provided a comprehensive template for a corrective action or remediation plan to all providers as part of the self-assessment process. | Arkansas<br>Tennessee |
| State has outlined a process for following up with settings that require remediation to comply with the rule, including but not limited to the negotiation of individual corrective action plans with providers that address each area in which a setting is not currently in compliant with the rule. | Indiana<br>North Dakota<br>Pennsylvania |
| State has outlined a comprehensive approach to apply tiered standards to elevate the quality and level of integration of one or more categories of HCBS settings. | Indiana; Minnesota; Ohio; Tennessee |
| State has identified those settings that cannot or will not comply with the rule and thus will no longer be considered home and community-based after the transition period. State has also established an appropriate communication strategy for affected beneficiaries. | Ohio<br>North Carolina |
| State has established strong ongoing monitoring mechanisms to assure that settings continue to remain in compliance and have access to ongoing training & technical assistance (even for individual private homes). | Idaho; Connecticut; DC |

# HCBS should be aligned with preserving and improving social determinants of health among beneficiaries

## Social Determinants of Health as Cost Control

- Enlightened cost control strategy—not just for Medicaid, but health care system overall
- Increase efficiency while also improving health of enrollees
- Interventions for targeted populations have demonstrated cost savings, such as:
  - Intensive case management for super-utilizers
  - Coordinating access to safe, affordable housing for individuals who are homeless or housing-insecure



# HCBS should also support individuals to….


**Live in their own home with the people they choose to live with**

**Enjoy the support and engagement of family and friends**

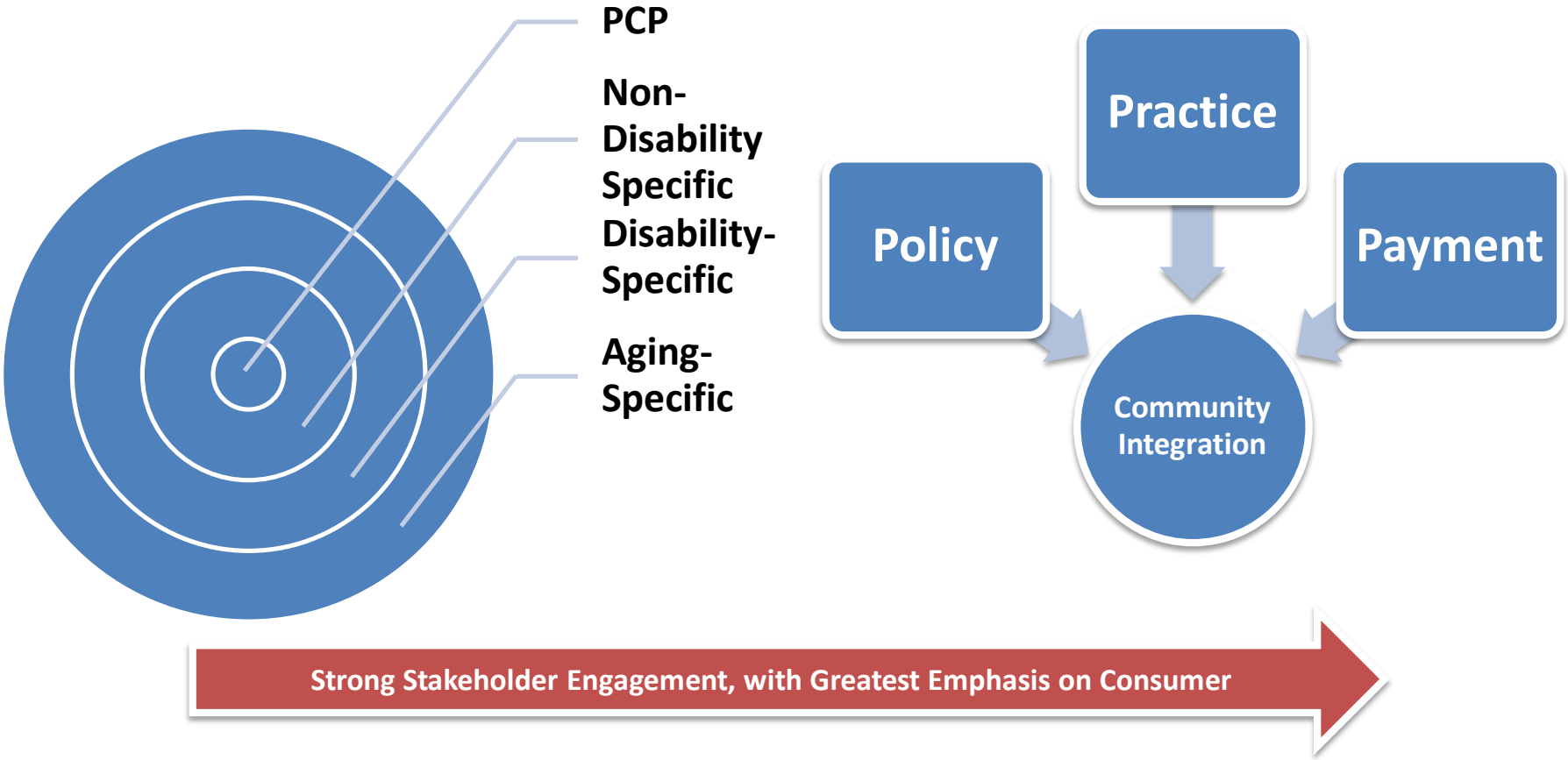
**Get a job, volunteer, or retire but continue to engage**

**Enjoy good health**

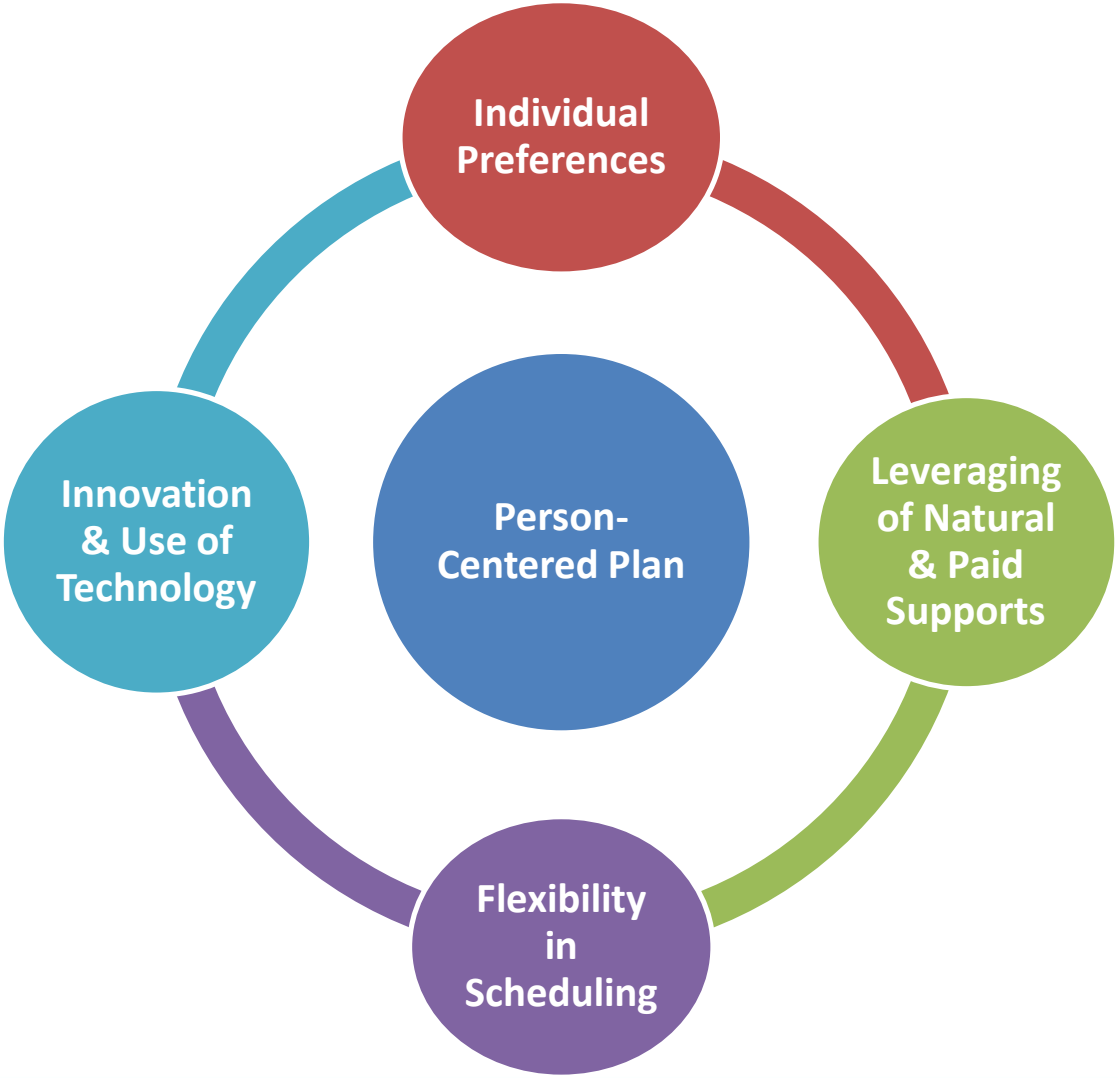
**Be a meaningful part of and contribute to their community**

**Achieve their personal potential for independence, inclusion and self sufficiency**

# How to Approach HCBS Systems-Change to Improve Community Integration



# Person Centered Planning in the Context of HCBS



# Person-Centered Planning

- A Planning Process for LTSS needs:
  - Plans describe the preferences and interests that make up a desired life and the supports (paid and unpaid) needed to achieve it.
  - Plans are directed by the person along with independent facilitation support as needed.
  - Planning with federal, state systems, communities, and families is necessary for people with LTSS needs live their desired life.

# Interactions: Person-Centered Planning, Assessments, Service Authorization

- Distinct functions that are often conflated in practice
  - Person centered planning: driven by the person and reflects his/her perspective
  - Assessments:  judgments made by professionals (e.g. diagnosis, functioning, service needs)
  - Service Authorizations: the final determination of what services are provided for what purpose

# Common Approaches

- Essential Lifestyle Planning/Person Centered Thinking
- Motivational Interviewing
- Shared Decision Making
- Graphic Approaches (PATH, MAPS)
- State driven models

# PATH


16th November 2012
MOLLY'S PATH
NOW
ENVISION
STAYING STRONG
ACHIEVING
ONE YEAR FROM NOW
THE DREAM
HAWAII
POSITIVE
NEGATIVE
16th November 2013
VISIT TO SCOTLAND
STARTING
ARCHITECT

# Ruth's One Page Description (At Home)

What People Like and Admire about Ruth

- Such a "grandmother"
- A true lady
- Has the gift of gab—can hold a conversation with anyone!
- Always dressed so nicely—everything always matches, right down to socks and earrings
- Very liberal thinker

What is Important to Ruth

- Living with her granddaughter and grandson-in-law
- Being warm and feeling safe with caregivers
- Having a "little pour" before bed (rum and tea)
- Being a part of whatever is going on at home—being in the middle of it!
- Sweets during the day!

Supports Ruth Needs to be Content, Healthy and Safe

- Needs people to ask <u>frequently</u> if she is warm enough and help her put on sweater/sweatshirt if she is not (she'll be cold when you're not)
- Must have assistance with her medications—knows them by color but you need to dole them out and keep track of times
- Needs assistance with bathing and dressing—will tell you what clothes she wants to wear for the day/event
- When bathing, no water on face—she will was h with cloth
- Must talk with daughter 2-3 times a week on the phone—will need you to dial for her
- Must see her doctor right away if she has cough, fever or is "off balance"—indications of systematic infection that will grow quickly!

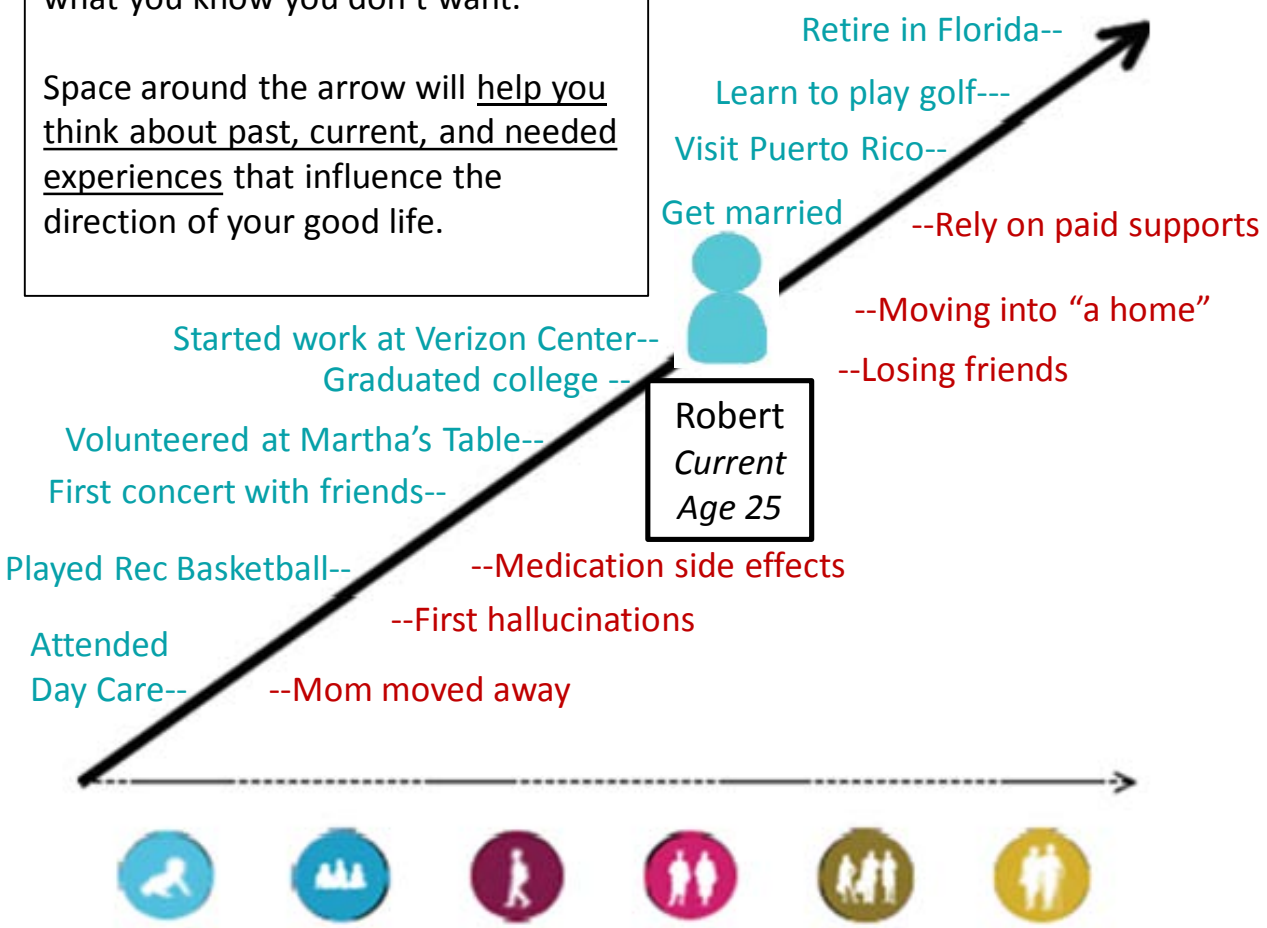
People who Support her Best

- Like to chit chat
- Are timely and stay busy
- Polite and mannerly
- Have a witty and dry sense of humor
- Can be reassuring and help Ruth feel safe

# Example of Person Centered Planning Results with Life Trajectory Tool Completed with Person Supported: Robert

Everyone wants a good life. The boxes on the right will help you think about what a good life means for you or your family member, and identifying what you know you don't want.

Space around the arrow will help you think about past, current, and needed experiences that influence the direction of your good life.




## Vision for a GOOD Life

-Money, job or own business
-Healthy and fit
-Staying active
-Married (5 kids?!)
-Attending concerts
-Vacations to Puerto Rico
-Contribute to my community
-Living in my own home

## Vision for what I DON'T Want

-Poverty, no savings
-Guardianship
-Institution/group home living
-Being lonely and isolated
-Frequent hospitalization
-Family separated from me
-No friends

Adapted from

# Person-Centered Planning: Systems-Level Questions to Ask

- **Person-Centered Planning Facilitators:**
  - Training requirements?
  - Credential or competency demonstration?
  - Are there any specific tools or resources used to implement the process?
  - Is there any research on the approach?
  - Ongoing learning?
- **How are trainers supported?**
  - Train the trainer, private consultants?
- **How do providers know what is expected of them?**
  - Clear descriptions of requirements?
  - Review processes?
  - Is there a focus on systems level changes?
- **How do consumers know they are getting a qualified facilitator?**
  - Consumer education on expectations?

# Person-Centered Planning: Systems-Level Questions to Ask (cont.)

- **How are programs reimbursing for person centered planning?**
  - Part of Case Management, peer supports, independent?
  - Conflict of interest standards?
  - How are person centered planning functions differentiated from functional assessments and service authorizations?
- **How does the process become a plan?**
  - How is the plan introduced to others?
  - How are goals linked to services and supports?
  - How are unpaid supports woven in to support goals?
- **How are plans implemented?**
  - Do all providers and the person receive copies and know their responsibilities?
- **How are plans monitored?**
  - Consumer experience measures?
  - Review of goal achievement/progress?

# Stakeholder Engagement: How

- Ongoing (from design to implementation to oversight)
- Robust and meaningful
- Responsive
- Transparent
- Timely notice of meetings, public comment & other opportunities for meaningful input
- Meetings at times convenient for all
- Multiple vehicles for input

# Stakeholder Process: How (cont'd)

- Multiple locations across the service delivery area
- Updates/summary of policy changes and ideas in clear, easy-to-digest language
- Accessible locations
  - Supports and accommodations to ensure full participation of and by individuals with disabilities; transportation; personal assistance; interpreters; alternate formats for materials; appropriate literacy level
- Web-based input and reporting; transparency of the process

# HCBS & Non-Disability Specific Settings: *Strategies for States*

- *Invest in capacity building activities of existing and new providers to assure the development of multiple non-disability specific setting options across all categories of home and community-based services offered by the state.*
- *Provide ongoing in the training and technical assistance needed to help address systems-wide modification requirements of specific settings.*
- *Disseminate information to existing and potential provider entities about any local or state tax or other financial incentives available for establishing no-disability specific HCBS setting options in the state.*
- *Review existing HCBS service definitions, policies, and rate structures to assure outcome-oriented, incentives-based approach to HCBS, including but not limited to promoting innovative transportation and natural support strategies that facilitate individual community integration.*

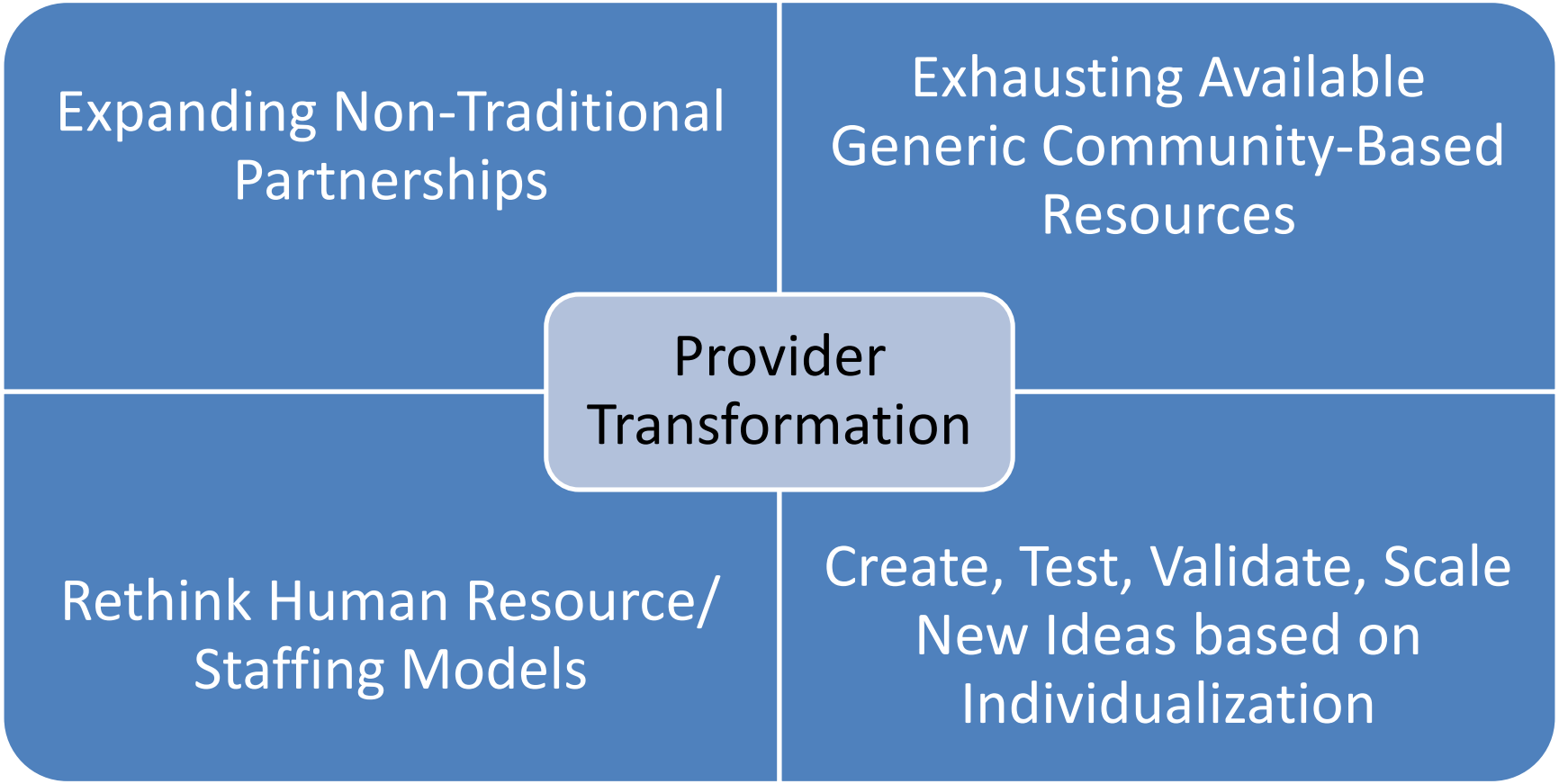
Strategies for Promoting Provider Transformation to Spur Increased Community Integration among Medicaid HCBS Beneficiaries with Disabilities

# PROVIDER TRANSFORMATION IN DISABILITY-SPECIFIC HCBS SETTINGS

# Provider Transformation:
## *What Are We Trying to Accomplish?*

- Consistently high quality services
  - Customer focused and customer driven services
  - Quality control, cost control and innovation
  - Continuity in the delivery of best practices and procedures
- Sustainability
  - Helping providers become high-performing, learning organizations
- Keys to Success
  - Ensure that the ORGANIZATIONAL STRUCTURE supports the services provided
  - Build and sustain a CULTURE of consistent best practice and continuous process improvement across the organization
  - Monitor manager and team member ENGAGEMENT very closely

# Modernizing HCBS Settings: Provider Capacity Building (1)



# Modernizing HCBS Settings: Provider Capacity Building (2)

## Innovative Provider Service Principles

- The best places to learn how to live and work in the community are in the community.
- Our buildings should be places for people to come and go – not to stay.
- We shouldn't provide things here that exist naturally in the community.
- We should never make the people we support look incompetent in the community.
- We must balance preservation of safety with the dignity of risk….there is room for both, just as there is for all other adults that do not have disabilities. The key is in striking the right balance *on an individual basis*.

## Provider-to-Provider Tips on Making the Shift to Community Integration

- Invest time and resources into effective practices.
- Build your social capital at all levels.
- Explore traditional and non-traditional revenue sources.
- Do it one person at a time, and do it a lot of times until you're done. You'll get better at what you do.
- Start small – clear the path. Don't get stuck in planning, processing and waiting for the right "time" for change.
- Hire for who you want to become, not for who you are.

# Decentralization of CRP Business Models

**Operationalizing Decentralization**

- Many current agency business models based on people coming to agency facility (centralized)
- Community integration – individualized and everywhere in the community
- Agency support provided to people where they are – no longer at centralized places
- A significant change in business structure – any type of business would have significant retooling to accommodate new approach

**Resource Allocation to Accommodate Changes**

- Moving resources out of a centralized location and out to where people are being supported
- Involves resources such as:
  - Staff
  - Communication and electronic record keeping devices
  - Transportation
  - Management support
- Facility consolidation and/or liquidation - one of the tough choices

# HCBS in Disability-Specific Settings:
## *Promoting Community Integration*

**Access**

- Availability of supports to allow a person to engage in the broader community for the maximum number of hours desired daily.
- Activities designed to maximize independence, autonomy and self-direction.

**Variety**

- Broad range of activities/offerings that are comparable to those in which individuals not receiving HCBS routinely engage.
- Access to both individualized and small-group activities, on and off site.

**Quality**

- Cultural competency
- Measurement focused on Increasing Community Access, Decreasing Social Isolation

# Assuring Optimal Community Integration in HCBS:
## *Promising Practices for Providers – Community Engagement*

- *Spending time with HCBS beneficiaries in natural environments and exposing beneficiaries to a number of community-based experiences as a way to better inform the person-centered planning and follow-along assessment processes.*
- *Developing partnerships and alliances with generic, community-based entities that result in mainstream inclusion of HCBS beneficiaries in activities available within the broader community.*
- *Establishing a public relations programs that highlight and incentivize stronger engagement of community-based partners directly with HCBS beneficiaries.*
- *Establishing a community-based advisory group to help identify and design new models and strategies for the setting to expand its individualized service offerings and increase greater access to activities in the broader community.*

# Assuring Optimal Community Integration in HCBS:
## *Promising Practices for Providers – Generic & Natural Supports*

- *Reaching out to local businesses and community partners to request program/activity/event discounts and free memberships for individuals receiving HCBS similar to offerings provided to aging Americans, military service personnel/veterans, and other special populations.*
- *Exhausting public transportation options (including ride shares, taxi services, public metro or bus systems, trains, virtual transportation services, and offer) to promote optimal individualization of scheduling and activities.*
- *Fostering access to technology, virtual applications, and other innovations as a way to stimulate natural supports and provide solutions-oriented strategies to facilitate greater participation in activities by HCBS beneficiaries in the broader community.*
- *Offering activities and programs that encourage families and friends to participate regularly and that promote greater independence and autonomy on the part of HCBS beneficiaries.*

# Assuring Optimal Community Integration in HCBS:
## *Promising Practices for Providers – Staffing*

- *Assuring the level of support required, appropriate staffing levels, and transportation options to offer both group and individualized options that facilitate optimal community engagement.*
- *Decentralizing staff structures so as to promote greater flexibility and encouragement of community-based staffing over facility-based staff structures.*
- *Hiring of logistics coordinator or purchasing of logistics software to help facilitate and promote increased individualization and small group activity scheduling.*
- *Encourage staff through incentives, rewards systems, or other promotional strategies for the development of new or expanded community-based partnerships, creation of new or expanded community-based activities, and fostering of natural supports for HCBS beneficiaries.*

# Assuring Optimal Community Integration in HCBS:
## *Promising Practices for Providers – Sustainability*

- *Collaborating with providers of similar settings to share administrative functions and leverage resources focused on training and ongoing capacity building of managers and front-line staff in the implementation of effective practices that result optimal community integration of HCBS beneficiaries.*
- *Designing activities that may begin as a small group endeavor but allow for some individualization and individual personal growth and development as part of the activity.*
- *Emphasizing community-based activities that promote the development of skills and facilitate training and educational opportunities among HCBS beneficiaries that could lead to attaining and expanding volunteering and competitive, integrated employment opportunities.*
- *Facilitating skills-building workshops and activities that encourage greater control over personal resources and promote increased independence and personal autonomy of HCBS beneficiaries.*
- *Look at non-traditional funding streams to support sustainability work.*

# Systems-wide Reform Strategies & Promising Practices for Improving Community Integration in Medicaid HCBS for Beneficiaries with Disabilities

- Tennessee:  9-15 new service definitions on the various phases related to the employment pathway
- Ohio:  Through tiered standards, transitioning 10,000 individuals out of day habilitation into community-based day; creation of new definitions/service parameters to incentivize and encourage community-based day
- Minnesota:  Increasing supportive housing options through tiered standards
- Wyoming & Michigan:  Collaborative provider transformation work between state, provider associations, and advocacy groups

Promising Practices for Spurring Optimal Community Engagement & Integration

# AGING SPECIFIC HCBS SETTINGS

# HOW DO WE CREATE A PERSON-CENTERED HOME CARE SUPPORT ENVIRONMENT?

- 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.
- Funders need to allow for flexibility in resource allocation.

# Promoting Community Integration within Residential Settings for Aging Beneficiaries

## PCP Process

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

## Create Meaningful Opportunities in the Community

- Welcoming committee
- Use talents to enhance quality of life & environment of care
- Host events & publicize/create opportunities to engage in community events
- 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 & news events
- Intergenerational programs
  - Fulfill the need to be a caregiver
- Technology- computers, phones

## Physical Health & 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

# One State Model: *Innovation, Key Learnings, Future Plans for Expansion*

- **Innovative Strategies**
  - Concerning Activity Log
  - Joint Provider Training
- **Key Learnings**
  - Length of Stay
  - Level of Care
- **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.

# Adult Day Health

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

# Adult Day Services

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

# Care Planning

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

# HCBS in Non-Residential Settings Focused on Aging Beneficiaries: *Strategies*

- *Promising practices for non-residential HCBS settings focused on aging beneficiaries to consider incorporating in an effort to promote greater access to the broader community and increased personal autonomy include but are not limited to:*
  - *Design of multiple daily activities and access to the broader community through a combination of natural supports, formal community partnerships, and formal programming that allows for each individual to be able to select from an array of individual and/or group options and control his or her own schedule.*
  - *Provision of services in a culturally competent way, with options that meet the needs of diverse populations such as limited-English proficient older adults.*

# HCBS in Non-Residential Settings Focused on Aging Beneficiaries: *Strategies (2)*

- *Opportunities designed to enable individual HCBS beneficiaries to attain or maintain as much independence as possible and to decrease social isolation.*
- *Availability of sufficient levels of well-trained staff, including staff that is knowledgeable about each person, in order to allow the person to engage in a meaningful day with positive experiences.*
- *Readily available transportation provided in a way that promotes ease of access for older adults and optimizes individuals' ability to select their own options and make decisions about their services and supports. Transportation should include individually planned and delivered options to allow maximal participation in community life. Availability of public transportation should be supplemented with training, exposure and practice to foster access to the broader community.*

# Strategies for Facilitating Community *Engagement in an ALF and/or ADHC Model*

<u>Alzheimer's Cafes</u>

- Meet in the community
- Socialization
- Peer support

<u>Collaborative Projects with Schools</u>

- Halloween show
- Craft projects
- Story times

<u>Community Computer Lab</u>

## Community Engagement Strategies for Settings specific to Aging Beneficiaries: *Building Strong Community Partners*

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