TCM Affiliate Meeting
11.05.15

Present: Tim Gorton, Sheltered Living; Christina Petree, Sheltered Living, Shawna Link, Caring and Compassionate Care; Erin Arnold, Caring and Compassionate Care; Sabrina Crevoiserat, Easter Seals Capper Foundation; Tym Frear, Lifeworx; Merilee Larson, Lifeworx; Susie Kirkwood, CDDO; Nancy Rhone, CDDO; Robert Smith, CDDO; Paula O'Brian, CDDO; Coleen Hernandez, CDDO; Sabrina Winston, CDDO

CDDO Updates:

- Discussion regarding Designated Representative signatures. It is the understanding of the CDDO that the designated representative signs documentation for HCBS-related services only. Release of information and other documentation should be signed by the legal guardian.
- There is an updated Service Provider Choice form in BCI forms with a place for designated representatives to sign if applicable.
- When an individual turns 18 make sure you update the BCI with guardianship documentation if one has been established.
- Notification of a late PCSPs are just that and if we need corrected information or you need to update, please do so.
- There is a new alphabet chart (see attached) for Functional Assessments effective Jan. 1, 2016.
- As of December 1, 2015 it will be mandatory to submit an invite for ALL Functional Assessment meetings. Blank invitations can be found in BCI forms one with the CDDO logo and one without (both are labeled Notice) or you can use your own. The invite may be sent as an email attachment. An email without the attachment will not be accepted as an invitation.
    - If an invitation is not received there is no guarantee that the assessor will be in attendance.
    - It is suggested that you:
        - Schedule the January birthdays as soon as possible (be aware of upcoming holidays and training of new assessor when hired).
        - Be sure everyone is aware that it is a Functional Assessment meeting and bring as much documentation as possible. Promptness is appreciated.
        - Per CDDO Policy the person must be in attendance for at least part of the meeting, except under extenuating circumstances that the Assessor has been informed of and approved prior to the meeting and the guardian, if one is appointed, does attend.
        - Be sure to let the Assessors know as soon as possible if the meeting needs to be rescheduled.
- When closing an individual out of services please indicate the reason so that the CDDO can follow-up before closing them completely out of services.

- It was asked who is responsible for completing PCSPs if an individual is in a Health Home? It is unclear who is responsible.
- Discussion on ISPs. It was stated that they will be quite lengthy as it will include PSCP information.
- The CDDO is requesting that TCMs continue to do PCSPs and Needs Assessments.
- It was stated that the TCM manual can only be found under Training on the KDADS website. It was also stated that the manual and tests need to be updated.
- Greg Wintle, KDADS, is out on leave, send all correspondence to hcbs-ks@kdads.ks.gov
- What is the difference between 3160's and 3161's? The 3160's is the forms that KDADS sends to DCF to open a HCBS case. The 3161's is the form used to show changes after a case is opened.
- Discussion on individuals switching from PAS services to agency-directed providers a date has not been set. It was stated that there is a need to educate families on the difference between FMS and agency-directed agencies.
- An email was forwarded (11.04.15) from Hetlinger CDDO looking for TCMs interested in affiliating as they are experiencing a shortage of TCM providers taking new referrals. It was mentioned that several CDDOs are experiencing the same, shortage of TCM providers.
- Let the CDDO know if a provider is open for referrals but does not accept a referral.
- KDADS PCSP Training (handout)
- Susie Kirkwood, Assessor, last day is Nov. 30th.

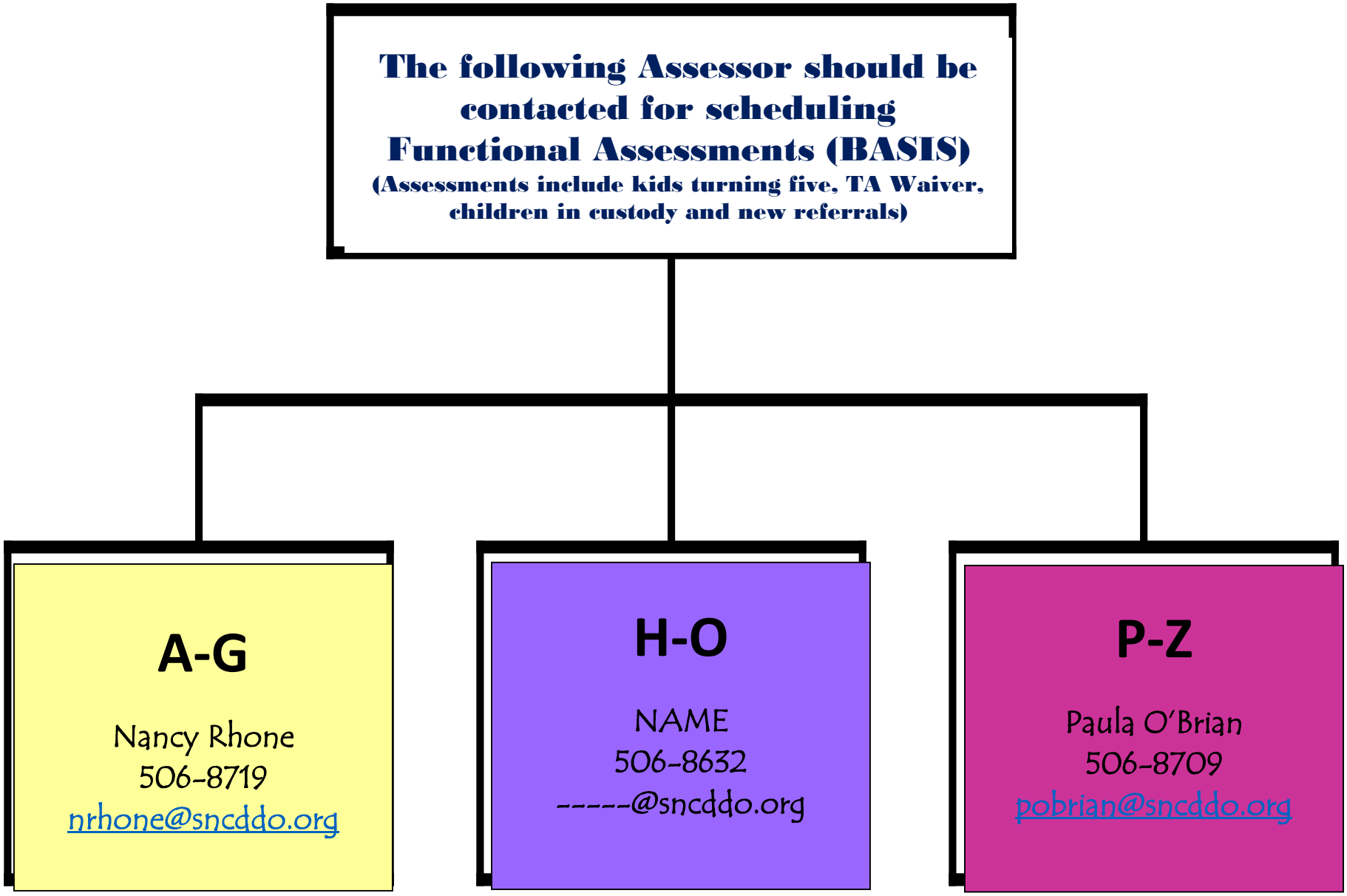
Training:

CDDO Quarterly Training – Dec. TBA

Other

KDADS Org Chart (forwarded 10.28.15)
KanCare Public Meetings – Amendment to 2017 and 2018 –
Tuesday, Nov. 10th 1-3:30 pm (providers) 5:30-7:30 pm (consumers & families) (forwarded 10.29.15)
KYSYLF – 2016 Kansas Youth Leadership Forum for Students with Disabilities (forwarded 10.29.15)

The next meeting is January 7th at 3 pm.


The following Assessor should be contacted for scheduling Functional Assessments (BASIS)
(Assessments include kids turning five, TA Waiver, children in custody and new referrals)
A-G
Nancy Rhone
506-8719
nrhone@sncddo.org
H-O
NAME
506-8632
-----@sncddo.org
P-Z
Paula O'Brian
506-8709
pobrian@sncddo.org

Kansas

Department for Aging and Disability Services

Listen. To. ME!

Person-Centered Planning

October 16, 2015 – Interhab Conference

Summary of the CMS Final Rule

- **Citation:** 42 CFR 441.301 (Contents of HCBS Waiver)
- **Issued:** January 2014
- **Effective:** March 17, 2014
  - Exception: Statewide Transition Plan – 5 year period
- **Basic Changes:**
  - Person-Centered Support Planning
  - Conflict Free System in HCBS Programs
  - HCBS Settings Transition Plan
  - Combine HCBS programs, age groups, and disabilities
- **Application:**
  - Applies to 1915(c), 1915(i), 1915(k) (in regulation)
  - Applies to 1115 Demonstration (at HHS Secretary's discretion)

Highlights of the Final Rule

1. Defines, describes, and aligns home and community-based setting requirements across three Medicaid authorities
2. **Defines person-centered planning requirements for persons in HCBS settings under 1915(c) HCBS waivers**
3. Establishes Independent Assessment and Provider Qualifications to Mitigate Conflicts of Interest
4. Allows states to combine target populations across age, disability, and conditions

1Rule. 3 Issues.

Person-Centered Planning

Supporting People

- Integrated Service Planning
- Person-Centered Plans
- Limit Restraints, Restrictions, and Seclusion

Conflict Free System

Mitigating Conflicts

- Targeted Case Management
- Guardianship & DPOA
- Separation of Services and Assessment
- System Improvements

HCB Settings Transition Plan

Assessing Settings

- Non-residential Settings (Day/Work)
- Residential Settings
- Provider Assessment
- Quality of Life
- Person's Rights and Freedoms

What does the New Rule say?

In General, the new rule includes 5 standards that all home and community-based services need to meet.

1. Integrated Setting Supports Access to Community ("to the same degree" as other people)
2. Individual Choice of Settings
3. Individual Rights (privacy, dignity and respect, and freedom from coercion and restraint)
4. Autonomy (optimizes but does not regiment individual initiative, autonomy and independence)
5. Choice Regarding Services and Providers

- 42 CFR 441.301(c)(4)(i)-(v)

What does the New Rule say?

Under the new rule, **everyone** who gets home and community-based services (HCBS) should have a **"person-centered service plan."**

- Must be in writing
- Must be created through a process that "includes people chosen by the individual."

The Plan must address:

- Choice & Access (food, visitors, community)
- Community Inclusion & Employment
- Settings and housing options
- Paid and unpaid supports
- Cultural & Communication Needs
- Health, Safety & Welfare
- Individual's choice to self-direct services
- Restrictive Interventions & Supports
- Entity responsible for monitoring plan

Listen. To. ME!

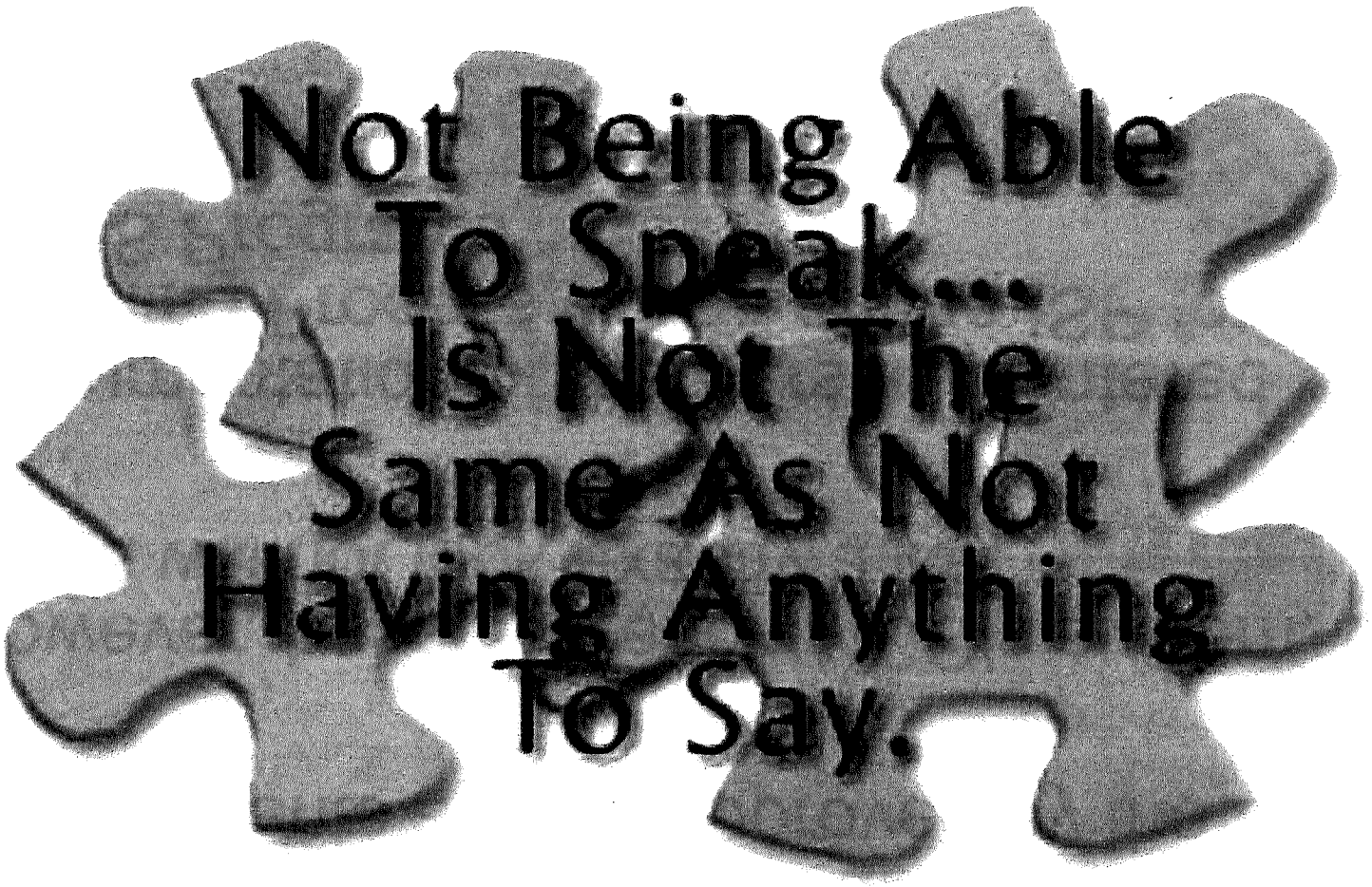
Person-centered Process helps figure out:

- ❑ Where someone is going → **Life Goals**
- ❑ What someone needs get there → **Supports**
- ❑ What someone likes to do → **Preferences**
- ❑ What someone does well → **Strengths**
- ❑ What someone is good at → **Capabilities**
- ❑ What gets in the way → **Barriers**

Ask Questions!

What the Plan Looks Like

- All 3 MCO plans will meet all the federal requirements and be approved by the State.
- However, based on each MCO's system, the forms will not look exactly alike.
- Documentation of the Person-Centered Planning Process will be on the ISP for all HCBS Programs



CAPTURING THE WHOLE IN PERSON IN THE PLAN

Assessments

- **Type of Assessment**
  - Functional (LOC)
  - Health/Risk
  - Universal/Needs
  - Behavioral Health
- **When to Assess**
  - Changing needs may require assessment
- **Purpose**
  - Where to Live
  - How to spend day
  - Who to spend with
  - Hopes/dreams
- **Goal to Assess**
  - Life Goals
  - Strengths/Capabilities
  - Preferences
  - Barriers/Limitations

- **Assessments (Consistent and Predictable)**
- **Participant Choice**
- **Participant Needs Are Met**
  - Participation in Person-Centered Process
  - Plan of Care Meets Needs & Preferences
  - Plan of Care Service Initiation & Timelines
  - Health and Safety Risks
  - Participants Are Safe
  - Protection of Participant in Emergency

Assessments

- **Comprehensive/Universal Needs Assessment**
  - Performed by qualified evaluator
  - Participant involved in assessments
- **Functional Assessment**
  - Conducted by qualified assessor (CDDO, CMHC, KVC, ADRC, MES)
  - Timing of Assessment
    - CC may participate if member wants or chooses
    - Assessment is scheduled around person
- **Health Risk/Needs Assessment**
  - Conducted by MCO Care Coordinator (TCM for IDD)
  - Can be conducted at the same time as PCSP or other assessments
  - Identify needed supports, services, and risks for a person
  - Used to develop the comprehensive Integrated Service Plan

Personal Goals: It's About ME!

What makes it a goal?

- The "Goal" is:
  - The desired end result
  - What we hope to accomplish this year
  - Use "short-tem goal" if needed
  - What we will see in the person's life
- The "Goal" is not:
  - The process (supports and services)
  - The result of the Support Strategy

Personal Goals: It's About ME!

What makes it personal?

- "Personal" is:
  - What the person wants
  - What is important to the person
  - What is the person's passions and values
  - What brings the person pleasure and enjoyment

- "Personal" is not:
  - What the person needs (habilitation, health & safety)
  - What is good for a person
  - What others think the person should want

Person-Centered Process

- **Person should**
  - Be present
  - lead or direct as much as possible
  - choose others to participate
- **Plan should** include:
  - goals & preferences
  - information about work, housing, and informal supports
  - Updates/reviews
  - changes to meet changing needs

- Assessments
- Participant Choice
- Participant Needs Are Met

- **Participation in Person-Centered Process**
- **Integrated Service Plan Meets Needs & Preferences**
- **Service Initiation & Timelines**

- Health and Safety Risks
- Participants Are Safe
- Protection of Participant in Emergency

Person-Centered is a Process

- It is a process for both planning and service delivery, not a tool or an instrument
- **Person centered means conducting all activities from the Person's Point of View– what is important to them**
- Balancing what others believe is important for the person against their right to self-determination

Focus on the Person

- Employment
- Choice
- Self-Determination
- Independence
- Relationships
- Community
- Self-Advocacy
- Skill Development
- Relationship-Based Living Arrangement
- Assistive Technology

Two Parts of the Plan

- What the person tells us, either verbally or behaviorally, is "most" important **TO** the person.

  What is important **TO** a person includes what a person says:
  - With their words
  - With their behavior

- What others tell us is important **FOR** the person to be successful

  What is important FOR the person
  - Issues of health or safety
  - What others see as important to help the person (the person may or may not agree

Health, Safety and Welfare

- Emergency Back-up Plan updated
- Self-Direction
- Abuse, Neglect, Exploitation
- Critical Incidents
- Adverse Incident Reporting System
- Health & Safety Risks are identified
- Minimize restrictions and interventions

- Assessments
- Participant Choice
- Participant Needs Are Met
- Participation in Person-Centered Process
- Integrated Service Plan Meets Needs & Preferences
- Service Initiation & Timelines
- **Health and Safety Risks**
- **Participants Are Safe**
- **Protection of Participant in Emergency**

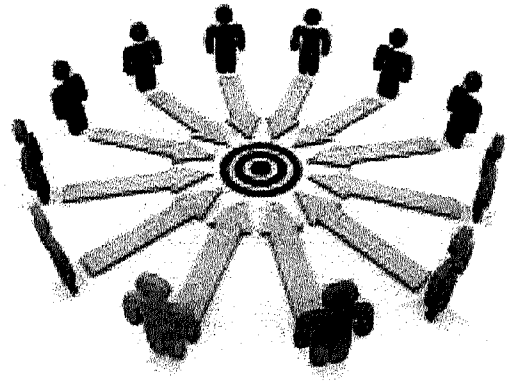
Risks & Positive Interventions

If a person has a restrictive intervention to address a risk, these requirements must be documented in the person-centered service plan:

i. Identify a specific and individualized assessed need;
ii. Document the positive interventions and supports used prior to any modifications of the person-centered service plan;
iii. Document less intrusive methods of meeting the need that have been tried but did not work;
iv. Include a clear description of the condition that is directly proportionate to the specific assessed need;
v. Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
vii. Include informed consent of the individual; and
viii. Include an assurance that the interventions and supports will cause no harm to the individual.

Participants are Safe

- All critical incidents are identified and addressed.
  - Individuals know how to report abuse, neglect and exploitation
  - Providers are monitored to make sure services are provided
- Effective and current emergency plans are in place.
  - Fire and Other Disaster
  - Service provider or worker does not show up
- Physician's/RN Statement of person's ability to self-direct health maintenance activities
- Annual review of critical incidents, hospitalizations, and strategies to address prevention of future incidents



Person Centered Care Planning

If the person centered planning is honored, the person's supports and services should be based on his or her needs, preferences, and goals.

Care Coordination

"Care coordination" is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care and service plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

Case Management

- **Definitions:**
  - **Case management consists of services** which help beneficiaries gain access to needed medical, social, educational, and other services.
  - **"Targeted" case management services** are those aimed specifically at special groups of enrollees such as those with **Intellectual/ developmental disabilities** or chronic mental illness.
- Case management services are comprehensive and must include all of the following (42 CFR 440.169(d)):
  - (1) assessment of an eligible individual (1);
  - (2) development of a specific care plan;
  - (3) referral to services; and
  - (4) monitoring activities

Person-Centered Process for IDD

MCO Care Coordination includes:

- Developing an Integrated Service Plan
- Conducting health and risk-based needs assessment
- Authorizing services based on assessed need for services and supports
- Coordinating/collaborating with all service providers, including medical/behavioral

IDD Targeted Case Management (TCM) includes:

- Developing Person-Centered Support Plan and Behavior Support Plan
- Conducting IDD Needs Assessment
- Monitoring services are provided as described in the PCSP and the ISP
- Referring to services or supports as needed

Coordination works with TCM

Development of an Integrated Service Plan

(based on information collected through the assessment process)

- **Person-Centered Support Planning (PCSP)**
  - PCSP lists the goals and actions necessary to address the medical, social, educational and other services person needs based on Article 63
  - The TCM provides the BSP, Emergency Back-Up Plan, and other support plans to be used in developing the ISP

- **Integrated Service Plan (ISP)**
  - The ISP is comprehensive and includes information from the PCSP, Behavioral Health and Physical Health supports and services based on federal regulation
  - TCM should work closely with a Care Coordinator to create an Integrated Service Plan that meets an individual's needs

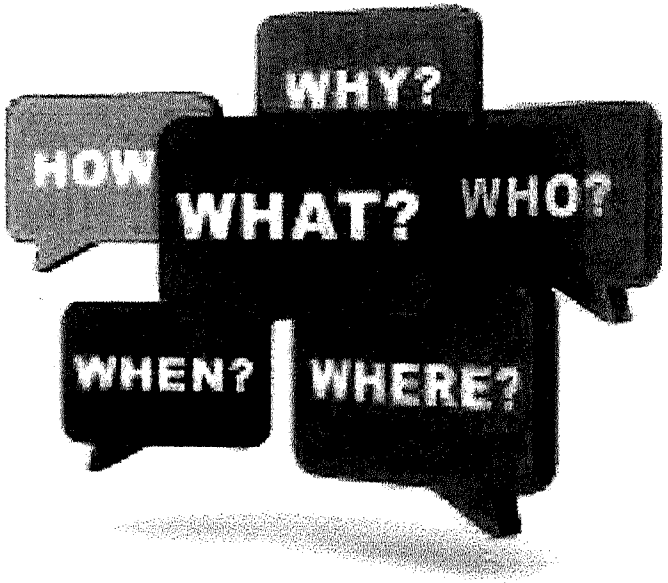
MCO Presentations

- Amerigroup ISP – Lifestyle Goals
- Sunflower ISP – Integrated Life Plan
- United ISP – Integrated Service Plan

Overview:

- Review of the process
- Review of the tool used
- TCM Notification Process

Discussion



QUESTIONS