Indiana Family and Social Services Administration

Long Term Care Transformation Stakeholder Workgroup

Meeting 5
February 5, 2018

Members and observers - please sign-in!

Welcome

- Round-robin of core members and observers

Agenda Overview

- Review ground rules, roles and responsibilities, and timeline
- Re-Cap January Meeting and Follow-Up on Commitments
- Transportation
- Dementia and Cognitive Impairment within HCBS
- Outcomes and Quality
- Next Steps for a Stakeholder Advisory Group

Proposed Workgroup Ground Rules

1. Show up on time, come prepared, and leave your "hat" at the door.
2. Listen attentively to others and don't interrupt or have side conversations. Treat all meeting participants with the same respect you would want from them.
3. Share your unique perspectives and experiences. If you disagree, try to offer a solution.
4. Seek first to understand, then to be understood.
5. Value learning from others. You can respect another person's point of view without agreeing. Respectfully challenge ideas, not people.
6. Stay open to new ways of doing things and watch/listen for the future to emerge.
7. Stay on point and on time. Keep comments brief and to the point.
8. Attend in person; do not send substitutes if at all possible.
9. If you raise an issue that is not part of the current discussion, we will place it in the "parking lot" for a future discussion.

Roles and Responsibilities

Division of Aging

- Develop Workgroup meeting agendas and materials
- Communicate with Workgroup members
- Facilitate discussions and keep group focused on session topics and questions
- Compile minutes including the tracking of action items and/or items in the "parking lot"
- Post agendas, materials, and minutes to the FSSA Long-Term Care Transformation website

Workgroup Members

- Review materials in advance of each meeting.
- Provide verbal input on redesign program elements.
- Exchange ideas, innovations, strategies and solutions.
- Follow workgroup ground rules (see above).
- Review meeting minutes for accuracy before posting.

Timeline

Meeting #	Date	Location
Meeting #1	October 2, 2017 ✓	Conference Room C
Meeting #2	November 6, 2017 ✓	Conference Room 1+2
Meeting #3	December 4, 2017 ✓	Conference Room C
Meeting #4	January 8, 2018 ✓	Conference Room C
Meeting #5	February 5, 2018	Conference Room C

January Stakeholder Workgroup Overview

1. Case Management Conflict of Interest
2. A&D Services
3. Review of Case Management
4. Review of Supported Services

Follow Up on Commitments

Transportation

Stakeholder Feedback on Transportation Challenges

- In online stakeholder surveys and meetings with providers, the following transportation challenges were identified:
  - Non-emergency ambulance transportation is not available in many areas of the state
  - There is an unmet need for transportation on weekends
  - Providers are unable transport people across county lines
  - People experience difficulty in coordinating medical versus nonmedical appointments
  - There are a lack of options for persons in wheelchairs
- Transportation challenges may be under-reported by waiver participants because their transportation needs are being met by family caregivers, or by others, even service providers, who are not compensated for transportation expenses

Waiver Non-Medical Transportation

Non-Medical Transportation

- Waiver transportation service: “services offered in order to enable individuals served under the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan”
- Other A&D waiver services offering non-medical transportation:
  - Adult Day Service Transportation (round-trip transportation to access adult day services)
  - Adult Family Care (transportation for community activities that are therapeutic in nature or assist with maintaining natural supports)
  - Structured Family Caregiving (transportation for community activities that are therapeutic in nature or assist with maintaining natural supports)
  - Assisted Living (separate payment for transportation not permitted)

Non-Medical Transportation

- Waiver Transportation Service Standards
  - Must follow a written service plan addressing specific needs determined by the individual's assessment
  - Offered in addition to medical transportation required under the State plan, not as a replacement
  - Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized
- Reimbursement
  - Level 1 (Non-Assisted): the individual does not require mechanical assistance to transfer in and out of the vehicle; $233.00/month
  - Level 2 (Assisted): the individual requires mechanical assistance to transfer into and out of the vehicle; $452.00/month
- Service reimbursed monthly, unclear on how many trips covered per month

State Examples of Non-Medical Transportation Service

State	Service Description and Limits	Rate Structure
CO	Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities, and resources, specified by the service plan. Limit to 4 one-way trips per week or 104 round trips per certification period	Taxi - Public Utility Commission Determined Rate (per one way trip) Mobility Van (per one way trip) • 0-10 miles = $8.92 • 11-20 miles = $16.44 • Over 20 miles = $24.46 Wheelchair Van (per one way trip) • 0-10 miles = $10.58 • 11-20 miles = $19.81 • Over 20 miles = $26.98
MA	Conveyance of participants by vehicle, from their residence to and from the site of HCBS waiver services and other community services, activities, and resources, including physical assistance to participants while entering and exiting the vehicle.	Reimbursement per trip, in alignment with State Plan NEMT fees Maximum allowable fees: Ground mileage = $2.93/mile Chair car, each way (plus mileage) = $20.94 Chair car = $1.46/mile

State Examples of Non-Medical Transportation Service (cont'd.)

State	Service Description and Limits	Rate Structure
MI	Services are offered to enable waiver participants to access waiver and other community services, activities, and resources as specified in the individual plan of services.	Rates individually set by regional waiver agencies (AAAs, home care, other human service agencies) through contracts with provider entities
CT	Services are offered to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. Payment per mile is made for a maximum of one round trip daily.	Transportation = $0.43 per mile Transportation (handicapped accessible) = $0.87 per mile (one way) Transportation (one way trip) = $25.25 per trip max

Group Discussion

- What is causing the underuse of waiver non-medical transportation?
- How can we modify the transportation service on the A&D waiver to facilitate access to, and use of, the service?

Non-Emergency Medical Transportation (NEMT)

NEMT in Indiana

- Medically necessary transportation for any eligible member (and escort, if required) who has no available transportation to any Medicaid-reimbursable service or Covered Pharmacy Trip
- Limited to 20 one-way trips annually that are each less than 50 miles in distance.

NEMT in Other States

- Vast majority of states do not have service limits on NEMT offered through the Medicaid State Plan
- Few examples of states using 1915(c) waivers to extend NEMT services
  - California's 1915(c) HIV/AIDS Waiver offers an NEMT service which enables individuals to gain access to waiver and other community services (subject to $40 monthly cap)
    - Includes transportation to health and social service providers once State Plan NEMT has been exhausted
    - Allows for taxi/shuttle vouchers and mileage reimbursement
  - Wisconsin's 1915(c) Family Care Waiver offers a medical transportation service but is only offered to individuals with budget authority over waiver services
    - Allows for coverage of tickets, fare cards, direct payment for transportation services, or mileage reimbursement

Group Discussion

- What are the opportunities for non-emergency medical transportation in conjunction with, or added to, waiver services?

Supporting Individuals with Dementia and Cognitive Impairment with HCBS

Individuals with Alzheimer's Disease and Related Dementias

- One-fifth of people with dementia live in nursing homes or residential care settings (assisted living)
- Most people with dementia live in the community
  - Majority live with others in the community
  - 30% of individuals living in the community live alone; more individuals live alone in the community than the total number of people who live in nursing homes or residential care settings

LTSS for Individuals with Dementia in Home-Based Settings

- Home health and adult day services are used by many individuals with dementia:
  - 31.4% of Medicare home health agency patients
  - 29.9% of adult day service center participants
- Among individuals with dementia who live at home, many have high fall risk, behavioral symptoms, pain, sleep disturbance, and environmental challenges
- Among individuals with dementia with regularly engaged informal caregivers, 99% had one or more unmet needs
  - More than 90% experienced unmet needs in the domain of safety

Caregivers of Individuals with Dementia

- Over 50% of caregivers of individuals with dementia provide more than 21 hours of care per week
- One-third of caregivers are 65+
- Two-thirds of caregivers live with the person with dementia
- One-quarter are “sandwich” caregivers who take care of both a parent and children under 18

Supporting Individuals with Dementia with HCBS

MA Frail Elder Waiver

- Aims to divert frail, elderly beneficiaries from nursing facilities by providing services to support them in the community
- Specialized services offered through this waiver include:
  - Alzheimer's/dementia coaching
  - Home based wandering response systems
  - Home delivery of pre-packaged medication/medication dispensing system
  - Supportive home care aide (such as escort services)
- Other services include chore services (such as minor home repairs or maintenance), companion services (such as non-medical supervision and socialization), grocery shopping and delivery, laundry

Supporting Individuals with Dementia with HCBS

Connecticut Statewide Respite Care Program

- State-funded program that provides information, support, and development of an appropriate plan of care, and services for the individual with Alzheimer's Disease or related dementias (cannot also be enrolled in the 1915(c) waiver for elders)
  - Individuals may choose to use traditional agency model or self-directed care model
  - Co-payment of 20% of the cost of services unless waived by the care manager due to financial hardship
- Max. of $7,500 in services available per year to each person and a max. of 30 days of out of home respite care services (excluding Adult Day Care) available per year

Supporting Individuals with Dementia with HCBS

West Virginia Family Alzheimer's In-Home Respite (FAIR) Program

- State-funded program that provides respite for caregivers of individuals with Alzheimer's or a related dementia
  - FAIR In-Home: In-home respite
  - FAIR Congregate: Respite provided in a community setting
- Socialization and stimulation for the individual with dementia through an activities plan developed for that individual
- All staff are required to complete dementia care training and all FAIR provider agencies must also be Title III-B providers
- Payment according to a cost share schedule based on the income of the individual with dementia (and spouse if individual is married)

Supporting Individuals with Dementia with HCBS

- Many states exploring the expansion of adult day programs and respite care for caregivers of individuals with dementia
  - Several states developing new dementia-specific licensures for adult day services
- Some states exploring the development of new targeted Medicaid waivers and/or the expansion of existing waivers to provide additional HCBS support to individuals with dementia
- Several states expanding accessibility and awareness of services through further development of their ADRC programs

Group Discussion

- How can A&D waiver services be modified or added to support individuals with dementia and/or cognitive impairment?
- How can the A&D waiver enhance support to caregivers?

Outcomes and Quality

Outcomes and Quality

- Statutory Assurances and Quality Measures in 1915c HCBS Waivers

1915c HCBS Statutory Assurance	Example Performance Measure
Administrative Authority	# and % of enrolled waiver providers who met all provider enrollment requirements corresponding to the executed contract
Level of Care	# and % of enrolled participants who are reevaluated annually
Qualified Providers	# and % of newly enrolled case managers who completed initial case management training
Service Plan	# and % of participants that are afforded choice between/among waiver services and providers
Health and Welfare	# and % of incidents that were reported within the required time periods
Financial Accountability	# and % of rates for waiver services adhering to reimbursement methodology in the approved waiver

Outcomes and Quality

- Other measures
  - Days at Home
  - Healthy Days in the Community
  - National Quality Forum Measures
  - National Core Indicators

Outcomes and Quality – Days at Home

- The University of Nottingham highlights Days at Home (DAH) as a reasonably acceptable indicator of the success of many services
  - DAH = (total days of follow up) – (days in hospital, including readmissions) – (days in intermediate care facilities) – (days in a long term care placement) – (days of overnight care in respite care)
- Limitations
  - DAH does not include direct health status measurement – could be at home with poor health or quality of life
  - It is not necessarily a bad outcome to be in long term care, a hospital, or another health care facility
- Strengths
  - DAH is likely to be easily understood by patients, families, providers, etc. – being at home is usually preferable
  - Measuring DAH does not require direct patient contact and can be drawn from records – useful because measuring health status among older people can be difficult

Source: Gladman JRF, Harwood RH, Conroy SP. The University of Nottingham. Days at home: an outcome measure in studies of specialist services providing care for older people. October 2010. https://nottingham.ac.uk/mcop/documents/papers/issue4-mcop-issn2044-4230.pdf

Outcomes and Quality

- Healthy Days in the Community proposed by CMS
  - Based on average number of days within a year that a person is residing in the community without utilizing acute or post-acute health care services (hospital inpatient care , hospital outpatient observation, inpatient rehabilitation facility, long-term care hospital, inpatient psychiatric facility, skilled nursing facility, emergency department use, and home health care)
  - An expansion of the concept of "community tenure" – days spent between hospitalizations
  - Applies to dual eligibles, people receiving managed long-term services and supports, people with addictive disorders, and persons with complex needs, physical and mental health conditions, or who receive LTSS in the community
  - The CMS measure is similar to the CDC measure "health-related quality of life" – developed as far back as 1993. "Health-related quality of life (HRQoL) is a multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning. It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status has on quality of life. A related concept of HRQoL is well-being, which assesses the positive aspects of a person's life, such as positive emotions and life satisfaction."

Outcomes and Quality – Other Measures

- National Quality Forum's 2015 Compendium on HCBS Quality Measures
  - Proportion of adults with disabilities who participate in social, spiritual, recreational, community and civic activities to the degree that they wish
  - Plan of care includes at least one public and/or private community service/resource
  - Discharged to community – percentage of home health episode after which patients remained at home
  - Community Tenure - 6 months and 1-year post-discharge
- NCI Measures
  - The proportion of people who make choices about their everyday lives, including: housing, roommates, daily routines, jobs, support staff or providers, what to spend money on, and social activities
  - The proportion of people who report having been provided options about where to live, work, and go during the day
  - The proportion of people who report that they would like to live somewhere else
  - Frequency of medical care

Outcomes and Quality

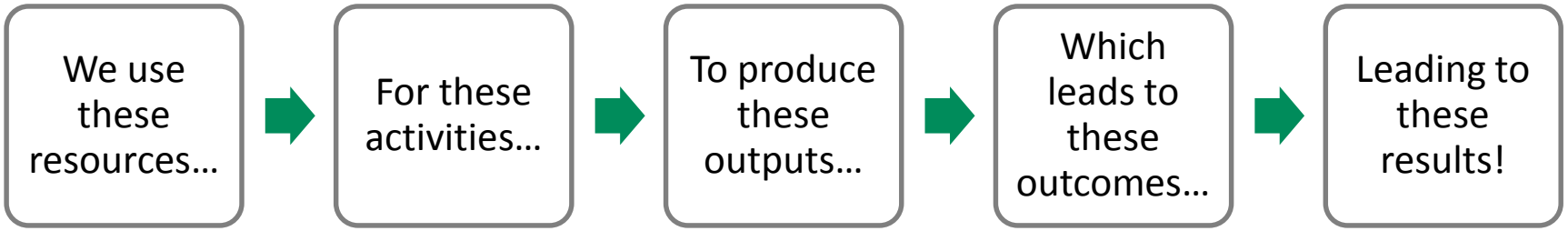
- State examples:
  - California
    - the number and proportion of beneficiaries who transition from institutional to community settings who are not re-institutionalized within one year
  - Ohio
    - 1) the number of beneficiaries who were discharged from NF to community setting and did not return to NF during the current year as a proportion of the number of beneficiaries who resided in a NF during the previous year,
    - 2) the number of beneficiaries who were in a NF during the current year, previous year, or combination of both years who were discharged to a community setting for at least 9 months during the current year as a proportion of the number of enrollees who resided in a NF during the current year, previous year or combination of both years (>100 days)

Outcomes and Quality

- What other Quality Measures could be included in DA's Waivers?

Outcomes and Quality – Logic Model Approach

- A logic model is a plausible and sensible diagram of the sequence of causes (resources, activities, and outputs) that produce the effects (outcomes) sought by the program. It can be used for conceptualizing, planning, and communicating.



Logic Model Example: NWD System

- Developed by the Administration for Community Living (ACL) in order to map outcome measures for a fully functioning NWD System
- The Four Functions of a NWD System "roll up" into the overall logic model with the same long term outcome goals
  1. State Governance and Administration
  2. Public Outreach and Coordination with Key Referral Sources
  3. Person Centered Counseling
  4. Streamlined Eligibility for Public Programs

Logic Model Example: NWD System

State Governance and Administration

Inputs	Activities	Outputs	Outcomes		
			Short Term	Medium Term	Long Term
• State Leadership buy-in • Public/private partnerships • Funding by source • NWD System Staff by type • MIS System • Basic Standards: Functional Partnership • Person Centered Standards[1] • Standardized MOUs and procedural templates • Governing body • Statewide coverage • Multi-years operation plan w/ regulations • cross-disability stakeholder group to collect meaningful feedback • Continuous Quality Improvement (CQI)[2]	• Governance and administration of the NWD system: o Staff training regarding NWD policies procedures o Secure data/ information sharing o Annual reporting • Secure sustainable funding streams • Oversee quality control • Operationalize roles and responsibilities of formally designated entities in the NWD system (manage agreements, CQI, State leadership) • Solicit feedback on system • Monitoring alignment of the program	• Governance reviews • #/% of staff trained • #/% of partners sharing data • Improved communication • Produced annual performance reports (Y/N) • Amount of $ spent on NWD • Amount $ received for NWD activities • Sources of funding • Number of public/private partnerships sharing resources • # /% stakeholders participating in governing body • Level of CQI activity (including feedback from staff, vendors, and consumers)	System Level: • Increased PCP knowledge by staff • Demonstrated commitment for collaborative work • Shift in business processes • Reduce burden on staff • Increased #/% staff credentialed? • #/% of staff that have information they need at the time they need it • Service gaps Identified • Increased political support • Expanded funding sources for the NWD	System Level: • Increased service activation • More effective use of resources • Legislative/Gubernatorial changes • Increased use of data for decision-making • New policies and procedures implemented • Expanded awareness of service gaps, waiting lists, and consumer preference • Reduced threats to the system (e.g., unstable funding, lawsuits) Consumer Level (more): • Consumer trust • Active decision-making • Knowledge of LTSS/life options • Needs/goals met • Efficient use of personal resources • Personal activation • Consumer preferences met	System Level: • Sustainability/ Organizational integration • Maintained/enhanced community presence • Wide-spread LTSS reform/culture change (e.g., available and covered services) • Decreased system costs (cross programs) and/or decreased growth in costs • Increased provision of preferred services Consumer Level: • Maintaining or improving quality of life: • Community tenure • Independence/dignity • Well being • Community participation • Improved health/ healthcare utilization

Logic Model Example: NWD System

Public Outreach and Coordination with Key Referral Sources

Inputs	Activities	Outputs	Outcomes		
			Short Term	Medium Term	Long Term
• Funding by source (List all payers) • Staff (type, certification, core competencies or standards, levels, # of FTEs) • Framework for public/private agreements • Basic Standards: # and % of public/private formal agreements • # and % of sites approved to refer or accept referrals from public programs (e.g., have passed the VD-HCBS readiness review) • Person-Centered Standards: Existing infrastructure, applying BIP standards, NWD/SEP system, ADRC core criteria, level of service coverage, strategic plan elements, functionality of data system, performance management system • Cultural/linguistic competence assessment • State leadership	• Conduct public outreach, education, awareness campaigns • Coordinate with I&R entities • Develop transition protocols with acute care and LTSS entities • Build relationships with VAMC re: implementation of VD-HCBS • Marketing/branding • Developing referral tools • Strengthen interagency agreements • Develop cultural and linguistic competency framework	• Number of campaigns • # of materials distributed/ presentations made • # of web hits • # of people reached by demographics and device type • # and % of entities in partnerships • # and % of entities with formal transition protocols in place • # and % of referrals from critical pathway providers • NWD designated as LCA • # and % of organizations in partnerships	System Level: • Increased visibility of the NWD/Increased consumer volume • Higher rates of engagement by target population • Increased # and % of referrals • Increased service provider engagement • More efficient cross system information sharing • More holistic approach to the work • Expanded funding sources (VA)/ increased leveraging of community resources	System Level: • Improved access to existing services (by geography, and target group) • Reduced consumer burden/LOE to access needed services/meet preferences • Expanded awareness of service gaps, waiting lists, and consumer preference • Increased accuracy of referrals/referral quality • Increased emphasis on community living: • Increased numbers of people transitions to the community (NH, Acute care, Youth) • Increased numbers of low risk individuals transitions from nursing homes Consumer Level: More: • Knowledge of LTSS/life options • Needs/goals met • Personal activation • Consumer preferences met	System Level: • Sustainability/ Organizational integration • Maintained/enhanced community presence • Wide-spread LTSS reform/culture change (e.g., available and covered services) • Decreased system costs (cross programs) and/or decreased growth in costs • Increased provision of preferred services Consumer Level: Maintaining or improving quality of life: • Community tenure • Independence/dignity • Well being • Community participation • Improved health/healthcare utilization/ readmissions

Logic Model Example: NWD System

Person Centered Counseling

Inputs	Activities	Outputs	Outcomes		
			Short Term	Medium Term	Long Term
• Funding by source (List all payers) • Staff (type, certification, core competencies or standards, levels, # of FTEs • Basic Standards: Functional Partnership (Org. type, agreement types, activities, purpose) • Person Centered Standards: Existing infrastructure, applying BIP standards, NWD/SEP system, ADRC core criteria, level of service coverage, strategic plan elements, functionality of data system, performance management system • Cultural/linguistic competence	• Providing PCC Training Program according to PCP national standards • Providing Person Centered Thinking training for admin. staff (Federal/State/ Local/etc). • Provide guiding documents to coordinate transition services btw. Acute care, SNF, VAMC, etc. • Implementing a PCC/P credentialing process • Monitoring the quality of PCC/P training and implementation • Cultural and linguistic adaptation • Encourage relationships between PCC and benefits counselors (e.g., training, role modeling, removing structural barriers)	• # and % of 'Person-Centered Counselors' trained • #/% of administrators trained • # and % of line staff in the credentialing pipeline • # and % of private sector/ non-profit individuals trained • # of trained staff who participate in follow-up/ booster training • Level of adherence to quality standards in training for PCC/P • # and % of culturally/ linguistically appropriate materials/ services	System Level: • Increase counselors / administrators comprehension in targeted areas • Increase counsellors / administrators ability in targeted areas • Increase # and % of counselors credentialed • Increase quality of person centered counselling	System Level: • Increased use of PCP/C tools by counselors* • More people receiving PCP/PCC from credentialed counselors • Increased consistency of staffing (one counsellor follows a client through the process) • Increased job satisfaction of staff • Improved access to existing services • Increased service activation • Increased and more accurate referral to public resources • Increased emphasis on community living • Increased program wide fidelity to PCC/P standards • Decrease duplication of services • Decrease time required to develop a person-centered plan Consumer Level (more): • Consumer trust • Active decision-making • Knowledge of LTSS/life options • Needs/goals and preferences met • Efficient use of personal resources • Personal activation • Consumers have a more holistic approach to their services	System Level: • Sustainability/ Organizational integration • Maintained/enhanced community presence • Wide-spread LTSS reform/culture change (e.g., available and covered services) • Decreased system costs (cross programs) and/or decreased growth in costs • Increased provision of preferred services Consumer Level: Maintaining or improving quality of life: • Choice • Community tenure • Independence/dignity • Well being • Community participation • Improved health • Decreased healthcare utilization

Logic Model Example: NWD System

Streamlined Eligibility for Public Programs

Inputs	Activities	Outputs	Outcomes		
			Short Term	Medium Term	Long Term
• Funding by source (List all payers) • Staff (type, certification, core competencies or standards, levels, # of FTEs) • Basic Standards: Functional Partnership (Org. type, agreement types, activities, purpose) • Person Centered Standards: Existing infrastructure, applying BIP standards, NWD/SEP system, ADRC core criteria, level of service coverage, strategic plan elements, functionality of data system, performance management system • Ability to share data • A statewide plan involving a process for accessing all public programs	• Streamlined access to public programs • Integrate and manage a two-stage (Level 1 and Level II) financial eligibility and determination process • Integrate and manage a two-stage (Level I and Level II) functional eligibility and determination process • Person Centered Counselors (PCCs) support and contribute to the eligibility determination process • Help consumers understand various eligibility rules/options • Encourage relationships between PCC and benefits counselors (e.g., removing structural barriers) • Train on streamlined access and systems navigation	• Number of steps in the public program determination process that are integrated • Partnership agreement with the State offices to perform eligibility and determination tasks that are eligible for reimbursement • # of MOAs for inter-agency collaboration • Co-location (virtual and physical) of functional and financial eligibility determination staff • Centralized information on all NWD agency operations • Amount of education for consumers regarding eligibility for public programs • PCCs ideally designated by public programs to participate in and facilitate the assessment process	System Level: • Number of public programs access points • Number of sites capable of conducting two-stage financial preliminary eligibility and/or determination • Number of sites capable of conducting two-stage functional preliminary eligibility and/or determination • Number of PCCs trained to assist with applications to ensure "camera readiness" • Number of PCCs who are designated to perform financial preliminary eligibility and determination • Number of PCCs who are designated to perform functional preliminary eligibility and determination	System Level: • Decrease in application errors • Increase in public dollars funding NWD access • Percent match between program 'referrals' and program acceptance (i.e., reduce number of consumers found ineligible) • Increase uniformity of data needed for public program access Consumer Level: • Decrease in average length of time of the application process • Decreased burden on the individual and on public program staff	System Level: • Sustainability/ Organizational integration • Maintained/enhanced community presence • Wide-spread LTSS reform/culture change (e.g., available and covered services) • Decreased system costs (cross programs) and/or decreased growth in costs • Increased provision of preferred services Consumer Level: • Maintaining or improving quality of life: • Choice • Community tenure • Independence/dignity • Well being • Community participation • Improved health/ healthcare utilization

Logic Model Example: NWD System

Overall NWD Model

Inputs	Activities	Outputs	Outcomes		
			Short Term	Medium Term	Long Term
• Funding by source (List all payers) • Staff (type, certification, core competencies or standards, levels, no. FTEs) • Basic Standards: Functional Partnership (Org. type, agreement types, activities, purpose) • Person Centered Standards: Existing infrastructure, applying BIP standards, NWD/SEP system, ADRC core criteria, level of service coverage, strategic plan elements, functionality of data system, performance management system • State leadership/buy in • Governing Body • Statewide coverage • Business/Operation Plan • Cross-disability group • CQI Process	Developments of the following components: • Public outreach and links to key referral sources • Person centered counseling • Streamlined eligibility and access to public programs • Governance and administration of the NWD system	• Level of core service provision • Counts of: • Partnerships by type and level • Continuous Quality Improvement activity • Access points • Streamlined access to public programs (# of entry points capable of conducting functional and financial eligibility assessments) • Number of people served/screened by type • Governance reviews • #/% of staff trained • Amount of training by type • #/% staff credentialed/in process • #/% of partners sharing data • Produced annual performance reports (Y/N) • Adherence to quality standards for training PCC • Public Outreach: # of campaigns, materials, entities with formal transition protocols in place, referrals from critical pathway providers	System Level: • Increased visibility of NWD • Increased strength of person-centered practice /consumer / practitioner engagement • Increased service provider engagement • Improved consumer targeting • Increased staff capacity to provide person-centered services (responsiveness, knowledge, credentials, comprehension) • More efficient cross-systems information sharing (service gaps identified) • Expanded funding sources for the NWD: (Medicaid, Medicare, VA, State, Private • Governance • Staff burden • Staff efficiency Public Program Access: • Statewide • Sites able to do two stage financial and functional preliminary eligibility determination	System Level: • Improved access to existing services • Increased service activation • More effective use of public resources • Increased use of data for decision-making • New policies and procedures implemented • Increased emphasis on community living • Expanded awareness of service gaps, waiting lists, and consumer preference Consumer* Level • More: Consumer trust, active decision-making, knowledge of LTSS/life options, needs/goals met, informed use of personal resources, personal activation, consumer preferences met	System Level: • Sustainability/ Organizational integration • Broad public awareness of federal vision of the NWD • Wide-spread LTSS reform/culture change (e.g., available and covered services) • System efficiency/ duplication • Increased provision of preferred services Consumer* Level: • Maintaining or improving quality of life: • Community tenure, independence/dignity, well-being, community participation, improved health/healthcare utilization • New policies and procedures: use of tools, consistency of staffing, service from credentialed PCC, fidelity to PCC/P standards • Fully developed system, visible/trusted by citizens, improved efficiency, consumer QoL

Indiana's HCBS Logic Model

- What interventions, programs, attributes "roll up" into Indiana's HCBS Logic Model?

Indiana's HCBS Logic Model – Proposed Interventions

1. Person-Centered Planning and Service Delivery

   (This would include the Case Management outcome and quality measures discussed during the January meeting)

2. Statewide No Wrong Door (NWD) System
3. Accessible HCBS
4. Systems that Support Transitions Among Settings and Services
5. Direct Service Workforce and Caregivers
6. Housing to Support Community-Based Living Options
7. Employment Supports
8. Transportation for Community Inclusion

Indiana's HCBS Logic Model – Long Term Goals

- Increased days in the community
- Increased quality of life
- Decrease in ER, hospital, SNF utilization
- Decrease in 30-day readmission rate
- Decrease in adverse events related to falls and medication non-compliance
- Rebalancing of Medicaid spending
- Others?

Outcomes and Quality

- Logic Model Exercise

Inputs	Activities	Outputs	Outcomes		
Resources and contributions	Tasks conducted by case managers, staff, providers, volunteers, etc. Activities are directly linked to outputs	Products and services delivered	Changes in individuals, agencies, systems, and communities. Outcomes may be intended or unintended.		
			<u>Short-Term</u> Learning Awareness Knowledge Attitude Skills Opinions Aspirations Motivations	<u>Intermediate</u> Action Behavior Practice Policies Social Action Decision-Making	<u>Long-Term</u> Conditions Social Economic Civic Environment

Next Steps for a Stakeholder Advisory Group

Stakeholder Advisory Group

Questions to Consider:

- How should we structure an ongoing Advisory Group to ensure consistent participation?
- Would webinar or telephone options be beneficial?
- Are there stakeholders that were not included in the LTC Stakeholder Workgroup that should be invited to participate in an ongoing Stakeholder Advisory Group?
- How frequently should the Stakeholder Advisory Group convene?
- What do you, as stakeholders, see as your role in an ongoing Stakeholder Advisory Group? What would you hope to achieve?

Wrap-Up

- *Review minutes from today's meeting*
- *Questions or Comments:*
  Indiana-HCBS@Lewin.com
- *Any commitments?*

THANK YOU!!!