



MI Choice Waiver Renewal Stakeholder Meeting

MINUTES

Date: Thursday, November 30, 2017

Time: 9:00AM – 12:00PM

Where: Michigan Department of Health and Human Services (MDHHS)
Capitol Commons Center (CCC) Conference Rooms E and F
400 S. Pine Street
Lansing, MI 48913

Welcome and Introductions

The MI Choice Renewal Panel is made up of the MI Choice Design Team. This Lean Process Improvement team is comprised of the following individuals: Elizabeth Gallagher of MDHHS, Weylin Douglas of MDHHS, Cheryl Decker of MDHHS, L. Alisyn Daniel-Crawford of MDHHS, Stacy Strauss of Senior Resources, and Ben Keaster of Area Agency on Aging Region II. The application renewal of the MI Choice Waiver Program provided an opportunity for the MI Choice Design Team to approach the application with a focus on continuous quality improvement.

All members of the MI Choice Design Team were present at this meeting.

This meeting is meant to get input from the attendees about how to improve the MI Choice program and what could be done to make it easier for participants to receive services in their homes and in the community. It is also important to know what is working well and should not be changed. The topics on the agenda serve as starting points, but do not have to be discussed if other topics are more relevant to those attending the meeting.

Person-Centered Planning (PCP)

- Where does policy conflict with person-centered planning?
- What can be done to facilitate person-centered planning?
- How can beneficiaries be better supported in using person-centered planning for their goals?
- How can we use support brokers?
- What requirements can be eliminated or lessened to encourage person-centered planning?
- Other relevant concerns regarding PCP?

Attendees were presented with the above questions to help generate meaningful discussion regarding PCP.

- A provider brought up the use of Supports Brokerage, which was discussed in a previous stakeholder meeting. In the previous meeting, it was suggested that Support Brokerage service be discontinued from the Waiver Program.

- Providers presented questions regarding who is eligible to provide supports brokerage. The attendees were informed that friends, family members, and the like, could service as support brokers.
- A provider reported that their agency used Centers for Independent Living (CILs) as Supports Brokerage to help support participant with self-determination process.
- A provider questioned whether a supports broker could be involved with Medicaid determination. The provider was informed that the service was not limited and such activity would be allowed.
- A provider inquired about whether this service would need to be contracted out. The Department stated that the supports broker would need to be part of the provider network unless part of a self-determined relationship.
- A provider brought up the issue of PCP conflicting with policy, with the most common complaint that the waiver is be payer of last resort. For example, the use of skilled bath aides instead of being able to use normal community living supports worker.
- A provider opined and noted concern with not having face-to-face assessments throughout the year, as face time with the participants and being in their home, seeing their environment is critical. Same provider noted that instead of limiting face time with participants, it would be best to reduce paperwork requirements.
- A provider brought up MI Health Link participant contact requirements, which are monthly contacts over phone and quarterly in-person contacts, but these are not assessments.
- The Department asked which paperwork was unnecessary. A Waiver Agency provider responded by asking why do they have to have participants submit request to stop services in writing following a verbal request.
- A provider asked if they could email participants a letter that says they requested "X service be stopped on X date, if this is incorrect, please contact us."
- A provider brought social isolation as a huge issue as well as access to public transportation. The provider reported that some are either afraid to use public transportation or cost constraints. A subject matter expert on self-determination noted that a supports broker might be able to help with getting someone acclimated with using public transportation and MI Choice could pay for the bus pass.
- A provider expressed concerns with Supports Brokerage, as it adds another layer of possible confusion. The provider noted that support coordinators and support brokers would not know who is responsible for what could cause more confusion for the participant.
- An attendee stated that the waiver program could help participants get out in the community more. The waiver program could help them with other needs they may have as well. A provider noted that every time there is a mandate/requirement made (with the intention of helping the participant) it takes more and more time away from spending time with the participant and determining what their actual needs/goals are.
- There was discussion about additional services like evidenced-based training, like smoking cessation, weight management, diabetes management.
- A provider read from Consumer Focus Group/Consumer Quality Group Summary (Please see **MI Choice Stakeholder Feedback Person-Centered Planning** below)

- A provider asked why they had to get oxygen orders for those on oxygen for the Clinical Quality Assurance Review and the Level of Care Determination. Several providers spoke up and said they had been cited for this in the past.

Support Coordinators & Participant Contact

- How often should supports coordinators contact participants?
- How often should reassessments be conducted?
- Should there be more frequent contact upon enrollment?
- Other relevant concerns regarding supports coordinators and participant contact?

Attendees were provided an overview of the current required requirements of participant contact for support coordinators and were asked if changes were needed. Below is some general feedback that was provided.

- A provider brought up that they were looking at cutting down on current assessment, but had concerns about what constitutes a “significant change” and requires a dual discipline reassessment.
- A provider brought up concerns about quality requirements for the waiver and current level of quality provided by waiver agency are costly and that Integrated Care Organizations will come in and say they can provide for much lower cost and eventually they will be audited and realize the quality will not be what Waiver agencies provide.

Health & Welfare

The final agenda topic dealt with health and welfare. The Department asked the attendees if there were things we should or should not be reporting. The Department explained what defines critical incidents – suspicious death, worker using drugs or alcohol on the job, abuse, neglect or exploitation, worker no shows for at risk, etc.

- Topics related to Waiver Application:
 - *Critical Incident Reporting and Management*
 - *Use of Restraints or Seclusion*
 - *Use of Restrictive Interventions*
 - *Medication Management and Administration*
- Provider noted that use of the Critical Incident Portal has been helpful as it is easy to use and has helped with reporting.
- A provider noted that the critical care worker shortage has caused several Critical Incidents.
- A provider asked if there is a way to track all of the referrals to Adult Protective Services (APS) from the Critical Incident Portal statewide as they feel they are often not taking action on referrals that they feel are significant concern.
- Feedback received from participant quality group via text asking to look at Critical Incident Portal data and analyze trends to look at ways to prevent future occurrence.

- Provider asked if we are providing education regarding alternative methods of keeping participant safe such as using baby monitors at night to keep from wandering and they continue to lock them in room or tie them in bed.
- Several providers provided discussion and feedback on the possibility of adding prescription drug abuse to Critical Incident Portal. They noted that it would be good to provide education for support coordinators on this topic.
- Provider stated that they received information that aides under Community Mental Health workers can pass medications, as well Home for the Aged and Adult Foster Care home staff, and asked why is this different from waiver standards.

Below please find stakeholder feedback provided in writing at the meeting:

MI Choice Stakeholder Feedback Person-Centered Planning

The Person-Centered Planning Guideline (Attachment M) in the contract outlines the person-centered planning process of case management. The InterRAI-Home Care Assessment tool identifies risk factors that should be discussed with the client and their allies.

CQAR care plan trainings and audits in the past few years have identified that the care plan needs to include all of the identified assessment triggers (risk factors). The person-centered care plan should be meaningful to the client and should reflect what is important to them including strengths, wishes and barriers. Health, Welfare and Safety issues (Important for) that impact the client's ability to remain independent and they refuse to work on are service plans.

Making the person-centered plan meaningful a care plan needs to be written in the client's words and not be drop-down driven from the assessment triggers.

The person-centered plan should be a living breathing document that is managed by the client with the assistance of their supports coordinator and not just a regulatory requirement. It needs to bring the client value. It should be the first place the supports coordinator goes to understand the client and not the assessment or progress notes.

CQAR audits should focus on the client's care plan and whether or not outcomes are being attained versus on whether or not identified assessment issues are listed on the care plan. Consumer focus group or asking local consumer quality council members to give feedback on what makes a meaningful care to them should be considered.

Frequency of Support Coordinator contact with participants

For some individuals monthly is not needed or wanted. If we are doing true person-centered planning the participant would indicate the frequency. Perhaps the participant could determine the frequency after they are on the program for six months and the contacts would either be monthly or quarterly but no greater than quarterly.

Could we focus more on Care Transitions and do more frequent contacts similar to what readmission protocols are for hospitals, home care etc.? Then we could measure outcomes versus process compliance.

The published reassessment options seem reasonable and perhaps criteria for when 90 day reassessments should be considered needs to be evaluated. For example: An individual has 2 unplanned hospitalizations within a 60 day period of time. This individual is moved back to every 90-day assessments for the next six months.

Health and Welfare

Critical incident tracking is necessary but it seems like it is just numbers and data. What can we do with the data at the State level to improve health, welfare and safety? For example: No shows. If the client elects to go without services because they want their paid family caregiver to provide the service who is the no show. The emergency back-up plan is implemented which is no service per their request. So it is tracked. There could still be a health, welfare and safety issue for the client. At this point, they receive education and asked if they want someone else and the answer is no. So we are done. Is it a critical incident or not. This is one that is open to interpretation by the CQAR reviewers and it depends on the reviewer.

The Critical Incident Tracking system in some respects puts a barrier between the agency and the State where we use to have discussions at State Quality meetings on the patterns and trends regarding critical incidents. We could then work together to identify interventions to help prevent critical incidents. We have lost consistency without the information being discussed and Quality members discussing cause and effect.

Other Health, Welfare and Safety Issues

When a participant knows that they should consider fixing a roof, floor, or move to a new place and they elect to not complete the repair at what point is this their decision and we accept it. If there are required documentation by CMS then it would be a best practice for us all to know the requirements instead of going back and forth with CQAR on trying to resolve the issue through documentation when it is clearly the participant's choice.