



# CBAS Home and Community-Based (HCB) Settings Stakeholder Process Webinar/Meeting

**Meeting Date** March 17, 2015  
2:00 – 5:00 p.m.  
Sacramento – California Department of Aging (CDA)

**Attendees** Registered for the webinar: 137  
Attended via webinar: 107

On-site Attendees	Organization
Bobbie Wunsch (Facilitator)	Pacific Health Consulting Group
Lydia Missaelides	California Association for Adult Day Services (CAADS)
Gretchen Brickson	LA Care Health Plan
Debbie Toth	Rehabilitation Services of Northern California
Nina Weiler-Harwell	AARP California
Rebecca Schupp	California Department of Health Care Services (DHCS)
Michael Luu	DHCS
Lora Connolly	California Department of Aging (CDA)
Ed Long	CDA
Denise Peach	CDA
Staff	CDA & DHCS

- Meeting Agenda**
- Welcome and Overview of Meeting Agenda and Objectives
  - Review Past Meeting (2/24/15)
    - Meeting Summary
    - Stakeholder Input Log
    - Work Tool Progress – Centers for Medicare & Medicaid Services (CMS) Exploratory Questions and CBAS Transition Plan Outline
  - California’s Statewide Transition Plan Update
  - Review CMS Special Terms and Conditions (96(c)) Person-Centered Planning Expectations
  - Person-Centered Planning Discussion
    - Participant/Caregiver Engagement
    - Provider Perspective
    - Managed Care Plan Perspective
    - Workgroups
  - Q&A/Public Comments
  - Next Steps/Review of Action Items





## Summary

### **Welcome and Overview of Meeting Agenda & Objectives**

Bobbie Wunsch of Pacific Health Consulting Group welcomed everyone participating in the webinar and reviewed the agenda and meeting objectives. The purpose of the meeting was to: (1) engage CBAS stakeholders in a discussion about CBAS settings and person-centered care in the context of the HCB Settings regulations; and (2) identify issues for inclusion in the CBAS Transition Plan. The purpose of the CBAS Transition Plan is to bring CBAS centers into compliance with the requirements of the HCB Settings rule as specified in the CBAS provisions of California's 1115 Bridge to Reform Demonstration Waiver, Special Terms and Conditions (STC) Items 95 and 96. CBAS participants have the right to make choices about services and settings and to receive quality care. The CBAS Transition Plan will be integrated into California's Statewide Transition Plan.

All future meeting dates for the CBAS HCB Settings Stakeholder Process have been posted on the CDA website as follows:

- April 23, 2-5 p.m. – to continue Plan Development
- May 19, 2-5 p.m. – to release the Draft CBAS Transition Plan
- July 8, 2-5 p.m. – to review the revised Draft CBAS Transition Plan for inclusion in California's Statewide Transition Plan

### **Review Past Meeting (2/24/15)**

Bobbie informed stakeholders that the February 24<sup>th</sup> Meeting Summary, Stakeholder Input Log, CMS Exploratory Questions and CBAS Transition Plan Outline Work Tools are posted on the CDA website at:

[www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/HCB\\_Settings\\_Stakeholder\\_Process/](http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/HCB_Settings_Stakeholder_Process/)

### **California's Statewide Transition Plan (STP) Update**

Jalal Haddad, DHCS Long Term Care Division, reported that DHCS has not yet received any feedback from CMS about California's Statewide Transition Plan which DHCS submitted for approval on December 19, 2014. California's STP is posted on the DHCS website at the link below; this link is also posted on the CDA website under CBAS Key Documents.

[www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx)

CMS recently issued the HCBS Basic Element Review Tool for Statewide Transition Plans Version 1.0 which CMS will use to review all submitted Statewide Transition Plans. DHCS has started to review and revise California's STP using this tool in anticipation of CMS' feedback. A copy of the CMS review tool is posted on the CDA website at:





[www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/hcbs-statewide-transition-plan.pdf](http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/hcbs-statewide-transition-plan.pdf)

### **Review CMS Special Terms and Conditions 96(c) Person-Centered Planning Expectations**

Today's meeting is to begin the conversation about person-centered planning.

Denise Peach reviewed the CMS directives in CBAS STC 96(c) for CBAS to comply with the federal person centered planning requirements. This includes revising the Individual Plan of Care (IPC) to address the following: (1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; (2) How the plan will enable the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; (3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and (4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee. The CBAS Transition Plan will include a section on Person-Centered Planning in which the CMS questions will be addressed.

CMS issued guidance on Person-Centered Planning which includes the following: (1) It is a process directed by the person or their representative; (2) It addresses the person's needs in the context of personal goals, preferences, community and family supports, financial resources and other issues important to the person; (3) It identifies a person's strengths, goals, preferences, needs, desired outcomes; (4) It assists the individual to articulate a vision for the future and to engage in decision-making and problem-solving to reach his/her goals. More CMS guidance is posted in Key Documents on the CDA Website.

Questions to guide the March 17, 2015 discussion included: (1) How does the PCP process work in the CBAS setting? (2) How do CBAS providers and managed health care plans define and implement person-centered planning and coordinate care? (3) How is person-centered care implemented with persons who are cognitively impaired?

The following potential actions were posed to stakeholders to consider while listening to the discussion: (1) forming a workgroup to redesign the IPC; (2) identifying best practice tools and training; (3) developing policies and procedures; (4) creating standardized forms; (5) considering statutory and/or regulatory reform; and (6) developing oversight and monitoring practices.





### **Person-Centered Planning Discussion**

Bobbie prefaced the discussion stating that person-centered planning can be viewed from different angles and perspectives, including participants' and their caregivers', providers', and managed care plans'. In preparation for the March 17, 2015 meeting, the following individuals/organizations agreed to provide their perspectives to start the conversation, followed by a dialogue among all stakeholders participating on the webinar:

- Lydia Missaelides, Executive Director of CAADS
- Amanda Sillars, Total ADHC Solutions
- CBAS Providers:
  - Dawn Meyers-Purkey, Yolo ADHC; Debbie Toth, Rehabilitation Services of Northern California;
- Managed Health Care Plans:
  - Gretchen Brickson, LA Care
  - Duane McWaine, MD, Anthem Blue Cross
  - Ogo Nwosu, Kathleen Heckard, Partnership Health Plan

### **Highlights of Comments**

For more discussion details, listen to the meeting's audio recording posted on the CDA website at: [www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/HCB\\_Settings\\_Stakeholder\\_Process/Meetings/Plan\\_Development/](http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/HCB_Settings_Stakeholder_Process/Meetings/Plan_Development/)

- **Lydia Missaelides, CAADS**
  - Training was provided at the CAADS Fall Conference 2014 on person-centered care by Lynn Geboy and Beth Arnold Meyers and will be provided again at the CAADS Spring Conference 2015. Key elements of this person-centered, research-based model are the person, program and environment and how they work in harmony to promote person-centered care. The training was inspirational and aspirational.
  - CAADS will host a webinar on March 18, 2015, to facilitate a dialogue and promote a "learning collaborative" among CBAS providers who are implementing person-centered care at their centers including providers involved in the CAADS Community-Based Health Home Model pilot project.
  - The CAADS Community-Based Health Home Model pilot project is an evidence-based model that targets participants considered to be at high risk, including participants with cognitive impairment and behavioral health challenges, and integrates person-centered care into the assessment process. This model has enabled center staff to develop deep and trusting relationships with center participants, to understand a participant's aspirations and goals and to achieve





positive outcomes. The pilot project is moving into its third year and will add up to six more pilot sites. The centers involved in this pilot are forming a learning community and developing best practices that will inform all of us about person-centered care in the CBAS setting. Contact Lydia for more information about this pilot project. ([Lydia@caads.org](mailto:Lydia@caads.org))

- The ADHC model is forward-thinking and has person-centered elements wired into it. Person-centered planning and care have enriched CBAS staff and participants.
- **Dawn Meyers-Purkey, Yolo ADHC**
  - Person-centered care training at the CAADS conference provided her with tools, exercises and vignettes that helped person-centered planning implementation at her center. For example, the “20 Questions” tool promoted the development of activities/programs to meet participants’ interests/needs, develop trust, and inform the treatment plan.
  - The training provided a different way of thinking for staff—transforming staff attitudes to being more of a facilitator than a provider. Participants have become the driver of care which enhances a sense of self-value and self-esteem.
  - Person-centered care uses/enhances participants’ strengths. The center serves multiple populations—those who are cognitively impaired, have traumatic brain injury, or have developmental disabilities.
  - The center has a small grant to support Caregiver Resource Specialist, provide support groups, community education on handling challenging behaviors and end of life planning.
- **Debbie Toth, Rehabilitation Services of Northern California**
  - The CAADS conference person-centered planning training challenged existing beliefs such as the principle of “no lying” to cognitively impaired participants. This principle – to always be truthful - contradicts recommendations by the Alzheimer’s Association, and has been the biggest challenge of her staff’s “rethinking.”
  - Staff implemented changing the seating arrangements to right angles to increase participant engagement with one another which has been successful. Additional changes included using the “20 Questions” to learn more about the participants, and paying attention to language in speaking with and about participants.
  - Staff was excited to make changes, which makes them feel better about what they are doing and has a positive impact on participants.
  - Recommend starting with small changes. Engage participants in what interests and excites them. It takes time to implement/integrate





person-centered planning and requires flexibility.

- **Amanda Sillars, Total ADHC Solutions**
  - Has written person-centered care plan manuals for nursing, activities, and social services which incorporate person-centered care principles/perspectives.
  - The person-centered care model is holistic, strength-based, goal directed and collaborative, not paternalistic or judgmental. The person/participant is at the center of care and an equal member of the treatment team involved in the treatment planning process 100 percent.
  - Treatment plans should help participants identify their goals and address anything that impedes them from reaching their goals.
  - Use of language is important to communicate person-centered care principles. For example, words such as “noncompliant” are not person-centered.
  - Refer to written comments submitted/documented on Stakeholder Input log.
  
- **Gretchen Brickson, LA Care**
  - CBAS participants are considered to be at high risk (Health Risk Assessment) and receive Interdisciplinary Care Planning (ICP).
  - The managed care plan member is at the center of the decision-making process to identify their needs and network of services including who is on their Care Management Team (IDT.) The health plan addresses the member’s language and cultural needs including the provision of interpretation and translation services to support this process.
  - The member and health plan have shared decision making when looking at services and supports. It is a collaborative process. The plan member has choices and preferences as to home and community-based services, such as IHSS/personal care and choice of caregiver/physician.
  - If the member has cognitive impairment, the health plan collaborates with family or legal guardian, or evaluates for public guardianship.
  
- **Ogo Nwosu and Kathleen Heckard, Partnership Health Plan**
  - Partnership is new to person-centered planning. The Care Coordination Department’s goal is to promote the self-sufficiency of plan members and utilize active listening.
  
- **Duane McWaine, MD, Anthem Blue Cross**
  - The plan member is at the geographic center of the circle, starting





with the face-to-face evaluation with the member. Anthem talks to the participant and everyone involved with the participant’s care—the family, primary care physician, specialists, CBAS and other providers. The goal is to ensure care that is all about the member—“Member-centered care” is at the center of everything Anthem does.

- Anthem visits CBAS providers to know the strengths of the providers to determine which provider might be a good match for each member.
- Dr. McWaine presented an example of an Anthem member who is a CBAS participant for whom the health plan provided significant care coordination among providers, including the CBAS center, a neurologist, and community resources. Services were provided that addressed the member’s mobility issues, requiring a home evaluation, home accommodations and durable medical equipment to improve the home situation.

Discussion Concepts

Bobbi wrote the following concepts on the “white board” reflecting key concepts discussed during the webinar related to CMS directives in STC 96(c).

<b>Preferences/Choices</b>	<b>Participate in Treatment</b>
Physical layout, Services, Trust, Interests, My goals, Whole person	Listening/Looking, Interdisciplinary team assessment, Privacy, Caregiver role, Comfortable with care, Staff facilitate, Time, No lies Family patience
<b>Informed Choices</b>	<b>Collaborative</b>
Assessment, Trust	Facilitative, Takes time, Listening, Looking, Trust, No lying, Physician, Privacy, Assessment, Services, Language, Whole person, Engagement

Additional Issues/Questions Raised during the Discussion

- Care coordination among CBAS centers, health plans and resources/providers outside center. Who does what? What CBAS can do is influenced by program regulations and rules, staffing, rates, rate cuts and workload due to healthcare reform.
- How to extend CBAS staff expertise to coordinate care with the participant, health plans, families, community resources/IHSS. The CBAS center team is suited to do more if they have adequate resources/funding. Need clearer expectation of what care coordination needs to be done, particularly if participant is not in CalMedi-Connect.





- What role does the CBAS center play in partnership with health plans?
- Challenges facing CBAS centers include bridging the relationship with the physician. CBAS and physicians working together can do amazing things.
  - How can centers use health plans to facilitate conversations between CBAS centers and physicians to coordinate care? Recommendations were made from the health plans specific to their organizations. More conversation about care coordination is needed between CBAS centers and health plans.
  - How do centers and health plans coordinate care with caregivers within the framework of person-centered planning, particularly if the participant and caregiver perspectives differ? Important to have family input but also ensure that participant has private conversations with staff in case there are issues of abuse. Need to create trust so the participant can share what is happening at home with caregivers.
  - Training on person-centered care planning is needed.

Bobbi summarized that the following two workgroups will be formed that are integral to the CBAS Transition Plan: (1) IPC Revisions to address the CMS directives in STC 96(c), and (2) Quality Indicators to promote quality care.

Anyone interested in participating in these work groups should inform CDA. DHCS and CDA will develop a plan to facilitate the formation and implementation of these work groups, with a starting date yet to be determined. Denise mentioned that other work groups may be formed that address Provider and Beneficiary Assessments, yet to be determined based on collaboration with the California Statewide Transition Plan efforts to develop these assessment tools.

#### Additional Stakeholder Comments

#### **Nina Weiler-Harwell, PhD, Associate State Director-Advocacy of AARP**

Nina provided comments at the end of the webinar. The following are highlights of her comments:

- There are over three million AARP members in California. All persons age 50+ have the right to have choices and independence as they age. AARP is pleased with the federal HCBS Rules and the proposed Consumer Assessment Tool to give voice to the needs of consumers. (AARP submitted written comments to CDA after the meeting which are documented in the Stakeholder Input Log.)

Stakeholders who participated in the webinar/meeting submitted comments/questions via their computer which were read during the webinar and will be documented in the Stakeholder Input Log and/or Meeting Summary to be





posted before the April 23<sup>rd</sup> meeting.

**Action  
Items /  
Next Steps**

- ✓ CDA will post the following on the CDA website before the April 23<sup>rd</sup> meeting:
  - March 17<sup>th</sup> Meeting Summary and Webinar recording
  - Stakeholder Input Log documenting all written comments submitted by stakeholders during and after the March 17<sup>th</sup> meeting
- ✓ Stakeholders are invited to submit additional comments/questions after the webinar/meeting on any issue or document discussed during the webinar, including comments about the stakeholder meeting process.
- ✓ Stakeholders may prepare for the April 23<sup>rd</sup> meeting by reviewing the CBAS Transition Plan Outline and the CMS Review Tool for Statewide Transition Plans.

Bobbie thanked all stakeholders who participated and CDA and DHCS staff.