

MEETING INFORMATION

Title: Community First Choice Implementation Council Meeting
Host: Maryland Department of Health and Mental Hygiene
Day/Time: Thursday, November 15, 2012
Location: Kennedy Krieger Institute, PACT site

ANNOUNCEMENTS

- Please send additional comments, questions, or concerns to dhmh.cfc@maryland.gov.

INTRODUCTION

- All persons in attendance introduced themselves. The Department announced the appointment of three new members in attendance: Chad McCrudden, Adah Marie Guy, Mike Fitzpatrick

OVERVIEW OF CFC

- See powerpoint presentation “CFC 11.15.2012 ppt” for associated slides.
- **CFC Program Flow**
 - The interRAI assessment is used to evaluate the medical needs of a person requesting services. Once the person’s medical needs are determined, allowable services are identified to meet those needs.
 - The medical eligibility evaluation process (interRAI) will be performed annually or following a major life event in order to ensure that the services are closely aligned with the needs of the individual.
- **Maryland Access Point (MAP) sites**
 - Designed as “single entry points” for a variety of services, including non-Medicaid services available in the community. There are 20 sites currently operational in Maryland.
 - MAPs triage individuals into programs or services and provide information and referrals to assist individuals in getting the help that they need.
 - Individuals who contact or are directed to MAPs will be referred to the programs or services that best suit their needs.
 - Individuals may contact their local MAP site by:
 - Going to the MAP website at: <http://www.marylandaccesspoint.info/>
 - Calling a 1-800 number, currently in development.
 - Visiting their local site in-person.
- **Medical and Technical Eligibility**
 - Anyone entering CFC needs to meet a nursing facility level of care; this is determined by the interRAI. The interRAI is a comprehensive, face-to-face medical assessment.
 - Following the medical eligibility determination, a medical plan of care is developed which must be supported by findings in the assessment. These are
 - All services must relate to an ADL need.
 - Eligibility determinations will be finalized by Delmarva’s review. All eligibility denials will be reviewed, as well as a percentage of eligibility approvals to ensure quality. All persons denied will have an opportunity to appeal.
- **Role of Case Manager and Supports Planner**
 - Supports planners and case managers will be trained to emphasize person-centered planning.
 - All CFC participants will be assigned a Supports Planner.
 - Participants will be able to determine how much/how little they want their supports planner to do for them. Under the current waiver system, most self-directing participants maintain a case manager for application assistance during the annual redetermination.

- If a self-directing participant falls behind in managing their services, an alert will go to the supports planner and the Department to ensure that the person's needs are being met.
- **Plan of Service**
 - Plan of service is directly linked to the ADL needs identified in the interRAI assessment.
 - POS should be developed with the Supports Planner, case manager, family members, etc.
 - POS should include the participant's strengths, goals, and preferences, which should be reflected in the services received.
- **CFC Organization: Services, not Programs**
 - The current system organizes services around programs rather than services available to participants. Under CFC, the services will be consistent in both regulations and payment methodology.
- **Payment Rates**
 - Case management: case managers will continue to be paid in 15-minute increments.
 - MAPC personal care will no longer pay a per diem after implementation of CFC.
- **Cost Neutrality Requirements in the Waiver vs. the State Plan**
 - Waiver programs (LAH, WOA) must be "cost neutral." This means that the cost of serving a person in the community must be less than or equal to the cost of serving them in a nursing facility. There is a cost cap for services rendered.
 - State plan programs (MAPC, CFC), by contrast, do not have a cost neutrality requirement. Services must be related to the assessment.
- **Service Definitions and Provider Qualifications**
 - Services
 - Currently, there are different definitions and requirements for services under each program. The Council will be tasked with looking at the definitions, what the differences are, and which qualifications are most appropriate for CFC. Materials relating to this project will be circulated prior to the discussion.
 - Personal and Attendant Care
 - Council members recommended altering the regulations to permit a provider to take on more cases so that there is more flexibility in developing backup plans.
 - Council members recommended increasing the professionalism of providers by increasing their caseload and allowing them the opportunity to work fulltime, which is not possible with the current caseload restrictions and training limitations.
 - DHMH will need to review labor laws and other State/federal requirements to ensure that providers obtain necessary flexibility within the bounds of what is legally feasible.
- **Provider Registry**
 - The personal care workers union is working with the CILs for guidance in the development of a personal care worker registry. The registry is part of collective bargaining negotiations with the State and will be finalized through that process. Additional recommendations to the personal care worker union will be accepted from the CFC Implementation Council.
 - The registry can help to fill gaps left by absent providers. Because no provider will be accessible 24/7/365, having another place to find support options is important.

DISCUSSION: QUALITY

- **What does quality mean to consumers?**
 - Allow risk
 - Flexibility in provider selection, ability to waive certain qualifications
 - Adequate provider pool to offer real choices (types and number of providers)
 - Are they safe?
 - Are they happy?

- Providers have a person-centered approach, honor and respect the participant's choices and home (polite, thorough, professionalism, etc.)
- Open communication
- Freedom from abuse/fear
- Community inclusion/integration – employment, education, recreation, independent living skill development
- Training on how to manage providers, get help in an emergency, access supports
- **What does quality mean to providers?**
 - Providing quality care gets recognition (higher pay, professional treatment, respect)
 - Adequate and ongoing opportunities for training; in-home, experience-based with participants, and classroom
 - Are treated with respect by participants
 - Open communication
 - Freedom from abuse
- **How should quality measures be collected?**
 - Not just the numbers
 - Self-reports/short and simple participant surveys
 - Interview/survey family members or supporters of participants
 - Not try to collect every data point (missed care days, etc.)
 - Focus on outcomes: institutionalization/hospitalization rate, improved quality of life
- **What method is effective at getting the best information?**
 - Talk to participants, identify individual indicators/definitions of quality
 - Include individual quality assurance measures on the plan of service
- **What data should we collect?**
 - Consider what elected officials use to determine the levels of funding for the program (CFC costs vs institution)
 - Focus on outcomes: institutionalization/hospitalization rate, improved quality of life

TOPICS FOR FUTURE DISCUSSIONS

- Provider qualifications in CFC
- Tools used in developing and using the Plan of Service