

**DD Waiver Renewal
Focus Group Summaries
12/2/19 and 12/3/19**

Dec. 2, 2019

29 Participants: 9 providers, 6 Advocate agencies, 3 parents, 2 self-advocates, 11 state personnel, 2 University of New Mexico staff (some people have multiple roles)

Person Centered Planning and Individual Service Plan (ISP) Redesign

1. Proposals:

- Look at pre-ISP meeting process- make this more meaningful
- Look at composition of the IDT, ISP development, then a separate budget meeting
- Consider ISP Quality Assurance (QA) audit by the Outside Review committee
- Look at duplication among assessments
- Pilot a streamlined work learn history with Jackson Class Members (JCMs)

2. Summary of comments/recommendations:

- Pre-ISP meetings are really helpful.
- Offer a choice for people to run their own IDT meeting through a prompt on the ISP. Need a continuum to learn how to do this, not just yes or no. Ex. if you want to learn how, who do you want help? This could be a person's goal to work on if they want to.
- People do not want a separate budget meeting; there are already too many meetings. The budget and fiscal reality could be discussed at the Pre ISP meeting.
- The budget should be the last thing on the IDT agenda, after a person's goals, etc.
- People really liked the Wisconsin (WI) person centered plan. It has a good flow, is very person centered, very positive and user friendly.
- People recommend using a WI type template and then have separate documents as attachments/back up for people who need more detail on clinical justification, training, issues, etc. Not everybody needs the details and it can become very confusing.
- People do not support the Outside Review Committee doing ISP audits. There are already multiple audits and the auditors all have different recommendations.
- Agreement that there are currently too many assessments. These need to be reviewed for overlap and then reduced. For ex. the ISP and the Person-Centered Plan duplicate each other. We need objective not subjective audits.
- The assessments roll into the ISP - unintended implication of looking at ISP will require a look at other assessments to ensure alignment.

Emergency Physical Restraint (EPR), Restrictions and Human Rights Committees (HRCs)

1. Proposals:

- Look at establishing Quality Improvement committee (participants, providers, advocates) to evaluate use of restraint/restrictive practices & recommend strategies to remediate deficiencies.

- Look at establishing a “supercommittee” that can address issues related to 1) committees approving prohibited activities or approving activities that ought to be time-limited; 2) attempting to resolve disputes between provider agencies, teams, guardians and/or individuals.

2. Summary of comments/recommendations:

- People like the idea of these team as additional resources but strongly recommend against using them as another layer of oversight.
- People recommend using something like "HRC Resource Team" instead of the term super committee and HRC Strategic Planning Comm. instead of the term Quality Improvement Comm.
- Recommend the committee serve as resource for updates on best practices. e.g. topic of medical marijuana; hospice and palliative care when served by dual systems, DNR controversies, etc
- Make body available at state level as a resource or when there is a dispute in a committee that cannot be resolved. HRC's could use this committee as an additional level of expertise to utilize.
- Make sure everyone is represented including advocates

Case Management

1. Proposals:

- Implement 24 hours of annual mandatory training for case managers.
- Allow Dual Caseloads for Cases Managers

2. Summary of comments/recommendations:

- People generally think 24 hours is excessive
- Case Managers Action and Advocacy Council (CMAAC) sent a letter opposing the 24-hour annual mandatory training.
- If staff has a license in an acceptable field they should get "grandfathered in" and don't need to take extra trainings except the annual Abuse, Neglect and Exploitation (ANE) training. (According to DDSD records, currently less than 20 case managers out of 150 have a license; CMAAC will confirm this)
- Recommend the state accept all CEUs in a related field as training hours.
- Recommendation to reduce the training requirement to 10-15 hours annually for people without a license. CMAAC was asked to make a recommendation on # of hours.
- Training areas needed for each staff should be decided by the Case Manager director vs. state (more flexibility on self-selection.
- Advocates- Case managers need self- advocacy and person-centered training so they can bring that philosophy to the team.
- If a person teaches the training this should count as taking the training.
- People really support dual caseloads
- Would like Medically Fragile CM's to be included as well.

Therapies and Behavior Support Consultants (BSCs)- Telehealth

1. Proposals:

- Extend the usage of telehealth, particularly for the monitoring and fading portion of therapy and BSC implementation
- What are the challenges/barriers to minimizing or preventing fading opportunities?
- Consider creation of a targeted Person-Centered Planning training “module” designed to guide teams in the: 1) consistent implementation of plans; 2) appropriate identification and utilization of fading supports, and 3) guidance when change of condition happens and reinstatement of services needs to occur.

2. Summary of comments/recommendations:

- People have had mixed success with tele-health- some people do not like it; some prefer it. It could be really helpful to people who are rural and do not get services otherwise; it may not be preferred by someone not in rural areas. Problems may include bandwidth and competence in technology.
- It is better than not having services, especially in rural areas.
- If the state is expanding tele-health, we still need a commitment from the state to have therapists available on site as well. People do not want tele-health to become the exclusive model.
- Who is deciding on the tele-health option (person, caregiver, family)? Unintended consequence- person does not want to be seen face to face when this really needs to happen. Ex. Home visit is required but person only wants remote visit.
- People support a hybrid model: determine what part of assessment/plan can be done remotely and what needs to be done on site. This may be different for different disciplines. Some things in therapies should not be done by a non- professional; potential liability issues
- We would need to have distinct requirements about what can be done considering certification requirements of the various boards. Unintended possibility- a therapist could choose to do all tele-health, not travel and make more money so this needs some external parameters.
- Conduct a pilot - start small and see it grow. One size does not fit all.
- Barriers to fading include staff being busier now; not just the ability of the staff to provide the activity but do staff have time to engage in activities related to fading.
- Families and teams are often the ones resistant to fading.
- Flexibility with hours is needed. If you fade out - what will it take to “fade back in”? It cannot be too burdensome or time consuming to get back into service; otherwise, there is a disincentive to fade. Some therapists said they don't fade because of fear they won't be able to get back in if there is a crisis and the person needs a quick response.
- Not much support for a targeted Person-Centered Planning training module, people don't know what this would add that is not already being done.

Remote Personal Support Technology

1. Proposals

- Change name of service from Personal Support Technology to Remote Personal Support Technology (RPST)
- Add State or Contract position
- RPST provider will act as fiscal agent with primary responsibility for payment, tracking, and documentation.
- Consider changing reimbursement methodology from a percentage of total to a flat rate to better align with provider

2. Summary of comments/recommendations

- People did not express an opinion on changing the name; no preference one way or the other.
- People strongly support a new State position. This would be very beneficial. Often teams don't know what is available and don't have time to do the research
- There currently is no incentive to provide the service. It's too expensive to provide.
- Should New Mexico take this on versus having a provider agency do it? We could explore whether the state could get the Medicaid match if the state operated this service out of State General Funds or somewhere else.
- People support a flat rate for the administrative fee instead of a percentage
- Focus group supports increasing the dollar amount available. This could save money in the long-term and help person's independence and quality of life. The person could add devices over time for funding constraints; not get everything all at once.

Assistive Technology

1. Proposals

- The limit for purchasing Assistive Technology (AT) be increased for the DD Wavier renewal. This service should also allow an exception process to be in place

2. Summary of comments/recommendations

- An exception process would be great! Increasing the fund limit is great! We need to figure out a combination of funding- MCO's, AT Fund, PST, etc. We also need this to be flexible enough so a therapist is not required to access AT and PST; some people may not have a therapist but could still benefit from PST and /or AT.
- We need to make access to this service easier to understand - make steps to getting funding easier and more transparent. For ex. create a flow chart.
- Recommend adding an additional prompt in the ISP in a different section of the ISP, maybe in an increased independence section. Currently the prompt is only in Health and Safety, so it does not encourage AT devices other than health and safety.

- Teams do not understand difference between Remote Personal Support Technology and Assistive Technology. They don't know what's available and don't have time or resources to research this.
- Barrier- a family currently has to come up with the full balance owed for AT, there is no payment plan.

Non-Medical Transportation

1. Proposals

- Expand the definition of what the public transportation pass can be used for to include ridesharing services. (Uber/Lyft)
- Raise service limit for Nonmedical Transportation Mileage from \$750 to \$810 to reflect mileage rate change from .41 to .44 cents per mile that was recommended by 2019 PCG rate study.
- Add exception to mileage limit of \$810 for people in rural and frontier counties only.

2. Summary of comments/recommendations

- People support all of the proposals
- Staff and individual will need training on how to take Uber/ how to be safe
- The Focus Group likes the exception process. Once a year may work typically but we would need an emergency exception process for unplanned things such as a funeral.
- Case manager could type up memo or letter to justify exception for rural areas
- It would be very helpful to make this funding source available to natural supports to provide transportation. Could this be connected to a person's ABLE account?
- We still need options for people with wheelchairs
- We need to figure out how to fund round trip mileage because the person still has to return.

Dec. 3, 2019

26 Participants: 8 providers, 3 advocate agencies, 4 parents, 1 self-advocate, 12 state personnel (some people have multiple roles)

Family Living-nursing requirements

1. Proposals:

- Should nursing continue to be required in the Family Living Model? Does that requirement as it stands now limit person centeredness and choice (i.e., if you want to be in Family Living you must have a nursing assessment?)
- Would nursing as an add-on like in CIHS provide more flexibility? Does it pose problems for individuals in FL who need assistance with medication?
- What about nursing which is required for JCM's?

2. Summary of comments/recommendations:

- If you opt into nursing as a natural family member you are opting into the whole nursing requirements package and may not need it. We would like a menu of services as options versus all the requirements.
- Surrogate families may want nursing unbundled, but it may place people at risk with surrogate families.
- We need to make clear what options are available. We agree that the annual assessment is important.
- Stable, healthy individuals should be able to opt out of nursing (family or surrogate).
- Case managers like the assessment but people should be able to opt out of ongoing services. The Focus Group recommends keeping the annual nursing assessment even if it is sometimes a nuisance.
- It is a choice, but education is critical for parents, guardian and individual on potential consequences of actions.
- Assistance with medication is a big issue when figuring out nursing requirements
- Providers worry because they honor person's choice and then agency gets blamed if something happens
- If we removed extra JCM requirements the consequences would be no different than the rest of the system. We don't take any less care of people who are non JCM's.

Staying Home when I want to

1. Proposals:

- A Supported Living (SL) aide for someone being at home; an hourly rate with modifier within SL. This is essentially building in some hourly billing options to address the rate-build up that typically assumes 30 hours a week outside of SL care.
- Encourage the use of PST and on call staffing requirements in SL/FL, so people can stay home alone with appropriate planning and supports including weekends and evenings.
- Tackle in part with targeted rates study

2. Summary of comments/recommendations:

- People recommend more flexibility with CCS in the home - look for ways to bring community activities to the home. It is a health risk for people in wheelchairs or more medically fragile to go out in inclement weather. Staying home can also be personal preference; ex. introverts and extroverts This needs to be person centered not regulation centered.
- Getting a substitute care personnel at the last minute is very difficult. Is it possible to have on call personnel/ floaters around for these situations?
- There are 2 different circumstances- people who can stay home alone and people who need staff to be there.
- The person's desire to stay home could be written in the ISP. Safety factors could be addressed, need staff or are they ok alone. Use technology to increase safety factor.
- We cannot rely on extra pool of people to step in because of the intensity of the Individual Specific Training Requirements for each person.

- Many individual's preference is to do a variety of activities; ex. day hab twice a week to see their friends, work 2 days a week and then stay home one day.
- Some agencies require a person to attend a minimum # of hours in their program. Families and advocates disagree with this policy.
- We need to look at meaningful day in rural communities where community integration may be hours away.

Supporting People with complex mobility and personal care needs

1. Proposals

- Non-Ambulatory Stipend will continue but not be expanded
- Limits in state plan generally don't pay for the more expensive barrier free lifts which allow for one person transfers (Can HSD look at state plan or DDW be extension of state plan?)
- Person centered planning for two-person staffing at key times in FL, CIHS
- Community Inclusion is looking at leveraging aide scopes to add second person
- Look at staffing ratio requirements for SL providers when someone is non ambulatory and receiving Cat 3 and 4 rates?
- Consider the 20K paid annually for this stipend – would use of this amount of money be more efficient/effective leveraging alternative supports like aides, supplemental staffing at critical points in persons day, or DME etc.

2. Summary of comments/recommendations

- Equipment for people with complex needs can be very expensive but in the long-term, the device can have huge benefits financially, and for the person's quality of life and independence. For ex. the cost of ceiling tracking systems is high (\$10,000) but it has eliminated the need for a 2-person transfer for one individual.
- Ceiling tracking systems for transfers can be used for more than one individual- this is less than the annual Non-Ambulatory Stipend. Some agencies move the tracking system from house to house as needed.
- There can be challenges if the agency is modifying a house that is rented.
- Van with a ramp - NAS should and could be used on technology - it is a long-term solution for family /individual that may eliminate need for two-person transfer.
- We need to be creative and flexible. For ex. can individuals pool AT funding for Supported Living or Day Habilitation?
- A potential barrier is that AT fund equipment belongs to the person not the agency. What happens if the person moves to a different agency? Does the tracking system move with the person?
- Environmental Modifications are limited to certain contractors now-, it would be helpful if this was opened up to more contractors.

Employment

1. Proposals:

- Break out the current monthly CIE Rate into 3 categories/payment rates Job Development, Job Coaching, Long-Term Job Maintenance.
- Highly recommend Association of Community Rehabilitation Educators (ACRE) or Certified Employment Support Professionals (CESP) credentialing for job developers and job coaches. Building the foundation to require at least one of these credentials in the future
- Explore options for redefining Job Aid to be used in general terms for CCS, CIE and other services as needed

2. Comments/recommendations:

- Some people are in favor of breaking out the monthly rate. It increases accountability, allows data tracking to see what specific services people are receiving.
- Some people are not in favor of breaking out the monthly rate. They say the monthly rate covers 40 hours well, lends itself to providing as much as needed and provides more flexibility.
- There is concern about someone becoming unstable at the job and needing more hours immediately.
- Regarding certification, people thought this was a good idea especially if there are financial incentives; higher rate for certified staff. This would provide a more consistent quality of services.
- Professionalizing the field may keep good staff longer if there is a higher rate of pay and more training is provided so they are not overwhelmed.
- The cost to the agency for staff time for training is a concern, even if the training itself is paid for.
- People support the idea of an aide across all services, this would be very beneficial.
- A concern is that an aide is expensive and it's very difficult to schedule for full time work.
- There is currently a staffing crisis which is a big barrier.
- We need to think outside of the box - Explore models like that of Caregivers Coalition (a pool of caregivers - instacar) in elderly care -business operations – apps, etc. We need to move in different a direction and be creative.

Customized Community Supports

1. Proposals:

- Discontinue CCS-IIBS and revise the CCS-I definition to allow this service to be provided in the community and facility or 75% in the community and 25% in the facility
- Institute a cap on units and budget for all CCS services. 6240 units is the recommendation for the CCS (a combination of all CCS Services) cap.
- Redefine the community inclusion aid

- Allow more time in the home per day, not to exceed 3 hours/day or 15 hours/week.

2. Summary of comments/recommendations:

- The focus group supports discontinuing the CCS-IIBS as long as the definition is revised so the CCS-I definition allows this service to be provided in the community and facility or 75% in the community and 25% in the facility.
- People support expanding the definition of CCS I to accommodate needs of people with CCS - IIBS who need to have option to be supported in a center-based program
- The focus group support the proposed CAP as long as there is an exception process.
- The CAP would not appear to violate ADA requirements as long as an exception process is in place for people with higher needs.
- People support increasing the number of hours at home and also like the 15 hours a week option for more flexibility. This would need to be spelled out in the standards.
- An important question is once a person's 3 hours at home are up and they want to stay home, who covers staffing if needed?

Service limits

1. Proposals:

- Thoughts on CAP's in general and the methodology utilized.

2. Summary of comments/recommendations:

- Caps are necessary but considerations across the lifespan should be considered.
- Caps can possibly violate the ADA (discrimination on basis of disability) but having an exception is an acceptable way around it.
- CMAAC approves of CAP's.
- CAP's are needed because it provides structure that allows people to plan.
- There is concern about how quickly exceptions could be approved in emergencies. The focus group recommends bringing back the prior RO review process to approve immediate services for a short period of time (14-day approval process).
- An unintended consequence may be that some teams may automatically ask for the CAP (maximum number of units) even if it's not needed.
- We need to maximize what we can use through MCO and close the current gaps on care coordination.
- Regarding methodology there were no method specific recommendations but overall the methodology should include data, assessment information, face to face observations and some kind of scoring (not SIS). This needs to be fair and objective.