The Lewin Group
Self-Direction for Dually Eligible Individuals Utilizing LTSS
August 21, 2019 - 12:00pm to 1:30pm

Alana Nur: Thank you so much. My name is Alana Nur. I'm with the Lewin Group. Welcome to the webinar, Self-Direction for Dually Eligible Individuals Utilizing LTSS. Today's session will include a 60-minute presenter-led discussion followed up with 30 minutes discussion among the presenters and participants.

This session will be recorded and a video replay with a copy of today's slides will be available at resourcesforintegratedcare.com. The audio portion of the presentation will automatically stream to your computer. Phone lines are also available for this presentation. To access the number, click the black phone widget at the bottom of your screen.

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For today's webinar, the planners and faculty have no relevant financial interests or affiliation.

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To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate_Care.

At this time, I'd like to introduce our moderator. Carol Regan is the Senior Advisor to Community Catalyst Center for Consumer Engagement Health Innovation which

provides resources and expertise to ensure that patients and families, particularly the most vulnerable, have a voice at levels of the health care delivery system from individual care to health system design to state and national policies.

Carol has more than 30 years of experience with national and state-based public policy and advocacy organizations including a focus on long-term care and workforce development.

Carol, I'll pass it over to you.

Carol Regan: Thanks, Alana. Good morning or good afternoon to everyone on the phone today. I'm delighted to participate again Community Catalyst, and the Lewin Group, Center for Medicare-Medicaid Services. We've been working together for many years now on this series of geriatric competent care webinars and we're so delighted to do this one, such an important topic.

What I'm going to do is introduce all the speakers first, and then we're going to go over a little bit about the objectives, and then turn it over to our speakers. But we will do a couple of polls also just to just to get a sense of who's on the line.

So you can see on the screen, we have several wonderful speakers. I had to shorten their bios because they're so accomplished, but let me try to introduce them.

Kristen Bugara is currently a Supervisor at Direction Home Akron Canton Area Agency on Aging and Disabilities In Akron, Ohio. She has over 20 years of experience working with children, families, hospice, long-term care, and home- and community-based services. She works alongside nurses and social workers who provide care and management for individuals over the age of 60 who wish to remain in their homes as long as possible.

Kristen is the lead staff in management of MyCare Ohio UnitedHealthcare Waiver program and this Medicaid Waiver program and the PASSPORT Waiver program and is known as a subject matter expert and functions as the agency's coordinator for self-directed care. Kristen has a Bachelor of Arts in Psychology and a Master's in Social Work from the University of Akron. I want to welcome Kristen.

Next, we'll have Courtland Townes, III. Courtland is the Deputy Director of the Boston Center for Independent Living where he oversees the agency's Personal Care Attendant program where he ensures that over 1,100 consumers of PCA services are able to effectively use the program so they can maintain their independence.

He first served as the Director of Services at the Boston Center for Independent Living. He oversaw the vocational rehab program, information referral services, and the independent living services to adults and youth with disabilities. During this period, Courtland also served as BCIL's designate to the Access Now Coalition, a coalition that

promoted the empowerment and inclusion of people with disabilities from Boston's communities of color.

He also worked as the Director of Advocacy and Public Policy at the National Council of Independent Living and currently, as a board member, chairs their Civil Rights committee. He is a leading voice in the state-wide Personal Assistance Coalition and the PCA Improvement Work Group, always seeking to make this program run more efficiently

And as a person with a disability and fierce advocate for the civil rights of all, Courtland remains committed to the philosophy of independent living and the provision of high-quality services to BCIL's consumers. Welcome, Courtland.

Then, we'll have Corinne Eldrige. Corinne is the Executive Director of the California Long-Term Care Education Center, an organization dedicated to ensuring that workers are prepared to meet the growing demands of long-term care.

She successfully led the center's program to train over 10,000 in-home supportive services providers and -- with funding primarily from the Health Care Innovation fund at the Centers for Medicare & Medicaid Innovation. This program -- this project produced the first study to find that training homecare workers is associated with both better health outcomes and cost-savings. She's promoted the value to the health care system of direct care workers at numerous conferences with the Center for Medicare & Medicaid Services and the California Future Workforce -- Health Care Workforce Commission.

In addition, she established partnerships with Health Net, LA Care Health Plan, and Blue Shield of Promise California to provide training for IHSS homecare providers in LA. She serves on the advisory committee for UCLA's Geriatric Workforce Enhancement Program and is a graduate of California State University in LA.

And then following Corinne, we're really delighted to have two participants from the California IHSS Program. Carole Stewart has been an IHSS consumer for 20 years and Maida Castellanos has been an IHSS worker or a personal care attendant for one-and-a-half years and has worked with Carole since she started. Maida went through the center's 10-week training program which integrates the training for the interpersonal care team.

So you see, we have an incredibly rich group, so welcome.

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So today's learning objectives, just to recap what we want to get out of today's, we want to describe really what self-direction is and the key features and what it means for the consumer who may choose to enroll and self-direct. We want to identify the role of care managers and care coordinators in helping facilitate those decisions on self-direction and make that part of the patient-centered care plan. And then, define the role of the PCA in the interdisciplinary care team. Next objective -- I mean, next slide.

So today, we're going to do the following. We're going to have a few poll questions that really helps us to learn who you are on the line. We're going to talk about an overview of self-direction and the role of the care managers, the role of the LTSS coordinators in supporting consumer choice. And then, we'll talk a little bit about personal care attendants or providers in California, they're called, and the interdisciplinary care team. And then, making it work. We're going to hear from, as I mentioned, Carole and Maida who is a consumer and a provider. And then, we'll have time, as Alana said, for Q&A and then to evaluate. So thank you so much for joining.

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We're going to take a quick poll to get a sense of who's on the phone. So in what setting do you work primarily? If you work at more than one, just say which setting you primarily work in. Plan, an ambulatory care, long-term care facility, community-based organization. You can see the choices here, but just select one.

Great. Thanks. And now let's see what we've got as the results. Oh, terrific. Okay. So one of the settings, we have a lot of people, the majority of people are with a health plan and a few with community-based organizations. Wonderful. Thank you so much.

Next poll.

Which best describes your professional area? Again, some of you may work in multiple ways, but just pick what you would say primarily is your professional area. Administration, customer service, care coordination, pharmacy. You'll see a whole list there.

Okay. All right, great. Let's see what we've got. Great over almost half are care managers, care coordinators. Great. And then, we have some people that are in administration and management, and medicine, and some clinical providers. Anybody else a little bit -- oh, quite a few in social work, advocacy, and policy. Great. We have a really nice spread of people interested in this area. Terrific. Thanks.

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All right. Now, thank you all so much for participating and let me turn it over to Kristen. Kristen?

Kristen Bugara: Okay, thank you so much. Okay, so let's jump right in. Next slide.

What is self-direction? The self-direction is a service model or a philosophy that describes service delivery and it differs from the traditional route of providing services. It helps people of all ages and disabilities maintain their independence at home by choosing the mix of supports and services that work best for them based on their assessed needs. Self-direction or participant-direction is grounded in the independent living philosophy.

In 1993, self-directed options for home- and community-based services were included in the health care reform recommendations. And then by 2010, Affordable Care Act improved options for self-direction in Medicaid waivers and authorized new programs focusing on participant-direction or self-direction.

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The self-direction model empowers people by expanding their degree of choice and control over their supports and services that they choose to receive in their home so that they can remain independent for as long as possible.

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The goals of self-direction seeks to maximize each person's ability to control their own decisions and really promotes self-efficacy which is the belief that what -- the belief in one's own ability to succeed. Self-direction complements person-centered planning and facilitation. It broadens choice and control over services and supports, and staff to further individualize and delivers supports that are tailored to the person's needs.

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Some good characteristics of candidates that are good for self-directed individuals are a desire or a want to have input in their decisions regarding care, an ability to manage and communicate their own decisions, an ability to understand what is allowable under each service, and access the employer of record. They should have a stable living environment and a strong backup plan.

Members who would not be ideal candidates for self-direction would be those people who have been deemed incompetent by a doctor or individuals who do not have any desire to participate in their capacity for -- regarding their own care. So that brings me -- next slide.

So that brings me to the subject of authorized representatives in self-direction. An authorized representative is a person's legal guardian or family member or any other person identified by a member to help manage the services as defined in the care plan and supervise employees if a person is unable to do so independently. So if a person is unable to maintain control over their own supports and services, they may assign somebody to act as an authorized representative to do that on their behalf. This option allows for many people who wouldn't ordinarily be able to self-direct, participate in self-directed services.

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Within self-direction, there are two different types of self-directed authority. There is an employer authority and a budget authority. Within self-directed employer authority, when that authority takes place, there is an assessed need for personal care services. The person

then assumes the responsibility for being the personal care provider's employer. And what this includes is hiring their provider, training their provider, assisting with setting a pay rate within guidelines, directing their own care, and then potentially terminating their provider if that's necessary.

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In budget authority, a person must have an assessed need for anyone of the listed services here, so choice of home care attendant service, alternative meal services, pest control, home modification, maintenance and repair, home medical equipment, supplemental adaptive and assistive devices. If the assessed need is there for any one of those services, the person can assume the responsibility for choosing a provider for that service, scheduling the service and then setting the pay rate within guidelines for that service. And that's what's considered budget authority.

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So this slide shows a snapshot of what traditional care management looks like versus self-directed care management. The left side lists traditional care management and you can see that the consumer -- at the beginning, the consumer and the care manager decide which services are needed based on the assessment. The consumer then locates a provider or an agency. The agency decides which workers to send and when to provide -- and when to provide care. And then the case manager helps to resolve service issues with the agency taking direction from the -- from the person.

On the right side through self-directed care management, the consumer and the case manager decide which services are best, based on the assessment, but then the consumer locates the providers and determines their own schedule based on their assessed needs. The consumer then will hire and manage their own employees and directly resolve their own service issues. Of course, the case manager is very supportive through this process, which brings me to my next slide.

The role of care management within self-direction. The care managers play a very important role within self-direction, through education, facilitation and support.

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Education is the foundation for a successful self-directed person. A care manager is responsible for each person, for informing each person what services and supports they qualify for, based on the assessment. It is the care manager's responsibility to ensure that the self-directed person is aware of their responsibilities as the employer and how to communicate when their needs are not being met.

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Facilitation. Another role within care management with a self-directed individual is facilitation. So during the assessment process, discussion of health goals, likes, and dislikes should be clearly identified so that the person and the care manager are aware. Barriers to care should be discussed, for example, living in a remote area, challenging family members that may be present during care hours or what a process would look like when a service is not completed to satisfaction.

For employer authority, the application process may become very overwhelming for both the person and the prospective provider. So assistance and explanation from the case manager is very helpful.

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And finally, support. Care managers are the glue -- care manager support is the glue that holds self-direction together. Although the case manager doesn't take a front seat role in the scheduling of services, it's essential for support to be there when it comes to discussing services.

The case manager should encourage each person to make good decisions and reminders of what the health goals are. There should be continuous review of the care plan to ensure that each person is achieving what they had intended to achieve.

Guiding the individual to make sound decisions and supporting them through their decision process helps to reduce any possible negative outcomes that may come of making negative decisions.

And of course, a good backup plan is required and should be discussed often. This is important because there are times when a service, particularly personal care service, can fall through and there needs to be a backup plan when that happens.

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So there are several benefits to consumers through self-direction. Since the consumer is in control of their own supports and services, flexible scheduling is an option. Shifts can be scheduled whenever that they are ready for services. It also reduces unmet needs and call-offs because working closely with an employee and addressing your needs on a day-to-day basis does reduce these unmet needs.

It also enhances feelings of safety and promotes independent choices, self-determination. Since individuals can choose their own service providers, they often feel more comfortable with their own decisions and communicating their decisions to that person.

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Of course, there are care management benefits too. The main benefit is the reduction of service gaps. Service gaps and call-offs are a care manager's nightmare and can become

detrimental to a person's health and safety. Since the self-directed person is hiring a reliable employee, often times -- and often times, that employee is a neighbor or a friend, call-offs and service gaps seem to be reduced and there are fewer requests for changes in service providers.

The self-directed care can be very satisfying and a personal option for people who want to want receive services and supports in their homes.

Thank you. Courtland?

Courtland Townes: Hi. This is Courtland and I'm a Deputy Director at the Boston Center for Independent Living. And Independent Living Centers are somewhat unique as we do not provide any case management services at all. Independent Living Centers are organizations that are run by and for people with disabilities and it's a cross-disability organization.

So legally, the definition of -- for to be an IOC, you have to have over 51% of staff be persons with disabilities. We're probably about 75% and same with the board. It's board directed, so 51% of the board has to be people with disabilities and we exceed that number as well.

So what I'm going to be talking a little bit is One Care, the model that we have in Massachusetts, which is our Independent Living Long-term Services and Supports model and it's a Medicare-Medicaid demonstration for folks that are dually eligible. And so, that's for folks who have both Medicare and Medicaid. And for folks used to deal with that population, you know that Medicaid typically is the payee of last resort. And sometimes folks that have both Medicare and Medicaid have problems accessing services because they get into the -- well, you have to ask Medicare to pay for it first and -- or get Medicaid to deny it before somebody else will pay for it, so this kind of helps to alleviate that.

And the way it's set up is that when somebody becomes enrolled in One Care, they have what's called an interdisciplinary care team and that can be a mix of different medical professionals, discharge planner, behavioral health. It really matters what the consumer's needs are, so the makeup of those care teams can differ for each consumer. And then once enrolled, members have the right to have an IL-LTSS Coordinator, Independent Living and Long-Term Services and Support Coordinator as part of their team.

Again, in keeping with consumer direction, consumer control, they have -- they can choose it. They don't have to have it automatically. So they join the plan, the plan explains to them what the LTSS coordinator does and they're given an explanation of it and then they can choose to have one if they want to, but only then does it get referred to my agency.

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The beauty of having an LTSS coordinator is multiple because we're not employed by the health plans. So the health plans, in our case we work with an organization called Community Case Management and Community Management, we are not employed by them. They actually contract with Independent Living Centers, like our Recover Learning Centers and ASAP, Aging Services Access Points to provide the services, work with the consumer, help them figure out what they need and as well as do the service coordination once those services get approved.

The beauty of it is that we're not working for the health plan, so can be an advocate for the consumer on the interdisciplinary care team. And sometimes there's disagreement where we say -- this is what the consumer wants and the care plan may want to go in a different direction. Sometimes they see it's cost effective, but again, we're advocating for the consumer as part of that care team under the premises of Independent Living and consumer control, consumer direction.

So an important part of that process is meeting with the consumer and building a rapport with them, really. So it's important that at the Independent Living Centers we employ people with disabilities. And that while it may not be the same disability of the consumer that they're working with, there's that shared experience of having a disability, probably facing some of the same barriers and discrimination and et cetera.

And so they go out and they meet the consumers in their homes. And they use a tool that they work with the consumer to help identify what their needs are, what they want for their long goals to live independently. And it may not even be goals that we agree with, that's not our role, our role is to help the consumer identify what services and supports that they need to live independently in the community, advocate for those as part of the interdisciplinary care team and then go from there. Next slide, please.

So I talked about some of the bullets that are on here, because we're able to provide the expertise in a long-term services and supports because it's the same services that we're providing the consumers that come through our door. And the same with the folks that are from the recovery learning model, which is very similar to the Independent Living model, whereas independent living centers are cross-disability organizations, with the Recovery Learning models in those centers, they have folks that also have a diagnosis of mental health and mental illness working with that population. And so they're also providing skills training and pure mentoring much in the same way that the Independent Living Centers do.

And this slide really kind of talks about some of the benefits because the same people that have disabilities and may have used some of the services that they're helping other consumers to access in the role of the long-term service and supports as well.

And again, as I've mentioned before, the initial assessment is assessed in the consumer's home. And once somebody gets on the program, they are often seen about quarterly during the first year, to make sure that the services and supports they are working for them and that they're still the same. They can change over time.

We've seen people who initially maybe eligible for PCA services, but they may not be ready, they don't feel like they have the skill sets to do the managing and the hiring and firing and scheduling of PCAs. So they may initially start out with services like meals-on-wheels, laundry services, things like that and they may have home health aides coming in doing some of their hands-on care needs. But then they may get to a point where they feel like they can manage PCA services and will make a referral for that. Next slide.

So when the LTSS meets with the consumer in their home, they explain to them what their role is. The One Care entity is supposed to that, but sometimes there's so many people involved with consumers from different agencies that we kind of have to go over that with them and explain that we're not case managers, we're not there to try to tell them what they need, but really to talk to them, figure out what their skill sets are, what it is that they want and need to live more independently in the community.

And the key is that independence is different for each consumer. Some people may not want that many people in their homes and they may have friends and family members that are providing some services that other agencies could do, but they're not comfortable with that and that's okay. But our folks work with them to identify their short- and long-term goals, figure out what their current barriers to independence are and how that they can overcome some of those.

So once we figure out what those are, we have to go back to the interdisciplinary care team, advocate for those, get them approved by the plan and then the LTSS coordinators switches into more of a service coordinator role to get those services in play. So again, consumers have the right to make changes to those selected services.

Next slide.

Now the packages of services might differ for each consumer and as I said, they may change over time. So what are some of the types of services? Skills training and education, that's something that all consumers of Independent Living Centers get, that's part of our core services. Peer support, a lot of consumers need assistance with accessing non-medical transportation or modifications, meals on wheels, adult day health programs, they maybe want to have more socialization and interaction and recreation with other folks with disabilities and homemaker and companion services.

That's one of the beauties in our state with the One Care, because One Care is able to get certain things approved, that our state funded straight PCA services will not cover. So companion services, anything with chewing or supervision, our regular state Mass Health PCA program does not allow that, but that is something that One Care entities have the flexibility to do.

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And this really talks about the methodology, because again, it's a person with a disability that's working with another person with a disability and we use a strength-based needs assessment. So that means we're operating under the premise that everybody has their own unique strengths, no matter what their situation is. And those help and identify what those strengths are, can be used as a starting place to start to develop more strengths that will support the person's efforts to reach their goals and be as independent as possible for them. And oftentimes, somebody from outside of that person's immediate environment, can be the person that's best able to help them to point out their unique strengths, talents, abilities and strengths.

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So this is a bit more on utilizing a strength-based approach. And these are some of the questions that we ask during that initial assessment. And sometimes the assessment may take more than one visit but the tool that we use and the questions that we ask, what is working well right now for you? What do you want to accomplish? What do you feel that you can build on? It's designed to build rapport and also remind the consumer of their own skill set and their strengths and really put them in charge in understanding that they are setting the path that which we will be following and assisting them with, but it's their path and they determine where it is that they want to go.

So instead of assuming that an individual has a weakness in a particular area, assume that the individual has not had opportunities yet that are essential to learning, developing and mastering a skill set in a particular area that's going to leave them to a greater independence. The next couple of slides are a couple of case studies.

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The first one is Karen. She's 51-year-old woman with a history of falls, diagnosis of PTSD, anxiety, bipolar disorder and a couple of other diagnoses. She was initially really reluctant to engage with our skills training, and in fact the initial person who we had assigned to her ended up getting switched to somebody that actually spoke her language -- Spanish was her first language. And so switched and she was very reliant on her family members to provide her assistance with IADLs.

After some time, building rapport with the skills trainer, she was able to identify what type of services that she felt would help her. And so she chose Homemaking Services, Companion Services, Social and Medical Transportation.

She's been on the One Care program for a little over a year now at this point and she reports that the services have lessened her feelings of anxiety and stress, have allowed her to feel safer and more self-sufficient in her environment. And it's also freed up her family members to do other things as opposed to them being her primary caretakers.

We've seen that oftentimes in the personal care attendant program, where you have family members that are maybe not out making money or doing all the things that they

want to do because they're care taking for a family member. And then once somebody is able to access services, it lessens that reliance on the family members. And so we're seeing more than just the benefit to the actual consumer, but sometimes the friends and family members that have been doing some of the hands on needs.

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Ricardo is a very, very recent one, in fact when I was looking at his case study, I had met with his long term services and support coordinator that day and, he was very, very excited because Ricardo has just gotten in into a Single Room Occupancy Program. But I imagine like for many folks, Boston, we have a pretty severe housing shortage and it's particularly bad for folks with disabilities that are living from low-income housing and accessible housing.

Ricardo's 53, he has a diagnosis of depression, anxiety and has some cognitive disabilities. And he had been homeless for about five years. He had a service animal at one point into the shelter but he had to give up his service animal when he went in to the shelter and that wasn't working well for him. So he left the shelter system and has been living in a U-Haul van for the last couple of years.

Oftentimes when we would meet with him, because he did not have a domicile, we would either meet with him at the office or at a coffee shop at a place that he chose. And also sometimes there can be some difficulties in even accessing the consumers, because folks that are homeless oftentimes, they may have a cellphone number that is not always on or they don't have minutes. So sometimes that can be a barrier and it can take longer to get stuff done but we just have to kind of keep going with it.

But his initial focus was on housing assistance and he was somebody who would come to our bi-monthly housing workshops. Over time, we were able to get him on a priority list because he was in fact homeless and a person with a disability. And he was able to get into -- he was just getting in the keys today, that I used -- selected him for the case study to the Single Room Occupancy Program. And that's a program that will give him access to permanent housing if he makes it through the program without any problems. So if he's able to maintain this apartment, pay his bills on time and really have no issues, then he would be eligible for permanent housing, once he completes that program.

So he's working with his LTSS coordinator, Jose, right now to get additional supports like home-delivered meals and laundry service. But Ricardo is almost basically like -- he's like, once he got he secure housing he was like -- I don't need anything else. We had to convince him there's other services that can complement you right now. But he was so focused on getting housing, so we were so glad to see him get accepted into the single-room occupancy program.

And so that's it for what I have and I'll be happy to take questions at the end as part of our wrap-up.

Corinne Eldridge: Hi, good morning, this Corinne Eldridge. I'm the Executive Director of the California Long-Term Care Education Center. We're a 501(c)(3) that was originally founded in 2000 by the labor union that represents IHSS workers. And the mission of our organization is to utilize trainings, the tools and empowerment for the long-term care workers.

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So in California we are very unique. Our personal care attendant program is called the In-Home Supportive Services Program, you'll hear me call it IHSS and you'll hear me call IHSS workers as providers. So when I say provider, I'm not talking about clinical providers but the IHSS workers. There are 1.4 million duly eligible individuals in California and the IHSS Program currently serves around 564,000 consumers.

56% of those are 65 years or older, 37% are between 18 to 64, 7% are under 18, and 50% of those speak a primary language other than English. California's IHSS Program is the oldest personal care attendant program in the country and there are over half a million IHSS workers in California, and over 50% of the IHSS workers are family members. Next slide.

CLTCEC began training IHSS consumer and provider carers in 2012, when we received the Health Care Innovation Award from CMMI. We created this program in conjunction with SEIU Local 2015], the union that represents the IHSS workers in California. And the program was created out of the desire to equip workers with the set of skills that would allow them to take on new roles on care teams and provide better care to help meet the (technical difficulty).

Under the CMMI program, we began with six health plans across three counties in California, and two of those counties are part of the duals demonstration projects that were beginning implementation. We've been able to continue our IHSS training program work with specific health plan partners. LA Care has been a great champion of our work and we began a partnership with them in 2017, that is ongoing. And we're excited to have a new partnership with Blue Shield California Promise Health Plan that began in this year.

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The different tenets of our IHSS training program honor voluntary participation. So that's voluntary participations for the IHSS workers and it honors the consumer-directed model of care so that way the consumer, the IHSS recipient gives permission for the IHSS worker to participate on the care team, and we ensure that our curriculum honors the consumer and it's at the center of our curriculum.

The IHSS providers learns a new skill and it's a competency-based education, so that way we're able to teach individuals who may not have been in a traditional classroom at any -- for many years. And the provider also receives an economic enhancement post

training to honor the new skills that they're bringing back into the system. Next slide please.

Our IHSS training program is a course that last either 10 or 17 weeks and our students learn a variety of skills. Where possible the consumers attend the second and last classes, and it's an opportunity for both the consumers and providers to learn about the benefits of the training program and develop a sense of shared process. We identify rights, roles, and responsibilities of consumers and IHSS care providers. We articulate the importance of safeguarding the privacy of the consumer's personal health information and we call that Code P.

In all the modules, the role of the IHSS provider and the integration into the consumer's care team are discussed. We always emphasize the provider roles and the extent of care team integration are choices that the consumer makes. And by discussing these roles, we're not giving license to the IHSS provider to assume these roles in all circumstances because that will be up to the consumer. We also talked through the definition of care teams, person-centered care, and ensuring that the desires and the preferences of the consumer are at the front of all, describe what it means to integrate the IHSS provider into the consumer's care team, the principles of consumer direction, and identify the five enhanced roles that IHSS provider can take on the care team; monitor, communicator, coach, navigator, and care aide, and there are four skills that supports the enhanced roles, observe, monitor, document, and share. And this is practiced by utilizing a documentation form.

As you might imagine, communication is spread through the entirety of the curriculum, and so that's a really important skill for the IHSS provider to continue to learn in a variety of settings. There's also take-home assignments throughout the curriculum, every week, every module, and that word, take-home assignment is used instead of homework because it's really important that the workers are supported in knowing that they can maintain the work in the classroom. And in those take-home assignments, we encourage and have part of assignment that the IHSS provider has discussions with the consumer about what was learned in class that week.

Then we move on to the five key roles of the IHSS provider. Integration is a recognition that the IHSS provider, through their relationship with the consumer, can become a participating member of the consumer's care team. The provider's perspective, familiarity, and ability to communicate well are valuable contributions to the care of the consumer. IHSS providers fulfill the traditional role of a home care provider.

They assist the consumer with helpful chores, personal care safety, help with ADLs, IEDLs, and they could support the consumer in living an active, independent life at home.

Because of these roles and the frequent contact that the provider has with the consumer in the consumer's home, the provider really has a unique perspective on the consumer's health and well-being, because they're with the consumer, it's so much more frequently

than any other person. And so they can serve as an extra set of eyes and ears, and they really play an important role on the consumer's care team.

This integration can help the provider play an even more active role in ensuring the consumer receives the highest possible quality of care.

To be an active member on the care team, the IHSS provider needs to learn to play some additional roles and enhanced roles, and we support those throughout the curriculum of with a series of care team role plays, where we have a tool built in to the curriculum, where the form is reviewed in the classroom with both the consumer and the provider, and they go over the roles that the consumer is comfortable for the provider to play. It's also a tool that providers can use to talk with consumer's doctor, primary care physician, and other members of the care team, about integration into the care team. It gives details about what the provider has learned through our training program, and it also make suggestion of words on what to use once you're with the care team.

It's really designed to be filled out and left with the consumer's primary health physician or any other member of the care team. So that way there's an introduction and an inclusion on the care team. And this is utilized again in the classroom so that way the provider is able to practice and work against any barriers that they may have either in communication or awareness of our program.

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IHSS providers play really valuable roles on care teams. As I've talked about earlier, they really can play and act as an extra set of eyes and ears. And they can notice important information about the day-to-day health of the consumer, any changes in diet, mood, skin health, energy, and many other important factors, and bring them to the consumer's attention, and if required, up to the clinical care team or the primary care physician.

The doctor sees the consumers occasionally and the provider sees the consumer regularly. So they really do have valuable insight. The consumer and the provider are a team and they work together with the rest of the care team to obtain the best possible care for the consumer.

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For successful care team integration, there are always successes and challenges. The integration process can be challenging because it's not always clear what integration looks like. It can be open to interpretation and just like individuals, this may vary from consumer to consumer. So some examples of success are the provider is invited to inter-disciplinary care team meetings, the consumer's care team is the provider. The care managers and clinicians can see EMR, electronic medical record, that the care recipient has and IHSS worker who they have given permission to be part of his or her care team.

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And it's really wonderful to be able to share some of our program successes. We have trained over 6,300 IHSS consumer and provider carers under our CMMI grant that was from 2012 to 2016, around 60 so far in our partnership with Blue Shield and almost 2,000 in our partnership with LA Care. Our collaboration with health plans has been really successful and after year one in our LA Care program, we're excited to be able to share that 95% of IHSS providers reported more confidence and their ability to talk with the consumer's care team, and 96% of consumers who responded to the survey reported the communication with their IHSS provider improved.

The best practices in care coordination that we've been able to implement are that the care coordination team is able to come out to particular classes, that there's full orientation on our training program to care coordination teams and there's a transfer of information. So we've really been able to build a great partnership with LA Care.

So now it's my pleasure to introduce Carole Stewart and Maida Castellanos. Carol Stewart is an IHSS Consumer living with a disability and Maida Castellanos is an IHSS Care attendant who has been working with Carole for the last year-and-a-half. She comes to Carole's house six days a week and works with her for around 25 hours in a week.

So Carole and Maida, can you just tell me about the way that the two of you communicate with each other?

Carole Stewart: We talk, and we call each other every day. We talk about things Maida knows, needs to be done and she notices when things are off for me.

Maida Castellanos: I tell her that she needs to make an appointment to go check out to make sure everything is okay. Carole makes her own appointment. I work within my schedule and my schedule will be in my apartment.

Carol Regan: This is Carol. I will just interrupt for second. Can you -- I know it's so hard to hear with the cellphone. Perhaps you could speak a little bit closer into the mic.

Carole Stewart: Will do.

Carol Regan: We want to hear you. Thank you.

Corrine Eldridge: Okay. And so how did each of you separately and as a team, communicate to the care team?

Carole Stewart: Up to this point, I think, the discussion with my care team, Maida comes with me to my primary and specialty care appointments because I need to pick up prescription, to taking pictures with me when I'm having episodes, and then I take those pictures with me to my visits. I typically go in on my own.

Maida Castellanos: Carole does as much as she can. It is good for her to take care of everything that she can and stay in charge of her own care. After she goes to the doctor, we go through all paper work together, we go through all of the medication.

Carole Stewart: We have a calendar that we see together. And so if something that Maida thinks that I need to discuss with the doctor, I take it with me when I go in. When she notices something is off with me, she suggested that we went to the ER and I agreed, and she came at 1 a.m. to the ER. I would have waited until the next day, but she could tell something was off. I was admitted and then she (technical difficulty).

Corrine Eldridge: What do you (technical difficulty)?

Carole Stewart: Maida helps with that --

Carol Regan: We're having a little bit of a difficulty hearing. It might just be a bad connection.

Carole Stewart: Maida helps me by checking –

Carol Regan: Oh, great, thank you.

Carole Stewart: Both my son and daughter know that having Maida here is how I'm able to stay in my home.

Maida Castellanos: Carole (inaudible) I let her family know how she's doing and call them when it's urgent.

Carole Stewart: My son said it makes it to continue living where I live, it gives him and my daughter peace of mind. Maida will take pictures when I have issues, bring them to the doctor in the hospital, and as a patient, we don't always think of that. Pictures can have -- helped with the number of my specialist as she take pictures and they can see what is going on. It is important to have Maida as part of my care planning.

Corrine Eldridge: Carole and Maida, there are several roles that Maida was trained on in our training program. Let's talk about how some of those play out day-to-day. What about as a care aide?

Maida Castellanos: She has a pill box. We refill her pill box together. I check how much water she's drinking and track it. I check off her medication and check the prescription bottles, I need to decide the right medication administration.

Carole Stewart: I leave my empty bottles on the counter so she can see how much I am drinking and she checks my pill box every morning when she arrives.

Corrine Eldridge: What about a coach? How does that play out day-to-day?

Maida Castellanos: I remember she was laying on her sofa on not getting up at all when I first started working with her. I encouraged her to do crafting. I take her to the parks, I told her to get out of the house. We walk at the garden center, also encourage her to get (technical difficulty).

Carole Stewart: It's really important to get out of the house, get outside and move around. Even walking through the garden center at Lowes, it really helps. It gets easy to get stuck as a patient.

Corrine Eldridge: And what about monitoring certain conditions? How does that play out day-to-day?

Maida Castellanos: (Technical difficulty) once I come in to her house, I look at her face. I can see if she's good or not. (Technical difficulty) I tell her she needs something. Every day, her house (technical difficulty) so good and she needs to go to the doctor, I'll be there for her to (technical difficulty) so she could feel confident that someone is looking after her.

Carole Stewart: Maida always assesses how I am doing. Talk to me about what she sees. My son and daughter say that it has -- gives them comfort having Maida here. When I go to the ER, she can evaluate how I am doing. I then went in to the ER and pictures were taken -- pictures that Maida has taken. The nurses knew she was in the waiting room, and I always tell all my nurses that my caregiver is in the waiting room.

Corrine Eldridge: Thank you, Maida and Carole.

Alana Nur: Wonderful. Well, thank you to Maida, and Carole, and Corrine as well, and Kristen and Courtland, so much for your presentations.

As promised, we now have some time for questions from the audience and a little bit of Q&A with all of our speakers. Thank you to everyone who has already submitted your questions. If you have questions now that you would like to submit, please submit them using the Q&A feature on the lower left of the presentation. Type your comment at the bottom of the Q&A box and press Submit to send it.

We'll get started with some of the questions that we received already.

Courtland, I'll start with a question for you. How is your Center for Independent Living adapted to cultural differences that you might see across your consumers or adapting to different cultural preferences?

Courtland Townes: That's something that we really prioritize. I mean, our office is literally right in downtown Boston where the downtown crossing train stop. And so we serve a diverse community of folks who walk in the door and so we want to make sure that our staff reflect that.

So we have a pretty diverse staff as far as cultural. We have several different languages spoken. I have folks that speak Spanish, Haitian Creole, ASL, variety of different languages. I just lost -- I had a Cantonese speaker in the LTSS department and Mandarin speaker, but she just left to go back to graduate school. So it's just something that we kind of prioritize to make sure we are a diverse staff that reflects the community we serve.

We're actually about to open a satellite office in an area called Field's Corner, which has a large Latino and Vietnamese population so that we can do more outreach to those communities.

Alana Nur: Great. Thanks so much, Courtland.

Kristen, the next one is for you. You talked about the importance of a backup plan. What are some of the elements that you recommend to including to make sure that that backup plan is a strong one?

Kristen Bugara: So we often tried to tell people that, of course, in a perfect world, your services are going to -- your service provider is going to come every single day. But some elements to consider would be maybe a family member that could potentially step in and provide services for a day that your service provider couldn't provide the services, or potentially adult day-- attending adult day services or an adult day center intermittently if your service provider couldn't provide the services on any given day, or needed to take some time off work. So those are the items that -- or the things that we would discuss to make sure that there's a solid backup plan in place.

Courtland Townes: Yeah, and actually -- this is Courtland, if I could also add. In Massachusetts, we require folks that are getting personal care attendant services, as part of their independent living service plan, they are asked to identify who is their backup person in the event that their PCA doesn't show up. So it's not somebody has to be signed up with paper work to be paid. It could be a friend, a family member, a neighbor, but we ask them for the first name, the last, initial, and we document that as part of their independent service living service plan.

Kristen Bugara: Correct, that's correct. We do that to, here in Ohio.

Alana Nur: Thank you both. That sounds like a great best practice.

So Corrine, I'll turn to you. And you talked a little bit about sort of why you started your IHSS training program and the successes that you have. For other organizations who are starting, training programs or personal care attendance, what recommendations do you have, or any lessons learned that you can share?

Corrine Eldridge: Sure, so I think it's really important to engage your stakeholders, so IHSS consumer, IHSS providers, and the labor union that represents the workers. And also having the understanding of what sort of curriculum is required to be successful. Our

training program is all done in-person, it's didactic, and so it's really important to understand the needs of the student population.

I would also say where possible, it's really great to be able to have consumers participate in the training program that I talked about and some of the work that we do. It's not always possible based on the relative health of the consumer, but honoring consumer direction and making sure consumer choice is part of the curriculum, is really key.

But I really say, the lesson learned is ensuring that you have stakeholders as part of that. And if you're working as we are, with health plans, it's critical to have an understanding of the practices within the health plan that may intersect with the IHSS consumer and the provider, not doing -- the IHSS workers are not learning medical techniques, but it's really where there's an intersection with the health plan on that care team integration.

Alana Nur: Thank you so much, Corrine.

Carole, I wanted to turn to you. What has Maida had done that has helped you the most in terms of feeling most comfortable, and you mentioned your family feeling comfortable, what had she done that have helped you the most?

Carole Stewart: Well, I've been a member of IHSS as a recipient for 20 years. But when Maida came in, she also took a series of classes, and then she made it a point to get to know my kids before there was an emergency. I mean, she wasn't seeing them, but she just let them know what was going on.

I like the fact that she comes in, she knows certain things that are required by IHSS, but also that she really cares about me. And I think our families are blending and that is not part of the normal IHSS as my rheumatologist told me just yesterday, told me to hang on to Maida because there aren't many of them like that.

Alana Nur: That's great to hear. Thank you so much. That's really helpful.

Kristen, I wanted to ask you a question as a supervisor of care managers. What is one, or more than one important lesson that you've learned in helping your care managers understand and be able to support consumers who are self-directing?

Kristen Bugara: The biggest thing that I've come across is the understanding that education and support are the key to getting the word out there about self-direction. Many times, we find here, at our agency and in North East Ohio, the individuals that we serve on waiver services, often times feel that when they're assessed for the needs, to need personal care services, or to need home delivered meals, they often times feel like they're losing a part of themselves because they're needing help.

And so when we introduce self-direction as a service option, it's important for our case managers to introduce it as though even though they have these needs, they can still have control over those decisions.

Alana Nur: Okay, thank you so much, Kristen. Courtland, a question for you. You mentioned using a tool that the LTSS coordinators work with consumers to identify their needs. Can you share a little bit about that tool and how it helps them?

Courtland Townes: Yeah, well, there's a big pack at the intake packet that they have, but then also, it's the intake and assessment tool that they use to get like certain demographic information, and then what type of services that they best want. And so we collect some data related to, what's your primary disability, what are the hands on needs that you may have, what are the instrumental activities of daily living that you may need that are hands on, laundry, shopping, housekeeping, things like that.

And then there's a separate tool if they select PCA services, then we have a nurse and an OT who go out and do a hands on assessment of like functional needs, that's a separate tool.

Alana Nur: Thanks so much, Courtland. Courtland, this can go to you and Kristen, Corinne as well. Can you speak a little bit about how you handle background checks? And how that works with consumers who are self-directing?

Courtland Townes: Background checks for who? For the LTSS coordinators or for people that may be coming to their home to provide services?

Alana Nur: The latter, for people who would be coming into their home.

Courtland Townes: I know for us, we typically use vendors that the healthcare agency has contracts with, so whether it be for laundry services, meal prep services, things like that. For PCA services, it's not required in Massachusetts that the PCA have be checked, but we do provide information to the consumers on how to do so, and how they can get a waiver for a fee that's associated with it.

Kristen Bugara: In Ohio, All of our self-directed providers are required to have a background check and if they've lived outside of Ohio for longer than five years, they have to have an FBI check too, prior to being certified as a self-directed provider. So that is a requirement in Ohio prior to certification.

Alana Nur: Thank you, Kristen. Corinne, this one's to you. When you were talking about the different training modules for the IHSS training program, you mentioned take-home assignments and encouraging providers to have discussions with the consumers that they're working with.

And can you talk a little bit about those assignments, and maybe some examples of what those examples might look like?

Corinne Eldrige: Sure. So the assignments refer back to what was learned in class, say, on a particular day. And so if a module happens to be about medication adherence, and

the five rights, there would be two to three questions where the IHSS provider goes into the home and has a conversation with the consumer about things that they learned on the five rights, and talking through, if they are, each of them as a team, are following through those five rights.

And then the IHSS worker fills out the form and fills out that information as their take-home assignment, and then brings it back into the classroom and the instructor collects and corrects that homework assignment and turns it back to the participant. No PHI is shared in those take-home assignments, and PHI is not talked about in the classroom, but it's a way again, to reinforce the learning that's done in the classroom, bringing it into the home, so that way there's a conversation, and then it's brought back into the classroom to reinforce.

Alana Nur: Thank you, Corinne, Carole, or Maida, is there anything that you would add about some of those conversations that you thought that had been helpful with each other?

Carole Stewart: Can you repeat the question, please?

Alana Nur: Yeah, so Corinne was talking about with the training, how the recommendation from that training were some of the things that you were learning to come back and have a discussion with each other about some of the things that you were learning, and how you can work together. Do you have any recommendations for other consumers and personal care attendants who are working together on how they can support each other?

Maida Castellanos: Yeah, well, I really like the way the classes were, I really -- when Corinne talked to me I told her I learned a lot, especially, you know, with the medication and the communication and everything. I told her that many IHSSs, need to take those classes, need to be aware that there's so much to learn to provide more to the recipient, as a provider.

So I really recommend that this program would go to all the providers, for them to have much training to the recipient, and also, I really recommend you know, the CPR, we really learned a lot with the CPR, how it was done and everything. That helps us be confident that if something happens, we know we are aware to do the CPR and to help them, you know, meanwhile, the other help is still coming.

Alana Nur: Thank you, Maida. Carole, anything that you would like to add?

Carole Stewart: Well, I met Corrine because I was invited by Maida to go to her graduation. And every week after her classes, she'd come here and tell me what she has learned, and things that she saw might be helpful for us, and things that made her more confident.

I mean she has repeatedly said the CPR certification was paid by her going to IHSS. She didn't have to pay to go to Red Cross to learn how to work on a dummy. They had a class and they had multiple dummies, and every provider had the opportunity to learn.

Alana Nur: Thank you, Carole. Okay, so we have one closing question, and Courtland, this one goes to you. You talked about the importance of a strength-based assessment. Can you talk a little bit about how strength-based assessments can help coordinators support consumers who are self-directing?

Courtland Townes: Yeah. I mean, I think often times, it helps to build a rapport because I think sometimes, folks with significant disabilities often interact with service providers in a way that can sometimes feel degrading or alienating. And I think it's important, when folks come into an independent living center and they see, oh, okay, there's people with disabilities that may not be the same one that I have, but people with disabilities that are here living and working, and providing peer mentoring, and they've done that.

So it's really, as opposed to like, what's wrong with you, or that type of line of questioning, it's more about, what skill sets do you have that you wish to strengthen? So it's assuming that there is a base to build upon. So it's really, it's more of an attitude and how you interact with the folks, and making it clear that we're not here to make decisions for you.

When folks enter into the independent living center and independent living network, it's more about here's the services that we can provide, what would you like to choose, and you can choose your own goals, you can draft those goals, you can change those goals, and we're here to support you.

So even if it's a goal that, say, the skills trainer thinks will be pretty hard to attain, with those said, let's break it into chunks. The example we often us is, somebody could come in that hasn't graduated from school, and they say, "I want to be an astrophysicist," we go, okay, what are the steps necessary to get there? We have to break it into smaller chunks. So let's work on getting a GED first, and go from there, you know what I mean? As opposed to say, well, you won't be able to do that, or that's ridiculous.

It's their goal, folks with disabilities have the same right to try something and fail, as anybody else, and so what is it that you want to achieve, how can we best help you do that, we want to help you make informed choice, but it's about what are the skill sets that you possess and where do you want to go next, and what does independence mean for you.

Alana Nur: Thank you so much, Courtland. And thank you to all of our speakers. At this time, if you have additional questions of comments, please email us at RIC@lewin.com.

The slides for today's presentation, a recording, and a transcript, will be available on the Resources for Integrated Care website, shortly. As a reminder, additional guidance about obtaining credits and accessing the links to the pre and post tests can be found within the

Continuing Education Credit Guide and the resource guide on the left-hand side of your screen or at the Resources for Integrated Care website.

As a note, we included additional resources on self-direction at the Resources slide at the end of this presentation.

Thank you so much for joining us today, thank you to all of our speakers, for your presentations and for sharing your insight with us.

Please, for all of our participants, complete our brief evaluation so that we can continue to deliver high quality presentations. And if you have any questions for us, please email us at RIC@lewin.com.

Thank you again, everyone, have a wonderful afternoon, and thank you so much for your participation.