

# MEETING RECORD

## PERSONAL CARE SERVICES STAKEHOLDERS MEETING



April 16, 2015 | 1:00pm-2:30pm | Meeting Location: Dix Campus, Kirby Building, Conference Room 297

### AGENDA TOPICS

#### 1) Welcome/Introductions

Facilitator: Sabrena Lea, Associate Director, DMA and Cassandra McFadden, PCS Policy Analyst, DMA  
Round-robin of individual introductions with name and agency representation  
Handouts: ① Reference documentation is included in this meeting record/minutes

#### 2) Program Updates

##### a) DMA PCS Updates (Cassandra McFadden, DMA)

**Clinical Policy 3L** is currently posted on the website for the 45-day public comment period—please submit comments or questions through the portal. Policy 3L is expected to be effective June 1, 2015. For those submitting suggestions, they may contact Policy Development to get specific responses.

We are preparing for **Regional Trainings** starting May 5. Registration is up, the agenda is attached to the registration. The agenda items will include the update of the PCS Clinical Coverage Policy 3L. *Stakeholders raised concerns over a conflict with some of the association meetings dates (including 1068s) and the dates for the Regional Training dates and asked that there not be overlapping training dates as May and October are standard annual dates for provider conferences.* DMA acknowledged this situation and will make every effort that this does not occur in the future.

The **PASSRR manual**, is tentatively scheduled to be posted by Regional Training. Johnnie McManus from DMH will be the presenter at Regional Training and will go through the changes in the manual. *Stakeholders asked about the PASRR Manual and when it would be posted. It is tentatively scheduled to be posted prior to the regional training but there is no firm posting date at this time. When it is posted the link will be shared with the Stakeholders via Email.*

The Regional Training next agenda item will be the **PCS Service Plan** that will be conducted by VieBridge; Emonique Whitfield and Kevin Goddard will be the presenters.

The Regional Training last agenda topic will be **DMA Program Integrity Audit Process** and will be conducted by Carol Lukosius and Jeff Horton from DMA PI.

In regards to the **1% SPA**, the RAI response has been submitted. No further information is available.

##### b) Service Plan Pilot Project Update, Findings, and Moving Forward (Alan Ackman, VieBridge)

Official pilot period ended the 3/20/15 and we have used the last three weeks to review the findings that included going back and reviewing with individual sites their issues and concerns about what they saw, what they worked with, and what the implications of the proposed approach appeared to be from their perspective.

We completed a review with every participating pilot project site of which there were 15 and continue to review all of the service plans that were developed during the pilot project which were in excess of 200 service plans. Looking at the content of those, whether or not we saw any issues, in terms of the actual functionality of the system and the accuracy of the information that was entered into the pilot project, among other things, making sure our validations routines appeared to be working the way that we expected them to work; and also to better understand how easy or difficult it was to initially become exposed to the functionality in the provider interface that relates to the service plan and how

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easy it would be to get into the process of routinely receiving a referral and completing a service plan based on the independent assessment.

We have prepared a summary report to DMA, DMA has been reviewing that report since last week as a basis for again making final determinations about how to proceed. As you know the focus of the proposed new functionality in QiRePort on the provider interface is the service plan (SP) functionality, it is not the only thing, but it is the significant primary focus for this round of enhancements to QiRePort.

**Service Planning Update--** ① See Attached PowerPoint Presentation (Alan Ackman, VieBridge)

### **PILOT PROJECT FINDINGS** ①

**Navigation easy**--generally people found that finding the SP in QiRePort, once they completed a referral, the ability to go to it in an end-process display, access it, and move through the SP. We didn't see significant issues from the cross-section of providers about navigating through to the SP or within the SP itself.

The **average time to completion**, once they were familiar with what was expected, was somewhere between 5-10 minutes, in terms of the average time it took to complete the SP. Now I think this is slightly misleading because generally what we found were that the providers, in order to complete the SP, even though the SP populates the significant findings from the assessment, I think that our sense of it is that the majority of providers want to actually bring up the assessment and look through it in terms of from A-Z, to make sure they've seen the comments, they've viewed all the sections, particularly exacerbating conditions, and any notes to try to inform the completion of the SP. But with that preliminary step completed, the average time to complete the SP, once they were familiar with the mechanics of it, was reasonably brief.

In the SP we do populate the SP template with the assessment findings and one of our major questions during the pilot was whether or not the assessment data that populates into the SP is clear and capable of providing the basis by which the SP is developed. What we do for each qualifying ADL, populate the SP with all aide tasks that have a need frequency greater than 1, meaning that there are going to be hours associated with the requirement that that aide task be done. Each SP then requires looking at those aide tasks and developing the SP or a task plan schedule.

Now what we ran into early in the pilot, like in the first week, is that the scheduling functionality of the SP functionality, we developed it with an eye towards there being a typical weekly schedule and we've retained that functionality but we've made a change to reflect input from the provider community. What we found was that the scheduling functionality that we built into the system that we put in front of the pilot sites would require a weekly schedule with "from and to" times for each day that the PCS service was to be provided. The consistent feedback from the residential care providers was that we are in a 24/7 business. We are required to be able to provide this service 7 days a week. So we don't want to have to be in a position to develop that part of the SP schedule.

Rather than wait to the end of the pilot project, we decided to go ahead and as early in the pilot as possible, change the functionality of the SP to allow the system to default to the fact that in a typical week a residential care provider is going to assume to be providing PCS support aide task services 7 days a week. That simplifies the SP template substantially for the PCS provider that are in the residential care environment.

When we tested the population of the assessment findings into the SP at the aide task level, one of the things that we found ourselves needing to do is to make sure that not only are we conveying the need

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frequency but also whether or not the IA identifies the need for there to be accessibility of PCS service for weekend hours. For a residential care provider—this is not so much an issue, for in-home, it is. So we've altered the SP functionality as far as what we populate, as far as assessment findings to pick up on that. By the way, I would say that during the course of the pilot, there are probably 20 to 25 modifications we made to reflect provider input.

As a result of the final review, there are probably another 20 refinements that were actively either making or making final decisions on as part of finalization of the functionality for the SP and other related functionality.

### **Optional Service Plan Functionality**

The significant changes as a result of the pilot is that we have two versions; one for residential care providers and one for in-home providers. In both, we have retained the aide-task scheduling functionality with the requirement that it be done consistently with the aide tasks that were identified in the IA.

There were multiple comments received by the pilot site saying: when they go out and do their IA that they are required to do (and plan of care as part of their licensure requirements) they not infrequently find that their findings in terms of potential task needs might be different than what the IA shows, which raises the obvious question, then what do we do? So this is an issue that has continued to be discussed and reviewed internally and with DMA.

We went into this with the thinking that at least as it related to PCS that the SP needs to be consistent with the IA, but there has to be some realization and capacity to deal with incidences where the assessment by the provider can somehow lead to the ability to document the past that may need to be provided that are either an extension or different than the IA results. What we have done is basically move in the direction that is where and how the POC functionality will allow those deviations to take place and that it would not occur in the SP because then the SP would be out of sync with the authorized hours. So we are trying to sync authorized hours back to the IA and then ensure that the SP is consistent with the IA set up in the ability to ensure that a documentation is consistent with the SP, that in turn reflects the authorized hours.

We feel like that is a significant observation by the participating providers in terms of understanding where and or how any of those "deviations" from their assessment would be documented relative to the IA. We also, as you know, made provision for the ability to add and utilize optional SP functionality including aide assignments, service outcomes, aide instructions and narrative feature, what have you. We received a variety of different feedback on that in terms of what agencies feel like that they will use or not use. I will say in general I think the aide task functionality or the aide assignment functionality in the SP, input that we have is more logically suited to the in-home environment than it is to the residential environment because of the shifts and/or the multiple people on the floor or in a wing that potentially are going to be charged with providing that care sometime during the course of a day. So we've actually been looking at that and have done a few things to refine aide assignment but remember that's "optional" functionality, it is not something that a provider is expected to do.

**Service outcomes**—one of the things that we originally rolled out was that the notion that it would be typology driven—meaning that we would have a list of different kinds of outcomes, you could put one or more in, that you thought were pertinent to the definition of what PCS can realistically accomplish relative to that individual beneficiary during the course of the plan period.

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The more we worked with the individual sites, we changed it so that you have the option of putting in an outcome related to their ambulatory capacity or something else. We now allow that to be customized so that the outcome category can be selected but the outcome description can be tailored and customized to that individual beneficiary to try to make the concept of setting a PCS outcome more rooted in the assessment of the provider of what outcome really makes sense for that individual beneficiary so that customization feature was added as part of the functionality to the service planning module.

Also, on the aide instructions, we've set that up to where any aide instructions that are written into the SP can be forwarded automatically into an aide task worksheet should an agency choose to use the aide task worksheet that's built into QiRePort. One of the things that we ran into is, is that some agencies prefer to really break the instructions up, and again, I won't get into too many details, but I think this is an interesting conclusion. Some of the providers assume that if there are special assistance tasks or delegated medical monitoring tasks that are required, they want the monitoring parameters to be identified as part of the internal service plan development that occurs such that those monitoring parameters can be made clear to the aide that may be charged with the responsibility of working with that individual (whether it's their glucose levels, blood pressure, etc., whatever). So we are actually modifying the basic service plan template to allow that to be identified in the SP template as distinct from having it put into the aide instructions as a generic guide. These are examples of the kinds of refinements that we are making to the SP.

**Aide Tasks Sheets** – We received more comments on this than anything else and we weren't surprised by that. Agencies typically have, either thru systems they've acquired or systems they have internally through long-standing practice, have different ways that they view an aide-task worksheet needing to be packaged, formatted, and/or used. And so we ran into any number of different ideas about how that should be done. We've made multiple changes to the aide-task worksheet to reflect various types of input from how the beneficiary information is displayed to whether or not the aide information needs to appear, and if so, how—to how actual documentation is done on the aide-task worksheet to address deviations and how deviation documentation should be done on the worksheet. As well as the issue of just the length of the aide-task worksheet. We are actually working, as part of the final version, at trying to shrink it into simply one page. Doing that, given what we were trying to do, is a slight challenge but not a goal that we've ruled out.

So there are likely to be a variety of more refinements to the aide-task worksheet. Again, as part of the briefing here, aide-task worksheets are not required. Agencies will not be required to generate the aide-task worksheets. If you have your own aide work task sheets that you like, that people are used to using, and that you feel are comfortably that provide you with the capacity to do the documentation you need to withstand a, not least of which, a Program Integrity review, than agencies will certainly be encouraged to use those. I will say this, that the aide-task worksheets that are built into this are designed to exactly represent what was documented in a validated service plan, and that therefore, the ability to either generate at the point of SP development or at a later point, recreate the aide-task worksheet as a point of reference, it would provide to anyone looking at what it is you're responsible to do under PCS, an exact representation of, this is what should have been the aide-task schedule and tasks that need to be done for the defined period that was selected for generation for that aide-task worksheet. So those can be recreated back in time (e.g. see what it should have looked like six months ago for that week), you are going to be able to see it for that client, and see it exactly that this is what the documentation should have gone in as.

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**Stakeholder Question:** *can you modify aide-task worksheets or you can't modify them (e.g. there is a **change of status** in the residence condition or do we have wait until another change of status assessment is done)?*

**VieBridge Answer:** yes you would because they are driven off of the modified revised SP. So that is in force now in terms of the functionality

**Stakeholder Comment:** *expressed concern over providers not being adequately informed of **documentation requirements** required by audit.*

**DMA Answer:** The SP does allow for deviations. Program Integrity (PI) will be at Regional Training and we are working to outline and provide for the provider community, the audit process so you know what is going to be looked at when you have these audits done and the point in bringing PI to these meetings last month so that they outline the process so that you do know what to expect in the audit. They (PI) are working closely with us on the SP so they are clear on how this function works and what to look at in regards to deviations and what is allowable. We are working closely with all parties involved to make sure that when we do roll this out or when you are audited, that we have outlined the steps and the appropriate protocol so that you are not audited for something that was not outlined correctly.

**NOTE:** Any comments that are directly related to the Service Plan (SP) and the way SP will be implemented – please add this to the public comments. Your feedback will be reviewed and anything that needs to be updated will be.

**Provider training** Per Liberty Healthcare, if you have questions, you may provide Liberty with all pre-provider training questions that can be sent to their website INBOX. This training will include Program Integrity (PI), PASRR, the audit process, documentation, etc. This training will be posted on Liberty's website and you will receive a notification via email. Try to send those questions right now so Liberty may best prepare and cover those topics at this training.

As part of the functionality regarding the aide task work sheets "what are the implications of this in terms of it further highlighting and shining a light on any kind of PI review of PCS service that a provider provides and what clarification and/or support does this process or tool set provide to a provider that helps them be assured that they have the proper documentation in place. This was the major issue driving the discussion about anything that QiRePort would either do through the SP specification itself or by extension in the aide task worksheet.

In addition to that, we built into QiRePort as part of the service planning, an ability to catalog or register aides that would be potentially on staff and designated and given the responsibility for providing PCS service support. We set up an aide reference file to basically facilitate that aide assignment process. We increasingly through the pilot project, as we received input, have moved more towards that aide task reference file. Again, this is an optional functionality—it's not required, it is there to encourage and support providers.

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Validations are built into the SP and to assure compliance with the assessment. We didn't run into any material issues with the validation logic that has been deployed. It also, as part of the pilot, implemented a SP print feature. We got a variety of different feedback on essentially the layout of these SPs and the formats of those that were not as complicated as the aide task sheet issues, but again speak to the issue that agencies are concerned about what documentation is on hand either in terms of the SP itself or an aide task worksheet that would both guide and support any kind of documentation consistent with a review by Program Integrity.

Another broad overarching issue is the question of the SP documentation versus the plan of care (POC)—the issue of where and how that plays out which we have discussed for several months now. At this time providers are required to complete both the PCS Service Plan and the Licensure required Plan of Care.

Optional functionality—the beneficiary profile in general, the layout of it, we didn't find that there were major issues with its content and/or the way that information can be entered, with one exception. The way this system is set up when there is a new referral or a new beneficiary, the system creates a beneficiary profile record into QiRePort based on the IA, and it populates that beneficiary profile with diagnosis and medications information from the IA. We have not infrequently heard from providers, “well I see that but when we go in and really do our assessment and work on the POC, we see diagnosis that were not identified or we have some questions about what was there and the same thing for the medication.” So we, as part of the final rollout, are looking at how that information is populated and what flexibility exists on the part of the provider to deal with that reality. And again this is “**optional**” functionality. We want to make sure that we don't leave that as an open issue. So another area where guidance and direction and specificity is quite important to understand what we would either encourage or caution people to do relative to incidences when they view their assessment is coming up with different results. We've added the capability to upload supporting documentation into QiRePort is either supplement the aide reference file, the SP, or the beneficiary profile. The only real recommendation we got on that was that in certain incidences, the ability to upload in batch form might be helpful.

Another area is **person-centered goals**—we tried to create a presence as far as person centered planning, in this concept without really trying to build the entire SP model around the Person Center planning model. A notable recommendation is that area, if you are going to identify to goals than r we going to allow providers to develop a task or activity plan that would establish what the agency is going to do during the course of the plan period to try to help realize that Person Center goal. If you going to set goals, then you want the ability to have a task plan to help that goal being achieved that's been identified by the beneficiary.

**PA Generation**—no change in terms of current functionality. Approached to all the participating sites the idea that we might, with the presence of the SP, look to the option of being able to, once a SP is validated, to generate Pas that reflect the specifics of the SP as it relates to an individual month and to also reflect the days of the month. The net of that is that right now, as you know, the Pas are the same for each month. They are authorized for 80 hours so you write a PA for March that is for 80-hours, April for 80 hours even though the days in the month are different.

We solicited input on the utility of altering the PA hours to reflect the SP and the days of the month. We got an underwhelming response to that, to the point that we recommended that we don't change anything in terms of PA generation and that we leave that as it is. That while we gain precision in terms of the PA exactly how many hours would you really be moving toward?

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**Reports**—no major issues—there are two general types 1) **beneficiary based** and the other is 2) **Service Plan (SP) based**. We've got extensive feedback on those. The general feeling is that kind of reporting will be helpful because it looks at current caseload, it looks at, roughly speaking, acuity profiles of the different individuals that are in the current caseload that can be run pretty much at any time not only for an individual in PI but across PI when there is a corporate presence and the need to see the entire caseload. So it is set up to run in both ways. Based on user input we made a variety of tweaks and changes to the report templates themselves. We also developed and tested instructional materials that focus on the mechanics of how to complete the SP. We've developed videos and instructional materials that are out there. We invited the pilot sites to review those and give input on their utility and/or their usefulness in learning how to use this new functionality. So those are basically developed, now we're going through the refinements to those to make sure those are an active and important part of the rollout that occurs. Right now we are talking about, as far as an implementation schedule, **June 10, 2015**.

The rollout is focused on the Service Plan and in order for us to get from here to there, back to the issues that are being raised. We are looking at a variety of steps. As you know, the Regional training is going to be the first place where the specifics of what is going to be implemented are summarized. The goal in the regional training is not to do the training but make people clear on what the functionality is that is going to be included and what the general rules of the road are and starting there to deal with what we consider to be the major questions people are asking. We are not assuming that the policy statements will provide all the details. So what we are looking at is companion guidance material that take every one of these issues on. One of the most important vehicles is going to be the creation of FAQs on every issue related to the mechanics of the Service Planning and the implications of how to interpret the policy relative to this functionality and that is where the aide-task documentation—what the guidance is for how that plays out for PCS and Program Integrity audit—we are really trying to zero in on that to make sure that it isn't overlooked or not accurately addressed.

So the baseline introduction is the Regional Training (May 5-18, 2015) and then in the middle of May we are actually going to roll out onto QiRePort all the basic training material and instructional materials in advance of webinars so that people can start going through and actually seeing the video of: here's how you complete a service plan, here are the FAQs, here are the written instructional materials, so people can see—okay I get it, I see how it's different from what I do now. Our goal is to roll that out no later than May 15<sup>th</sup>!

Then starting at the end of May, we will start a series of webinars and we are going to break those up into two drafts. We want to do not just two webinars but a series that is targeted to in-home providers and residential care providers because the questions are different and the issues are different as we see it. And we will be able to offer guidance more clearly in how to interpret the policies to reflect those different environments. We may very well as a subset to the residential training break it up into a couple of sub-categories because there are a large number of very small residential care providers. The dates are set for the webinars, we will announce them in the next couple of days and certainly as part of the Regional Training. We didn't want the webinars to run in parallel with the Regional Training so we wanted to clear the Regional Training, allow the public policy comment period to be completed, finalize the policy as of June 1, and finalize the critical guidance material between the middle of May and the rollout on June 10<sup>th</sup>.

### c) PCS Monthly Report (Sabrena Lea, DMA) -- attached

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### 3) Announcements

June 10<sup>th</sup> is the expected "Go Live" Service Plan Implementation.

Multimedia training materials intended to be available May 15<sup>th</sup>.

Guidance and Training Webinars intended to occur from May 27<sup>th</sup> through June 9<sup>th</sup> with 12-13 sessions.

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### 4) Reports from Other Divisions

- a) DAAS (none provided)
- b) DMA/DD/SAS(none provided)

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### 5) Stakeholder Feedback

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6) Meeting Adjourned at 2:30pm