# Adult Services and Aging
# Home and Community-Based Services Workgroup
# July 9, 2015

**Members Present:** Gerald Beninga, Advisory Council on Aging; Deb Fischer-Clemens, Avera; Shawn Groft, Redfield Community Memorial Home Health; Rep. Jean Hunhoff; Amy Iversen-Pollreisz, Department of Social Services; Sarah Jennings, AARP; Paul Millman, Interim Healthcare; Steven Novotny, Homecare Services of SD; Rich Ostert, Edgewood Vista; Marcy Ramsey, Phillip Health Services; Ramona Simon, West Winds Home Health; Yvette Thomas, Department of Social Services; Steve Vande Kop, Assisted Living Association of South Dakota; Ronda Williams, Department of Human Services.

**Members Not present:** Carol Cameron, Consumer; Mark Deak, SDHCA; Loren Diekman, Jenkin's Living Center; Scott Duke, SDAHO; Lisa Griffin, consumer; Leslie Morrow, Alzheimer's Association; Chris Qualm, DOH; Sen. Bruce Rampelberg; Jody Towey, West Hills Village

**Also attending:** Wendy Mead (SDAHO), Jennifer Stalley (Midwest Solutions), Carol Vande Kop

**Purpose of Meeting**
The purpose of the workgroup is to explore options to increase availability of community-based services and further explore information on other supports currently being utilized in South Dakota.

**Follow up Items from Previous Meeting**

- Currently there is only one full-time parish nurse in Sioux Falls, the rest are either volunteer part-time or paid part-time. There is no established registry of parish nurses although they do use a group email to communicate.
- A report on the outcomes of the Aging and Disability Resource Connections (ADRC) project was distributed to members.
- Informational brochures on the South Dakota Department of Health, Office of Rural Health's Recruitment Assistance for Healthcare Professional program were distributed to members. This has been a very successful program for South Dakota, candidates from every county have been supported and the support amount has increased from $5,000 to $10,000.
- Verification was provided that there are current 9 Nursing Homes in South Dakota designated as "Access Critical". They are located in Britton, Chamberlain, Eureka, Hot Springs, Lemmon, Martin, Miller, Philip and White River. As a reminder, these designations were a result of Senate Bill 140 during the 2011 Legislative Session. There are requirements in order to meet the designation including: the facility must be located at least 20 miles from the next nursing facility, the facility must be located in the largest town within 35 miles, the facility must be Medicare/Medicaid certified, and the facility must be associated

with healthcare services. The implementation of this model has served to ensure the availability of the continuum of care in small, rural communities. On two occasions, the Department of Social Services has been involved in efforts to keep these facilities viable. A few years ago a rate adjustment was successful in keeping Bennett County Nursing Home in Martin viable. Most recently, Five Counties Nursing Home in Lemmon has been experiencing financial difficulties, due in part to staff shortages and their extremely rural nature. With good support from the community and an adjusted Medicaid rate, the prospects are good to keep this facility viable and available to our rural South Dakota residents.

**Yvette Thomas presented an Overview on Medicare Skilled Home Health.**

Good discussion followed the presentation, particularly surrounding the need for solid documentation of the reasons the participant will continue to benefit from Medicare skilled home health. Some providers indicated that after the second recertification period, the federal government scrutinizes the records carefully; however, that is not a problem when the documentation is good. Providers mentioned that they have had people on skilled for several years and experienced no problems. Representative Hunhoff shared that the scrutiny goes back to the incidence of abuse of the program nationally. There have been some states with high incidence of fraud and abuse; therefore all states are feeling the impact. Representative Hunhoff also reminded the group that there is not a Homebound criteria for Medicaid. Clarification to the definition of homebound (for Medicare) in the last few years has made a big improvement; however, there is still some reluctance on the part of doctors in some areas to fill out the necessary paperwork. Some providers have worked extensively with their doctors to ease the paperwork burden for them and demonstrated to them how they can be reimbursed for their time completing the necessary paperwork. A concern was expressed about the increasing needs of future generations and that this is a critical service; there aren't enough Assisted Living Beds to accommodate everyone. Steve Vande Kop shared that many people who come into the Assisted Living make a significant improvement after just a few weeks of medication management and good nutrition.

Marcy Ramsey shared that their home health agency does follow up visits with any person leaving their hospital that will agree to a visit. The agency does two in person visits and 4 follow up calls. Workgroup participants agreed that Medication Management is a common issue, and that better communication would improve matters. The Aging and Disabilities Resource Connections (ADRC) process was explained to the group including the intake, assessment and options counseling pieces. A question was asked if the assessments completed by Adult Services and Aging (ASA) could be shared with home health agencies, and Yvette Thomas clarified that they could if the individual consumer agrees. Providers expressed

concern that when people are going home they have been told that they have to be home for three days before ASA can do an assessment. Yvette Thomas clarified that while the consumer has to be in their home environment for three days for the assessment to be accurate, ASA staff have been instructed to implement services to meet the immediate needs of the consumer, and then do the assessment at three days. ASA can't always assure services will be in place immediately as it depends on provider availability.

A suggestion was offered that a model needed to be created to allow two visits by a home health agency nurse after a hospitalization. During that visit, the nurse could determine if the visits were eligible to be billed to the VA, Medicare, etc.; but could rely on Social Services to pay if they didn't qualify for other programs. It was reported that the initial first visit did the most good, and often assures consumers that they can accept help without fear of being placed in a nursing home. A follow up question was asked regarding whether or not most home health agencies are open on weekends, and work group members clarified that most are available 24/7.

One additional issue identified with Skilled Home Health was that it must be a SD licensed doctor who makes the referral/admission to Home Health or the claims will be denied. This becomes a problem with physicians practicing under umbrella agency licensing such as Indian Health Services and the Veteran's Administration. It is also an issue with consumers along state borders who may seek their primary healthcare across the state line. State staff will follow-up with Department of Health, Office of Licensure and Certification to see if this is a state requirement or a CMS requirement.

**Yvette Thomas presented information on additional services that could be offered through the waiver service.**

There was discussion surrounding the different service options that might be implemented and how they would benefit consumers. Some services are already available under other programs; for example job skills training isn't a service that would likely be added in the ASA waiver as that service is already available through Vocational Rehabilitation, at the Department of Human Services, Division of Rehabilitation Services. Caregiver training, counseling and relief services are a significant need. The group reviewed other services available for implementation under the waiver. The group was supportive of those additional services suggested by the Department of Social Services as higher priority services (day habilitation, vehicle modifications, non-medical transportation, assistive technology, community transition services, chore services, and training and counseling services for unpaid caregivers). The group agreed to give some additional thought to other services that might be considered for recommendations at the next meeting . It was also discussed that implementing these services through the waiver first allows the state to establish a provider base which is then available to serve consumers.

Case management as a waiver service was discussed. ASA provides case management but does not bill for it as a waiver service; the ADLS waiver contracts with providers to provide case management. There is some concern with the ADLS waiver that they may have a conflict of interest and they are currently reviewing this feature of their waiver. Yvette Thomas provided information on ASA case management, which includes an annual assessment at a minimum, other assessment as needed, quarterly contacts with the consumer, twice a year in home visits with the consumer and as needed contact with the provider and consumer. ASA staff carry an average of 90-110 cases.

**Next Steps:**

Workgroup members are interested in what models other states use to deliver services. This information will be provided at the next workgroup meeting.

Members will review the additional optional waiver services to determine whether or not to make a recommendation to include these services in the upcoming waiver renewal application (2016).

Meeting adjourned at 3:00 p.m.