Adult Services and Aging
Home and Community Based Services Workgroup
August 20, 2015

Members present: Chris Qualm, Department of Health; Marcy Ramsey, Phillip Home Health Services; Rep. Jean Hunhoff; Deb Fischer-Clemens, Avera; Carol Cameron, Consumer; Ramona Simon, West Winds Home Health; Leslie Morrow, Alzheimer's Association; Yvette Thomas, Department of Social Services; Amy Iversen-Pollreisz, Department of Social Services; Steve VandeKop, Assisted Living Association of South Dakota; Paul Millman, Interim Healthcare; Gerald Beninga, Advisory Council on Aging; Rich Ostert, Edgewood; Mark Deak, South Dakota Health Care Association (SDHCA); Loren Diekman, Jenkin's Living Center; Scott Duke, South Dakota Association of Healthcare Organizations (SDAHO).

Also attending:
Erik Nelson, AARP; Kelsey Webb, Governor's Office; Deb Petersen, Department of Social Services; Carol VandeKop

Members absent:
Ronda Williams, Department of Human Services; Sen. Bruce Rampelberg; Steven Novotny, Homecare Services of SD; Lisa Griffin, Caregiver

Follow up from previous meeting:
Chris Qualm reported back on the question regarding the Centers for Medicare and Medicaid Services (CMS) position on physician qualifications for home health state models for Medicare. CMS regional office maintains the position that any physician orders received by a home health agency must be from a physician licensed within the state the physician is located and writing orders within and where the home health agency is located. No exceptions are allowed. Qualm also talked to Margaret Hansen, Executive Director of the State Medical Board, and she confirmed that no waivers are available.

Discussion was held that Medicare requires an individual to be homebound whereas Medicaid does not. The Department of Social Services modified ARSD 67:16:05:05.01 per CMS's direction to delete the requirement that a recipient be homebound in order to receive home health services prescribed by a physician as medically necessary.

Members questioned whether Medicaid requirements differed from Medicare regarding provider qualifications and licensure. Chris Qualm will research and conduct additional follow up with CMS regarding practitioners (Physician, Physician Assistants and Certified Nurse Practitioners) and Medicaid.

FOLLOW UP:
The Department of Health certifies Home Health Agencies seeking Medicare and Medicaid certification for CMS. The Conditions of Participation (CoP) regulations apply to all individuals receiving services through the certified agency regardless of payer source (Medicare or Medicaid). Section 484.4 states: Personnel Qualifications: Physician. A doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed. State statute SDCL 36.2.2 requires a doctor of medicine or osteopathy to be licensed by the SD Board of Medical and Osteopathic Examiners and the doctor of podiatry would need to be licensed by the SD Board of Podiatry Examiners to practice in South Dakota. Physicians within the VA or IHS are allowed to treat and write orders for patients within their system, but they are not allowed to treat or

write an order to patients outside their service area unless they possess a SD license to do so. Further questions relating to the certification requirements may be directed to Deb Carlson at Deb.Carlson@state.sd.us or phone (605) 995-8073.

South Dakota's Aging and Disability Resource Connections (ADRC):
Deb Petersen presented on the Aging and Disability Resource Connections/Centers (ADRCs) and walked members through the ADRC website. (Refer to the *Aging and Disability Resource Connections (ADRC)* power point.) South Dakota is a Single State Unit on Aging, but has created a structure of ADRC calling centers in 5 regions. Implemented in 2009 through a federal grant, the ADRC is a single point of entry where objective information and assistance is provided to help individuals regardless of income or resources, identify and access available public and private long-term care services and supports within their local communities, following the 'no wrong door' approach.

Adult Services and Aging (ASA) specialists make referrals to providers; however, specialists do not recommend a particular provider. Instead a list of provider options and a resource guide are provided to assist the individual in choosing a provider.

The group discussed the Caregiver program and the need to increase awareness of availability of this program, especially that the program is not income based. Individual Caregivers can utilize existing home health agencies or find an individual care provider in their location. Caregivers are paid when the person supported signs that the care was provided. Cameron attested that the process works well and is simple. Deb Petersen is available to present to care giver support groups and other organizations to increase awareness. It was recommended a list of support groups could be shared with ASA; Carol Cameron and Leslie Morrow will follow up with information. It was also recommended that the list of caregiver support groups be added to the ADRC webpage. As an update, the online ADRC Resource Directory found online at http://southdakota.assistguide.net/site/371/DesktopDefault.aspx?tabid=371 already allows individuals to find a listing of caregiver and other support groups that are available. Typing the word 'caregiver' into the search engine will provide a list of agencies that provide caregiver supports. If you type in the word 'support', the agencies that provide support groups (Alzheimer's, Caregiver, Parkinson's, etc.) displays. Additionally, the Department's website links to the National Family Caregiver Association and is located at http://dss.sd.gov/asa/linksandresources.aspx.

Representative Hunhoff suggested looking at a different model; the role of the state and the role of ASA and community based providers and engagement levels; suggesting partnering with the communities to provide resources from the state but with decisions made at the community level. Deb Fischer-Clemens commented that this might be the appropriate time to make changes to ASA and the ADRCs based on outcomes. No one suggested things are currently being done wrong; rather, questioned how we can all do a better job of assisting people who need services in a changing society. Iversen-Pollreisz commented that these suggestions are beyond the scope of this workgroup's purpose; the request will be taken back for discussion regarding having future conversations to analyze the current ADRC system.

Hospital Discharge Referral Protocol:
Deb Petersen also presented on the **hospital discharge referral protocol** which guides the process of hospital discharge staff to refer individuals who are in the process of discharging from a hospital stay. (Refer to the *Hospital Discharge Referral Protocol* handout.)

Retention and Recruitment Efforts:
The group discussed **retention and recruitment efforts for healthcare workers**. Suggestions included:

- Improving position titles: *the average job seeker spends 6 seconds looking for a job; it is important to grab their interest right away.*

- Establishing career paths: *creating an opportunity for a career path so the prospective employee can see there is a future for them with the company is important.*

- Generational Differences: *employers need to be prepared for a changing workforce generationally; work ethic is changing - employers now reward people for being a responsible employee (showing up for work as assigned) rather than expecting a solid work ethic as the norm.*

- *It was suggested the state could create a short, succinct resource of recruitment and retention strategies and share with employers, keeping in mind that younger people value time over money, and they value their lifestyle, family.*

- Competing with the fast food industry*: The healthcare industry is competing with the fast food sector for entry level workers. Often with a fast food business, applicants are interviewed by the manager, offered a position on the spot, and start the next day – the healthcare industry takes too long. Reconsider application processes and requirements: entry level employees may not have 5 references.*

- Alternative compensation:
    - *find out what is important to the employee (recognition, time off, money, etc…)*
    - *have staff complete an "All About Me" questionnaire so you can appreciate and recognize them as they prefer (such as their favorite pop)*
    - *"Praise Board" (board to post cards of praise and appreciation for staff)*

- Retention*: The best way to retain people is to have a good workplace culture and recognize valued employees. Long term care and healthcare will never only use robots because we need personalized, hands on care. The industry does need to look at technological and innovative ways to deliver care, such as the way Avera uses robots to deliver medicine from the pharmacy. This allows staff to focus on areas where human contact is needed.*

Recommendations:
The services recommended at the July 9 meeting were discussed as provided on the "draft recommendations" document. Live-in caregiver services were discussed as a possible additional need. Members were unsure about the extent that this services might be utilized, as not many folks have a paid, live-in caregiver who resides with the individual full time. Members commented that there is a demand but more likely is it for more than one caregiver who does not spend 24 hours in the individual's home. This is a barrier because we cannot find the people to provide 24 hour live-in care. There is a concern with the amount of bodies available in SD to provide this type of service. The additional payment would be available to offset the rent and food costs of the paid Caregiver for the individual supported. It was suggested that this may be attractive to prospective employees because they are provided a place to live in addition to full or part time employment.

Additional discussion was held regarding the need to enhance the HCBS waiver operated by the Division of Adult Services and Aging to include day habilitation, vehicle modifications, non-medical transportation, assistive technology, community transition services, chore services, and training and counseling services for unpaid caregivers as well as compensating for the expenses related to live in caregivers. Workgroup members were in agreement that there is/will be a significant need for these services. There was discussion on the analysis that will need to be done to determine the fiscal impact of adding these services to the HCBS waiver and that an appropriation will likely be needed by the legislature. Additionally, approval by the Centers for Medicare and Medicaid Services (CMS) will be necessary. Between now and the waiver renewal period, Adult Services and Aging (ASA) will conduct additional research, including fiscal impact of expanding HCBS waiver services to include these services. Once the analysis is complete, ASA will initiate the waiver application/approval process for approval by CMS. The group also discussed that services may be implemented in stages and that in areas where there is only a minimal need for a service, it would not make sense to proceed with developing a system to provide the service.

Deb Fischer-Clemens commented that there needs to be additional efforts to get information about services to people who need it – for example, every social worker in the state needs to see the hospital discharge protocol sheet. DSS staff will make efforts and continue to work with professional organizations, present to hospitals and assisted living organizations, family practice groups, the medical association, as well as church groups and the Parish Nurses.

Next step:
Finalize the recommendations and distribute to the group for review and determine financial impact and timeline for implementation.

The meeting adjourned at 1:50pm.