HCBS Final Rule Live Q&A 10/26/2020 11:00 AM - 2:00 PM (PST)

SPEAKERS

Joseph Billingsley: Joseph
Amanda Alvey: Amanda
Cathy Anderson: Cathy
Brittani Trujillo: Brittani
Margot Jones: Margot

Amanda: “Thank you all for joining our question and answer session today on an overview of the HCBS settings Final Rule. I will turn it over quickly to Joseph Billingsley with the Department of Health Care Services to provide a brief introduction. Joseph.”

Joseph: “Good morning everybody or almost good afternoon maybe in some cases. This is Joseph Billingsley. I'm with the Department of Health Care Services working within our Integrated Systems of Care division and. My area of the Department is primarily responsible for the Medicaid1915 C waivers that we operate here in California, including the Assisted Living Waiver and the Home and Community Based Alternatives Waiver, and specifically the Assisted Living Waiver settings, Residential care Facilities for the Elderly and Adult Residential Facilities, as well as the Congregate Living Health Facilities under the Home and Community Based Alternatives Waiver. So today's presentation. Is specifically tailored towards those settings and basically providing meant to provide operators of those settings. Overview of the home based services Final Rule issued by the federal government several years back and the implementation of that rule and basically identifying or talking about work we have done with our partners at Public Consulting Group to do reviews of providers. Operators of those provider types in settings under the waiver and really educate you about the HCBS Final rule. What those reviews have identified and work with you to come into compliance. So with that, I'll turn back over to Amanda and team at Public Consulting Group to get our presentation started. Thank you”.

Amanda: “Thanks, Joseph. So we did distribute a training about a week and a half ago, which was an overview of the HCBS settings Final rule. So today we're going to start with giving you a brief overview of what's contained in that training. We do have the expectation that you did review the training prior to attending this Q&A session, so we will only go over that content briefly. We have provided it at the end of this session as a resource. In the meantime, if you have questions as we go along with the content, please feel free to submit your question via the Q&A chat function. We will address questions that come in through that Channel, as well as have an opportunity to take questions once we open it up for live questions. So I will go ahead and turn it over to Cathy Anderson. She's going to give you some introductions of our team and go over the agenda”.

Cathy: “Hi good morning or good afternoon depending on where you're located. On this slide you'll see Amanda Alvey, who Amanda was just speaking with you. She's a senior consultant with Public Consulting Group and she's located in Indiana. Next is Brittani Trujillo. Excuse me, senior consultant. Located in Denver, Co. So the mountain background is very apropos for should have snow caps on it today, I think. I'm Cathy Anderson, the senior advisor with Public Consulting Group. Also located in Washington DC. And Margot Jones, who is a consultant with PCG the four of us are the primary speakers today, although we have others from PCG on the line and we have some members of the staff from DHCS so we may have some other speakers who pop on occasionally. On the agenda for today is first to review of some common terms that we use throughout these trainings and any kind of events or conversations that we have regarding this work. The next area will cover is an overview of the HCBS Final Rule training. Then we'll talk about common areas of non-compliance. We will switch then to questions and answers, so these are either questions that were submitted in advance or submitted as we go today and then we will talk about next steps and at the end of the power

point. There is a resource section with links to valuable resources for everyone. So I think I turn it back to Amanda".

Amanda: "Thanks Cathy. One of the first things that's contained in the HCBS overrule training that you received as well as every training that we have moving forward. It's just the set of common terms or baseline terms. I'm not going to read each one of these to you, but these are some of the terms that you'll hear most often from us. We often in government work speak in terms of acronyms, so you hear a lot of things like HCBS, and CMS and so this really sets the foundation for what we mean when we say all of those things. These terms are, you know, not only critical to your program and understanding the content, but really understanding what the information that will be producing moving forward in the context of the HCBS settings, final rule, and that in and of itself is more in the most critical terms that we use. This was a federal regulation, as Joseph mentioned that was released from the Centers for Medicare and Medicaid Services back in 2014. And that's really why we're here today. So that's the basis of the training on the basis of the information that we're producing. As well as the work that PCG has conducted in conjunction with DHCS. So you'll see a few slides here. The next set of terms are relatively specific to the HCBS settings rule itself, so you'll hear about remediation and heightened scrutiny. Those are steps within the process that will be speaking to later today, person centered, which really is the foundation of all of the work, and it's a practice that making sure individuals receiving the services and supports. Really are part of an integral and the primary point of all of this. These are just a couple other terms. These may seem pretty basic and baseline to everybody involved, but again, want to make sure that when we say individual or we say family member were all on the same page and understanding with what exactly those terms mean. As Joseph mentioned this work, this is this overview of the settings that are specifically impacted by the HCBS settings rule. These are settings that are specifically identified as part of California statewide transition plan and contained within California's 1915 C waiver as settings that provide services for individuals. So residential care facilities for the elderly or are RCFE's adult residential facilities, and congregate living health facilities. Again, you'll see all of these slides if you haven't already reviewed the content and the HCBS overview, training all of this information is contained within there. As I've alluded to, we did release the training on October 16th. It was sent out via email. I know DHCS also sent out a notification letting everybody know that the training was available for viewing. This is a quick overview of all of the information that was contained within, so we did background and highlights of the final rule. Including the characteristics of what makes a home and community based setting, which we will also touch on today. Person centered planning, so the final rule has information contained within there as to what the settings expectations are. If modifications are made to any of the characteristics that make up a Home and Community Based Setting and how those should follow the person centered planning process and the modification process specifically, that's outlined in the final rule. We'll also talk about federal guidance on heightened scrutiny settings. This is definitely an important piece of the process because it has an impact to a good number of the settings that provide services in the state of California. It sounds much more scary than what the term actually is. Actually a very positive part of the process that allows the state to attest to see CMS that these settings can become compliant with the final rule, despite some potentially institutional or isolating qualities. We'll also touch on some common areas of non-compliance. Again, all of this information is something we dive a lot deeper into all of that within the training that was distributed, but we will touch briefly on

these areas today". What we provided here is just a very quick overview of the timeline of the settings rule. So at this point the rule was initially released from CMS in March 17th, 2014.The original effective date, as I'm sure most of you are aware, was March 17th, 2019. So originally states had five years to complete all of the tasks and activities outlined in the final rule, which included developing a State-wide Transition Plan for how they were going to review their own system, as well as how they were going to assess all of the settings that provide home and community based services. I'm a couple years later see CMS realized that they listened to a lot of feedback from states, in particular that that they felt that 2019 wasn't sufficient time in order to assess all of the settings, especially in places like California where there are a large number of settings that provide homing. Home and Community Based services to a very big population of individuals. So CMS extended the effective date until 2022. I talked about heightened scrutiny very briefly, we'll touch on it again, but again, that was an area that a lot of states had questions on. So in March of 2019 CMS issued some frequently asked Questions which clarified some of those qualities for settings that were identified for the heightened scrutiny process in particular settings that may unintentionally have the effect of isolating individuals from the broader community. Most recently CMS just this past July extended the effective date one more year, so we are currently looking at an effective date of March 17th, 2023. This may still sound like it's quite a ways off, but there are a lot of asks that the state has to undertake in that time as well as providers, so ensuring that there are any areas that need remediated or worked on to ensure that you're setting comes into compliance status. The State and CMS want to ensure that you have sufficient time, training, information, and technical assistance. One of the most critical things that is outlined as part of the HCBS Final Rule as defining exactly what the characteristics of a home and community based setting are. So within the rule itself CMS outlined these first five characteristics that apply to every setting that provides common community based services. This is whether you're a residential provider or a non-resident provider. We know most settings in attendance today, are residential providers, but this does apply to any non-residential or day programs as well. Those key characteristics include integration, and access to the broader community. Ensuring that the setting is selected by the individual among setting options that would include options that include settings that are non-disability specific. Ensuring individual rights privacy, dignity respect, freedom from coercion and restraint. Those are all things that again we dive a little bit deeper into in the training. The two other key characteristics are optimizing autonomy and independence in making life choices. As well as facilitating choice regarding services and supports, and who provides those. The next set of characteristics apply specifically to provider owned or controlled residential settings, so all of the residential settings must meet those first characteristics, so the one through five contained on the previous slide as well as these characteristics, which includes having a lease or other legally enforceable agreement in place for individuals. Ensuring that individuals have privacy in their unit so they're sleeping unit, they're living unit. Having lockable doors, choice of roommates, and choices to furniture. Decorate their sleeping or living units as they choose. The individual should also have the opportunity to control his or her own schedule, which does include access to food at any time. Individuals having access to visitors at any time and again ensuring that the setting is physically accessible to all individuals that are living in the setting. We will talk about again, very briefly, modifications to any of these characteristics in the process that that should follow while we touch on that today. I know there's generally a lot of questions around those types of modifications and how they can be managed. We'll dive under that again if you review the

training, there's a lot more details in terms of what that modification process. This slide is a very quick overview of each step in the process, so each state developed what is called a State-wide Transition Plan that outlines the steps for assessing the state system. So how the state was going to look at their own policies, procedures, rules, etc. That document you've probably heard about it. It is always posted for public comment each time that the state makes substantive edits to it. California does have initial approval from CMS on that document and there will be additional information that will be posted, that outline some of the further steps and provides additional clarification on what each one of these steps team. As you all are probably very well aware, PCG worked with DHCS and conducted on-site assessments last year. So each residential setting was visited. We conducted an onsite assessment and have produced a report for DHCS which outlines some of the areas that we found that may not currently be in compliance with the final rule. For any of those areas that were identified, we will be working with DHCS in supporting providers through that remediation process, so that's one of the things that is mentioned in the training and will touch on again, briefly here today about what that process looks like, how providers can develop a remediation work plan that will let the state know how you're going to address each one of those areas and then work through that process and achieve everyone's goal of each setting coming into compliance. So individuals can continue receiving services in the setting that they're currently living. Again, we'll touch on the heightened scrutiny process, which is specifically outlined by CMS and addresses. Some of those settings that appear to be institutional or unintentionally isolate individuals from the broader community we'll look at what some of those findings were, for some of those common qualities are that we found in heightened scrutiny settings. Let you know how we can work through that process together again to make sure all settings having others come into compliance with the final rule by that deadline of March 2023.

Amanda: [Slide on screen captures providers next steps] “This slide just provides a little bit more detail on what each one of those three key steps are. When you receive your site report, please keep in mind that those were point in time assessments, so the information and observations that were collected were one at the time that we were in person touring your site, you'll see details about some of the areas that we identified that may need correction. There might be pictures contained within the report. It will be a lot of narrative information about what some of those findings are. Again, remediation is that process where we can work with you all to correct any of those areas that were identified during the on-site, and then if you're setting was identified as the heightened scrutiny process, is really not going to look or feel necessarily any different to you. Every provider goes through the remediation process, high scrutiny just puts a little bit more bonus on the state to craft an argument to CMS on why your setting is or can become compliant with the final rule. Most of that argument again comes through the remediation process where we're working with you all to develop a remediation work plan and outlining specific tasks and activities that you're setting can undertake to make sure that you're correcting any of those areas identified during that on site process. Now that you've heard heightened scrutiny mentioned multiple times, these are the three prongs, so to speak. That will have a setting identified for the heightened scrutiny process. The first is for any setting that's located in a building that's also a publicly or privately operated facility that provides inpatient institutional treatment, so this is primarily if you're setting is located in a building that also has a hospital, a skilled nursing facility, an IMD or an institutional care facility for individuals with intellectual and developmental disabilities. The second prong is similar, so if

you were in a building that is located on the grounds of or immediately adjacent to a public institution. And then the third prong. It's a little bit trickier, which is what a lot of states and providers had questions about over the years is if you're setting has the effect of isolating individuals receiving Medicaid, home and community based services from the broader community of individuals not receiving Medicaid Home and Community Based Services. Again, I say the word unintentional, because most often you know, settings are not intentionally preventing individuals receiving each HCBS from integrating into the broader community. But by the way they deliver services or have some blanket restrictions in place they can inadvertently do so. That's a piece of the process that we're definitely here to address some questions on and help all of the settings understand and support how to correct some of those areas. I will go ahead and turn it over to Brittani and she's going to talk a little bit about the person center planning requirements in the final rule."

Brittani: "Great, thanks Amanda. Also contained within the training that was sent out on October 16th. Little more detail about the final rule and the requirements for person Centered Service plan before any individual can actually receive HCBS waiver services, they have to go and receive a person centered Service plan that has to be developed. That process also must be a person centered planning process. All of the requirements about that are outlined in that training again mentioned and sent out on October 16th, but I think of. Key importance for this piece is. That the planning process but the plan is developed at a time and location convenient to the person and that it includes people chosen by the person. Again, more details about that are in the training that we've mentioned, and then person centered planning doesn't just stop. Once that plan is developed. The plan has to be implemented and that should also be in person centered practices in ways. So that includes ongoing conversation or communication with the individual and any guardians or family or the case manager. What is working about services? What's not working? Providers should recognize what changes might be necessary supporting self-advocacy for that person. In regards to providers and their staffing ongoing training, guidance and support. It doesn't just stop with this training or one specific training that training needs to be on going, modeling that reassessment. Access to plan- staff should have access to those persons under plans to know what those persons needs are and how to best support them. And then providers would also have policies that reflect and support person centered practices".

Amanda: "Thanks, Brittani. I think one of our biggest finding from a lot of the on-site assessments that we have done. You know both in California and the other states that we've supported in this process. Often time we will see glimpses of person centered practices, but the key really it comes down to documentation, and again, you know within that training we talk about that modifications processed, but any type of restriction that's placed should be placed on an individualized basis. It should be based on an individualized need. And document in that person centered plan. I'll, also give a quick overview of the on site assessment process, so again, this is the reviews that we conducted back in 2019. Overall there were 301 providers accessed as part of this process, and those are those three setting types that we talked about at the very beginning. Each one of these settings were visited and completed. PCG staff completed a site assessment report that was sent over to the Department of Health Care Services for their review and approval as well. The quick break down at the bottom of location so the majority of the settings were located in Southern California. We had 35 in Northern

California and 20 in the San Francisco Bay Area. When you receive your site report along with your request to develop a remediation work plan. Each setting received an initial finding of compliance, so there were four different compliance categories that your site could have fell into, one being compliant which is already in full compliance with the final rule and there were no modifications needed. Two being needs modifications or remediation. So that means your setting can become compliant. We just need to do work on a couple areas or a few areas that are outlined in your report. And undertake some of those tasks. Maybe it's person center planning training for your staff. There's a variety of things, but"...

Brittani: "Amanda".

Amanda: "Yes..."

Brittani: "Before you continue. I don't know if you changed the slide on your screen".

Amanda: "Thanks. So yes, needs modification or remediation. Is that second category. The third category is being identified for heightened scrutiny. So again that means site would have fell into one of those three categories that are outlined in the final rule. I do want to reiterate that while the term heightened scrutiny sounds negative, again, it's actually a positive process where the state can say through remediation this site can or will become compliant with the final rule. It's just that additional designation that really puts a couple extra tasks on the state side. A couple extra questions that they have to address with CMS, but all providers can work through the remediation process with the goal of becoming compliant. The last category is not compliant, so this would be any setting that exhibit doesn't exhibit any of the characteristics of a Home and Community Based Setting. And can't overcome that presumption of being institutional, so these primarily are going to be any settings where they provide inpatient institutional care on site and can't make any modifications to the way that they deliver services to get out of that that institutional treatment. This is something that we will definitely touch on more as we continue through other trainings as well as have other opportunities for providers to work with us directly for some targeted training and technical assistance. Overall, we found just in the way that a lot of the settings operate. There were some systemic barriers to compliance, so these were really very common findings across the board. One being a lack of community integration and access, which we will touch on a little bit today, but again can easily work through the remediation process to help correct some of those concerns. Lack of true person centered planning and practices. Again a lot of what Brittani touched on and just really ensuring that this is an ongoing process. It's not just one training, it's not just one staff member that understands this process. You know, we've often found that the staff really do understand and know the individuals that they're supporting very well, but that doesn't always mean that it gets documented, and that documentation piece is really key. That helps mitigate some of those blanket restrictions so we know with these settings in particular. You all serve a lot of individuals that have been diagnosed with dementia, so we often see a lot of blanket restrictions in place. So people if they can have visitors they have to sign in or out. They can't have overnight visitors, so a lot of those things that aren't really based on an individualized need, but just more so convenient for staff or just managing the setting as a whole. A lot of blanket restrictions on access to food. Individuals engaging in just daily activities and chores like cleaning, laundry, cooking and meal planning. You know one thing that we want to discuss

and help providers understand. Obviously you all support these individuals on a daily basis, but understanding, that you know, dementia while it can be challenging. There are different ways to still provide individualized services and not restrict every individual based on maybe one person's diagnosis or one person exhibiting side effects of their diagnosis differently than other individuals. So making sure that we start to sort some of that stuff out on an individualized basis rather than no one having access to food or no one having the opportunity to engage in cooking their own meal or meal prep. The other thing that we saw a lot of was just the institutional appearance. While some settings are very small and service small number of individuals, others are significantly larger, serving over 100 individuals, which has the appearance of more like a skilled nursing facility or place that provides inpatient institutional treatment. We also saw the presence of medical staff and medical equipment. Locked gates and entries which we will definitely talk about. I know that's kind of been an area where we will get a lot of questions, so we want to provide some clarification there, but the key really being that, you know, if it's a homelike setting and there's a privacy fence that you know is very common in the neighborhood and everybody has those got in and of itself is not an issue, it's really what the gates of the entries are used for. So if they their sole function is to keep individuals. In the setting or individuals don't have the freedom to come and go from the setting as they choose. That's when we could potentially run into a compliance area issue. Also the same thing with the use of video surveillance you know can be a very common thing for individuals to have this in their own home where you know safety and security. They have video cameras in place, but if their purpose, again, is to monitor individual movement or restrict movement in certain areas, that's something that we need to dive a little bit deeper on. But this would all be if this was an issue or concern with your setting you would see that information contained within your site report. Similarly with heightened scrutiny, so of the settings that were identified for heightened scrutiny, most of them exhibited those institutional qualities that further isolated individuals from their broader community. So we saw some restricted access to the community based on a diagnosis. You know, it's very, very clear within the final rule and CMS has said over the last six years since this rule was released, that restrictions based on a medical diagnosis are not really appropriate. You know these are supposed to be home and community based settings. And those things need to really be managed on an individualized basis. We touched on the locks, and secured entries. Similar issue with alarm doors and windows. Again, understanding that individuals may have a diagnosis with a diagnosis of dementia, but not all individuals with dementia have wandering behaviors. So some of those place, some of those things in place that end up restricting everybody may not be appropriate for everybody that is served in the setting, but maybe you know just a few people. Lack of individualized schedules, so again, there's not a lot of choices for individuals to engage in activities of their choice, but rather what the group is doing. We'll talk a lot at various points in different trainings about through choice and so you know individual should just get to choose from A or B. They should understand what all of their options are and it's the same thing with developing their schedule. Similarly, restrictions on visitors and access to food and meal choice. All of those were really managed on a blanket basis and all have the effect of unintentionally isolating individuals from their communities. So if you're restricting visitors that come in, you're restricting their schedules to leave the setting, etc., those are all things that can potentially land you in that category of heightened scrutiny. I realize this was a lot of information thrown at you very quickly, but hopefully you all had read the email from the 16th and went ahead and went over the training so you had a little bit more detail on these areas. I

do want to go ahead and turn it over to Margot. We have a few questions that we prepared ahead and then we will open it up for some additional questions.

Margot: “Great thanks Amanda, Can you hear me?”

Amanda: “Yes”.

Margot: “OK, so first and foremost, what are the best practice strategies for maintaining a person centered approach through the pandemic?”

Cathy: “OK, and I'm going to, this is Cathy, I going to provide some examples and responses. No, I'm sorry Amanda, did I take your role here?”

Amanda: “No, you were on it. Thank you”.

Cathy: “Well, I think one of the most important things is really getting to know the person, and knowing what's important to them and while there have been restrictions that have been mandated where states have said "you know people cannot leave, visit settings or people can't leave the settings" Those kinds of things, it still doesn't mean you can't be person centered in that you can assist and support the person to be able to still maintain contact with others or maintained contact with the outside world, so a broader world then just what the setting that they're in, and it's really important to make sure that there are, while there could be blanket restrictions that come down from government, make sure that people understand what those are and why those are being applied to everyone in the setting. So there is a process that we can go over at some point where it talks about if there are restrictions, the requirements for making sure those are approved. But the worst thing is that a restriction is put in place, and people are not it’s not explained to them, and so it's not something that they are able to understand and work with. Great, thanks Cathy next question. If a person has been participating in the program or living in the home for a long time, how can we be sure that this is the setting they choose? OK, one of the things that's important is to make sure that the options are presented are provided to the individuals on a regular basis, and so you may not have been the staff person or people who were in place when the person came to the setting. They may have, or you may have come after them, and so it's important that you at least address this at least once a year at their person centered planning meeting so that people know what options are available to them and for them as far as where they can live, it's really important again to present those just fairly, you know, by asking questions of the person. Its part of that getting to know the person which is part of a person centered practice. You know, making sure that you understand what the person likes and dislikes, what are their goals and their values, and what they're looking for. And that can come up through this discussion of whether or not this is a setting that they chose. Or there's something that they would like that could be different, and so it's important to explain these things to people and make sure that they understand that there are options, or if there aren't options. Why aren't there options, but you know, none of us don't know what we don't know, so if something is not familiar to us and nobody ever asks us, it can feel very isolating and not very pleasant. If nobody really cares or wants to know how we're feeling about where we're living or what's going on in our life”.

Margot: “OK, great next question. If people choose to have services provided in the home rather than the community, is that an alignment with the final rule?”

Cathy: “Yes, so this question really, I think, has kind of two prongs and one is we know that things have been done differently during this pandemic and so that some of the services or supports a person might have gone or left the setting for they've not. That's has not been an option for us. You know, people haven't been able to go out and get haircuts to their salon of their choice, and so many of us have had to. Make do with either you know our own devices or if someone could come in, but it shouldn't be mandated that people receive, for example, that there is one hair salon it's on site and that's the one that everyone must use. If that's an option that's available for people, they should know it's an option. It's not the pre-selected requirement for them. There also may be reasons there are limits to why a person receives a certain type of service. On site, for example, we are familiar where in one situation there was a person who the dentist was coming in to clean their teeth and to do dental services, and it's because the dentist was something that was very traumatic for the person and it really caused anxieties, anxiety and lots of other problems and so. Excuse me, the program had arranged for a dentist and a dental assistant to come onsite to address this issue, but they were also working on a process to desensitize the person. So maybe the next time they went to the dental office and they, you know got some X Rays or they sat in the chair for a while. So there should be a plan to try to get the person to get the service where most people would normally receive that services and that you know the dentist is just an example, but that can fall into under many, many categories. Thanks Margot.

Margot: “Totally, OK, another one. How do we balance the requirements of the final rule with health and safety concerns?”

Cathy: “Well CMS does afford some of the state’s flexibility and addressing individual needs regarding health and safety. And we also know that again health and safety, especially at a time like the present is really been paramount in something that we have made a lot of focus on because we want to make sure people's basic needs of health and safety are met. But it is important that. There be still person centeredness and person centered. Planning at the heart of that and it is at the heart of the home and community based rule. It's foundational for any of the supports and services and interventions, and so while you're assuring a person's health and safety net goes back to the information I talked about in the beginning, make sure the person understands why certain activities or actions are not safe. For them are not in the best interest of the their health and make sure that people are able to make an informed choice if you will, so they know that if I go out and let's just say that you didn't have. If you don't have a mask, mandate. So if I go out and I don't wear a mask, I am taking a risk of not only my health but the health of others is. If there is a mask, mandate. If that's required, you can explain to them. What kinds of negative ramifications? That could mean people might not want to help them if they were out in the community or with the ramifications in some instances. You know they can be given a citation or the police officer might come up and speak to them, which could be disconcerting about to remind them that they need to have a mask, so there needs to be a balance between health and safety. And you should also discuss those issues at a person's person centered planning meeting. And for example, if a person, if it were not talking pandemic time. But if a person is a diabetic and they need to watch their diet but they have something

that they really prefer, you know they really would eat chocolate with every meal, and as every snack that they could have. And some of us would definitely choose that understandable. But work with the person and help them understand. Why doing that is going to have all kinds of serious implications for them, and so it's not that you're being mean or that you just don't want them to have it, but it has serious implications and really make sure you talk about those in a way that the person understands. So that means that you would provide them training and education, whatever's necessary, and it might be that you sit down and brainstorm with the person about how you can resolve or work to a happy compromise on what is good for them as well as important to them, so it's kind of that important to and important for it's important for all of us to be safe and careful or careful during the pandemic. But it's also important for all of us or to all of us that we maintain some kind of social contacts and we also have somebody we can talk to about that frustration that we might be feeling because we don't have the same kind of contacts that we would normally. So you know, work toward getting to know the individual one on one. That's something that happens overtime. You can do a formal assessment, get to know a person, but it also is going to come through regular conversation with them about their interests. And do they have children? Do they have grandchildren, nieces, nephews? Do they like to garden? Do they like Flowers? What kinds of things do they like to do? When do they like alone time? How do they express themselves when they're happy or sad? Those kinds of things so that you can understand what they're telling you, either verbally or nonverbally, throughout this entire process".

Amanda: "Thanks, Cathy. Margot will check and see if we got any questions in the Q&A".

Margot: "We haven't received any questions in the Q&A and we don't have any in the form either at this time. OK, I will go ahead and pause for a few minutes. You could use the raise your hand function or you can submit a question through the Q and A piece, but I will take a few minutes and pause and see if anybody has any questions on any of the content that we've covered so far…Let's see, it looks like George Cutter has a question George. I'm going to go ahead and unmute you. OK you're unmuted now.
We can hear you".

George Cutter (Stakeholder): "Hi can you hear me?"

Margot: "Yep".

George: "OK, great! A couple questions… it doesn't look like there's a lot of other attendees, so if I may, one of the questions I have is about the perimeter or the issue of alarms, so I thought that's one of the kind of items for potential heightened scrutiny. So there are yet these, especially smaller settings, some that may have alarms on their front doors or their perimeter gates, for example, that are used to alert staff about residents who may wander out. I'd like to distinguish that from delayed egress, where someone tries to get out and the doors actually locked for a certain number of seconds. So I'm strictly talking about just audio alarmed doors, whether it be the front door, the perimeter gate. These are pretty common and they're becoming more common, so I just want to make sure that those are going to be OK, because the alternative is wearable devices that are specific to only residents that exhibits symptoms of wandering. However, the challenge with wearable devices is that generally you need a

conservator to be able to consent to that and most residents with the diagnosis of dementia who exhibit wandering don't necessarily have a conservator. A court appointed conservator, and that's a costly legal process. So I want to make sure that there's a way for communities that have alarmed front doors and perimeter gates or side doors. That they're able to be in compliance with the final rule, so that's my first question, if there's any guidance or initial response that you can provide to that?"

Amanda: "Yes, so I'll go ahead and start briefly and then turn it over to Cathy. I will just preface this by saying that CMS has released several years ago, but this question came up quite a bit you know, I think this final rule in general has been a little bit more complicated for settings that serve individuals that are aging. So especially, you know a lot of that population does have dementia, so CMS received a lot of questions initially on things like this and they release some guidance on specifically addressing individuals that exhibit wandering behaviors. That's all in the context of the final rule, so that's something that we can we can send around. We can send you directly. It really comes down still to person centered planning and a lot of the things that we talked about. And really the key is training and education. So how well do individuals understand why this is in place, what it used for, you know? And if let's say you have an individual that doesn't exhibit wondering behaviors. Are they still permitted to go into the community or to leave the setting, even if that alarm sounds? It's really looked at on, a setting by setting basis, so when you receive your site report, you can see if that's something that we flagged and if we did, then that's something that we can work with you directly on through remediation. And Cathy, I don't know what you want to add to that?"

Cathy: "I concur with your response, Amanda. I mean, I think it is, as you said, it needs to be noted in. Each person's person centered plan that, that restriction is being used, but you also, can indicate you know. At least that there was an attempt to explain and to achieve understanding of what was going on. And important for the person who doesn't exhibit the wandering behavior but is living in the home where the monitoring is in place, so that they know can leave. And is not necessarily. I'm going to ask permission, but I'm telling you that I'm going to leave now so the alarm may sound. You don't have to chase after me so that they know how that's how to get out, if they want to leave. If that's their choice, and if they're not somebody who has to be monitored because of the wandering behavior. So I think that those two things are important. Make sure it's personalized to each person in the setting".

George: "Thank you, that's very helpful. Another question, if I may, I saw something about video monitoring, so if there's indoor video monitoring strictly in common area, as long as if that's explained to residents and then there's a policy on what that monitoring is used for and there's an actual consent on file, I'm assuming that's going to be OK, but could you provide some clarification on video monitoring? Indoors and common areas".

Amanda: "Yeah, I think it's pretty similar to the first question, I think, where some of the primary concern comes with the video surveillance internal to the setting is that it brings on that institutional appearing. So that's something you're going to see in, say, a skilled nursing facility where it's designed to control movement. So again, we'll look at that on kind of a setting by step basis, making sure that their staff training individuals are educated and supported. Really

back to person centered planning. You're going hear that a lot. I don't know. Cathy if there's any other fine points on that. We do get that question a lot, so again, another good question".

Cathy: "Right, I think that you covered the important points about making sure that there is at least an explanation, an education about the common areas, why it's used in those common areas, and what its use is limited to. If people sign a consent to that upon admission, it's probably something that is important to revisit at least once a year so that it's not a forever kind of thing because people. Could forget about it. Or they could have different questions about it, but they may not ask them until it's brought up again. So those kinds of things in, as Amanda said, it really goes back to the person centered planning and then it's a whole different situation. If you are doing it in individual rooms and that's a whole different conversation.

Amanda: " Yeah, I think you know what we've seen with that before is you know you might have a setting that kind of hides that surveillance piece somewhere deep in their residential agreement. Don't really stop and explain that piece to individuals when they are, you know, moving into the setting. As Cathy mentioned, it's really part of that ongoing conversation too. So as long as you're having that conversation with individuals, they understand the functions and they are consenting, then that can be addressed".

George: "Thank you, that is also very helpful. My final question is about more on the kind of the physical settings and kind of the future of where some design and development is headed in terms of providing care for older adults and how that might relate to the heightened scrutiny criteria. So one of the things that kind of gaining traction nationally is this concept of Pocket neighborhoods, and so imagine you have a site piece of land that developed as a series of a pocket neighborhood that has clusters of homes that are licensed residential care settings, taking care of HCBS beneficiaries and within that also does master community. Imagine you have...it's kind of like the neighborhood, but it's also like a care campus. And imagine you have a skilled nursing facility within the neighborhood. And maybe another type of medical setting such as maybe inpatient Hospice care? How does, can all of that be reconciled within the final rule? Or what are the challenges that you see because integrated care is something that's already happening and people are getting creative and how to develop these kind of purpose built neighborhoods? And it's going to be something more of the future, but how does it, how can it reconcile with the final Rule guidelines?"

Amanda: "Cathy, do you want to start or do you want me to?"

Cathy: "I'll take a stab at this one. I think it's like, I think it's a challenge and I think that it's like many of these issues that Devil is in the detail and so it would really. I understand exactly why you've talked about it. And of course it sounds like it makes a lot of sense and it could. Execution is really where the difference comes because if it serves the purpose to restrict people or to confine people to a certain area of a community where they can live and what they can do. Then it becomes, you know, you become skeptical of it or you start to question it. I think that the issue again goes to a person's education and knowledge about the setting about the environment that they are moving to their understanding of that and in that person centered planning so that it is something that the person. Is consenting to, if they are not able to consent that then there is a legal representative, whether it's a Guardian or a power of attorney or a

conservator or something like that that can help them in making those decisions. But I think that the import. Another important aspect is always making sure that those kinds of settings aren't for the convenience of the provider and the providers staff, but they are in fact meeting real needs for the people who are being supported. So that's my preachy little comment on it".

Amanda: "I'm going to back that up because I think I'm going to expand on that too. So I think you know as Cathy mentioned. It's definitely complicated. It can happen. We've done this type of work and numerous other States and one in particular. For the last two decades by state statute, their programs were set up so all of their adult day health programs were statutory required to be co-located with a skilled nursing facility. Some of the key things come into the separation of staff and individuals in those settings, so you know you could run a home in Community based setting on the same property as a setting that provides inpatient institutional treatment, but you have to think through those things about making sure you're not sharing staff that individuals have opportunities to engage in the community, and they're not just engaging with individuals in the skilled nursing facility. You know we would see sometimes where the nursing facility would have. Activities like bingo at 3:00 o'clock, and everybody in both settings has to participate. So CMS is really going to look for, and the state is going to look for that separation. And between the administrative, the financial, a lot of those operations staff should be trained separately and understanding that you know your HCBS setting should be the home and community based setting. It's not an institution, so they really have to be functionally separate and treated differently. I think the other, potentially complicating factor with campus like settings originally when CMS released this rule, they specifically identified campus like settings as heightened scrutiny. So they called out several types of settings, in particular. Initially CMS scaled back from that, but still recognizes some of those complicating factors, one of which is the appearance to the community. So does that router community. Look at that campus and say, Oh well, that's where all the people with dementia live, or that for all the individuals that are developmentally delayed live and it kind of becomes an area that the broader community doesn't interact with or engage with because it's seen is more of like an institution or separate from the rest of the community".

George: "RIGHT. So it's that public perception to be mindful of as well. So if non HCBS folks from the broader community came into the campus to use the skilled nursing facility or they came in from the broader community to use the Adult day Health care center that on the same campus, I'm assuming that would be viewed positively from a from the scrutiny standpoint because it's not just the people living in the HCBS settings in the neighborhood or campus. But actually broader people from the broader community are also utilizing services that are offered on the campus. I'm assuming that would be viewed positively is that would that be fair?

Amanda: "That's always helpful. I mean, I think it's critical to make sure that there is that balance. You know, you find a strike that balance between the fact that people could certainly defend this type of setting by saying, you know we're making sure people are healthy and safe, and this is a better environment because they can, you know, age in place so they can easily access the supports and services, but it's that balance of that important for and important to, so you can be healthy and safe, but you can be very unhappy, which can lead to other kinds of behaviors and depression and things like that for people. And so it is really keeping up perspective to make sure, just metaphorically, that the gates are open, that they're not closed.

It's not a lock down, it's not a very separate kind of thing that becomes stigmatizing. Yeah, and I think you know it's broader than just receiving services. You know some of those other non-paid support. So are there volunteers that are welcome from the community, that come in and maybe teach classes or do different things with all of the individuals in the settings. You know, what that type of involvement looks like with integration rather than just different people receiving services".

George: "Great, well that response and all of those responses were very helpful and that was going to be my last question, but speaking of the gates, the issue of gates, one thing that came to mind, is it acceptable if the community? Has a gate for vehicular access, but it has basically a pedestrian access gate, where it's not locked is that. Would that be OK for an older adult community? Or our gate for vehicular access frowned upon?"

Amanda: "No, I mean, I think generally those should be fine. You know, we've seen a lot of different settings. You know, I've been to one in particular in a different state where they had a large concrete barrier in the back of a setting, but it wasn't there for controlling movement, it was there for safety concerns, because behind that concrete wall was a giant drop off. That was a safety concern for anybody, so anybody could have tripped and fell and been injured. So it's kind of the same thing with vehicular access, you know controlling where and how vehicles come and go, that that's generally not a problem, especially if there's other gated access for individuals to come and go, and it's not locked and they can make that choice freely".

George: "Got it OK. Thank you so much. Appreciate it, very helpful".

Amanda: "Thank you, good questions. Thanks".

Margot: "Amanda, we have a few questions in the chat and the Q&A, one when will the CLHF's receive the reports or get feedback from site visits?"

Amanda: "Good question. So we're going to cover that quickly in the next steps, but we are releasing the site reports within the next couple of weeks. I think November 13th is the date that we have outlined, so you will receive an email from PCG and that will include your site report as well as your request to develop a remediation work plan.

Margot: "Next, can an individual be enrolled in both DD waiver and HCBA waiver concurrently? The waiver agency PICF informed me that the individual may only be enrolled in one waiver".

Amanda: "I will defer to Joseph or someone from DHCS to address that question. I don't know if you wanted and I yeah I can go ahead and take that question so. This individual is referring to Partners in Care Foundation Waiver Agency. Is one of our waiver agencies under the home and community based alternatives waiver and so that would be the waiver agency responsible for working in that waiver. The Congregate Living Health Facility or CLHF provider to have services authorized for that, that person plan of treatment under the HCBA waiver. So yes, in California because there is a pretty significant overlap across waivers in the services that are available in each waiver, especially given that each primary component of each waiver is the

conference of Case Management components. We do not allow concurrent enrollments in multiple 1915 C waivers. Individuals enrolled in the DD waiver would be able to receive a majority of services necessary through that waiver if for whatever reason, it was determined that because of the acuity level of their needs it would be more appropriate to receive services through you know, the more intensive nursing services available through the HCBA waiver. Then they can be disenrolled from the DD waiver and enrolled in HCBA waiver. One more thing I want to point out there is that for the purposes of individuals transferring from one waiver to another. So say disenrolling from the DD waiver to enroll in the HCBA waiver. We do consider that a priority enrollment population, so when referred to the Agency they would not go on the wait list. They would quickly be enrolled".

Margot: "Thank you. Another question received is will we receive a template for person centered care or is the person centered planning incorporated into our general plan of care".

Amanda: "So we do not provide the template. I do not believe, but Joseph, I'll defer to you and DHCS, if you have a template or anything that they require. I would just say generally you know a person centered plan. Isn't typically a template form, you know, because it's such an individualized process and you want to make sure you know, there's a list of things you definitely want to capture, like an individual's interests and goals, and things like that a person sends complaint is definitely much more broad than just their medical needs. It should also have those those social needs as well. But again, Joseph i'll defer to you it if there's a specific form that DHCS prefers that settings use.

Joseph: "Thank you, Amanda, and no there's not a specific template for person centered planning, as you were saying. The person centered care planning approach is really more built into how you're working to complete that care plan, and it varies by waiver as well. So with the Assisted Living Waiver. This is where speaks to the interaction between the actual Assisted Living providers, RCFE and ARF providers with Care Coordination Agencies under the waiver, the Care Coordination Agencies are responsible for putting together care plans for the individuals and those should include input from the assisted living provider, but also fully aware that in many cases, typically the assisted living provider also has its own care plan that it utilizes for identifying the care needs of each individual participant, and that should align with The care plan that's constructed with the Care Coordination Agency and really again, be speaking to the individual. Participant residence needs versus a less person centered, more general approach, right? So we're really looking at that content of how the care plan is addressing each person's needs should be individualized to speak to that person specifically".

Brittani: "And Amanda, Joseph, can I just add a couple of things really quickly?"

Amanda: "Perfect, Brittani".

Brittani: "Thank you and Joseph was getting there with what he was saying as well. But that person centered plan or person centered service plan whatever terms might be used within your state or agency really starts at that case management, development level or service coordinator, resource coordinator every state and I think every waiver probably uses a different term but they are really the ones who start building that Person Centered Service plan with the

individual and that is the plan that's identifying the needs and what services are being authorized to address those needs. What that individuals goals are, what risks there might be and how those risks are going to be mitigated with their backup or contingency plans are if they are unable to receive services. That information then gets shared with those provider agencies who are responsible for helping to implement that plan. And then if there are other plans that are maybe used within that provider agency to address the actual services and how those are being delivered, information from that person center plan I think can absolutely be incorporated into that and should be. But that plan was really getting developed between the case manager, the individual and then anyone else chosen by that individual, which may include providers. But it starts at that piece and then is, you know, shared with everyone else is responsible for implementing it and then being able to incorporate that into whatever else you might have within your own agency. Yeah, and I would just reinforce what Brittani said right at the end. That plan is shared with everyone who's involved in the supports and services and in the person's life. So it's really important that that just doesn't become something that the case management agency or whomever is keeping, but that impact the people who are doing direct support and are involved in the person's life are aware of that and are part of that process to the extent possible".

Margot: [Inaudible talking]

Amanda: "Margot, I think you're talking, but you might be muted".

Margot: "Sorry, I had muted my ear piece, phone, and computer. Sorry about that. That's all the questions in the chat, but just a couple of questions in the Q&A. Do we have to have a sign in sheet or not? It looks like because the state of California wants us to have a sign in or out sheet for everyone as far as I know.
Amanda: "I'll let Joseph speak to whether that's a California requirement. I would say generally with the HCBS final rule sign in and out sheets are they have that appearance again of being an institutional setting, you know visitors and individuals should be free to come and go as they choose, unless there is a documented modification that again has been identified as part of an individualized need and documented in their person centered plan. I don't know Joseph if you have anything specifically from a DHCS standpoint to add to that".

Joseph: "No, I think there we would just work with providers to identify that concerns is specifically tying back to any specific Licensing requirement, because all of these facilities these provider types that that this is training is geared towards and that we visited each as part of this process are either Assisted Living Facilities licensed through the Department of Social Services, or Congregate Living Health Facilities License through California Department of Public Health. So in that instance that's where their specific concerns are then we can work with you to identify you know, that requirement and work with our partners in one of those licensing entities to again, talk about what our potential solutions are for addressing that. Thank you".

Margot: "Great, I believe that is everything. Let me just do one last check. George, I see that your hand is raised, but is that from before? Do you have a question? I unmuted you so you

can respond. George, do you have a question or is your hand raised from before? From before? OK, thanks George. Great, and I think that's everything I have".

Joseph: "Amanda. Quick question. This is Joseph again I see also displayed under George's name was a Samuel Tet, was there question from him as well or?"

Margot: "Yes, those were from the Q&A. Those were about the sign in sheets. Yep, thank you. OK, so great. So next. What are the next steps in this process for assessing compliance with the HCBS Final rule?"

Amanda: "Alright, so this is where the good information comes out, so you're going to, you'll see a letter from DHCS coming out that's going to advise you of what those next steps are. You'll also see the same information coming from PCG. I mentioned earlier you will be receiving your site report, and a request to complete a remediation work plan so you'll when we send out that notification with the report and the work plan, it is also going to have an instructional tool along with it so you can watch video and it will walk you through all of the steps on how to complete that remediation work plan. You will have 45 days to complete that work-plan. During that 45 days PCG and DHCS will be here to help provide support for completing those work plans. You'll see within your site report and your workplan, you'll get the name and information, contact information of the PCG staff member that will be your primary point of contact for your technical assistance. So we will be here again to address any questions that you have. If you don't understand the work plan or you have trouble developing, maybe some tasks or activities that you think can help remediate any of those areas that were identified in your site report. Just reach out and we can help walk you through that process. The goal at the end of that 45 days is to have an approved remediation plan. Once we have approved your plan, then you put that plan in action, so that's when you start taking on all the steps that you identified in your work plan. Whether it's staff training, whether it's Changing the way that certain services are delivered, providing additional access to community, whatever some of the steps are, start putting that plan into action, there will be future trainings we will be releasing information specifically from this training. There's been some really good questions that were asked so we will produce a document to help walk you through some of those things, but that is the immediate next steps that you'll see. And this is just another quick touch on remediation. And what those steps look like. So again, you'll get that site report with the compliance determination. You'll complete your work plan PCG and the state will review and approve that work plan and there will still be some ongoing technical assistance for values. We've talked about this a few times, but here are, this is a hyper link we can send this power point out to everybody that attended, but this is a lot of that key information that we've talked about today and that we talked about on the training that was set on the 16th. So CMS is obviously the primary resource for the final rule itself. If you ever find yourself with a lot of time and want to read 100 pages of the federal Regulation, you can always go to that first website and find that there. I will say the preamble to the final rule is extremely helpful. There's a lot of question and answers in there, from CMS when they were developing rules so, quick history, CMS spent about an entire decade working on this final rule from when it was first released in its proposed form to when it was finalized. So within that time there was a lot of feedback and questions that came from advocacy groups that came from states that came from provider organizations, etc. So there is that Q&A can be really helpful in understanding

the context and why the rule is structured the way that it is. The heightened scrutiny guidance can be found in the second link, California statewide transition plan, so this is the full document that outlines all of the steps that California has taken to assess its own system. So those policies, rules, procedures, etc. And then, it is a living document at this point, and is currently being updated to account for some of those systemic assessment, so the the site assessments that we've conducted being onsite, how the remediation process is going to go, etc. The 4th Link is a hyper link to the extension that CMS released the past July, extending the deadline until 2023 and then that last link is what we sent out on October 16th, which is a link to the final rule overview training. I definitely want to reiterate that we are always here as a resource. We appreciate you all attending today and asking questions. Very good questions that hopefully help provide some additional context to the final rule and the expectation of this process. This training was recorded so it will be posted for future reference as well. I also want to make sure I send it over to Joseph to see if DHCS has any closing comments".

Joseph: "Thank you, Amanda. No, again appreciate the opportunity to meet with you all today. We will, as Amanda said, be following with sending out the site reports. In the near future and then also following up with information around additional training information, and opportunities, so be on the lookout for additional information coming out from us and we look forward to working with this process. Thank you".