DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

Permanent Supportive Housing Providers Training

Mission Statement

The Office of Aging and Adult Services (OAAS) aims to develop, provide and enhance services that offer meaningful choices for people in need of long-term care.

The office is committed to developing a long-term care system that provides choice, ensures quality, meets the needs of consumers and caregivers, and does so in a fiscally responsible manner.

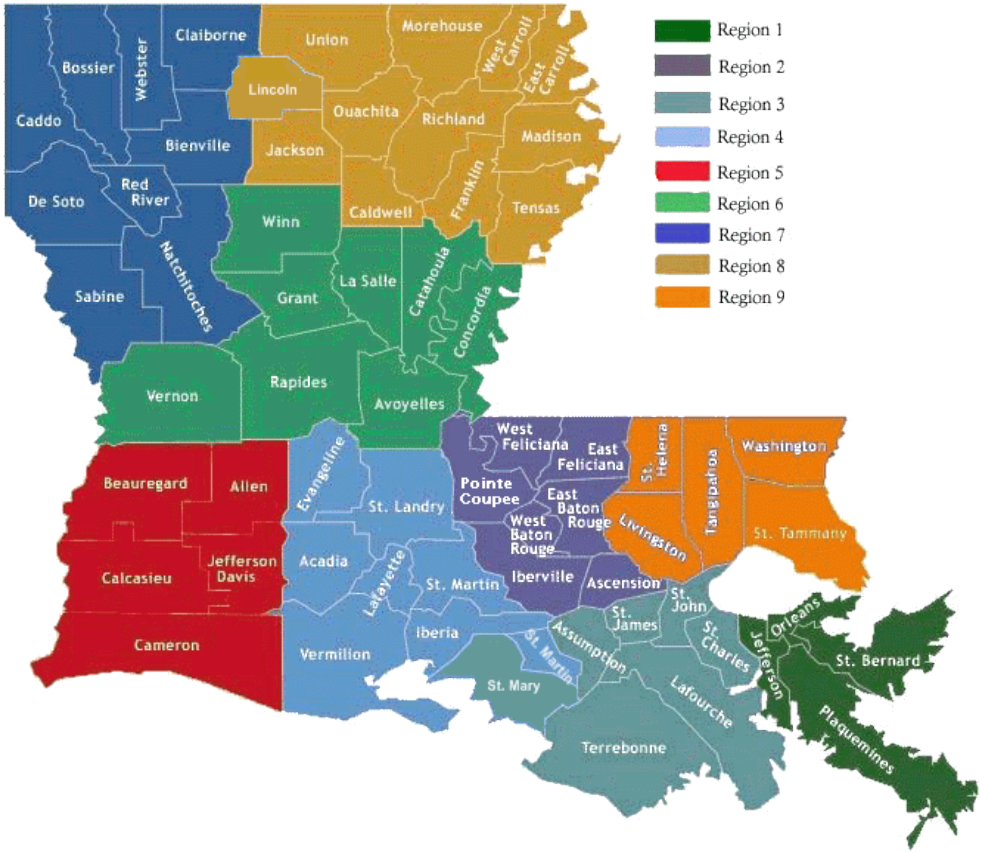
OAAS

- About Us
  - Agency within Department of Health and Hospitals (DHH)
  - Serves senior citizens and people with adult-onset disabilities
  - Provides Home and Community Based Services (HCBS) to those eligible.
  - Includes Nursing Facilities, Waiver Services, and Long Term Personal Care Services(LT-PCS).

OAAS vs. OCDD

- OAAS
  - Serves people 21/22 years old and older that meet NF LOC
  - Provides these Medicaid Home and Community Based Services
    - Community Choices Waiver (CCW) (21 yrs. or older)
    - Adult Day Health Care Waiver (ADHC) (22 yrs. or older)
    - Nursing Facility Services
    - PACE (55 yrs. or older)
    - LT-PCS (21yrs. or older)
  - 9 Regional Office Locations
- OCDD
  - Serves people from birth to end of life that have a disability that manifest prior to age 22 meeting the Louisiana legal specifications for developmental disability.
  - Provides these Medicaid Home and Community Based Services
    - New Opportunities Wavier
    - Children 's Choice Waiver
    - Supports Waiver
    - Residential Options Waiver
  - 10 Regional Office Locations

OAAS Regional Offices



- Contact address and phone number
- http://new.dhh.louisiana.gov/index.cfm/directory/category/141

What is CCW?

- Federally authorized 1915c waiver for HCBS.
- Comes with certain special federal requirements that must be met.
- Provides services in the home and in the community to elders or adults with disabilities who qualify.
- This program does not, by itself or in combination with other OAAS programs, provide supports 24 hours a day.

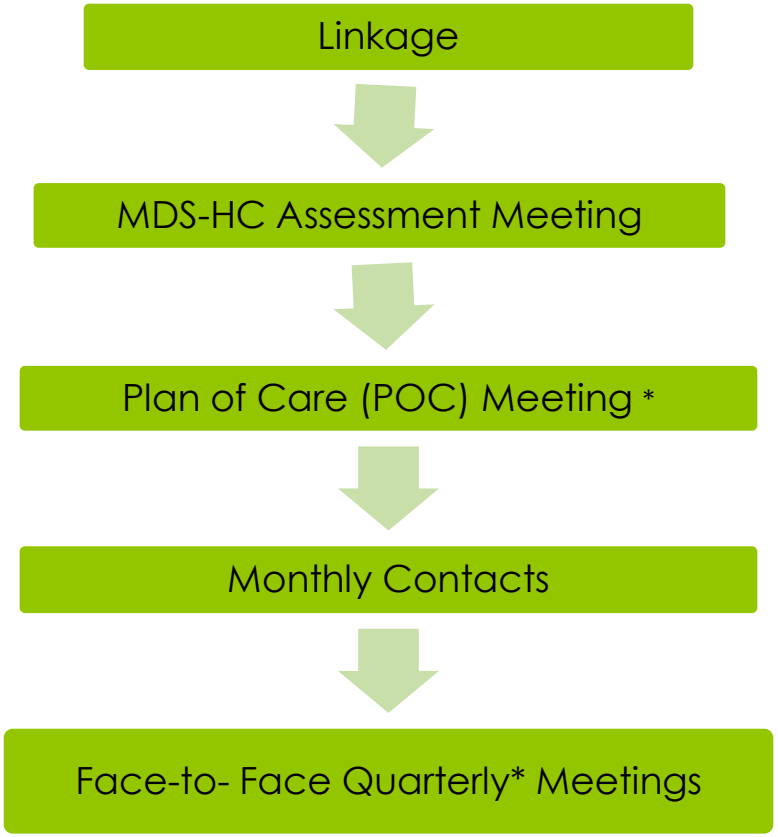
CCW Services

- Support Coordination (SC)
- Transition Intensive Support Coordination(TISC)
- Transition Service
- Environmental Accessibility Adaptations(EAA)
- Home Delivered Meals
- Personal Emergency Response System (PERS)
- Adult Day Health Care (ADHC)
- Personal Assistance Service (PAS)
- Nursing Services
- Skilled Maintenance Therapies
- Assistive Technology

Federal Requirement: Support Coordination

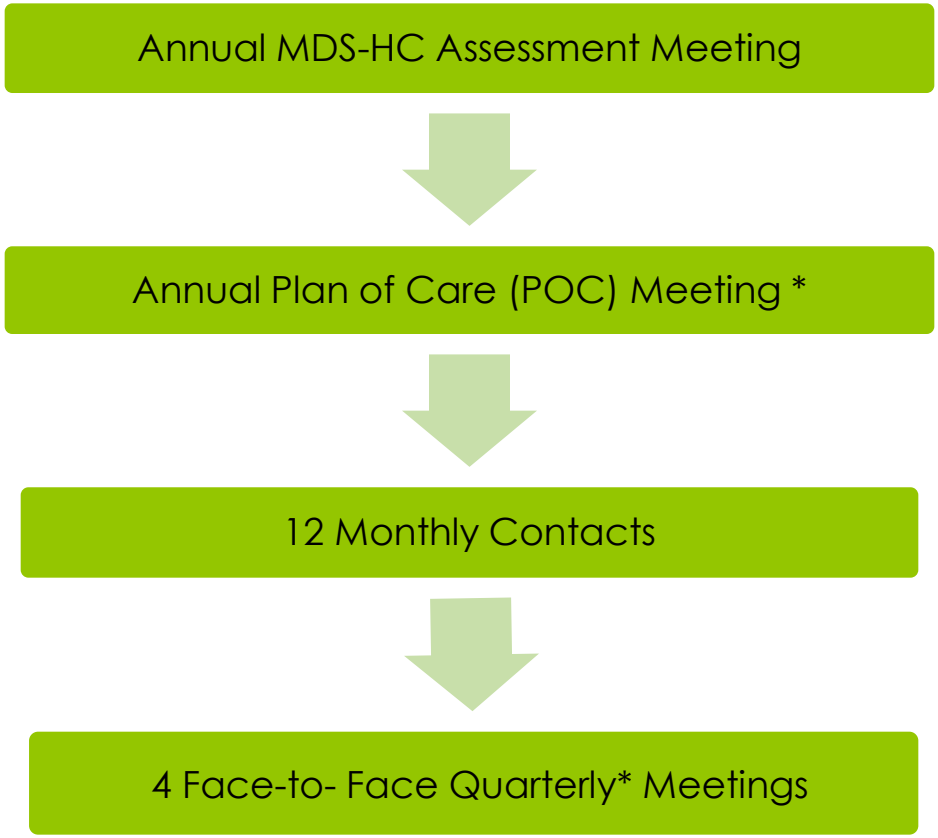
- Sometimes referred to as "case management"
- Service is mandated for all waiver participants.
- Completes initially/annually MDS-HC Assessment and Plan of Care
- Conducts quarterly face-to-face meetings and monthly phone calls.
- Ensures health, welfare and participant's needs are being addressed.
- Eyes and ears to the waiver participants.

Initial to Waiver Process Overview



* PSH Providers encourage attend POC and Quarterly Meetings.

Waiver Process Overview



* PSH Providers encourage attend POC and Quarterly Meetings.

MDS-HC Assessment Tool

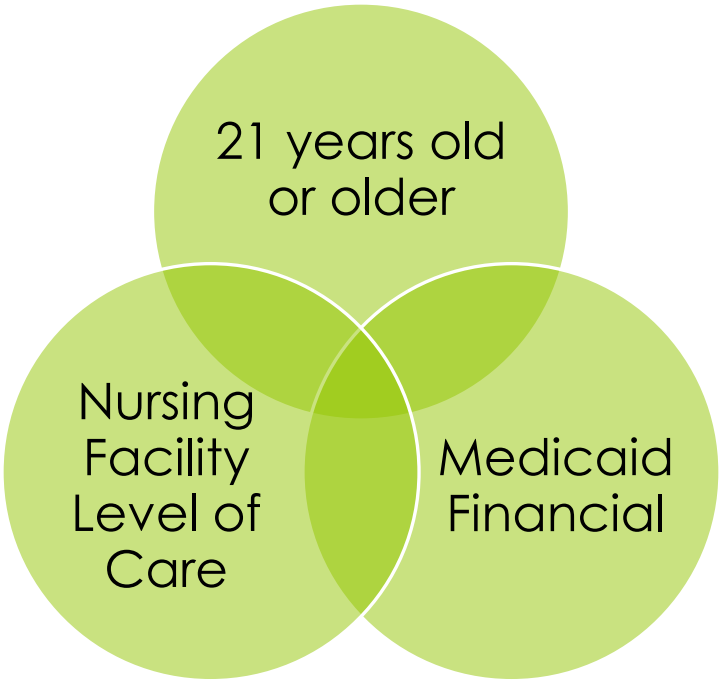
- MDS-HC Assessment Tool provides:
  - Comprehensive Assessment
  - Program Eligibility
  - Acuity based score that determines budget amount

- PSH Provider will continue completing the Housing Needs Assessment
  - SC will need to know the outcome of the assessment to assist and address the needs in the Plan of Care (POC).

Plan of Care

- Plan of Care address PSH services in the Intervention Section that will be provided to the participant.
- Flexible Schedule will have monthly units and the months being delivered.
  - PSH provider agrees orally or by signing POC that they will provide service
- Budget
  - SC responsible for accuracy and does not exceed individual's budget amount

Eligibility to CCW



- Participant must meet all 3 requirements in order to receive CCW services.
- Eligibility determined initially and annually by Support Coordinators using MDS-HC assessment.

Federal Requirement: Freedom of Choice

- Participants have the right to choose their provider of services
- Participants have the right to change providers

Federal Requirement: Participant Rights and Responsibilities

- Home Community Based Services Rights and Responsibilities OAAS-RF-10-005 issued 9/5/13
- Given initially and annually to CCW participants
- Includes how to:
  - Report abuse and neglect
  - Report Critical Incidents
  - File complaints, grievances, and appeals
  - Inform SC/Providers medical, health, supports, address, and phone number changes

http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1429

Federal Requirement:
Ensuring Health and Safety

- State must "assure" to the federal government that waiver recipients will be safe in the community.
- Individuals must sometimes be discharged from CCW because their safety cannot be assured.
- This often happens due to decline in physical, cognitive, or mental health; &/or if person is non-compliant with plan of care, treatments, etc.

Waiver Discharge

- What happens when a participant is in jeopardy of not meeting Health and Welfare?
  - SC, PSH provider, and other members of individual's team need to work together to resolve the risk
  - If additional assistance is needed, include RO
  - RO may refer to Service Review Panel (SRP) at State Office
  - No one is discharged for H&W without SRP review
- If participant does not meet LOC:
  - SC will discuss with Regional Office (RO) possible closure

Note: Participant may lose waiver but <u>not</u> PSH unit.

Health and Welfare (cont.)

- Get to know your participants and their environment/Build rapport
- Identify and document risks
- Maintain regular communication; detect early warning signs
- Reinforce the right to be safe and how to report abuse
- Help implement strategies for addressing and monitoring situations that arise
- Contribute to quality improvement

Frequently Asked Questions

- www.oaas.dhh.louisiana.gov

- Click on Resources
- Click on Provider resources located below Publications, Manuals, Forms and Reports.

Role of PSH Providers, Transition Coordinators and Support Coordinators

Support Coordination

- Called "case management" by CMS
- Coordinate waiver and non-waiver services
- Facilitate services
- Do not duplicate services

Transition Coordinators

- One Transition Coordinator(TC) per region
- Only the TCs in Region 1, 2, 3 4, 5 and 9 work with PSH Providers.
- TC supports are only for 365 days from actual transition date.
- TC work from home

Team Approach

- Teams are comprised of participant, PSH providers, SC, TC and natural supports.
  - In some cases other types of CCW providers.
- Common goal is to assist and support participants to remain in their home.
- Communicate with each other to ensure transition or remain in the home.
- Team meets at Plan of Care (POC)meeting
  - Discuss roles and interventions to include in POC
- Invite the team to quarterly meetings

Discussion