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September 21, 2017

TO: Deborah Morales  
FROM: Bill Flynn, Executive Director  
Maureen Maignet, Policy Consultant  
RE: Comments on Specialized LTSS AE Quality Methodology

Thank you for the opportunity to comment on the proposed Specialized LTSS AE Quality Methodology/Preliminary Measures Slate. The Specialized LTSS AE model is a complicated one and it is not clear to see how consumers will directly benefit from it, especially those who are already receiving LTSS and participate in the MMP program with NHPRI with its emphasis on care management and care coordination and attention to social issues. While developing Specialized LTSS AE's may possibly lead to greater use of home and community service alternatives to nursing homes (rebalancing), there have been many recommendations made in the past to accelerate such rebalancing that have yet to be implemented that could accomplish the same goal with far less need for the costly infrastructure requirements required in the proposal. This includes approved but yet to be implemented elements of the Global Waiver/1115 extension (limited LTSS expedited eligibility, increases in monthly maintenance allowance for persons in home and community care and expansion of the DEA co-pay program to name a few) and recommendations made by the Long Term Care group for Reinventing Medicaid, the Lewin Report on Rebalancing Strategies commissioned by EOHHS in 2016 and components of the Healthy Aging Initiative.

There are several things to applaud in the proposed model – attention to social determinants of health, inclusion of caregiver input and need for support in care planning, requirement for a Geriatrician to be on the Governing Board (We would propose this could also be a certified geriatric nurse specialist) and consumer representation in Governance. Some of these could be accomplished absent a Specialized LTSS AE, but through Medicaid certification standards or MCO requirements for non-skilled home care entities.

We have a concern with the premise that the Specialized LTSS AE's can accomplish improvements in such areas as reductions in ED visits and 30-day hospital readmissions. While the certification standards require Integrated Care Management how this will be accomplished and by whom is somewhat vague. Nurse case management would be a critical service to quickly assess changes in a person's condition and need for intervention but is not in the list of mandatory services in Attachment B although nursing assessment does appear in the Provider Reference Manual for Home and Community Based Services (Version 1.5; July 2017.) Also, Section 6.2.3 of the Certification Standards states the Care Management Team have *“Well defined set of providers – can vary, but in all cases, must represent LTSS caregivers. Should also include PCPs, behavioral health, and expertise in social determinants (e.g., Community Health Worker,*

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*Social Worker) as needed.*” These services are not in the TCOC calculation and it is not clear how these services would be authorized or how payment would be made.

In reviewing the Preliminary Measures Slate, we offer the following comments.

Measure #2. Falls with Major Injury. % of attributed population experiencing one or more falls with major injury

Comment. This seems to be 20% of the total score. It would be advisable to have a measure geared toward fall prevention as opposed to waiting for a fall with injury to occur. Such a measure would include % of persons who had a fall risk assessment (there are many validated ones available) and appropriate follow up when indicated (PT evaluation, home safety modifications, referral to balance class, etc.).

Measure #5. Rate of emergency department visits among attributed population.

Comment. The service package (Attachment B) does not include services that would address urgent needs (i.e. home visit by nurse or NP) that could avoid ER visits if person assessed and attended to promptly. Nor does it seem to include nurse case management/supervision services that could be used to address emergent issues by close collaboration with a client/person's primary medical provider. Absent these it is difficult to assume that the LTSS AE could effectively reduce ER visits.

Measure #6. 30-Day All-Cause Readmission

Comments on Measure #5 also apply to this measure

Measure #7. Social Determinants of Health Screening. % of attributed population screened as defined per the SDOH elements in the Medicaid AE certification standards.

Comment. Section 5.2.2 of the AE Certification Standards refer to screening for SDOH and lists what needs to be included. Transportation is not included as one of the required elements. Transportation is a critical SDOH and should absolutely be included as part of the screening.

Measure #8. Patient/Client Satisfaction. Average patient/client satisfaction rating among the attributed population

Comment. While there are standardized tools being used for nursing facility residents to measure satisfaction, the state does not currently require the use of standardized methods for measuring satisfaction among assisted living, adult day and non-skilled home care clients. Would such standardized tools be recommended or need to be developed for use in the LTSS AE's? Whatever methods are used should be standardized and include questions that measure a person's perception of their quality of life and ability to make choices about their care.

Measures 9 & 10. Caregiver Support/Caregiver Burden and Social Isolation.

Comment. These are both important elements in caring for persons with LTSS needs and there are tools available to measure both. However, what capacity would the LTSS AE

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have to address caregiver burden and social isolation? While respite services can help reduce caregiver stress and burden and were an approved element of the state's 1115 waiver extension these services have yet to be implemented for older adults and so would probably not show up in historical cost calculations used for TCOC. Moreover, the current shortages in the home care workforce may impede the ability to provide such services. Likewise, adult companions are listed in the Service package, but are not

usually part of current care plan services for persons receiving home care services so would not appear in historical expenditures. This is probably a service that would need to be developed and could be based on the federally funded senior companion program. Another program that could address isolation among older adults would be participation in senior center services. Workforce and funding issues would need to be addressed for these types of services to become a way to address social isolation along with improved access to non-medical transportation.