

Stakeholders Present:

Cordula Dick-Muehlke, PhD, Dept. of Family Medicine & Division of Geriatrics, UCI School of Medicine; **Pamela Mokler**, RN, VP, LTSS, Care 1st; **John Galandines**, Social Worker, Alameda County SSA; **Elissa Gershon**, Disability Rights California; **Gail Gronert**, Special Assistant to Speaker Perez, California State Assembly; **Lisa Hall**, RN, Director of Regulatory Affairs, California Association of Health Facilities; **Karen Kessler**, Executive Director, California Association of Public Authorities for IHSS (CAPA) (by phone); **Leoma Lee**, Sacramento IHSS Advisory Committee; **Denise Likar**, MSW, Vice President, Independence at Home; **Marty Lynch**, PhD, MPA, MS, Executive Director, Lifelong Medical Care; **Lourdes Ramirez**, Program Manager, Aging & Independent Services, Department of Health & Human Services; **Celine Regalia**, Napa Valley Hospice and Adult Day Services; **Sara Rogers**, California State Assembly; **Kim Rutledge**, MSW, Budget and Policy Analyst, UDW/AFSCME Local 3930 (by phone); **Martha Tasinga**, Inland Empire Health Plan; **Victoria Tolbert**, Division Director/Director AAA, Adult, Aging and Medi-Cal Services, County of Alameda; **Paul Van Doren**, Riverside ILC (by phone); **Janie Whiteford**, Consumer Alliance, Santa Clara County;

Funder: Lisa Shugarman, The SCAN Foundation

Staff and Consultants Present:

Eileen Carroll, Hafida Habek, CDSS; Lora Connolly, Ed Long, CDA; John Shen, DHCS

Debra Saliba, MD, UCLA Borun Center, and Kate Wilber, Ph.D., USC

Lori Clarke, Convergent Horizons and Bobbie Wunsch, Pacific Health Consulting Group, Facilitators

Members of the Public Present:

Three members of the public attended in person and 13 individuals attended via telephone.

The meeting convened at 10:00 a.m.

Welcome and Introductions

Facilitators Lori Clarke and Bobbie Wunsch welcomed everyone to the meeting especially our newest member, Martha Tasinga from the Inland Empire Health Plan.

Bobbie and Lori presented for adoption the revised Universal Assessment Stakeholder Workgroup Charter and thanked the subcommittee – Diana Boyer, CWDA; Elissa Gershon, Disability Rights California; and Gail Gronert, California Assembly – for their collaboration in developing the final charter.

Introduction of Design Vendor to Assist with Development of Universal Assessment Tool and Process

Lisa Shugarman explained the design vendor process: A Request for Information (RFI) was developed and disseminated it to a group of potential vendors. There were three excellent candidates who responded to the RFI and interviewed. The Advisory Team (DSS, DHCS, CDA and SCAN) plus a subcommittee of the Universal Assessment Stakeholder Workgroup – Cordula Dick-Muelke, Janie Whiteford, John Galadines, Denise Likar, Martha Tasinga - reviewed proposals and interviewed vendors. The responses from the vendors provided insight into the level of expertise. The subcommittee rated the vendor responses. The approach to selection was fair, efficient, fast and geared toward identifying the most experienced vendor with deep understanding of California's context for the job.

Phase One of the project will include process and tool development and pre-testing of the tool. Phase Two will include piloting the tool in specific counties. Phase Two is a separate process. SCAN and DSS will jointly provide funding for Phase One.

Then the selected team was introduced: the Borun Center, led by Debra Saliba, MD, PhD, with Kate Wilber, PhD, Kisa Fulbright, UCLA and Robert (Bob) Newcomer, PhD. (Kisa and Bob could not be at the meeting) plus additional other team members.

Debra Saliba, MD, introduced her team, and noted their diversity and level of experience. Dr. Saliba is a geriatrician seeking to improve the quality of life for older adults. She revised the minimum data set for nursing homes for CMS to make it more person-centered. Kisa Fulbright from UCLA worked on external standards. Kate Wilbur and Bob Newcomer bring years of experience in community based work for quality of life for persons with disabilities. They are a diverse group with complementary skills.

Workgroup on Universal Assessment Next Steps and Planning Assumptions Moving Forward

Ed Long, CDA, reviewed the purpose of SB 1036, the guiding legislation for the Universal Assessment Workgroup.

Eileen Carroll, DSS, commented that there is a lot of work ahead and that the three departments and The SCAN Foundation will be working closely together with the stakeholder workgroup in the coming months on many issues. Eileen Carroll reminded everyone of what might be obvious already: Changes may occur as we move forward. There are multiple factors currently at play that may impact our work. These include budget and timeline, progress on the Coordinated Care Initiative, new requirements for each of the Departments, the fiscal environment of the state, and others. In particular regarding the timeline, we expect to have the UA tool developed by the end of 2014. We are estimating that the pilots will launch in 2015, with adoption statewide no sooner than 2016. With respect to the budget, there is no appropriation in State FY 14/15 at this time, but will work closely with legislative staff around fiscal issues.

John Shen, DHCS, presented a number of reminders to the group about the Universal Assessment process. The UA tool will create a common language among HCBS providers, the medical community, and health plans in assessing and determining the needs of plan members. In CCI counties, health plans have responsibility for LTSS services (HCBS and skilled nursing facilities) and it is important that the health plans are able to identify their members with LTSS. This can be done through the plan's risk stratification or Health Risk Assessment (HRA) processes or by receiving referrals from providers or plan members. The UA tool is not for risk stratification or HRA. It is for assessment and for care planning, leading to appropriate referrals to the proper providers or programs (e.g. IHSS, CBAS, etc.) for services that assist members to stay in their own homes and communities. For CCI implementation, it is anticipated that the UA tool will be implemented through face-to-face assessment by health plans care managers, alongside with all medical record information and utilization information, to create individualized care plans with other providers. In addition to the development of the UA tool, the UA process, which is also a task of this Workgroup, will define (a) how the plan members and the interdisciplinary care team are formed; and (b) how the assessment processes are coordinated and synchronized to create coherent care plans.

The Universal Assessment Process and Tool Development:

Dr. Saliba presented a set of guiding principles for the development of the Universal Assessment:

- Build on California's unique programs, size and diversity
- Consider key goals/values
 - Person centered processes and items
 - View assessments as strength based
 - Support care planning focused on independent living in the community
 - Not adversely impact current recipients
- Base Universal Assessment on collaborative input from stakeholders
- Explore Domains for California's Universal Assessment.

Dr. Saliba explained previous work for the Advisory Team and then reviewed the wide range of potential topics and compared them against nine domains: a person's background, financial status, health, function, cognitive/social/emotional/behavioral status, goals and preferences, the environment, caregiver(s) and other specific issues.

In addition to IHSS County staff, the health plans will be key to the process, and will need to integrate information, helping to decide what should be included from medical concerns, such as chronic conditions. It is a daunting task to develop a single tool to identify all needs. After so many years of being in different silos, this is a paradigm shift for all of the providers.

Several workgroup members noted that it will be important to keep the client in the center of all decisions and consider what the tool will look like from the client's

perspective. Consumer protections will be essential, especially built into agreements for information sharing. Privacy is a key consideration.

The purpose of the UA is to drive services and care planning, and so it must be easily used by IHSS county staff and the health plans, along with all of the other providers and be action oriented.

The focus of the UA is needs determination and care planning components of assessment. Needs determination is about the identification of specific service needs. Care planning involves the development of a plan of service delivery that takes into account an individual's needs and goals of care, existing sources of care and support, and resources available through a range of formal programs and information supports.

Goals and values to consider include person centered processes and items; assessments should be strength-based; support care planning focused on independent living in the community; and not adversely impact current recipients in terms of burden and equity. Four CCI counties are currently successfully sharing data and receiving data downloads from IHSS.

The Universal Assessment will have two draft sections: a core item set for HCBS, including IHSS, MSSP and CBAS, and the second a supplemental section. The design team will use an iterative process with item matrices, stakeholder input and pre-testing. There will be stakeholder subcommittees for item vetting, looking at the nine domains. Ideally the subcommittees will have 7-10 members representing diverse perspectives with a variety of roles. This might include consumers, expertise in domains, program administrators, people with experience in conducting in-home assessments, and case managers and health plan providers who do care planning—also aiming for geographic diversity and representation of consumer groups.

It will be important to engender trust between providers to avoid duplication. It will also be important to determine the optimal length of the assessment from both the point of view of the assessor and the person being assessed.

Pre-testing will address both clarity of the instrument and for agreement between users of the assessment.

The goal of the process is that the universal assessment will have a positive and non-disruptive effect.

Stakeholders raised a number of issues about the role and use of the Universal Assessment:

- What is the optimal length of the universal assessment and how long should it take to administer?
- What are the key elements that are used by all programs to offer a common language to use?

- Will everyone use the same tool or just the same common elements? Some clients will need additional, more comprehensive assessments?
- There will need to be a trust factor between providers to avoid duplication. How will this be achieved?
- Will the assessment take place by phone, in an office, in a person's home?
- The assessment process must replace something that already takes place. There is no additional time for an additional assessment. What is the thinking about this approach?
- How will integration occur with the medical information collected by the physicians, clinics and health plans? How will medication management fit it as an example?
- Will the assessment be used to divert individuals from nursing homes?
- There is a role for the skilled nursing facility. How will the assessment take this service into consideration?
- Can the assessment be pre-populated with information that is already known?
- How will training of assessors and compliance with health, safety and welfare be achieved?
- How will other waiver services like the assisted living waiver fit into this universal assessment process?
- How will the universal assessment intersect with the health plan required Health Risk Assessment (HRA)?
- How will we keep focused on the client and the clients' needs?
- How will the programs exchange data and information on a regular and continuous basis? This is not just a one-time data exchange.
- How will the assessment recognize adherence to consumer protections and will consumer protections be built into every step?

Stakeholder workgroup members raised the following questions and issues in response to Dr. Saliba's presentation about the potential process:

1. Are there funds to support members to attend subcommittee meetings?
Members were asked to join the Universal Assessment Stakeholder Workgroup as volunteers for a specific amount of time and effort. Each member will have to consider the additional time commitment and travel costs.
2. From a consumer perspective, it is hard to give up two days; it is doable but has a big cost impact. How much time will be required and when?
3. Scheduling is needed in advance. Will this be possible?
4. In terms of time commitment, might some work be done not face to face in order to preserve work time; or on one day with advance phone calls? Or is it better to get into a room and just do the work?
5. What will be the location of the additional meetings? Probably in Sacramento, but it could be nice to have meetings in Southern California.
6. Who will suggest others to join the discussions?

Identifying Domains and Topics for the Universal Assessment Tool:

The Universal Assessment Stakeholder Workgroup was then instructed on an exercise to find consensus among the potential domains and topics that have been highlighted through previous research. Large sheets were posted and all stakeholder workgroup members and members of the public in attendance were asked to place 'dots' on the domains and items to be potentially included in the universal assessment tool and to add any comments in writing on the sheets identifying new topics or new issues for discussion. Please see Appendix A for results of the activity.

Discussion Regarding Domains and Topics:

After the exercise, there was a discussion about the level of consensus on most issues and the areas where there was less agreement as well as the addition of new topics or items.

Is there a domain missing?

- Also need to assess for other resources the consumer may be using. For example a Regional Center
- Cognitive functioning needs to be more nuanced; don't just use "memory"
 - Examples include The Montreal Cognitive Assessment (MOCA) and the Dementia Severity Rating Scale
- Strengthen behavioral health items; add items that would pull for a full assessment by an expert
- Ask about weight change and treat obesity as a separate item, particularly in light of recent increase in bariatric procedures

What does "behavioral health" mean to the health plans?

- Does not include cognitive impairment
- a general term, treatment of mental illness, substance abuse, alcohol, psychological services or programs
- Everything other than severely mentally ill, which are served by county specialty mental health plans
- Dementia is not a mental health diagnosis covered by county specialty mental health plans
- County assessment staff sometimes consider dementia as a medical issue
- The measure in the UA should be geared to identifying potential presence of dementia; the UA process should specify how it is to be dealt with

Additional comments:

- The UA tool must be useful to diverse populations in terms of language and culture
- In the process we must consider the clinical expertise needed to administer the tool
- Topics and items should be related to program goals and services; it is unclear whether appropriate to ask about sexual functioning and if do, how to use assessment information
- Example of appropriate form of question: “Is sexuality important to you? If so, would you like to talk about it”?
- May need to ask different questions based on age and status

Regarding Caregiver Assessment:

- Reference to Patient Activation Tool; assesses for skills a caregiver needs and the confidence level of the caregiver to comply with the care plan
- Ask why they are providing care and how they feel about their role
- Assess financial stability of caregivers
- Assess caregiver’s support system
- Clarify authorization to collect information from the caregiver
- Differentiate family caregivers (paid and unpaid)

Public Comment Period:

Members of the Public were asked to make comments and to limit their comments to 1 minute including their name, organizational affiliation and comment.

Beau Henneman, IHSS Program Manager, LA Care Health Plan thanked the Universal Assessment Stakeholder Workgroup for their hard work and noted appreciation for the discussions. He mentioned that this group is important to the work of LA Care and looks forward to future meetings.

Debbi Thompson, IHSS Program Manager, Sacramento County commented on the critical nature of staying focused on what the consumer/IHSS recipient wants from the assessment and to honor their values.

Next Steps

The next Universal Assessment Stakeholder Workgroup meeting is scheduled for May 8, 2014, Sacramento, 9:30am – 3:30pm. Future meetings working with Dr. Saliba and her team will be announced soon.

The meeting was adjourned at 3:30pm.