HCBS Reform Community Forums

Fall 2016

Monday, October 24, 2016 – Ketchikan, 12 participants

Comments/Questions/Input

- Is SDS working to bring back the 16 people who currently reside in out of state ICF/IIDs?
- Glad to see tiered assessment approach
- Like the idea of a "mini C" waiver for those on DDRR to get services while they await IDD waiver services
- Acuity 1:1 rates are too difficult to get, doesn't work in the best interests of the individual
- Like idea of refinancing PCA services to 1915 K option to get a higher rate and also like idea of expanded eligibility
- SDS inconsistent with reviewers and what we can get, depends on the person we talk with at SDS
- When a person has Complex Behavior collaborative supports and services, SDS reviewers tend to cut other service hours inappropriately because CBC is for staff and not the person, SDS needs more education about CBC intentions.
- The number of children diagnosed with autism is increasing just like the number of elders with ADRD and we need a plan of action for this.
- FASD must be addressed, not necessarily by the creation of an FASD waiver but with life coaching, semi-independent living skills, etc.
- Southeast AK needs provider that supplies medi-sets
- State encouraged to look at state of Ohio HCBS system
- Would like SDS to consider 1915 I targeted toward ADRD population with behaviors that are significant enough to require interventions. Common indicators of ADRD behaviors which require increased staffing or placement in a facility could be used in combination for eligibility determination during an assessment once the frequency or parameters are set.
    - Self-Neglect Behaviors which could relate in serious health complications i.e. poor nutrition (as documented in H&P or progress note by physician or health care practitioner within last 6 months), lack of medication compliance (report of medication error by pharmacist, primary caregiver, physician at least once in last 30 days), lack of personal care that has impacted health such as gum infection, skin breakdown, diagnosis of cellulitis or other skin condition or infection (as documented in H&P by physician or health care practitioner at least once during past ? days)
    - Episodes of uncontrollable tearfulness despite mood altering medications (documented episodes lasting more than 30 minutes every day which are not easily altered through intervention and re-direction
    - Wandering which requires use of safety equipment such as bed/or chair alarms or alerts such as Wanderguards (unable to remember that they cannot walk so alarm alerts when they move from bed or chair, wander guard temporarily prevents them from leaving through an exit and is meant to alert those in the house/facility that they are attempting to leave)
    - Episodes of combative behavior (typical during care routines towards caregiver or unprovoked or unanticipated striking out towards others – documented behaviors at least one time during past 14 days)
    - Medication management support – medication must be administered
    - Episodes of agitation which are not easily altered through redirection or intervention, typically has physician orders of Risperdal and/or Ativan and typically requiring 1:1 care during most acute episodes

of agitation. This behavior can be demonstrated through crying out, yelling, repeated requests for assistance, pacing, screaming or crying.

- Socially inappropriate behavior. This could be measured/indicated through presence of one of the following: need for ADRD specific clothing (clothes that zip in the back so resident is unable to remove them in order to prevent nudity in public places), regular episodes of sexually inappropriate behavior towards others (or pets), regular episodes of urinating or defecating in inappropriate places and/or removal of soiled incontinent products in public places, and hoarding potential hazardous material.