Long-term Services and Supports (LTSS) Collaboration: Workgroup Recommendations

December 4, 2019

Indiana LTSS Collaboration Overview

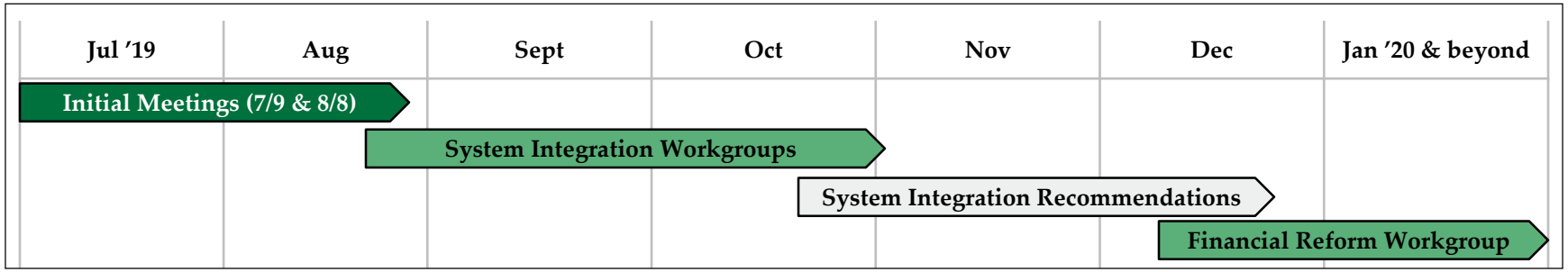
In July 2019, FSSA convened stakeholders to collaborate on key LTSS system integration and payment issues. Five topic-centric workgroups then focused on specific considerations.

Collaboration Goal: Examine current State LTSS infrastructure and systems for the purpose of recommending changes and reforms that promote equity of access to LTSS for all Medicaid-eligible individuals in need of those services. In any proposed future state, the individual in need of LTSS should have equivalent access to all appropriate LTSS regardless of setting within 48 hours.

Invited Stakeholders:

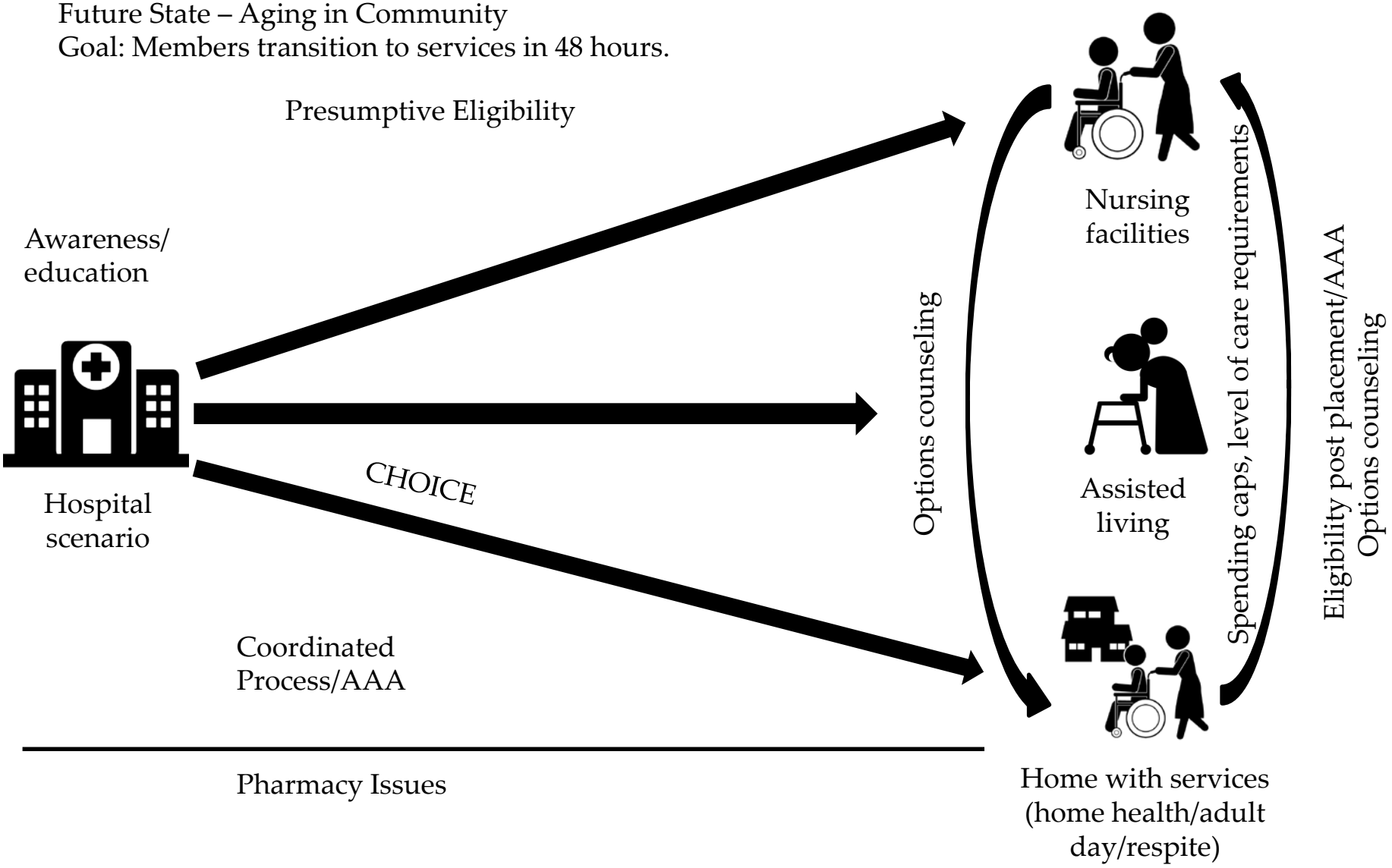
- FSSA incl. DA, OMPP, DFR
- ISDH
- IHCDA
- IAAAA
- IHCA/IN-CAL
- HOPE
- IN Association for Home and Hospice
- LeadingAge Indiana
- IN Association for Adult Day Services
- Center for Aging and Community - UIndy
- Various providers: Assisted living, area agencies on aging, and adult day services
- IN Hospital Association

Timeline



Recap: July 9, 2019 System Integration Discussion

Future State – Aging in Community
Goal: Members transition to services in 48 hours.



LTSS Collaboration Vision

LTSS vision:

- Design a PE-like process for HCBS and facilitate ability to access LTSS services within 48 hours of initiating process
- Utilize best practices and evidence-based models
- Ensure consumer knowledge and choice
- Value person-centered care and services
- Improve coordination of services and collaboration between providers
- Use data and technology to inform and deliver services
- Better value caregiver supports
- Ensure program sustainability

Issues we are addressing:

- Length of time to access services, particularly determination of financial eligibility
- Long-term financial viability of current service delivery with a growing population
- Provider capacity to deliver services
- Consumer and provider lack of knowledge regarding options or how to prepare

What we do not want for LTSS:

- Unnecessary delays in accessing care
- Consumer to be confused or feel as though they have no options
- Exclusion of the consumer
- Unsustainability of LTSS
- Consumer demand exceeding available provider capacity

Workgroups & Recommendations Overview

System Integration

- Workgroup 1: Awareness, Education, Communication and Data
- Workgroup 2: Capacity Building
- Workgroup 3: Eligibility and Prevention
- Workgroup 4: Options Counseling, Care Planning, and Coordination of Key Entities

Financial Reform

- Workgroup 5: Payment

Recommendations

- One PE-like process for HCBS recommendation
- Seven common system integration themes spanning multiple workgroups and recommendations
- A workgroup-specific recommendation from each individual system integration workgroup (four total)
- *TBD financial reform recommendations*

PE-Like Process for HCBS Recommendation

PE-Like Process for HCBS Recommendation
Recommendation: Design and implement a presumptive eligibility-like (PE-like) process specifically for LTC Medicaid applications to allow access to needed services in 48 hours.
Details: 1. Train and certify AAA staff and/or other appropriate providers to serve as "PE Providers" and to assist with Medicaid applications in all care settings including hospitals.* 2. Populate financial information obtained in PE process into LTC Medicaid application. 3. Connect CaMSS with Medicaid system for AAA submissions of financial information. 4. Determine the most appropriate method to offer HCBS services under a 'PE-like period.'* 5. Plan for what happens if person is granted PE and is receiving services but found ineligible for Medicaid. Consider funding a "transition period" allowing services to continue temporarily while alternative arrangements are made to meet the person's needs.*

*Details #1,4, and 5 may require a change to statute and/or CMS approval

System Integration - Common Themes Overview

The following table lists seven themes observed across the workgroup recommendations.

Themes	Workgroups			
	1	2	3	4
Utilize Hospital-Embedded Staff (p.7)	✓	✓	✓	✓
Leverage Existing Resources and Partnerships (p.8)	✓	✓	✓	✓
Review and Update Statute/Rule (p.9)	✓	✓	✓	✓
Reconsider Who May Also Conduct Eligibility (p.10)		✓	✓	
Support Caregivers (p.11)	✓	✓	✓	✓
Initiate Preventive Efforts (p.12)	✓		✓	
Improve Data Systems and Sharing (p.13)	✓	✓	✓	✓

Common Theme 1: Utilize Hospital-Embedded Staff

Workgroup	Recommendation
1	Establish and deploy a hospital-embedded workforce position dedicated to coordinating care and facilitating equitable access to all appropriate LTSS options for LTSS participants upon hospital discharge.
2	Identify and expand the universe of appropriate settings and providers for conducting initial eligibility assessments to increase meaningful access to a full continuum of LTSS within 48 hours.
3	Train and certify AAA staff and/or other appropriate individuals to serve as "PE Providers" and assist with Medicaid applications in all settings, including the hospital.*
4	Develop strategies that promote increased use of options counselors in hospitals and any other appropriate settings identified.

*This is a sub-component of the PE-like process recommendation on slide 5

Common Theme 2: Leverage Existing Resources/Partnerships

Workgroup	Recommendation
1	Leverage and support existing resources and community partnerships to educate LTSS system participants with clear, comprehensive, and unbiased information in order to increase levels of awareness regarding LTSS system infrastructure and all available services across the LTSS care continuum.
2	Support and enhance existing LTSS provider network by fostering nontraditional provider partnerships, reducing unnecessary regulatory and financial burdens, and allowing for more efficient and effective service delivery to reduce the over-incentivizing of institutional care.
3	Identify and implement DFR processes that increase efficiency, improve coordination with Area Agency on Aging (AAA) staff, and enhance continuity.*
4	Develop strategies that promote increased use of options counselors in hospitals and any other appropriate settings identified.

*For a list of specific considerations/examples related to the Workgroup 3 recommendation, please see the appendix.

Common Theme 3: Review and Update Statute/Rule

Workgroup	Recommendation
1	Review current State statutory, regulatory, and policy language related to LTSS coordination of care and LTSS information/data collection to locate areas that would benefit from improved system efficiencies, added enforcement mechanisms, or other meaningful reforms.
2	Improve and increase cooperation, collaboration, and synergy between individual State health agencies such as FSSA and ISDH to better align respective agency policies and regulations and reduce any unnecessary administrative burdens on LTSS providers where possible.*
3	Waive or revise specific LTC Medicaid application rules and deadlines, which would in part require increased contacts with participant before a denial.
4	Enact reforms to the LTSS person-centered plan process that build on established institutional knowledge and existing policies and procedures that have proven effective in achieving similar goals for other programs and populations.

*FSSA and ISDH have proactively met in response to stakeholder feedback to identify potential legislative/regulatory reforms to reduce unnecessary administrative burden on LTSS providers.

Common Theme 4: Reconsider Who May Also Conduct Eligibility

Workgroup	Recommendation
2	Identify and expand the universe of appropriate settings and providers for conducting initial eligibility assessments to increase meaningful access to a full continuum of LTSS services within 48 hours.
3	Identify and support DFR processes that increase efficiency, improve coordination with Area Agency on Aging (AAA) staff, and enhance continuity of care for LTSS participants.

Common Theme 5: Support Caregivers

Workgroup	Recommendation
1	Build and foster the collaboration, community engagement, partnerships (traditional and non-traditional), and information-gathering practices necessary for swifter identification, deeper understanding, and more robust support for a diverse population of informal caregivers.
2	Create and maintain sufficient and effective statewide resources and strategies to support the informal caregiver population.
3	Develop a guide or resource list for participants, caregivers, and providers on where to find program eligibility information online (e.g., rules surrounding property owned, marriage license, divorce papers, etc.).
4	Enhance and support options counseling and care planning processes that better account for and recognize informal caregivers as a key component in the LTSS continuum of care.

FSSA has also been working on caregiver support efforts:

- FSSA and ISDH are pursuing ways to provide caregivers and clients self-direction and additional skilled care options.
- DA recently proposed a small pilot self-directed program to CMS that would allow for self-direction of some skilled type of services through the A&D waiver.

Common Theme 6: Initiate Preventative Efforts

Workgroup	Recommendation
1	Initiate and maintain ongoing collaboration and community engagement with traditional and nontraditional LTSS partners to support more timely identification and referral of individuals who are pre-crisis and/or who are at-risk of institutionalization and do not have established access/linkages to appropriate social and medical services.
3	Proactively exchange referrals between the AAAs and DFR to derive increased benefits from shared access as well as the capability to perform more advanced planning and crisis mitigation.

Common Theme 7: Improving Data Systems and Sharing

Workgroup	Recommendation
1	Develop and/or implement statewide interoperability strategies to support real-time data access for timely and transparent referrals. Explore and leverage technology platforms to assist community members in accessing necessary information to assess and identify their medical and social service needs and make better LTSS decisions based on improved access to information.
2	Streamline technology systems to create efficiency and transparency to improve the long-term durability of the provider/participant relationship.
3	Enhance eligibility processes through increased data-sharing between Medicaid eligibility systems and CaMSS.
4	Leverage available data systems and datasets to promote quicker and more efficient decision-making processes to improve coordination between key LTSS entities and providers.

System Integration – Specific Workgroup Recommendations

The following slides contain recommendations unique to a particular workgroup.

- Workgroup 1: Awareness, Education, Communication and Data – Develop and deploy a statewide awareness and education campaign to de-mystify LTSS and increase informed decision-making
- Workgroup 2: Capacity Building – Create a new housing with services model
- Workgroup 3: Eligibility and Prevention – Implement changes to the Medicaid LTSS application process
- Workgroup 4: Options Counseling, Care Planning, and Coordination of Key Entities – Enact reforms to person-centered planning process

Workgroup 1: Awareness, Education, Communication, and Data Recommendation

Workgroup 1 Recommendation
Recommendation: Develop and deploy an innovative statewide awareness and education campaign with the involvement of professional communication and data strategists that uses both traditional and non-traditional media approaches to reach a multi-tiered audience, including professionals, participants, and caregivers, to demystify the LTSS infrastructure and increase informed decision-making for LTSS services.
Details: 1. Identify and target the following audiences for awareness and education regarding LTSS infrastructure: Primary care physicians, hospital discharge planners, care transition coaches, hospitalists, skilled nursing facility physicians, participants (especially duals), and caregivers. 2. Inform and educate on LTSS infrastructure components such as the LTSS continuum, service delivery options, service delivery definitions, and community role clarifications. 3. Create and utilize messaging that fosters a participant-centered culture and targets a participant and his/her caregiver's needs rather than the services/programs available.

Workgroup 2: Capacity Building Recommendation

Workgroup 2 Recommendation
Recommendation: Collaborate with internal and external partners to create new housing with services models that meet needs for short-term transitional housing and/or long-term family housing.
Details: Form workgroup of internal and external stakeholders and community partners to identify statewide populations that need housing with services, and discuss ideas for non-traditional housing models to support a broad population in need of housing with services.

On a related topic, FSSA and IHCDA are discussing capacity as follows:

- Collaborate with IHCDA regarding access to housing for individuals with Traumatic Brain Injuries which could be similar to a DDRS/IHCDA project.
- Collaborate with IHCDA as well as assisted living and adult day providers and related stakeholders for the potential of future affordable assisted living facilities to include an adult day component in buildings that would be newly built.

Workgroup 3: Eligibility and Prevention Recommendation

Workgroup 3 Recommendation
Recommendation[1]: Identify and implement changes to the LTC Medicaid application process to improve the Medicaid applicant experience and timeliness of eligibility decisions.
Details[2]: 1. DFR review LTC Medicaid application for pending waiver individuals immediately using special income limit (SIL) eligibility criteria instead of waiting for waiver Service Plan/CCB approval. 2. As with spousal impoverishment asset transfers, allow participant 90 days after Medicaid approval to deal with cash value life insurance (or omit this from eligibility process if under a certain value). 3. Allow participant's application to be saved and added to in the future instead of requiring participants to start over if their application is denied, for example, due to unmet deadline and an incomplete application. 4. Minimize documentation that the participant must submit to DFR by having DFR access needed information through other means when available (e.g., birth certificate when Medicare card is available which has this information)

[1] The workgroup 3 recommendations on slides 9 and 11 are also details that are part of this recommendation
[2] Details #1-3 would require a change to statute

Workgroup 4: Options Counseling, Care Planning, and Coordination Recommendation

Workgroup 4 Recommendation
Recommendation: Identify and enact reforms to person-centered service plan process that will facilitate quicker access to services while still ensuring procedural rigor.
Details: 1. Develop workable multi-tiered service standard preliminary plan process. 2. Further explore the possibility of expanding who can initiate the "multi-tiered preliminary" care plan. 3. Model and transpose existing governmental/organizational practices that have been effective in other program/policy areas (e.g. Code 42 process—current code that allows for general authorization of a limited suite of services for a set duration of time (30 days).

Next Steps

- Convene payment workgroup. Targeting payment recommendations by Spring/Summer 2020
- Develop PE-like process for eligibility by 2021
- Determine legislative changes and timeline:
  - Administrative burden reduction with ISDH
  - PE-like process and current eligibility changes

Appendix: Workgroup Submission Details

Workgroup 1 - Final Strategies and Recommendations

Awareness, Education, Communication & Data Workgroup

Specific Consideration 1: Promote greater awareness and education about current LTSS systems and the inclusion of both public and provider perspectives
Strategy 1: Implement proactive (early) and reactive (crisis) awareness and education tactics utilizing a participant-centered philosophy to encourage clarity of service options, avoid service silos and promote equity of access to LTSS.

- **Recommendation 1.1:** Support and leverage existing resources and community partnerships to educate the community with clear, comprehensive and unbiased information about available services to increase awareness and knowledge regarding the full LTSS infrastructure continuum.
- **Consideration 1.1:** Identify existing resources and community partnerships such as the Franciscan Health Paramedicine Program, INconnect Alliance, State Health Insurance Assistance Program, Indiana Department of Revenue, Emergency Medical Services, AARP, Indiana 211, etc.
- **Recommendation 1.2:** Develop and deploy an innovative statewide awareness and education campaign with the involvement of professional communication and data strategists, that uses both traditional and non-traditional media approaches, to reach a multi-tier audience, including professionals, participants, and caregivers, that demystifies the LTSS infrastructure and increases informed decision-making for LTSS services.
- **Consideration 1.2:** Identify and target the following audiences for awareness and education regarding LTSS infrastructure: Primary care physicians, hospital discharge planners, care transition coaches, hospitalists, skilled nursing facility physicians, participants (especially duals), and caregivers. Inform and educate on LTSS infrastructure components such as the LTSS continuum, service delivery options, service delivery definitions and community role clarifications. Create and utilize messaging that fosters a participant-centered culture and targets a participant and his/her caregiver's needs rather than the services/programs available.
- **Recommendation 1.3:** Establish and deploy a hospital-embedded workforce position dedicated to coordinating the care of participants navigating the LTSS continuum upon hospital discharge.
- **Consideration 1.3**: Research workflow best practices to establish and implement a hospital-embedded position, such as a Care Navigator, to facilitate the transition from the hospital to a community-based setting.

Specific Consideration 2: Improve and standardize communication between consumers, hospitals, nursing facilities, AAAs, medical providers, elder law attorneys, and other LTSS advocates to improve coordination of care for Medicaid enrollees receiving LTSS services (with an emphasis on A&D waiver recipients).
Strategy 2: Implement awareness and education tactics to facilitate enhanced regulatory compliance regarding long-term services and supports and to improve and standardize coordination of care for Medicaid enrollees receiving services.

- **Recommendation 2.1:** Identify and adopt effective communication best practices and evidence-based models to improve coordination across the care continuum.
- **Consideration 2.1:** Recognize established best practices between AAAs and county hospitals for statewide dissemination and implementation.
- **Recommendation 2.2:** Review current statutory and regulatory language that would relate to information gathering and coordination of care to determine potential areas for added efficiencies, enforcement and reform.
- **Consideration 2.2:** Review and propose new language related to House Enrolled Act 1265 (Designation of Caregiver for patients- 2015) and House Enrolled Act 1211 (Hospital Discharge Process-2012) that ensures scope, oversight and enforcement to improve the sharing of information and coordination of care.
- **Recommendation 2.3:** Initiate and maintain collaboration and community engagement that includes traditional and nontraditional partners to identify, understand and support the lay caregiver population.
- **Consideration 2.3:** Review and revise the Division of Aging State Plan to require the implementation of caregiver support evidence-based interventions. Leverage the House Enrolled Act 1265 in-hospital point of contact to identify caregivers, assess needs, and provide education and tools to support the caregiver.

Workgroup 1 Final Strategies and Recommendations Cont'd

Awareness, Education, Communication & Data Workgroup

Specific Consideration 3: Optimize data sharing between providers for coordination purposes; and use data to identify and systematically flag persons at risk for LTSS and needing options counseling.
Strategy 3: Identify participants at-risk for LTSS utilization pre-crisis to improve data sharing and care coordination to address participant needs through integration of both social and medical services.
Recommendation 3.1: Initiate and maintain collaboration and community engagement that includes traditional and nontraditional partners to identify and refer individuals to social and medical services and supports in a timely manner.
Consideration 3.1: Target participants at-risk for institutionalization who do not have an established relationship with an AAA for linkage to a case manager/options counselor. Explore the state's D-SNP initiative for opportunities to leverage the MIPPA contract for data collection and reporting requirements. Identify mechanisms to target individuals earlier in life (pre-crisis) to help them get the tools they need to successfully age in place.
Recommendation 3.2: Develop and/or implement statewide interoperability strategies to support real-time data access for timely and transparent referrals.
Consideration 3.2: Explore and deploy an automatic notification system that flags participants in the MDS such as an Event Notification System. Leverage the identification and flagging process being utilized for Money Follows the Person in the MDS. Support and expand AAA membership with IHIE for statewide interoperability. Explore mechanisms to promote SNF membership with IHIE for improved data sharing capabilities.
Recommendation 3.3: Explore and leverage technology platforms to assist community members in accessing information tailored to their medical and social service needs to make informed decisions regarding LTSS.
Consideration 3.3: Develop and utilize technology platforms to allow participants to self-identify services in which they are qualified. Explore and leverage existing technology platforms such as smart phone features and applications. Utilize web analytics to identify caregiver needs and drive decision-making related to caregiver support.

Workgroup 2 Final Strategies and Recommendations

Capacity Building Workgroup

Recommendation 1: Identify accessible settings and providers that are most appropriate to conduct initial eligibility assessments to increase access to LTSS services within forty-eight hours.

- **Consideration 1.1:** Embed options counselors within the hospital setting to perform initial eligibility assessments.
- **Consideration 1.2:** Allow an array of provider types to conduct initial eligibility assessments (SFC, AL, ADS) with appropriate oversight.
- **Consideration 1.3:** Implement a third party vendor initial eligibility assessment process.

Recommendation 2: Support and leverage provider agencies by partnering with nontraditional providers, reducing regulatory burden and implementing financial tactics to allow for efficient and effective service implementation to reduce institutionalization.

- **Consideration 2.1:** Implement financial tactics to increase the amount of participants that agencies can serve, which, in turn will allow providers to better invest in staff.
- **Consideration 2.2:** Partner with existing community workforce to fill gaps until a provider can begin long term staffing.
- **Consideration 2.3**: Partner with ISDH to review regulatory guidelines to reduce administrative burden to allow providers to focus on rendering services.

Recommendation 3: Streamline technology systems that create efficiency and transparency to improve durability of the provider/participant relationship.

- **Consideration 3.1:** Establish interoperability among case management systems to reduce AAA administrative burden.
- **Consideration 3.2:** Create electronic picklist that identifies provider availability as well as scope of services rendered by provider and needed by participant.

Recommendation 4: Implementation of statewide caregiver support resources and strategies to support informal caregivers.

- **Consideration 4.1:** Identification of paid and unpaid caregivers statewide to better understand needs of this population in order to provide more tailored supports.
- **Consideration 4.2:** Develop partnerships with colleges to build a network of students interested in providing caregiver/caregiver peer support to Hoosiers in need of caregivers in a crisis situation or long term care.
- **Consideration 4.3:** Development of caregiver resource hub and call center to provide caregiver support and guidance in order to reduce caregiver burnout.
- **Consideration 4.4:** Outreach to different system points of entry about caregiver resources in order to build capacity for more caregivers have support resources, and increase caregiver education before a participant enters crisis.
- **Consideration 4.5:** Development of participant service plans to address supports for caregivers in order to provide clear guidance to caregivers and reduce burnout.

Recommendation 5: Collaborate with internal and external partners to create new housing with services models that meet needs for short-term transitional housing and/or long-term family housing

- **Consideration 5.1:** Form separate long-term workgroup of internal and external stakeholders and community partners to identify statewide populations that need housing with services, and discuss ideas for non-traditional housing models to support a broad population in need of housing with services.

Workgroup 3 Final Strategies and Recommendations

Eligibility and Prevention Workgroup

Recommendation 1: Design and implement a presumptive eligibility (PE) process specifically for LTC Medicaid applications to allow access to needed services in 48 hours.

- **Key Component 1.1:** Allow AAA staff to be trained and certified as "PE Providers" and collect financial information needed to complete an eligibility worksheet that is submitted for PE determination.*
- ***Key Component 1.2:*** *Populate financial information obtained in PE process into LTC Medicaid application.*
- ***Key Component 1.3:*** *Connect CaMSS with Medicaid system for AAA submissions of financial information.*
- ***Key Component 1.4:*** *Make available a subset or all waiver services during the PE period.**
- ***Key Component 1.5****: Plan for what happens if person is granted PE and is receiving services but found ineligible for Medicaid. Consider funding a "transition period" allowing services to continue temporarily while alternative arrangements are made to meet the person's needs.**

Recommendation 2: Identify and implement DFR processes that increase efficiency, improve coordination with Area Agency on Aging (AAA) staff, and enhance continuity.

- ***Key Component 2.1****: Process LTC Medicaid applications through DFR LTC specialists beginning to end instead of starting with DFR generalist and only accessing LTC specialist if problems; and increase number of DFR LTC specialists who process applications.*
- ***Key Component 2.2:*** *Provide direct electronic access and communication via CaMSS with Medicaid eligibility system to auto-populate participant information (i.e., open application programming interface, or API line).*
- **Key Component 2.3:** Assign DFR liaison to each AAA.
- **Key Component 2.4:** Assign DFR case worker to each Medicaid applicant for continuity in process.
- **Key Component 2.5:** DFR communicate to AAA about incomplete applications and deadlines.
- **Key Component 2.6:** Provide AAA staff with automatic access to Medicaid application system to better assist participants.
- **Key Component 2.7:** Co-locate DFR with AAA for person-to-person collaboration.
- **Key Component 2.8:** Proactively exchange referrals between AAA and DFR, since persons accessing one may benefit from the other; and which may facilitate planning ahead and averting a crisis.

Recommendation 3: Identify and implement changes to the LTC Medicaid application process to improve the Medicaid applicant experience and timeliness of eligibility decisions.

- ***Key Component 3.1:*** *DFR review LTC Medicaid application for pending waiver individuals immediately using special income limit (SIL) eligibility criteria instead of waiting for waiver Service Plan/CCB approval.*
- ***Key Component 3.2:*** *As with spousal impoverishment asset transfers, allow participant 90 days after Medicaid approval to deal with cash value life insurance (or omit this from eligibility process if under a certain value).**
- ***Key Component 3.3:*** *Allow participant's application to be saved (or "suspended") and added to in the future instead of requiring participants to start over if their application is denied, for example, due to unmet deadline and an incomplete application.*
- **Key Component 3.4:** Minimize documentation that the participant must submit to DFR by having DFR access needed information through other means when available (e.g., birth certificate when Medicare card is available which has this information).
- **Key Component 3.5:** Waive or revise specific application rules and deadlines for LTC Medicaid applications, including requiring increased contacts with participant before a denial.*
- **Key Component 3.6:** Develop a guide or resource list for participants, caregivers and providers on where to find information online (e.g., property owned, marriage license, divorce papers, etc.).

Note: Recommendations are outlined in order of priority and those in italics represent workgroup recommendations for greatest impact; an asterisk (*) represents recommendations that need legislative support and/or action.

Workgroup 4 Final Strategies and Recommendations

Options Counseling, Care Planning, and Coordination of Key Entities Workgroup

Specific Consideration 1: Identifying and leveraging existing program and system infrastructure to achieve efficiencies

Strategy 1: Identify and enact reforms to person-centered service plan process that will facilitate quicker access to services but still ensure procedural rigor

- **Recommendation 1.1:** Develop workable multi-tiered service standard preliminary plan process
- **Recommendation 1.2:** Further explore the possibility of expanding who can initiate the "multi-tiered preliminary" care plan
- **Recommendation 1.3:** Model and transpose existing governmental/organizational practices that have been effective in other program/policy areas (e.g. Code 42 process—current code that allows for general authorization of a limited suite of services for a set duration of time (30 days))

Strategy 2: Identify and develop strategies to encourage and facilitate the increased use of options counselors in hospitals and other appropriate settings

- **Recommendation 2.1:** Implement changes to mitigate specific barriers to operationalization (i.e urban/rural differences; differences in LOC needs)
- **Recommendation 2.2:** Locate and collect key information and data that will support the added value associated with embedded options counselors
- **Recommendation 2.3:** Identify local pilots/initiatives that could potentially be modeled to scale (i.e. Indianapolis, Evansville, and Richmond pilots)
- **Recommendation 2.4:** Coordinate and collaborate with hospitals and hospital association in order to achieve best possible outcomes for option counselor placement

Specific Consideration 3: Integration of current data and information systems to improve and streamline processes and operations

Strategy 3: Leverage existing data systems and datasets to facilitate quicker decision-making and efficient processes for coordinating key entities and providers

- **Recommendation 3.1:** Establish enhanced connectivity between more real-time data systems and current governmental/organizational data repositories (IHIE, CaMSS, CoreMMIS)
- **Recommendation 3.2:** Implement changes to receive, house, and use available data to better inform program and system choices (Medicare datasets; contract requirements for D-SNPs)

Specific Consideration 4: Identifying and including lay caregivers in any LTSS care coordination strategies and reforms

Strategy 4: Identify and enact specific enhancements to options counseling and care planning processes that better account for and include lay caregivers

- **Recommendation 4.1:** Leverage the House Enrolled Act 1265 in-hospital point of contact to identify caregivers, assess needs, and provide education and tools to support the caregiver.
- **Recommendation 4.2:** Identify additional data collection processes that can be leveraged for better information gathering and planning to develop better State strategies concerning lay caregivers