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Member Forum

August 27, 2021

Board Chair Report

Welcome

- Debbie Bennett, President & CEO, Hillcroft Services, Inc.

Today's Agenda

- Crisis Services Planning - Jay Chaudhary, Director of Indiana Division of Mental Health and Addiction
- OSHA Emergency Temporary Standard - Cheryl Kuritz, Department of Labor
- DSP Wage Increase Impact on Individuals Budget - Cathy Robinson, Director, BDDS
- Association Update - Nanette Hagedorn, INARF
- Industry Update - John Barth, Katy Stafford-Cunningham, Brian Carnes and Phillip Parnell, INARF

Upcoming Events

Professional Interest Section Meetings / Professional Development:

- October 14 - Child and Family Services (10 AM-Noon)
- October 28 - Business & Industry / Certified Ability Indiana Organizations (10 AM-Noon)
- November 2 - Community Supports (10 AM-Noon) / Employment Supports (12:30-2:30 PM)
- November 4 - Pieces to the Group Home Financial Puzzle Training
- November 11 - Financial Management (10 AM-Noon) / Human Resources (12:30-2:30 PM)

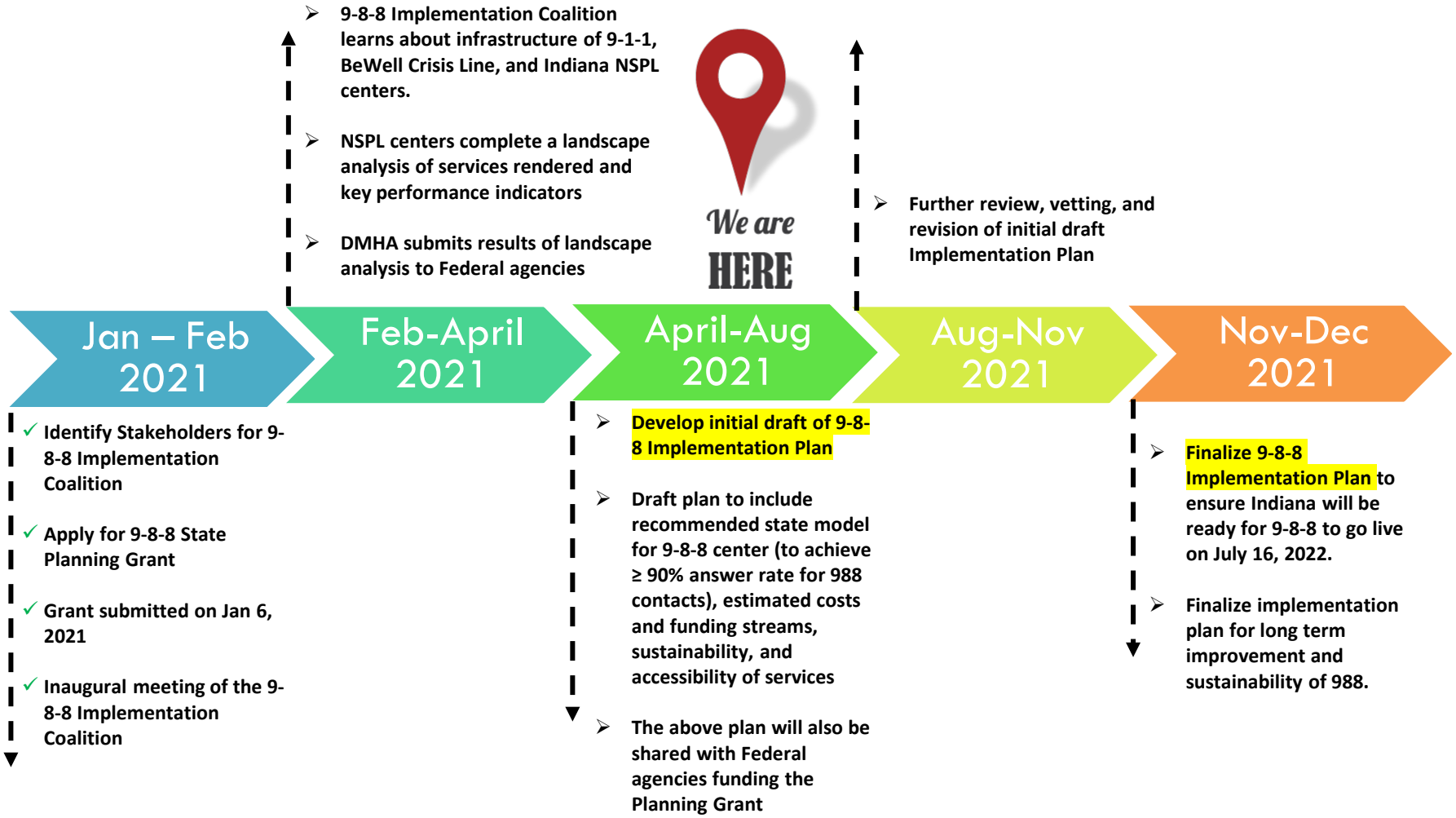
Upcoming Member Forum and Board of Directors Meetings:

- September 25 - Member Forum / Board of Directors Meeting - Virtual
- October 22 - Member Forum / Board of Directors Meeting – Hybrid – location TBD

Registration for each meeting is available 3 weeks in advance. Recordings and materials will be available on the INARF Member Portal within 2-3 business days following each meeting.

Crisis Services Planning

Jay Chaudhary
Director of Indiana Division of Mental Health and Addiction



Adapted Slide. Original creator: Oregon Health Authority

Proposed Vision and Mission Statements for 9-8-8

Vision

Providing quick, competent, and nation-leading crisis response services for every Indiana resident

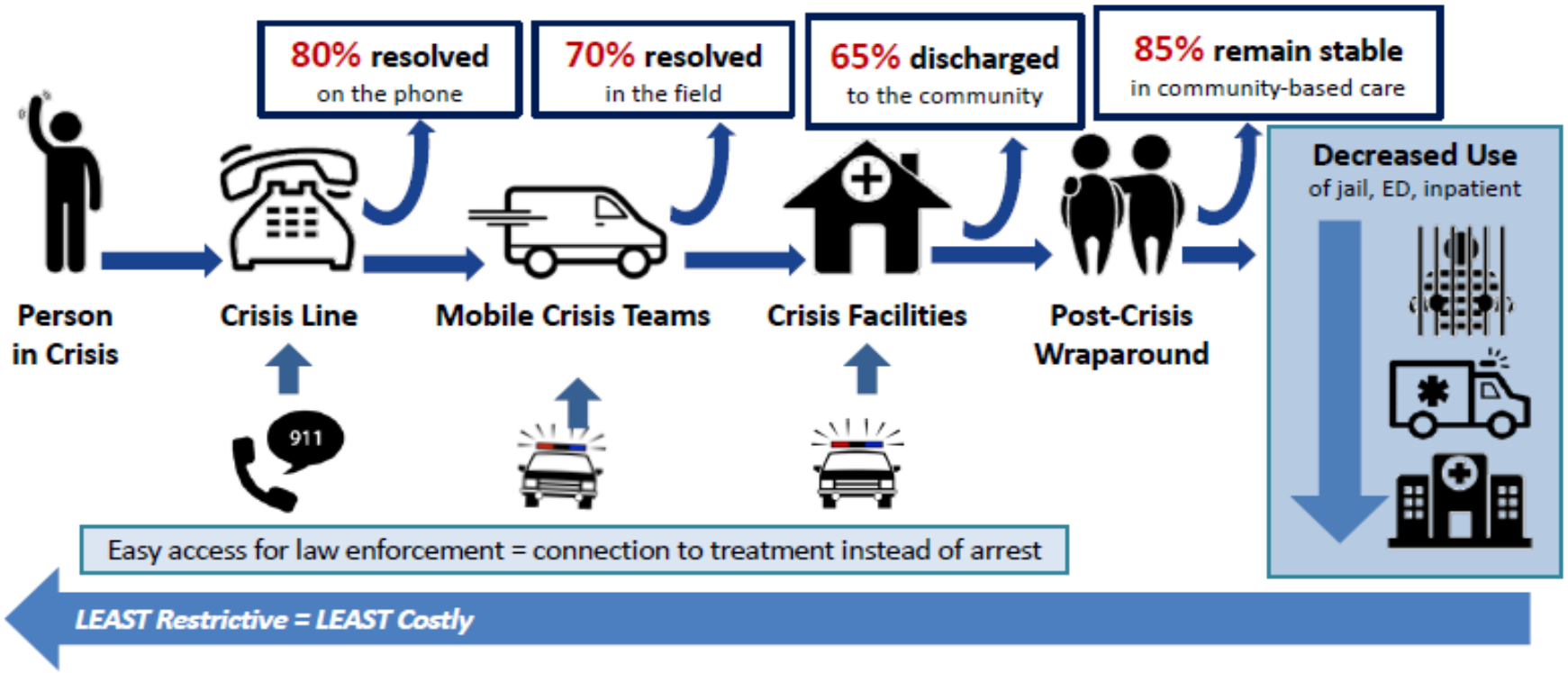
Mission

Creating a sustainable infrastructure that will fully coordinate crisis care for mental health, substance use, and suicidal crises (through implementing the SAMHSA-adopted Crisis Now Model). **We are building a Level 5 Crisis Center (air traffic control)**

Crisis Now Model

- Statewide 24/7 coverage for 9-8-8 calls, text, and chat (***Someone to Talk to***)
- Centrally deployed, 24/7 mobile crisis (***Someone to Respond***)
- Short-term sub-acute residential crisis stabilization programs (***A Place to Go***)
- **A system that will serve anyone, anytime, and anywhere**
- A recovery orientation that includes:
  - trauma-informed care,
  - significant use of peer staff,
  - collaboration with law enforcement,
  - and a commitment to Zero suicide/suicide safer care and the safety of consumers and staff

Crisis System: Alignment of services toward a common goal



Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.* Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

The above image is a reproduced slide from the April 2, 2021 Congressional Briefing: Mental Health is Not a Crime: How 988 and Crisis Services will Transform Care

Introduction of 9-8-8 Workgroups

- **Mobile Team Workgroup**
  - **Clarify roles and responsibilities of the various mobile teams** (law enforcement, mobile integrated health teams, mobile integrated response systems, quick response teams, LOSS teams, mobile crisis assistance teams, etc.)
- **Crisis Line Workgroup**
  - **Clarify roles and responsibilities** (9-1-1, suicide prevention lifelines, domestic violence hotlines, child abuse hotline, 2-1-1/Be Well, warmlines, etc.)
- **Child and Adolescent Crisis Care Continuum Workgroup**
  - **Identify and/or create crisis care continuum best practices for children and adolescents** (call centers, mobile crisis, stabilization units, family and youth peer support, etc.)
- **Training Workgroup**
  - **Identify and/or create best practice training curricula** for those who access any part of the crisis care continuum (call center[s], mobile teams, crisis stabilization units, etc.).
- **Community and Lived Experience Focus Group(s)**
  - How can we build a crisis response system that can be trusted?

OSHA Emergency Temporary Standards

Cheryl Kuritz
Department of Labor

INDIANA DEPARTMENT OF LABOR

Brad Freeman, CIH, CSP Gary Hulbert, CHMM, CSP

COVID-19 Emergency Temporary Standard For Healthcare

Objectives

- Scope of 29 CFR 1910 subpart U
- Requirements for Healthcare
- Mini Respiratory Protection Program
- Incorporation by Reference

Emergency Temporary Standard (ETS)

- Determination that healthcare and healthcare support employees face a grave danger from COVID-19
  - Subpart U contains the following temporary standards:
    - 1910.502, Healthcare
    - 1910.504, Mini Respiratory Protection Program
    - 1910.505, Severability
    - 1910.509, Incorporation by Reference of CDC and consensus standard guidelines
- ETS effective dates for Federal OSHA
  - Effective immediately upon publication in Federal Register on June 21, 2021
  - Most provisions were effective on July 6, 2021
  - Training, ventilation, and barrier provisions by July 21, 2021
  - *Indiana has 30 additional days to begin enforcement*

1910.502(a) Scope and Application

- This standard applies to healthcare worksites where any employee provides healthcare services or healthcare support services:
  - Hospitals
  - Nursing homes/long-term care facilities
  - Healthcare settings embedded in a non-healthcare setting (e.g., medical clinic in a manufacturing facility; walk-in clinic in a retail setting)
  - Autopsy settings in funeral homes, mortuaries, and morgues but not other handling of human remains

Note: Where EMTs or other healthcare providers enter a non-healthcare setting to provide healthcare services, only the provision of healthcare services by that employee is covered.

Definitions

- *Healthcare services* mean services that are provided to individuals by professional healthcare practitioners (*e.g.*, doctors, nurses, emergency medical personnel and oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health. Healthcare services are delivered through various means including: Hospitalization, long-term care, ambulatory care, home health and hospice care, emergency medical response, and patient transport. For the purposes of this section, healthcare services include autopsies.
- *Healthcare support services* mean services that facilitate the provision of healthcare services. Healthcare support services include patient intake/ admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/reprocessing services.

Definitions

- *Ambulatory care* means healthcare services performed on an outpatient basis, without admission to a hospital or other facility. It is provided in settings such as: Offices of physicians and other health care professionals; hospital outpatient departments; ambulatory surgical centers; specialty clinics or centers (*e.g.*, dialysis, infusion, medical imaging); and urgent care clinics. Ambulatory care does not include home healthcare settings for the purposes of this section.
- Well defined area means a portion of the facility that could be an entire department such as a radiology unit or a section of a building such as a room, floor, or wing.

1910.502(a) Healthcare

- Does not apply to:
  - First aid performed by an employee who is not a licensed healthcare provider
  - Dispensing of prescriptions by pharmacists in retail settings
  - Non-hospital ambulatory care settings if non-employees are screened and COVID positive/suspected people are not allowed entry
  - Hospital ambulatory care settings if well defined area, all workers are fully vaccinated, non-employees are screened and COVID positive/suspected people are not allowed entry
  - Home healthcare settings if all employees are fully vaccinated, non-employees screened
  - Off-site healthcare support services
  - Telehealth services outside of direct patient care settings

1910.502 Partial Exemption

- In well defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present, paragraphs (f) PPE, (h) physical distancing, and (i) physical barriers do not apply to employees who are fully vaccinated.

Examples of Applicability of 1910.502

- Examples using clinic in a manufacturing facility:
  - 1910.502 applies to the nurses duties whether in the clinic or out on the plant floor
  - 1910.502 does not apply to other employees in the manufacturing facility when the nurse is providing healthcare on the plant floor
- Examples using a pharmacy embedded in a general merchandise store:
  - 1910.502 applies to the pharmacist/staff performing medical processes and procedures
  - 1910.502 does not apply to dispensing of prescriptions or to the general merchandise part of the store

1910.502 Requirements

- Develop and Implement COVID-19 Plan
- Patient screening and management
- Standard and Transmission-Based Precautions
- Personal Protection Equipment (PPE)
- Aerosol–generating procedures on a person with suspected or confirmed COVID-19
- Physical distancing/physical barriers
- Cleaning and disinfection

Requirements for Healthcare

- Ventilation
- Health screening and medical management
- Vaccination
- Training
- Anti-retaliation
- Implemented at no cost to employees
- Recordkeeping
- Reporting COVID-19 fatalities and hospitalizations to OSHA

1910.502(c) COVID-19 Plan

- Plan developed and implemented for each workplace
- In writing if > than 10 employees
- Document designated *safety coordinator(s) that will implement and monitor the plan
- Conduct a workplace-specific hazard assessment
- If the hazard assessment is based on employees' fully vaccinated status, the plan must include procedures to determine employee's vaccination status

**The COVID-19 safety coordinator should be someone who is able to understand and identify COVID-19 hazards in the workplace, and must be knowledgeable in infection control principles and practices as they apply to the workplace and employee job operations. Additionally, the safety coordinator must have the authority to ensure compliance with all aspects of the COVID-19 plan so that they can take prompt corrective measures when hazards are identified.*

1910.502(c) COVID-19 Plan

- Employer must seek the input of non-managerial employees and their representatives
- Monitor ongoing effectiveness and update it as needed
- Develop procedures to address the hazards identified which:
  - Minimize the risk of transmission
  - Effectively communicate and coordinate with other employers
  - Protect employees who in the course of their employment enter into private residence or other physical locations controlled by a person not covered by the OSH Act

1910.502(d) Patient Screening and Management

- In settings where direct patient care is provided, the employer must:
  - Limit and monitor points of entry
  - Screen and triage all entrants
  - Implement other applicable patient management strategies in accordance with CDCs "COVID-19 Infection Prevention and Control Recommendations"

Examples include:

- Telehealth when applicable
- Isolate patients in exam rooms
- Use distancing and barriers in waiting rooms

1910.502(e) Standard and Transmission-Based Precautions

- Employers must adhere to Standard and Transmission-Based Precautions in accordance with CDCs “Guidelines for Isolation Precautions”

Examples include:

- Tight-fitting facemasks for patients
- Physical distancing
- Hand hygiene
- Ventilation
- Outdoor Triage
- Isolation Rooms

1910.502(f) Personal Protective Equipment (PPE)

- Facemasks:
  - Facemasks must be FDA approved or authorized
  - Employers must provide sufficient number and enforce use
  - Cover nose and mouth when indoors and when occupying a vehicle with other people for work purposes
  - Provide a sufficient number to allow at least one change per day, whenever they are soiled or damaged, and more frequently as necessary

- *Use of respirators when not required must comply with 1910.504*

1910.502(f) Personal Protective Equipment

- Respirators and other PPE for exposure to people with suspected or confirmed COVID-19
  - Respirators provided and used in accordance with 1910.134, *Respiratory Protection Standard*
  - Gloves, an isolation gown or protective clothing, and eye protection provided and used in accordance with 1910 subpart I

Note to paragraph (f)(2): when there are limited supplys of FFRs employers may follow the CDCs " Strategies for Optimizing the Supply of N95 Respirators"

1910.502(f) and (g) Aerosol-Generating Procedures on a Person with Suspected or Confirmed COVID-19

- Respirators must be provided and used in accordance with 1910.134
- Gloves, an isolation gown or protective clothing, and eye protection provided and used in accordance with Subpart 1
- Limit the number of employees present during the procedure to only those essential for patient care and procedure support.
- Perform the procedure in an aerosol infection isolation room (AIIR) if available
- After the procedure is completed, clean and disinfect the surfaces and equipment

1910.502(h) Physical Distancing

- Each employee is separated from all other people by at least 6 feet when indoors
- If not feasible for a specific activity (e.g., hands-on medical care), ensure that the employee is as far apart from all other people as is feasible

Does not apply to momentary exposure while people are in movement, such as when coworkers pass each other in a hallway.

1910.502(i) Physical Barriers

- At each fixed work location outside of direct patient care areas where 6 feet of distance is not feasible, the employer must install cleanable or disposable solid barriers
- Barriers must be sized and located to block face-to-face pathways between individuals
- Barrier may have a pass-through space at the bottom

1910.502(j) Cleaning and Disinfection

- In patient care areas, resident rooms, and for medical devices and equipment, follow standard practices for cleaning and disinfection in accordance with CDC's "COVID-19 Infection Prevention and Control Recommendations" and CDC's "Guidelines for Environmental Infection Control"

  Examples include:

  -Dedicated medical equipment for infected patients

  -Use pathogen-appropriate EPA registered disinfectants

1910.502(j) Cleaning and Disinfection

- **In <u>all other areas,</u> the employer must:**
  - Clean high-touch surfaces and equipment at least once a day
  - When the employer is aware that a person who is COVID-19 positive has been in the workplace within the last 24 hours, clean and disinfect, in accordance with CDC's "Cleaning and Disinfecting Guidance" (incorporated by reference, 1910.509), any areas, materials, and equipment under the employer's control that have likely been contaminated by the person who is COVID-19 positive
- The employer must provide alcohol-based hand rub that is at least 60% alcohol or provide readily accessible hand washing facilities

1910.502(k) Ventilation

- Employer-owned or controlled buildings with existing HVAC systems:
  - Follow manufacturer's instructions/specifications
  - Maximize outside air and air changes per hour, as appropriate
  - Use air filters with MERV equal to or greater than 13, if compatible with system
  - Replace filters as necessary
  - Intake ports must be cleaned, maintained, and cleared of debris

MERV-Minimum Efficiency Reporting Value

1910.502(k) Ventilation

- Airborne infection isolation rooms (AIIR)
  - Maintain and operate in accordance with design/construction criteria

Note: Consider other measures to increase ventilation in CDC's "Ventilation Guidance"

1910.502(l) Health Screening and Medical Management

- Screening of employees:
  - Before each workday and each shift
  - Self-monitoring or conducted in-person by employer
  - Any required screening COVID-19 tests at no cost to employees

- Employee notification to employer of COVID-19 illness or symptoms:
  - Confirmed positive test, diagnosis
  - Suspected diagnosis (told by HCP)
  - Recent loss of taste and/or smell
  - Fever ≥100.4 *and* new unexplained cough with shortness of breath

1910.502(l) Health Screening and Medical Management

- Employer notification to employees of COVID-19 exposure:
  - Triggered by any positive person in the workplace (*except patients in worksites where services normally provided to COVID-19 patients*)
  - Within 24 hours
  - Each employee not wearing respirator/other required PPE
    - who had close contact: dates that contact occurred
    - who worked in a portion of the workplace in which that person was present during potential transmission period: dates the person was in the person was in the workplace

1910.502(l) Health Screening and Medical Management

- Notification of other employers whose employees were not wearing respirators/other required PPE:
  - who had close contact
  - who worked in a portion of the workplace in which the person was present during the potential transmission period

1910.502(l) Medical Removal

- Persons meeting positive test/diagnosis criteria: immediately remove until they meet return to work criteria
- Persons meeting suspected diagnosis/symptom criteria: immediately remove until they meet return to work criteria or have a negative PCR test
- Persons with close contact must be removed immediately either:
  - For 14 days
  - Until they have a negative PCR test taken after at least 5 days or,
  - Exemption: if asymptomatic and fully vaccinated or recovered from COVID-19 in the past 3 months
- Working remotely or in isolation is acceptable alternative to removal

1910.502(l) Medical Removal Protection Benefits

- Employers with less than 10 employees exempt from removal pay
- Working remotely or in isolation: same pay and benefits
- Removed employees maintain their regular pay and benefits:
  - Up to $1400 per week
  - Employers with less than 500 employees: in third week of removal, limited to only 2/3 of pay up to $200 per day
  - Payment reduced by compensation from any other source
- Return to work: same job status, rights, and benefits

1910.502(l) Return to Work Criteria

- Guidance from licensed health care provider, or
- Use of CDC's "Isolation Guidance" and "Return to Work Healthcare Guidance"

1910.502(m) Vaccination

- The employer must support vaccination by providing reasonable time and paid leave
  - For vaccination
  - For any side effects experienced following vaccination

1910.502(n) Training

- Each employee, in language and literacy level the employee understands
- Content:
  - COVID-19 transmission, hygiene, ways to reduce risk of spread, signs and symptoms, risk factors for severe illness, when to seek medical attention
  - Employer-specific policies and procedures on patient screening and management
  - Workplace tasks and situations that could result in infection
  - Workplace policies and procedures for preventing spread
  - Multi-employer agreements related to infection control policies and procedures

1010.502(n) Training

- Content:
  - Policies and procedures for PPE
  - Workplace policies and procedures for health screening and medical management
  - Sick leave policies
  - The identity of the safety coordinator(s) specified in the plan
  - Details of the standard and how the employee can obtain copies as well as copies of employer-specific policies and procedures

Note: May rely on training completed prior to the effective date if it meets the relevant training requirements

1910.502(n) Training

- Additional training:
  - Changes in the workplace or employee's job
  - Changes in policies or procedures
  - Indications that the employee has not retained understanding or skill
- Training oversight or provision by a person knowledgeable in the subject matter related to employee's job duties
- Opportunity for interactive question and answers

1910.502(o) Anti-Retaliation

- Employers must:
  - Inform employee of their right to protections
  - Not discharge or discriminate against any employee for exercising rights under the standard

1910.502(p) Requirements Implemented at No Cost to Employees

- Implementation of requirements is at no cost to employees

Exceptions: employee self-monitoring for signs/symptoms of infection

1910.502(q) Recordkeeping

- Exemption : Employers with ten or less employees
- Required records:
  - All versions of COVID-19 positives (regardless of whether work-related)
  - Employee's name, contact information, occupation, location of work, date of last day at workplace, date of positive test or diagnosis, first date of symptoms if any
  - Recorded within 24 hours of the employer's learning that the employee is COVID-19 positive

1910.502(q) Recordkeeping

- Available by end of next business day after a request
- COVID-19 plan: to employees, personal representatives, authorized representatives
- Individual COVID-19 log entry for a particular employee:
  - to the employee, anyone having a written authorized consent from employee
  - Redacted version of COVID-19 log with personally identifying information removed: to any employee, personal representatives, authorized representative
  - All records: to the Assistant Secretary

1910.502(r) –Reporting COVID-19 Fatalities and Hospitalizations to OSHA

- Work-related COVID-19 fatalities within 8 hours of learning of the fatality
- Work-related in-patient hospitalizations within 24 hours of learning of the hospitalization

1910.504 Mini Respiratory Protection Program

- Applies only to respiratory use in accordance with 1910.502(f)(4): Use of respirators when not required:
  - When the employer provides a respirator to the employee instead of a facemask as required by (f)(1)
  - When an employee provides their own respirator instead of a facemask required by (f)(1)

Applicability of 1910.504 vs 1910.134

- 1910.502(f)(2): for exposure with expected/confirmed COVID-19 - ***1910.134 applies***
- 1910.502(f)(3): for AGP with suspected/confirmed COVID-19 – ***1910.134 applies***
- 1910.502(f)(4): in place of facemask when respirator is not required – ***1910.504 applies***
- 1910.502(f)(5): for Standard and Transmission Based precautions – ***1910.134 applies***

Key Elements of Mini Respiratory Program vs Respiratory Protection Standard

3 key differences for mini respiratory program

- No medical evaluation needed
- No fit test needed
- No written program required

1910.504(c) Responsibilities of Employers When Workers Provide Their Own Respirators

- Provide workers with notice in 1910.504(c) – informs them to take precautions to be sure the respirator itself does not present a hazard

1910.504(d) Training Responsibilities

- Provide specific respirator training such as:
  - How to inspect, put on, remove, use a respirator
  - Limitations and capabilities of the respirator
  - How to store, maintain, inspect a respirator
  - How to conduct a user seal check
  - How to recognize medical signs and symptoms and what to do
- Training must be in appropriate language and literacy level:
  - Before the first use of the respirator
  - Seal checks before each use
  - Reuse properly

1910.509 Incorporate by Reference

- The material listed in this section is incorporated by reference into this subpart

Implementing ETS

- COVID-19 Plan Template
- COVID-19 Healthcare Worksite Checklist & Employee Job Hazard Analysis
- Sample COVID-19 Log
- Reporting COVID-19 Fatalities and In-Patient Hospitalizations to OSHA
- Employer Notification Tool
- Communication and Coordination Between Employers
- Sample Employee COVID-19 Health Screening Questionnaire *(Spanish)*
- Notification Removal and Return to Work Flow Chart for Employees
- Notification Removal and Return to Work Flow Chart for Employers
- Employee Training Presentation – Healthcare ETS
- Employee Training Presentation – Mini Respiratory Protection Program

https://www.osha.gov/coronavirus/ets

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DSP Wage Increase Impact of Individuals Budget

Cathy Robinson
Director, BDDS

Agenda

Conversion Process
Approach – what was different
Process for Unit Reductions
Conversion Issues & ‘Mini Conversion’
Allocation Impacts & Reasons for Reductions
Team Discussions
Buckets

Rate Increase Conversions

As part of implementation of rate increases, BDDS conducts a conversion by which the rates are rolled out in systems (InSite, CoreMMIS) and CCBs and NOAs are updated accordingly to capture the rates, and to ensure the Objective Based Allocation stays within the approved amount.

This implementation was slightly different…

Rate Conversion Approach

Differences

- Timeline
- Issues identified, which resulting in a second ‘mini’ conversion

Conversion & Allocation Impacts

When a situation exists where an individual is set to go over their OBA as the result of a rate increase with one or more services, BDDS will systematically apply the rate increases against the allocations and then automatically reduce units of services on the CCB to bring the allocation within the existing approved allocation.

When rates increase on the FSW, if the cap is not increased services will be reduced or lost and even if the cap is increased, some services are lost regardless

When rates increase on the CIH, generally the allocation increases (but in this case, not fully).

Historically some service reductions are caused by rate increases, for a variety of reasons.

Unit Reduction Approach

1. We start with the last month of the plan that is available to be reduced and reduce all eligible services by one percent.
2. If still over, we go to the next to last month that available to be reduced and reduce all eligible services by one percent.
3. BDDS will repeat with the next months until all available months have been reduced by one percent.
4. If still over cap, start with the first step above and reduce by another percent for a total of two percent.
5. Repeat until budget is under the cap. When the reduction is applied, the "units to be retained" will be rounded-up (fractional units are not allowed).

Case Management & Res Hab Daily are not eligible services to reduce

Issues Identified

During the initial conversion, some issues were identified and encountered:

A number of individuals on the CIH were already over their allocation before the conversion. This happens but is not common and usually is a result in a change in the budget, where the case manager has not yet addressed it on the CCB. We made case managers aware of these situations prior to the conversion.

Insite was not applying limits to Transportation on the FSW. Case managers were also not adhering to the waiver restrictions for this service for many individuals, causing some to have further reductions.

This particular issue resulted in a second ‘mini conversion’ for anyone with the Transportation service.

Issues Identified and Mini Conversion

Because of the significance of the Transportation issue, BDDS had to complete a ‘mini conversion’ to further recalculate allocations to fully capture the allowable Transportation cap.

This resulted in a second round of CCBs and NOAs being issued for those individuals who had the Transportation service on their plans.

This second round ensured that BDDS adhered to the current rules and requirements for the existing Transportation caps, and it allowed for BDDS to implement system rules to prevent future instances of individuals’ Transportation units going over the allowable amounts.

*BDDS does not currently have approval to increase the pre-existing caps for Transportation on the CIH or FSW.

Post Conversion

Once BDDS completes the conversion activities, and issues updated CCBs and NOAs, additional steps are usually needed by the team.

The changes made to the CCBs as part of the conversion are solely intended to ensure the budget stays within the approved allocation.

The updated CCBs SHOULD be revisited by the team to ensure the individuals' needs and preferences are fully considered. In many situations the case manager will need to update the CCB again to reflect any adjustments or changes that are needed to reflect individualized support needs in a person-centered manner.

Team Discussions

In review of the new CCBs, teams should support individuals in evaluating what adjustments or changes may need to be made to account for what the new CCB and allocation can support.

For individuals on the FSW, this is generally limited to looking at reconfiguring services in consideration of any units that were lost. It could also mean looking at what other services or supports (paid or unpaid) that may be able to augment budgeted services.

For individuals on the CIH, allocations were adjusted to account for rate increases occurring in the ‘day services’ bucket and the ‘residential habilitation’ bucket. The third bucket of the OBA is the ‘behavior supports’ bucket.

The Buckets

While many of you recall we ‘unbucketed’ our budget allocations several years ago, the core elements of the allocation calculation, or OBA, are still based on assessed needs of day service supports, residential supports, and behavioral supports.

Both the residential bucket and day services bucket were increased in conjunction with the approved rate increases, however there was no approved rate increase to behavioral support services, so that part of the CIH allocation did not increase.

Because the rate for BMAN services didn’t increase, neither did the allocation, so if the other services that were purchased with those funds had rate increases, the number of units ultimately had to be reduced

This appears to be the situation for situations where more units were reduced.

Reasons for Reductions

CIH

- ‘Buckets’ issue
- Existing budget over approved allocation
- Plan year timing and service ‘loading’

FSW

- Transportation limit already exceeded
- Plan year timing and service ‘loading’

*Allocations could be ultimately impacted by one or more of the above

Takeaways & Other Questions

Systems issues

Conversion CCB vs. Actual need and team discussions

Data issues post conversion

Other Questions?

Association Update

Nanette Hagedorn, INARF

Membership Recruitment

Welcome New Organizational Member …

= 72

AID of Indiana: Located in Ft. Wayne, IN, AID of Indiana began in 2016 as an idea, a dream, and a desire to see quality driven and positive residential and community programs.
Per Executive Director, Latasha Lesure, "*AID of Indiana's purpose of pursuing INARF membership includes a vast range of hopes for the future of our business and our field. As this field continues to evolve, AID hopes to be a part of a group that is involved with assisting all individuals of all abilities to grow and achieve independence with dignity.*"

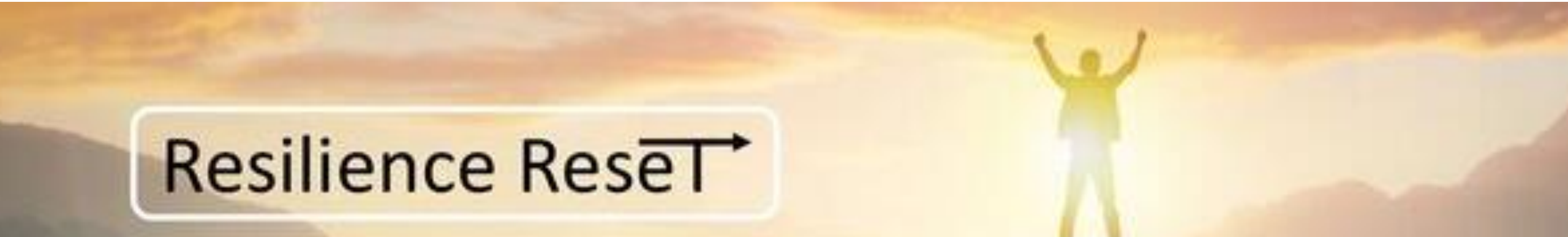
Agency Overview:

- For Profit
- Staff: Full-time 132, Part-time: 180, Volunteers: None at this time
- Accreditations: CARF
- Clients Served: 378
- Services Provided: Community Habilitation, PAC, Residential Habilitation, Respite Care Services, Transportation, and Wellness Coordination
- Counties Served: Adams, Allen, Blackford, DeKalb, Elkhart, Grant, Hamilton, Henry, Huntington, Jay, Kosciusko, LaGrange, Madison, Marion, Marshall, Noble, Randolph, St. Joseph, Steuben, Wells, and Whitley

Association Current Initiatives

2021 Pre & Annual Conference: **Early Bird Deadline August 31**

- ✓ Al Condeluci, Keynote
- ✓ 35 Diverse Educational Sessions
- ✓ 42 Exhibitors featuring new and innovative Resources & Solutions
- ✓ 15 Artisans showcasing hand-crafted items for sale and insights into their Art Programs
- ✓ 1 Celebratory Annual Award & Scholarship Recognition Luncheon
- ✓ Unlimited Opportunities to Revisit Old Friends and Meet New Ones
- ✓ and….



2021 Pre & Annual Conference: Early Bird Deadline August 31

✓ Updated **In-Person Meeting and Event Protocols:**

I. Guiding Resources continue to be - Centers for Disease Control and Prevention (CDC) Guidelines; Indiana Executive Orders and County Transmission Data

II. Safety Protocols will include –

- Mask wearing is recommended and customized masks will be provided to all Conference attendees
- Registration Desk with be fitted with plexiglass sneeze guards
- Social distancing accommodations will be offered when possible
- Signs will be posted as reminders to wear masks, wash hands often, and think twice before shaking hands

Association Current Initiatives

2021 DSP Virtual Conference – September 8

Line-up -

We Couldn't Get Through this Pandemic without YOU!

Kim Opsahl, Director - Division of Disability & Rehabilitative Services, Indiana Family and Social Services Administration

Person-Centered Practices and the DSP

Gwen Chesterfield, Education & Human Services Consultant, Gwen K. Chesterfield, LLC

Improving Communication with Internal Stakeholders

Jan Breiner Frazier, Managing Partner, and Christine Shepard, Partner, Planning Plus, LLC

Positive Behavior Supports, Perception, and the Pursuit of Happiness

Kelly Hartman, President & CEO, Insights Consulting, Inc.

Being the Best YOU!

Alonzo Kelly, Strategic Leadership Partner & Executive Coach, Kelly Leadership Group, LLC

Registration Tiers - **NEW**

Leadership Academy: Class of 2022

- ❑ October 6 - Curriculum Unveiling at the Annual Conference
- ❑ October 19 - Call for Applications
  - ✓ The Academy will be offered at the Embassy Suites Noblesville Conference Center; will meet four times a year (March, April, May and June), with each session lasting two full days; and Graduation to occur during the June INARF Member Forum.
  - ✓ The Class of 2022 will be limited to 24 individuals who will be selected based on the **quality** and **thoroughness of their essay** balanced with consideration of their **organization's geographical location** and **size,** and the **applicant's position** and **experience** within the industry. Tuition is $1,095.
- ❑ November 16 – Applications due (limit 1 per organization)
- ❑ December 13 – Applicant Notification

inarf Leadership Academy

Industry Update

John Barth, Katy Stafford-Cunningham, Brian Carnes, and Phillip Parnell, INARF

COVID-19 Vaccine Updates

- The Biden Administration has made several important COVID-19 vaccine updates in recent days:
  - Advise boosters for most Americans 8 months after vaccination
  - Nursing home residents and health care workers will most likely be the first to get booster shots
  - Pfizer's two-dose vaccine received full approval from the US Food and Drug Administration. This is the first vaccine to be fully licensed vs emergency use status.
- INARF has communicated with DDRS on vaccine availability and whether opportunities for distribution will be made available for this round. DDRS advises to proceed with existing pharmacy partners.

Vaccination Requirements in LTC

- Per an announcement from CMS on August 18th, the Biden Administration plans to require staff vaccinations at all Medicare and Medicaid-participating nursing homes.
  - Nationally, 60% of nursing home staff are vaccinated
- Via consultation with ANCOR, INARF's understanding of HHS' intent for the emergency regulation is that it will not apply in settings beyond nursing homes.
- However, we will not have certainty until the proposed regulation is publicly available, which CMS projects to issue in late September
- INARF will continue to stay in close contact with ANCOR, as well as the Indiana Department of Health and the Indiana Health Care Association

DSP Wage Increase Update

- INARF has held multiple meetings providing technical assistance on the implementation, including a joint meeting with DDRS and the Arc held on August 19th. The recording of the INARF Financial Management Meeting is available. FMS recording.
- As discussed in BR202133, claims processed from July 1, 2021, through Aug. 17, 2021, for the services in Table 2 of BR202133 will be mass adjusted, as appropriate. Providers should see adjusted claims on Remittance Advices (RAs) beginning Sept. 22, 2021.
- Reminder that implementation plans are due to DDRS by September 1, 2021.

Quality On-Site Provider Review (QOPR) Update

- Beginning in September 2021, each quarter approximately 30 providers will be selected to participate in a QOPR
- BQIS will review key CMS regulatory requirements and will conduct a person-centered review which will include conversations with individuals and their families and on-site review observations
- Through this evaluation, BQIS will be able to identify best practice models among service providers and provide technical assistance
- BQIS QOPR Process webinar – August 27, 10-11 AM EDT

DDRS Advisory Council: COVID-19 Data

- BDDS COVID Positive Cases – as of 8/15/21
  - CIH: 1523
  - FSW: 1186
  - SGL: 872
  - Total Cases: 3,581
  - Total COVID Related Deaths: 56
- Total number of Staff COVID Positive Cases
  - Waiver: 1433
  - SGL: 641
  - Total Cases: 2074
  - Total COVID Related Deaths: 5

Upcoming Events

- Welcome Reception for Secretary Rusyniak & Kim Opsahl
  - Joint event with The Arc of Indiana
  - September 2, 3 PM – 5 PM
  - Lobby of 143 W. Market Street, Indianapolis
- Save the Date!
  - INARF & The Arc of Indiana Critical Issues Forum – December 1
  - Topic Announcements Coming Soon!

Contribute to the PAC

Your contributions to the INARF PAC are a critical part of INARF's legislative advocacy efforts. They are used to support elected officials who serve as champions of the provider community. Please consider supporting the INARF PAC today.

INARF PAC

For more information and to contribute, visit: www.INARF.org/INARF-PAC

Upcoming Managed Care Education

- September 24 - INARF Member Forum (virtual)
- October 5 - INARF Pre-Conference Leadership Symposium
- October 7 - INARF Annual Conference Educational Session

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Thank you!

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