

Going Home Plus – Advisory Council

Queen Lili`uokalani Building,
Board of Education Board Room

April 16, 2009

Minutes

Introductions/Present: Madi Silverman, Christy Nishita, Becky Ozaki, Leslie Tawata, David Fray, Keith Ridley, Ruthie Agbayani, Leolinda Parlin, Waynette Cabral, Sheryl Nelson, John McDermott, Linda Guess, Lou Erteschik, Garrick Lau, Lani Akee, Marie May, Patti Bazin

Progress and Updates

- General discussion: a) John McDermott provided an update on legislation about training for nursing homes. b) David Fray reported that the Visions curriculum is being updated by Josie Wall. DOD-DDD will work with Leeward Community College when completed for training in adult foster homes. Issue is behavior. DDD has a new policy for behaviors and restraints. Aware of about 100 people who have DD diagnoses in hospitals and nursing homes.
- MFP binder distributed and reviewed policies and procedures:
 - Supplemental Transitional services– provides deposit for first month rent, some clothing, furniture and other start up needs for persons moving to own home or apartment.
 - Going Home Plus (GHP) residences (Foster homes) can only have 4 or less people.
 - Referral form is available in the binder and on-line. Will modify the form to include the 1150 form. Any recommendations for the forms please share with Madi. Tried to keep language at 6th grade level. Also requested feedback for the website.
- Suggestion: Development Disabilities Division – DDD waiver no longer uses the term “MR” except for ICF-MR facility.
- Madi Silverman attended CMS conference for all Money Follows the Person grantees and shared that HI is below target numbers. Many states are in same situation. However, some states have moved too fast and many individuals have died.

- Review of GHP Referral and Transition process: Discharge process is slow to ensure everyone is stable. Person must be in a nursing home for a minimum of 6 months. Need to make sure there is a good place for individuals to transition. Have targeted the hospitals but those in hospitals are usually complex cases. They may have people that are on the waitlist but don't meet GHP criteria either because they have not been in the facility for 6 months or not eligible for Medicaid services.
- Late referrals: A problem that needs to be addressed is the receipt of referrals for persons who are moving out of a facility immediately but have no support services. Need to get the word out to grow the project. Options/ ideas needed on how to get GHP information to agencies:
 - Work with social workers get information in their newsletter and attend quarterly meeting,
 - Hawaii Health Systems Association
 - Talk with Dr. Ellis, Evercare Health Plan
 - Olelo and public service announcements
 - Get GHP information in all newsletters,
 - Speak at Waikiki Board and be on TV
 - Kupuna Connections broadcasts
 - Elderhood project with Kirk Mathews – every Thursday morning at 6:00 am.
- Institutional providers need to know that if a participant leaves AMA he/she can't participate in GHP program.
- Coordination meetings: Madi Silverman is working with Ohana and Evercare health plans to discuss coordinated services. She will present at the Long-Term Care social worker quarterly meeting on May 8. She is also working with Leahi, Maluhia, Hilo Medical Center, and Hawaii Health Systems Corporation. Madi met with Hawaii Centers for Independent Living to discuss a potential partnership on housing coordinator issues. HCIL recently hired a new person on Big Island of Hawaii who has experience with a nursing home transition project in Las Vegas.

Referral and Transition Numbers to Date: see evaluation report – 6 transitioned as of April 1, 2009

- Discussed profile of transition candidates and participants

- Of the 5 that did not meet GHP eligibility requirements: provide information about what the project did even though they don't count for the project
- Break down the island information- compare current GHP numbers to the number on the hospital waitlist on each island
- Page 3- change quad and para to paraplegia and quadriplegia
- Important issue: trying to find the right match between the case manager and participant - call it post transition adjustment. Are there issues because participants don't have their immediate needs met?

Case manager issues: teaming some of the issues, recognizing the participant will have fears about the transition.

Challenging to get the service package together to make it right for the person. How do we identify what the clients issues are when they come out? How do we consistently deal with those transition issues? How are things going, are they resolved and how do clients feel about being out. Develop tool to evaluate the transition process. Working with 8 case management groups now. Two additional agencies just committed.

Challenges and Recommendations:

- Obtaining provider, self, and family referral.
- Enrollment and placement – need to be known as one-stop, first stop referral.
- Training case managers on how complicated and time consuming the task is and providing appropriate information to prepare them.
- Housing – can't find in the community. One referral does not want to be separated from her family so this woman won't go to a foster home. GHP is proposing to use foster home as a stepping stone before moving to independent living for many.
- Hilo Medical Center may need power scooters. Medicare doesn't pay for them.
- Many homeless individuals in facilities – haven't tackled that issue yet.
- Have a housing case manager assigned to participant – they might move up on the housing waitlists.
- There are community case managers for homeless- need to identify how to coordinate with them for placements. Can target the homeless who are the current HUD priority.
- Partner with Catholic Charities regarding group homes – Betty Lou Larson and Tom? Need to follow up and see what kind of homes. Want to move people to their own apt or a licensed home.

- Availability of foster homes: have had difficulties in identifying homes. Issue of identifying vacancies. List of 900 homes but can't tell where the vacancies are. Need to centralize the homes vacancies. Conducted survey to ask foster homes what kind of clients they would like to take and 115 responded. Will create a database with different homes to identify who is more interested in taking certain types of clients. What about Real Choices? Talked with Community Ties of America (CCFFH licensing agency) to assist the GHP project to get the survey completed with all new foster home applicants and possible updates with license renewals. Recommendations on how this can be accomplished. In hands of health plan and need to be able to identify where the vacancies are. R-tones – only as good as reports. Fewer beds available to Medicaid – homes holding out for private-pay clients.
- Need to develop a RN and LPN list based on foster home survey database.
- Suggestion to focus on people in nursing homes that are not as complicated as the hospital referrals. Talk to nursing facility resident councils. Are facilities taking advantage of the GHP by trying to move out problem cases? How do we get to the residents' families involved and informed? Have the GHP brochure in admission package to inform people or options.
- Training Needs:
 - General consensus: homes are dealing with current level 1 and 2. Payment schedules rate is based on SSI or . Level 1-2 \$16, 2-3 \$16, level 3+ \$20 around \$80 per day. E-Arch needs behavior training. Visions training is only for the DD providers. Not about money, it's about training. Even home accessibility is an issue. Training component could be provided as the "Counseling and Training" waiver service – one-on-one training. Looking at providing behavior training. and UH will assist. Currently, there is a snag in the proposal to develop the training institute. May need to find another trainer group.
 - Wound care – treatment and prevention – can consultants go to the homes to assist – will project pay for in-home services?
 - Issue- coverage at the foster home while caregiver is at the training program. Maybe offering training through Olelo TV? What are other avenues to offer training? How do you grade training? How do you know the knowledge is acquired? TV is one approach but need case managers to follow up.
 - Trainer recommendations: Office of Health Care Assurance would like to participate.
 - Shared resources with OHCA, GHP and Ruthie Agbayani to get the people. Ruthie Agbayani wanted to do a conference. Issue -everything is

aggregated at conference instead of having reinforcement with lessons learned. Madi Silverman will meet with Ruthie Agbayani about training needs.

- Recommendation for people to participate on training committee.
- Have a separate meeting with ICF-MRs.
- Federal regulations for nursing homes: residents have a right to be fully informed. Recommendation to mandate through DOH that GHP information be shared with residents. Facilities can be cited if information has not been shared. Have DHS and DOH work together on the survey. DHS has OBRA 87 – ask them to add – DOH and DHS need to coordinate to make sure that OHCA informs clients.
- Nursing home Minimum Data Set (MDS) report identifies various levels of functioning and Madi Silverman will work to identify people who might be interested in the program

Olelo 834-0007 – use of Kapiolani Community College studio, do TV training. Talk with Lou Erteschik about show on 4th Friday of month.

Next meeting: Thursday, September 10, 2009 10:00 to 12:00.