

## **Going Home Plus (GHP) Stakeholder Meeting Minutes**

September 16, 2009

10:00am to 12:00 noon

DOE Boardroom

In attendance: Madi Silverman, Christy Nishita, Patti Bazin, Sharon Ogawa, Waynette Cabral, Sheryl Nelson, Nathan Say, Ruthie Agbayani, Lou Erteschik

### I. Introductions

### II. Progress and Updates

- a. GHP presented an overview of referral and transition numbers to date (see Evaluation Report- September 2009)
  - i. Question: How do we handle out of state referrals? HI GHP is working closely with other state on transition [requires careful planning and coordination which includes Medicaid eligibility, transport, payment for equipment and supplies, start date of GHP payment. GHP will learn lessons from the 3 current out of state participants.
  - ii. Question: How many participants have returned to facility? Madi discussed the situation of 1 participant who has returned to the hospital that include both cost and lack of support from family. GHP is working on plans to cost – effectively move the participant back to the community. Other questions were raised as to the participant’s preferences and the age of parents.
  - iii. Question: Does GHP look at the cost effectiveness of participant? If a person requires a lot of services in community, is it more cost-effective to be in facility? GHP indicated cost is closely monitored and cannot be more costly than a facility.
- b. GHP announced that the project is extended to 2012 and 2013. December 31<sup>st</sup> is the last day to admit a GHP participant. States progress meeting their projected goals has been slower than anticipated.
  - i. Question: How Hawaii compares with other 31 grantees? GHP indicated that we are probably in the bottom 5 states in terms of meeting transition targets. Other higher performing states were recipients of an earlier CMS nursing home transition grant and started the current MFP grant with experience and a system in place. Hawaii progress has also been seriously impacted by the State’s move to managed care in 2/09 which will take some adjustment.
- c. New referral process- Use of MDS data
  - i. GHP obtained nursing home Minimum Dataset (2.0) information on all HI residents who expressed a preference to transition (based on Q1a) and were approaching or reached 6 month eligibility criteria. GHP is preparing to use this information to visit facilities and talk with residents on this list.
  - ii. Comment: GHP referrals from facilities have been increasing. Not all are challenging cases, however the number of referrals who no longer meet level of care in the nursing facility are still high.
  - iii. GHP reminded stakeholders that the project referral form is on the GHP website. Form helps to ensure minimum eligibility criteria: Medicaid, length of stay and Level of Care scores.
- d. Collaboration with NFs and Hospitals

- i. GHP shared the facility PowerPoint presentation slides on “discharge planning for success”, i.e. Resident preparation activities (PT/OT, diet, medication), family preparation, documents needed, and services that need to be in place.
  - 1. For example, diet is an important area for pre-discharge planning. Residents need exercise, nutrition counseling, and possible restrictions on type and quantity of outside food. In community- it is too costly to have 2 “agency” assistants in the home for multiple daily transfers/ repositioning of participant.
  - 2. Comment: diet issue in foster homes is complicated because it is the participant’s choice. Foster home caregivers would be worried about complaints.
  - 3. Comment: Discharge planners need to focus on the outcome the resident is trying to achieve. If resident cannot be accommodated in the community because of size/weight, it may become a motivator for resident to lose weight.
  - 4. Comment: Many concurrent issues going on that complicate the ability to lose weight and return to the community. Individuals need to set their own goals.
  - 5. GHP believes in a team approach (individual, family, health professionals) to discuss individual’s goals and what will it take to achieve success. A lot of time is spent with the individual post-transition as well.
  - 6. Comment: Make sure you introduce choice slowly. If a person is institutionalized for a long time, making own decisions will be difficult
  - 7. Comment: Setting goals can be an important motivator. Another goal: become as ambulatory as possible to assist in transfers. This may be a motivator for a person to return to community.
  - 8. GHP shared success stories- participant who lost 300lbs and now ambulatory. Another participant who worked hard to learn how to transfer in order to return to the community.

### III. GHP coordination with QExA health plans

- a. GHP now meeting with service coordination staffs from both QExA plans to keep the plans informed about GHP eligibility and enrollment mechanisms.
  - i. Question: How does GHP overlap with plans? QExA plans identify GHP eligible individuals. Contracted case managers with the QExA plans are currently the GHP case managers. QExA service coordinators and contracted case managers oversee capitated HCBS services for individuals who have been institutionalized less than 6months. GHP will be paying for those whose length of stay is >6mos in a facility. After 365 days, the QExA plans will pay for continued HCB services under their HCBS capitation. GHP is trying to ensure participation in the MFP grant for all eligible facility residents so that the state can capture the MFP’s enhanced federal match-especially during the State’s current financial crisis.
  - ii. GHP mentioned that stimulus funding is available for the project.

### IV. MFP Policy Addendum: Qualified Residence- Apartment with an Individual Lease

- a. CMS policy addendum outlines 7 conditions that must be met in order for assisted living providers to participate in the MFP demonstration as a qualified residence

- b. ALF issue: Whether current DOH-OCHA rules allow “aging in place” to occur in the ALF. OCHA currently has very restrictive policies on level of care /disability as it related to participants ability to maintain their ALF housing.

#### V. Housing-

- a. GHP Housing Coordinator position: GHP is recruiting a housing coordinator, position is on Work at UH site and Going Home Plus website ([www.cds.hawaii.edu/goinghome](http://www.cds.hawaii.edu/goinghome))
- b. HUD Voucher Opportunity for institutionalized residents: In July a NOFA came out that 1000 housing vouchers would be available specifically for MFP participants. Hawaii submitted public comment on the NOFA. To date the final application has not been announced. Hawaii in the process of determining how many facility residents would be eligible/benefit for vouchers:
  - i. Limitations
    - 1. Persons must already be on a housing voucher waitlist
    - 2. Those that HI identifies MUST be transitioned. E.g. if we say that HI needs 10 vouchers, we must use the 10.
    - 3. Hawaii numbers are really small. So far, GHP has identified 3 persons that would benefit. It is questionable whether the public housing authority will complete lengthy application process for these 3 persons.
    - 4. GHP sent out an email to the facilities asking them to identify potential residents that could live independently. If there is a potential candidate, need to get them on housing voucher waiting list ASAP. GHP will send out another email soon.

#### VI. Technical Assistance

- a. HI has been identified by CMS to get technical assistance on:
  - i. Direct Service Workers
  - ii. Quality

#### VII. Training Institute

- a. Working with Kapiolani Community College on a training institute grant award from Hawaii Community Foundation
- b. Target: case managers, foster home caregivers
- c. First step approach- “Train the trainer” models
- d. Training areas to be developed by end of 2009:
  - i. Caring for Heavier Residents
  - ii. Philosophy of Client Directed Care- enabling individual to be independent
- e. GHP exploring different formats and modalities for delivering training.
- f. Key issue- Coverage for primary caregiver who leaves the home to receive training, ?
- g. Cost of training - may be at no cost in the beginning. Will need to be a modest cost so that the project can be sustained.
- h. Other training modules will be developed by KCC in year 1, for example:
  - i. Medication management
  - ii. Skin/wound care
  - iii. Culturally appropriate nutrition
  - iv. Diabetes management
- i. Training for case managers to start Oct/Nov and foster home caregivers to start by the end of the year.
- j. Comment: can we come up with more positive, inviting titles? Titles suggested for the Obesity training included: “Showing skin successfully”, “SOS: save our skin”, “Love the skin you’re in”

### VIII. ICF/MR facilities

- a. GHP wants to support DOH case managers in transitioning persons from ICF/MRs.
- b. GHP has had mtgs. with ARC of Hawaii. ARC wants to preserve the ICF/MR placements. GHP looking at ways to proceed. GHP would like to consider identifying clients who can return to DD Doms, some ICF-MR conversions to DD Doms, DD-Dom conversion to DD-FH, increased use of DD foster homes, ideas for new living arrangements. Issue: Providers dependent on higher ICF-MR reimbursement, due to Hawaii's current financial climate.
- c. GHP plan: Identify ICF/MR residents who have reached their max bed-hold days as candidates to move to a less restrictive environment.
- d. DDD has greatly increased the number of DD foster homes. There are a number of vacancies in those homes. GHP will explore how to reach these homes. DDD has also recruited a large number of RN homes

### IX. CTA-Certified Foster Homes

- a. GHP sent out a survey to all foster homes as well to ask basic info: professional background of caregiver, wheelchair accessibility, types of conditions interested in caring for (diabetes, HIV, dialysis, obese) GHP would like to make this survey part of the foster home application and renewal process.
- b. As a result of the 2009 legislative session- foster home vacancies being reported on DHS website. Problem: Not all homes reporting vacancies or when it is filled.
- c. Goal: GHP would like to develop a database that case managers can use to identify homes that are interested in caring for specific conditions.

### Comment from Stakeholders:

- Need to meet more frequently- try to schedule next meeting for December.