

Hawai‘i Going Home Plus Operational Protocol

B. DEMONSTRATION IMPLEMENTATION AND PROCEDURES

B.1 Participant Recruitment and Enrollment

Target Populations: The target populations for Hawaii’s *Going Home Plus* will be elderly, physically disabled and DDMR individuals of all ages who reside in nursing facilities, hospitals and ICF-MR facilities. Persons with mental illness and traumatic brain injury who are nursing facility level of care (LOC) may also participate in the *Going Home Plus* and will be reported under the elderly or physically disabled target population. Medically fragile children admitted to the *Going Home Plus* will be reported under the disabled target population. The *Going Home Plus* demonstration will be available on a statewide basis.

a. Participant Selection Method: Identifying Individuals for Transition

Facility residents will be identified for *Going Home Plus* participation using several methods that include the following:

- Facility residents may self select to participate in the demonstration;
- Family and friends may advocate for the resident to move to the community;
- Facility staff may identify individuals who desire to return to the community and/or who would be good candidates for discharge;
- Department of Health (DOH) State licensing staff and the Ombudsman may identify individuals who desire to return to the community and/or who would be good candidates for discharge and
- Strategic targeting of potential candidates using assessment tools available to the State.

In addition, the Department of Human Services (DHS) will be providing continuous community outreach education and information services, described later in Section B.3 Outreach, Marketing, and Education, to inform the public about the *Going Home Plus* program.

Residents in Nursing Facilities. MDS data. In Hawaii, MDS data is maintained by the DOH/ Office of Health Care Assurance (OCHA) State licensing branch. DHS has a data use agreement and will be using a Medicaid consultant to produce MDS reports for the MFP to identify potential MFP participants. DHS plans to run a quarterly MDS report to extract the scores for Section Q, question 1.a “, Section Q, question 1.b, Cognitive Performance Scale (CPS), Resource Utilization Groups (RUG) and Activities of Daily Living (ADL).

A trial report of Section Q.1.and Q.1.b. produced very low numbers of individuals expressing interest to transition. For that reason, the *Going Home Plus* will not rely solely on Section Q to identify interested participants. Residents with low CPS and RUG scores, reflecting less complex needs will be targeted first. As the project gains experience, the MFP will increase the score range to identify potential transition candidates. Residents with high CPS and/or RUG scores who request transition assistance will not be excluded from the demonstration if there are adequate formal and informal supports available to support a safe and successful home or community-based transition.

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DHS1147 Level of Care (LOC) Evaluation Tool. The DHS1147 Level of Care evaluation is a State tool that is used to determine nursing facility level of care. The State uses the same tool for nursing home beds and home and community based 1915c waiver program admissions, annual reviews and mid year LOC changes. DHS will review the functional scores and skilled nursing information from the DHS 1147 LOC tool to identify potential transition candidates. The results of the MDS and DHS 1147 reports will be matched to generate a list of potential candidates. Individuals with higher LOC scores will not be excluded from transitioning if they express a desire to transition, and if there is a community residential setting where adequate formal and informal supports can be established.

Residents who responded positively to Section Q.1.a. and/or Section Q.1.b. will be mailed a letter that provides a brief description of the program services, explains why they are being contacted, provides contact information for the transition coordinator and invites them to notify the nursing facility staff of their interest in transitioning. In addition, DHS will provide lists of potential candidates identified by the MDS and 1147 cognition and functioning scores to transition coordinators. This list will be given to the transition coordinators, who will then begin contacting residents, family members, and guardians by telephone or in person (as appropriate) to introduce the project and set up an initial meeting.

Additional strategies to assist DHS to identify potential *Going Home Plus* candidates will be to work with to the Office of Health Care Assurance to determine strategies to increase the consistency and response rate by facilities to Section Q on the MDS. As noted in a discussion paper by Reinhard and Hendrickson¹, the project is also open to advocating to CMS for a improvements in the question wording and the user manual in Section Q to be more direct, structured, and positive toward transitioning. Until improvements to Section Q are made, the project will administer the California Nursing Facility Transition Screen² (CNFTS) to all candidates at an initial meeting as a structured and direct means of determining the resident’s preference to transition. Finally, DHS will provide additional training to hospitals and nursing facilities on the DHS1147 Section XXX, about counseling on the HCBS community options available.

Residents in Hospitals. In addition to maintaining a small number of certified nursing home beds, hospitals have an increasing number of complex “challenging patients” who are medically stable and waitlisted for nursing facility placement. While these patients occupy acute care beds that otherwise would be reserved for patients with more acute medical problems, the hospital is only compensated at the nursing home reimbursement rate and fewer beds are available for sick patients.

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¹ Reinhard, S.C. & Hendrickson, L. (2007). The Minimum Data Set: Recommendations to help States better support nursing home residents who seek community living. New Brunswick, NJ: Rutgers Center for State Health Policy.

² Nishita, C.M., Wilber, K.H., Matsumoto, S., & Schnelle, J. (2008). Transitioning Residents from Nursing Facilities to Community Living: Who Wants to Leave? *Journal of the American Geriatrics Society*, 56, 1-7.

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DHS will receive monthly lists of patients who are ICF or SNF acute waitlisted in hospitals and select the individuals who have been institutionalized for six months. DHS will compile the DHS1147 LOC scores and provide this data to the transition coordinator who will conduct a preference assessment using the CNFTS on each eligible hospital waitlist patient.

In addition, DHS1147 LOC Evaluation and MDS data will be used to identify potential *Going Home Plus* candidates currently in hospital nursing home beds. As in the nursing facilities, the results of the MDS and DHS 1147 reports will be matched to generate a list of residents who will be contacted to determine interest in transition. Individuals with higher scores will not be excluded from transitioning if they express a desire to transition, and if there are adequate formal and informal supports and an appropriate residence available for a safe and successful transition. Hospital residents in NF beds who responded positively to Section Q.1.a. and/or Section Q.1.b. on the MDS will be mailed the same letter that is used in the nursing facilities described in the section above.

Residents in ICF-MRs. Identification of potential *Going Home Plus* participants within the ICF/MRs will be achieved by marketing the program to ICFMR residents, their families, DD/MR advocates and ICF/MR facility staff; self/family/ advocate referrals for *Going Home Plus* community living; and resurrecting discussions between the ICF/MR facility providers, the Department of Health Developmental Disabilities Division (DOH-DDD) and the DD Council targeting beds for voluntary conversion to DD foster homes or DD Domiciliary Homes. Other strategies that are being planned include:

- Revising the DHS1150 ICFMR LOC form to document HCBS options counseling with choice
- Reinstating the annual DHS 1150 renewal requirement for the ICF-MR facilities.
- Distributing HCB information from the DOH-DDD to all persons receiving institutional services on an annual basis.
- Creating a team to reassess all institutionalized DD/MR individuals primarily because the LOC forms are old.

In 2008, the existing DHS1150 ICFMR assessments for each of the ICF/MR residents will be reviewed to identify which residents might be candidates for community transition and prioritizing the reassessment schedule, starting with those residents with relatively lower ADL needs.

In January 2009, letters will be mailed to all ICF/MR residents and their families/guardians/ legal representatives inviting them to participate in several informational meetings with the transition coordinator at the ICF/MR facility or agency overseeing multiple ICF-MR facilities. The transition coordinator will promptly follow up on any transition requests.

Access to Facilities

The goal of the *Going Home Plus* project is to build and maintain relationships with the institutional providers in the State. By keeping everyone informed and involved in the development and operation of this project we hope to limit problems related to facility access. The two (2) nursing facility organizations representing the majority of the Hawaii's nursing facilities and hospitals are members of the *Going Home Plus* stakeholder committee. Staff from

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several nursing facilities and hospitals have participated in *Going Home Plus* workgroup meetings. The *Going Home Plus* management team has attended several membership and special committee meetings of both organizations to update and engage the membership in planning and problem solving issues particularly relating to serving the challenging patient group living in the hospitals. The project will assign transition coordinators to facilities geographically, as much as possible. This will provide the constancy and familiarity between the transition coordinator, facility staff and residents that can yield a team process with successful thorough discharge planning results.

Upon submission of the Operational Protocol to the Centers for Medicaid and Medicare Services, the *Going Home Plus* Management Team will schedule meetings with each of the ICF-MR facilities.

Information provided to Potential Participants. DHS will make transition information available to the nursing facilities, ICF/MRs, hospital discharge planners, the Ombudsman, waiver case managers and managed care organizations. Anyone of these providers could be the initial contact for potential *Going Home Plus* participants. An individual may also request transition information and assistance by contacting DHS directly. *Going Home Plus* will be using the toll free lines in the DHS Quest managed care Enrollment Center. Calls for the *Going Home Plus* will be logged and transferred to the Project Director.

b. Qualified Institutional Settings

Qualified institutional settings for the *Going Home Plus* program will include nursing facilities, hospitals, rehabilitation facilities and ICF-MRc facilities statewide. Refer to Appendix X for a list of Hawaii's nursing facilities, hospitals and ICF-/MR facilities.

Nursing Facilities and Hospitals: Hawaii's 50 nursing facilities and 29 hospitals are licensed by the DOH/OCHA. Fifteen (15) of Hawaii's 50 licensed nursing facilities are hospitals with nursing home beds. The state plans to initiate the *Going Home Plus* program on the island O'ahu in 2008 and 2009, then extend services to Maui, Kaua'i and Hawai'i counties in 2010 and 2011. Any transition requests in 2008 or 2009 from the neighbor islands will be accepted.

ICF-MR: The Hawaii DOH/OCHA has licensed 18 small ICF-MR facilities located on the islands of O'ahu and Maui. The *Going Home Plus* program will start enrolling ICFMR residents in 2009, however, the state will not deny any earlier transition requests from ICF/MR residents and their families/guardians/legal representatives.

c. Minimum Residency Period

Individuals must have resided in an institutional setting continuously for at least 6 months to be eligible for the *Going Home Plus* project. Institutional residency may include time spent in a hospital, rehab facility, nursing facility or ICF-MR.

Nursing Facility: Compliance with this requirement will be confirmed using quarterly nursing facility census reports that indicate the admit date to the facility. Additional length of stay

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verification will be retrieved from the Hawaii Pre-Paid Medicaid Management Information System (HPMMIS) claims data if needed. DHS will provide this information to the transition coordinator.

ICF-MR: Compliance with this requirement will be confirmed using monthly ICF-MR census reports that indicate the admit date to the facility. Additional length of stay verification will be retrieved from the HPMMIS claims data if needed. DHS will provide this information to the transition coordinator.

Hospital: This is primarily the “challenging patients” population discussed earlier in this section. DHS will receive monthly lists of patients with admission dates. Transition coordinators will verify the hospital records and DHS will confirm the HPMMIS claims data.

d. Eligibility for Medicaid.

Individuals must have been eligible for Medicaid for a month prior to the transition date to the community. Eligibility requirements will be verified by the transition coordinator regardless of which institutional setting the applicant is residing. Transition coordinators will contact each individual’s DHS eligibility worker to confirm the Medicaid status and later to report the facility discharge date, provide updated financial and residential status and obtain the community spend-down amount when applicable.

e. Reenrollment into the Demonstration.

Going Home Plus participants who are institutionalized during the project period will be considered suspended from the project until the individual can return to the community. When the participant returns to the community he/she will continue their participation in the project until completion of the 365 day entitlement. However, the participant may be discharged from the *Going Home Plus* based on a decision by the individual’s team that the participant’s health and safety is endangered by returning to a qualified community based residence. Reasons for all hospitalizations and re-institutionalizations will be tracked in a quality management database.

Participants who have completed 12 months of demonstration service and are hospitalized or readmitted to a nursing facility or ICF-MR will be eligible for an additional 365 days of demonstration services under the following conditions:

- The participant meets the 6 month residency requirement.
- There is a change in condition that would improve the likelihood of success in the community.
- A thorough review of the original transition will be conducted to mitigate any problems for a second transition.

The *Going Home Plus* Project Director will offer the former participant re-enrollment based on team recommendations and the availability of the needed services and supports. All re-enrollment review and decision processes will be documented in the participant’s record.

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All re-enrollments and hospitalizations that exceed 30 days will be reviewed by a team that includes the transition coordinators, the *Going Home Plus* staff, diagnosis/therapy related specialists and MCO staff as applicable. The review will attempt to determine if the re-institutionalization or hospitalization resulted from a change in the participant’s medical and functional status or from a deficit in a needed service or support under the MFP. The team will recommend supports needed to allow the participant to succeed in the MFP and sustainability in the community setting post demonstration.

f. Processes to Ensure Participants have Informed Choice about Their Care

The transition coordinator is responsible to ensure that the participant and their family are informed about the feasible alternatives available under the applicable waivers, the home and community based services, the available service providers and that the selection of providers is unbiased. The DHS1680 Service Authorization Form (SAF) is used to document freedom of choice, identify the waiver program, the case management provider and describe the appeal process. This form is signed by the waiver participant or representative and the transition coordinator during the initial assessment visit and when the participant changes the case management providers.

Education about the DHS Protective Services programs is provided to all prospective *Going Home Plus* participants. The Hawaii Adult & Child Protection laws , HRS Chapter 346, (Dependent Adults) and Chapter 587, (Child Protective Service), require that any individual who has reason to believe that a child or dependent adult is being abused, neglected, exploited, or is self-neglecting in their home or in the community must report this information to DHS.

- As part of the initial assessment, the transition coordinator conducts an assessment for evidence of abuse, neglect and exploitation; discusses the different types of abuse, neglect and exploitation with the participant, involved family and other unpaid and paid caregivers; explains the participant’s rights; and provides the participant and/or representative with phone numbers and instructions about how to obtain help.
- A copy of the department’s adult protective services and child protective services brochures are provided to the participant during the initial assessment and again as part of the transition/waiver admission packet.
- After transition, the waiver case manager will assess for abuse, neglect and exploitation during monitoring contacts and reassessment visits.
- Participants and/or representatives are also given instruction about timely reporting of adverse events, which include incidents of possible suspected abuse, neglect or exploitation, to the case manager and protective services and/or law enforcement agencies as applicable.
- Contracted waiver provider agencies: All provider service agreements stipulate that service providers must inform the waiver case manager and DHS within 24 hours of the occurrence of an adverse event and submit a written report within 72 hours.