



CO HCBS Residential Stakeholder Workgroup Meeting #4 February 9, 2016

The intent of these workgroups is to problem solve and gather ideas surrounding implementation of the HCBS Settings Final Rule. This group is moderated by The Lewin Group at the request of The Department. The intent of these notes is to capture the exact nature of the comments of the workgroup participants and is not representative of policy decisions or the Department's stance on implementation. Notes from workgroups to date can be found at:

www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule

I. Workgroup Participants

Christina Neill Bowen, The Lewin Group
(facilitator)

Anais Stewart, The Lewin Group (note-
taker)

Caitlin Phillips, HCPF

Adam Tucker, HCPF

Amy Scangarella, HCPF

Megan Phillips, Weld County AAA, SEP

Kristie Braaten, DDRC

Steve Valente, Dungarvin, Service Provider

Carol Meredith, Arc

Anita Evanyo, Rocky Mountain HS

Jennifer Palmer, Greely Center for

Independence

Stakeholders Present:

Ann Turner, Cheyenne Village

Blair Wyles, Rooster Ranch

Megan Hart, CALA/Heritage Haus

Lori Hamilton and Jonathan Wolf, Lennox
Guest Home

Karen Lillie, Pueblo Diversified Industries

Judy Tomcak, Foothills Gateway

Heather Porreca, DRCOG

Hanni Raley, Arc Aurora

Ginger Stinger, Parent

Lori Woods, Jeffco OLTC, SEP

Stakeholders Absent:

Joan Levy, Strive, CCB

Pat Cook, Colorado Gerontological Society

Sarita Reddy, Greely Center for

Independence

Leah Pogoriler, HCPF

Ann Petersen -Smith, University of Colorado
Hospital

Judy Malin, Smith Agency

II. Introduction

Christina Neill-Bowen welcomed the residential stakeholder group attendees and reiterated the purpose of the workgroup, to complete a compendium of best practices related to the Final Rule. Adam Tucker, Amy Scangarella, and Caitlin Phillips introduced themselves as representatives from HCPF on the call. Christina then followed with a roll call of attendees and asked each stakeholder to share what they think of when they hear “community integration”. Christina summarized and presented the following key words from the stakeholder sharing: knowledge, opportunity, relationships and connections, safety considerations, natural incorporation, the individual feeling values by friends, family, and the community, education and family involvement, and integration vs. segregation. Today’s group will discuss the progress to date and pending topics to be included in the compendium. Lori Hamilton and Jennifer Palmer will then share during consultancy. Adam, Amy, and Caitlin from HCPF had no other additions to the call agenda.

III. Updates on Progress to Date

Christina presented themes and progress to date from previous meetings. She then asked for feedback on what was missing from the list. The list of themes included:

- PCP as process vs event;
- Making the most of a care planning meeting and engaging a broad team;
- Definition of informed choice to promote a common understanding among providers;
- Ongoing dialogue around rights;
- Opportunities for people to have one on one support;
- Human Rights Committee (HRC) for all populations (exists now in DD system);
- Working with guardians to protecting participant rights; and
- Managing rights and decision making.

Comments were as follows:

- Where does financial reimbursement fit into this? And being a parent I am obviously involved without reimbursement. Does that fit into the plan? How can a team work to help an individual outside of office hours? I think that is a big piece for professionals who can’t just donate time.
- I think that one other theme is that the pot of money may not get larger, we might be more limited. We might just need to work with those constraints.
 - Caitlin/Adam: HCPF is constantly looking for better ways to work with what we are allotted. We are in a budget shortfall, and while we understand the need for reimbursement, and especially as you said people are going to want a higher rate to come in outside of office hours. We hear you, and have noted these concerns. For this group, one of the main ideas is that even though we’ve noted that reimbursement is not where we want it to be, the goal is to look at the current structure and see what we can do. Not only are we in a budget crunch in Colorado, but we also don’t have control over legislative issues. At the same

time, we hear it, and we want to continue to hear it because it will actually push that issue forward. But for now, we don't have much control over the budget. So we are working on being creative and building some best practices.

- What this brings up for me is the hard reality. Are we are talking about true community inclusion and natural ratios? Are we talking about eight members going to the zoo and interacting with staff members, or are we are talking about people interacting at Starbucks on individual level? It's hard to do unless you have a bunch of volunteers supporting that network. But to get it started will be difficult.
- One of my sister homes was an ACF the CMS team visited. We take care of the younger population with mental illness as an assisted living, but do not I/DD population. When they came, they never even opened up a care plan. They couldn't wrap their head around shower schedules and meal plans. I feel like it's so much more of, "are you running on your schedule or the residents' schedule?" I feel like people are looking at integration too broadly. If the resources are not there, they are not there. But what are you planning to do to get the resources? This is a Medicaid rule. Private pay residents do not have to have person centered planning.
 - Christina: So to take what you are saying and give that a title, it sounded like it needs to go beyond the care plan. A care plan is secondary to actually working with someone and seeing if their rights work into person centered support.
- The harsh reality of our world is that our child doesn't have any friends that aren't paid. He doesn't have anyone who just wants to watch a game, go to Starbucks, unless they are getting paid. So maybe the existing structure is part of the issue. How can we utilize maybe a different structure of Medicaid? Is there a different way to structure that money that is already being spent, to use it more in a personal manner?
 - I need to clarify a few things. It's not just in the Medicaid world. Person centered care is under resident rights in the state Assisted Living regulations, and they are required to include residents in care planning and be person centered.
- I think that when we are looking at the new HCBS rule, we have to make sure we are prioritizing expanding housing options. Funding is tight, so are there other ways to expand housing beyond facility based environment? Perhaps resources to have apartments, but that is difficult. Maybe there is a way to look at collaborating and expand government funding? Maybe we need to look more broadly at how we expand resources to be more inclusive.

III. The Consultancy Process

Challenge Presentation #1 – Jennifer Palmer (Greely Center)

Our challenge is that we are a residential program with 18 residents with brain injuries. We provide wrap-around supports. Eighteen people may seem like a small program, but not when we are trying to get people engaged in the community in areas they are interested in. Our goal is for them to be able to make friends that aren't paid. Our challenge is that, at least initially, there has to be one on one support, then you can back it down. But, with 18 people it is

difficult and we are not able to provide the necessary one on one support. Invariably you get involved with one activity, and then that snowballs into other invitations. We have issues with staffing and adequate transportation.

Clarifying Questions:

- What is the staff to customer ratio?
 - It varies. With 18 residents, I have two overnight staff, anywhere between three and six to nine people are on campus at a time. It can be as high as nine, and as low as three.
 - All of those people do not have roles as one on one support in community engagement. Some may be housekeepers, cooks, and other staff.
- So if you have an individual that wanted to take a shower at midnight, would you be able to accommodate?
 - I don't even have a response. We could at midnight, changing from 7 to 9am might be harder. But we have to talk about that in person-centered planning meetings. In terms of changing on daily basis, it gets challenging and leads to a lot of frustration.

Group Brainstorming:

- This is an emphasis on person centeredness being a process and not an event. I would think about the social capital they already have, and then maximize and build out from there. I don't think this is an organizational issue, examining what are the easiest wins for each individual. Have we identified interest? Is there something close by? Is there a family member serving as a bridge?

Presenter Response:

- I love what she said about easy wins and capitalizing on social capital. Every six months there is a person-centered planning meeting, and a person can request them in between. That has been the main forum to figure out their interests, and dreaming big. In response to that, we hired a new position of Community Engagement Manager and she has a team of two other people, all of her time is dedicated to facilitating those connections. Her two team members have about 60% of that time dedicated to connections. We run into the challenge of it still feeling like a group. We are trying to get away from a whole busload traveling. Two residents were interested in knitting, a community group meets every Monday, and they have set up their own trip to a Christmas party. Friendships that really have nothing to do with us. But that leaves 16 other people that may not have community connections that we need to work on.
 - It started out with us sitting there with them in the knitting group and helping to learn names and facilitate conversation, and now we just drop them off. The lady that gave them a ride to the Christmas party is just kind hearted. I think that we just got really lucky with that particular group of people. It doesn't take much staff time anymore, other than weather and snow problem solving.

Challenge Presentation #2 – Lori Hamilton

We have a resident who was in a hospital for 20 years. He wanted a job, but was out of touch with the process. He was nervous about his resume with a large gap in employment. He was also very concerned about social skills, and making too much money that would jeopardize his housing situation.

Clarifying Questions:

- Have staff or anyone in his life helped him access support, like a workforce center, skills agencies to help identify interest levels and skills set, as well as the necessary steps?
 - Yes, will elaborate at the end.
- Did he work before he was hospitalized?
 - No, not much. He was rather young at the time, so not much of a work history.
- What were some of the attributes of what he wanted to do? What is he interested in?
 - Initially he was not even sure, he did talk about cooking, but that was really the only thing he tied into.
- Is there something that changed to all of a sudden that made him desire to work?
 - No, I think when he was released he just wanted to be part of the community and wanted to expand on doing something outside and feeling useful.

Group Brainstorming:

- Did he try volunteering with any of those activities? I think a lot of people who have been out of the workforce for a long time have volunteered to see if it is an area they want to work in. That setting might give him more ideas.
- In place of volunteering, maybe shadowing. I used to be with Colorado Center for Blind where he helped students get jobs. There was apprehension of employees in the community, so there is groundwork ahead of time. But they can just watch and see what the job entails before they even get to the point of volunteering.

Presenter Response:

- We did communicate with the resident to try volunteering. He connected with the VA to do some volunteer work, but did not express interest in that for very long. We got him involved with shadowing within the residential setting to see what it was like to put a meal together and doing dishes. Then he kept asking questions about interviews and applications, so we got him familiar with the computer and online applications. He is now very capable of completing applications and goes to the library frequently to do research. We also did some mock interviews with him, and since doing that, he has had two jobs. The first for about three months, the second he currently holds. He goes in once a week, because he is worried about making too much money. He is working unpacking at a dollar store, and seems very happy with that.

IV. Open Discussion

The group reflected on the discussion of best practices today and commented on any reactions or additions.

- One theme has been trying to maximize services in the community.
- Residential staff can get involved in helping to think outside the box and expose residents to potential employment, like in the example above.
- Create a network for key interests. So for cooking, create list of organizations that support brain injuries, I/DD individuals. It could serve as almost a database.
- What else would you need to know if you were going to try to replicate a best practice in this area?
 - Share a list of volunteer organizations, and a list of skills that your staff has that they would be willing to share with residents.
- What is coming to mind from the SEP and CCB perspective?
 - Today's discussion doesn't have a lot of impact to what we do. But I am excited and will support that in any way.

V. Leaving In Action

- Christina presented the federal definition of person centered planning, and asked for reactions to the definition orally and through the chat feature.

“Definition of Person Centered Planning

Person-centered planning is a process directed by the person with LTSS needs. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. PCP should also include family members, legal guardians, friends, caregivers, and others the person or his/her representative wishes to include. PCP should involve the individuals receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes. The role of agency workers (e.g., options counselors, support brokers, social workers and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.”

- Saying the legal guardian needs to be there, what if the person is not happy with what they are saying? There needs to be a balance, but I ultimately think it needs to be the person's choice.
- I think it is really inclusive as everything we've worked on. I wish it worked as easy in real life, but the definition is good.

- Want more talk about the written plan piece at the end. My concern is having an additional plan for the person, rather than incorporate into what we are already doing.
- I think this is a good definition of all the discussions, but it seems to take away from the philosophical shift towards incorporating people. This may be good rule and statute language, but something simpler needs to be for application. That definition feels like a barrier and too heavy. Might not excite and motivate me.

Next Meeting: Review work to date

- Tuesday, March 8, 2016 from 9:30 to 11:00 am
- Pre work is to review the compendium draft slides and submit written comments by March 1, 2016.