COLORADO
Department of Health Care Policy & Financing

MINUTES

Transitions Stakeholder Advisory Council

Google Hangout Weblink: meet.google.com/emq-kfpb-aex
Google Hangout Call-in: +1 470-268-2030
PIN: 614 405 288#

Thursday, November 4, 2021
2:30 – 4:30 p.m.

COUNCIL MEMBERS

- Clarice Ambler, DRCOG X
- Meghan Baker, Disability Law Colorado
- Anne Bartels, Sandata X
- Amy Dixon, CPWD X
- Monique Flemings, AHOD Services X
- Paige Gallaher, Atlantis X
- Jennifer Giurgila, Jefferson County
- Fallon Gillespie, Rocky Mountain Human Services X
- Jennifer Krulewich, Focus Cares X
- Tracy Martinez, Touch of Care
- Ryan McGee, DRCOG
- Jenn Ochs X
- Neal Waite, ADRC Region 3B X
- Miriam White, SJBAAA X

Attendance Link: https://forms.gle/EDaybu73WZAnPZHX7

1. Welcome and Introductions 2:30 p.m.

- Approval of the October Minutes - Minutes were approved
- Purpose of Today's Meeting – Katy provided an overview of today's meeting, starting with Department updates, the Council will have an discussion on barriers to long-distance transitions as well as transitions from other settings today, Clarice will share Council updates and we will end with an open forum.

2. Council Member Application 2:35 p.m.

- Jane Sinclare – CPWD

  Jane shared her interest in joining the council. She has been involved in transitions for long time. Starting in 2002 and 2004 with the nursing faculty project, where she was in a state coordination position being a liaison between ICL and HCPF. The goal of grant was to transition 130 individuals from SNFs back to the community as well as inform 1,200 SNF residents they had the right to live on their own. Back in 1999 Olmsted decision was a huge deal and stated people with disabilities had right to live in community which had never really been stated before. Intention of project was to show it was less expense to live on own than nursing home. The project was a success in many ways and transitioned more than 130 people. Ten ILCs in Colorado participated but we didn't quite meet 1,200 contacts, we did 960 contacts. It was an important piece of work laying the groundwork for CCT. Continued with passion of transition. She was trained nationally ILRU training - how to assist individuals interested in transitioning. Worked in disability right for 20 years. Oversee nursing home transitions program 5 1/2 years. Familiar with CCT

  Jennifer Ochs shared her support for Jane saying Jane helped her transition out, really special to Jen.

  Ian Engle also shared he's a big fan of Jane.

3. Program Updates 2:40 p.m.

Matt shared that the MFP grant getting underway and he is planning to dive in and understand program better in the next few months and spend the first months of the new year heavily planning. As stands now the Access Unit will have two positions under MFP funding. The Benefits team will also have several new positions to work on Community First Choice or CFC. The goal is to use the funding to provide a number of opportunities to meet someone where they are, not one program to meet everyone's needs. Matt hopes to have a project plan ready in January and to start bringing vendors on board.

Matt also shared an update on ARPA. As part of the most recent federal relief program, resources were provided to states to support and enhance HCBS services. It is a time limited funding opportunity, so the Department is working feverishly to get positions filled and contracts issued. There is going to be a lot more information to come over next 6 months. There will not be positions for transitions work, but other opportunities are going to be available. Katy shared the link to keep track of ARPA projects: https://hcpf.colorado.gov/arpa

Matt shared that the PHE, for now, is continuing and more information will come in the next few months. Several pieces of policy in clearance at this time to clarify expectations.

Pauline commented the vaccine mandate for companies of 100 plus employees has created issues with transitions. A lot is going on because of the vaccine mandate with social workers quitting and TC's are overtasked because they are doing everyone's job. Matt offered to connect with Pauline offline to discuss further and confirmed the vaccine mandate is causing additional issues to find providers. Matt said they are discussing with Case Manager's and will come back to the group with more details. Ian reminded everyone to not get false sense of security if you are vaccinated. Everyone should follow policy protocols for safety. Matt Bohanan, Access Unit Manager: matthew.bohanan@state.co.us

Katy shared HCPF is adding a number of jobs to the Dept and requested that the group shares open positions with others that would be good candidates. Jobs Listings: https://www.governmentjobs.com/careers/colorado?department%5B0%5D=Department%20of%20Health%20Care%20Policy%20and%20Financing

Katy and Ann shared there is a new home modification stakeholder engagement meeting and would love to see people on this call attend. Meetings occur on the 2nd Wednesday of the month from 1:00 - 2:30 pm. Home Mod Group: https://hcpf.colorado.gov/home-modification-benefit#Meeting

Katy provided an update on drafting the community-to-community fact sheet and how members can access benefits to accommodate life transitions, so folks can access home delivered meal and other services. The fact sheet will be translated to Spanish.

Ann shared the good news that the voucher program with the Atlantis community Foundation is back on board to manage vouchers for those in the Metro area. Excited to have Atlantis back on board. Also, wanted to let everyone know that DOLA is adding a staff person to their voucher program and Tiara is coming back to work on their program. Jane added to the chat that she's happy to have Tiara back on the team!

4. Long-Distance Transitions 3:00 p.m.

Katy opened up the long-distance transitions discussions by asking group what makes these transitions complex and complicated and how the dept can help make that a smoother process. Structure is open ended, would like to hear challenges from the group and figure out what the Dept can do and work on developing best practices.

Ian shared issues with housing vouchers in Steamboat as they don't come close to covering cost and prevents transitions. There is also a lack of resources for induvial to

live in their own home including shortage of personal care workers. They have to send people to congregate or nursing facilities because they can't afford to stay in the community which isn't cost effective.

Pauline said it would help to define the roles between two agencies involved with transition and risk mitigation. They do a lot or work with the client and would have more conversations with client and care facility if there was a clear definition on roles of what to take care of moving forward including clear understanding of transition funds, such as transportation from one city to another, who pays for that? Frank had question on transportation for long distance transition. Pauline said they didn't have a lot of details ahead of time which made it complicated. Frank said it was the same for his transition. BUS system is another issue for transitioning county to county, the receiving TCA has to take over but then have to ensure they are entering data correctly.

Shannon added that she had a transition from Pueblo to Moffatt County, she did most the work but since you can only have two people on the BUS that was an issue and not clear who is truly responsible for what with the long-distance transitions and who can claim what on billing is imperative. Who bills what and who is in charge of what needs to be clearly defined.

Brad shared that when someone wants to move to another county and just works with the person in that county, they are moving to can make it can go smoother and/or faster because they are working with someone doing everything from beginning to end.

LaShawn echoed everything already discussed, agrees with Pauline we need tighter system that supports person centered access. Also, billing and who can leave notes is also an issue. She also gave a shout out to Jane Sinclair and Frank that worked together to the best they could and members are thriving in the committee. Katy said that's great they we were able to work collectively. Frank asked LaShawn how billing worked as this transition went well, they were able to work with Nora to ensure they had enough units to complete transition and do monitoring piece. Katy asked if it would be helpful to have billing piece outlined to know if you go in the system to see what was actually billed? LaShawn said it depends on agency billing cycles some bill per month, some per week.

Pauline said the other issue was they had to wait for housing to approve transition request. The problem was the voucher needed to be moved. Frank said the voucher had to be ported which can take up to 30-45 days, got process rolling quicker and the local agency in Denver was taking time. Frank was able to get it submitted in his area earlier.

Matt shared HCPF webpage has memos organized by year. As shared, there have been many over the last two years. Please feel free to email us with questions you may have. Memo Series: https://hcpf.colorado.gov/memo-series

Courtney wanted to go back to what Frank said about porting process so all can be on the same page. It can take up to 60 days and need to start 60 days in advance because of all that goes into it so all some page to make sure participants have enough time. Courtney shared Port is actually out of state. In state transfer is any transfer within the state. Based on that, once applicant is assigned to agency, need to make sure housing coordinator and agency are working closely with the TC and the client. Courtney said to make sure that all work together to make sure they remain housed and get housed after discharge. The TC's are instrumental and they need to ensure housing coordinators are in touch with them. Escalate concerns to Courtney or Ann if HCPF is process is taking a long time.

Jenny shared in chat we see extended delays in long term care Medicaid to HCBS switch/financial approval when moving from SNF in one county to residence in another county. They see delay in process with more players involved. If they can get supervisor at SEP working with them, if it's more than 30 days following up with Nora and it's been helpful.

Ian said there is conversation on how to move needle on Housing modifications, getting noticed this is an area that needs to be addressed for folks that are transitioning. Katy suggested group gets involved on house modification discussions and provide feedback from community on what is working and what is not.

Katy asked group for good strategies to find resources from county-to-county. Frank said to get in touch with local VA that has their own set of benefits and resources that can help set up home health, get records ahead of time, they play important role and really helped their member that transitioned.

Ian asked if HCPF could facilitate opportunities for some TCA where we can share best practices?

Jenn asked who to direct friend to that needs housing voucher and living with his mother. Ann said right now they only have vouchers for those transitioning from institution. There is a standard voucher program and suggested to get on any waiting list you can get on. Contact everyone that covers area you want to live, find out what process is, when they will open waiting list and be proactive. Ian said to contact him as there are angles to work around.

Katy thanked everyone for the great discussion and summed up takeaways from conversation. Porter from one state to another state is different from in state. Define who is doing what role transitioning TC to TC. Billing in BUS is an issue, who bills from where.

5. Transitions from Other Settings 3:30 p.m.

Katy began conversation on transitions from other settings, interested in feedback on where group sees opportunity for transitions. Moving from waiver to waivers or from children to adult waiver, hospitals to home. Where does the group see complications in system and where does support come into play?

Shannon said she has done a hospital transition; they don't do discharge planning or care plans. She assists as if it was transition and services Shannon provides are the same. This is an area to keep people in the community and good to have coordinator to have services. Once in community what wrap around services do they need to be successful. Coordinating with agencies to ensure they get additional services that they may not realize they have on that waiver. Education to member on what is available.

Frank had person in transition program two years ago, admitted to hospital six months ago. Had to do same thing to transition out of the nursing facility. Did risk mitigation at faster pace, individual regularly worked with, escalated pace but couldn't get out before 180 days when he would lose housing voucher. Frank confirmed gentlemen in nursing facility, needed to retain housing voucher already in the community and had to establish risk mitigation protocol to get him out. Running into too tight timeframe because hospitals won't hold on to patients for as long as process would take. Issues with swing beds in hospitals and reintroduce transitions out of nursing facilities that aren't necessary community transitions. Ann asked to define swing beds. Frank defined they are beds in Hospital that serve the same role as a nursing facility bed.

Ian shared in chat overworked hospital discharge planners need more options to offer.

Shannon said on the swing beds, they run across problem and went back to hospital as a life changing event. Would be beneficial to have extra services to keep them out of nursing facility or from hospital into nursing facility to keep in play. Katy shared that the one pager they are releasing will discuss life change events. Katy said to reach out to Janelle if question on what entails life changing event. Benefit's staff for community-to-community staff: janelle.poullier@state.co.us

Frank included swing beds in hospitals are utilized because level of care is greater than what is in the area. Hospitals have switched regular bed into swing bed and get nursing home level of care on that basis. Frank had two individuals interested in transition, one was successful, and one wasn't. One qualified under TBI waiver and was able to get them in that program with housing.

Matt said if trying to work with someone from swing bed, there may be work the Dept can do to help. The community-to-community fact sheet will be a good resource. Reach out to the dept if there are situations they can help with. Matt offered if in a situation

where uncertain, reach out and see how the Dept can help. MFP allows to target SNF, ICF and can get better at serving those from hospitals.

Brad said transitions from hospital to community are in need of something in place for people to get paid to do it. CIL's are helping but aren't getting reimbursed. Independent Living Centers are helping but there is a need for reimbursement.

Lashawn echoed need to look at hospital to community transition. Will MFP address this? Matt said alternative life events that need to be supported will be looked at. Something much larger than transitions, something wants to look at and not sure what will be the solution. Looking for this group to provide feedback on what we need to look at more closely.

LaShawn said even though HCBS SEP's are getting better, the members with BI waiver that have to wait past 30 days puts them at more risk. If ILST services were put in place initially that would help considerably. Katy shared there is a subcommittee to look at eligibility and LaShawn said she is interested in joining. Clarice asked if others want to join the eligibility work group, email her at cambler@drcog.org.

Shannon said there needs to be education in hospital system if doing traditional swing bed if operation on facility to care plan. Also, gave shout out to Matt who always makes himself available when needed.

Amy asked if anyone in group knows criteria for hospital to release patient to the community as they had a member that wasn't able to go back to nursing facility and ended up passing away. Katy shared that if anyone comes across those situations with complex cases to get someone stabilized to let the Dept know.

Frank is sharing intensive case management to keep patients from cycling from hospital. Sharing transcripts and links. They see in Mesa county where individuals are discharged to the street and written in as discharge going to homeless shelter but the homeless shelter won't accept because of high level needs.

Frank shared Independence Center has a program model that has been in place for a while now with Hospital to Home. CO Spring Independence Center Hospital to Home program: https://www.theindependencecenter.org/home-health/hospital-to-home-resource-page/

Ann shared that the Denver housing authority is working on project that will include 40 studio apartments and anyone Denver Health admits can use one of these apartments if they find out individual is homeless. Wanted to let everyone know people in housing community know this is an issue and working on solutions to address as well.

Katy thanked everyone for the robust conversation on issues seeing in the community. Will keep conversation going and get back to group on swing beds.

6. Council Updates 4:00 p.m.

Clarice shared they are starting a financial eligibility group and are working on setting up meeting. Let her know if you want to be included by emailing her at cambler@drcog.org.

Clarice asked group if we want to invite Adult Protective Services (APS) to future meeting to talk about their role and services they provide> Group concurred that is a great idea. Monique said when we talk about members not being safe, not having services is an issue.

Frank shared in chat they have not seen a response from APS in their county. They have all been in agreement that the person is in danger, is gravely disabled but no one can do anything. It is like the equivalent of saying, "Yep He's drowning but, we can't do anything until he starts swimming to shore." Jenny shard in chat a lot of times APS is used to working with people that don't have advocates like us involved and has noticed a bit of an assumption our members are not as high risk.

Clarice said there is fear that if APS is involved. Facilitating conversation is good idea. Peggy reminded group that as mandatory reporters, there are consequences to not reporting so please be aware of that. Jose included that being a former APS worker, times have changed and they appear to be more narrowly focused on what complaints they respond to. Each county has different interpretations of what constitutes a complaint.

Matt said if we have questions about member safety or welfare, APS is resource available. We can discuss function of APS and what is appropriate or not appropriate, general statement confirmed about members safety report. Ian said they are having issues getting APS response and its situation beyond their control. Matt said hopeful if we can bring someone on board and understand how cases are reviewed, support available and understanding nuances of what info is communicated and what isn't. Discussion points that we get value out of.

7. Open Forum 4:10 p.m.

LaShawn asked if any clarification on the VOD (verification of disability) Form. Ann said they have a standard form of documents to use, and they do need someone with license to complete the form. Verification of disability form serves as Dr's note. Has to be licensed social worker and needs to be documented they have disability. LaShawn said for particular member it's documented has mental disability but not documented on form and its an issue. Trying to get community doctor to pick him up to look over

history instead. Clarice asked if ombudsmen is looped into the situation. Lashawn confirmed not yet but she will do so.

Frank shared point of order on VOD as he has one he's looking at not that was declined recently. On the form itself, it says signature of knowledgeable professional and license number if applicable. What is printed with requirements on form and who is actually able to sign are different things. Ann said she is pushing to change form on paperwork. Frank confirmed its stated a licensed professional. Amy said another option is if you have RN for home health they can sign. Ann said Frank is right, it needs to be medical professional. Ann said in context of reasonable when verifying disability to confirm eligibility of funding it goes to next level of wanting licensed professional.

Shannon asked if this is required for people on SSDI. Courtney said if it says on form if you've been determined disable on this date that is one of things needed. They also need VOD across the board, so it's been verified with Social Security and on SNF side. Need award letter and VOD. Courtney said they are going off HUD definition of disability, so they need documentation of SS and VOD. Shannon feels this is redundancy in paperwork if already deemed disabled federally. Courtney said at this time not able to serve anyone that isn't deemed disabled by HUD definition.

Monique had question how do you disagree with diagnosis on face sheet? LaShawn said some people may have temp disability and not permanent. LaShawn pointed out that actual physician in nursing facility doesn't see members all the time. Frank said are we looking at people that have disability on discharge or permanent disability. How do we gauge that- permanent condition that affects ability to stay at home? Courtney shared definition from DOH website: a. is expected to be of long-continued and indefinite duration; b. substantially impedes his or her ability to live independently, and c. is of such a nature that the ability to live independently could be improved by measurable housing conditions.

Frank shared Who Is a Person with a Disability? Federal nondiscrimination laws define a person with a disability to include any (1) individual with a physical or mental impairment that substantially limits one or more major life activities; (2) individual with a record of such impairment; or (3) individual who is regarded as having such an impairment. In general, a physical or mental impairment includes, but is not limited to, examples of conditions such as orthopedic, visual, speech and hearing impairments

Jenny asked Courtney and Ann if it is a conflict of interest to fill out for members as she is a licensed social worker. Can she verify for people that she serves as TC since she's a social worker? Ann/Courtney said good question and they will look into it.

Katy said putting on hold for next conversation and can have follow up for next discussion. Ann and Courtney will be able to follow up and come back to conversation in December.

Katy closed by thanking everyone for feedback. The Dept has a lot to look at for BUS and having multiple agencies and very valuable feedback to add to the December meeting.

8. Adjourn 4:50 p.m.

Next Meeting December 2, 2021 -
Rural Issues & Home Health

Submit Questions, Issues, and Comments:

https://forms.gle/iRZb5zWq5SyMctEe8

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify John Barry at john.r.barry@state.co.us or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.