Idaho HCBS Stakeholders: Presentation and Discussion

Friday, May 5, 2023

Introduction

Jen Magelky-Seiler, Program Coordinator, Idaho Living Well Project

Idaho faces many of the same challenges with the rest of the country when it comes to providing home and community-based services, however our large rural state, growing population, and changing demographics create additional barriers to people's ability to effectively access HCBS services and live in the community of their choosing.

I am going to briefly review these factors and how they impact our state, others will share key concerns in our state around Heighten Scrutiny, Quality Assurance, Capacity, and Person-Centered Planning.

<u>Idaho is large and predominantly rural.</u>

> **Ten Northern Counties of Idaho:** This area covers more than 21,000 square miles, just short of the size of the State of West Virginia. This area has approximately 19.5% of the state's population and 22.8% of the state's disabled population. Approximately 20.4% of the population is aged 65+. (United State Census Bureau, 2021)
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> **Southeastern/Central Idaho**: These 18 counties cover nearly 33,000 square miles, slightly less area than the state of South Carolina. This area has approximately 24.9% of the state's population and 25.2% of the state's disabled population. Approximately 13.8% of the population is age 65+. (United State Census Bureau, 2021)
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> **Southwestern/Central Idaho:** This 16-county area includes nearly 9,000 square miles and hosts the state's most populated areas as well substantial frontier locations in an area that is roughly the size of the State of New Hampshire. This area has approximately 55.5% of the state's overall population and 53.9% of the state's individuals with disabilities. Approximately 15.9% of the population is aged 65+. United State Census Bureau

Population Growth

In 2022, Idaho was the second fastest growing state in the country (United States Census Bureau, 2022). In the last 10 years the population of Idaho has grown by 18%, including a 19% increase in people with disabilities and a 54% increase in individual who are 65 years or older (Office of Performance Evaluations, 2023). This population increase has put additional pressures on areas of our state that are already in crisis.

Housing Crisis
Lack of affordable and accessible housing is a barrier to independent living and community integration in our state. There are 40,000 extremely low-income renter households in Idaho, but only about 15,000 affordable rental homes are available. Statewide there are also only 1,037 accessible housing units, for the estimated 104,000 individuals who need them, (Root Policy Research, 2022).

Certified Family Homes which provide support and housing to over 3,000 individuals on the developmental disabilities wavier is seeing an increased rate of closures this year and an estimated 25% of Certified Family home providers in the state are 65 or older suggesting that we will see more closures in the future. (Millwood, 2023)

Direct Care Workforce Crisis
Is an issue nationally but is even more critical in our state. A recent report by our Office of Performance Evaluation found that Idaho's direct care workforce shortage is significantly greater than the national average, with a need of 3,000 additional workers to meet national staffing shortage levels. This gap is only expected to grow (Office of Performance Evaluations, 2023). At times, participants have had to move across the state to find services forcing them to leave their families and home communities to receive services.

Lack of Transportation
Access to transportation is an important aspect of community integration and it impacts both our rural and urban communities. Many individuals depend on HCBS services to provide transportation; however, we have found it does not get incorporated into individuals service planning and if it does, there are not enough staff to provide adequate transportation. In rural and remote areas this issue is particularly acute due to no public transportation options being available.

Additionally, we have a lack of quality non-emergency medical transportation providers. In rural and remote areas this service is largely not available due to a lack of providers. Those who can access the service report chronic issues with not arriving on time and not picking up for scheduled appointments. All these factors prevent people individuals from Idaho from accessing their community including places like church, clubs, work, and grocery stores.

Heightened Scrutiny

Mary Tabb, Non-Attorney Advocate, Disability Rights Idaho

Idaho's Statewide Transition Plan went through six iterations before the final plan was sent to CMS for approval. This final plan received approval in 2018 and identified four residential settings requiring heightened scrutiny and zero non-residential settings. These settings are Residential Assisted Living Facilities (RALFs) that are attached to Skilled Nursing Facilities (SNFs). Of the four residential settings identified, only three are still operational and include:

Royal Plaza Retirement and Care Center, LLC/RCF

Sawtooth Healthcare, Inc., DBA Discovery Care Center

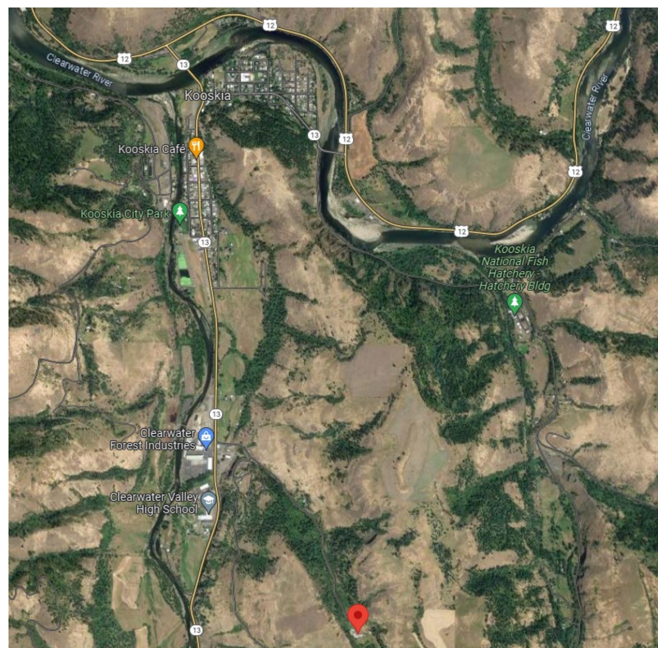
Sunbridge Healthcare Corporation DBA Sunny Ridge Rehabilitation and Retirement Center (Genesis)

This list of locations only addresses the first two qualities of an institution and does not properly identify settings that isolate. Without a more thorough review of settings that may isolate participants from the greater community, it is difficult to assess Idaho's compliance with the HCBS rules.

Settings that Isolate

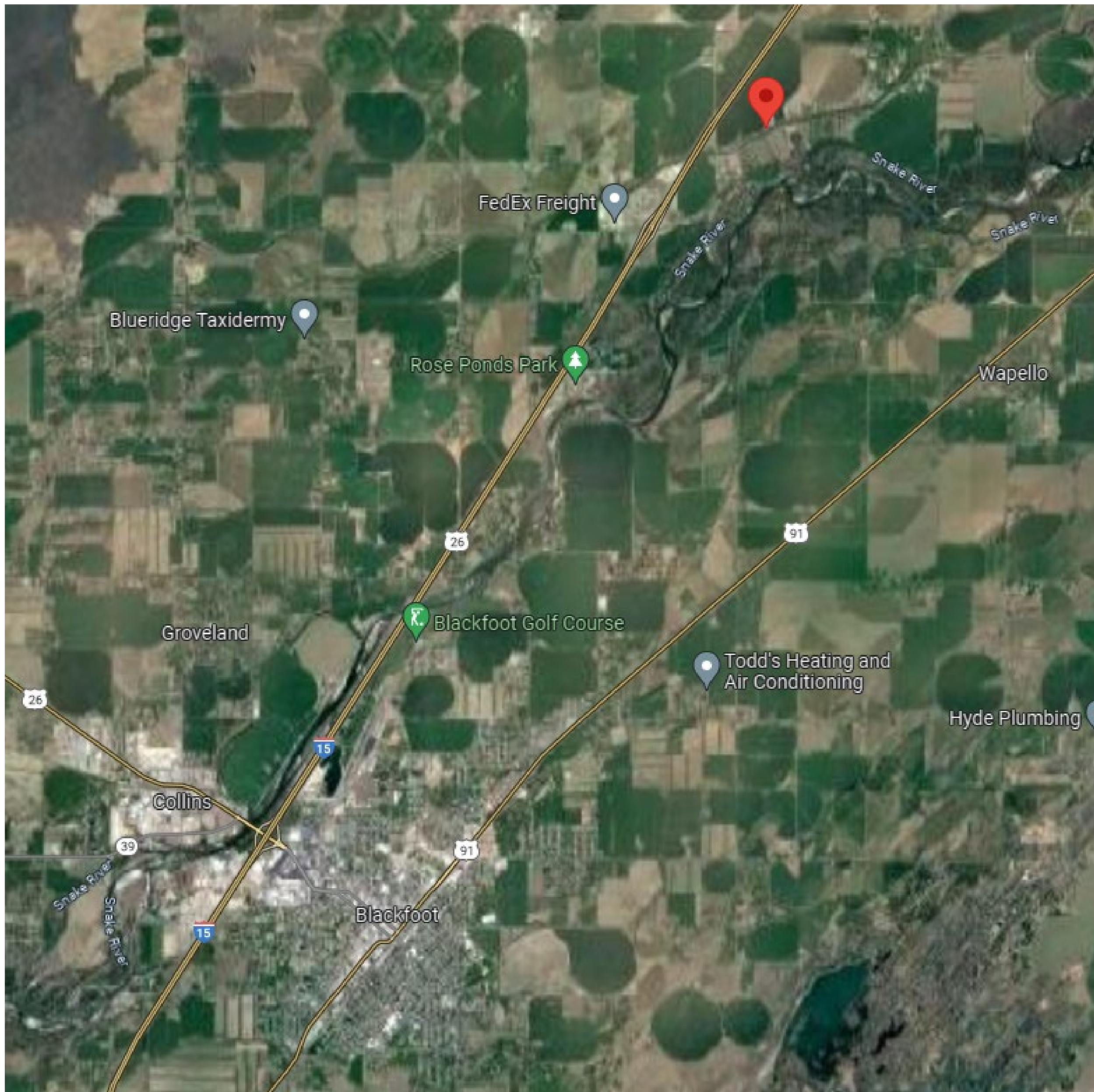
As previously mentioned, Idaho has many rural and remote areas where the population is spread out and has limited access to the services available in larger towns. These areas are particularly concerning when considering the prerogative of the HCBS rules to create opportunities for community integration. Previous guidance has of course said that merely being in a rural or remote area does not necessarily disqualify a setting from receiving HCBS funding, but that does not negate the need to enhanced review. By googling the locations of many of the RALFs in Idaho, it is possible to identify multiple settings that are not only in rural areas but also situated in locations that further isolate them from the available community more than the average individual not receiving Medicaid HCBS services in that same area.

One notable example is a RALF by the name of B&B Residential Care which is located at 261 Big Buck Road in Kooskia, ID.



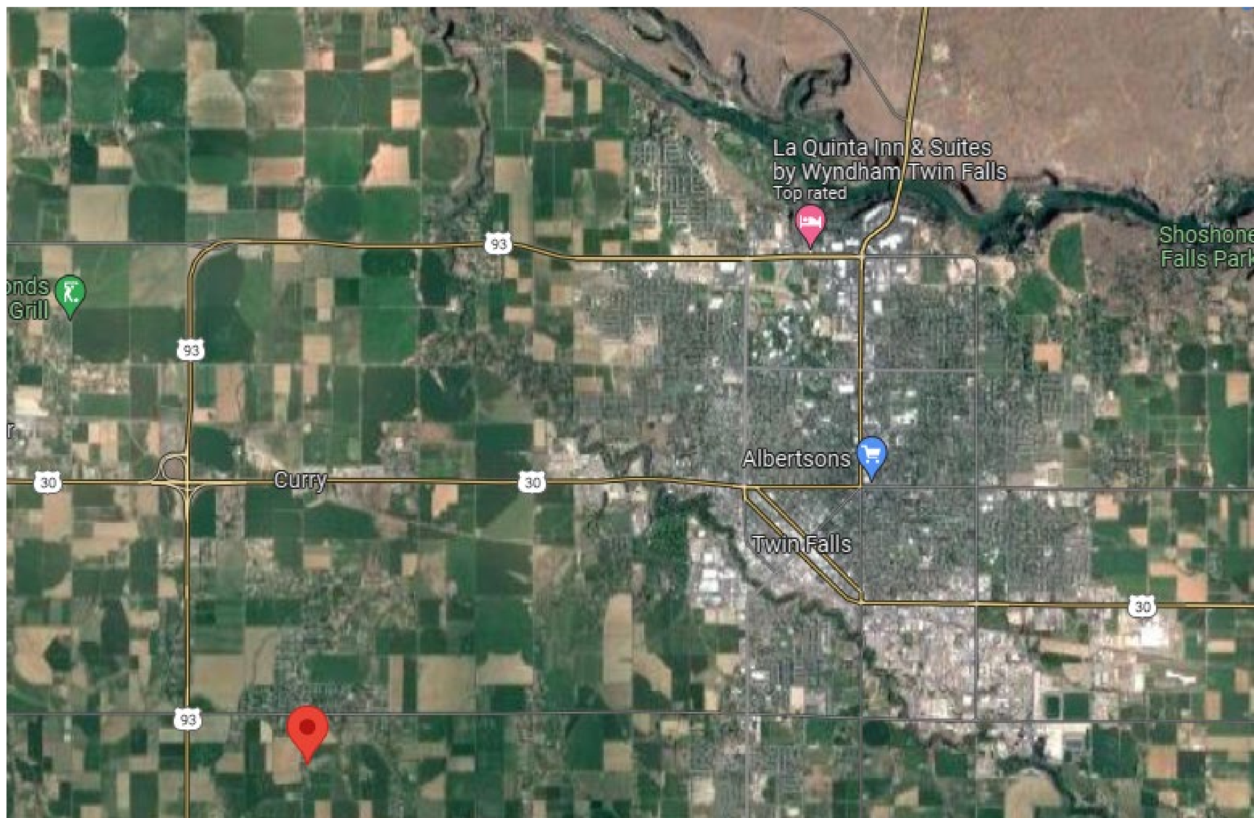
This RALF is almost 3 miles away from the main town of Kooskia and is over a mile down a isolate road with no other neighbors. Additionally, none of the residents in this home have their own vehicle and Kooskia has no public transportation options. There are also no other RALFs in Kooskia or any CFHs with vacancies in the area. With this evidence in mind, it seems like this RALF could have been a potential location for heightened scrutiny.

Another example is Kimball's Residential Care, located at 54 East River Rd. in Blackfoot, ID.



This home is not only in a rural part of Idaho but also well outside the city limits of Blackfoot. In fact, you would need to drive over 7 miles to reach the very edge of town. There are very few

neighbors in the area and the nearest bus stop is again over 7 miles away. With these facts in mind, the residents living at Kimball's Residential care, may be more isolated than the average resident of Blackfoot who is receiving Medicaid HCBS services.
Country Cottage Assisted Living located at 3652 North 2500 East in Twin Falls, ID is another example of a setting that may be isolated.



Country Cottage is similarly on the outskirts of town and would require a drive of over 5 miles to reach the very edge of the Twin Falls. Additionally, this setting has very few neighbors and is surrounded by farmland. Twin Falls also has a very limited public transportation system with no bus access near the Country Cottage Home. While Twin Falls offers more options than Blackfoot and Kooskia when it comes to choice of provider, the setting's location and lack of public transportation options suggest the residents may experience more isolation from their community than the average individual in Twin Falls.

These are just three examples of settings that have the potential to isolate participants and only reflect RALFs in Idaho. There are many more RALFs and CFH that have the effect of isolating and should have been reviewed more thoroughly during the heightened scrutiny process.

Finally, due to the limited providers in general, many participants who are qualified for these services are not able to access them or must move across the state in order to find a home that will accept them. This sometimes means that participants must leave their family, friends and supports in order to receive services only to end up in a place that is remote and isolated.

Having access to family who can drive is one way many participants are able to enter the community and receive services such as doctors outside their home as RALFs are not always willing to provide that transportation and MTM services are not reliable. By moving far away from these supports, participants are further isolated and stuck in homes that may not be able to meet their needs.

Quality Assurance and Medicaid Capacity

Christine Pisani, Executive Director, Idaho Council on Developmental Disabilities

Quality assurance measures required for HCBS services is poorly understood by service users, family members, direct support workers and the general public. Helping people with intellectual and developmental disabilities and family members understand how to report concerns, actual violations and abuses is often placed solely on the shoulders of targeted service coordinators and support brokers. Both of these provider types typically have heavy caseloads, are often poorly trained, and without support on policy or process changes. Bringing direct support workers up to speed on requirements around quality assurance measures seems very haphazardly delivered across Idaho. The mechanism to contact the Quality Assurance staff within Medicaid is not widely known and often only publicized on a difficult to navigate website system. If a person with a disability or family member has been able to file a complaint, it is not unusual to hear that a service provider has responded with a corrective action plan that resolves the matter by firing the involved employee. We are aware of additional examples of quality assurance concerns where a family was refused information about how incidents involving physical abuse of their loved one would be handled, addressed with staff to ensure the abuse would stop. From the front end of the process of knowing how and to whom to make a report all the way through appropriate resolution of an incident, there is currently no meaningful way for people with disabilities or family members to have their voices heard about their needs and to make substantive changes in the quality of the services they receive.

Quality assurance measures required for the A&D services are also poorly understood by participants, family, guardians and home care workers and in the case of people who are duel eligibles (managed care) or Medicaid Plus, the MMCP Care Coordinator or Idaho Medicaid Plus Care Specialist. For Medicaid only participants, there are no care or case managers to help a participant, or their family understand the services available or their rights within the program. Even in the MMC program, high turnover has resulted in a combination of the following: no care manager, a care manager who may have little or no experience working with people with disabilities and seniors (vulnerable populations), a care manager with an excessively large caseload. The nurse reviewer is in the position of completing the UAI annually (which may be virtual). Within the medical model in which they are trained, Nurse Reviewers may not be aware that people with significant disabilities can work and attend community functions. Nurse Reviewers are assessing physical and cognitive ability to qualify for facility level of care – many do not think outside the home. Further, nursing shortages have exacerbated the shortage of nurse reviewers that understand HCBS. Nurse reviewers are required to tell participants about their rights and how to make a complaint, including providing

individuals a brochure outlining the information. There is little indication that they ensure the person/family understands their rights. Families are often grateful that any help is coming because by this time in the initial assessment process, they have waited a long time to get help. They don't know what questions to ask and have shared that they don't want to "rock the boat." In cases where abuse has been reported to the provider agency about a worker, little to nothing done beyond a corrective action plan. The worker may remain in the home or be sent to another without warning the next participant.

It is extremely challenging to file a complaint about poor quality of services, or about the lack of care providers in rural areas. People have been told they need to move to another town to get services they need and to find better qualified staff. This isn't an option for many people as they own their home, have family in the area, or have no funds to move. Additionally, if you have a place to live in Idaho, you are best to stay there due to lack of affordable/accessible housing. To one person it was recommended by the nurse reviewer that the person move to a SNF if they needed more help as none is available in their town. Further, finding information about how to make any kind of complaint is very difficult for people who don't have or use the internet. The complaint page has moved several times on the Bureau of Long-Term Care website.

It appears that more work is being done by phone through virtual tele-medicine appointments. It is hard for someone to talk to their doctor, nurse reviewers, or other medical provider about quality issues through this medium. Surveys for RALFs and other group settings are often done via self-reporting with in-person monitoring to occur every 3 years. It is unclear how thorough the monitor/surveys are beyond looking at files.

Person-Centered Planning

Julie Foder, Director, Center on Disabilities and Human Development

Person-Centered Planning (PCP) for people with disabilities across the age-span is not a new concept. Since the early 90's, and perhaps even earlier, Idaho disability advocacy groups have engaged in multiple forums to 1) develop assurances around the delivery of quality PCP planning, among other things, and 2) provide state-wide training with direct support staff, educators, and health care professionals on best practices in PCP. In the late 90's and early 2000's the CDHD developed training and certification requirements for developmental specialists and Intensive behavioral intervention personnel who worked for people served on the DD waiver. Person centered planning and care was a central part of the training curriculum. In the mid 2000's as part of implementation of self-direction in the state of Idaho, the CDHD along with partners developed PCP training for support brokers. A couple of years later, the CDHD and the DD Council, through grant funding, created a network of people across the state who were trained in quality PCP practices.

In FY 2016, the CDHD and the DD Council interviewed people with disabilities, family members and/or support providers to identify the perceptions of adults with developmental disabilities

receiving Home and Community Based Services (HCBS). A total of 112 people were interviewed. One part of the interview focused on the development of an individual's person-center plan. The results from this study indicated that: 1) Ninety four percent (94%) of adult recipients attended their planning meeting; 2) most did not identify with the "person-centered" planning process and did not recognize the term; 3) the majority of people were asked a series of questions that were not adjusted for various levels of understanding, language levels, time needed to process; 4) plans were created with the recipients in the room, but often without their direct input; 5) Sixty percent (60%) of recipients either had support from another person to answer questions, or the questions were answered without active involvement by the recipient; 5) most recipients were not asked directly about their strengths and preferences; 6) family members, guardians and support staff did not seem to fully understand how or why strengths and preferences should incorporated into the person's plan, and often goals were created with no relationship to perceived strengths and preferences; and 7) goals were developed primarily from assessments (SIB-R) and driven by skill deficits rather than related to preferred life outcomes (e.g., learn fill out a time sheet without an employment related goal). With the advent of Community Now! PCP was the focus of planning for over two years. Yet, to date, the detailed plans have not been addressed due largely to implementation of new rate reimbursement methodology, necessary action as the result of a class action lawsuit against the Idaho Department of Health and Welfare.

Evidence would suggest that person-centered planning is not carried out as specified in current rule. The efforts of Community Now! planning have been put aside by the division of Medicaid due primarily to capacity issues and no fault of their own.

With all the historic and on-going planning and training delivered across the state, we often ask why person-centered plans do not result in quality person-centered care. The answer is largely based on quality assurance practices.

Quality Assurance

In large part, person-centered planning has no real teeth. Quality assurance practices are "paper tests." The Idaho Department of Health and Welfare does not have the capacity to effectively assess planning processes or life outcomes, let along abuse, neglect, and exploitation complaints made by people with disabilities. To achieve continuous improvement, people who receive services and deliver services should receive comprehensive training followed with on-going feedback, along with a cyclical assessment of quality of life measured by talking with recipients of services in the manner of communication and supports they need to be understood.

Simply put, quality of life for people who receive paid supports depends on the quality of support providers receive, training followed by supervision and feedback, and the quality assurance assessments that focus on the quality of a person's life, from their perspective.

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