OPENING PLENARY: ADRC ROLE IN NURSING FACILITY TRANSITION AND DIVERSION ADRC JULY 2007 CONFERENCE

Speakers: **Melissa Hulbert, CMS**
Lisa Alecxih, The Lewin Group
Jim Raye, Wyoming ADRC

Melissa Hulbert, CMS

Hulbert noted that in transforming long-term care (LTC) systems, CMS is a facilitator, but that states are the leaders. Hulbert provided context for the audience. Long-term care is mainly financed by public programs, and a huge share of Medicaid funding is for LTC. States are making progress in spending money for community-based alternatives.

She noted that CMS combines older adults and people with physical disabilities in their data, and noted that among these groups, CMS and the states have reduced institutional spending significantly in the last 20 -25 years. However, she noted that for persons with mental retardation/ developmental disabilities (MRDD), the reduction is dramatic and far exceeds what has been accomplished for older adults and persons with physical disabilities.

Hulbert shared some data on the institutional bias:

- Almost two-thirds of Medicaid LTC expenditures are devoted to “institutional” care
- 13% of nursing home residents are under age 65
- 40.9% of nursing home residents have no ADLs
- 80% of nursing home residents have no, or only mild, or moderate cognitive impairments
- For residents with a length of stay of +30 days, 11% of the nearly 2.8 million discharges from nursing homes were to the consumer’s home with no additional services and 28% went home with only home health services

She described some core elements of a balanced long-term care system:

- Improved Access to LTC Supports
- Increased Choice and Control
- Comprehensive Quality Management Systems
- Information Technology to Support Systems Change
- Seamless funding system that supports individual choice
- Adequate workforce to support community life

Hulbert lauded the Real Choice Systems Change grant program as a catalyst for rebalancing the long-term care system. Real Choice Systems Change grants, including ADRCs, represent a significant infusion of resources into the states. She noted that for Nursing Facility Transition grants, some grantees were Independent Living Centers. She also noted that in some cases Independent Living Centers have a large number of transitions, which outpace efforts of the aging network and the state.

She praised ADRCs for their efforts to increase LTC options counseling and outreach, provide comprehensive information and referral services, streamline application and eligibility determinations, develop web-based database and information systems, and create partnerships with providers to prevent long-term facility placements.

Hulbert identified some future opportunities for ADRCs – (1) greater promulgation of the ADRC or other single entry point model, (2) partnerships with Centers for Independent Living, (3) greater collaboration with "facility" discharge planners – serving as the bridge with Medicaid, and (4) integral role in Money Follows the Person.

She noted that the Deficit Reduction Act has a provision related to discharge planning on acute services. Starting in January 2008, 10 states will be testing a comprehensive discharge planning tool. She believes there are opportunities to collaborate where there are ADRCs in those states.

In addition, the 2007 Real Choice Systems Change grant solicitation is awarding approximately $13 million in grants to qualifying states. There are two grant categories this year: State Profile Tool (SPT): and Person-Centered Planning Implementation Grants (PCPIG).

State Profile Tool
Three-year grants in the amount of $350,000 to $500,000 per grant. Only one grant per state can be awarded. The award is intended to assist states in developing a consistent and systematic way to measure the degree and success of their efforts to balance their long-term support systems. States will develop ways to measure the reduction of institutionalization and increased opportunities for persons with disabilities to live in the community.

Person Centered Planning Implementation Grant
Three-year grants to states are to be awarded in the amount of $350,000 to $500,000 per grant. The purpose is to assist states in developing and implementing a distinct Person-Centered Planning (PCP) model specifically addressing the consumer's informal support system States may elect to address any of the six optional components:

- Self-Direction
- Comprehensive community-based resource directory (web-based)
- Comprehensive risk management strategy
- Web-based care planning tool
- Evidence-based practice(s)
- Planning for youth with co-occurring disorders

Applications for both are due to CMS by July 27 and awards will be made by September 28, 2007.

CMS is also hiring a contractor to that will build an indicator system so CMS can better assess where states are in their rebalancing system and compare across states. The contractor will develop a set of national indicators to assess states' efforts to balance their long-term support system between institutional and community-based supports including characteristics correlated with improved qualities of life for individuals. The selected contractor will work closely with FY 07 Real Choice Systems Change Grantees awarded "State Profile Tool Grants" to develop and test a set of measures and provide technical assistance to help build the data infrastructure necessary to support on-going collection of the measures.

Hulbert encouraged ADRCs to collaborate with the Money Follows the Person grants. She noted that 31 states were awarded MFP grants (see contacts at end of these notes) and encouraged ADRCs to get involved if they weren't already. She noted that states have one year to develop an operational protocol and are in the pre-implementation phase right now. Upon approval of the operational plan, states receive additional funding for continuation.

Hulbert outlined several potential roles for ADRCs in assisting with the Money Follows the Person Initiative:

- Marketing and Information Dissemination
- Collaboration in performing assessments and transition care planning
- Identification of AoA and other support services
- Support states in the identification and referral of individuals for transition
- Work with the states to develop benchmarks that support broader MFP goals
    - Diversion
    - Streamlining eligibility
    - Flexible funding

She also provided some websites for more information:

http://www.cms.hhs.gov/newfreedominitiative
http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp
http://www.hcbs.org

Lisa Alecxih – Candidates for Nursing Home Transition and Diversion

Alecxih began by distinguishing between the two types of nursing home residents: (1) those who are there for short-term post-acute restorative or rehabilitative care and (2) those who need long term assistance with personal care. She described that there are limitations in the data collected on nursing home residents—one data set includes information on admissions and discharges, and another can show residents on a given day in time. The admissions/ discharge data focuses on short term residents (because they come and go more frequently). The "given day" approach shows more long term residents. Of the 2.5 million discharges each year, 75% were there less than 6 months. However, at the same time, when looking at a given day, 70 % have been there more than 6 months.

She noted that if a state wants to consider a nursing home diversion strategy, an obvious place may be hospital discharge planners. However, because of the pressure on discharge planners and high turnover, some states have chosen to intervene once a person gets to the nursing facility.

Regarding the role of Medicaid, Alecxih noted that about 30% of people who enter nursing facilities are on Medicaid, and an additional 7-10% will spend down to Medicaid. However, spenddown usually happens quickly, so it's critical to get to people early if you want to keep them off Medicaid.

Alecxih described AoA's new Community Living Incentive and Choices programs. The target group is older adults at high risk of nursing facility use and Medicaid spenddown. The goal of the programs is to intervene with flexible supports while the individuals is still in the community.

Alecxih said ADRCs will play a critical role in identifying high risk groups. She noted that methods for identifying high-risk individuals are not the same as functional eligibility (e.g., overburdened caregiver, living alone). She also recommended that in efforts to identify those at risk for Medicaid spenddown, states should not target those who are just barely above Medicaid because they are likely to spenddown anyway, but shoot a little higher in income.

Alecxih also discussed the role of ADRCs in diversion activities. She said intake assessment and options counseling are critical. She urged ADRCs to work with Centers for Independent Living, noting that they already do transition activities and do them well. She also recommended capitalizing on relationships with nursing homes in nearby communities

Jim Raye, Wyoming Resource Center

Jim Raye provided a state example for the audience. Wyoming is a 2005 grantee and the ADRC serves seniors (50 and over) and adults with disabilities (21 and over). The population is 525,000 people in the state and there are two areas for the ADRC, in Casper and Glenrock. The actual grantee is the Wyoming Institute for Disabilities at University of Wyoming. The state also has a successful transition program called "Project Out."

Raye described ADRCs as a store window for long-term care services. The ADRC includes five programs:

1. The Resource Center – ADRC
2. CIL
3. Project Out
4. Self-directed care
5. Extensive loan closet

Raye described the ADRC like a funnel, or a conduit for people who call inquiring about services. Interestingly, at this time, ADRC assistance is not limited to LTC issues alone. The ADRC serves all people and answers any questions (e.g., bus line hours), because Wyoming staff want to get people into the habit of calling.

Raye described Wyoming's nursing home transition program (Project Out) as a key program. He said it is the most profound demonstration of the independent living philosophy, it's highly visible/ people remember and talk, it's enthusiastically endorsed by Medicaid, and it helps to defray the cost for ILC services and staff, because the Resource Centers is a Medicaid provider for targeted case management.

He said that for the first 4 years, they did transition only – finding individuals in nursing facilities and helping them get out. Raye said they developed relationships with nursing home staff and traveled with the ombudsman on quarterly rounds. He mentioned that typical referrals for transition are from home health providers (working with someone on a waiver). He said that social workers or nurses will call Project Out if they identify a person could be transitioned. They added a diversion component in 2006.

Recently, he said, they got together with state leaders, the Department of Family Services (financial assessment) and public health nursing (functional assessment). Subsequently, people who are given a functional assessment are referred to the Resource Center for assistance throughout the process. The Resource Center can be sure they get options counseling and have

informed choice about where they want to go. At present, he said, about 25% of referrals for Project OUT are through Resource Center.

Questions

Jim, have you seen impact on nursing home census and beds closing?
No, not yet

Jim, what are you using to track transition / diversion data?
Pretty informal, an excel spreadsheet

How many nursing home beds does WY have?
Not sure exactly, but probably about 800-1000

Do you have 211 and how do you work with them?
No, but we are looking at that.

How do you manage pushback from the nursing home industry?
We're small, we try to be collegial with staff and are not their enemies. Raye taught a class for nursing home program directors on Project Out.

Are you working with AAA?
We don't have AAAs in Wyoming, but we do work with the aging division.

Can you describe the quarterly rounds with the Ombudsman?
The Ombudsman makes a quarterly trip to small communities in northeast Wyoming, the kind of place that's a combined hospital / swing bed nursing home. ADRC staff goes along, almost every quarter because of staff turnover.

Lisa, is it possible to identify people who are entering nursing homes who are likely to stay?
The dilemma is identifying who's going home anyway and who is likely to stay for the long term; sometimes the person in the NF doesn't want to stay but the family wants that person to stay. Lisa thinks it would be simpler to divert people than to get them out later. But the question is what is a diversion vs. what would have happened.
Melissa – Agrees, but it's so unpredictable that efforts now need to be broad;

Q1A is used as an example of asking people in nursing homes if they want to live somewhere else. Industry folks say it's unreliable and it depends on when you ask the question. How did you get access to Q1A data and have you Identified when in the stay you have pulled that data?

We do not have the data yet, but are anticipating that we'll ask as soon as possible. We don't want to barge into a facility with a long list; also we don't want to raise hopes of someone who is not a feasible candidate.

CMS thinks that you can get a data use agreement between the state Medicaid agency and CMS; then the state Medicaid agency will have to give it to you. There are issues on the timeliness of the data. There are some promising practices papers (Reinhard/ Hendricksson) on this issue. Another issue is that the assessment is delivered in different ways – Q1A may be asked or the assessor can decide yes/no. Next version will be a direct question to the individual that this is their preference. Are you interested in talking with someone about potentially moving back into the community?

Have you looked at people with comorbidities especially for people with mental health needs?
Did not for this presentation, but easy to do. There are lots of people with mental health needs, contributing to the burnout of the family member.

How do we get to information about people who are not on Medicaid who might want to transition?
Melissas – its part of hospital participation agreements/ home health agencies are on a list for hospital referrals, so harass your discharge planner to get on the list.

How do you count savings from diversions?
Jim, savings is calculated in a simple way. Milliman consultants
Lisa – Just because you don't have a bed close or a reduced census, doesn't mean you have failed, need to look at measures over time – days of Medicaid residents, rates,
Think through the data you need to request from Medicaid, also make adjustments for higher cost of care for people who stay in the NF (vs. those who leave)

Even if you can't demonstrate diversions and get money diverted back to the community, it's still good for the person and it's good for Medicaid, we need to figure out how to bring the money back to the community, have a dialogue about this.

Also need to discuss the cost of informal supports – especially in states with large rural areas. People may quit job or reduce hours to help keep a person in the community. The deteriorating health of the caregiver is a critical concern – these people will develop chronic conditions!

CMS Money Follow the Person Awards and Contact Information
Phase 1

State	Proposed Transitions	Award Amount	CONTACT	PHONE	EMAIL
WI	1322	$56,282,998	Charles Wilhelm	608.266.8402	wilheca@dhfs.state.wi.us
NY	2800	$82,636,864	Robert Sherman	518.408.3744	rxs16@health.state.ny.us
WA	660	$19,626,869	Bea Rector	360.725.2527	rectobm@dshs.wa.gov
CT	700	$24,207,383	David Parrella	860.424.5116	david.parrella@ct.gov
MI	2500	$67,834,348	Michael Head	517.335.0276	head@michigan.gov
OK	2100	$41,805,358	Dennis Pennington	405.522.7587	Dennis.Pennington@okhca.org
AR	305	$20,923,775	Herb Sanderson	501.682.8520	herb.sanderson@arkansas.gov
MD	3091	$67,155,856	Stacey Davis	410.767.5954	srdavis@dhmh.state.md.us
NE	900	$27,538,984	Mary Steiner	402.471.9567	mary.steiner@hhss.ne.gov
NH	370	$11,406,499	Susan Lombard	603.271.3452	slombard@dhhs.state.nh.us
CA	2000	$130,387,500	Paula Acosta	916.440.7544	pacosta@dhs.ca.gov
IN	1039	$21,047,402	Natalie Angel	317.234.4753	natalie.angel@fssa.in.gov
TX	2616	$142,700,353	Marc Gold	512.438.2260	marc.gold@dads.state.tx.us
SC	192	$5,768,496	Sam Waldrep	803.898.2590	waldrep@scdhhs.gov
MO	250	$17,692,006	Steven Renne	573.751.6922	karen.a.lewis@dss.mo.gov
IA	528	$50,965,815	Deborah Johnson	515.725.1012	djohnso6@dhs.state.ia.us
OH	2231	$100,645,125	Enka Robbins	614.466.4443	robbie@odjfs.state.oh.us
Totals	**23604**	**$888,625,631**			

CMS Money Follow the Person Awards and Contact Information
Phase 2

State	Proposed Transitions	Five Year Commitment	*Contact*	*Phone*	*Email*
DE	100	$5,372,007	Joyce Pinkett	302-255-9616	joyce.pinkett@state.de.us
DC	1110	$26,377,620	Robert Cosby	202-442-5972	robert.cosby@dc.gov
GA	1,347	$34,091,671	Judy Hagebak	404-657-5467	jhagebak@dch.ga.gov
HI	415	$10,263,736	Aileen Hiramatsu	808-587-5721	ahiramatsu@dhs.hawaii.gov
IL	3,357	$55,703,078	Theresa Eagleson	217-782-2570	theresa.wyatt@illinois.gov
KS	934	$36,787,453	Frank Stahl	785-296-2081	fzs@srs.ks.gov
KY	431	$49,831,580	Mary Walker	502-564-7540	mary.walker@ky.gov
LA	760	$30,963,664	Jerry Phillips	225-342-3891	jphilli2@dhh.la.gov
NJ	590	$30,300,000	Joseph Bongiovanni	609-987-2040	joe.bongiovanni@dhs.state.nj.us
NC	552	$16,897,391	Tara Larson	919-855-4261	tara.larson@ncmail.net
ND	110	$8,945,209	Maggie Anderson	701-328-2321	soandm@nd.gov
OR	780	$114,727,864	Julia Huddleston	503-945-6392	julia.a.huddleston@state.or.us
PA	2600	$98,196,439	Linda Blanchette	717-783-0508	lblanchett@state.pa.us
VA	1041	$28,626,136	Karen Lawson	804-225-2364	karen.lawson@dmas.virginia.gov
Totals	14127	**$547,083,848**			