

**Assessment/Transition Work Group Policy Priorities
Olmstead Advisory Committee Meeting
Presentation to Full Committee: September 15, 2006**

Summary: The Assessment/Transition work group met on July 25 and September 6 to identify and develop policy priorities to present at the September 15, 2006 meeting. These policies were identified using the state's Olmstead Plan, as well as other best practices not included within the plan. The five policy priorities are as follows, and as outlined in the below document (not listed in any particular order of importance):

1. Establish Statewide Nursing Home Transition Efforts
2. Establish Transition/Diversion One-Time Needs Fund (Special Circumstances Fund)
3. Address Barriers to IHSS Assessments in Nursing Homes
4. Revise the Rate Structures for Home and Community-Based Services (HCBS) and Develop a Flexible State Budgeting System
5. Create Incentives for Counties to Transfer Individuals into the Community

Background: The Assessment/Transition Work Group identified the policy priorities to present to Secretary Kim Belshé for her consideration at the September 15 full committee meeting. The policies were selected using the following criteria (these criteria were developed by the Diversion work group and have been slightly modified by the Assessment/Transition work group):

1. Immediate, wide-ranging and direct impact on the State's implementation of Olmstead.
2. An opportunity to shift funds or to provide alternative funds for community-based services.
3. Immediate opportunity at the federal level for this policy initiative with the possibility of federal funding.
4. Immediate opportunity at the state level to build on this policy initiative, with possibility of state and/or alternative sources of funding.
5. A direct impact on current Health and Human Services Agency issues, i.e. something the Agency can influence.
6. New Initiative: represents a new direction in state policy.

The work group will continue to consider additional issues on an ongoing basis.

The following priorities are not listed in any order of significance or importance.

Issue I:
***Developing Statewide Resources to
Facilitate Nursing Home Transitions***

Policy Goal: To provide nursing home residents the opportunity to return to the community.

Problem: Nursing home residents who have an interest in returning to the community often lack access to critical transition services, including assistance from a coordinator who can help facilitate connections to home and community-based services, resources to cover one-time emergency needs for return to the community, and access to affordable and accessible housing.

Barriers:

- Residents lack awareness of a process that could support their return to community if that is their preference.
- Lack of a systematic way to accurately identify those who want to transition.
- Lack of trained coordinators to work with residents who wish to return to community living.
- Lack of community organizations' and HCBS waiver capacity to provide for residents' temporary and long term needs upon return to community, including ongoing care coordination/case management if needed.
- Dearth of affordable and accessible housing necessary to facilitate transfers.

Work Group Policy Priorities

1. **Establish Statewide Nursing Home Transition Efforts:**
Expand community infrastructure and support "Transition Coordinators" who would be responsible for identifying and working with nursing home residents who wish to return to community. Resources could be targeted to developing a process through which nursing facility residents can express and act on a preference to return to community living and/or avoid institutionalization or reinstitutionalization. Along with a

fair and equitable process of informing residents about HCBS alternatives, transition coordinators could work with the residents in coordinating all aspects of a plan for return to the community, including housing, ongoing Medi-Cal eligibility, income maintenance, in-home services and supports and other aspects of independent living.

Within California, a few model programs have successfully transferred residents from nursing homes to the community, using trained nursing home transition coordinators. These programs operate in only a few areas of the state. For example:

- The Westside Center for Independent Living's Deinstitutionalization is About Living (DIAL) program has developed an infrastructure via policy and systems change to facilitate the transition of people with disabilities from institutional settings to community settings. The DIAL project relies on two transition coordinators to work with residents in facilitating the return to the community. To date, the project has transitioned 30 individuals to the community over an 18-month timeframe.
- In Santa Rosa, Community Resources for Independence's nursing home transition project has transitioned over 30 residents from nursing homes, with the assistance of transition coordinators. The transition coordinators work directly with the consumer (while also establishing appropriate point persons who will work under the consumer's direction) to assess needs and develop avenues to transition into the community. The program developed an assessment tool to identify those community services that the consumer will need to successfully transfer to the community. The staff makes the contacts and advises the consumer of procedures for following up on the necessary services.
- The Providing Assistance to Caregivers in Training (PACT) program began in 2001 and operated for 36 months as an interdisciplinary case management program designed to enhance nursing home discharge planning and case management support for the transitional period following a

person's return to the community. The program was funded by a grant from the U.S. Administration on Aging, and operated out of the Aging and Adult Service Bureau of the Contra Costa County Employment and Human Services Department. During the PACT program's initial 24 months of operation, 38 of 42 opened cases were assisted in a discharge to the community. Of these, 30 remained at home for at least 6 months, 5 were readmitted within 6 months, and 3 deceased.

- In San Francisco, the Targeted Case Management (TCM) Program assists individuals at Laguna Honda Hospital (LHH) who are seeking home and community based services with assessment and discharge planning. TCM is run by San Francisco's Department of Public Health and is independent of LHH. It is staffed by nurse and social worker case managers who screen, assess, and develop a Linkage Plan (discharge plan) for all class members. TCM is a Medi-Cal state plan service, funded through a 50% federal, 50% local match. TCM provides ongoing case management services, if appropriate and desired to ensure that residents receive all needed services, including referrals to housing waitlists and coordination of services once housing is secured. LHH residents who are scheduled for discharge within 180 days will receive case management services from the TCM Program. TCM case managers follow individuals once they are in the community until the individual is connected with a long-term case management program. Because it is a pilot program, TCM in San Francisco currently serves only those individuals at risk of placement at LHH or in LHH; however, other counties providing TCM do so on an ongoing basis.
- The Multipurpose Senior Services Program (MSSP), the Nursing Facility A/B Waiver, and the Subacute Waiver have been amended to allow transitional care planning that can help a person transition out of an institution and return to the community. At present, the NF A/B and MSSP waiver programs are operating at full capacity with waiting lists. Additionally, providing ongoing case management to current waiver enrollees consumes most allocated resources, allowing few, if any, resources to be available for new

caseload for transitional care planning. As a result, the current waivers do not have the capacity to provide these transitional care planning services to residents of nursing homes.

The work group supports development and testing of a systematic approach to enabling nursing facility transition to be accessible to those whose preference it is to return to community living. There are a number of actions that would be needed to initiate and support such a system:

- Development and implementation of a protocol, including application of current requirements, by which individuals can make their preference to transition known; for example, assessment of preference, informing notice, MDS, PASRR, other. Nursing home residents are, by law, required to be informed about community services and options, including waivers, at every level of care determination. The process should facilitate transitions using level of care determinations as an opportunity to discuss individual preferences.
- Partnership with the nursing home providers and community providers to ensure that transitions are smooth and care plan information is available.
- Expansion of the number of slots provided in HCBS waivers in order to address wait list issues.
- Funding of and training for Transitional Coordinators and transitional care planning activities, including funding for transitional case management services and provider expansion.
- Expedited IHSS assessments in institutions, including hospitals and nursing facilities.
- Funding for ongoing caseload expansion of HCBS organizations.

The federal Deficit Reduction Act's Money Follows the Person demonstration provides the state an opportunity to work with stakeholders to explore such operational changes and to demonstrate the potential for statewide application.

Other states:

In Oregon, state statutes establishes a vision for a system of care that emphasizes the transition to home and community-based long-term care. All programs focus on promoting diversion from nursing homes and relocation/transition for nursing home residents who request care in the community.

In 1982, Oregon used state funds to begin hiring state “relocation workers” to assist individuals with nursing home transitions. The relocation workers contacted nursing facility residents who had been flagged, usually upon admission (Oregon requires face-to-face screening for all nursing facility applicants within thirty days of nursing facility admission), as potentially eligible for transition and followed up with them on a monthly basis for the first ninety days to investigate transition possibilities. The workers would help the residents devise and implement a transition plan. Most of the individuals were transitioned to adult foster homes, although some transitioned to assisted living. Between 1982 and 1996, approximately 10,000 individuals were transitioned from Oregon’s nursing facilities.

New Jersey: In 1998, New Jersey sponsored a nursing home transition program called “Community Choice.” Community Choice hired approximately thirty to forty “counselors” who were assigned to specific nursing facilities with the purpose of identifying and working with residents who were potential candidates for transition. These counselors focused initially on individuals who entered as short-stay residents. This effort resulted in approximately 1500 individuals transitioned from nursing facilities over a period of two to three years. Given that the initial focus was on these “short-stay” residents, it is possible that individuals who may have left on their own are included in this number. New Jersey continues to expand its efforts with a current staff of approximately seventy Community Choice counselors who transition several hundred people each year on an ongoing basis. According to New Jersey’s Department of Aging and Human Services, Community Choice has assisted more than 4,735 individuals in transitioning from nursing facilities to the community.

Texas: As part of its plan to comply with the 1999 *Olmstead* decision, Texas created the “Promoting Independence Initiative.” Under this initiative, the Texas Department of Human Services (TDHS) sent a letter to nursing facility residents and their authorized representatives informing them about their community options and giving them the phone number for their local TDHS Community Care office. If a Medicaid-funded resident indicates a desire to transition to the community, then either a state-employed care coordinator or a transition coordinator from an independent living center assesses the person to determine medical and/or functional eligibility for community services. After establishing eligibility, the care coordinator works with the person to develop and implement a care plan for the community, using any service for which they are eligible. Between mid-2001 and early 2004 approximately 3,180 individuals transitioned out of nursing homes.

- 2. Establish Transition/Diversion One-Time Essential Needs Fund (Re-establish Special Circumstances Fund):** The work group places a high priority on establishing ongoing funds to provide for one-time essential needs for transition. While a few programs offer these funds on a limited basis, funds are not available on an on-going, statewide basis.

Background: Nursing home residents [including people living in skilled nursing facilities, developmental centers, Institutes for Mental Disease (IMDs), and Intermediate Care Facilities for the developmentally Disabled (ICF-DDs)] who return to the community often face additional expenses for moving, and other one-time needs including covering costs for heaters, refrigerators, cleaning, and pest control. Without any additional resources provided for these one-time needs, residents often cannot afford to return to the community.

California's Efforts: In California, Governor Schwarzenegger signed SB 643 (Chesbro, Statutes of 2005) providing, as part of the Nursing Facility A/B Waiver, one-time community transition services including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, moving expenses, deposits for utility or service

access, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs cannot exceed five thousand dollars (\$5,000). These funds are limited only to persons enrolled in the waiver program, and will be included in the person's cost-cap.

The Department of Rehabilitation administers a program providing one-time costs for transition. The Department provides up to \$4,000 to assist consumers in meeting the one-time costs associated with moving from nursing facilities and similar settings to the community – generally, the individuals' homes or apartments. Typical expenses include clothing, an initial stock of food, a month's rent, house wares, assistive devices and minor home modifications. Independent Living Centers are required to look for other community resources before requesting funds through this project. The Department has designed a streamlined process for these grants in which centers apply for authorization by e-mail and approvals are communicated in the same way. This process makes it possible to turn around requests usually within twenty-four hours. This program is funded out of the State Plan for Independent Living, with \$100,000 in limited funds available for this purpose.

Previous One-Time Emergency Funds Available through California's Special Circumstances Program: The Special Circumstances Program was a state-funded, county-administered special needs assistance program for SSI/SSP recipients, supervised by the Department of Social Services. The program provided emergency payments to SSI/P or IHSS recipients for special non-recurring needs. These one-time payments were intended to meet immediate needs in order to maintain individuals in their homes rather than institutions. The program recognized that in poverty households, such events as a fire or the breakdown of an appliance could be catastrophic. Special Circumstance funds could be used to include replacement of essential household furniture (refrigerator or oven), necessary housing repairs (e.g., a leaky window or roof), and unmet shelter needs.

The Special Circumstances Program was reinstated on August 21, 1998 after being suspended since 1992. The Budget Act of 1998 allocated \$8.3 million for this program. In 2001-02, the Governor vetoed \$3.3 million from the program's budget, leaving \$5 million in the overall program budget. The program was pulled from the budget in 2002. Program Problems: The Legislative Analyst's Office reported that the program had high administrative costs- 40 cents of every \$1 were spent on administrative expenses. Given the relatively high fixed costs of administration, the Legislature determined that the program was not a cost-effective means of providing one-time cash assistance.

The work group places a high priority on the establishment of a permanent, on-going fund to use for transition and diversion purposes, similar to the method used by the Department of Rehabilitation as mentioned above. This fund would be used to help people living in institutions (including skilled nursing facilities, developmental centers, IMDs, and ICF-DDs) transition back to the community, as well as help people living in the community avoid institutionalization.

3. Address Barriers to IHSS Assessments in Nursing Homes:

The work group believes a critical component to successful nursing home transition (including skilled nursing facilities, developmental centers, IMDs, and ICF-DDs) entails connecting with home and community-based services before discharge, including IHSS. Counties are responsible for providing preliminary In-Home Supportive Services (IHSS) assessments for applicants who are discharged from hospitals, medical institutions or non-medical out-of-home care facilities (see All County Letter 02-68). Several counties do not conduct these preliminary assessments in skilled nursing facilities, developmental centers, IMDs, ICF-DDs or hospitals. As a result, nursing home residents who need access to IHSS services must wait to be assessed until they return home; for many, the lapse in time is too long, as IHSS services are needed immediately upon return home. Many counties contend that these preliminary IHSS assessments have not been

conducted due to lack of resources, as counties receive 11.5 hours per client for all assessment needs over a year.

The work group supports efforts to ensure that counties follow the law and conduct IHSS assessments in skilled nursing facilities, developmental centers, IMDs, ICF-DDs or hospitals by both increasing assessment resources, as well as through continued education to inform counties and nursing homes of the importance of conducting these assessments, in line with California's Olmstead efforts.

***Issue II:
Developing Policies that Create
Incentives for LTC Systems Rebalancing***

Policy Goal: Address the “institutional bias” and rebalance California’s long term care system by ensuring that sufficient resources are placed in the development of home and community-based alternatives to institutionalization, in order to more effectively facilitate the transfer of nursing home residents to the community.

Problem: Counties lack incentives to transfer individuals out of nursing homes, and communities often lack the capacity to provide for the range of services needed for a safe return to the community.

Barriers:

- **Home and Community-Based Services Rate Structures.** Rates for most home and community-based services do not include automatic rate increases or Cost-of-Living Adjustments as do nursing facilities. As a result, most HCBS rates have remained stagnant while nursing facility rates have increased. Stagnant rates impact the ability of providers to expand provision of HCBS.
- **Medicaid Institutional Bias:** Medicaid’s institutional bias is one of the main factors contributing to lack of community capacity,

thereby impacting an individual's ability to remain in the community. Medicaid is the major source of public financing for long-term services and supports for people with disabilities. Medicaid law requires states to provide institutional services to all eligible persons as a mandatory benefit, and permits (but does not require) states to offer home and community-based services in the community through a Medicaid waiver, whose rules limit eligibility and "statewideness" and funding. This federal policy is referred to as the "institutional bias."

- **California's Realignment System:** Under California's realignment system, counties are required to pay a 17.5% match for IHSS services, the state pays 32.5%, and the federal government pays 50%. For nursing facility services, however, counties do not pay a share-of-cost; the state pays 50% and the federal government pays 50% of the cost of services under Medicaid. Counties need a fiscal incentive to keep people in the community.

Policy Priorities:

4. **Revise Rate Structures for Home and Community-Based Services (HCBS) and Develop a Flexible State Budgeting System:** The work group supports development of a revised HCBS rate structure whereby cost-of-living increases or automatic rate adjustments are built into HCBS program rates, as opposed to the current flat-funded structure. As the cost of doing business escalates, HCBS providers are unable to meet consumer demand for services in the community. As a result, community capacity diminishes. In contrast, rate structures for institutional providers (nursing homes) include automatic cost-of-living adjustments as well as adjustments authorized under the newly-enacted provider bed tax (AB 1629, Chapter 875, Statutes of 2004). The work group would like to see parity between the structure of HCBS rates and institutional rates.

In addition, the work group is interested in exploring options to develop a consolidated budget for Medicaid Long Term Care spending, to allow for greater flexibility and ability to transfer funds between institutional programs to fund HCBS program. At

present, California's budget system separates institutional and HCBS; as a result, funds cannot be transferred between institutional to HCBS. With a pooled budgeting system, funding saved from institutional expenditures could be targeted directly to HCBS services which would create a mechanism through which to provide incentives to counties to transition people out of nursing homes.

Other States: Based on a 1996 initiative, Vermont requires that the rate of growth for Medicaid nursing home expenditures be reduced and that the savings be invested in home and community-based supports. The initiative established specific targets for savings to be achieved in each of the four years following its enactment, with savings used to expand existing programs or to fund new programs. As a result of this legislation, Vermont successfully expanded community-based options including new residential services, and offered greater opportunities for participants to self-direct their supports. In 1986, Washington consolidated the administration of all long-term care supports for older people and people with physical disabilities. The Aging and Disability Services Administration has a single budget line item for both community and institutional long-term care. To provide services immediately, the state presumes eligibility if it appears that the client will be eligible for waiver services.

- 5. Create Incentives for Counties to Transfer Individuals into the Community:** The work group places a high priority on creating incentives for counties to help nursing home residents transition to the community. As an example, Wisconsin provides an incentive to counties that assist individuals in transitioning out of nursing facilities. Wisconsin adds an amount to the county's allocation of HCBS waiver funds for each occupied nursing facility bed closed in which the person moves into the community. The state increases the county's allocation by the amount necessary to meet the needs of each person who leaves a nursing facility while using the HCBS waiver funds. Once this person no longer needs waiver services, the funds remain available for other people in that county who need home and community based services.