Assessment/Transition Work Group
Actions-to-Date, and Next Steps

Assessment/Transition Work Group Meeting

The third meeting of the Assessment/Transition Work Group was held on Monday, February 6, 2006. Olmstead Advisory Committee member Tony Sauer of the Nevada-Sierra Regional IHSS Public Authority chairs the workgroup. The workgroup is charged with analyzing the problem and the barriers related to assessment and transition out of institutions; assisting in efforts to identify, develop and implement a uniform or coordinated assessment tool and protocol; and highlighting issues to consider for the Secretary of the Health and Human Services Agency as the state moves forward with implementation of the Olmstead decision.

The purpose of meeting was to review and discuss the proposed Community Options and Assessment Protocol (COAP) project, and nursing home transition assessment issues.

I. Community Options and Assessment Protocol: The work group reviewed the Community Options and Assessment Protocol (COAP) protocol proposal. This budget proposal provides $595,000 ($295,000 General Fund) for two years to develop and test a coordinated assessment tool that identifies consumer needs across programs for seniors and persons with disabilities, in order to ensure access to necessary services and supports. The COAP will identify core assessment elements commonly used by most HCBS programs and will develop program cross-referral protocols that builds on assessment procedures currently used by key HCBS programs to assess consumer and caregiver needs. The project's goal is to develop and test a process that can better help consumers access HCBS programs that best meet their needs and that can do so in a more timely manner.

This proposal directs the Department of Health Services to contract for the development of a coordinated tool that can be used across home and community-based programs, in consultation with other Health and Human Services departments and stakeholders including the Olmstead Advisory Committee. This proposal does not provide for the implementation of the tool, but focuses on the development of the tool and its protocol.

Committee Questions: The work group was supportive of the direction of the proposal, but had a number of questions that the Department will clarify at the March 3 full committee meeting, as follows:

1. New tool or common data elements: The work group would like clarification on whether the proposal calls for development of a screening tool with common data elements shared between programs, or whether the proposal would develop a new assessment tool that programs would use in addition to assessments currently conducted.
2. Time required: The work group wanted an explanation of how long it would take to carry out this project, and whether it would be possible to develop tool and the protocol in less than the proposed three-year period outlined in the proposal.
3. Data: The work group requested clarification on whether the tool and protocol would lead to development of a data warehouse that stores assessment data across programs, and, if so, where the data would be stored (county or state level), how it would be transmitted, and how it would be used by the state and local levels.
4. Testing and validation of draft tool: The work group would like additional information on how the draft tool will be tested and validated, and what process would be used.

II. Nursing Home Transitions and Assessments: Building off of efforts from the November 2005 Assessment Forum, the work group focused on transition assessments (assessments focused on transitioning people out of nursing homes) and issues regarding statewide replication. The work group discussed current transition initiatives, what qualifications should be required for persons/entities conducting the transition assessments, barriers and opportunities to expand these efforts statewide.

Current Efforts in Transition Assessments: At present, some Independent Living Centers offer transition assessment programs that assess individuals who have expressed an interest in returning to the community, and assist them with accessing home and community-based services and housing. The Westside Center for Independent Living (WCIL) in Los Angeles and Community Resources for Independence (CRI) in Santa Rosa both have

established programs that assist consumers with transitioning from nursing homes and returning to the community.

- WCIL's Deinstitutionalization Is About Living (DIAL) project has served 24 consumers during its first year, working with consumers in 18 skilled nursing facilities and one local hospital. The individuals assisted often had severe and complicated medical situations. Only one consumer served had significant family support; the majorities had no savings, were receiving Medi-Cal coverage and had no housing.
- CRI's Project Independence program seeks to transition consumers from nursing homes to the community. The project staff identifies consumers to transition from nursing homes into the community. Most of the consumers are referred to the program from social workers in the skilled nursing facilities, acute care hospitals, and rehabilitation units. Others are referred from the Ombudsman office and families. The project staff meets 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.

Transition Program Expansion and Procedural Issues to Address:
The work group noted that the transition programs only operate in a few areas of the state, and identified a number of procedural issues to resolve in examining options for expanding the transition programs – including:

1. How to identify consumers interested in transitioning out of facility: The work group discussed using the MDS Q1A data as a way to identify these individuals, acknowledging that there are shortcomings with the data, but that it still could provide a start to these efforts.
2. Resources- how to fund programs similar to WCIL and CRI: Transition programs cannot operate without resources to cover staff cost. There may be opportunities to fund similar programs using resources provided under the expanded Money Follows

the Person Initiative (see section below providing more information).

3. Requirements for assessors and organizations: The work group recommends that assessments be conducted by community-based organizations, as opposed to nursing facilities to avoid potential conflict-of-interest. The work group discussed various qualifications that could be considered for organizations interested in establishing these programs, including access to a multi-disciplinary team in order to address the consumer's social and medical needs. In addition, it is possible for nursing home residents to receive a medical evaluation through the Adult Day Health Care Program, as regulations permit nursing home residents to visit ADHC programs for three days without a Treatment Authorization Request (TAR). The work group will continue its discussion on qualifications for who should be performing assessments at upcoming work group meetings.
4. Caregiver issues: The work group noted that programs must consider the availability of caregivers in the community, and assessing them to understand their needs before caring for a loved one upon discharge from a nursing home.
5. Systems change: The work group noted that there is a significant need for more accessible, affordable housing to facilitate a person's return to the community. Often, nursing home transitions are hindered by lack of housing options.
6. State-level support: The work group noted that if programs were to expand at the local levels, it would be important to have state-level technical assistance, providing training and quality assurance in program operations.
7. Other resources: Additional resources may be available at the local level to help facilitate a person's return to the community, including the Multipurpose Senior Services Program's (MSSP) deinstitutionalization efforts. The program allows MSSP to offer case management transition services for 180 days prior to a person's discharge to the community. The work group will ask representatives of the Department of Aging to attend the next work group meeting to provide an update on these efforts.

<u>Leveraging New Resources: Opportunities to Expand Nursing Home Transition Efforts -</u> The recent passage of the Federal Deficit Reduction act includes resources to expand the Federal Money Follows the Person Demonstration Program, providing a

potential opportunity to fund nursing home transition efforts. A summary of the program follows.

MONEY FOLLOWS THE PERSON INITIATIVE:
The Deficit Reduction Omnibus Reconciliation Act of 2005 authorizes a Money Follows the Person Demonstration Grant Program that will provide states with an enhanced match for services for up to 12 months for individuals who move from an inpatient setting to a qualified community residence. Information on this initiative is as follows:

The Act appropriates funds for the Money Follows the Person Demonstration Program proposed by the Administration earlier this year. The conference committee made some changes in the bill that passed the Senate. Grants may be made beginning January 2007 rather than 2009, and provisions for enhanced federal reimbursement were clarified.

The Act allows grants to states to pay for home and community-based services, including transition services, for up to 12 months for people who move from an inpatient facility (nursing home, hospital, ICF MR) to a "qualified residence." To qualify for services, an individual must have resided in the inpatient facility for at least six months but not more than two years and must receive Medicaid benefits

The Act defines a qualified residence as a home that is owned or leased by the individual or family member, an apartment with an individual lease, or a residence in a community-based residential setting in which no more than four unrelated individuals reside. Apartment-style assisted living units would not qualify.

Applications
States interested in participating in the demonstration program will need to submit applications that include:

- An assurance of a public process to design, develop, and evaluate the project;
- Connection to a qualified HCBS program to assure continuation of services for individuals after 12 months of service coverage;
- A description of the service area;

- A description of the groups of individuals to be served;
- The number of individuals in each group who will be served; and
- The total annual qualified expenditures for each year of the project.

Balancing

To participate in the program, a state will also have to describe how it will balance its long-term care spending. States will need to submit data on institutional and HCBS expenditures in the fiscal year prior to the demonstration and to specify the methods that will be used to increase both the actual expenditures for HCBS and the percentage of spending for those services. The application will also need to describe how the state will eliminate legal, budgetary, and other barriers to supporting individuals in the setting of their choice.

The Act also requires maintenance of effort. Total HCBS expenditures during the demonstration must be greater than the highest of what was spent in FY 2005 or in any subsequent fiscal year prior to the demonstration.

Funding

The Act appropriates $250 million for the demonstration program for the nine months of FY 2007 (January to September), $300 million for FY 2008; $350 million for FY 2009; $400 million for FY 2010; and $450 million for FY 2011.

The conference report changes the state matching requirement included in the Senate bill. Under the Act, grantees will receive an enhanced Federal Medicaid Assistance Percentage (FMAP) that is equal to one half of the difference between the regular matching rate and 100 percent. However, the matching rate cannot exceed 90 percent. For instance, a state with FMAP of 60 percent would receive 80 percent reimbursement for 12 months for services to individuals who moved to a qualified residence.

Each quarter, the state would be paid from its grant award the lesser of the enhanced FMAP for the qualified expenditures or the amount remaining in the grant. If expenditures exceed the amount of the grant, grantees may claim reimbursement using the regular FMAP.

Other requirements
Under the Act, state programs must operate for at least two consecutive years during the five-year demonstration period. State proposals must include a quality assurance plan and may include an option for self-directed services. Funding is included for technical assistance and oversight for states seeking to upgrade their quality assurance and improvement systems.

The work group will continue to explore opportunities to develop transition programs under the Money Follows the Person Grant opportunities, as more information comes forward from the Centers for Medicare and Medicaid Services.

Continuing Next steps for Assessment Work Group:

- Gather additional information on opportunities provided through the federal Money Follows the Person initiative;
- Follow up on other related transition issues including: IHSS assessments in nursing homes, MSSP transitional assessments, and the Department of Mental Health's Intensive Service Agencies as a model for transition efforts.
- The next meeting of the Assessment work group is scheduled for March 27 at 1:30 pm at the California Health and Human Services Agency.

-