CSHP
Rutgers Center for State Health Policy
NATIONAL ACADEMY for STATE HEALTH POLICY

January 2006

Meeting Summary

Community Living Exchange

Funded by Centers for Medicare & Medicaid Services (CMS)

Sustaining Nursing Home Transition

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The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

This document was developed under Grant No. 11-P-92015/2-01 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government. Please include this disclaimer whenever copying or using all or any of this document in dissemination activities.

Sustaining Nursing Home Transition: Meeting Summary

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Summary

The Nursing Home Transition Summit, convened by Rutgers Center for State Health Policy (CSHP), was held September 28 through September 30, 2005 in Plainsboro, New Jersey. It brought together 39 participants from ten states, in addition to representatives from the Centers for Medicare & Medicaid Services, to discuss how to sustain nursing home transition (NHT) programs. The New Jersey Community Choice Counseling program served as the summit centerpiece, with presentations by program staff and visits to several sites in the Central New Jersey area.

Major Points

- Building relationships with other stakeholders is a key strategy to making nursing home transitions work logistically and convincing policymakers to pass enabling legislation and fund NHT programs.

    - Different stakeholders may not have a common vocabulary, and it takes time to build trust and a common understanding.
    - In order to get others to take ownership, it is necessary to share the credit, and can be helpful to be willing to give up control.

- It is critical to budget for evaluation, as an evaluation is important in building a case for NHT and also for improving programming. An external evaluation will have more legitimacy. Involving stakeholders in the design of the evaluation can be helpful.

- One way to get NHT onto the policy agenda is to make it part of a larger issue or agenda. For example, one summit participant will attempt to include transition as part of her state Medicaid agency's initiative to develop a uniform assessment tool for all programs and to link the tool to community care networks.

- Consumer involvement and motivation may be the key predictors of a successful transition (as opposed to level of care needs). Several states pointed to this as important, and Michigan focused on the resident's choice to move, as opposed to the resident's abilities, as the key identifying criterion in its pilot transition program. Transition staff from other states indicated that consumers who were involved in their transition planning and sufficiently motivated to take action on their own behalf (to the extent that they were able to do so) were more likely to be able to transition successfully.

- A successful nursing home transition often requires intensive case management, which requires creativity and flexibility among staff members.

    - During a nursing home site visit, summit participants heard about the challenges of transitioning a consumer who cannot speak, due to a stroke. The consumer had limited literacy before the stroke, making communication difficult. The consumer is determined to transition, and staff are working on obtaining technology that will allow the consumer to communicate with others so that the consumer can be relatively independent in the community.
    - In addition to consumer counseling and knowledge of state/federal programs, nursing home transition staff can take on significant procurement responsibilities in carrying out transitions, requiring them to build relationships with vendors and contractors.

- It is important to identify consumers for nursing home diversion or transition before consumers lose their housing in the community while they spend months or years in a nursing home. Having to obtain housing in order to transition can make transition costs higher in terms of dollars, and also can increase the psychological cost for consumers. The lack of affordable and accessible housing remains an important barrier to successful transition for many consumers.

Learning Across the States

To foster learning across the states, the Rutgers CSHP/ National Association for State Health Policy (NASHP) team invited leaders involved in nursing home transition efforts from ten states: Connecticut, Delaware, Indiana, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania and Wisconsin. We also invited representatives from the Centers for Medicare & Medicaid Services (see a list of attendees in Appendix A).

The specific objectives of this technical assistance event were to:

- Describe New Jersey's evolving Community Choice Counseling (CCC) program for transitioning nursing home residents back to their homes and communities.
- Discuss other states' NHT models, focusing on "critical elements"[1] with an emphasis on overcoming barriers to program implementation as well as barriers for achieving sustainability.
- Identify specific critical steps to take to sustain NHT in participants' states.
- Collect current technical assistance resources to advance sustainable NHT programs.
- Suggest future technical assistance activities to advance sustainable NHT programs across the states.

Participants' Goals for the Summit

Prior to the summit, we asked participants to let us know what they would most like to take away from the conference. Their requests fell into the following categories:

[1] See Appendix B for a detailed list of these elements.

- Improving collaboration with other long-term care stakeholders (e.g., Area Agencies on Aging, discharge planners, Independent Living Centers, Aging and Disability Resource Centers);
- Improving quality of life for transitionees;
- Building the case for nursing home transition with policymakers;
- Developing financing strategies;
- Addressing housing issues;
- Identifying candidates for transition; and,
- Discussing regulatory issues (e.g., sample language, streamlining processes).

Each state team provided a brief overview of critical elements of their NHT program, emphasizing barriers (those that have been overcome and those that have not), learning needs and plans for sustainability in relation to the long-term system of supports and services. (See Appendix C for a detailed discussion of each state's program.) Experience in NHT efforts for more than a decade led the Rutgers CSHP/NASHP team to identify specific "critical elements" for sustaining a statewide NHT program. Examples of these critical elements include: a statutory framework, adequate and sustainable funding, transition funding, collaboration with key local partners, data tracking and advocacy (see Appendix B for a complete list).

Staff from the New Jersey Department of Health and Senior Services presented an overview of the state's Community Choice Counseling (CCC) program (see Reinhard and Petlick (2005) for a detailed discussion of this program). A panel of Community Choice Counselors gave an overview of the work they do transitioning consumers. Summit participants visited the Water's Edge Health Care & Rehabilitation Center in Trenton, NJ to meet with nursing home staff involved in planning transitions for consumers and to discuss one transition case in depth with the CCC counselor and the nursing home staff. They also had an opportunity to tour the nursing home and ask questions of the staff.

Participants also toured "Project Freedom" in Lawrence, NJ,[2] a 54-unit barrier-free housing development constructed with funds from multiple sources, including tax credits. The site has provided housing for several individuals that were transitioned, and the group toured the apartment of one such individual. Staff from the CCC program joined staff from Resources for Independent Living, an Independent Living Center (ILC), to discuss consumer roundtables, where the consumer meets with the professionals involved with their transition to discuss, plan and strategize regarding the consumer's goals. A key difference between this type of meeting and general care meetings is the involvement of consumers. Many at the summit felt that consumer motivation and involvement was the most important factor in ensuring the success of transitions.

To get a picture of the variety of care offered in the area, participants also toured the Bear Creek Assisted Living Facility in West Windsor, NJ. The CCC staff work with people going into assisted living facilities, and had suggested that participants see this facility. Bear

[2] See web site at http://projectfreedom.org

Creek offers more care than the units at Project Freedom, but less intensive care than a nursing home setting, though they have 24-hour nursing available on site.

Finally, participants discussed lessons learned, adjustments made to their programs, and contributions to their programs by community stakeholders, consumers or other Systems Change or Aging and Disability Resource Center (ADRC) grantees. Participants also offered general insights regarding realizing sustainable change, both with respect to frustrations and successful strategies. The themes of this discussion are summarized below.

Meeting Outcome

Many things need to come together to assure a successful transition from a nursing home to the community. As one of the New Jersey Community Choice Counselors put it, *"It's like Thanksgiving dinner—you're trying to get things ready and get them to be at the right temperature, all at the same time. You're sweating!"* (Nancy Gratzel, New Jersey Department of Health and Senior Services, Community Choice Counselor).

Working With Policymakers and Other Stakeholders

In addition to funding, supportive legislative and regulatory frameworks are critical elements for nursing home transitions to occur successfully. These may include preadmission screening, equal financial eligibility requirements for nursing home and community-based care, and streamlined processes to ensure that community-based care is a true option. Achieving this outcome requires working with policymakers, and often other stakeholders as well.

For example, in Delaware it used to take six to seven months to establish a waiver "slot," but by establishing relationships with stakeholders, it now sometimes takes only weeks, though NHT staff want to further streamline the process. Delaware is also pursuing state legislation allowing money to follow the consumer,[3] and is seeking to amend its Nurse Practice Act to allow for more consumer direction.[4] The state already has a preadmission screening law.

State Talk: Pennsylvania

"We have been working very closely with our housing planning agency to make sure that they'll give [tax credit applications] more points if they go to 10% accessible on housing, and make them affordable… We're also partnering with them on their 10-year housing study ... gathering information around the housing needs of people with disabilities and elderly people. And … we now have a statewide web-based housing registry."
Jennifer Burnett, LTL Strategic Operations Administrator, Governor's Office of Health Care Reform

[3] For a recent publication on this topic, see Milligan, C. (2005, January). Money Follows the Person: Reducing Nursing Facility Utilization and Expenditures to Expand Home- and Community-Based Services. Rutgers CSHP/NASHP. Available at: http://www.hcbs.org/files/66/3264/MilliganReducingNursing.pdf

[4] For recent publications on this topic, see Friss Feinberg, L. and Newman, S.L. (2005, July). Consumer Direction and Family Caregiving: Results from a National Survey. Rutgers CSHP/NASHP. Available at: http://www.hcbs.org/files/79/3926/ConsumerDirection&FamilyCaregivingNWEB.pdf . See also Reinhard, S., Crisp, S. & Bemis, A. (2005, July). Participant-Centered Planning and Individual Budgeting. Rutgers CSHP/NASHP. Available at: http://www.hcbs.org/files/77/3847/Individual_Budget_Final_July_8_WEB.pdf

Building a Case for NHT

Policymakers are constantly confronted with competing priorities and are awash in data and arguments about the importance of various issues. How can those interested in sustaining nursing home transition programs get their attention? The following suggestions emerged.

- Evaluation: external and independent

Data to build your case is important whether it is collected internally or by an external evaluator. However, an external evaluation has more legitimacy because it is done by someone with no direct interest in securing funding for the program. Assuming that an external evaluator will have expertise in program evaluation that internal evaluators may not, it will carry more weight for this reason as well. In addition to helping build a case, the evaluation can provide essential information for program improvements. Several states mentioned the importance of external evaluations not only for helping to improve their program, but as additional clout with policymakers.

Connecticut highlighted the importance of budgeting for evaluation and the need to use data to build your case, even though the University of Connecticut offered to do a free evaluation. They also felt that the external evaluation was much more powerful.

State Talk: Connecticut

"We didn't budget for extensive evaluation--lessons learned… An outside assessor, in terms of trust of data, was critical. The University of Connecticut actually volunteered after the first year to evaluate our project for us so we're not paying for the evaluation at all." Dawn Lambert, Policy Analyst at the Connecticut Department of Social Services

- Hitching NHT to a larger initiative

It may be that NHT advocates can find a way to place NHT ideas within the confines of a larger initiative of some type, rather than going directly to policymakers. State agencies or advocacy groups can be alternative opportunities. For example, Linda Kendall-Fields from North Carolina mentions the state Medicaid agency's initiative for integrated access—developing a uniform assessment tool for all programs and linking this to community care networks—as an example of where she may want to make sure transition is included.

State Talk: North Carolina

"Our blip on the radar is still rather low, and so while I like to think that we're helping drive the train, very often what I'm trying to do is to find the best train to attach to… to put the transitions "bullet point" on somebody's agenda for their bigger, grander scheme." Linda Kendall-Fields, North Carolina Nursing Facility Grant Project Director

- Build a constituency for the program or issue by reaching out to other stakeholders

The next section discusses suggestions for building relationships with other stakeholders. If policymakers are hearing an argument in favor of NHT from several

groups, it will seem much more salient. All of the programs discussed the importance of building relationships, and several provided examples of how this had helped secure additional funding.

Building relationships

Policymakers, the nursing home industry, advocacy groups, service providers and vendors are all important actors in making nursing home transition a possibility. What tactics have programs used to build relationships with others?

- <u>Recognizing the importance of time to build trust and common understanding</u>

  All organizations have their own culture and ideas. It takes time for people in different organizations to realize whether terms mean the same thing across organizations and to learn whether promises will lead to results.

State Talk: Delaware

"Whatever we need to do, [the collaboration of all the stakeholders] is the key for us. The Delaware Health Care Facilities Association, an association of nursing home administrators, felt that we are coming in to empty the nursing homes. We have not done that, so everything we have done along the way I have kept them involved." Victor Orija, Delaware Social Services Administrator

- <u>Get others to take ownership by giving up control, and be sure to share the credit</u>

  Several participants mentioned that they had to give up some control of the NHT agenda in order for other stakeholders to buy in and take ownership. For example, Connecticut placed a nursing facility administrator on their steering committee and got a lot of help developing outreach materials. When it came to deciding how to do their cost-benefit analysis, they asked Medicaid officials for advice, and then did what they suggested. This prevented the analysis from being questioned later. Delaware also collaborates closely with other stakeholders in designing their program and feels that giving up control and sharing credit is essential.

State Talk: Connecticut

"We had [the folks who made systemic changes in Connecticut] present what it is that they did to help in the transition process, and we stood back and let them. The state agencies all owned [the project] jointly." Dawn Lambert, Policy Analyst at the Connecticut Department of Social Services

- Recognizing and addressing the needs of another stakeholder can benefit you as well

The North Carolina program designed NHT training for nursing facility staff. By making the training eligible for continuing education units (CEU) credit, they made it more useful for the staff and participation increased.

Several participants voiced the opinion that, contrary to the stereotype of NHT staff/nursing facility conflict, the two share similar interests, and that many involved in transition activities were also working to shore up or strengthen the nursing home industry because facilities are an important component of long term care. This attitude undoubtedly makes the nursing facilities much more willing to work with them.

Other participants found it useful to help other stakeholders, such as Centers for Independent Living (CILs), build strength and capacity to take on NHT responsibilities.

State Talk: Massachusetts

"[Massachusetts' nursing home transition staff] established excellent relationships with the nursing facility industry. They also established excellent working relationships with our independent living centers, which became a very important referral service for the folks in the nursing facility. And they also made referrals to our area agencies on aging in the region. Our AAA system is very important in … nursing facility diversion and discharge." Ellie Shea-Delaney, Assistant Secretary of the Massachusetts Executive Office of Elder Affairs, Planning and Development Unit

Identifying Consumers for Transition

There is much discussion across states with respect to how to identify consumers for transition. Self-identification is ideal. For summit participants, this question had two components: 1) efficiency--figuring out who can transition successfully and 2) equity--allocating scarce resources fairly.

Consumer Involvement and Motivation

In terms of identifying consumers who can transition successfully, both Massachusetts and Michigan highlighted consumer motivation as essential. In Michigan's case, the desire to leave is the sole identifying criteria.

State Talk: Michigan

"We had one eligibility question. 'Do you want to live in the community?' … If they said yes, then we start to work with them to prepare transition." David Youngs, CEO, DYNS Services Inc. (Evaluator). *"What the Centers for Independent Living brought to the table was this perspective that anybody that wants to should be able to get out of nursing home and the people that don't want to may not know what options are available."* Michael Daeschlein, Program Specialist at the Michigan Dept. of Community Health

The New Jersey Round Table process (with consumers, Resources for Independent Living staff and NHT staff) discussed during the summit (see also Reinhard and Petlick (2005)), has consumer empowerment and direction at its core. Staff involved in the Round Tables described giving tasks to consumers such as calling to look for housing or to line up other resources, and then following up at the next meeting to see if the consumer had

followed through. Experience has demonstrated that those who are unwilling or unable to take action on their own behalf are unlikely to be able to transition successfully.

Using the MDS

The MDS instrument has a question about whether the respondent indicates a preference to return to the community (see Reinhard, Hendrickson & Bemis 2005 for a discussion of how to use MDS data). Several states (PA, MI, MA and IN) use or are preparing to use MDS data to identify potential transitionees.

Handling Transition Logistics

Preadmission Screening

Many states have some type of preadmission screening requirement. However, having a requirement for preadmission screening and doing it effectively are very different. Effective preadmission screening involves a quick but thorough assessment of the care needs of consumers at risk of entering a nursing home, and educates them about their options for care. The following points were stressed in summit discussions of effective preadmission screening.

- <u>Seeing the consumer firsthand (often multiple times) and getting the whole picture regarding their condition</u>

  One of the New Jersey Community Choice Counselors noted that consumers' stories are like an onion, with multiple layers, and that it takes time to get to know the whole story. Another counselor, a nurse, noted that she studied all the consumers' medical files before meeting with them to become familiar with others' assessment of their condition. Assessing the amount and likely persistence of informal supports is another important element of the screening. Finally, another counselor noted that sorting out conflicting information is also key.

State Talk: New Jersey

"I often compare my clients to an onion because it'll take many visits before I peel away different layers and really get a true sense of what their story and what their history is. After the first few visits, I certainly don't have that, or it certainly changes over time… It takes a while to develop a rapport and a relationship." Lisa Melnyk, Program Support Specialist III at the New Jersey Department of Health and Senior Services

- <u>Screening before the consumer loses his or her housing in the community</u>

  For many people, giving up their home in the community marks the psychological transition from the community and into the nursing home, and they may be resistant to thinking about leaving. Also, transition expenses tend to skyrocket once belongings are sold or given away and housing is given up to new occupants because people

State Talk: Delaware

"When I go talk to them [they say] 'I don't have money for deposit. I don't have money for rent. I don't have money to do this.' I tell them that our transition fund will help them."" Victor Orija, Delaware Social Services Administrator

need deposits, start up fees and household goods. Summer (2005) notes that once people become comfortable in a nursing facility, they are less willing to consider relocating. Almost all participants identified the lack of affordable, accessible housing as a major barrier to transition. See Cooper and O'Hara (2003) for a discussion of housing resources and strategies.

State Talk: New Jersey

"We try to get to the client before they give up their apartment. The nursing home may say, 'This person needs 24-hour supervision.' The family says, 'I have to get rid of this apartment and clean out for this person.' But we explain what our services are and not to give up the apartment because there is an allowance to be able to maintain that apartment while they are in the nursing facility." Lisa Melnyk, Program Support Specialist III at the New Jersey Department of Health and Senior Services

- Making the screening process consumer-friendly

New Jersey's Community Choice Counseling program educates consumers about their options with respect to the choices available, as well as focusing on assessing the consumer's level of care needs. Other states, such as Indiana, are considering incorporating options counseling into their preadmission screening process, reasoning that consumers cannot choose HCBS if they don't know about their options. Minnesota examined its process and realized that consumers were being screened more than once for different things, and is combining all screening and assessment processes for persons with disabilities to minimize consumer hassles and connect people quickly with the most appropriate services.

State Talk: Minnesota

"What's successful has been forming geographic teams. People who are doing assessments can talk about all of the options … [Assigning a paraprofessional] has worked really well to help families have some connection with somebody during the transition from assessment to community plan implementation and any on-going case management." Alex Bartolic, Area Manager for the Minnesota Aging and Disability Services

Streamlining Procedures

Determining eligibility, getting HCBS paid for, and keeping the consumer informed and empowered can be a challenge. Delaware substantially reduced the time it took to establish eligibility for waivers, allowing for more responsiveness to the consumer. Minnesota assigned a paraprofessional to bridge from assessment to community support plan implementation (when the same professional doesn't complete all activities), to follow the transitionee throughout the process, so that the consumer and their informal supports have consistency with one person and receive coordinated care.

State Talk: Indiana

"We're working on a uniform assessment tool across all populations, which is being tested in the MR/DD population and state-operated facilities…We really examined tools that would measure behaviors and functional outcomes in all populations served." Emily Hancock, Director, Long Term Care, Indiana Office of Medicaid Policy and Planning

Working with Vendors

One of New Jersey's Community Choice Counselors described building a relationship with a thrift store where she often shopped for transitioning consumers. She helped the store through the process to become a state vendor, so that the store could invoice the state for the things she wished to purchase and there would not be a delay in getting the items. This meant, however, that the store had to wait for payment.

Wisconsin described an arrangement they had with home modification contractors to forego payment until after the transition, and also to finish the work on the day of the transition so that it would be ready for the consumer to move in, but still eligible for payment as a transition expense. The county-based system in Wisconsin makes it easier to build such relationships.

Creativity/Flexibility in Transition Staff

Every transition case presents different challenges, and staff must be able to think creatively to deal with these challenges. The New Jersey Community Choice Counseling program makes an effort to recruit counselors with experience handling situations requiring flexibility and who enjoy that type of work. All states reported a variety of consumers transitioned—from young to old, with a wide variety of disabilities. As suggested above, the type of work done by transition staff can range from arranging home health services to dealing with contractors and vendors. Some consumers have barriers not directly related to physical or mental disabilities, such as credit problems, that staff must address for transition.

Data Collection and Analysis

All participants agreed that collecting and analyzing data on their programs was essential, both to make their case to policymakers and to learn about and improve their programs. There is as yet no comparable data for HCBS versus institutional care, though researchers have called for it (see Marek et al. 2005). The MDS-HC could be used in this fashion (Hirdes et al. 2004). Michigan uses the MDS-HC to track its transitionees, and it is used by about nine other states and several other countries as well). In many cases, data can also help consumers make more informed decisions. For example, after conducting a survey on housing needs, Minnesota is working on an initiative to improve housing information available on the internet.

State Talk: Wisconsin

"It gave us the data to be able to say, 'We know we can do this for these dollars, and we know that for the people relocated over the last couple years the average savings in Medicaid has been $33 per day.'" Judith Frye, Associate Administrator for Long-Term Support at the Wisconsin Department of Health and Family Services

Some participants reported some surprises from their data—for example, both New Jersey and Michigan reported that about 40 percent of consumers transitioning from nursing homes either required no waiver services or very inexpensive services, creating large savings. Many participants expressed the idea that a shortage of affordable, accessible housing was the main thing keeping many people in nursing homes.

Financing Issues

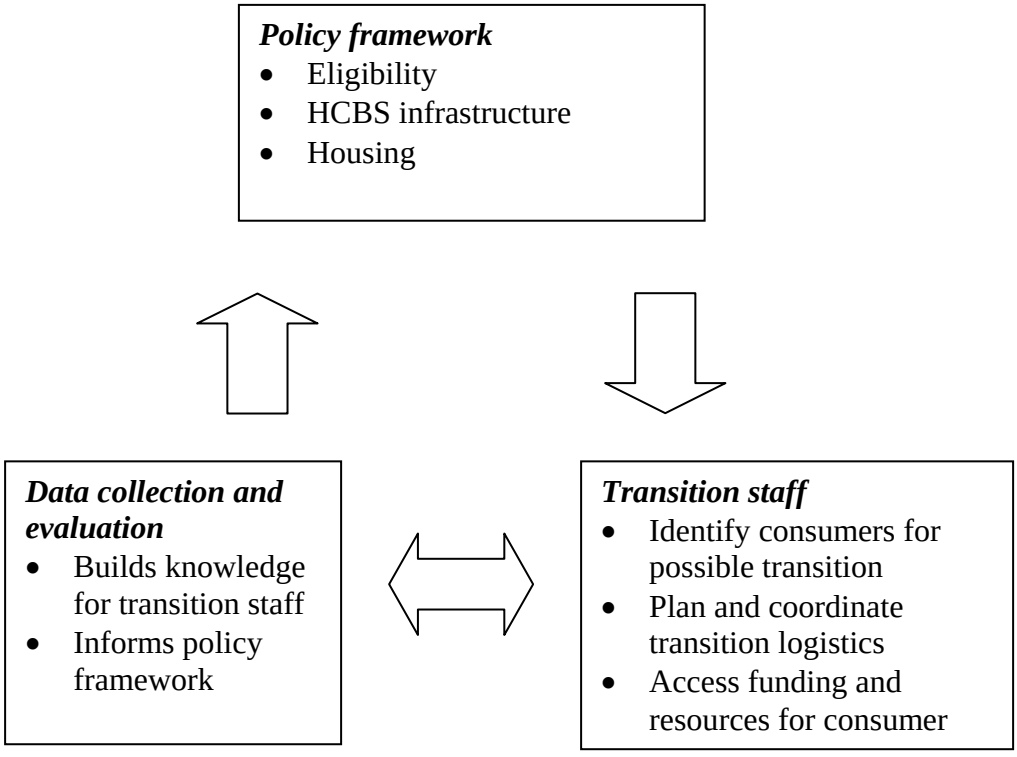
During tight times for states and sometimes inadequate funds provided by the federal government, it can be difficult to find money. A lively topic of discussion at the summit was the use of Civil Monetary Penalty (CMP) Funds for nursing home transition expenses. Although one state had been told this was not allowed, CMS representatives shared the memo that clarifies that it is allowed (Pelovitz, 2002).[5]

Time Required to Hire and Develop Staff

Several participants mentioned delays in grant activities because it took longer than expected to hire and develop staff for the project. Given the complexity of the work involved in transitioning nursing home residents, this is not surprising.

Wisconsin described a method of using state money as a bridge for hiring staff to build a caseload that will later be reimbursed as Medicaid targeted case management or waiver funded care management. This strategic use of resources solves the problem of not being able to build a caseload that can be reimbursed without proper staffing.

Conceptual Model of Transition Relationships



[5] Pelovitz, S.A. (2002, August 2). *Use of Civil Money Penalty (CMP) Funds by States.* Memo from Director, Survey and Certification Group, Center for Medicaid and State Operations, Reference: S&C-02-42. Available at: http://63.241.27.79/medicaid/survey-cert/sc0242.pdf

References

Cooper, E. & O'Hara, A. (2003, March). *Regional Housing Forum: A Technical Assistance Guide for Housing Resources and Strategies.* New Brunswick, NJ: Rutgers Center for State Health Policy. Available at http://www.hcbs.org/files/51/2539/Final_Regional_Forum_guide.pdf .

Friss Feinberg, L. & Newman, S.L. (2005, July). *Consumer Direction and Family Caregiving: Results from a National Survey.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/79/3926/ConsumerDirection&FamilyCaregivingNWEB.pdf

Hirdes J.P., Fries, B.E., Morris, J.N., Ikegami, N., Zimmerman, D., Dalby, D.M., Aliaga, P., Hammer, S. & Jones, R. 2004. Home Care Quality Indicators (HCQIs) Based on the MDS-HC. *The Gerontologis,*. *44*(5), 665–679.

Marek, K. D., Popejoy, L., Petroski, G., Mehr, D., Rantz, M. & Lin, W. (2005). Clinical Outcomes of Aging in Place. *Nursing Research, 54*(3): 202–211.

Milligan, C. (2005, January). *Money Follows the Person: Reducing Nursing Facility Utilization and Expenditures to Expand Home- and Community-Based Services.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/66/3264/MilliganReducingNursing.pdf

Pelovitz, S.A. (2002, August 2). *Use of Civil Money Penalty (CMP) Funds by States.* Memo from Director, Survey and Certification Group, Center for Medicaid and State Operations, Reference: S&C-02-42. Available at: http://63.241.27.79/medicaid/survey-cert/sc0242.pdf

Reinhard, S., Crisp, S. & Bemis, A. (2005, July). *Participant-Centered Planning and Individual Budgeting.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/77/3847/Individual_Budget_Final_July_8_WEB.pdf

Reinhard, S., Hendrickson, L., Bemis, A. (2005). *Using the Minimum Data Set (MDS) to Facilitate Nursing Home Transition.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/66/3279/MDSReportFeb05.pdf

Reinhard, S. and Gillespie, J. (2005, October). *Nursing Facility Transition Toolbox.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/80/3964/NFTToolbox10-12-05WEB.pdf

Reinhard, S. and Petlick, N.H. (2005, October). *Sustaining New Jersey's Evolving Community Choice Counseling Program.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/83/4109/NJCCCdec20WEB.pdf

Summer, L. (2005, October). *Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at http://kff.org/medicaid/7402.cfm

Acknowledgments: *We would like to thank the staff of the New Jersey Community Choice Counseling program, and in particular Bette Sorrento, for the work they did to make the summit possible. In addition to the authors, the following staff at the Rutgers Center for State Health Policy made contributions to this document: Angele Cabanilla, Marlene Walsh, Ann Bemis and Camille Long.*

Appendix A

Nursing Home Transition Invitational Summit

September 28-30, 2005
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Appendix B

Critical Elements for Nursing Home Transition

Since 2001 we have found through our work as National Technical Assistance Providers for the CMS "Real Choice Systems Change" Initiative that it is necessary for states to focus on the "Critical Elements" below in order to implement a successful NHT model and advance a sustainable component of the long-term system of supports and services.

Critical Elements:

- Statutory framework (preadmission screening law)
- Staffing: skill mix, numbers, funding, training
- Collaboration with "single entry point"/ADRCs and Centers for Independent Living
- Consumer and stakeholder input and advocacy
- Methods for identifying NH residents for potential transfer
    a) Tracking system (e.g. New Jersey's Track 1,2,3)
    b) Current and future plans for using MDS
    c) Hospital to nursing home critical pathway
- Assessment tools
- Characteristics of NH residents seeking transfer
    a) older adults
    b) younger persons with disabilities
    c) Payer status (Medicaid, Medicare, other)
- Planning for Transfers
    a) Roundtables in nursing homes
- Transition funding
    a) State
    b) Medicaid waiver
    c) Methods for paying transition costs (furniture, etc.)
- Housing
    a) Accessible, affordable
    b) Assisted living
- Data tracking and evaluation
    a) Internal tracking
    b) External evaluation
- Overcoming Barriers & Lessons learned
- Plans for sustainability

Appendix C

State Summaries

These ten state summaries are based on written material submitted by the participants to the conference. They were edited for consistency--in some cases we added information, in other cases we deleted information or changed the wording.

Across the US

For a list of resources from many states, see the Nursing Home Transition Toolbox developed by the Rutgers CSHP/NASHP team, available at
http://www.hcbs.org/files/80/3964/NFTToolbox10-12-05WEB.pdf

Connecticut

Overview and key elements of Nursing Home Transition Program

- Full time transition coordinator at each Center for Independent Living (CIL)—five total
- Full time staff person providing technical assistance to CILs (state in consultant role)
- Outreach campaign to inform consumers in nursing facilities and professionals about community options
- **Evaluative component provides evidence of systems barriers relative to transition and cost benefit analysis**
- 25 person steering committee
- Toll free number for transition, will ring at closest CIL

Significant successes, barriers, or lessons learned

Successes:

- **Project as described above fully funded by the State of Connecticut in 2006 budget**
- State rental assistance from Department of Social Services and access modification money from Department of Economic and Community Development are coordinated with the project
- Visibility of project led to offer of free evaluation from University of Connecticut

Lessons:

- Need to budget for evaluation—data important to make your case
- Outside evaluation more powerful
- Need to give up some control to get others to take ownership and build support
- Best way to reach out to nursing home staff was one-to-one as opposed to mass outreach

Sustainability plans

Maintain existing state funded program and increase number of transitions both by removing additional barriers to transition and by increasing access to transition coordination through amending waivers to include transition as a service.

Related materials

Fink, D.B., Gaynor, C, Bruder, M.B. (2005). *Connecticut Real Choice Consumer Survey*. Available from: http://www.hcbs.org /files/79/3924/RC_survey.pdf

Third Southwestern Connecticut Regional Forum on Community Inclusion: A Sharing of Ideas on Community Inclusion for People with Disabilities. (2005). Available from: http://www.hcbs.org /files/72/3581/Westport_Regional_Forum.pdf (other similar items also available at HCBS.org)

Connecticut Department of Social Services & CT Association of Centers for Independent Living (CACIL), Inc. *Transition Guide.* (2004). Available from: http://www.hcbs.org /files/44/2181/CTTransitionGuide.pdf

Fink, D.B.. (2004). *Beyond Services to Clients: Are We Training Staff to Support Self-Determination and Consumer Decision Making?* University of Connecticut, A.J. Pappanikou Center for Excellence in Developmental Disabilities. Available from: http://www.hcbs.org/files/53/2630/Real_Choice_State_Agencies.pdf

Gruman, C. & Pettigrew, M. (2004). *Nursing Facility Transition Grant: Outreach Process and Strategies.* Available from: http://www.hcbs.org/files/29/1432/Outreach_Survey_-_General_Questions_Results.doc http://www.hcbs.org/files/29/1434/Outreach_Survey_Recommendations.doc http://www.hcbs.org/files/29/1433/Outreach_Survey_-_Results.doc

Connecticut Accessible Housing Registry Homepage (2003): http://www.housingregistry.org/

Delaware

Overview and key elements of Nursing Home Transition Program

1. Method to identify nursing home residents who want to transition
2. Intensive case management coordinators
3. One-time transition fund
4. Stakeholders role in program design and implementation
5. Included funding for an external evaluation (in progress)

Significant successes, barriers, or lessons learned

Successes:

1. 50 assessments; 34 referrals to intensive case management; 15 transitioned; 19 still waiting because of housing or medical reasons (Nursing home population is 824)
2. Stakeholder collaboration
3. Establishment of the Governor's Commission On Community-Based Alternatives For Individuals With Disabilities (seven subcommittees)
4. Reduction in time it takes to determine waiver eligibility (from six to seven months to weeks)
5. Residents demonstrate new skills

Barriers:

1. Scope and variety of HCBS
2. Internal process can be inflexible
3. Inadequate number of housing vouchers
4. Lack of affordable and accessible housing

Lessons:

1. Case management coordinators contributed to program success
2. Stakeholder collaboration is important
3. Early communication is vital
4. Transition fund is beneficial
5. Nursing home transition is difficult
6. Families can be helpful or otherwise
7. Nursing home residents with shorter stay, usually male, sought transition

Sustainability plans

1. Budget request for SFY2007
2. Active involvement of division's community service program staff in transition
3. Governor's Commission initiatives
4. Collaboration with IRI, Inc. a Center for Independent Living

Related materials

State of Delaware. (2005, June). *Delaware Passport to Independence: Presentation, Assessment and Survey Forms.* Available from: http://www.hcbs.org/files/72/3559/ASSESSMENT_TOOL.pdf

http://www.hcbs.org/files/72/3556/EducOutreach.pdf
http://www.hcbs.org/files/72/3561/Survey.pdf

State of Delaware. (2005, April). *Passport to Independence - Delaware's Nursing Home Transition Program. Brochures and Transition Guide.* Available from:
http://www.hcbs.org/files/70/3467/Passport_to_I_dep_broch_NH_.pdf
http://www.hcbs.org/files/70/3469/Passport_to_Indep_broch.pdf
http://www.hcbs.org/files/70/3468/Passport_to_Ind_Guide.pdf

State of Delaware. (2004). *Consumer Centered Quality Assurance and Quality Improvement in Home and Community Based Services RFP* http://www.hcbs.org/files/53/2603/DERFP.pdf

Indiana

Overview and key elements of Nursing Home Transition Program

Worked with Area Agencies on Aging (AAAs) to develop infrastructure for transition program on the local level. Identified key policy issues that need to be addressed to encourage more transitions. Developed best practices manual for AAAs. Analysis of residents that transitioned out of nursing facilities. For more detail on Indiana, see Reinhard and Farnham (2006).

Significant successes, barriers, or lessons learned

Successes:

- 110 people transitioned through grant program
- Developed survey to analyze transitions
- Drafted transition manual
- State commitment to the issue is outstanding

Barriers:

- Lack of interest and genuine support from provider community
- Staff turnover
- State funded plan (CHOICE) pays higher rates than Medicaid, and providers can cherry-pick

Sustainability plans

The State has made nursing home diversions and transitions part of its strategic plan and is looking a variety of options including restructuring the preadmission screening process and funding to support the diversion/transition process.

Related materials

Reinhard, S. and Farnham, J. (2006, forthcoming). *State Policy in Practice: Indiana.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange.

Alecxih, L. (2004, February 8). *ADRC Roles in Rebalancing Long Term Care Systems: Diversion Initiatives.* The Lewin Group, ADRC-TAE Issue Brief. Available at: http://www.communitylivingta.info/files/75/3720/Diversion_Inititives.pdf

Governor's Commission on Home and Community-Based Services (Governor's Commission). (2003, June 30). *June 2003 Report.* State of Indiana. Available at: http://www.in.gov/fssa/community/

Indiana Administrative Code, Title 460 Division of Disability, Aging, and Rehabilitative Services, Article 1. Aging, Rule 1. Nursing Home Prescreening. Available at from: http://www.in.gov/legislative/iac/T04600/A00010.PDF

Indiana Code, Title 12 Human Services, Article 10 Aging Services, Chapter 12 Health Facility Preadmission Services. Available at: http://www.in.gov/legislative/ic/code/title12/ar10/ch12.html

Indiana Division of Disability and Rehabilitative Services (DDARS). (2005). *Indiana Fact Sheet, SFY 2005 Cumulative: A Comparative Review of Selected Statistics.* Available at: http://www.state.in.us/fssa/statistics/pdf/ddrsfact3rdq2005.pdf

Lewin Group. (2005, May). *Impact of SEA 493 Provisions on Indiana's Aged and Disabled Waiver. Prepared for Indiana Family and Social Services Administration.* Available at: http://www.in.gov/fssa/elderly/aging/pdf/lewinreport052005.pdf

Reinhard, S. & Mollica, R. (2005, April). *Connecting the Dots: Indiana: Meeting Summary and Recommendations.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange.

State of Indiana. (2000, January). *IPAS & PASRR Program Manual.* Indianapolis, IN: Family and Social Services Administration. Available at: http://www.in.gov/fssa/elderly/aging/ipaspasrr.html

Massachusetts

Overview and key elements of Nursing Home Transition Program

The Massachusetts Bridges to Community Project was a 2001-2005 model demonstration located in greater Worcester, MA, which was chosen because it is a centrally-located social service center with a high number of nursing facilities and rehabilitation centers. In greater Worcester there were 28 nursing facilities and over 3000 nursing facility residents as of August 2002. The key elements of the design were:

1. Interagency leadership (7 state agencies including Medicaid were on a planning and steering group);
2. A project interdisciplinary case management team (2.5 project staff included a social worker, registered nurse & psychologist);
3. Cross-age and cross-disability design (Medicaid-eligible adults of all ages and with any disability were eligible);
4. Case management/relocation assistance both to plan and implement a move (individualized support including person-centered planning, coaching & advocacy);
5. Funds for assisting consumers with relocation (an average of $2000 per person per move);
6. A detailed data base and comprehensive evaluation plan to provide information for policy makers.

Significant successes, barriers, or lessons learned

Successes: In just over two years,

- 31 adult nursing facility residents returned to community living with full assistance from the project (i.e., received both case management and money for moving and set-up).
- An additional 9 persons engaged with staff in several months of 1:1 planning but did not move because of personal decision and/or decline in health.
- Project staff provided advice and advocacy to over 60 additional consumers, families or advocates who implemented a relocation.
- Of the 31 consumers who moved with full project support, 29 lived in the community with supports at lower Medicaid cost.
- Two young adults with brain injuries moved into more expensive transitional programs and both now have moved into their own homes with minimal ongoing support.
- Long-range Medicaid savings per person ranged from $200 to over $3000 per month. For most people, the average project costs were $4500 for case management plus moving expense. Consequently, the full net savings to Medicaid might not be realized until the second year.
- Through a subcontract with a local university, we completed a study and resource mapping project on accessible, affordable housing in the demonstration area.
- Through an interagency volunteer work group we completed a study on discharge planning.
- Through a consumer work group we developed materials for a transition tool kit.
- Through our data collection we produced data on costs and benefits of nursing facility transition.

- Through data analysis we produced a clearer picture of a specific nursing facility population who are characterized by minimal ADL needs but have other support needs.
- Through our networking we established mechanisms for smoother transition planning and implementation.
- Health and Human Services 2007 budget proposes money for relocation case management.
- Began face-to-face screenings in 2004 for people entering nursing homes who are on Medicaid or applying for Medicaid.

Barriers:

- *Bridges* did not begin outreach in the Worcester nursing facilities until Spring of 2003. This start-up delay was due to two obstacles: hiring staff for a short-term project and developing inter-agency data use agreements.
- The persistent major barrier was categorical eligibility and funding criteria. These criteria often are difficult to understand, sometimes are contradictory, and frequently place a paperwork burden and burden of proof on consumers. These criteria also produced delays, for example when consumers who move to the community must wait 1-3 weeks for their health insurance to convert from the long-term care to the community mode. Consumers' needs change over time, and the system is not flexible in addressing this.
- Transition expenses not are not in all waivers and the funding stream needs to be reviewed.

Lessons:

One lesson learned is the importance of setting aside time at the beginning of a project to build relationships and common understandings along with building an evaluation plan and data systems to support evaluation. While the slow start-up and complexities of interagency leadership seemed frustrating in the beginning, both paid off in terms of the quality of the project design and outcomes. The first 1.5 years were spent in developing networks, developing common understanding of project purpose, and developing a data base from ground up.

A second lesson we learned was the importance of enlisting nursing facilities as full and willing partners whose main objective, like ours, is service. Many other states reported difficulties in gaining entry to nursing facilities. This was not our experience. Our state Medicaid agency wrote a cover letter to each NF administrator explaining the project. Project staff presented our project as a resource to the NF's and scheduled meetings with NF staff to explain the project and answer their questions. By our second year in the NF's, the majority of referrals came from NF staff (including ombudsmen), NF staff volunteered on their own time to participate in planning, and our staff were recognized and welcome presences on the floor, in meetings, and in the record and billing offices where we assisted consumers to research their files. There were conflicts, but most were resolved quickly. Both the president and vice president of the state's long-term care association participated in our workgroups.

The importance of data collection and analysis is a third lesson learned. Although the project is over, the process and outcome data continue to inform practice and policy development. Ultimately sustainability will be a result of compelling outcome data. Data also played an important role in project design. Our demographic data provided insight into a population whose support needs (low for ADL, high for care coordination) were poorly understood.

Consumers who took responsibility for paperwork, advocacy, planning, and negotiating during the planning phase were better prepared to handle these tasks in the community. Bridges enlisted consumers as full partners in transition process. We quickly learned that skill training is a major component in transition planning that will set the stage for the success or failure of the move to the community. Most of our consumers did not have a support network in the community and would be on their own to manage their care.

Long-term follow-up was very valuable. We maintained long-term contact with the 31 persons we supported and with a few of the larger group to whom we provided advice. Not only did we learn about obstacles that occurred after a move (and that in most cases could have been avoided with better planning), but also we had the reward of witnessing long-term successes such as consumers obtaining jobs, forming new relationships, making their own independent moves to even better situations, and becoming powerful advocates for system's change.

Sustainability plans

Community First is an overarching policy of the Administration with many activities falling into that realm. Some of those activities are as follows:

The Comprehensive Services and Supports Model (CSSM) is an initiative of the Executive Office for Elder Affairs. CSSM funds each of the state's ASAP's to provide face to face screening and discharge planning to nursing facility residents across the state. The focus of the CSSM is to engage the consumer in discharge planning as soon as possible after nursing facility admission and to insure that interdisciplinary planning takes place.

The state's Real Choices, Independence Plus and ADRC New Freedom grants all have projects related to nursing facility diversion and transition. Each of these grants is using the Nursing Facility Transition (NFT) grant data and methods to complete their work. Real Choices is piloting a "cash and carry" model, Independence Plus is completing major work on waiver design, and the ADRC grant is establishing an interagency demonstration project to support nursing facility diversion and transition.

The NFT grant recommendations include establishing "relocation case management" and "relocation funds" as an allowable service under the state's HCBS Waivers and ultimately under the Medicaid state plan. During the implementation of the NFT grant, both the Elder and DD/MR waivers added language allowing for funding of transition services. We hope to see access to these services grow.

In-state Networks – The NFT grant contributed to ongoing state activities relating to implementation of the Olmstead Decision. Both the state's Independent Living Centers and the elder lobby (e.g., Mass Home Care) are engaged in NF diversion and transition. The NFT grant has provided data, tools, and a forum for furthering those efforts.

The Virtual Gateway is a website sponsored by the MA Executive Office of Health and Human Services. This site offers links to numerous agencies and information data banks. The "Resource Locator" is a Virtual Gateway project that was informed by the NFT grant's experience and recommendations on the importance of access to information. The Locator will be in pilot phase September-October 2005. It is a site structured around the information needs of persons moving from NF/hospital to the community or of persons who need more support to stay home. A work group of NFT partners developed the support categories and "plain English" screen language that the Locator uses.

Related materials

UMASS Center for Health Policy and Research. (2005). *Real Choice Functional Assessment Tool*. Available at: http://www.hcbs.org/files/68/3387/MA_Real_Choice_Functional_Assessment_Tool_-_FOR_REVIEW.pdf

Mollica, R. & Morris, M. (2005). *The Massachusetts Supportive Housing Program*. New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/66/3278/Mollica_MA_Supportive_Housing_WEB.pdf

Mollica, R. & Reinhard, S. (2004). *Connecting the Dots: Massachusetts: Meeting Summary and Recommendations.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/66/3267/MollicaRobertMACTD.pdf

Massachusetts: Merrimack Valley Elder Services and Northeast Independent Living Program. (2004). Available at: http://www.hcbs.org/moreInfo.php/state/161/doc/950/The_Massachusetts_ADRC_Project

Medstat. (2003). *Promising Practices in HCBS: The Massachusetts Accessible Housing Registry*. Available at: http://www.hcbs.org/files/39/1940/MAHousingRegistry.pdf

MA Bridges to Community Project - Staff Presentation, 2000. Available at: http://www.hcbs.org/files/42/2062/BridgesNFStaffPresentation3[1].ppt

Michigan

Overview and key elements of Nursing Home Transition Program

Michigan's Nursing Facility Transition Initiative (NFTI) is comprised of the following major components:

1) Transition component: Enhance Michigan's capacity to reach out to nursing home residents and support the transition of individuals who reside in nursing facilities to the community.
2) Diversion component: Establish a model to divert individuals from potential nursing facility placement to remain in their homes.
3) Educational component: To provide education and training on specific aspects of this initiative to community collaboratives, health care professionals, and project partners.
4) Evaluation component: Provide an evaluation of the program and a study of comparative cost-effectiveness of community living versus NF living, using grant funds.

The focus of the grant was to develop a system to enhance locally available supports and services to support the transition from nursing facilities to one's home. NFTI staff and resources connected community resources together to facilitate effective transitions using a person-centered planning. A key to the program's success was building on existing housing programs provided by the Michigan State Housing Development Authority and services and supports provided by the MI Choice Waiver program for elderly and disabled persons.

In the pilot project, Michigan relied on only one question to assess transition eligibility, which is whether the individual wanted to leave the nursing home. The philosophy, influenced by the Centers for Independent Living, is that anyone can be supported in the community—the individual's choice is the determining factor.

Other elements:

- Using MDS-HC to track participants
- Up to $3000 for transition costs without authorization (in one of the 14 waivers); more allowed with authorization
- Used Civil Monetary Penalty funds for those not eligible for Medicaid, for individuals who do not ultimately move to the MI Choice waiver program, and for transition expenses that are not covered by Medicaid

Significant successes, barriers, or lessons learned

<u>Successes:</u>

1) Preliminary data from pilot (study to be finished October 2005): 112 people in two counties transitioned thus far; 41 percent did not require further program services after transition. The others received services under Medicaid or state/local programs. Individuals with a wide variety of acuity levels transitioned. Found that men more likely to transition—possibly because they were less concerned about services being in place in the community. Plan to do a national call or webcast to show others.

2) Addition of transition services to the Michigan MI Choice waiver (1915c Medicaid Home and Community Based program for the elder and disabled) program to include transition activities statewide.
3) Development of education materials for MI Choice and Centers for Independent living to develop transition programs.
4) Developed partnerships between Centers for Independent Living and MI Choice waiver agencies.
5) Developed housing models for people in the community.
6) During last year, Medicaid agreed to add a waiver slot for each person transitioned out of a nursing home.

Barriers:

1) Michigan's financial situation makes funding transition services difficult. Implementation of a money follows the person approach to shift funds is under development but not operational.
2) Lack of funds to pay for community supports coordinators. Agencies' capacity to provide transition services has been unstable due to changing, short-term funding methods.
3) Lack of housing options; MSHDA Section 8 housing certificates were very helpful, but more are needed.

Sustainability plans

The project will endure as part of Michigan's MI Choice waiver program service and supports package. Transition services will be implemented through waiver agents. The MI Choice waiver funds staff and service costs incurred to implement transition plans for residents of nursing facilities.

Michigan's CMS ADRC grant includes plans to develop a Housing Locator system that will help people in institutions and the community access information about available housing options. This will be developed over the next year and will provide a huge resource to supporting transition activities. Housing and supports options will be enhanced through installation of a new web based computer system which links community resources together into a centralized resource director and community care planning system. This will reduce barriers to identification and coordination of services and supports.

Michigan is also developing a single point of entry system for LTC. Transition and diversion services will be integrated into the model to be implemented in three pilot sites, and then replicated statewide.

Related materials

Contractor website http://www.dynsinc.com/NFTI/

Ownes, M.T. & Eggleston, R. (2005). *A Labor of Love: Assessing the Status of the Direct-Care Workforce in the Tri-County Area.* Available at: http://www.hcbs.org/files/74/3678/LaborofLove.pdf

Medstat. (2004). *Promising Practices in HCBS: Michigan: Increasing Access and Choice through Person-Centered Planning.* Available at: http://www.hcbs.org/files/67/3314/Michigan_--_Person_Centered_Planning_--_Updated.pdf

Cash and Counseling. (2004, October). *Michigan to Launch Model Program that Offers More Autonomy and Better Quality of Life to Elderly Medicaid Beneficiaries and Those with Disabilities.* Available at: http://www.cashandcounseling.org/events/archive/2004100707.html

Eiken, S., Burwell, B. & Asciutto, A. (2002, July). *Michigan's Transitioning Persons from Nursing Homes to Community Living Program.* Cambridge, MA: Medstat. Available at: http://aspe.os.dhhs.gov/daltcp/reports/MItrans.pdf

Minnesota

Overview and key elements of Nursing Home Transition Program

Long Term Care Consultation is provided by county social workers and/or public health nurses within 40 days of admission into nursing facility. The goal is to prevent unnecessary nursing home placement and reduce the length of stays by helping people access appropriate community services.

Relocation Service Coordination is available to any person in an institutional setting who would like to relocate to the community. This Medicaid targeted case management option will pay for up to 180 days of relocation assistance. Transition services either are or will be available in all five of Minnesota's Medicaid home and community based service programs to help cover transition costs of up to $3,000 for persons leaving institutional settings.

Counties are responsible for local development of community based services for persons in nursing facilities or at risk of nursing facility placement. There is a county share of nursing home costs for persons who remain in nursing facilities for 90 days or longer.

ADRC grant activities were recently expanded by a state funded grant to Hennepin County to work with physicians, clinics and community agencies to prevent nursing home admission or reduce length of stay if nursing facility placement required. Goals include developing a greater awareness of community options, referral protocol to assure timely access to community alternatives and resident training program to help increase understanding by physicians of community service options that can support their patients in their homes.

Significant successes, barriers, or lessons learned

Successes:

- From October 2004 to September 2005, transitioned 70 individuals from nursing homes and diverted 190.
- Created and distributed over 800 consumer handbooks and brochures to educate about HCBS, and over 100 videos.
- Conducted a survey on housing needs. Started a special housing unit to work with developers. Piloting ways to help people connect to share housing and for providers to distribute vacancy information effectively. Helped sponsor a bimonthly housing forum to exchange information.
- An ongoing infrastructure seeded by a statewide conference in December 2004 attended by 262 individuals representing Centers for Independent living (CILs), county social services, vendors, consumers, family members, state department of human service personnel and others. The goals of the conference: a.) provide an update on the status of Olmstead implementation in Minnesota; b.) present results of the housing study; c.) provide training on best practices; and d.) provide a forum for networking and relationship building statewide. Throughout 2005, the project has hosted seven regional forums across the state of Minnesota attended by nearly 200 individuals, with more in the planning stages.

Barriers:

1) Gaps in community resources to meet the needs of nursing home residents, such as:
    - Affordable and accessible housing

- Landlords that will rent to persons with "reputations", such as unlawful detainers, behaviors that require supervision, mental illness
- Transportation
- Community Service (e.g., HCBS) funding limitations
- Missing critical data elements in the LTCC assessment documentation maintained by the state that is needed at a local level for service and housing development

2) Challenge to develop practices and tools that track the progress of persons who wish to move (barriers and desires) as well as help "match" people who may wish to live together in order to jointly afford housing and/or community services while maintaining person centered approach of individuals selecting living arrangement, provider and who they live with.

3) Unplanned nursing facility closures occur very quickly. It is very difficult to assure that people have the most inclusive alternatives when a facility closes in less than 60 days. Legislation and additional funding is needed to require a closure process with adequate planning time and appropriate facility rate adjustments. State protocol for closure of larger ICFs/MR was successful due to variable facility rate structure during closure, planning process that included facility, county and state, and rich community based service funding for those leaving closing ICF/MR.

Lessons:

- Coordinated across entities with respect to PASAR so that consumers don't have to go through multiple assessments
- Changed focus of screening from trying to fit people into programs to finding needs, existing supports, eligibility and then resource allocation and providers
- Forming geographic teams and separating assessment and case management to avoid conflicts
- Assigned a "bridger" to each person who is assessed if there will be a change in professional during the transition from the assessment to community support plan implementation to follow the person from beginning to end
- Assigned county staff to nursing homes to build relationships

Sustainability plans

Statute requires every person entering a nursing home to have a face to face assessment and consultation (long term care consultation) about community service options within 40 days to facilitate timely transitions. Medicaid reimbursement is available; the state budget includes non-federal share for this activity.

Relocation service coordination is available for any person who wishes to relocate from an institution. This targeted case management service provides reimbursement for up to 180 days of assistance.

Transitional services are now included as a waiver service in all Medicaid home and community based service plans and cover up to $3,000 of typical expenses associated with helping a person transition from a licensed setting to their own home.

A legislated task force of state agencies and stakeholders is meeting throughout 2006 to examine successes and barriers affecting relocation and diversion from institutions, and is

developing action plans to alleviate barriers and provide timely access to appropriate, inclusive services.

Working relationships have developed between agencies and resulting partnership agreements to continue activities, such as regional relocation service coordination meetings, that support important work of those providing relocation services.

Related materials

Auerbach, R. & Reinhard, S. (2005). *Minnesota's Long Term care Consultations (LTCC) Services.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/80/3965/MinnesotaLTCC100705WEB.pdf

Screening tool utilized by ADRCs: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3427-ENG , discussion at http://www.hcbs.org/moreInfo.php/state/163/doc/1332/Long_Term_Care_Screening_Tools

Reinhard, S., Crisp, S & Bemis, A. (2005). *Participant-Centered Planning and Individual Budgeting.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/77/3847/Individual_Budget_Final_July_8_WEB.pdf

Minnesota Association of Centers for Independent Living (MACIL). (2005). *Take the Road to Independence: The Options Initiative.* Available at: http://www.hcbs.org/files/73/3638/take_the_road.doc

MinnesotaHelp.com Technology Project and Presentations. (2005). Available at: http://www.hcbs.org/moreInfo.php/state/163/doc/1331/MinnesotaHelp.com_Technology_Project_and_Presentat

Morris, M. (2005). *Advanced Strategies Teleconference - May 2005.* Available at: http://www.hcbs.org/moreInfo.php/state/163/doc/1282/Advanced_Strategies_Teleconference_-_May_2005

Medstat. (2005). *Promising Practices in HCBS: Minnesota-American Indian Tribe Providing Assessment and Case Management for Home and Community-Based Waiver Services.* Available at: http://www.hcbs.org/files/70/3490/MN_Tribal4-15.pdf

New Jersey

For a comprehensive writeup of New Jersey's program, see the following:

Reinhard, S. and Huhtala Petlick, N. (2005, December). *Sustaining New Jersey's Evolving Community Choice Counseling Program.* New Brunswick, New Jersey: Rutgers Center for State Health Policy. Available at: http://www.hcbs.org/files/83/4109/NJCCCdec20WEB.pdf

Other publications

Medstat, CMS. (2005, February). *Promising Practices in HCBS: New Jersey- Community Choice Initiative.* Available at: http://www.hcbs.org/files/67/3316/New_Jersey_--_Community_Choice_Update.pdf

Howell-White, S. (2003). *Current Living Situation and Service Needs of Former Nursing Home Residents: An Evaluation of New Jersey's Nursing Home Transition Program.* New Brunswick, New Jersey: Rutgers Center for State Health Policy. Available at: http://www.hcbs.org/files/19/907/CurrentLivingSituation1yearPostNJsNFTprogram.pdf

State web site: http://www.state.nj.us/health/consumer/choice/index.shtml

North Carolina

Overview and key elements of Nursing Home Transition Program

The major goals of the grant are: 1) To transition 80 – 100 people out of NC nursing facilities; 2) To build the infrastructure and capacity statewide to sustain the transition effort beyond the grant period.

Key elements have included:

- Building transition coalitions in 16 regions of the state
- Identifying people who want to move to the community through outreach continuing educational units (CEU) training programs with nursing facility staff
- Addressing barriers (housing, personal care assistants, eligibility, etc.) through education and Transition Task Force recommendations

Significant successes, barriers, or lessons learned

Successes:

- Building transition coalitions in all 16 regions in transitions and reaching grant goal of 80+
- Experiencing large turnouts for nursing facility staff CEU training in "Going Home: Helping Residents Transition from your Facility to the Community"
- Creating collaborative roles in nursing home transitions for Centers for Independent Living and Vocational Rehabilitation /Independent Living Programs in North Carolina

Barriers:

- Deeply worn turf battles between agencies
- Budget constraints blocking removal (or improvement) of key barriers, i.e., Medicaid financial eligibility issues

Sustainability plans

- Complete CAP-DA waiver amendment request for transition monies
- Collaborate with Housing grant in regional work groups
- Follow-up with decision makers on recommendations submitted by Transition Task Force at the end of the three-year grant period.
- Include "Transitions" in the DMA Integrated Screening, Assessment and LOC Determination Network, due for implementation in July, 2006

Related materials

Forsyth County Aging and Disability Resource Initiative Update Site. (2005). Available at: http://www.seniorservicesinc.org/ADRC/index.htm

North Carolina's Information and Referral Vendor RFP, 2005. Available at: http://www.hcbs.org/files/60/2969/north_carolina_rfp.pdf

Patnaik, B. and Geltman, A. (2004). *Developing Access Services in Mecklenburg County, NC: The Just1Call Experience.* Duke University Long Term Care Resources Program. Available at:

http://www.hcbs.org/moreInfo.php/state/173/doc/911/Developing_Access_Services_in_Mecklenburg_County,_

North Carolina CAP Data Set and AQUIP. (2004).
Available Files:
AQUIP plan of care form:
http://www.hcbs.org/files/48/2355/AQUIP_Plan_of_Care_Form_-_NC.pdf
NC CAP/DA Assessment Tool:
http://www.hcbs.org/files/44/2178/NCCAPDADataSet.pdf

Pennsylvania

Overview and key elements of Nursing Home Transition Program

In 2000, the Commonwealth of PA was one of four states (12 total) to receive a One Year $500,000 Nursing Home Transition (NHT) grant from CMS. The demonstration continues for three years using two no-cost extensions, and state funding to continue staffing levels. A Project Manager as well as two Nursing Home Transition Coordinators were contracted with to demonstrate a nursing home transition program in four counties. Reports from this project can be found in the resource list below.

Significant successes, barriers, or lessons learned

Successes:

1. Transitioned 50 people in three years.
2. Waiver Amendments: Six of Pennsylvania's 11 Home and Community Based Waivers were amended to include Community Transition Services.
3. Expansion to two Area Agencies on Aging who were involved in the Community Choice Pilot: Southwest Pennsylvania AA and Philadelphia Corporation on Aging.
4. Establishment of the Governor's Office of Health Care Reform.
5. Request for NHT Funding for State FY04-05 to include nursing home transition in budgets for Department of Public Welfare and PA Department of Aging. NHT appropriations were included in budget legislation for two cabinet level departments: Department of Aging and Public Welfare.
6. Nursing Home Transition Project staff, who were involved in original NHT Grant, developed training materials, provided technical assistance, and coordinated efforts between two departments.
7. Local agencies serving aging population (AAAs) and those serving four waivers for people with physical disabilities and TBI (DPW providers) were asked to submit collaborative plans.
8. Thirty collaborative plans submitted and approved. Five regional trainings provided, technical assistance available, and policy development continues at state level.
9. NHT Summit, which brought 180 people involved in nursing home transition from across the state to Harrisburg, held on September 23, 2005.

Barriers:

1. Hard to do grant for just one year—took nine months to hire needed personnel.
2. Complicated to implement new billing procedures with waiver.
3. Need to separate assessment and service provision.
4. Many needs in housing—addressing through web site, getting housing grant to work with Centers for Independent Living (CILs), developing relationship with housing finance agency, and bringing together the different agencies offering home modification assistance to develop standards.

Lessons learned:

1. Need to help strengthen partners, not just bring people together.

2. Need housing for people to be transitioned. It was very useful to partner with our Housing Finance Agency in pursuit of this goal.
3. It would be useful to enhance our web access for all our collaborative partners so that they can view materials online.

Sustainability plans

1. Find permanent home for Transition staff (out of governor's office).
2. Continue support of collaborative plans and cross departmental technical assistance provided by the Governor's Office, including website development and other technical support.
3. Address presumptive eligibility issue related to home modifications and other large expenditures.
4. Advocate for continued and expanded funding; support use of Waiver to provide necessary NHT services.

Related materials

Mollica, R. & Reinhard, S. (2005) *Money Follows the Person Site Visit: Pennsylvania Community Choice Initiative.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.hcbs.org/files/77/3846/PA_sitevisitsummary1WEB.pdf

Pennsylvania Community Choice ADRC Survey and Assessment Instrument, 2005. Available at: http://www.hcbs.org/moreInfo.php/state/178/doc/1145/Pennsylvania_Community_Choice_ADRC_Survey_and_Asse

Medstat. (2004). *Promising Practices in HCBS: Pennsylvania- Resource Counseling and Financial Assistance for Informal Caregivers.* Available at: http://www.hcbs.org/files/67/3321/Pennsylvania_--_Resource_Counseling_update.pdf

Pennsylvania Transition to Home reports: http://www.aging.state.pa.us/aging/cwp/view.asp?a=285&Q=251226

2004 Community Choice Assessment Instrument: http://www.hcbs.org/files/47/2318/Community_Choice_Assessment_Instrument_-_PA.pdf

2004 Pennsylvania Community Choice Customer Satisfaction Surveys: http://www.hcbs.org/moreInfo.php/state/178/doc/914/Pennslyvania_Community_Choice_Customer_Satisfactio

Lewin Group. (2004). *Pennsylvania's Streamlined Eligibility Conference Call.* Available at: http://www.hcbs.org/files/47/2339/PA_Streamlined_Eligibility_Conference_Call_Summary_-_April_1.pdf

Medstat. (2003). *Pennsylvania: Independent Monitoring for Quality (IM4Q).* Available at: http://www.hcbs.org/files/3/146/Pennsylvania_PP.pdf

Pennsylvania Intra-Governmental Council on Long Term Care. (2002). *Home and Community-Based Services Barriers Elimination Work Group.* Available at: http://www.hcbs.org/files/47/2325/Home_and_Community-Based_Services_Elimination_Work_Group_-_P.pdf

Wisconsin

Overview and key elements of Nursing Home Transition Program

Goal 1 – To facilitate transition of 400 people from nursing homes
Goal 2 – Strengthen a system to use available resources to help people live in the least restrictive setting.

Wisconsin's system is county based, which provides many on-the-ground advantages in terms of having staff who are knowledgeable about area resources and can move quickly. It has caused some challenges with respect to the federal government questioning uniformity. Wisconsin has 11 ADRCs with responsibility to provide info, referral, LTC options counseling and in some areas preadmission screenings for potential LTC facility admittances. The resource centers provide information, referral, and some options counseling, even for people not covered by Medicaid.

For transitions, the state hired a staff person at the Department to coordinate nursing home transition activities around the state. Counties identified individuals and developed relocation plans with assistance from the state coordinator. The state coordinator managed special one time and on-going funding that was available to counties to fund the relocations. The state staff person also worked with people in closing nursing homes to ensure that they had a choice to move to the community. Experience gained through this initiative resulted in legislation to allow nursing home funding to follow the person into the community. For people (about 20%) helped with transition costs, the average amount spent was $3,000—averaged over everyone, the amount was about $500.

Significant successes, barriers, or lessons learned

Successes:

- Transitioned 625 people from 2001-2004.
- Nursing Facility Transition (NFT) and Independent Living Center (ILC) grants.
- Effective marketing campaign making calendar of successfully transitioned consumers.

Barrier:

- The main frustration or barrier was the lack of a consistent source of on-going funding for relocations. County staff were able to identify more individuals who wanted to move than we were able to fund.

Lessons:

- Having dedicated state staff was important. The Department also hired a relocation facilitator through the independent living center in Wisconsin's largest county to help with the large number of relocations due to nursing home closures.
- Using state money to start up funding for about six months of case management (hiring new staff and building a caseload) that can then be sustained by Medicaid waiver.
- Working creatively with vendors—for example, the cost of home modifications completed prior to transition cannot be covered. However, the modifications can be started prior to the transition so that they can be finished the day of transition.

- Found that churches are helpful in providing donated housewares for transitionees.

Sustainability plans

The new Community Relocation Initiative enacted as part of the 2005-2007 budget provides a source of on-going funding for persons who wish to relocate from nursing homes. The state funded the Community Options Program (COP) and our waiver amendment to fund transition services will help us to provide up-front funding for the one-time costs of making a new home in the community.

Related materials

Community Relocation Initiative information for consumers is available at: http://dhfs.wisconsin.gov/ltc_cop/CommunityRelocationInitiative.pdf

Karon, S., Ryther, B. & Kopp, D. (2005). *Review and Discussion of Current Approaches to Outcomes Measurement in Wisconsin's Medicaid Waiver Programs.* Available at: http://www.hcbs.org/files/77/3829/outcome_measurement.pdf

Lewin Group and Wisconsin. (2005). *Short-Term Case Management for Aging and Disability Resource Centers (ADRCs): National Vision and the Wisconsin Experience- A Fact Sheet.* Available at: http://www.hcbs.org/files/74/3673/Short-Term_Case_Management.pdf

Wisconsin. (2005). *Memorandum Of Understanding (MOU) Regarding Family Care Eligibility Determination And Enrollment-Wisconsin.* Available at: http://www.hcbs.org/files/60/2959/Richland_County_MOU_with_Economic_Support_Unit.pdf

Medstat. (2005). *Promising Practices in HCBS: Wisconsin-Supporting Consumer-Directed Services within Managed Care.* Available at: http://www.hcbs.org/files/67/3305/Wisconsin_HCBS.pdf

Medstat, CMS. (2005). *Promising Practices in HCBS: Wisconsin- Assistance to People Who Want to Leave Nursing Facilities.* Available at: http://www.hcbs.org/files/67/3330/Wisconsin_--_HCBS_Availability_Update.pdf

Wisconsin Regulatory Requirement for Pre-Admission Consultation Referrals, 2004: http://www.hcbs.org/moreInfo.php/state/189/doc/1099/Wisconsin_Regulatory_Requirement_for_Pre-Admission

Wisconsin Department of Health and Family Services. (2004). *Long-Term Support Direct Care Arrangements in Wisconsin Counties: Survey Results, 2004.* Available at: http://www.hcbs.org/files/55/2723/directcare.pdf

Resource Center of La Crosse County. (2004). *Annual Report.* Available at: http://www.co.la-crosse.wi.us/HumanServices/docs/Annual%20Reports/2004/RCAnRpt04.pdf

Wisconsin Department of Health and Family Services. (2004). *Wisconsin's Functional Screen for Multiple Populations.* Available at: http://www.dhfs.state.wi.us/LTCare/FunctionalScreen/Index.htm

Wisconsin Department of Health and Family Services. (2004). *Wisconsin ADRC Lessons Learned.* Available at: http://www.dhfs.state.wi.us/LTCare/pdf/ADRCLessonsLearned.pdf

Lewin Group. (2003). *TAE Issue Brief: An Annotated History of Wisconsin's Aging and Disability Resource Centers.* Available at: http://www.hcbs.org/files/49/2428/TAE_Issue_Brief_-_Annotated_History_of_WI_ADRCs.pdf

Medstat. (2003). *Wisconsin: Consumer Outcomes Survey.* Available at: http://www.hcbs.org/files/4/157/Wisconsin_PP.pdf

Steigman, D. (2003). *Promising Practices in HCBS: Wisconsin- Supported Housing for People with Disabilities.* Medstat, CMS. Available at: http://www.hcbs.org/files/39/1930/WisconsinHousingSpecialist.pdf

Justice, D. (2003). *Promising Practices in Long Term Care Systems Reform: Wisconsin Family Care.* CMS, Medstat. Available at: http://www.hcbs.org/files/45/2214/Wisconsin.pdf