Rutgers Center for State Health Policy

The Institute for Health, Health Care Policy and Aging Research

An Evaluation of the Pennsylvania Nursing Home Transition Program SFY 2006 – 2007

L. Hendrickson
N. Petlick
J. Farnham
A. Bemis

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Summary

Transition is not for the faint of heart. Pennsylvania staff has worked for about nine years to develop a nursing home transition (NHT) program. In 2007, the State of Pennsylvania asked the Center for State Health Policy at Rutgers University to evaluate its current nursing home transition work. Pennsylvania asked the Center to:

- Prepare descriptions of past and current nursing home transition efforts;
- Interview staff in state and local agencies;
- Evaluate activities done by state agencies including nursing home transition policies,
- Examine the funding offered local agencies doing nursing home transition,
- Collect local agency comment on the amount and kind of technical assistance the state provided; and
- Identify activities done by local agencies including how they used the Minimum Data Set (MDS) information provided by the state, their assessment and counseling procedures, their organization of transition activities, and how they provided transition assistance.

Rutgers staff interviewed approximately 100 persons in 2 state agencies and 20 local agencies during 2007 and data was obtained from state staff, state contractors, and local agencies. The interviews and data collection centered on the topics requested by the state. The evaluation contains useful comparative information for states that have nursing home transition or Money Follows the Person programs that encourage the use of home and community-based services. The evaluation documents how the state continually rethought its transition activities, the different methods it used to identify suitable persons to provide transition assistance to, including how it used the nursing home Minimum Data Set (MDS) and how it funded local agencies. The evaluation provides data on the relationship between local agency FTE levels and number of persons transitioned.

These nine years of work have produced an outstanding program compared to what the majority of other states have been able to accomplish.[1] In 2006 - 2007, the state dramatically expanded its efforts with an ambitious statewide program that successfully helped almost 1,700 persons.

The strengths of the 2006-2007 program were:

- Building upon the experience of local agencies with transition, (see discussion in NHT Outcomes in 2005 and Early 2006);

- Centralizing long-term care programs into a single agency, (see discussion in The Office of Long Term Living: 2007);

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[1] See Appendix D

- Expanding the new program to all Area Agencies on Aging (AAA) in the state (see discussion in The Front Door: Announced July 2006 and Implemented Fall 2006);

- Spending the opening months of the program working with nursing facilities to ensure access, (see discussion in Access to Nursing Homes);

- Making available training and technical assistance in the form of web site development, statewide and regional conferences, phone call conferences, and support from departmental liaison staff, (see discussion in Training and Technical Assistance Activities);

- Building collaborative relationships among Area Agencies on Aging, Centers for Independent Living (CILs), housing authorities, and other agencies, (see discussion in Collaborative Partnerships);

- Testing different strategies for identifying whom to transition, (see discussions in Side Door: Implemented March 2006 and What Kind of Minimum Data Set (MDS) Information Do Agencies Receive?), and,

- Offering incentives to local agencies to participate in transition work, (see discussion in Payments to Agencies).

Areas that the 2006-2007 program would have benefited from include:

- Establishing transition goals for local agencies that are realistic given the history and characteristics of the agencies, (see discussion in Payments to Agencies);

- Developing a better understanding of, and changing how, state policies impact economic relationships among Centers for Independent Living, (see discussion in Cooperation Among Agencies);

- Studying cost-related methods to fund local agency transition work including flat rates, cost-based rates, or provider-specific cost-based amounts, (see discussion in Payments to Agencies);

- Understanding how functional and financial eligibility for Medicaid can be improved to make transition easier to accomplish, (see discussions in State-Level Barriers to Transition, and Use of MA 51 Form and Requiring a Doctor’s Signature for Waiver Services);

- Looking at how information about new admissions, as well as long-term residents, may be more efficiently shared among Area Agencies on Aging and

Centers for Independent Living; (see discussion in What Kind of Minimum Data Set (MDS) Information Do Agencies Receive?); and,

- Expanding Medicaid residential options to provide a better range of housing alternatives for persons being transitioned, (see discussion in State Level Barriers to Transition).

Background

As part of its continuing work on long-term living programs, Pennsylvania decided to evaluate how its state fiscal year (SFY) 2006-2007 nursing home transition program operated, and asked the Rutgers University Center for State Health Policy to conduct the evaluation. The Rutgers Center for State Health Policy (CSHP) interviewed state staff in two departments and interviewed local staff in 20 agencies during August and September 2007. Approximately 100 persons were present during these interviews. State staff selected the 20 local agencies to represent all geographical areas of the state and be sure that both large and small agencies were interviewed. The report also uses data developed by state staff in two Departments: Public Welfare and Aging, and a private firm, Myers and Stauffer, which contracts with Pennsylvania. CSHP staff prepared the report based upon the collected information.

The programmatic context this effort takes place within has been well described before and another description of Pennsylvania's long-term care programs would be redundant. Instead, readers are referred to the annotated studies listed in Appendix A for program descriptions of Pennsylvania's Medicaid home and community-based waivers, nursing facility programs, and state-funded long-term living programs.

History of Nursing Home Transition Activities

This section concerns the history of efforts Pennsylvania has made to help older adults and individuals with disabilities to transition from the state's 726 nursing homes to community settings.[2] The section highlights organizational changes and program strategies to provide a brief chronology of how nursing home transition activities have evolved. This section shows the substantive history of Pennsylvania's transition efforts, its maturation into an established program, and puts in context the data and judgments developed during the evaluation.

Before FY 2000

Pennsylvania has a history of using state funds to support home and community-based services for individuals with mental retardation, mental illness, physical disabilities, and for older adults. Since Medicaid waivers became available for home and community-based services in the early 1980s, the state has created 11 waivers in addition

[2] During this fiscal year, the state had approximately 625 homes that were certified to accept Medicaid patients. While state staff told evaluators that the state directed/requested local agencies to work with Medicaid certified homes, local agencies report that they work with any one, Medicaid and non-Medicaid who requests transition assistance.

to its state-funded programs.[3] Only Florida has more waivers than Pennsylvania. For example, the OBRA waiver, developed in response to the federal Omnibus Budget Reconciliation Act (OBRA) of 1989, focused on individuals who had been institutionalized. In the late 1990s, it was expanded to all individuals meeting its criteria, including those having a disability apparent before age 22 that affects physical functioning.[4]

In addition to federal Medicaid waivers, the state also generously uses state-funded programs for those on Medicaid waiting lists or those not eligible for Medicaid. For example, in FY 2004-2005 state-funded programs served approximately 103,000 older adults.[5]

Local agencies have a history of working on transition projects and this is important, as Pennsylvania's system of long-term living was developed and remains based at the county level.[6] Centers for Independent Living and non-profits have been doing transition work since the early 1980s, according to persons interviewed.[7]

State executive changes were also made during this period. For example, to research and coordinate long-term living efforts, the Intra-Governmental Council on Long-Term Care was created in 1988, with representation from the state (executive and legislative), service providers, and consumers. The Secretary of Aging chairs this council.[8] It was created based upon a suggestion by the Select Committee on Long-Term Care, which was established by the Pennsylvania House of Representatives in 1986.[9]

This combination of numerous waivers and state-funded programs, a history of local agency experience with transition, and the progressive morphing of state executive organizations, created a base for a state-operated Medicaid demonstration grant beginning in about 2000. This growth was enabled by a major change in federal Medicaid thinking.

Federal Medicaid Policy Since 2000

From FY 2001 to July 2006, the Centers for Medicare & Medicaid Services (CMS) authorized $245 million in Real Choice Systems Change (RCSC) grants to all states, the District of Columbia, and two territories. In addition, the Administration on Aging (AoA) and CMS jointly awarded 43 Aging and Disability Resource Center grants

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[3] Eiken, S., Nadash, P., & Burwell, B. (2006). Available at: http://www.hcbs.org/files/101/5031/ProfileOfPALong.pdf.
[4] Ibid., p. 25.
[5] Ibid., p. 15.
[6] Ibid., p. 6.
[7] Interviews with Center for Independent Living and non-profit staff during August and September 2007.
[8] Pennsylvania Department of Aging. Available at: http://www.aging.state.pa.us/aging/cwp/view.asp?a=290&Q=197410&agingNav=|.
[9] Intra-Governmental Council on Long-Term Care. (2005). Available at: http://www.aging.state.pa.us/longtermcare/cwp/view.asp?a=486&Q=244065&LongtermcareNav=|5346|&longtermcareNav=|5346|.

of up to $800,000 each to help states, and in 2007 the AoA authorized $5.7 million in federal funds to 12 states to modernize nursing home diversion efforts.

This unprecedented federal funding took place against a backdrop of lawsuits circumscribing states' ability to limit community services for people with developmental disabilities. As of May 2007, such suits had been filed in 25 states: 16 were settled, six were dismissed including the Pennsylvania case of *Sabree vs. Richman*, and three were pending.[10] While the *Olmstead* decision is widely known, other influential decisions contributed to the cumulative impact of this litigation effort.[11] For example, the 1998 11th U.S. Circuit Court of Appeals decision in the *Doe v. Chiles* lawsuit held that the state of Florida could not limit access to entitled ICF/MR services.[12] CMS actions in developing the Real Choice Systems Change grants were also consistent with the New Freedom Initiative developed by the Bush administration and articulated in President Bush's Executive Order 13217, "Community-Based Alternatives for Individuals with Disabilities," on June 18, 2001.[13] Federal agencies responded to this executive order, including CMS.[14]

FY 2000 and Afterwards

Pennsylvania was one of 12 states to receive a grant between 1998 and 2000 from the Centers for Medicare & Medicaid Services for the Nursing Home Transition Demonstration Program. A FY 2000 grant funded the Pennsylvania Transition to Home (PATH) program until September of 2003. The program began operations in November 2001 in four pilot counties and expanded in 2003 to an additional three counties using state funds. These state funds extended operations into 2004. Outcomes were as follows:[15]

- Transitioned 51 people through September 2003;
- Allowed experimentation with transition models;
- Identified barriers to transition and service gaps;[16]

[10] Smith, G. A. (2007). Available at: http://www.hsri.org/docs/litigation052307.DOC.
[11] Olmstead v. L. C. (1999). Available at: http://www.law.cornell.edu/supct/html/98-536.ZS.html.
[12] Doe v. Bush. (2001). Available at: http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=11th&navby=case&no=9914590OPN.
[13] For a discussion of this see: http://www.hhs.gov/newfreedom/eo13217.html.
[14] For a department-by-department description of their responses to Executive Order 13217 see: http://www.hhs.gov/newfreedom/final/.
[15] Sources for this section are: Eiken, S., & Heestand, A. (2003). Available at: http://aspe.hhs.gov/daltcp/reports/PAtrans.htm; Pennsylvania Intra-Governmental Council on Long-Term Care. (2004). Available at: http://www.aging.state.pa.us/aging/lib/aging/040301_PATH_Final_Report.pdf; Southwestern Pennsylvania Area Agency on Aging. (2005).
[16] See Pennsylvania Intra-Governmental Council on Long-Term Care. (2002). Available at: http://www.aging.state.pa.us/aging/lib/aging/barrierseliminationreport.pdf.

- Developed relationships with local agencies, nursing facilities, long-term care ombudsmen and housing entities;

- Received Housing and Urban Development (HUD) Project Access vouchers to transition non-elderly nursing home residents: 15 consumers used them, and four of these were pending when the final report was written;

- Initiated development of a transition database;

- Introduced use of Minimal Data Set (MDS) information;

- Formulated waiver amendments to better serve consumers in PDA, Independence, Attendant Care, COMMCARE and OBRA waivers by: 1) making transition expenses a funded service; and, 2) by having an aggregate, rather than individual, cap on expenses in the PDA waiver; and,

- Proposed initiative for the Governor's 2004-2005 budget to add transition services to the Department of Aging Programs, and to include transition in the Community Choice demonstration in pilot areas.

The state went on to obtain six other CMS grants from FY 2002 through FY 2006. This provided a source of funds to innovate state programs, and nursing home transition efforts benefited from these grants as well.[17]

In 2002, the Pennsylvania Intra-Governmental Council on Long-Term Care published its report on barriers to home and community-based services.[18] This was a well-documented report that described barriers and set a tone for future state activities.

Comparison of PATH with Other Transition Programs

After the Nursing Home Transition Demonstration Program ended, CMS authorized the funding of 33 nursing home transition programs in 28 states during FY 2001 and FY 2002. This was an expansion built upon experience with the Transition Demonstration. These programs were evaluated in 2005 and the number of persons transitioned by the 28 states was estimated to be 4,003 persons.[19] However, two of the states, Washington and Wisconsin, accounted for almost half the persons transitioned in the three-year reporting period. The other 26 states reported transitioning about 68 persons on average, over the entire three-year period. The 51 persons transitioned by the PATH grant are on the same scale with the results found in the 26 states.

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[17] CMS records show a Real Choice grant in 2002, a Money Follows the Person grant in 2003, a Quality Assurance and Quality Improvement grant in 2003, a Mental Health System Transformation grant in 2004, Integrating Long-Term Supports with Affordable Housing in 2004, and a Medicaid Infrastructure Grant in 2006.

[18] Ibid.

[19] O'Keeffe, J. (2005, June). Available at: http://www.hcbs.org/files/74/3655/NFT_final.htm.

Governor's Office of Health Care Reform, 2003

Governor Rendell established the Office of Health Care Reform in January of 2003 with the purpose of redesigning the health care system.[20] Personnel in this office had been involved with the state's nursing home transition efforts and they were transferred to the Long-Term Living Council and the Office of Long-Term Living when these entities were established in 2005 and 2006.[21] The Office of Health Care Reform has also been involved in three grants from federal and other sources that are related to nursing home transition.

Figure 1: List of Three Grants Related to Nursing Home Transition, FYs 2003 - 2004

Grant Subject	Source	Year Received	Amount
Cash and Counseling	Robert Wood Johnson Foundation	2004	$250,000
Integrating Long-Term Supports with Affordable Housing	Centers for Medicare & Medicaid Services	2004	$893,340
Pennsylvania's HCBS Quality Project	Centers for Medicare & Medicaid Services	2003	$498,650

Community Choice Pilot: Began August, 2003

The Community Choice pilot was a joint project between the Governor's Office of Health Care Reform and the Departments of Aging, Public Welfare, and Health. The goal was to streamline access to home and community-based services by expediting Medicaid eligibility. The pilot also increased asset disregards and expanded outreach. It began in a three-county region of southwestern Pennsylvania near Pittsburgh in late 2003 and expanded to the Philadelphia area in January of 2004.[22] It is currently offered in 12

[20] Executive order at: http://www.ohcr.state.pa.us/assets/pdfs/1-21-03-HealthCareReformExeOrder.pdf.
[21] Eiken, S., Nadash, P., & Burwell, B. (2006, December), pp.10-11. Available at: http://www.hcbs.org/files/101/5031/ProfileOfPALong.pdf.; Pennsylvania Long-Term Living Council. (2006), p. 2.
[22] Rutgers University Center for State Health Policy wrote about this program in 2005. See Money Follows the Person Site Visit: Pennsylvania Community Choice Initiative. Available at: http://www.hcbs.org/files/77/3846/PA_sitevisitsummary1WEB.pdf.

counties.[23] The state had hoped that this pilot would prevent some nursing facility admissions and make it possible for hospitals to discharge to community settings. There is some indication of this occurring, but nursing facility use did not significantly decrease in the pilot areas as of 2005.[24] The Secretary of Aging indicated in early 2007 that the expedited strategy would be expanded statewide.[25]

Other Activities Related to Nursing Home Transition

In late 2004, agencies in southwestern Pennsylvania (AAAs and CILs for Independent Living) developed Local Housing Options Teams (LHOT) with health and human service agencies, housing agencies, developers and other local stakeholders. As of late 2005, there were active LHOTs in Fayette and Washington Counties and development was beginning in Greene County.[26]

During 2005, amendments were secured to six waivers administered by the Department of Public Welfare and Aging to add transition services as a covered waiver service. Community Transition Services were defined as one-time expenses, not to exceed $4,000 per consumer. In September of 2005, the state held a summit on NHT in Harrisburg, which was attended by 180 people involved in nursing home transition from across the state.[27]

Long-Term Living Council: 2005

In November 2005, the governor established the Long-Term Living Council to help meet the state's demographic challenges and to reach the state's vision of consumer choice in long-term living services by creating a more unified management structure.[28] The Council was made up of the Secretaries of Aging, Budget, Policy, and Welfare; the Director of the Governor's Office of Health Care Reform; and, the Governor's Deputy Chief of Staff. The Council originally had an Executive Director who reported directly to the Council and who had management responsibility for both institutional and community long-term living services. Deputy Secretaries in Aging and Welfare reported to the Council Executive Director in addition to their agency secretaries.

Interviews conducted with state staff suggest that this multifaceted reporting relationship helped move change along. Staff knew that they would have to answer to the

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[23] See Community Choices web site at: http://www.dpw.state.pa.us/partnersproviders/physicaldisabilities/homecommservices/003670971.htm.
[24] Eiken, S., Nadash, P. & Burwell, B. (2006, December), p. 19. Available at: http://www.hcbs.org/files/101/5031/ProfileOfPALong.pdf.
[25] Eisenhower, N. D. (2007, February 7). Available at: http://209.99.68.136/www/pa/library/2007/20070222TZ.pdf.
[26] Southwestern Pennsylvania Area Agency on Aging, Inc. (2005).
[27] Reinhard, S. & Farnham, J. (2006, January). Available at: http://www.cshp.rutgers.edu/cle/Products/NHTSummitNJSept05WEB.pdf.
[28] Pennsylvania Long-Term Living Council. (2006), p. 2.

council, which met on a biweekly basis.[29] This organizational and reporting structure was viewed as temporary until coordination was established among the various agencies.

NHT Outcomes in 2005 and Early 2006

There were 460 transitions reported from January 2005 to June of 2006, with an average of 18 transitions per month in the first six months of 2005, and an average of 29 per month from June 2005 to June 2006.[30] The difference in the average per month shows how the pace of transitions stepped up over this 18-month period.

It is not possible to compare Pennsylvania work done in 2004 and 2005 with work done in other states. Research into possible comparisons found no national studies showing which states continued their transition programs after the federal grants ended or how many persons these programs helped transition. No federal reporting collects this information and university researchers have not collected this information. Two other states reported being able to transition 500 or so persons a year: New Jersey and Wisconsin.[31] Texas has the largest transition program, having transitioned some 13,000 persons since its inception.[32] The majority of states that have transition programs appear to have smaller programs that transition between 30 and 200 persons a year.[33]

Changing the Home Maintenance Deduction

In January 2006, the state issued a policy clarification, Long-Term Care PMN12797468, stating the conditions under which a three-month home maintenance deduction could be provided to persons who were transitioning from a nursing home. This change in eligibility policy had the practical effect of providing funds to the person being transitioned by reducing their cost share for up to three months prior to leaving their home.

Evaluators conducted a search for a list of states that used the home maintenance deduction, but found that it was difficult to obtain. It is possible that information about the home maintenance deduction is not widely known among state home and community-based care staff. Pennsylvania probably introduced a very sensible policy when most states have not yet established a home maintenance policy that is relevant to nursing home transition.

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[29] Interviews conducted by Rutgers CSHP personnel July 18-20, 2007.
[30] Pennsylvania Long-Term Living Council. (2006), p. 5.
[31] Hendrickson, L., & Reinhard, S. (2006). Available at: http://www.hcbs.org/files/97/4838/MFPCostEffectivenessFinal090506.pdf
[32] Comments by Texas Health and Human Services staff at 2007 Home and Community-Based Services Conference, Albuquerque, New Mexico. September 2007.
[33] Rutgers Center for State Health Policy has published eight studies of nursing home transition including state specific studies of New Jersey, Connecticut and Michigan. For a list of the Center's publications see http://www.cshp.rutgers.edu/cle/.

Side Door: Implemented March 2006

In March of 2006, Pennsylvania began a pilot program to target lower acuity nursing facility residents, which they called the "side door."[34] In six counties, MDS information was used to identify residents who appeared to have a chance of transitioning based upon their clinical profile. Nursing personnel from the state's utilization management review teams, who work regularly with nursing facilities, assessed these residents and prioritized them into tracks for follow up by local agencies.

Though there did appear to be an increase in the number of residents transitioned in the pilot counties, the state felt that factors other than clinical characteristics best explained successful transitions, such as the desire to leave, availability of housing, and informal supports in the community. Thus, the state decided not to continue with the pilot and focused instead on using MDS data to identify new admissions (i.e., the front door policy), and to continue to work with all nursing facility residents expressing a desire to leave.[35]

New Level of Care Assessments: July 2006

The Long-Term Living Council's Eligibility Workgroup reviewed the existing level of care assessment form and revised the form to reduce the number of questions, improve consistency, and trigger appropriate supervisory review. The revised assessment was implemented in July 2006 and communicated through three regional trainings and individual trainings in some areas.[36]

The Office of Long Term Living: 2007

The Office of Long-Term Living was established during 2007 and staff was transferred to it from the Departments of Aging and Public Welfare and the Governor's Office of Health Care Reform. The Office of Long-Term Living has the following responsibilities:[37]

- Administers eight of Pennsylvania's 11 Medicaid waivers;[38]
- Oversees quality for all 11 Medicaid waivers;
- Manages nursing facility policy, adult day health, domiciliary care homes; and,
- Has financial responsibility for the Aging Waiver.

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[34] Pilot areas were selected in the summer and fall of 2005 (Interview with B. Rose, July 18, 2007).
[35] Pennsylvania Long-Term Living Council. (2006), pp.5-6; Eiken, S., Nadash, P., & Burwell, B. (2006), p. 31. Available at: http://www.hcbs.org/files/101/5031/ProfileOfPALong.pdf.
[36] Pennsylvania Long-Term Living Council. (2006), p. 8.
[37] Eiken, S., Nadash, P., & Burwell, B. (2006). Available at: http://www.hcbs.org/files/101/5031/ProfileOfPALong.pdf.
[38] Two waivers remain under the Department of Public Welfare but in different offices: one in the Office of Mental Retardation and one in the Office of Child Development. The Aging waiver remains under the Department of Aging.

In January 2007, the first Deputy Secretary for Long-Term Living was named and this position had dual reporting to the Secretaries of Aging and Public Welfare.[39] This consolidation of long-term living activities is similar to the administrative reorganizations taken by other states, such as Washington and New Jersey. In 2007, these actions were perceived as necessary steps to create the organization and leadership necessary to make progress in the state's long-term living programs, including nursing home transition.

Comments on the History of Transition Activities in Pennsylvania

This chronology shows that Pennsylvania has a respectable record of accomplishment in NHT. No national data exists showing how many states continued with their transition programs after the federal demonstration and Real Choice System Change grants ended. Pennsylvania continued with its program and steadily increased it in size and resource capability. There is no data on how many transitions were done by the programs that did continue. The growth of the Pennsylvania program was accompanied by continual change of administrative operations, the addition of transition assistance to six waivers, an aggressive application program for obtaining federal grants, improved data recording systems, and a continued testing of strategies for identifying persons who might be helped to transition. It took a large and significant amount of work to accomplish these activities.

By July 2006, the state was ready to build on its experiences and it announced the expanded nursing home transition program and its "front door" strategy.

Organization of Transition Activities: FY 2006 - 2007

The FY 2006 - 2007 saw the introduction of the Enhanced Nursing Home Transition program, which represented both a change in the way local agencies worked with one another and an expansion in the number of agencies brought into the effort. The state's 52 Area Agencies on Aging (AAAs) were now required to participate and 15 Centers for Independent Living (CILs) and non-profits were brought into the project.

To put the level of effort in perspective, as mentioned above, the PATH program had two transition coordinators and a project director, and helped 51 persons transition during a three-year project ending in 2003. Six years later, the state put in operation a program with 150 to 200 staff from 67 local agencies supported by state departmental staff.

[39] See Commonwealth of Pennsylvania Press Room. (2007). Available at: http://papress.state.pa.us/parelease/data/1070124.004.htm

The Front Door: Announced July 2006 and Implemented Fall 2006

In July 2006, Pennsylvania rolled out its new enhanced transition strategy focusing on new nursing facility admissions. The roll out activities and other state support for local agency staff included:

- Regional meetings in the summer of 2006 to introduce the new program;[40]

- Seven training sessions in October 2006 with AAAs around the state on the Front Door Information System (FDIS), which provides MDS information on new admissions;[41]

- A statewide NHT symposium in the Fall (October 31-November 1) to provide training to agencies across the state;[42]

- Monthly technical assistance (TA) calls by region (six regions) to address region-specific questions;[43]

- A technical assistance guide,[44] a "Toolbox" with forms, helpful information,[45] and other guides, posted on state web sites;[46] and,

- Training on the NHT computer-tracking system (OMNIA) provided in Harrisburg in January 2007.[47]

The program had the following general process:

- Nursing homes were contacted and told about the program;

- AAAs received lists of new admissions and the projected length of stay from the MDS forms that nursing facilities were required to submit, and they were to use the information to provide counseling to the new residents;

    - If residents under the age of 60 indicated an interest in transitioning, they were to be referred to under-60 providers;

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[40] Enhanced Nursing Home Transition: NHT Collaborative Partners Regional Meetings (2006). Available at: http://www.aging.state.pa.us/aging/lib/aging/Extended_regional_NHT_Rollout_Meetings.ppt.
[41] Interview with A. Chavez and B. Rose, July 18, 2007.
[42] Interview with S. Getchen, July 18, 2007.
[43] Interview D. Gingerich, July 20, 2007.
[44] Pennsylvania Department of Aging. Available at: http://www.aging.state.pa.us/aging/cwp/view.asp?A=3&Q=253536
[45] Pennsylvania Department of Aging. Aging: NHT Toolbox. Available at: http://www.aging.state.pa.us/aging/cwp/view.asp?A=3&Q=253410.
[46] Pennsylvania Department of Aging. Aging: Nursing Home Transition Services. Available at: http://www.aging.state.pa.us/aging/cwp/view.asp?a=3&q=252633.
[47] Interview, Voices for Independence, August 7, 2007.

- For residents 60 years old and over, the AAA would continue to assist them;

- AAAs use the FDIS system to record whether or not the resident is interested in transitioning;[48]

- A data collection system called OMNIA was designed to track those interested in transition[49] and was intended for use by both the AAAs and the under 60 providers;[50] and,

- A funding amount was provided to cover "transformational" costs in restructuring agency operations to support transition work, and incentive payments were designed to reward agencies for meeting numeric transition goals.[51]

The enhanced program in 2006 was also organized differently than work in 2005 and 2004. Prior to 2006, Centers for Independent Living had a lead agency role and Area Agencies on Aging worked through them. The rationale for this was based on the historically greater experience with transition issues that the CILs had. However, this changed in 2006 and CILs affected by the change learned of it at the roll out conferences introducing the new enhanced program.

Opinions about the change were volunteered in four of the 20 agency interviews. The opinions included comments that: the state introduced the change abruptly without prior consultation or opportunity to discuss it, that certain CILs may have been too aggressive in their dealings with the nursing homes; that AAAs needed to be more involved in transition activities, and the change was helpful in getting the AAAs to take responsibility for transitions.

Why Did the Enhanced Program Focus on Newer Admissions?

If a person is not eligible for Medicaid upon entering the nursing home, then they soon spend down their resources and become Medicaid eligible. State staff provided the following data table which shows that about 55% of private pay persons become eligible for Medicaid after 30 days, 72% within 31 - 60 days, 80% within 61 - 90 days, and by six months 90% are eligible for Medicaid (i.e., cumulative percents over time).

Figure 2: Residents Length of Stay before Becoming Eligible for Medicaid: SFY 2003 - 2004

48 Interview, D. Hopkins, July 19, 2007.
49 Interview, D. Hopkins, July 19, 2007.
50 Interviews with state staff, July 18-20, 2007.
51 Interview, R. Prushnok, July 24, 2007.

Length of Stay Before Becoming Medicaid Eligible	Resident Count	Percent of Total	Cumulative Percent
0-30 days	24,954	54.8%	54.8%
31-60 days	7,852	17.2%	72.0%
61-90 days	3,699	8.1%	80.1%
91-120 days	2,784	6.1%	86.2%
121-150 days	1,152	2.5%	88.8%
151-180 days	785	1.7%	90.5%
181-210 days	636	1.4%	91.9%
211-240 days	488	1.1%	93.0%
241-270 days	424	0.9%	93.9%
271-300 days	374	0.8%	94.7%
301-330 days	356	0.8%	95.5%
331-365 days	350	0.8%	96.3%
366-730 days	1,513	3.3%	99.6%
Greater Than 2 Years	186	0.4%	100.0%

Source: Pennsylvania Office of Long Term Living, 2007.

From a cost-effectiveness perspective, Medicaid nursing home costs are avoided if residents can be reached and helped back to the community before they become eligible for Medicaid.

Access to Nursing Homes

This expanded program first dealt with the issues of obtaining access to the state's 726 nursing homes and their 89,575 beds.[52] Unlike the CILs, the state's AAAs have always had access to nursing homes because AAA staff have done the level of care assessments that are required before Medicaid eligibility for nursing home services can be approved.

The Enhanced Nursing Home Transition began at the beginning of FY 2006 - 2007. While there was an established routine access, the transition program established a different relationship between the AAA and its nursing homes. Over half the local agencies interviewed described how they introduced the enhanced transition work to nursing homes in their areas. During the fall of 2006, the agencies had joint meetings with other agencies, called and wrote letters to nursing homes, and had repeated meetings with nursing home administrators and staff at the nursing homes to explain the program. For example, one AAA said it told the nursing home staff that the transition program was not going to go away and this was an opportunity to work together. Another agency, which had worked with PATH (the original federal nursing home grant) and had done transition work prior to 2006, reported that nursing homes in their area had become

[52] Data on the number of homes and beds is from 2007 lists supplied by state staff.

familiar with the program over the years and that the nursing homes had worked well with the agency. One non-profit that became formally involved in transition activities in 2005 reported that early in that year, its staff, in conjunction with staff from a CIL, made visits to the 55 - 60 nursing homes in its county and talked about the transition program with the nursing homes. AAAs that had not had transition programs prior to 2006 worked on nursing home cooperation in the fall of 2006.

Three agencies interviewed described how they developed literature and brochures for the public, families, and nursing home residents that provided agency contact information and described nursing home transition. These agencies got publications from other states and other agencies within Pennsylvania as models to use in creating their own literature. Agencies expressed opinions that it would have been helpful if the state had prepared literature for them to use rather than having each agency invent its own.

This establishment of access required a significant amount of start-up work. The impression from the interviews was that because of this work the nursing homes were generally cooperative. The state also wrote letters to the nursing homes and made public presentations about the program. For example, Pat Brady, then acting Secretary of the Department of Public Welfare, sent a letter to nursing homes on July 26, 2007 to inform them that their local Area Agency on Aging would be contacting them.

Why would a nursing home cooperate? Answers provided by agencies varied. Transition was a clearly emphasized state policy carried out by the same state and local agencies that license nursing homes, pay them, and control Medicaid admissions. Transition activities have been going on since the early 1990s in some areas of the state and have been emphasized across the state since 2001. The policy is not going to go away. Transition workers were helpful in transitioning persons that the nursing home did not want as residents. Transition workers helped the discharge capabilities of nursing home staff. Nursing homes are emphasizing their short-term rehabilitation services to obtain more Medicare revenue since Medicare pays better than Medicaid.[53] Local agencies will call staff in the state Departments of Aging and Public Welfare and tell them that an uncooperative nursing home is blocking access.

The joint effect of the reasons cited above was sufficient to obtain the cooperation of most nursing homes. Almost all agencies interviewed added that a few nursing homes are still resistant to transition work and that obtaining access to all nursing homes is still a widespread and open issue.

State staff does not routinely look at how many nursing homes each agency transitioned persons from. The state has this data, and if it were tracked over time, it would provide insightful information on the efficiency of local agency operations. For

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[53] The percentage of Pennsylvania nursing home residents paid for by Medicare has increased from 9.29% in December 2001 to 11.3% in June 2007. Data from the American Health Care Association retrieved from its Research site April 2007. The site is less useful now because historical data prior to 2007 has been removed from it.

example, it would be useful to know whether transitions are coming from a handful of cooperative nursing homes or whether they are coming broadly from all nursing homes in the agency's geographical area. Other useful data would include documenting the number of transitions coming from county-operated nursing homes.

What Kind of Minimum Data Set (MDS) Information Do Agencies Receive?

During FY 2006 – 2007, the state used the Minimum Data Set (MDS) to identify individuals to counsel about their nursing home stay. The MDS is the only national database collected on individual nursing home residents. By law, all residents in Medicare and/or Medicaid certified nursing homes must be assessed according to this prescribed process. CMS collects about ten million MDS records annually on approximately three million persons who use nursing homes each year.[54]

The MDS is part of the federally mandated Resident Assessment Instrument (RAI), which is the statutory name of the instrument that includes the MDS, Resident Assessment Protocols (RAPs), and the utilization guidelines. The MDS forms and manuals that detail the resident assessment process can be found and downloaded at the CMS web site.[55] The MDS assessment form is a nine-page questionnaire containing approximately 120 items. There are about 530 response options spread across 24 sections, or "domains" of the form that may be filled-in for a specific nursing home resident.

A primary use of the MDS data is for Medicaid rate setting. However, states also use the MDS to prepare reports describing the persons who use nursing home services.[56] States are also investigating how the MDS can be used in nursing home transition. For example, Minnesota has studied the relation between MDS information describing the characteristics of nursing home residents and when persons leave the nursing home.[57]

As noted in the chronology above, Pennsylvania used MDS answers in its "side-door strategy" in the spring of 2006 in a six-county pilot where there was a prevalence of nursing home residents with lower impairments: counties included Lancaster, Allegheny, Philadelphia, Bucks, Montgomery, and Delaware. To speed up the provision of MDS data from the nursing home, new case-mix regulations took effect on October 1, 2006

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[54] Reinhard, S., & Hendrickson, L. (2007).

[55] Centers for Medicare & Medicaid Services. MDS 2.0 for Nursing Homes. Available at: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage.

[56] For example, in 2006 Ohio collected about 325,000 MDS assessments a year on its nursing home residents and reported on their social, educational, medical and other characteristics. See Ohio Department of Job and Family Services, Bureau of Long-Term Care Facilities, Case Mix Section, MDS Frequency Report, 2001-2006. Available at: http://jfs.ohio.gov/OHP/bltcf/pdf/MDS Frequency Report CY 2001-2006.pdf

[57] For a study on which MDS characteristics are associated with discharge see Arling, G., Kane, R., & Bershadsky, J. (2007, July). *Promoting Resident Transitions from Nursing Home to Community,* Report submitted to the Minnesota Department of Human Services.

that required nursing facilities to submit new admission reports within seven days of the completed assessment.

State and local staff jointly developed the side-door selection criteria using the MDS. Determinants included: whether or not the resident was able to eat independently or with minimal assistance; whether they could move in bed, get in and out of bed and go to the toilet by themselves without aid or little support; and, whether or not they had only mild short-term memory loss, were able to make decisions, and make themselves understood. Residents selected for review also had to be both bowel and bladder continent and have no pressure ulcers or ulcers only at a blister state (stage2).

The following figure shows the results of using this low acuity method of identifying potential persons who might prefer to live outside of the nursing home.

Figure 3: Number of Persons in Side-Door Strategy by County

Counties Where the Side-Door Strategy was Used	Number of Low Acuity Persons Identified
Allegheny	190
Bucks	121
Delaware	190
Lancaster	187
Montgomery	321
Philadelphia	302
Total	1,311

The results of this work showed that identifying those who had lower levels of impairments did not necessarily mean that these persons could be quickly or easily helped to leave the nursing home. The clinical indicators did not provide sufficient information about the social situation of the person or provide appropriate indicators to assess the possibility of creating a home for them outside of the nursing home.

Therefore, this "side door" approach was deemphasized, and the enhanced program rolled out in the summer of 2006 emphasized identifying residents where there was uncertainty about their length of stay in the nursing home.

The state did not supply MDS information about long-term residents under the age of 60 to the CILs or the AAAs. One section of the MDS asks four questions about discharge planning. Persons interested in nursing home transition activities have sought to use answers to these, in conjunction with other MDS questions, in the planning of nursing home transition efforts.

Section Q of the MDS is shown below.

MDS Section Q – Discharge Potential and Overall Status

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0.No 1.Yes
		b. Resident has a support person who is positive towards discharge 0.No 1.Yes
		c. Stay projected to be of a short duration-discharge projected within 90 days (do not include expected discharge due to death) 0.No 2.Withing 31-90 days 1.Within 30 days 3.Discharge status uncertain
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0.No change 1.Improved-receives fewer supports, needs less restrictive care 2.Deteriorated-receives more support

Data from the state was used to estimate of the number of initial MDS assessments made each year.[58] The resulting estimates by county are shown in Appendix E. The Appendix shows that for FY 2006-2007 approximately 101,394 persons had an initial MDS filled out and of these approximately 32,398, or 32%, had "uncertain" marked as an answer to Q1c. Approximately 47% were marked as having a stay of within 90 days, and the remaining 21%, or 21,135 were marked as not being short-term (i.e., they were going to be long-term residents). Of the 101,394, a little more than 7%, (i.e., 7.16%) were under 60 years of age and the other 93% were 60 years of age or more.

[58] The state supplied two existing data runs of initial assessments with 13 months of data for the period 7-1-06 to 6-30-07. An estimate of the 13th month was made and this amount, by county, was subtracted from the total of the two runs to get an estimate of the 12-month period between 7-1-06 to 6-30-07. The data do not include persons who were comatose and persons who left the nursing home before an assessment could be filled.

The Enhanced Nursing Home Transition Program used the Front Door Information System (FDIS). This information system both extracted data from the state's MDS records and provided this information to the AAAs participating in the transition work. A list was sent every two weeks to each Area Agency on Aging showing: the names of each new admission; their nursing home; and, information on their length of stay, dementia, and age. CILs did not receive such lists and had to obtain MDS information through an AAA.

The FDIS system was implemented between July and September 2006 and started producing data in late September or early October 2006. In October 2006, seven trainings were held with the AAAs. Access to the FDIS system is generally limited to AAAs. Only a few non-AAA agencies have access. Access to FDIS is restricted because the access costs money. State staff interviewed in July 2007 reported that there were 99 active FDIS users in the last quarter of FY 2006 – 2007, the period April 1, 2007 through June 30, 2007. The average agency has from one to three users. One agency reported that its county firewall would only allow one user of FDIS at a time. Discussions with agency staff show that clerical workers have the most direct access since they get the FDIS reports and initiate contact with the nursing homes.

One of the larger agencies said that more access was needed because in a larger agency case managers also need their own access. This agency pointed out the state's contradiction with using the FDIS to enter contact and other consumer data but limit the FDIS to a few users. If the state is going to use the FDIS as something more than a generator of lists to AAAs and CILs, then case managers and agency workers who need access to the client data should have access to it.

Ten of the 20 agencies interviewed were Area Agencies on Aging and each described how they worked with the list of names. The most frequently described process was that the lists would be checked against existing client files in block grant, protective services, or case management programs, and then clerical staff would call or fax the list to contact persons in the nursing homes. The initial list received would be shortened by the elimination of persons who were already known to the agency or who were no longer in the nursing home.

The estimated length of time from the date of admission to the nursing home to when the AAA worked the list is five to six weeks. The nursing home has several weeks to collect and report the MDS data, the list is produced by the FDIS system every two weeks, and it takes up to a week to process the list.[59] Given this length of time, it is not surprising to find that persons have left the nursing home, have had a discharge date set, or were no longer coded as uncertains. Five of the ten AAAs and one CIL interviewed provided counts or estimates of the percentage of persons who were still there when the first calls were made. The percentages of persons who were still there were: 30%, 40%, 41%, 57.20%, 58.77%, and 70%.

[59] In 2006, the state issued new nursing home case-mix reimbursement regulations that required homes to submit the data within seven days of admission. This action was taken to speed-up the provision of the MDS assessment information.

The state designed the enhanced transition program so that the lists only go to the AAAs. This practice raised comments from both AAAs and CILs. Half of the CILs interviewed said the AAAs filtered the names of the persons who were under 60 and did not pass the names along. Two AAAs interviewed reported that they shared the lists with the local CILs as a result of discussing concerns about the filtering or winnowing out of names.

The use of the list is cited as an example of inconsistent state policy. The state does not send the MDS lists to the CILs, but does require AAAs to share names from the lists with the CILs. Program efficiency would be improved if those CILs that are transition providers also had direct access to MDS FDIS information relevant to persons under the age of 60.

What do the Agencies do with the MDS Information?

After the list of uncertains is narrowed, all of the AAAs interviewed said that they counseled current residents with an uncertain answer, including both under 60 and over 60. Seven out of ten talk to persons with a short-term stay or will talk to them if the AAA finds out that the residents are there past the discharge date. Residents with a long-term stay answer on the MDS may or may not be visited depending on the AAA. Four of the AAAs reported that they did not routinely visit long-term persons unless they were in the facility or had more information about the person. One AAA visited long-term residents who were over the age of 60, but did not visit persons under the age of 60.

Lack of resources was the most commonly cited reason for not visiting more residents marked as having a short- or long-term stay. The funding of staff was a frequently discussed topic in interviews with agency staff. Appendix E shows that there were roughly 32,000 persons during FY 2006 – 2007 with uncertain as an answer and 68,000 with an answer of short- or long-term stay.

One AAA interviewed suggested that it would be useful to have an FDIS report showing if residents who were initially marked short-term were still there beyond their anticipated discharge rate. This list would make it easier to keep track of the short-term folks since the ones who went home would not be on the list.

What is Counseling?

Neither the state nor the agencies interviewed have studied the impact of the counseling. AAAs were asked what counseling consisted of and below are five replies:

> ***Answer 1:*** The counseling visit consists of reviewing the consumer's service needs and desire to return to the community (with consumer and family). Time is also spent looking at the support network and discussing service options that could be provided in the community. The time spent in the counseling sessions

varies from no more than five minutes with consumers strongly indicating that they are happy where they are or "just not interested," to 30 minutes.

Answer 2: I introduce myself to the client and explain where I am from, whom I represent, what I do, and why I am here. I ask the client several questions regarding their current situation at the nursing home, what happened to bring them here to the facility, and what their plans/goals are about either remaining in the facility or leaving. If the resident indicates that they want to leave the facility and return to the community, I inform them of services and programs available to them in the community and county aging office.

If the resident is interested in pursuing this further, I talk about services and resources "in-depth" based on their needs. If there are family members, I ask permission of the consumer to contact them concerning discharge. A counseling session with the family is scheduled where the client's needs are addressed, as well as housing and financial issues. If the consumer is receptive, the average initial counseling time is between a half an hour and forty-five minutes.

Answer 3: Counseling consists of discussing with residents their current situation, future plans/goals, and options available if they are interested in a return to the community. A session can last as short as 15 minutes and as long as an hour. Most are about a half an hour.

Answer 4: We provide the residents and their informal support system with a comprehensive description of all services available in the community and attempt to break down any barriers they may encounter in their attempt to transition back to the community. Typically, a counseling session will last 30 to 45 minutes in the NF. Many times the counselor will return to the office and spend another 30 to 45 minutes speaking with informal supports and gathering collateral information.

Answer 5: We provide an overview of community-based options available; a referral to our Nursing Home Transition unit if they need assistance to return home; and, have a discussion with family at some point. The actual time spent with consumers face-to-face ranges from 15-30 minutes. More time is necessary for discussions with the family, the social worker from the facility, and to complete forms.

These answers indicate counseling sessions have a "meet and greet" and a screening component to them. The counselor establishes contact with a resident, which provides an opportunity for the resident to contact someone who can talk with him/her about leaving the nursing home, either now or later. There are screening questions to determine the resident's preference for a place to live and to identify the barriers and resources available to the person (e.g., how much assistance friends or family can provide and how much care a person can afford to purchase). The counseling sessions also provide community information, and if a preference for community living is expressed then this triggers additional activity.

Agency Statistics

During interviews with the AAAs, five agencies supplied data about the number of persons that were counseled. Each of the five tables below shows the number counseled and other statistics that the agencies provided. The tables are awkward to compare directly since agencies kept different statistics about their use of the MDS data. These five agencies reported counseling about 3,100 persons. As you can see in Figures 4 - 8, the number of persons transitioned using the MDS information is a low, single-digit percentage whether expressed as a percentage of all uncertains or a percentage of persons counseled.

Figure 4: Allegheny County, Pennsylvania AAA from 7/1/2006 to 6/30/2007

Transition Statistics	Number of Persons	Percent of Counseled
Number Counseled	1,500	100.00%
Number Referred for Transition	200	13.33%
Number Transitioned	20	1.33%

Figure 5: Philadelphia Corporation on Aging from 10/1/2006 to 2/28/2007

Transition Statistics	Number of Persons	Percent of Counseled
Number Counseled	345	100.00%
Number Referred for Transition	131	37.97%
Number Worked With	39	11.30%
Number Transitioned	8	2.32%

Figure 6: Lancaster County, Pennsylvania Office of Aging from 10/16/2006 to 6/30/2007

Transition Statistics	Number of Persons	Percent of Uncertains	Percent of Counseled
No. of "uncertains" on MDS	844	100.00%	
Number Counseled	496	58.77%	100.00%
Number That Said No	349	41.35%	70.36%
Number That Said Yes	147	17.42%	29.64%

Number Transitioned	22	2.61%	4.44%

Figure 7: Southwestern Pennsylvania AAA from 10/1/2006 to 6/30/2007

Transition Statistics	Number of Persons	Percent of Uncertains	Percent of Counseled
No. of "uncertains" on MDS	804	100.00%	
Number Counseled	385	47.89%	100.00%
Number Referred for Transition	125	15.55%	32.47%
Number Transitioned from MDS List	31	3.83%	8.00%

Figure 8: Lehigh County Aging and Adult Services from 7/1/2006 to 6/30/2007

Transition Statistics	Number of Persons	Percent of Uncertains	Percent of Counseled
No. of "uncertains" on MDS List	1569	100.00%	
Number Still There When Called	897	57.20%	
Number Counseled	434	27.66%	100.00%
Number Transitioned from MDS List	24	1.53%	5.53%

How Many Persons Were Transitioned During SFY 2006- 2007?

Figure 9 below shows the number of transitions by AAA as a percent of nursing home beds, the 1,437 transitions made by persons aged 60 and over during FY 2006 - 2007, the number of nursing homes in the AAA area, and the number of nursing home beds in the AAA area.

- The first column shows the number of transitions for persons over the age of 60 as a percent of the nursing home beds in the AAA area. This is an important indicator of the intensity of transitions. The average AAA had transitions that were 2.28% of its nursing home beds.

- The second column shows transitions of persons over the age of 60. A correlation analysis shows that about half the variance in transitions is accounted for by the number of nursing homes and beds in the AAA area. In other words, it makes sense that larger AAAs have more transitions since they

have larger staff and more nursing homes. However, size alone accounts only for half the variance in the number of transitions accomplished. Other factors, such as the efficiency and level of effort displayed by the AAA, account for the other half.

- The column on the far right is labeled "Cumulative % Discharges." This is not self-explanatory. The column shows the cumulative percentage increase in discharges over the fiscal years covering the period January 2001 through July 2007. The increase is found by summing the year-to-year percentage increases in discharges. This is a gross measure of discharge activity across the time period. The number of discharges is a difficult variable to work with since the level of nursing home discharges depends on: population increases, the number of short term Medicare rehabilitation patients that nursing homes increasingly seek, changing trends in senior living alternatives, eligibility, other changes in state programs such as the building of foster homes and other residential programs, and nursing home transition programs.

  The cumulative percent of discharges has a slight positive correlation, .17, with the number of transitions. Other factors, such as the increasing emphasis on Medicare rehabilitation, probably have impacts that are more important on the number of discharges.

Figure 9: Transition Information about AAA Areas during SFY 2006 – 2007

AAAs	Transitions as % of Beds	Transitions	Number of Nursing Homes in County	Number of Nursing Home Beds in County	Cumulative % Discharges
Pike	8.18%	9	2	110	3.40%
Jefferson	6.13%	23	4	375	6.15%
Potter	4.71%	8	2	170	-14.89%
Beaver	4.70%	57	7	1,214	36.35%
Clarion	4.50%	15	4	333	-0.40%
Hunt/Bed/Fulton	4.04%	22	6	544	4.85%
Perry	3.93%	11	4	280	20.48%
Forest, Warren	3.63%	21	6	578	2.20%
Cameron, Elk, McKean	3.60%	32	9	890	-18.30%
Armstrong	3.55%	13	4	366	4.85%
Crawford	3.49%	29	7	830	-3.44%
Southwest	3.17%	75	23	2,367	-2.88%

AAAs	Transitions as % of Beds	Transitions	Number of Nursing Homes in County	Number of Nursing Home Beds in County	Cumulative % Discharges
Clearfield	3.09%	21	4	679	6.43%
Allegheny	2.98%	243	63	8,166	33.77%
Erie	2.97%	65	21	2,187	21.07%
Somerset	2.80%	19	7	678	8.95%
Butler	2.78%	44	13	1,582	29.19%
Indiana	2.45%	12	5	490	26.27%
Blair	2.39%	37	12	1,551	-3.63%
Wayne	2.34%	9	3	384	-13.36%
Centre	2.31%	16	6	692	20.57%
Franklin	2.23%	22	7	987	30.25%
BSST	2.22%	26	12	1,171	33.65%
Columbia, Montour	2.11%	20	7	947	14.47%
Schuylkill	1.97%	33	14	1,671	34.11%
Lawrence	1.92%	16	10	833	-1.56%
Northumberland	1.67%	17	9	1,016	20.70%
Berks	1.67%	41	16	2,458	25.42%
Monroe	1.67%	7	3	420	-5.70%
Adams	1.64%	14	7	855	19.17%
Mercer	1.55%	18	15	1,159	23.23%
Mifflin/Juniata	1.55%	10	7	646	45.16%
Northampton	1.46%	30	13	2,057	28.00%
Westmoreland	1.31%	32	23	2,451	13.43%
Montgomery	1.30%	93	60	7,134	26.66%
Union Snyder	1.29%	7	4	544	29.37%
Lehigh	1.24%	34	16	2,752	32.91%
Cambria	1.21%	13	10	1,071	23.59%
Cumberland	1.20%	24	16	2,000	47.71%
Lebanon	1.20%	15	12	1,252	17.30%
Clinton, Lycoming	1.00%	14	11	1,397	5.07%
Lancaster	0.77%	32	32	4,182	14.59%
Philadelphia	0.72%	55	50	7,666	16.59%

AAAs	Transitions as % of Beds	Transitions	Number of Nursing Homes in County	Number of Nursing Home Beds in County	Cumulative % Discharges
Dauphin	0.57%	8	9	1,399	18.69%
Luzerne, Wyoming	0.53%	16	27	3,017	19.23%
Lackawanna	0.47%	11	19	2,360	40.86%
Delaware	0.42%	18	28	4,325	49.10%
Venango	0.41%	2	5	491	7.13%
Bucks	0.40%	15	32	3,752	21.77%
York	0.36%	8	16	2,193	17.85%
Chester	0.20%	5	21	2,462	36.68%
Carbon	0.00%	0	3	441	12.69%
Total	1.60%	1,437	726	89,575	22.14%

The number of persons under the age of 60 who were transitioned during SFY 2006 - 2007 was 1,437 persons. Under-60 providers transferred another 227 persons for a total of 1,664 persons.[60]
The average length of stay in the nursing facility prior to transition was 164 days, ranging from 9 to 2,742 days.[61]

Staffing at the Transition Agencies

Each of the agencies interviewed provided information on the size of its organization, as well as how many and what kind of staff, the number of full-time equivalent (FTE) transition workers that were assigned to transition work. Depending on the agency, staff that aided the transition activities included the head of the agency, a middle management supervisor, a unit supervisor, transition workers, a nurse, peer counselors, skill training counselors, and clerical staff. The amount of work performed by persons in these positions depended on the size and nature of the agency. To control for variations in the size and nature of the agency, information was collected on the number of full-time equivalent transition workers excluding management and support staff. The figure below shows only the number of estimated full-time equivalent transition workers by agency and the number of persons transitioned.

[60] Data by county are not available for this group of under-60 residents that were transitioned.
[61] This information on the mean average length of stay is based on an unpublished August 2007 study by Annette Chavez of Myers and Stauffer of 1,592 persons who had been transitioned during SFY 2006-2007. Chavez also reports that the median length stay was 81 days.

Figure 10: Number of Persons Transitioned & Full Time Equivalent (FTE) Transition Workers FY 2006 - 2007

Agencies Ranked by Number of Transitions	Number of Persons Transitioned During SFY 2007	Number of FTE Transition Workers	Number Peer Coordinators
1	243	7	
2	75	2	
3	55	5	
4	44	3.5	2
5	34	1	
6	32	1	
7	32	7	12
8	26	2	
9	24	1	7
10	21	2.5	
11	21	2	
12	18	1	
13	18	1	
14	16	1	
15	12	1.5	
16	12	1	
17	11	1.5	
18	8	2	
19	7	1.5	5
20	0		
Total numbers of persons transitioned and workers	709	44.5	26
Avg. number of persons transitioned per worker	15.93		

The table shows that across all 20 agencies the average worker helps to transition about 16 persons a year or one and one half persons a month. When agencies are grouped as to whether they are an AAA, a CIL, or a non-profit, the average number of persons transitioned per AAA worker was approximately 23.5 per year, the average per CIL worker was 8.4 per year, and the average for the only non-profit Center doing transitions was eight per year.

The smaller number of persons transitioned reflects the longer and more difficult transition process that the CILs and non-profits encounter. All agencies interviewed provided descriptions of transitions that they were doing. Descriptions of transition assistance show that it is a lengthy and labor-intensive process. Examples were typically provided of working with persons for six to twelve months, and a few agencies cited longer time intervals. For example, an agency staff member may visit a person for 3-4 months and talk, provide information, and establish a relationship. Then the person may enlist the staff member's help in finding alternative housing and there will be a flurry of work (e.g., getting a birth certificate and new social security card to meet the identification requirements of the public housing authority). Once the person is on a waiting list for the housing, then there needs to be monitoring and care planning such as identifying desirable assistive technology changes, taking the person to visit potential housing opportunities, and talking to ambivalent family member about planning for post-discharge. When an opening does occur, there is the work of doing the transition and the follow-up after that.

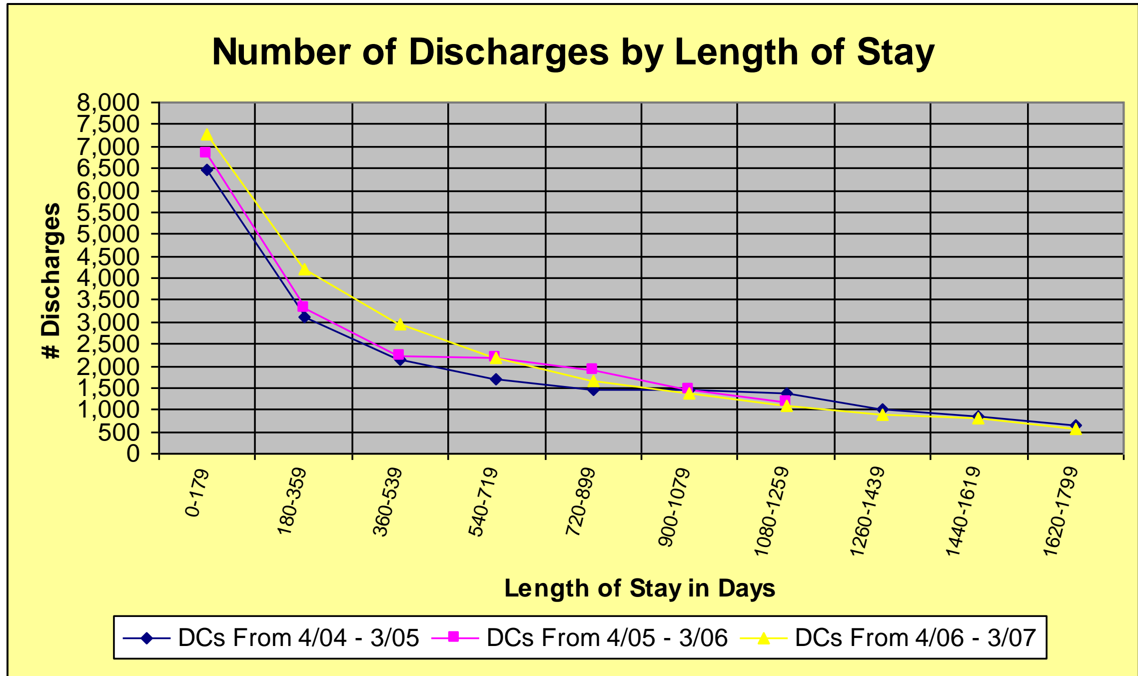
For the AAAs, an average of 23.5 persons per year, or 2 persons per month, is reasonable for a new statewide transition program. An inexperienced transition worker would be expected to help 1-2 persons a month who are 60 years of age or more.

Discharges by Year and Length of Stay of Persons

Figure 11 below shows the length of stay of persons discharged over a recent three-year period. In examining the impact of a nursing home transition programs, it is useful to look at changes in the number of discharges from year to year. However, nursing homes nationally have been increasing the percentage of Medicare post-acute patients they are discharging and, increases in discharges are partially due to this trend. Therefore, it is useful to look at discharges while controlling for length of stay since the Medicare length of stay for post-acute services is short, about 21 days. The table below shows there is a significant impact in the third year of data especially in the numbers of persons discharged who had been in the nursing home for six to eighteen months. Discharges of persons who had been in the nursing home for six to eighteen months increased from 3,000 to 4,000 persons. Similar numbers of persons might have been helped in the April 2004 - March 2005 and April 2005 - March 2006 periods had the larger transition programs been available during these years. This also implies that fewer Medicaid paid days in nursing facilities would have been paid for by the state.

The higher number of discharges in the April 2006 to March 2007 period indicates that Medicaid days are being taken off-line and that there is an ongoing cost avoidance effect here.

Figure 11: Number of Discharges by Length of Stay: April 2004 – March 2007



Definition of a Transition

Removing a Barrier

Nursing home transition programs need to have a clear concept of when a "transition" can be said to occur, in order to defend the program from the charge that persons would have left anyway and that the program is not cost effective. The definition used by the program in SFY 2006 - 2007 was that a specific "barrier" had to be present and removed with the help of a transition worker.

State-Level Barriers to Transition

Seventeen of the 20 agencies said that the most commonly described barrier to transition was the lack of affordable and accessible housing, especially for the under-60 population. In contrast to most regions of the state, three of the AAAs reported that housing was not the most significant barrier. In those regions, individuals already had a house or an apartment and waiting lists were not long.

First, housing is a large and complex area that AAAs have not traditionally been involved with. All but three AAAs reported that they had to learn a lot about housing in the fall of 2006 and that this was an unfamiliar activity for them. The two state departments involved in nursing home transition activities have undertaken frequent housing initiatives, including the development of statewide housing databases and the hiring of regional housing coordinators.

The comments made about housing were similar across agencies: persons in nursing homes often sell their homes and feel that they have lost everything. Persons cannot access subsidized housing because the waiting list for subsidized apartments is closed or lengthy. Even if consumers are able to get on the list for subsidized housing there is no guarantee that an accessible unit will be available. Issues of risk arise when the only available apartment is on the third floor, and nursing homes will not discharge individuals who are at risk. Relationships with local housing agencies vary considerably and when a subsidized apartment opens, the nursing home resident may have bad credit, a criminal history, or no identification papers, which prevent the person from taking the housing slot.

On the one hand, housing is a problem in and of itself. On the other hand, housing is a more significant problem because the state's Medicaid waiver programs choose to emphasize in-home services and do not develop residential programs. States that have been the most successful in balancing long-term programs, such as Oregon and Washington, have typically developed both in-home and residential options in waiver programs. The residential options used by these states include adult foster homes and assisted living.

During SFY 2006 - 2007 the state found itself in a position where it was becoming very effective in helping persons to leave nursing homes, but was slow in building Medicaid-funded options for the persons to go to. In July 2007, Governor Rendell signed Senate Bill 704, which provides for the regulation of assisted living services and, according to commentators, would permit Pennsylvania to add assisted living as a Medicaid service.[62]

Second, educating nursing home staff was also described as a frequent barrier to transition. Initially, agencies sent out letters and met with administrators, nurses, and social workers. This education work is ongoing given the high level of personnel turnover within nursing homes. All 20 agencies interviewed reported that they dealt with a couple of resistant nursing homes. The role of nursing home transition versus the role of discharge planning was uniformly described as a grey area. Two agencies described efforts in contacting state department staff for help with obtaining access to a nursing home. The help was successful in one case and not the other.

Third, the state has a Medically Needy Program that has an inadvertent institutional bias built into it. Pennsylvania is one of 30 states that uses a "medically

[62] Senate Bill 704, at: http://www.legis.state.pa.us/WU01/LI/BI/BH/2007/0/SB0704.HTM

needy" nursing home eligibility provision. The use of this federally allowable option helps persons who are normally "over income" to be eligible for Medicaid. If persons spend their income for medical services, and the amount of income remaining is below a state's Medicaid financial standard, then they can be eligible for Medicaid. This is a generous policy. However, when enacted for nursing home services, but not for home and community-based services, an institutional bias results.

In the nursing home the medically needy level is set at the cost of the nursing home services which could be, for example, as high as $6,000. If the state does not also use a Medically Needy Program for home and community services, then it is possible for a person who has been eligible for Medicaid in the nursing home for years to lose eligibility upon leaving the nursing home for an HCBS setting. Such persons are *over income* in the community because there is no equivalent income level for HCBS services. Income eligibility for HCBS is at 300% of the Federal Supplemental Security Income (SSI) level or $638 in 2008.

For example, one local agency provided an example of a person who had a Medicaid-paid stay in the nursing home for 10 years, but was then ineligible for Medicaid when they wished to leave the nursing home. This setting-based eligibility creates an economic coercion that circumscribes freedom of choice.

Evaluators requested information on the Medicaid eligibility of persons who were transitioned: how many persons were eligible for Medicaid in the nursing home and how many of those lost their Medicaid eligibility when they decided to live outside the nursing home? State staff did not provide this information.

Use of the MA 51 Form and/or Requiring a Doctor's Signature for Waiver Services

At the time the evaluation was done, the state required a physician to complete a form called the MA 51 before a person was allowed to receive Medicaid waiver services.[63] The observation that the form is an obstacle to home and community-based services has been made before.[64] Evaluators did not ask agency staff about the use of the MA 51, however, one of the twenty agencies interviewed volunteered that the requirement to obtain an MA 51 was a barrier.

This requirement is shown in the instructions to the County Assistance Offices in the Department of Public Welfare's Long-Term Care Handbook at 468.4 DETERMINING ELIGIBILITY FOR LTC FACILITY SERVICES, where it instructs eligibility workers in 468.4 1, "Verify that the individual has a medical need for nursing facility services by reviewing the MA-51." The text in 468.4 cross-references 55 Pa. Code § 181.452

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[63] A copy of this form is obtainable from http://www.northamptoncounty.org/northampton/lib/northampton/depts/humanservices/aging/omapma51.pdf.

[64] See *Pennsylvania Community Choice Program***,** ADRC Technical Assistance Special Topic Conference Call Summary. Available at: http://www.adrc-tae.org/tiki-download_file.php?fileId=554.

The requirement that a physician needs to certify the level of care assessment is a stricter standard than recommended by federal practice. The Code of Federal Regulations makes no comment on the requirement that a physician must determine the level of care. Rather CFR 441.303(c)(1) requires that the waiver specify the credentials (minimum qualifications) of level of care evaluators.

Appendix B of the Center for Medicare & Medicaid Services (CMS), "Instructions, Technical Guide and Review Criteria**"** for waivers says, "The state has latitude in determining these credentials. However, the qualifications should be appropriate for the waiver's target population. Examples might include a physician, registered nurse, licensed social worker, or qualified mental retardation professional."[65]

Federal guidance on the practice of the state requiring physician certification of level of care for wavier services is clear in saying such practices are unnecessary and state, "When ICF/MR level of care is evaluated, it is not required that a physician recommend, certify, or verify that the individual should receive the level of care furnished through the waiver. Similarly, a physician certification or recommendation is not required for nursing facility level."[66]

The requirement that a physician certify level of care, whether using an MA 51 or a prescription, is also an expensive practice, given the delays in obtaining paperwork from physician offices. The state pays a nursing home reimbursement for every day of delay. Thus, delays of a week or even a few days, when multiplied by the number of persons who leave nursing homes and seek other state services, results in a sizeable hidden yearly cost to the state.

Finally, the increasing practice of physicians' charging for completing an MA 51 was mentioned in two interviews. The issue is that if the Medicaid recipient has to pay the doctor's office for getting an MA 51, then the payment is a de facto requirement for determining Medicaid eligibility. This is an impermissible co-payment since it is necessary for obtaining Medicaid services, but neither the requirement to pay nor the amount has been established in the Medicaid State Plan.

Hard Transitions versus Soft Transitions

Interview results indicate that it took about six months to develop and communicate a clear policy on what a barrier was and what a countable transition was. In the interviews in August and September of 2007, the definition of a transition was clearly described by all agencies as removing a barrier. However, in the fall of 2006, it was not clear what types of barriers would meet the definition. At first, agencies understood that a physical barrier must be removed by some action of the agency in order for a transition to be credited. For example, for an individual who could not access steps to their home, a ramp was provided and that barrier was lifted. Other agencies had an

[65] Centers for Medicare & Medicaid Services. (2006), p. 91.
[66] Ibid., p. 92.

initial understanding that a transition would be counted for anyone who returns to the community outside of the realm of a "normal" discharge. That is, if it were not for the involvement of the agency, the consumer would remain in the nursing home. One agency reported that its understanding was that some amount of time and money must be spent to count a transition. If an individual did not need funds to return to the community, it was not a transition.

Contributing to confusion about countable transitions was that staff at the two state departments had underlying differences about the definition, which did not become apparent until a statewide conference in the fall of 2006, when the staff presented these differing views. Four agencies commented on these differences and cited them as an example of how state policy-making was typically done. The differences revolved around how tangible a barrier had to be. Questions arose as to whether the removed barrier needed to be a physical entity such as a home modification, or whether it could be less tangible such as the providing of information. These differences were captured in the lexicon of "hard" and "soft."

How and when agencies learned about acceptable definitions of transition depended on where the agencies were in the word-of-mouth communication chains. Agencies reported that they learned the terms ''hard transition" and "soft transition" at meetings and on technical assistance calls held between the months of September and December 2006. Two agencies reported learning of the distinction as late as April and May 2007. Agencies offered different understandings of why a difference between *hard* and *soft* transitions developed. One point of view was that these definitions came about because there was concern about low transition numbers, while another belief was that some providers were over-counting transitions and that this needed to be controlled. One AAA reported that initially soft transitions were not counted because there had to be a "magnificent barrier" that was overcome.

A *hard transition* was described as the removal of a physical barrier such as the lack of housing, the lack of furnishings, or the need for assistive technology. Hard transitions were often associated with needing services that are reported in the state outreach forms. One AAA described the definition of a hard transition as a service that allows an individual to return home.

The definition for *soft transition* was not the same at every agency. Across agencies, the provision of information and emotional intervention appeared to be a defining characteristic of a soft transition. Information was provided to persons who did not know how to access the system or needed someone to advocate with the nursing home and doctor. Overall, a soft transition was counted if the information provided changed the decision as to whether the person stayed in the nursing home. However, one agency counted a soft transition as occurring when a person received long-term living counseling and was referred to the nursing home transition team even though the team never worked with the person. One agency gave an example of a daughter who does not want her parent to transition, and the need to educate the daughter as the barrier. Another

example given was a person who leaves the nursing home to be on a Medicaid waiver program and the barrier is the extra work needed to enroll the individual.

By the end of the SFY 2006 - 2007, the common practice was to count soft transitions, although one agency felt there was still no clear practice or policy. Despite the common practice, staff interviewed at three agencies expressed reservations about counting soft transitions and only felt comfortable reporting hard transitions because "there is no doubt that they were truly transitions."

Three Limitations on the Counting of Transitions

During SFY 2006 - 2007, the state used three definitional limitations on when a person can be counted as a transition:

- *First*, both a Center and an AAA reported that they helped people move to a Personal Care Home. However, individuals transitioned to a personal care home could not be counted.
- *Second*, agencies in counties near state lines reported that a person who was transitioned to another state would not be counted as a transition.
- *Third,* one agency reported that individuals enrolled in a waiver program prior to nursing home admission could not be counted as a transition, even if the nursing home was viewed as a long-term placement. This was a situation where the person was on a waiver program and then leaves the nursing home to return to the waiver program.

Payments to Agencies

The transition program would not have been possible without funding for local agencies. Pennsylvania's decision to provide statewide funding contrasts favorably to states in which small amounts of Title VIIB rehabilitation funds are distributed to selected CILs to fund small transition programs.

In Pennsylvania, the state's funds were allocated to AAAs and CILs. The advantages of the allocation were that the money provided was proportional to the size of the Medicaid populations in the agency's area, both base funding and incentives were provided, the level of funding was helpful to most agencies, and the money allocated between under-60 providers and over-60 providers matched the number of transitions done by these providers. As a first time effort, this was a reasonable way of allocating the funds.

A disadvantage of the methodology was that it was an allocation and it was done without analyzing agency capabilities and costs resulting in the larger agencies receiving less on average per transition while the small agencies received more per transition for fewer transitions.

The state developed two sources of funds to support its enhanced nursing home transition programs: First, the Pennsylvania Department of Aging (PDA) made funding available to assist the transition of non-Medicaid persons who were unable to receive state-funded services from the state's OPTIONS program because of the program's waiting list.

The second source of funds was base and incentive payments to local agencies. The agencies were split into tiers based on the number of Medicaid residents in the counties that they operated in. Originally, the AAAs were divided into three tiers and then this was expanded to six tiers, as can be seen in the following table. The incentive payments were structured into four different types. The rationale for this approach was to make attainable goals that would impact all agencies and result in a transformation of the agency's activities. Half the money was provided up-front for base improvements. The intent was to front-load the money so that agencies would have resources to transform their activities. Using a pay-for-performance strategy, another one-quarter of the money was to be given when half the number of persons were transitioned, another one-quarter was to be given when the other half of the persons were transitioned. Finally, a bonus was discussed for those who transitioned everybody.

The funding took place in context of uncertainty about future funding and agency directors interviewed were wary about incurring permanent staff costs given this uncertainty.

Payments to Area Agencies on Aging

Figure 12 below shows that the goals were set at an average of 4.4% of the Medicaid population. In other words, the agencies received half the projected funds upfront to begin the transition activity, they would receive the third quarter of the funds when 2.2% of the Medicaid population in their nursing homes had been transitioned, and they would receive the last quarter of the funds when an additional 2.2% had been transitioned.

Figure 12: Amount of Total Projected Payments & Projected Transitions for AAAs SFY 2006 – 2007

Area Agency on Aging	Number of Medicaid Residents in Nursing Homes	Amount of total Payments	Number to be Transitioned	% to be Transitioned	Projected Cost per Transition
Philadelphia	5,370	$ 120,000	235	4.38%	$ 511
Allegheny	4,314	$ 120,000	188	4.36%	$ 638
BSST	3,857	$ 120,000	168	4.36%	$ 714
Montgomery	3,843	$ 120,000	168	4.37%	$ 714
Luzerne/Wyoming	3,293	$ 120,000	144	4.37%	$ 833
Delaware	2,444	$ 100,000	107	4.38%	$ 935
Bucks	2,228	$ 100,000	97	4.35%	$ 1,031
Lancaster	2,163	$ 100,000	94	4.35%	$ 1,064
Lehigh	1,711	$ 80,000	75	4.38%	$ 1,067
Wash/Fay/Gr	1,598	$ 80,000	70	4.38%	$ 1,143
Berks	1,562	$ 80,000	68	4.35%	$ 1,176
Westmoreland	1,473	$ 80,000	64	4.34%	$ 1,250
Lackawanna	1,446	$ 80,000	63	4.36%	$ 1,270
Erie	1,349	$ 80,000	59	4.37%	$ 1,356
York	1,322	$ 80,000	58	4.39%	$ 1,379
Cam/Elk/McK	1,191	$ 70,000	52	4.37%	$ 1,346
Northampton	1,132	$ 70,000	49	4.33%	$ 1,429
Schuylkill	1,114	$ 70,000	49	4.40%	$ 1,429
Chester	1,086	$ 70,000	47	4.33%	$ 1,489
Columbia/Montour	1,044	$ 70,000	46	4.41%	$ 1,522
Cumberland	963	$ 70,000	42	4.36%	$ 1,667
Dauphin	914	$ 70,000	40	4.38%	$ 1,750
Butler	891	$ 70,000	39	4.38%	$ 1,795
Beaver	774	$ 50,000	34	4.39%	$ 1,471
Blair	757	$ 50,000	33	4.36%	$ 1,515
Lebannon	743	$ 50,000	32	4.31%	$ 1,563
Cambria	708	$ 50,000	31	4.38%	$ 1,613
Hunt/Bed/Fulton	662	$ 50,000	29	4.38%	$ 1,724
Northumberland	654	$ 50,000	29	4.43%	$ 1,724
Mifflin/Juniata	611	$ 50,000	27	4.42%	$ 1,852
Mercer	608	$ 50,000	27	4.44%	$ 1,852
Clinton/Lycoming	583	$ 50,000	25	4.29%	$ 2,000
Crawford	525	$ 50,000	23	4.38%	$ 2,174
Lawrence	485	$ 40,000	21	4.33%	$ 1,905
Adams	479	$ 40,000	21	4.38%	$ 1,905
Franklin	456	$ 40,000	20	4.39%	$ 2,000
Clearfield	425	$ 40,000	19	4.47%	$ 2,105
Somerset	419	$ 40,000	18	4.30%	$ 2,222
Forest/Warren	410	$ 40,000	18	4.39%	$ 2,222
Centre	336	$ 40,000	15	4.46%	$ 2,667
Venango	324	$ 40,000	14	4.32%	$ 2,857
Carbon	309	$ 40,000	13	4.21%	$ 3,077
Monroe	289	$ 40,000	13	4.50%	$ 3,077
Union/Snyder	285	$ 40,000	12	4.21%	$ 3,333
Indiana	252	$ 40,000	11	4.37%	$ 3,636
Jefferson	229	$ 40,000	10	4.37%	$ 4,000
Wayne	226	$ 40,000	10	4.42%	$ 4,000
Armstrong	200	$ 40,000	10	5.00%	$ 4,000
Clarion	181	$ 40,000	10	5.52%	$ 4,000
Perry	174	$ 40,000	10	5.75%	$ 4,000
Potter	97	$ 40,000	10	10.31%	$ 4,000
Pike	59	$ 40,000	10	16.95%	$ 4,000
	58,568	$ 3,280,000	2,577	4.40%	$ 1,273

Department records indicate that a transition goal of approximately 2,500 persons emerged among discussions of department staff, the Governor's Office of Health Care Reform, and the Long-Term Living Council. When converted to a percentage it was roughly 4.4%.

None of the AAAs interviewed knew that the goal they were to reach was 4.4% of their Medicaid population. The fact that local agencies did not know was a puzzling response to state staff that worked on the incentive payments since the incentive payments were explained in regional meetings with local agency directors and one of the slides in the Power Point presentation used at these roll-out meetings makes reference to the statewide goal of transitioning 2,500 persons and says this is approximately 4% of the state's Medicaid population. A review of documents and electronic files collected during the evaluation does not find other references to 4%.

What may have happened is that even though the four percent figure was mentioned at the rollout meetings agencies did not later connect a 4% to the goals the state assigned them. The agencies knew the number of persons they were to transition, but not how the goal was obtained. One agency knew that an allocation method was used to arrive at each agency's funding level but did not know the basis of the allocation. Other agencies mentioned it was tied to Medicaid use of nursing homes but were not clear what the tie was.

Was 4.4% a reasonable goal? On the one hand, Pennsylvania had a solid history of steady improvements in the growth of its nursing home transition program and the coordination of state efforts. Aiming for a higher goal was a natural inclination given these years of work. On the other hand, this top-down goal was not developed through discussions with specific AAAs about their history and organizational capabilities. A 4.4% goal was a challenge for those local AAAs that had not had previous experience with operating transition programs,

Data from the results of the CMS-funded nursing facility transition grants indicates that start-up programs usually have low numbers the first year. A table in the appendix shows the number of persons transitioned by the 33 states that obtained a 2001 or 2002 grant. The numbers are low even at the end of three years.[67]

Other studies also report a small number of persons participating. For example, a study of Michigan's diversion program showed that the state worked with 118 persons over a three-year period.[68] A Delaware study that looked at data from six states compared the number of persons transitioned as a percentage of the nursing facility population, and found the following results:[69]

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[67] O'Keeffe, J. (2005, June).

[68] Supiano, K. Carroll, A., & Blomquist, A. (2004).

[69] Lewin Group. (2006).

Figure 13: Percentage of Nursing Facility Residents Helped by Transition Efforts

State	First Year	Second Year
Texas	1%	5%
New Jersey	1%	4%
Pennsylvania	1%	
Utah	3%	3%
Colorado	1%	
Indiana	5%	

The difficulties of having high goals were compounded by the state's comments that the incentive funds were one-time payments and there was no guarantee that payments would be made in future years. Thus, the first half of the payments were described as transformation payments to cover the administrative costs of changing existing staff assignments and making other costs necessary to convert existing operations.

Staff at all agencies interviewed were directly asked if the money was an incentive and no one said the money was an incentive to them. One person volunteered the comment, "There was a mad scramble for the money," and another person said that other agencies really went for the money. The general perspective was that the money was necessary and nice to have, but it was not an incentive. As reported by agency staff, the funding structure left agency administrators in an awkward position. They were mandated to begin a new program, but had to use staff already assigned to other programs. If the transformation funds were used to hire new staff, then there was no assurance of funding for staff beyond the first year. Larger organizations had the capability of shifting funds and staff. The burden of juggling this set of demands and resources seems to have been felt most keenly by the mid-sized and smaller agencies that had less flexibility to transfer staff assignments.

At year's end, the AAAs helped 1,437 persons to leave nursing homes, 55% of a projected 2,577. Correspondingly, the AAAs received an average 56% of the third quarter of funding, approximately $500,000 out of a potential $780,000, and approximately 53% of the fourth quarter funds, approximately $453,000 out of $860,000.

Was this a successful effort given that only 55% of its goal was attained? Yes, it was. The number of persons transitioned was a reasonable result given the level of funding available and the staff time that could be purchased with this funding.

As the table above shows, the incentive payment structure had built into it substantial differences in the cost per transition that agencies could receive: from $511 to $4,000 per person transitioned. On average, the more persons you had to transition, the less funding per person you received. The methodology helped the agencies with the smallest transition goals since they received a minimum guaranteed amount. The planned distribution probably adversely affected the larger agencies. While some economies of scale can be obtained by a larger agency, such as spreading supervisory costs over more workers, having more transition workers does not lower the cost of the average transition.

As an economic activity, nursing home transition work is labor-intensive, and this is not an economic activity where larger capital expenditures result in dramatic increases in worker productivity. Larger agencies have more nursing homes to gain access to, more admissions to counsel, and greater numbers of residents to work with.

The next figure shows, by AAA, the base transformation amount received and the actual incentive payments received for both the first half of the year and the second half. The table also shows the number of persons transitioned and the average payment each AAA received per transition.

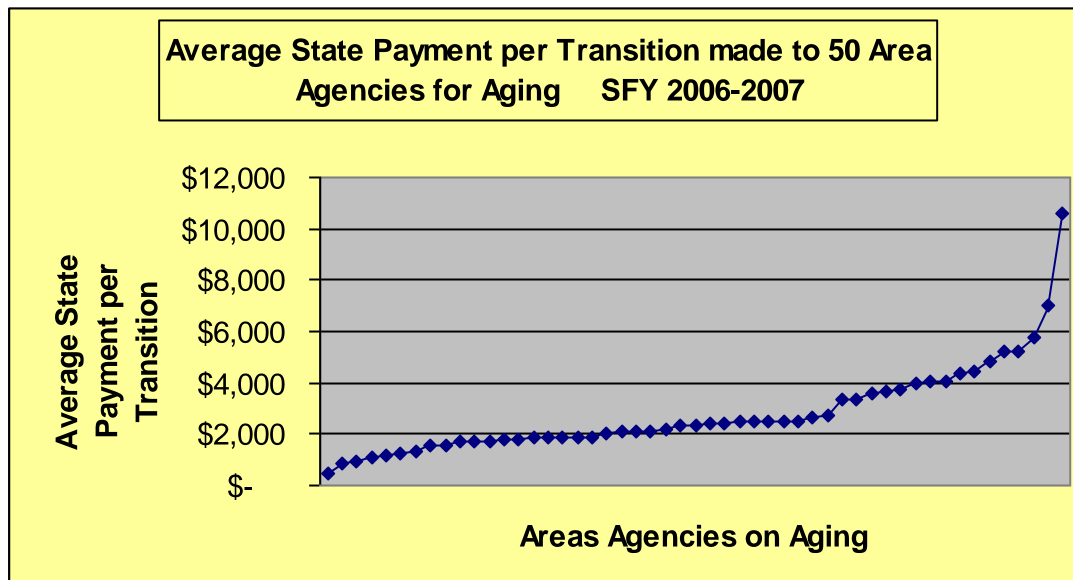
Figure 14: Amount of Total Payments & Transitions for AAAs SFY 2006 – 2007

AAA	Start-Up Transformation Funds Received	1st half Payments Receieved	2nd half Payments Received	Number of Persons Transitioned	Amount Received per Person
Allegheny	$ 60,000	$ 9,600	$ 45,400	243	$ 473
Beaver	$ 25,000	$ 15,000	$ 10,000	57	$ 877
Montgomery	$ 60,000	$ 11,418	$ 17,826	93	$ 960
Wash/Fay/Greene	$ 40,000	$ 15,000	$ 25,000	75	$ 1,067
Philadelphia	$ 60,000	$ 4,309	$ 319	55	$ 1,175
Erie	$ 40,000	$ 15,000	$ 25,000	65	$ 1,231
Blair	$ 25,000	$ 15,000	$ 10,000	37	$ 1,351
Berks	$ 40,000	$ 12,222	$ 11,585	41	$ 1,556
Butler	$ 35,000	$ 15,000	$ 20,000	44	$ 1,591
Lehigh	$ 40,000	$ -	$ 18,389	34	$ 1,717
Crawford	$ 25,000	$ 15,000	$ 10,000	29	$ 1,724
Jefferson	$ 20,000	$ 15,000	$ 5,000	23	$ 1,739
Cam/Elk/McK	$ 35,000	$ 10,000	$ 11,613	32	$ 1,769
Franklin	$ 20,000	$ 15,000	$ 5,000	22	$ 1,818
Schuylkill	$ 35,000	$ 15,000	$ 11,034	33	$ 1,850
Northampton	$ 35,000	$ 9,000	$ 12,474	30	$ 1,882
Westmoreland	$ 40,000	$ 4,038	$ 16,366	32	$ 1,888
Clearfield	$ 20,000	$ 15,000	$ 5,000	21	$ 1,905
Forest/Warren	$ 20,000	$ 15,000	$ 5,000	21	$ 1,905
Hunt/Bed/Fulton	$ 25,000	$ 11,250	$ 8,235	22	$ 2,022
Somerset	$ 20,000	$ 12,857	$ 7,143	19	$ 2,105
Adams	$ 20,000	$ 5,000	$ 4,583	14	$ 2,113
Lancaster	$ 50,000	$ 3,947	$ 13,750	32	$ 2,116
Centre	$ 20,000	$ 10,000	$ 5,000	16	$ 2,188
Cumberland	$ 35,000	$ 14,118	$ 6,400	24	$ 2,313
Lawrence	$ 20,000	$ 15,000	$ 2,917	16	$ 2,370
Lebanon	$ 25,000	$ 5,769	$ 5,263	15	$ 2,402
Clinton/Lycoming	$ 25,000	$ -	$ 9,333	14	$ 2,452
Mercer	$ 25,000	$ 15,000	$ 4,375	18	$ 2,465
Cambria	$ 25,000	$ -	$ 7,222	13	$ 2,479
Northumberland	$ 25,000	$ 12,500	$ 4,706	17	$ 2,483
Columbia/Montour	$ 35,000	$ 4,167	$ 10,833	20	$ 2,500
Armstrong	$ 20,000	$ 3,750	$ 8,750	13	$ 2,500
Clarion	$ 20,000	$ 15,000	$ 5,000	15	$ 2,667
BSST	$ 60,000	$ -	$ 11,584	26	$ 2,753
Delaware	$ 50,000	$ -	$ 9,844	18	$ 3,325
Indiana	$ 20,000	$ 15,000	$ 5,000	12	$ 3,333
Mifflin/Juniata	$ 25,000	$ 6,818	$ 3,750	10	$ 3,557
Perry	$ 20,000	$ 15,000	$ 5,000	11	$ 3,636
Luzerne/Wyoming	$ 60,000	$ -	$ -	16	$ 3,750
Bucks	$ 50,000	$ -	$ 9,052	15	$ 3,937
Pike	$ 20,000	$ 7,500	$ 8,750	9	$ 4,028
Lackawanna	$ 40,000	$ -	$ 4,800	11	$ 4,073
Wayne	$ 20,000	$ 15,000	$ 4,167	9	$ 4,352
Potter	$ 20,000	$ 3,750	$ 11,667	8	$ 4,427
Monroe	$ 20,000	$ 12,000	$ 1,875	7	$ 4,839
Union/Snyder	$ 20,000	$ 15,000	$ 1,429	7	$ 5,204
Dauphin	$ 35,000	$ -	$ 6,667	8	$ 5,208
York	$ 40,000	$ 5,870	$ -	8	$ 5,734
Chester	$ 35,000	$ -	$ -	5	$ 7,000
Venango	$ 20,000	$ -	$ 1,250	2	$ 10,625
Carbon	$ 20,000	$ -	$ -	0	
	$ 1,640,000	$ 449,883	$ 453,352	1437	$ 1,770

As Figure 14 above shows, the average AAA received $1,770 dollars in state support for a transition. The graph below shows the data in the table for the average state payment. The $1,770 is a useful number to establish since it is used in the calculation of the cost effectiveness of the transition program.[70] Again, there are substantial variations in the amounts received. The correlation coefficient between the number of transitions and the payment per transition is a negative .56. The more people transitioned, the lower the average state payment received.

It seems reasonable that the state would make a minimum transformation payment of $20,000 to those AAAs with fewer nursing homes in their region. What is harder to see as reasonable is the capping of transformation funds at $60,000 for the largest AAAs since this resulted in lower average state payments. Perhaps it was too low. There are modest economies of scale in a larger transition effort since relatively fixed administrative costs are spread over more transitions. However, transition work is labor intensive and the number of persons transitioned is a direct function of the number of full time equivalent (FTE) staff assigned to the work. Therefore, the average cost per person transitioned should have a modest decline as transitions increase.

Figure 15: Average State Payment per Transition Made to AAAs SFY 2006 – 2007



[70] The average could me adjusted by removing outliers. For a discussion of states that have measured the cost effectiveness of nursing home transition programs see Hendrickson, L., & Reinhard, S. (2006). Available at: http://www.hcbs.org/files/97/4838/MFPCostEffectivenessFinal090506.pdf.

Payments to Providers of Services to Persons under the Age of Sixty

The 15 participating Centers for Independent Living and non-profits working with persons under the age of 60 had a collective goal of 519 persons to transition. This represented about nine-tenths of one percent of the nursing home population in their counties. None of under-60 providers interviewed understood where their goal came from or that it represented less than one per cent of the Medicaid population in the counties in which they did transition work. As with the AAAs, the under-60 providers met about 53% of the goal, collectively transitioning about 277 persons out of a goal of 519.

Figure 16: Projected Transitions & Payments for Persons under the Age of 60 SFY 2006 – 2007

Providers for Persons under the age of 60	Number of Medicaid Residents in Nursing Homes	Amount of Projected Payments	Number to be transitioned	% to be Transitioned	Projected Payment per Transition
Liberty	22,597	$ 95,000	125	0.55%	$ 760
TRCIL	9,987	$ 65,000	70	0.70%	$ 929
CRI	7,427	$ 65,000	66	0.89%	$ 985
NEPACIL	289	$ 65,000	49	16.96%	$ 1,327
AIM	4,468	$ 40,000	39	0.87%	$ 1,026
HSMA		$ 40,000	33		$ 1,212
VFI	3,397	$ 40,000	30	0.88%	$ 1,333
JEVS	2,228	$ 30,000	19	0.85%	$ 1,579
Cumberland	2,051	$ 30,000	18	0.88%	$ 1,667
UCP South Central		$ 30,000	16		$ 1,875
TRIPIL		$ 30,000	14		$ 2,143
ARCIL	3,293	$ 30,000	10	0.30%	$ 3,000
CIL of Central PA	611	$ 30,000	10	1.64%	$ 3,000
UCP of So Alleghenies	419	$ 30,000	10	2.39%	$ 3,000
UCP Chester		$ 30,000	10		$ 3,000
Total		$ 650,000	519		$ 1,252

As with the AAAs, the methodology used to create transformation and incentive payments resulted in substantial variations in the amounts received per person. The correlation coefficient between the number of targeted transitions and the projected payment per transition is a negative .74, a higher negative correlation then the AAA correlation. The more people transitioned, the lower the average state payment received.

The agencies providing services to persons under the age of 60 helped 277 persons transition, or approximately 54% of the targeted goal of 519. The table below shows the payments received. Everyone received the one-time transformation funds, but received incentive payments to the extent that the first and second half goals were met. Funds to pay for 35 OMNIA licenses were included in the transformation funds.

Figure 17: Transitions & Payments Received for Persons under the Age of 60 SFY 2006 - 2007

Providers for Persons under the age of 60	Start-Up Transformation Funds Received	1st half Payments Receieved	2nd half Payments Received	Number of Persons Transitioned	Amount Received per Person
CIL of Central PA	$ 15,000	$ 2,500	$ 5,000	2	$ 11,250
UCP of So Alleghenies	$ 15,000	$ -	$ 5,000	3	$ 6,667
UCP Chester	$ 15,000	$ 3,750	$ 6,700	7	$ 3,636
ARCIL	$ 15,000	$ 3,750	$ 8,300	8	$ 3,381
TRIPIL	$ 15,000	$ -	$ 7,500	7	$ 3,214
UCP South Central	$ 15,000	$ 1,667	$ 7,000	9	$ 2,630
NEPACIL	$ 25,000	$ 3,000	$ -	12	$ 2,333
JEVS	$ 15,000	$ 5,385	$ 14,400	17	$ 2,046
Cumberland	$ 15,000	$ 4,286	$ 6,400	16	$ 1,605
VFI	$ 20,000	$ 7,500	$ 8,300	24	$ 1,492
AIM	$ 20,000	$ 6,875	$ 4,300	21	$ 1,485
TRCIL	$ 25,000	$ 5,357	$ 20,700	44	$ 1,160
CRI	$ 25,000	$ 8,077	$ 18,900	46	$ 1,130
Liberty	$ 25,000	$ 7,600	$ -	32	$ 1,019
HSMA	$ 20,000	$ 3,846	$ 4,600	29	$ 981
Total	$ 280,000	$ 63,592	$ 117,100	277	$ 1,240

The under-60 providers received approximately 71% of the possible incentive funds that they could have received. The amount received per person varies substantially. Again, the actual payments resulted so that the amount per person received by larger transition providers was smaller. The correlation coefficient was a negative .65. Again, this is a strong correlation and not grounded in an analysis of agencies' transition costs.

The table below compares the payments received and the persons transitioned. The incentive methodology evenly distributed funds between the under-60 providers and the AAAs. As the table shows, the under-60 providers received about 15% of the payments and did 16% of the transitions.

Figure 18: Payments Received & Persons Transitioned, SFY 2006 - 2007

	Payments Received	%
Under 60 Providers	$ 460,692	15.34%
AAAs	$ 2,543,235	84.66%
Total	$ 3,003,927	100%
	Persons Transitioned	%
Under 60 Providers	277	16.16%
AAAs	1,437	83.84%
Total	1,714	100%

Source: Pennsylvania Office of Long Term Living, January 2008

The collection of additional information on how the state can fund the agencies' nursing home transition activities would be useful. This information could range from the preparation of case studies on local agency costs, to a mailed cost report form filled out by all agencies. This information on local agency costs could be used to study alternative payment methods such as flat-rate reimbursement per transition, negotiated rates by provider such as a transition capitation concept, the use of cost-based amounts, or flat-rate amounts.

Training and Technical Assistance Activities

The state departments working on nursing home transition emphasized training and technical support through regional and national conferences, telephone calls, web site development, and liaison workers. As part of the evaluation, the state asked that feedback be collected from agencies on the training and technical assistance efforts made by the state.

Regional Conferences

Regional Conferences were held during August 14th and August 30th of 2006 to roll out the new program. The agencies surveyed provided few comments regarding regional conferences. A criticism from two agencies was that the meetings were largely geared towards agencies with no prior experience in negotiating NHT, therefore, these meetings held little value for those that had already been engaged in these activities for some time. One agency commented that its NHT regional training session, held on Aug 30, 2006, presented social work training that was too basic. Two agencies stated that the content of training sessions was vague and over-generalized, and that they would have preferred being presented with more practical, executable information (e.g., how to: structure a transition program; arrange transitions across counties; be more effective in executing transitions; and, identify and use available tools). One agency that agreed that

the regional training lacked practical information observed that the session was largely comprised of role-playing activities, and lacked information on how to actually navigate a transition and complete the paperwork that is required.

Statewide Conference 2005

Only one agency provided comments on the 2005 Statewide Conference. Staff at other agencies either did not attend the 2005 conference or did not have a memory of it that stimulated them to comment on it. The one person who did provide comments said the conference was "not memorable," that it was difficult to obtain clear answers regarding NHT, and the state was not specific regarding the types of reports it required nor did it provide details on the type of model it expected the agency to structure. The agency added that this problem continues to persist for Money Follows the Person (MFP) activities.

Statewide Conference 2006

Comments by agencies about the 2006 statewide conference were generally positive. There was some comment about staff from the two departments presenting different definitions of when helping someone could be counted as a transition.

Eight of the surveyed agencies evaluated the conference as being helpful in providing motivation to participants and in offering useful workshops on the NHT toolbox, housing information, and practical "nuts and bolts" guidelines. One agency reported that a topic that was covered extensively was clarification on the definition of a transition. However, another agency described the scenarios presented at the conference as confusing. The source of this confusion may have been captured in comments provided by two agencies that noted the state staff that delivered the sessions on definitions of a transition had differing ideas on what was required for an agency to get credit for completing a transition. Specifically, there was a lack of consensus on what constituted a "hard" and "soft" transition. Questions posed by agencies asking for clarification on these definitions were not resolved at the conference by presenters, and in fact, it was noted that there was a "dispute" among presenters about these definitions.

Other individual comments included one person saying they found little value in large conferences, though one positive outcome was that all attendees heard the same message. Two persons said the keynote speakers were excellent, and "inspirational." One person said that breakout sessions with the Department of Aging were not useful. Another person commented that the sessions did not provide enough information on how to deal with "advanced" problems and activities, but rather the information provided was too basic. In addition, two agencies thought the sessions were too short, with not enough time allotted for questions and answers.

The overall impression was that the 2006 conference was successful because of the information provided and the speakers, and was both more interesting and confusing because of the difference in state departments' view on what constituted a transition.

Other Conferences

The August 2006 roll out conference in Montgomery was described as having excellent workshops and providing good direction in what the state wanted from agencies.

A CILs training session in Boston, held in September 2006, had training sessions delivered by the Independent Living Research Utilization (ILRU) Center in Houston Texas. These were described as extremely useful by staff at one Center that participated in them.

Technical Assistance (TA) Calls

The state planned 48 regional calls from September 2006 through April 2007. Every month for eight months, state staff made six regional calls. The agencies surveyed had a range of opinions on the value of the technical assistance conference calls. One positive observation made by seven agencies was that the calls provided an opportunity for the participants to interact and compare information (e.g., discussions about progress made in completing transitions and guidelines that they were using to structure their own activities). Two agencies noted that the TA calls were useful initially, but provided redundant and “less clear” information as the program proceeded.

Agencies differed greatly on their assessment of the topics covered during TA conference calls depending on how relevant the topic of the calls was to their individual needs. Three agencies commented that they felt the topics of the calls were most appropriate for organizations that were less experienced in transition. These agencies voiced a need for information that was more of a problem-solving and strategizing nature. A suggestion was made that more “one-on-one” communication would have been useful.

This request for more targeted and localized discussions was also voiced by other agencies. One agency commented that much of the discussion during the calls focused on housing, and noted that this was not a concern for that particular organization. Alternatively, two agencies volunteered that the calls covering topics dealing with housing issues were very relevant to their needs. Another agency voiced a need for information on transition strategies for rural areas, and another wanted guidance on the home maintenance deduction.

Staff at two agencies suggested that distribution of a pre-meeting agenda might serve as a useful tool for alerting agencies as to when technical assistance calls would cover their specific concerns. Staff at another agency suggested that quarterly “networking meetings” might be a more productive alternative or addition to the calls. It was explained that, “all of our programs except OPTIONS have network meetings.” Their recommendation for technical assistance/training would be to have quarterly regional network meetings for staff doing the hands on transition work.

Other comments made by agencies referenced the time allotted to technical assistance discussions as a factor influencing the effectiveness of the telephone

conferences. One agency commented that the 50-minute calls were an ineffective format for addressing the concerns of all of the agencies in the nine counties, as this was not sufficient time to resolve the issues raised by participants. One agency commented that there was not enough time allotted for questions and answers. Another agency said that an hour and a half on a topic that is not of interest is “painful.” One agency commented that having calls every two weeks was not “timely enough.”

There were suggestions from the surveyed agencies for improving the outcome of conference calls. One agency proposed that the call moderators make an effort to generate more conversation between call participants. Another suggestion was to provide conference participants with transcriptions or notes from the calls: This agency reported making a request for such notes, however, the moderators responded by providing meeting summaries for only two subsequent call sessions. Another agency suggested that e-mail communication might serve as a more productive method for group communication. Another commented that staff members experienced problems with conferencing equipment and suggested that technology improvements should be made to alleviate these communication issues.

Several agencies commented on the atmosphere and tenor of the calls. One agency felt that when participants raised questions, the quality of responses by the call moderators was poor. One agency noted that calls were “overbearing” and answers could be “punitive.” Staff at these agencies noted a progressive lack of interaction on the calls, and conference participants proposed that this might have been a result of the moderators’ terse responses. It was suggested by one agency that this lack of participation might have contributed to the state’s decision to terminate the TA telephone conferences. Staff at three agencies said they thought state staff worked to get feedback from agencies but had difficulty encouraging persons to talk on the calls and getting agencies to tell the state what topics would interest them.

The calls helped to develop and communicate policy. For example, the telephone calls during Winter 2006 were useful in coming to an agreement on what counted as a transition. Differences in the departmental viewpoints were discussed and a consensus developed that soft transitions counted if the transition coordinator was involved in removing a barrier. This consensus was communicated among agencies both in the telephone calls and by word of mouth. Staff at one agency interviewed said they thought there was no consensus and that they were still confused.

Technology Training

The state offered agencies training on data systems. This included use of FDIS, the front door information system; the OMNIA data collection system for use with transition related-information; and, SAMS. Agencies offered assessments of the technology-related training and provided comments on how well the technology tools assisted them in achieving their transition goals.

Staff abilities to successfully use state-provided technologies are not solely a factor of training, but that success may also be contingent upon system compatibility, connectivity issues, interface usability, and other software and hardware factors. Because these issues are so closely intertwined, all comments by agency staff regarding technology are summarized here.

OMNIA

The OMNIA software was used as the software platform for recording key characteristics about persons transitioned, such as the specific barrier the person had and how it was solved. OMNIA is used in conjunction with another program called SAMS, which records wavier information. Training was provided by the state as part of the NHT program on the OMNIA software.

Almost all agencies that used SAMS and OMNIA expressed some comment on either the training or the functionality of the software programs. One agency surveyed had no comments on either the SAMS or OMNIA system, and two agencies related that they did not use the software systems at all.

Two agencies reported difficulty obtaining the software for its office computers. Another agency could not obtain enough copies of OMNIA for its workstations. One agency that had difficulty in accessing the software stated that staff were unable to access OMNIA for two weeks after initial training because they had been given an incorrect "procedure code to access [the] link" to the software. Three agencies noted that they were unable to enter data into the applications because the interface between SAMS and OMNIA did not allow for a transparent merging of the data. Two of these agencies noted that the result of this problem in submitting electronic forms was that the agency did not receive credit for all of its transitions. One of these agencies suggested that this data-merging problem could have occurred because its staff was not properly trained in usage of the systems. County firewall problems were reported by two agencies.

SAMS and OMNIA were cited by several agencies as not being user-friendly applications. Changes and updates to the systems were observed as not being "user-driven." Software usage problems were noted by agencies interviewed. Several agencies stated that they had attended state-sponsored training on the OMNIA and SAMS systems. The SAMS user group meeting and the OMNIA preliminary training sessions were noted by two agencies as being very helpful in introducing agency staff to the systems. However, some of the agencies that attended these sessions reported subsequent problems in applying this training when they returned to their offices and when they attempted to input data using the SAMS and OMNIA software interfaces.

One agency noted that SAMS and OMNIA required a significant commitment of time, which they felt could be better spent on other important transition activities, such as case management. The staff from this agency described their situation as being a "slave to data." Two agencies noted that there were different versions of OMNIA concurrently circulating, and that the upgrades were not distributed to everyone at the same time,

which resulted in compatibility problems with the software. One agency stated that it was necessary to spend a significant amount of time updating records because of a change in software releases. They proposed that most of their problems in using the software arose not from a lack of training, but rather because of irregularities in the software updating process. Another agency stated that it was aware of these periodic upgrades and recognized the need to update computers periodically.

Staff from agencies that discussed SAMS stated that they had benefited from ongoing technical support on the software through participation in a monthly SAMS telephone conference, and SAMS training sessions were well regarded.

Staff at two agencies described their reactions to the OMNIA training session in Harrisburg sometime during March - April 2007. They stated that there had not been a sufficient number of computers for all of the attendees and that the training was not well prepared. Another problem cited regarding this training session was that attendees were asked to hold their questions until the end of training, which resulted in many questions remaining unanswered due to lack of time or loss of context. This same person said that the trainer was "too technical."

When the staff returned to their organizations to use the software, they were not able to get direct access to technical support, but instead their questions were relayed through a transition coordinator to a technical support advisor. This third-party involvement in the inquiry process was perceived to have led to misunderstandings and delayed responses.

While agencies described their experiences as being related to the OMNIA and SAMS systems, it appeared that some software experiences were more related to communication and procedural disparities, and less about technology. For instance, one agency was uncertain about how to fill out an OMNIA form in instances when a single consumer had been provided transition assistance by two agencies: There was confusion about how this type of transition would be credited using the software interfaces to submit data. While such issues are situated in the context of technology, upon closer examination the problems experienced by the agency appear to have arisen more from problems interpreting and clarifying policy rather than a software problem.

During 2006 - 2007, there were hardware, installation, purchase, updating and firewall problems. On an individual user level, the impression received is that persons who are moderately familiar with computers and willing to take the time and effort can learn how to use OMNIA. Persons who are less experienced with computers or who are not willing to put in the sweat equity had more trouble learning the program.

The Front Door Information System (FDIS)

The state put on seven FDIS trainings with the AAAs in October 2006. The few comments provided by agency staff said that it was good. Agency comments clustered around access to FDIS and what, if anything, was done to the information entered into it.

The AAAs were the agencies that dealt directly with the FDIS and the CILs were generally not aware of it since they did not have access to it.

Department records show that 99 persons had access to the FDIS during the period April – June 2007. Interviews at the agencies reported that access was limited and most of the staff that accessed it were data entry persons. One factor that limits its use is the cost of access. One agency stated that more people should have access to FDIS and that it should be provided as a Web-based application.

An intertwined second issue is what happens to the data after it is entered. At the time agencies were interviewed, the state required case management data to be entered into the system, and this led to three agencies reporting that they did not have a good understanding of what happened to data after it was entered. The comment made was that this contributes to the impression that entering data is labor-intensive, but does not have much beneficial outcome. The intertwining of limited access with the requirement of adding general information led to the belief that if case management-related information is entered, then case mangers need access, not just data entry staff. More access would increase program efficiency.

Other comments included one agency saying they were not generally aware of specific features available in the system, such as the ability to run a report. This agency felt that additional training could have alleviated its problems. This same agency perceived that other agencies entered different data into FDIS and that more training and feedback on the software was needed to ensure its consistent use. Another agency wondered where FDIS left off and OMNIA began since it looked like similar information was being entered into the two data systems.

Communicating Policy and Procedure

The nursing home transition work occurs in the context of continually evolving procedural and policy adjustments. The state provided significant amounts of support to agencies including extensive websites, written material, training, e-mail capability to ask questions, and persons to call for policy clarification.

Agencies generally acknowledged the work of state staff, and had numerous specific suggestions as to how it could be further improved. One agency stated that the numerous and frequent changes in the program made it difficult to keep its staff informed of new requirements. Staff at this agency commented that processes and procedures were more complicated than they needed to be, and that the program could benefit from simplification. While this environment of change created significant communication challenges, staff at one responding agency acknowledged that such issues were likely to arise when radical change was made to well-established and familiar policies and best practices.

One agency expressed a perception that there was "very little in writing as to what policy and definition was." Two agencies noted that there was not a standardized

mechanism for updating changes in the printed handbooks and manuals that they had obtained as referral guides. Because the state had not devised and declared a mechanism for removing old pages and replacing them with new information, the agencies stated that they had been working from “draft” manuals since 2003. According to agencies surveyed, they received manual updates in memo form, and not in a more usable format.

Because printed updates to procedures were scarce, agency staff stated that they obtained information in other ways. Resources named for policy and procedure information included the transition handbook, and the Pennsylvania Department of Aging (PDA) and its web site. The PDA was cited as a good source of information because they were more aware of rules and regulations, and provided specific guidelines for specific procedures. The Pennsylvania Housing Authority web site was also named as a useful resource for activities. The “Toolbox” was uniformly described as very helpful in providing good ideas, such as how to help someone get their birth certificate.

This absence of a mass distribution process for policy information is a likely cause of a commonly referred to weakness in the transition policy update process, and an inconsistency in the information given to agencies. One agency suggested designating a single contact point to insure consistency in information, or locating a collection of written information all in a single [web site] location. This suggestion was made after the agency received conflicting answers to questions it had posed to both the DPW and the Department on Aging. Supporting this solution, one agency noted that during the first six to eight months of the program, it had a good source for consistent transition policy information. However, when their departmental contact left, the dependability of the information provided decreased.

While there were instances cited by agencies where the state could have improved its NHT updating processes, ten of the agencies identified one area where the state was particularly unsuccessful in transmitting newly issued, clearly defined information to agency staff: definitions of a transition that could be credited for incentives, in particular the differences between “soft” and “hard” transition, and how these types of transitions could be credited. This situation was further complicated when “information-based” transitions were introduced.

One agency stated that it did not receive timely notification from the state when the range of a credible transition expanded to include soft transitions and informational transitions, and that its ability to implement this change was further delayed due to confusion about the specific criteria for claiming this type of transition. Examples of areas where states needed additional clarification included specifying the amount of time an agency needed to devote to a transition to credit it towards incentives, and sorting out conflicting claims when two agencies wanted to count or be paid for the transition. Another agency was delayed in being apprised that a transition could be claimed in cases where they provided only information to an individual.

Some agencies related that they had received good responses from the state to specific inquiries they had submitted through e-mail. However, it was noted that these

informational responses could have had an increased value if they had been distributed to all of the agencies proactively, rather than directing the responses only to the requestor. One agency suggested that this situation might have been alleviated if the state had issued regular and formalized Frequently Asked Questions (FAQs).

Agency Suggestions Regarding Training

Agencies provided suggestions for training in areas that they felt were not adequately covered during their transition involvement. Following are topics mentioned that they felt would have value in being included in future training sessions:

- Identification of relevant information for billing submissions for fiscal persons in transitions services;
- Training on billing for waivers;
- Information on housing modifications (e.g., how to identify people doing modifications and information on the bid process and selection);
- Guidelines on technical reporting and how to interpret the technical assistance guide;
- Execution of special funding requests;
- Determination of outcome measures to assess program success;
- Explanation of how target numbers were determined for each agency;
- Guidance on relationship building with nursing facilities and discharge planners;
- Developing advocacy, particularly in cases of soft transitions;
- Organizing an office and developing workflow processes;
- Instruction on use of MDS (e.g., identify the consumer profiles that should be targeted);
- Guidance on management of consumers transitioning from nursing facilities against medical advice;
- Identification of funding sources; and,
- Explanations of the status of the NHT program in the future (e.g., will the program continue after January 2008, and will funding be available).

Cooperation among Agencies

One that Didn't and One that Didn't Want To

One agency interviewed had the training and qualifications to provide transition coordination, was informed and aware of the state's new program, and did not participate. The Center believed, and says the state confirmed, that it was supposed to get transition funding support from another Center that was acting as the "lead agency," but the other Center never provided the money. The Center interviewed was reluctant to ask for the money since it had other economic relationships with the other Center.

This was one of five situations in which CILs or non-profits interviewed described themselves as being in economic competition with other CILs. Three CILs described issues over, for example, who can claim fees for service coordination or transition assistance. If one center develops the client relationship and then sends the paperwork over to another Center because that Center is an enrolling agent for the program, then there is a possibility of conflict if the enrolling agency seeks to provide the services and/or do the coordination assistance.

Another non-profit it thought it could not charge for transition coordination because their "local administrative agency," another non-profit, told them they could not bill for transition coordination because everyone's salary was paid as part of the transition money that the state provided the agency. One AAA reported that during the previous year's transition program, SFY 2005 - 2006, it did not get the money it was supposed to from the lead agency, which was a Center.

When interviewed the director of one small Center said that he would not participate in the program next year because the amount received from the "lead agency," approximately $10,000, was too little to cover the program costs. This director said the paperwork and program complexity was daunting.

Staff at the agencies interviewed made frequent reference to the complexity of assessment, eligibility program enrollment, service coordination, and plan approval. The "lead agency" concept appears to add further complexity to an already messy situation. When considering how it structures economic relationship among CILs, non-profits, and AAAs, the state may wish to re-evaluate its use of the lead agency concept in transition programs.

Collaborative Partnerships

One of the stated goals for the Enhanced Transition Program was the strengthening and expansion of existing relationships, by encouraging collaborative partnerships that share experience, expertise and resources to support successful transitions. Surveyed agencies cited their partnerships as necessary and important sources for information and practice-guidance in transition activities.

In two instances CILs and AAAs exchanged information to support each other's needs (e.g., a Center in one partnership taught the AAA about transition services, and the AAA informed the Center about assessment and care planning as done by Aging). There was a suggestion from an agency for formal shared training of CILs and AAAs. Relationship building also expanded beyond direct partnerships.

Agencies stated that it was important to have all participants in the transition process involved and educated in procedures and goals, including nursing facilities, clients, hospitals, physicians, and others. Three agencies noted that to achieve this collaborative environment, some had conducted outreach and training for partners (e.g., informing doctors of MA 51 requirements, and nursing facilities of consumer identification processes). Strong relationships with nursing homes was necessary in some cases, to enable access to individuals who were potential NHT recipients, and this often involved negotiations with nursing home administrators and staff. While it was recognized that this activity was important, some agencies seemed somewhat unprepared for this type of outreach and expressed some need for training in this area.

Good "handoffs" from the transition worker to the case manager were cited as a "huge factor" in making successful transitions. A "team effort" was considered a necessary element of activities. Twelve agencies suggested that a more structured collaboration with housing mangers and designers would have been helpful, as available and appropriate housing was often cited as an area that was a strong determinant of transition successes. Developing approaches to housing took a significant amount of time, as transition coordinators were required to "become housing experts." One agency related that it had difficulty obtaining assistance from the Philadelphia Housing Authority because of past political history.

Agencies in the western part of the state described relationships between AAA, non-profits and CILs as going back 15-20 years and said that they were deep-rooted collaborations.

Acknowledgements

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Appendix A: Selected Pennsylvania NHT Reports

Eiken, S., Nadash, P., & Burwell, B. (2006, December). *Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System*. Prepared for the US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Disabled and Elderly Health Programs Group. (Contract Number 500-00-0021, Task Order 1). Cambridge, MA: Thomson MEDSTAT Research Division.

This report provides a profile of Pennsylvania's long-term care system and a description of the state's recent efforts to rebalance its programs. The report is based upon a variety of state and federal sources, and interviews with individuals who are participants in Pennsylvania's long-term care services. The report begins with a background section that focuses on three factors that have shaped Pennsylvania's long-term care support system: 1) demographic indicators of long-term support demand; 2) traditional service utilization patterns; and 3) the support system's historical and political characteristics. A description is provided of the government agencies responsible for publicly funded services, and the roles that the legislature, consumers, and families have played in Systems Change. A major part of the report focuses on describing the long-term support delivery systems for major population groups that are defined by either age or type of disability. For each of five groups, older adults, people with physical disabilities, people with mental retardation, people with mental illness, and children, the report provides detailed descriptions of the range of available home and community supports. The report also presents data on demographic and utilization trends for each population group related to the state's rebalancing efforts. Finally, each population is viewed from the perspective of eight infrastructure components that have been identified by researchers as important to a rebalanced long-term support system.
This report can be viewed at:
http://www.cms.hhs.gov/NewFreedomInitiative/Downloads/PA_Profile.pdf

US Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2007, March). *Real Choice Systems Change Grants: Compendium Sixth Edition.* Baltimore, MD: CMS.

The Compendium contains basic information about each of the Real Choice Systems Change Grant awards in FY03–FY04, plus the Family-to-Family and Systems Transformation Grantees awarded in FY05 and FY06. It was compiled to provide information on how these grants are used to allow people of all ages with a disability or long-term illness to live in their communities. It is also intended to assist Real Choice Systems Change grantees to identify other grantees with similar goals and activities. The sections on Pennsylvania include: *Integrating Long-Term Supports with Affordable Housing* (http://www.hcbs.org/files/115/5706/PA_HOUSE.htm), *Mental Health: Systems Transformation* (http://www.hcbs.org/files/115/5707/PA_MHST.htm) and *Quality Assurance*

and Quality Improvement in Home and Community Based Services (http://www.hcbs.org/files/115/5708/PA_QAQI.htm). Each section names the grant and grantee, provides grant amounts, contacts and subcontractors, goals and activities, and a summary of the project.
The complete Compendium is available at:
http://www.cms.hhs.gov/RealChoice/downloads/compendium.pdf

NHT Collaborative Partners, Regional Meetings. (2006, August). *Enhanced Nursing Home Transition.*

Five PowerPoint presentations provide information on the following:

1) A brief overview of Pennsylvania's Long-Term Living (LTL), including a chart illustrating the balance between waiver programs and nursing facilities from 2002 - 2007, and the outcomes of enhanced nursing home transitions;
2) Examples of Minimum Data Set (MDS) reports provided for Lancaster County, PA, describing its application for unified data tracking;
3) Comparisons of the status of long-term vs. newly admitted nursing home residents regarding nursing home transition, emotional responses that individuals experience during acclimation to nursing home stays, barriers to nursing home transition, how to address barriers, and how to capitalize on windows of opportunity before residents become resigned to nursing home residence;
4) An overview of technical assistance offerings; and,
5) A chart representing the coordination of long-term living and nursing home transition activities and supports in Pennsylvania.

This presentation can be obtained from Leslie Hendrickson at Rutgers Center for State Health Policy.

Funk, Ellen H. & Nevison, David M. (2005, March). *Direct Care Worker Association and Demonstration Grants: Final Report.* Philadelphia, PA: Philadelphia Corporation for Aging.

This report outlines the issues that Pennsylvania faces as the need for Direct Care Workers (paraprofessional workers who have direct contact with persons needing care) increases. Several studies focusing on the direct care worker problem are summarized, and funded initiatives to address the problem are described.

The report describes two grants initiated in 2003: the Direct Care Worker Association grant, which was generated to assist in creation of a direct care workers association; and the Direct Care Worker Demonstration grant, which was initiated to improve the recruitment and retention of direct care workers in long-term care settings. Descriptions are provided of the projects that were awarded grant funding. These include: two Association grants (CARE Direct Care Worker Association; Schuylkill Direct Care Association), and ten Demonstration projects (Certified Nursing Assistant Professional Empowerment Project; Effect of Supervisory Training of Line Supervisors on Retention of Direct Care Workers in Long-Term Care Facilities; Frontline Project-

Publishing a Magazine for Professional Caregivers; Learn, Empower, Achieve, Produce: LEAP for the 21st Century Long-Term Care Workforce; Management Skill Development for Nursing Leaders: Improving the Work Environment for Direct Care Workers; Mentor Demonstration Project; Retaining Direct Care Worker Professionals: Strategies for the 21st Century; Rural Direct Care Worker Dementia Care Training; Schuylkill Cares; Work Culture Shifts Through Team Building: A Demonstration Project with Adult Day Services. Summaries include project descriptions, accomplishments and outcomes, challenges and findings.
This report can be viewed at:
http://www.aging.state.pa.us/longtermcare/lib/longtermcare/DCW_IGT_report_FINAL_EF_3_.pdf

Kane, R.A., Kane, R.L., Priester, R., Spencer, D., Lakin, K.C., Lum, T., Clark-Helms, L, Mollica, R., Harrington, C., & Kitchener, M. (2005). *Rebalancing Long-Term Care Systems in Pennsylvania: Experience up to July 31, 2005, Abbreviated Report.* (Submitted to the Centers for Medicare & Medicaid Services (CMS), Advocacy and Special Initiatives Division). Baltimore, MD: CMS.

The report summarizes Pennsylvania's history in providing services and supports for long-term care and highlights recent progress in the state's efforts to rebalance services to reduce dependence on institutions and move towards home and community-based services (HCBS). An overview is provided of how Real Change Systems Grants have contributed to Pennsylvania's rebalancing efforts. Several management approaches for achieving HCBS goals are discussed including: establishment of the Governor's Office of Health Care Reform (OHCR) in 2003; operation of the Community Choice HCBS waiver program; initiation of the Pennsylvania Transition to Home Program (PATH) nursing home transition grants from CMS in 2000; intuitional downsizing; housing initiatives; efforts to develop recruitment and retention strategies to provide direct care workforce; an evaluation project of Area Agencies on Aging assessment. An evaluation of Minimum Data Set (MDS) data is used as a quantitative measure to assess the potential effect of HCBS on nursing home use for the years 2002, 2003, and 2004. Graphs are used to represent additional quantitative factors: changes in the number of clients served under a various Medicaid programs from 2000-2004; expenditures for these programs; and, costs per person served.
This report can be viewed at:
http://www.hpm.umn.edu/ltcresourcecenter/rebalancing_attachments/Pennsylvania%20Case%20Study%20Long%202005.pdf

Office of Governor Edward G. Rendell Health Care Reform. (2007, April 11). *Nursing Home Transition in Pennsylvania.* Medical Assistance Advisory Committee. Long-Term Care Subcommittee.

This PowerPoint presentation describes recent progress that Pennsylvania has made in rebalancing its long-term care system to enable nursing home residents who wish

to return to their home and community to transition safety from an intuitional setting. Charts illustrate: sources of referral to NHT; age and gender of transitioned consumers; types of post-transition services required; and, types of post-transition housing that consumers transitioned to.
To access this report contact: Jennifer Burnett, Governors Office of Health Care Reform jenburnett@state.pa.us, 717-346-9776.

Burwell, B. & Galantowicz, S. (2005, Oct. 15). *Long-Term Living in Pennsylvania: Presentation at Long-Term Living Weekend Retreat.* Cambridge, MA: Thomson MEDSTAT.

This PowerPoint presentation depicts Pennsylvania's long-term care rebalancing status with the following graphs:

Medicaid Long-Term Care Expenditures FFY 2004; Distribution of Medicaid Long- Term Care Expenditures (PA & US) FFY 2004; LTC Expenditures as a Percentage of Total Medicaid Expenditures FFY 2004 (PA & US); Pennsylvania State Ranking on Per Capita Expenditures for Various Medicaid Services FFY 2004; Distribution of Medicaid Long-Term Support Expenditures for Older People and People with Disabilities FFY 2004 (PA & US); Distribution of Medicaid Long-Term Support Expenditures for People with Mental Retardation/Developmental Disabilities FFY 2004 (PA & US); Total Medicaid Nursing Facility Expenditures in FY 00-04; Average Monthly Caseload of Medicaid Nursing Facility Residents FY 00-04; Medicaid Nursing Facility Annual Expenditures Per User FY 00-04; Distribution of the Aged Population 2004 (PA & US); Distribution of Medicaid NF Residents and Expenditures by Age FY 04-05; Medicaid NF Expenditures Per Person by Age FY 00-04 (PA & US); Medicaid NF Days of Care Per 1000 Persons by Age FY 00-04 (PA & US); Average Nursing Facility Daily Medicaid Reimbursement 2002 (Top 10 States & National Avg.); Avg. Annual Cost & Avg Daily Cost Per Medicaid NF Recipient FY 02 (PA & US); Turnover Patterns of Medicaid and Non-Medicaid Users of Nursing Homes FY 04; Counties with Lowest Occupancy Rate 2004; Selected Data on HCBS Waiver Programs in PA; Avg. Monthly Caseload of PA Dept. of Welfare Waiver Participants FY 00-04; Total PDA Waiver Expenditures FY 00-04; Avg. Annual Cost Per PDA Waiver Participant FY 00-04; Annual Percent Increase in PDA Waiver Recipients & Total Expenditures FY 01-04; Age Distribution of PDA Waiver Participants and Medicaid Nursing Home Residents FY 04; Avg. Annual Costs for PDA Waiver recipients & Nursing Facility Residents FY 04; PDA Costs in Excess of Waiver Cap 04-05; Discharge Status of PDA Waiver and Medicaid Nursing Home Residents FY 04-05; Nursing Facility Rates by County FY 04-05; PDA Waiver Utilization Rates by County FY 04-05; Medicaid Nursing Facility & PDA Waiver Utilization Rates: CommCare vs. Non-CommCare Counties FY 04-05; Recipients of MR/DD Services Per Capita FY 04 (PA & US).
This presentation is available from Leslie Hendrickson at Rutgers Center for State Health Policy.

Nursing Home Transition.

This is a PowerPoint presentation that identifies strategies that Pennsylvania adopted to achieve nursing home transition, goals, barriers and tools that would advance the state's efforts to encourage home and community-based long-term living solutions. It outlines a "3-pronged" pilot-study approach to using Minimum Data Set (MDS) data to foster nursing home transition: Side Door (identify low acuity patients); Front Door (new admissions); Back Door (non-new admissions).
This presentation is available from Leslie Hendrickson at Rutgers Center for State Health Policy.

Verdier, J. (2005, Sept. 23). *Pennsylvania Medical Assistance Program Reform Options*. Pittsburgh, PA: Mathematica Policy Research, Inc.

This PowerPoint presentation provides data on: Medicaid Sending Patterns; Pennsylvania vs. U.S. (Medicaid Spending Trends; Distribution of Medicaid Enrollees and Expenditures, PA vs. US, FY 2001, Medicaid Expenditures Per Enrollee, PA vs. US FY 2001; Medicaid Expenditures by Type of Provider, PA vs. US, FY 2003; Per Capita Medicaid Expenditures PA vs. US, FY 2004); Options for Containing Medicaid Spending Growth (Medicaid Managed Care Penetration Rates, PA vs. US, FY 2004; Medicaid Rx Drug Reimbursement, PA vs. US, 1999; Shift of Medicaid Rx Drug Coverage for Dual Eligibles to Medicare in 2006; Medicaid Reimbursement for Antipsychotic Drugs, PA vs. US, 1999); Potential to Control Costs by Improving Care Quality (Cost Containment Options Managed Care; Cost Containment Options Prescription Drugs; Cost Containment Options; Others, including creative financing, durable medical equipment, control of fraud and abuse).
This presentation is available from Leslie Hendrickson at Rutgers Center for State Health Policy.

Appendix B: Overview of Pennsylvania Long Term Living Programs

Programs	Medicaid	State/Other	Serves Older Adults	Serves Persons w/ Physical Disabilities	Number Served, SFY '04-'05	Growth Rate since SFY '01-02
Options		X	X		85,443	-3%
Nursing Facilities	X		X	X	81,707	0%
Aging Waiver	X		X		20,495	30%
SSI State Supplement – Personal Care Homes		X	X	X	10,756	-1%
Family Caregiver Support		X	X		5,053	-11%
Act 150 Attendant Care		X		X	2,268	1%
SSI State Supp-Domiciliary Care Homes		X	X	X	1,235	-2%
Independence Waiver	X			X	1,233	49%
Bridge		X	X		965	1%
LTC Capitated Asst. Prog. (PACE)	X		X		937	22%
OBRA Waiver	X			X	759	31%
COMMCARE Waiver*	X			X	152	230%
AIDS Waiver**	X			X	99	8%
Michael Dallas Waiver***	X			X	66	11%
Elwyn Waiver***	X			X	41	-2%
ICF/ORC	X			X	14	-14%

Source: Eiken, S., Nadash, P., & Burwell, B. (2006, December). *Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System.* Cambridge, MA: MEDSTAT (Prepared for U.S. Department of Health and Human Services). Available at: http://www.hcbs.org/files/101/5031/ProfileOfPALong.pdf . Data are from Tables 3 and 5

*Began in SFY 2002-2003; average growth calculated from then
**Data are from SFY 2002-2003
***Data are from SFY 2003-2004

Appendix C: List of Thirty States in 2008 with Medicaid Medically Needy Program for Nursing Home Services

States with Medicaid Medically Needy Programs for Nursing Home Services
Arkansas
California
Connecticut
District of Columbia
Hawaii
Illinois
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Montana
Nebraska
New Hampshire
New Jersey
New York
North Carolina
North Dakota
Pennsylvania
Rhode Island
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin

Source: Centers for Medicare & Medicaid Services (CMS)

Notes

Texas does not cover aged, blind and disabled medically needy at all.
Florida covers aged, blind and disabled medically needy but does not cover NF services
Georgia covers aged, blind and disabled medically needy but does not cover NF services
Tennessee covers aged blind and disabled medically needy under its 1115 program not under its state plan.

The identification of states is not officially published by CMS. Rather knowledgeable CMS staff drew up this list as a courtesy to the public. It is based on informal surveys of CMS regional offices by central office staff.

Appendix D: Transition Results from 2003 – 2004 of CMS Transition Grantees

The largest comparative study of nursing facility transition programs was done on eighteen states that received a CMS grant in 2001 and 2002.[71] Many of the states split the money between independent living councils and state agencies so the 18 states had about 33 different programs as shown below. The study collected data on the numbers of persons transitioned by state by year for 2002-2004.

Persons Transitioned by CMS Nursing Facility Transition Grantees, 2002-2004

Transition Grantees, 2002-2004				
State (Grant Type: SP = state program, ILP = Independent Living Council)	Number Transitioned			
	2002	2003	2004	Total
Alabama (ILP 2001)	2	13	16	31
Alabama (SP 2002)	—	n/a	n/a	n/a
Alaska (SP 2001)	2	12	47	61
Arkansas (SP 2002)	—	n/a	n/a	n/a
California (ILP 2002)	—	20	4	24
Colorado (SP 2001)	17	93	124	234
Connecticut (SP 2001)	1	31	40	72
Delaware (ILP 2002)	—	5	4	9
Delaware (SP 2002)	—	0	4	4
Georgia (ILP 2001)[1]	30	20	63	113
Georgia (SP 2001)[1]	n/a	8	n/a.	8
Indiana (SP 2001)[2]	0	0	4	4
Louisiana (SP 2002)	—	44	0	44
Maryland (ILP 2001)	n/a	n/a	n/a	0
Maryland (SP 2001)	23	78	65	166

[71] Siebenaler, K., O'Keeffe, J., Brown, D., O'Keeffe, C. (2005, June) Nursing *Facility Transition Initiatives of the Fiscal Year 2001 and 2002 Grantees: Progress and Challenges.* Report prepared under CMS Contract No. 500-00-0044, TO #2, RTI International, Research Triangle Park, NC

Transition Grantees, 2002-2004				
State **(Grant Type: SP = state program, ILP = Independent Living Council)**	**Number Transitioned**			
	2002	**2003**	**2004**	**Total**
Massachusetts (SP 2001)[3]	n/a	6	13	19
Michigan (SP 2001)	88	146	66	300
Minnesota (ILP 2002)	—	43	49	92
Nebraska (SP 2002)	—	147	86	233
New Hampshire (SP 2001)	n/a	1	4	5
New Jersey (ILP 2002)	—	11	27	38
New Jersey (SP 2002)	—	98	94	192
North Carolina (SP 2002)	—	13	37	50
Ohio (SP 2002)	—	n/a	3	3
Rhode Island (SP 2002)	—	16	156	172
South Carolina (SP 2002)	—	2	24	26
Texas (ILP 2001)	n/a	n/a	n/a	n/a
Utah (ILP 2002)	—	28	62	90
Washington (SP 2001)	12	209	1178	1,399
West Virginia (SP 2001)	0	15	32	47
Wisconsin (ILP 2001)	36	69	No Report	105
Wisconsin (SP 2001)	159	127	116	402
Wyoming (SP 2002)	—	13	47	60
Totals	**370**	**1268**	**2365**	**4003**

Source: Exhibit B-1 Nursing Facility Transition Initiatives of the Fiscal Year 2001 and 2002

Appendix E: Section Q MDS Answers on Initial Assessments FY 2006 - 2007

County	MDS question Qc.1. 0-30 days	MDS question Qc.2. 31-90 days	MDS question Qc.0. Long Term	MDS question Qc.3. Uncertain	Dementia	Under 60 Years of Age	60 years of age and over	Total Initial Assessments
Adams	70	139	246	442	263	43	854	898
Allegheny	3,910	3,549	1,736	4,048	3,383	1,246	12,134	13,381
Armstrong	85	82	108	175	112	47	402	449
Beaver	313	810	281	334	397	110	1,628	1,738
Bedford	116	197	42	57	84	33	379	412
Berks	386	669	545	713	615	144	2,212	2,356
Blair	251	140	412	393	316	61	1,136	1,197
Bradford	36	12	134	262	88	33	410	443
Bucks	1,726	1,224	805	1,146	1,163	252	4,665	4,918
Butler	735	472	468	616	604	141	2,151	2,292
Cambria	157	477	251	236	264	58	1,065	1,123
Cameron	8	3	8	14	6	1	32	32
Carbon	31	26	110	230	76	8	389	397
Centre	47	107	183	111	127	24	426	449
Chester	706	401	465	440	525	86	1,937	2,023
Clarion	28	81	70	194	79	46	328	374
Clearfield	117	89	123	449	199	71	708	779
Clinton	99	62	82	33	44	24	252	276
Columbia	116	48	99	145	107	27	380	408
Crawford	38	51	206	288	183	47	536	583

County	MDS question Qc.1. 0-30 days	MDS question Qc.2. 31-90 days	MDS question Qc.0. Long Term	MDS question Qc.3. Uncertain	Dementia	Under 60 Years of Age	60 years of age and over	Total Initial Assessments
Cumberland	672	272	522	865	646	115	2,228	2,343
Dauphin	129	341	316	471	341	71	1,196	1,266
Delaware	1,122	1,101	1,082	1,322	1,072	488	4,199	4,688
Elk	123	34	39	101	58	17	279	296
Erie	229	512	516	1,005	648	175	2,095	2,270
Fayette	157	216	121	371	193	54	811	865
Forest	1	-	48	5	25	17	36	53
Franklin	107	310	192	330	283	41	926	967
Greene	65	48	85	41	64	11	228	239
Huntingdon	42	40	68	82	68	4	230	234
Indiana	230	113	116	307	197	44	724	768
Jefferson	202	132	78	87	118	26	477	503
Juniata	52	44	49	128	53	10	263	274
Lackawanna	575	740	478	731	575	180	2,350	2,530
Lancaster	724	638	995	1,472	1,036	162	3,675	3,837
Lawrence	36	43	324	191	169	48	546	594
Lebanon	100	151	346	371	280	38	954	992
Lehigh	613	836	638	839	707	218	2,723	2,941
Luzerne	474	802	660	1,425	868	189	3,179	3,368
Lycoming	231	414	194	370	297	73	1,136	1,209
McKean	95	66	162	173	119	27	469	496
Mercer	55	137	373	346	255	66	845	911
Mifflin	66	23	90	275	126	11	443	454
Monroe	69	160	91	133	114	11	443	454
Montgomery	3,482	1,367	1,758	2,546	2,000	871	8,379	9,250

County	MDS question Qc.1. 0-30 days	MDS question Qc.2. 31-90 days	MDS question Qc.0. Long Term	MDS question Qc.3. Uncertain	Dementia	Under 60 Years of Age	60 years of age and over	Total Initial Assessments
Montour	40	26	45	247	80	31	326	357
Northampton	261	646	399	303	447	66	1,543	1,609
Northumberland	162	124	232	437	250	39	917	956
Perry	50	85	60	121	86	28	289	317
Philadelphia	2,072	1,208	1,920	2,326	1,788	717	6,852	7,569
Pike	89	12	34	75	38	4	206	210
Potter	52	9	41	58	54	19	143	161
Schuylkill	352	341	473	637	395	134	1,673	1,808
Snyder	39	30	40	79	32	12	177	189
Somerset	212	77	156	308	165	37	716	754
Sullivan	12	1	50	48	26	20	91	111
Susquehanna	8	27	57	111	79	4	198	202
Tioga	155	46	45	160	61	19	386	405
Union	143	73	81	111	112	12	399	411
Venango	43	74	91	199	111	40	370	409
Warren	47	41	120	131	116	16	324	340
Washington	1,239	519	269	663	594	209	2,512	2,721
Wayne	28	147	105	64	96	13	331	344
Westmoreland	688	1,062	527	1,065	858	233	3,117	3,351
Wyoming	14	15	46	131	30	5	203	208
York	358	807	615	810	689	129	2,475	2,605
Fulton	3	3	16	5	9	2	29	31
State Total	24,694	22,554	21,135	32,398	25,062	7,259	94,136	101,394