


Nursing Home Diversion Modernization Program

Prepared by the
New York State Office for the Aging
September 2009

Nursing Home Diversion Modernization Program (Community Living Program)

Background and History


- Grant from Administration on Aging to 14 states including New York
 - 18 Month grant for planning and implementation
 - Awarded September 2008
- 

County Participation

3 county demonstration with the Area Agencies on Aging in Broome, Oneida, and Onondaga

- Chosen as pilots since each has a long history of local innovation and a readiness for taking on this new initiative
- Builds on well established NY Connects, which provides a centralized point of entry into long term care system and is an essential component of the program

Goals

- Reach individuals at risk of Medicaid spend down and at risk of nursing home placement
 - Help maintain consumer independence and support aging in the community by offering consumer directed models of care
- 



Financial Eligibility

Income (125% to 300% of SSI Benefit Level)

- Single Person--\$951.25 to \$2,283/month
- Couple--\$1,393.75 to \$3,345/month

Assets

- Single Person--\$17,250 to \$41,400 (some adjustments to minimum asset requirements)
- Couple--\$25,125 to \$116,220

Functional Eligibility

Process

- Use Modified DMS-1 to determine score (assesses need for nursing care and therapy, functional and mental status, cognitive issues and impairments)
 - Scores below 59 will not be considered
 - Scores above 180 are in need of nursing home care and will not be considered
 - Scores between 60 and 180 will be considered at risk for nursing home placement and eligible for NHDMP

Functional Eligibility

Optional Addendum

- Used when care coordinators believe selected additional information may provide a supplemental score to items not captured from the DMS-1
 - Captures IADLs of transportation, preparing and cooking meals, self administration of medication and telephone use
 - Availability of informal supports
 - Health events—hospitalization and emergency room use

Infrastructure and Process

- **Role of AAA and NY Connects**
 - **NY Connects** pre-screens and identifies individuals who are at risk for nursing home placement and spend down to Medicaid
 - Offices for the Aging link individuals with assessment to determine the appropriate level of home and community services through consumer directed approach

What is Consumer-Directed Care

Consumer-directed or self-directed approaches:

- ▶ A facet of the larger self determination philosophy where:
 - Participants in long term care programs actively direct a wide range of long term care services and supports
 - Work with a care coordinator and service providers
 - Have maximum consumer choice and control


Person Centered Planning

Person-centered planning is based on values and principles of:

- ▶ Planning is individualized process and designed to respond to the personal goals, preferences, desires, and needs of the individual
- ▶ Each individual has strengths and the ability to determine personal goals, express preferences, and make choices
- ▶ Choices and preferences are always honored and considered
- ▶ Each individual contributes to the community and has the ability to choose how supports and services may help them to meaningfully participate in and contribute to the community
- ▶ Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals, and desires
- ▶ A person's cultural background is recognized and valued


Strength-based Approaches

Strengths-based approaches:

- Recognize, support, and enhance the inherent strengths and skills that each individual possesses, including their connections to others
 - Supports a consumer's independence
 - Strengths are identified rather than problems and deficits
 - Allows possibilities rather than problems to be the focus of care
 - Work in partnership with the consumer, viewing the relationship as person-to-person rather than professional-to-patient or client
- 


Who Can Self Direct

A consumer can self direct if the person is able to participate in decisions about his/her own care and are willing to:

- Work with the Care Coordinator to develop and manage a care plan and budget,
 - Work with the financial management services agency (FMS) (who will be the employer of record of their personal care workers) on hiring workers and in the completion of time records and other documentation, and
 - Report changes in his/her needs and care circumstances and his/her use of the supports provided under the care plan.
- 


Who Can Be a Consumer Representative

Requirements include:

- At least eighteen (18) years old,
 - Relationship between the representative and the potential participant appears caring and supportive, and
 - The designated representative is ready, willing, able, and available to serve as the representative.
- 


Who Can Provide Consumer Directed Care

In-home services worker must meet all of the following:

- Be aged 18 years or older
 - Not be legally or financially responsible for the consumer (e.g. spouse or guardian)
 - Not be the consumer representative
 - Be able to satisfactorily meet background and health screening criteria
- 


Diversion Services

Services, based on the participant's level of need, include:

- Personal care
 - Housekeeping
 - Chore and companion/supervision services
 - Social or medical adult day care
 - Home delivered meals
 - Congregate meals
 - Nutrition education
 - Nutrition counseling
 - Caregiver support including training, counseling, support groups and respite
 - Health promotion
 - Dementia specific services
 - Transportation
 - Medication management
 - Home modifications
- 

Goods / Ancillary Services

Goods that may be purchased include:

- Home modification—widening door frames, ramps
 - Assistive devices / assistive technology
 - Durable medical equipment
 - Home maintenance—snow shoveling
 - Appliances—microwaves
- 

Care Plan and Budget Development

Care Plan Development includes:

- Identify consumers goals, wishes and needs
- Establish the consumer (and/or the consumer representative) as the decision-maker for a care plan and budget that reflects his/her choice(s)
- Determine the types of services, equipment, supplies, home modifications and other goods available
- Determine the amount of funds needed and available for services and for what time period
- Schedule follow up meetings and calls
- Develop and adjust the care plan and a budget

Role of the FMS and Role of Consumer


Under contract with the AAA to be the employer of record and responsible to:

- Orient in-home service workers
- Handle the payroll functions and all paperwork related to in-home services worker
- Provide insurance and payments
- Cover tax and liability issues related to the employment of in-home services workers chosen by the consumer or the consumer representative
- Provide additional supportive services to the consumer (and/or consumer representative), such as providing emergency back up staff and referrals

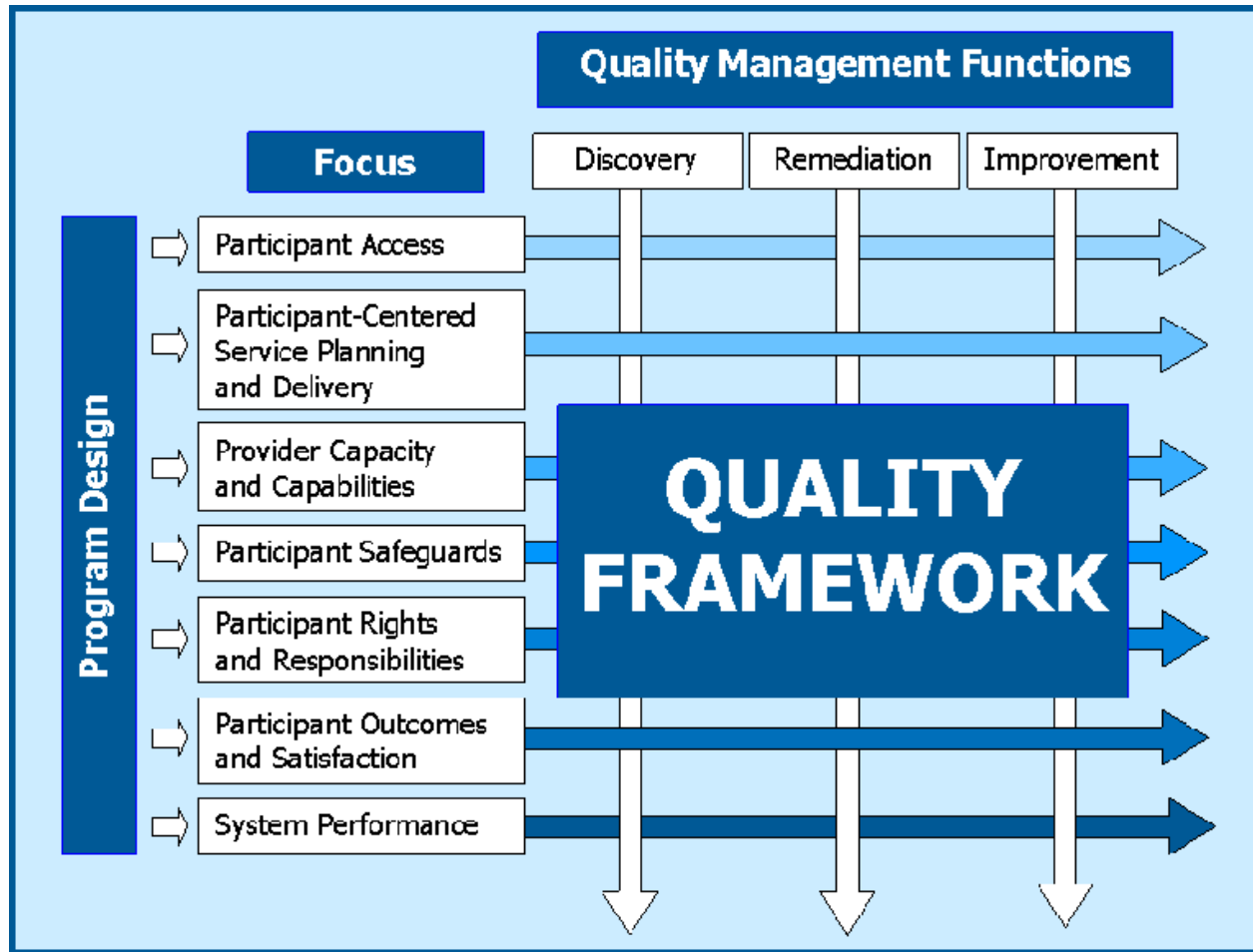
The consumer (and/or consumer representative) recruit, interview, select, hire, train, schedule, supervise and end employment of the in-home worker

Who Handles “Goods and Services”

Counties may choose to have the FMS agency:

- Handle payments for other goods and services purchased under the care plan and budget
 - Or handle this directly through the AAA or another agency.
- 

Quality Measures



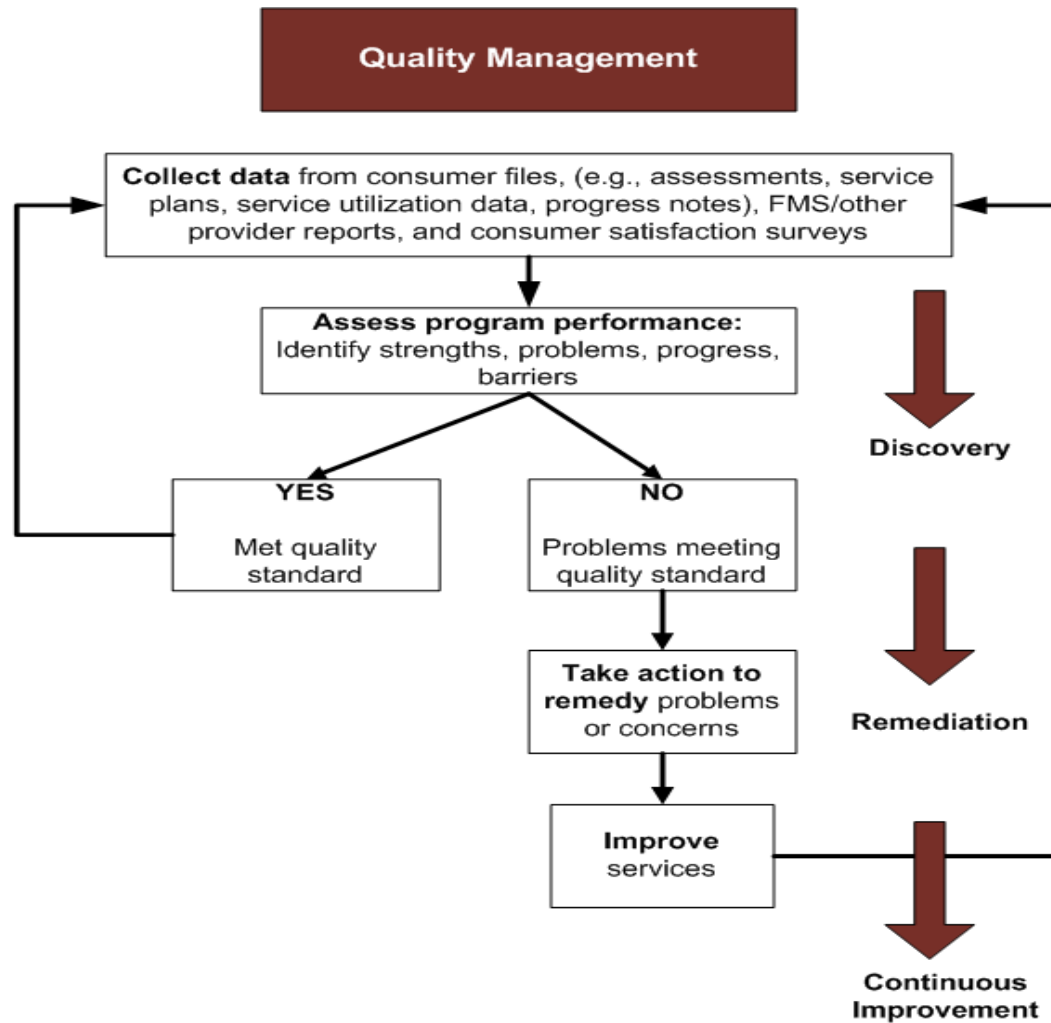
Functions of a Quality Management Framework

- **Discovery:** the process of collecting data, analyzing results, assessing performance and identifying areas of strength and opportunities for improvement
- **Remediation:** the process of taking action to remedy a specific problem, usually at the participant level
- **Continuous Improvement:** using analyzed data and other information to develop a continuous quality improvement model

Source: Fralich, J. et. al. (2005). *Discovery methods for remediation and quality improvement in HCBS.*

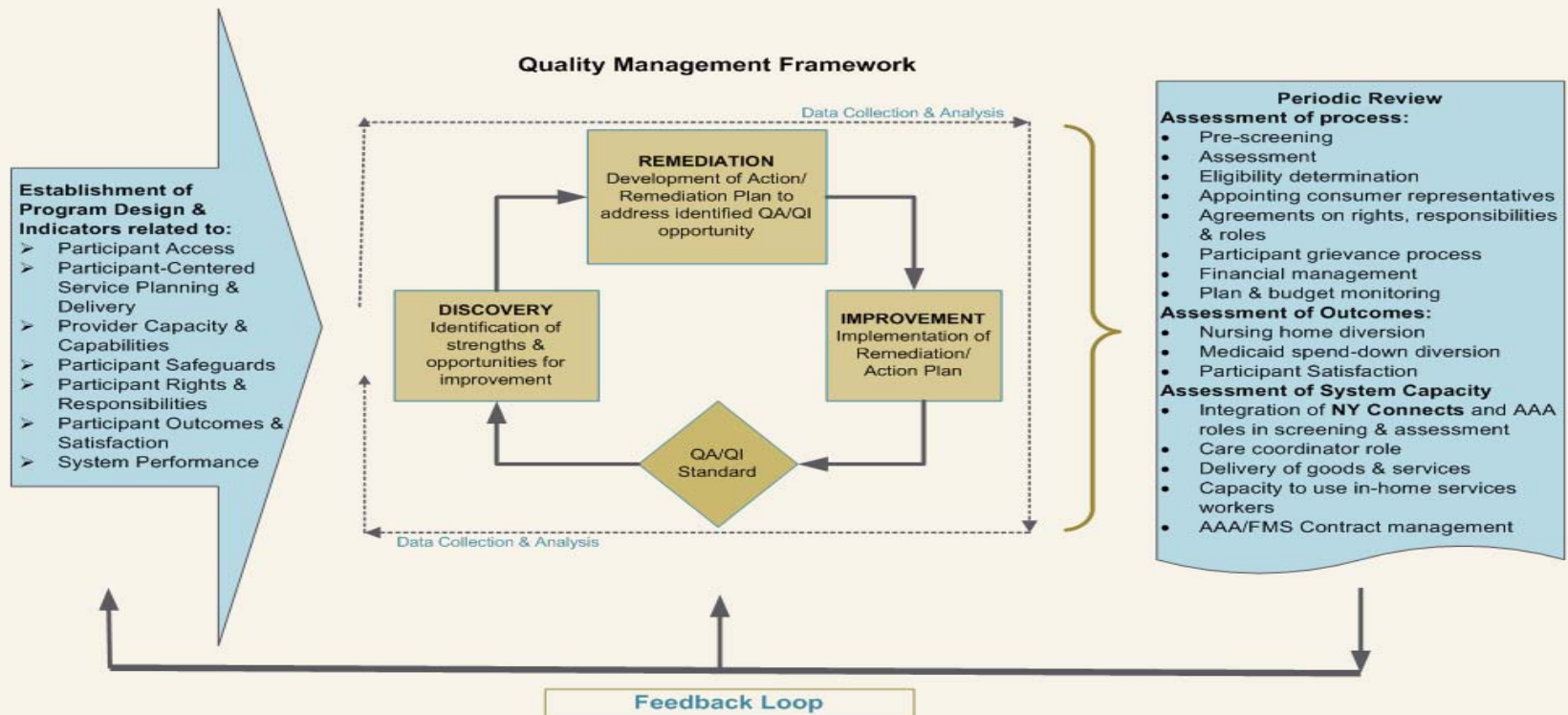


Quality Management




Quality Assurance/Quality Improvement


NHDMP Quality Assurance/Quality Improvement



Program Design Elements

- 1. Participant Access** --Individuals have access to home and community-based services and supports in their communities.
 - 2. Participant Centered Service Planning and Delivery**— Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
 - 3. Provider Capacity and Capabilities**--There are sufficient NHDMP providers and they possess and demonstrate the capability to effectively serve participants
- 

Program Design Elements

- 4. Participant Safeguards**--Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
 - 5. Participant Rights and Responsibilities**--Participants receive support to exercise their rights and in accepting personal responsibilities.
 - 6. Participant Outcomes and Satisfaction**--Participants are satisfied with their services and achieve desired outcomes.
 - 7. System Performance**--The system supports participants efficiently and effectively and constantly strives to improve quality.
- 



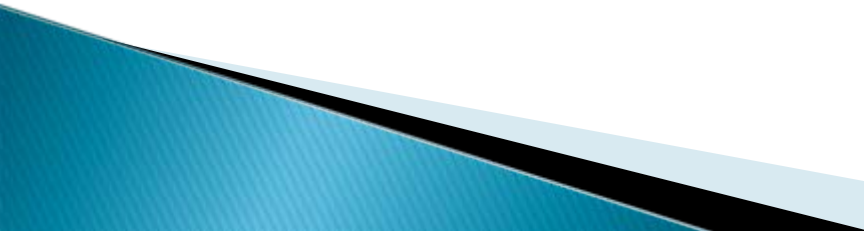
Program Accomplishments to Date

- AAA hired and trained care coordinators
- Designed the program model
- Developed state and local policies and protocols
- Identified and served consumers
- Provided personal care, companion services, durable medical equipment (stair glides, adaptive chairs), wheelchair ramps and home modifications
- Developed modules on program elements


Program Modules

- ▶ **Module 1:** concepts of consumer direction and strength based approaches
- ▶ **Module 2:** targeting and pre-screening
- ▶ **Module 3:** screening, assessment, eligibility determination including use of the COMPASS and the DMS-1
- ▶ **Module 4:** care plan development and budgeting including consumer's goals and needs
- ▶ **Module 5:** role of the financial management services (FMS) agency/fiscal intermediary (FI)
- ▶ **Module 6:** quality improvement and quality assurance including quality indicators

Lesson Learned thus Far

- Planning and program design require significant time at the state and local levels
 - Multiple skills (policy, programmatic, fiscal, legal) needed
 - Details count—difficult to predict issues
 - Need to continuously frame and re-frame issues
 - Implementation requires significant change in service delivery culture
 - Shift from traditional to consumer directed
 - Differing county administrative requirements result in varying program design and implementation
 - Variations in approach to billing for cost share and payment of goods
- 

Lessons Learned

- Service delivery approaches vary and have different implications
 - Use of existing case management staff vs. hiring new staff
 - Organizational structure for NY Connects
 - How assessment is conducted
 - Quality Assurance processes need to be developed and embedded into all aspects of program
- 



Lesson Learned

- ▶ Difficult to develop the right functional and financial criteria for program eligibility within required timeframe
 - Difficulty in finding consumers within asset limits
 - Diversity of county demographics impacts eligibility
- Fewer consumers have chosen consumer directed in-home services than anticipated
 - Older consumers may not wish to take on the management tasks and informal caregivers may not wish to do more
 - May focus on goods and services first
- ▶ Consumers want goods that they have not been able to get from other programs (e.g. asphalt pad for a wheel chair, adaptive chairs, stair glides) and make a real difference in every day tasks, independence and quality of life


Implications of Nursing Home Diversion Efforts

- Importance of demonstrations:
 - Able to test out consumer directed approaches for older adults who are at risk of nursing home placement and Medicaid spend down
 - Learn more about who is best served and what supports help them remain in the community
 - NYS recognized by AOA as ADRC state
 - Access to national Technical Assistance
 - Provide experience, knowledge and tools for Consumer Directed EISEP
 - Position NYS for Project 2020


Veteran Directed Home and Community Based Services (VDHCBS)

- VDHCBS introduced as a new supplemental component of AOA's 2008 Diversion Grant
- New York—one of 10 states awarded the VDHCBS grant
- Veterans Health Administration will purchase consumer directed and other home and community based services from the Aging Network for eligible veterans of all ages
- Consumer directed services a necessary component
- Provider agreement between the Syracuse VA Medical Center and three pilot counties
- \$10 million available to 10 states initially

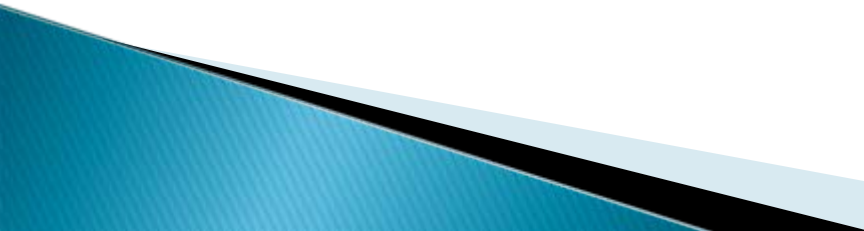
Goals of VDHCBS Program

- Better serve veterans of all ages at risk of nursing home placement and help avoid institutionalization
 - Encourage collaboration and partnerships between Aging and VA networks
 - Reduce duplication of effort and resources
 - Provide consumer directed options for Veterans
 - Replicate and expand program in other areas of the State
- 

Current Status of VDHCBS

- Understanding of each other's networks
 - Agreement on Consumer Directed Approach
 - Consensus on services to be provided
 - Discussions of rates
 - Determination of the referral process and care planning
 - Preparing to sign Provider Agreement
- 

Advocate/ Navigator -- Background

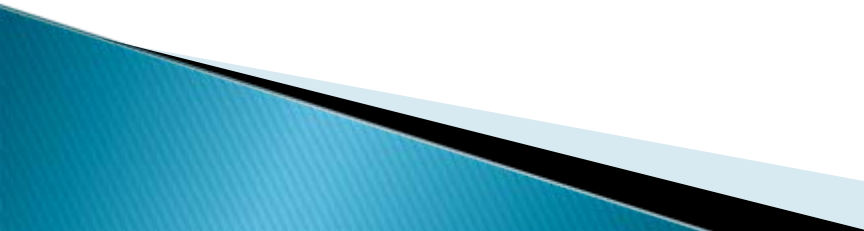
- Readmissions to hospitals cost the U.S. health care system billions of dollars annually
 - One-fifth of Medicare beneficiaries discharged from hospitals were re-hospitalized within 30 days, and most of those return visits were unplanned (Brophy Marcus/Bello, USA Today, 9/9)
 - Federal spending is about 12 billion annually on "potentially preventable" readmissions for Medicare beneficiaries, according to the Medicare Payment Advisory Commission (American Health Line, 7/29).
- 

Navigator--Partners and Approach

- Work with AAA/NY Connects, RSVP, Senior Companion Program, Health Association of New York State (HANYYS), local hospitals and other local organizations to:
 - Create a consumer advocate/navigator in New York State to work directly with targeted older adults and health and social service providers
 - Identify volunteers to become consumer advocates/navigators
 - Provide local training using a standard base curriculum to work directly with older adults and their caregivers who are discharged from local hospitals to provide support to attain optimum health and well-being and maintain their independence
 - Work in concert with hospital discharge planners and hospital auxiliary staff and others to perform functions

Navigator—Possible Tasks

Tasks for the Advocate/Navigator include:

- Help to arrange or provide transportation to doctor's and other appointments
 - Assure that prescriptions are filled and picked up from the pharmacy
 - Advocate on behalf of the older adult
 - Provide assistance with grocery shopping
 - Assist in reading mail
 - Regular contact to check on individuals well being
 - Assist to connect to supports/NY Connects
 - Assist with increasing access to community support services
- 

Navigator –Expected Outcomes

Consumer Outcomes

- (1) Improved care transitions from hospital/acute care setting to the community
- (2) Reduced readmission to the emergency room following a hospital stay
- (3) Improved access to needed medical and non–medical support services in the community
- (4) Increased confidence in role of caregivers and clients through higher health literacy and caregiver support
- (5) Increased compliance with planned medical treatments, leading to improved treatment outcomes and increased quality of life
- (6) Increasing older adult volunteer corps to help address a local need

Navigator—Next Steps

Next Steps

- Establish a “thinking” workgroup to help develop model
 - Review and summarize existing consumer advocates/navigators models to be considered for replication with this project
 - Select model(s) to be used that empower and support older adults and caregivers and support volunteers
 - Identify programs/locations that would like to participate in this project
 - Survey AAA’s/NY Connects and local hospitals interested in participating in the program
 - Design a program that meets their identified needs and priorities
 - Determine cost involved, lead time needed to design the training, etc.
 - If funded, develop Navigator in two demonstration counties
 - Develop training curriculum
- 