

AoA Community Living Program Grant Proposal

Project Narrative

Project Abstract

The State of Oregon Department of Human Services, Seniors and People with Disabilities Division (SPD), in collaboration with two Area Agencies on Aging—Multnomah County Aging & Disability Services (ADSD) and Washington County Disability, Aging, & Veterans Services (DAVS)—seeks Community Living Program grant funding to enhance efforts at diverting individuals from nursing home placement and empowering them to be well-informed long-term care consumers. The goal of this project is to pilot key systemic changes at ADSD and DAVS that will enable those at risk of nursing facility placement and spend-down to Medicaid to remain in home and community-based settings.

Project objectives include: 1) Revising the intake screening process to identify and respond quickly to those at imminent risk of nursing facility placement and spend-down to Medicaid; 2) Implementing long-term care options counseling to help targeted individuals and their families make informed decisions about available services; 3) Expanding existing programs that promote self-directed care and developing new Web-based tools that enable consumers to research benefits and service options; 4) Increasing knowledge, skills, and abilities of case management staff and community partners to equip them to provide consumer-directed care; 5) Developing an evaluation process to track client outcomes and cost avoidance attributable to nursing facility diversion activities.

The project will have four measurable outcomes: 1) Key indicators of imminent risk will be validated; 2) Consumer awareness and use of home and community-based services will increase as a result of long-term care options counseling; 3) 100 at-risk individuals will delay or avoid nursing home placement and spend-down to Medicaid; and 4) Screening and case management staff will increase their knowledge, skills, and abilities to provide consumer-directed care.

Current Status of Aging Network's Role in CLP Efforts in Oregon

CLP grant funding will enable the State of Oregon to build on its pioneering efforts to support older adults and people with disabilities in home and community-based settings (HCBS) and equip them to make informed choices about long-term care options. As the first state to be granted a waiver to serve Medicaid nursing facility-eligible seniors and people with disabilities outside of nursing homes, Oregon fundamentally transformed its Medicaid system by the early 1990s, successfully moving the majority of people out of nursing homes and developing community-based resources—adult care homes, assisted living facilities, and residential care facilities—to serve them. Currently, 81 percent of Medicaid long-term care clients reside in the community (41 percent in in-home and 40 percent in community-based care settings) while only 19 percent are in nursing facilities.

For older adults who do not receive Medicaid long-term care services, Oregon Project Independence (OPI) provides an important alternative to nursing home care. OPI is a state-funded program that serves individuals who are 60 years of age or older or who have been diagnosed with Alzheimer's disease or a related disorder. Services such as personal care, homemaker/home care, chore, assisted transportation, adult day care, respite, case management, registered nursing, and home delivered meals are provided through the state's Area Agency on Aging offices to clients with incomes between 100 percent and 200 percent of Federal Poverty Level who pay on a sliding fee scale. In 2008, over 3,600 clients were served by OPI. In 2005 the Oregon Legislature approved the addition of individuals with disabilities ages 19 – 59 as eligible for OPI services but to date no funds have been allocated to expand the program.

Consumer-directed care is supported by two programs in Oregon: the Client-Employed Provider Program (CEP) and the Independent Choices Program (ICP). Both of these programs meet AoA's definition of Fiscal Management Services. The CEP allows Medicaid and OPI clients to select and hire their own home care workers utilizing the Registry & Referral System of Home Care Workers. The registry is maintained by the Oregon Home Care Commission, which was established in 2000 and charged

with ensuring the quality of home care services that are funded by the state's Department of Human Services, Seniors and People with Disabilities Division (SPD). The Commission acts as the public authority/workforce council and has responsibility for managing payroll for home care workers. A key part of the Commission's responsibilities is providing training for clients to inform them about recruiting, hiring, and managing homecare workers, which is done through the STEPS program and offered by the state's Centers for Independent Living (CIL).

The Independent Choices Program is a "cash and counseling" model that was developed through a Medicaid 1115 demonstration waiver (and has since been converted to a 1915(j) waiver). Through this program, Medicaid clients have the option of having their monthly care plan budget "cashed out." The state sends monthly cash payments to clients' bank accounts and they are responsible for managing personal care and related services within the monthly allotment they receive. Clients are trained on their responsibilities pertaining to employment requirements and on managing their allotment. They also have the option to work with a vendor fiscal/employer agent that provides payroll management and fiscal oversight support.

Recently Oregon has strengthened its commitment to assisting people needing Medicaid long-term care services to remain in the least restrictive setting possible. While Oregon continues to lead the nation in having the lowest proportion of Medicaid long-term care recipients residing in nursing facilities, changes in the environment over the past 10 years (budget constraints, Medicare Advantage Plans, etc.) require a renewed focus and development of new strategies. AAA and state Medicaid programs are targeting diversion and transition services to key populations. Diversion services are provided to prevent a person from becoming a long term resident of a nursing facility. These services may occur prior to nursing facility placement or while a person is receiving skilled nursing facility care. Transition services are provided to persons residing in nursing facilities who have the potential of moving to a home or community-based care setting with the appropriate level of support.

One tool that Oregon has used to reduce unnecessary extended nursing facilities placements is the Private Admission Assessment (PAA) program. This program was developed in 1989 and linked to the federal Pre-Admission Screening/Resident Review (PASRR) Level 1 screening for serious mental illness and developmental disabilities. The goal of the PAA program is to identify and support consumers entering a nursing facility at the significant point in time when challenging and often difficult decisions about long-term care are required. Until recently Oregon has contracted with independent providers to conduct PAAs. A recent assessment of the program found that a significant number of contractors were commercial agencies with a financial interest in consumer long-term care choices. Seniors and People with Disabilities intends to transfer responsibility for this program to AAA and SPD state offices to ensure integration with nursing facility transition/diversion activities outlined above.

Multnomah County's population of people 60 years and older is just over 100,000, which represents approximately 14 percent of the county's total population. ADSD provides a range of services to support individuals seeking to remain in home and community based settings—information and assistance, state-funded case management and in-home services through Oregon Project Independence, nutrition programs, transportation, family caregiver support, Medicaid long-term case management and eligibility determination, and veterans services. Of particular note for this grant opportunity, ADSD's Information and Assistance program—Helpline—is an ADRC-type program that provides 24-hour access to county residents seeking help. Helpline was recently evaluated by an independent consultant charged with analyzing its current functions and making recommendations for moving from an ADRC-type system to becoming a full ADRC. Two key strategies for doing this are enhancing the capacity of Helpline through additional training, staffing, and technological improvements, and establishing a Long Term Care Options Counseling program modeled by integrating ADSD's Long Term Care Screening program for Medicaid-eligible clients with the Helpline and expanding to serve seniors, people with disabilities and their families at all income levels. Community Living Program grant funding would enable ADSD to begin development of a

regional single entry point for Multnomah and Washington counties that serves all older adults, people with disabilities, and veterans regardless of income level.

Washington County is a predominantly suburban and rural area that adjoins Multnomah County to the west. Its 60+ population is slightly more than 55,000, which constitutes 11 percent of its total population. Like ADSD, DAVS offers a full complement of OAA, state, Veterans Administration, and Medicaid-funded services to fulfill its mission of helping residents “create options to maintain quality of life.” DAVS will partner with ADSD to develop a two-county ADRC, which will substantially strengthen DAVS’s information and assistance services and reinforce the agency’s commitment to consumer-direction and helping older adults remain at home and in the least restrictive community settings.

Goals and Objectives

The goal of this project is to pilot key systemic changes at ADSD and DAVS that will enable those at risk of nursing facility placement and spend-down to Medicaid to remain in home and community-based settings.

Project objectives include: 1) Revising the intake screening process to identify and respond quickly to those at imminent risk of nursing facility placement and spend-down to Medicaid; 2) Implementing long-term care options counseling to help targeted individuals and their families make informed decisions about available services; 3) Expanding existing programs that promote self-directed care and developing new Web-based tools that enable consumers to research benefits and service options; 4) Increasing knowledge, skills, and abilities of case management staff and community partners to equip them to provide consumer-directed care ; 5) Developing an evaluation process to track client outcomes and cost avoidance attributable to nursing facility diversion activities.

Proposed Approach

This project will focus on five key areas to effectively divert those at risk of nursing facility placement and spend-down to Medicaid to home and community-based options. **First**, the intake screening

process at ADSD and DAVS will be substantially modified. Currently, ADSD has an ADRC-type information and assistance program and both agencies will benefit from developing a regional two-county ADRC that serves as a single entry point to screen at-risk individuals. This will entail adding staff, implementing changes to the technology currently in use, and enhancing training for ADRC staff so that they are well-equipped to provide information and assistance on the broad scope of programs and services that are available. It also will be necessary to develop an assessment tool that identifies risk indicators, some of which will pertain to physical condition (e.g., need for help with activities of daily living, incidence of falls) others to one's environment (e.g., living alone) and others to the financial resources one has (e.g., life savings). The project will include development of referral and rapid response protocols from the Helpline to LTC Options Counselors within both of the AAAs. In transitioning to a regional ADRC, marketing will be of the utmost importance, and a marketing plan will be formulated and implemented to advertise the ADRC as the single entry point for older adults, people with disabilities, and veterans in the two-county area.

Second, long term care options counseling will be implemented to help the project's target population make informed decisions about their care. Because acute care hospitals are ideal places to identify individuals at-risk for nursing home placement, grant resources will be focused on that setting. Two hospitals affiliated with Providence Health & Services in Oregon—Providence Portland and Providence St. Vincent—serve both Multnomah and Washington counties and are partners in this project, which they view as a unique opportunity to expand upon initiatives already underway to improve transitional care for individuals being discharged from the hospital.

Implementing long term care options counseling builds on established relationships with both hospitals. DAVS has been negotiating with Providence St. Vincent to establish a post-discharge volunteer peer mentor project to assist older adults transitioning back to home and community-based settings. ADSD has an agreement with Providence Portland that co-funds a Medicaid intake worker located in the hospital.

This staff member's primary responsibility is to expedite the application process for Medicaid-eligible patients referred by hospital discharge planning and financial determination staff.

There is good evidence that the risk factors for eventual nursing home placement are similar to those that also put a person at risk for an unnecessary hospital re-admission. Building on existing screening criteria and processes, the project will convene and staff a design team composed of hospital and AAA staff to (1) refine and test a high risk screening tool, and (2) develop referral mechanisms with both AAAs that direct at-risk patients to CLP case managers in a timely and efficient manner. The final products have the potential to impact significant numbers of people. The two hospitals together have an average daily census of 338 patients (all ages, all conditions).

It is anticipated that a good deal of synergy will be generated between the work described above and the work that is already underway with Oregon's Real Choices Systems Change person-centered hospital discharge project. That project features screening on admission to identify high risk individuals, referrals to a Medicaid Case Manager located in the hospital, post-hospital telephone follow-up to assess the stability of the discharge plan, and referrals to a "community health navigator" to intervene in unstable home care situations.

The capacity for provision of long-term care options counseling will be developed by building on the existing infrastructure available in each AAA, in order to ensure sustainability of the project. ADSD plans to utilize its network of non-profit District Seniors Centers that are currently funded through OAA, OPI and local funds for case management services. DAVS will hire a case manager to expand its capacity to provide this new service. Both AAAs will work with their local networks to develop volunteer peer mentoring resources to enhance the capacity of long-term care option counseling. ADSD will partner with Elders in Action, a non-profit organization with a focus on civic engagement for older adults, to expand their Personal Advocate program. DAVS will utilize its Project Reach volunteer program to develop volunteer peer mentors.

A key component of the grant will be to develop and implement a plan to transition grant-funded screening, intake and options counseling to long-term sustainable sources of revenue. Initially, project staff will work to incorporate the Private Admission Assessment program as a component of referrals and funding for the project. By the end of the grant period the AAA partners will have identified a plan for targeting OAA and OPI funds to support long-term care options counseling. To support the expansion of the ADSD 24-Hour Access Helpline to a regional entity the AAA partners will establish an agreement to coordinate funding support. ADSD will also be pursuing the full integration of Medicaid screening into the Helpline to strengthen the coordination of Medicaid and pre-Medicaid nursing facility diversion activities. This will also allow for the leveraging of existing Medicaid staffing resources to sustain the expansion of the Helpline.

Third, existing programs that promote self-directed care will be expanded to empower the target group of consumers to learn about and utilize available service options. The Independent Choices Program (ICP) referred to above, vests control in clients so that they can purchase services as they need them. In addition, consumers have access to training that helps them choose a care provider and services, and also assists them in managing their payroll. This cash and counseling model has proven effective for Oregon's Medicaid clients and it is worth replicating to extend its benefits to those at imminent risk of nursing facility placement and spend-down to Medicaid. Similarly, the Client Employed Provider (CEP) program, also cited above, which allows both Medicaid and OPI clients to select and hire their home care workers utilizing the Registry & Referral System of Home Care Workers, will be an important tool in promoting consumer-direction. As the reach of these programs is expanded, more consumers—e.g., those covered by OPI and paying privately—will be able to take advantage of training offered through STEPS, a program of Independent Living Resources (ILR), the Center for Independent Living (CIL) partner in this project.

In addition to expanding existing programs that support consumer-directed care, new Web-based resources will be developed to further long term care options counseling activities. Staff and partners will

require a thorough understanding of these resources so that they can provide counseling that is comprehensive in scope for both individuals and families. Equally important, consumers need to be equipped to research and direct their own services, or services needed by family members.

This project will implement, utilize and expand several Web-based tools that directly address the needs identified above. The customization of Benefits Check-up, modeled after the Washington state plan but utilizing Oregon-specific programs, will allow both benefits counselors and consumers to identify all federal, state and local programs that might provide financial assistance. The Home Care Registry, developed by the Oregon Home Care Commission, is a Web-based tool that matches employers with available homecare workers. This tool allows the consumer to limit their search by type of homecare provided, what location they are willing to serve, and their availability. This past year, Multnomah County ADSD's Adult Care Home Program was the recipient of the County's Innovative Awards Projects, and it is in the final stages of developing and implementing a comprehensive Web-based tool called Find-A-Home. This program will allow both case managers and consumers to not only identify adult care homes based on a variety of criteria that they identify, but will also include current vacancy information and photographs of homes. Finally, Oregon currently has a statewide database of resources, which due to staffing limitations, is incomplete in several areas of the state. The Real Choices Systems Change ADRC project now in process is evaluating several new statewide database resource directories that may provide more value statewide. Once the pilot ADRC identifies the most suitable statewide database software, ADSD and DAVS will adopt that program.

To ensure that both professionals and consumers are fully informed about the use and value of these tools, a marketing plan will be implemented to guide development of print materials and educational presentations for aging network staff and clients and their family members. The aim of this marketing effort will be to brand these tools in a way that makes them easy to remember as the best places to turn for information and emphasizes their user-friendliness.

Fourth, this project will increase the knowledge, skills and abilities of screening and case management staff and community partners to provide consumer-directed care. There is recognition that training and supports are needed to assist staff to expand their level of knowledge and to incorporate the philosophy of consumer self-direction into their work with clients. The AAAs will work with Portland State University and Independent Living Resources, the CIL serving the two areas, to implement a training and consultation plan for staff and community partners. Portland State University has developed a curriculum promoting “strength-based case management” which provides staff with hands-on training on how to reorient assessment, planning and interactions with clients towards supporting clients’ strengths. Two (2) training modules (introduction and advanced) will be offered repeatedly during the grant period. Independent Living Resources will be a full partner in the grant project and will provide consultation to the project coordinator and partners. It will assist in developing and implementing a quarterly training plan for staff and community partners that addresses a variety of topics pertaining to consumer self-direction. This training will be further reinforced by ILR providing monthly staff consultation services.

Last, project clients will be tracked using Oregon Access, the state-wide client database system. Key variables will be developed using expert-guided focus groups and will include information related to an individual’s health, financial status and perception of long term care options. Case management staff will conduct a re-assessment of each client six months after discharge and report on individual client outcomes. Data will be collected and evaluated by Multnomah County’s ADSD’s Research and Evaluation team. In addition to the development and monitoring of individual client outcomes, ADSD’s Research and Evaluation team will work with SPD to identify cost benefit analysis models regarding nursing facility diversions, applying national models to our regional data set so that an accurate cost savings per client in Washington and Multnomah counties can be developed.

Project Outcomes

The project will have four measurable outcomes: 1) Key indicators of imminent risk will be validated; 2) Consumer awareness and use of home and community-based services will increase as a result of long-term care options counseling; 3) 90 - 100 at-risk individuals will delay or avoid nursing home placement and spend-down to Medicaid; and 4) Screening and case management staff will increase their knowledge, skills, and abilities to provide consumer-directed care.

Within the first nine months of the grant term:

- Key indicators of imminent risk will be validated and an assessment tool will be developed.
- A rapid response screening process and protocols will be developed for the single entry point system serving Multnomah and Washington counties.
- Selected case management staff and community partners will receive training to provide consumer directed care.
- Targeted consumers will receive STEPS training.

Within the first 12 months of the grant term:

- The assessment tool and rapid response screening process and protocols will be fully operational.
- 10 individuals at risk of nursing facility placement will be diverted to home and community-based alternatives.

In the second year of the grant term:

- STEPS training will be provided to targeted consumers on a regular basis.
- Training for case management staff and community partners to provide consumer directed care will be ongoing, with time devoted to case staffings.
- 90 individuals at risk of nursing facility placement will be diverted to home and community-based alternatives.

Project Management

The Project Coordinator will be responsible for planning, organizing, and managing Community Living Program activities in ADSD's and DAVS's service areas. This will involve collaborating with grant partners—Independent Living Resources, Providence Health & Services, and the Portland Veteran's Administration Medical Center—and covering a local-level advisory committee to offer consultation on project aims and actions. In addition, the Project Coordinator will work closely with senior center case management staff to offer training that enhances case managers' ability to provide consumer-directed care in home and community-based settings, and collaborate with other ADRC grant projects in the state as well as state-level advisory committees to ensure effective communication about program development, lessons learned, and best practices. The Project Coordinator will submit required reports and monitor outcomes in conjunction with ADSD Research & Evaluation staff. ADSD's Community Services Manager (see attached ADSD organizational chart) will supervise the Project Coordinator, whose specific tasks are outlined in the attached Work Plan.

Organizational Capability Statement

Oregon's **State Unit on Aging**, the Department of Human Services, Seniors and People with Disabilities Division (SPD) will oversee the contract for this project to ensure compliance with its requirements and SPD staff will meet monthly with the Project Coordinator, ADSD Program Manager, and DAVS Supervisor. Activities will be coordinated at the local level through ADSD and DAVS, the Area Agencies on Aging for Multnomah and Washington counties, respectively.

ADSD will employ and supervise a Project Coordinator to manage the project; partner with DAVS to revise intake screening and develop a two-county ADRC; provide long-term care options counseling to clients in its service area; and evaluate client outcomes as well as cost avoidance that result from project activities. ADSD has a staff of 300 and provides a full range of services—information and assistance, state-funded case management and in-home services through Oregon Project Independence, nutrition programs,

transportation, family caregiver support, Medicaid long-term case management and eligibility determination, and veterans services--to low-income seniors and people with disabilities at nine Senior Centers and five Medicaid offices throughout the County. In addition, its Adult Protective Services, Adult Care Home Licensing, and Public Guardian/Conservator programs offer targeted assistance to those who are most vulnerable and at risk. ADSD offers clients seamless entry to services to ensure that they receive appropriate help regardless of where they enter the system, and to further that aim, four of the eight Senior Centers are co-located with Medicaid offices and all Medicaid sites serve both older adults and people with disabilities.

DAVS will collaborate with ADSD to revise intake screening and develop a two-county regional ADRC, and provide long term care options counseling to clients in its service area. DAVS offers a full complement of OAA, state, Veterans Administration, and Medicaid-funded services, providing direct services in the following areas: information and assistance, case management for OPI clients, family caregiver support, lifespan respite, SHIBA services, and veterans services. As the focal point for older adult services in Washington County, DAVS also provides public information, education, community presentations, service planning, and resource development. DAVS employs a staff of 19 to administer its services and partners with community organizations in developing quality services to meet the needs of a growing elderly population—contracting with approximately 28 community businesses and organizations to deliver services in the following areas: nutrition, counseling, money management, elder abuse, informational and outreach publications (newsletter and community resource directory), home repair, home and personal care, legal aid, caregiver support, RN services, volunteer transportation, friendly visiting, and homemaker services, durable medical equipment, and specialized services for ethnic populations.

Independent Living Resources (ILR) will provide training to clients to equip them to direct their care and it will also train case management staff to increase their knowledge, skills, and ability to provide consumer directed care. ILR is a non-profit Center for Independent Living (CIL) dedicated to helping people

with all disabilities by creating opportunities, encouraging choices, advancing equal access, and furthering independence. Its core services of Advocacy, Information and Referral, Peer Counseling, and Skills Training assist more than 3000 people annually. ILR's STEPS and Skills Training programs are designed to empower consumers by providing information about rights and responsibilities, and helping them develop the skills needed to hire and manage home care workers, thus enhancing their ability remain in home and community-based settings.

Providence Portland and Providence St. Vincent Medical Centers will collaborate with ADSD and DAVS to refer clients who are at imminent risk of nursing facility placement for long term care options counseling and diversion to home and community-based care alternatives. Providence Portland and Providence St. Vincent are part of Providence Health & Services in Oregon, a not-for-profit network of hospitals, health plans, physicians, clinics and affiliated health services. Providence Portland, which primarily serves residents in the Portland area, has 3,425 employees, 968 medical staff members, and 483 licensed beds. Its average daily census is 287. Providence Portland is recognized for excellence in patient care and research in areas such as cancer, heart, orthopedics, women's health, rehabilitation services and behavioral health. Providence St. Vincent, which serves both the Portland area and suburbs to the west in Washington County, has 4,240 employees, 1,786 medical staff members, and 523 licensed beds. Its average daily census based on the most recent data available is 390. Providence St. Vincent has been recognized multiple times as one of the top 100 hospitals in the nation by the Thomsen Reuters evaluation listing, which assesses hospital performance in nine areas: mortality, medical complications, patient safety, average length of stay, expenses, profitability, cash-to-debt ratio, patient satisfaction, and adherence to clinical standards of care.