

**OREGON STATE UNIT ON AGING APPLICATION FOR
THE REAL CHOICE SYSTEMS CHANGE GRANT
Agency Fund Opportunity Number: HHS-2008-CMS-RCS-0009**

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Abstract

The Oregon Department of Human Services (DHS) Division of Seniors and People with Disabilities (SPD) is submitting this application for \$800,000 to develop and implement a Person-centered Hospital Discharge Planning Model under the FY 2008 Combined Real Choice Systems Change grant solicitation. An additional proposal for \$800,000 is being submitted under option 2 of the solicitation to support the development of a new Aging and Disability Resource Center/Single Entry Point Program (ADRC/SEP).

The Division of Seniors and People with Disabilities (SPD) is responsible for administering programs for children and adults with developmental disabilities, seniors and people with physical disabilities. The overall mission of SPD is to assist seniors and people with disabilities of all ages with services and supports that promote choice, independence and dignity. SPD serves as the single Medicaid agency for services to seniors and people with physical disabilities through long-term services, supports programs, and financial assistance programs.

The primary target population of the proposed Discharge Planning Model is Medicaid-eligible individuals of any age, with physical disabilities or chronic illnesses, and their caregivers. The target population for the proposed ADRC/SEP is seniors (60 years of age and older) and people of any age with a physical disabilities.

SPD proposes a discharge planning model that reframes the definition of hospital “discharge” to “care transition” and ensures optimal integration of hospital and community services. Key elements of the model include risk assessment and identification of Medicaid consumers’ discharge goals on admission with early referral to a hospital-based Medicaid Case Manager to help coordinate the post-hospital care plan. For those members of the target population who transition back to home or a community-based care setting additional elements include a post-hospital telephone follow-up with triage and referral to the Local Assistance Center’s Options Counselors. The Options Counselors will be available to make on-site assessments of individuals in their home environment. The Options Counselors will function as community-based health “navigators,” by reinforcing the post-hospital care plan and facilitating the transition from acute to community-based care. Person-centered care planning principles and health literacy communication and education methods will underlie each key element.

The ADRC/SEP proposal is for the development of a statewide interactive online database of resources to be utilized by Information and Assistance programs in Oregon’s 17 Area Agencies on Aging. The database would initially be piloted in one region of the state and then deployed statewide. The second component is the development of a local Aging and Disability Assistance Center, serving both urban and rural residents of Lane County. The Assistance Center will be located in the urban center of Lane County with staff out-stationed in five rural communities. The Lane County Assistance Center will be a prototype for replication statewide in the remaining 16 Area Agencies on Aging.

Without information, skills or supports to make informed decisions people often end up using more intensive and expensive levels of care than necessary. This proposal will create collaboration between and among the critical pathways to long-term support and enable consumers to make decisions about balancing what is important TO them and FOR them.

Proposal for the Development and Implementation of a Person-centered Hospital Discharge Planning Model

Introduction

The Oregon Department of Human Services (DHS) Division of Seniors and People with Disabilities (SPD) is submitting this application for funds to develop and implement a Person-centered Hospital Discharge Planning Model under the FY 2008 Combined Real Choice Systems Change and Aging and Disability Resource Center/Area Agencies on Aging grant solicitation. An additional application to support the development of a new Aging and Disability Resource Center/Single Entry Point Program (ADRC/SEP) follows.

The primary target population of the proposed Discharge Planning Model is Medicaid eligible individuals of any age, with physical disabilities or chronic illnesses, and their caregivers. There is substantial research now to confirm that the discharge process significantly impacts patient satisfaction, potentially impacts health outcomes, and lacks a consistent, coordinated and safe approach.¹ The target population may be even more vulnerable to adverse discharge outcomes to the extent that they have more complex medical needs and lower health literacy.

In addition to addressing the needs of the target population, SPD must also develop a discharge planning model that aligns with Oregon's acute care environment. Data from the American Hospital Association 2006 Annual Survey of Hospitals show that Oregon ranks 44th in hospital admissions (age-adjusted); 49th in Medicare inpatient days, 47th in Medicare discharges and 48th in Medicare average length of stay (ALOS) with 4.69 days. While these data indicate that Oregon has one of the more efficient acute care systems in the country, it may contribute to outcomes that are not person-centered. Patients may be discharged as soon as they are clinically stable but not before all of their goals, preferences and needs have been addressed in their discharge plan. Given the short length of acute care stay, hospital staff may not have the time to empower patients and their caregivers with the information and tools they will need to successfully manage the post-hospital care plan. Similarly, patients and their caregivers are often not able to absorb and comprehend all of the information they are given. Hospital discharge planners may be more likely to direct members of the target population to institutional care because it is more readily available, takes less time to organize and appears safer in the short run.

To address these factors, SPD proposes a discharge planning model that reframes the definition of hospital "discharge" to "care transition" and ensures optimal integration of hospital and community services. Key elements of the model include risk assessment and identification of Medicaid consumers' discharge goals on admission with early referral to a hospital-based Medicaid Case Manager to help coordinate the post-hospital care plan. For those members of the target population who transition back to home or a community-based care setting (e.g., Assisted Living, Group Home, etc.) additional elements include a post-hospital telephone follow-up with triage and referral to Local Assistance Center's Options Counselors, if indicated. The Options Counselors will be available to make on-site assessments of individuals in their home environment. The Options Counselors will

¹ Society of Hospital Medicine Care Transitions Implementation Guide, project BOOST (Better Outcomes for Older adults through Safe Transitions) web accessed June 20, 2008.

function as community-based health “navigators,” by reinforcing the post-hospital care plan and facilitating the transition from acute to community-based care. Person-centered care planning principles and health literacy communication and education methods will underlie each key element.

Development of the Person-centered Hospital Discharge Planning Model

Geographic Reach and Target Population

SPD plans to develop and demonstrate the discharge planning model in concert with health care and community service providers within Lane County, Oregon. Eugene (the county seat) and Springfield comprise the second largest urban area in Oregon, yet the county also includes a large rural population. In 2004, 14.9% of the population was below Federal poverty guidelines compared to 12.9 for the state. A special study conducted by Portland State University’s College of Urban and Public Affairs estimated Lane County’s 2006 population (civilian, non-institutionalized) at 316,056. Of that number, 36,984 or 12%, included individuals age 5 and over with any disability. According to an April 2008 report from the Oregon Department of Human Services, Lane County had 9,784 individuals receiving Medicaid assistance who were eligible due to disability, blindness or age.

Lead Organizations

SPD has Memorandums of Agreements in place with the following organizations to develop and implement a prototype of the proposed discharge planning model.

Sacred Heart Medical Center is part of PeaceHealth, Oregon Region, an integrated health system that also includes critical access hospitals in Cottage Grove and Florence. PeaceHealth Medical Group is a multi-specialist practice with over 110 medical providers at seven locations in the Eugene-Springfield area. South Lane Medical Group has 24 providers in two clinic locations in Cottage Grove, and Health Associates has 20 providers at one clinic in Florence. The parent organization is PeaceHealth, a non-profit health care system headquartered in Bellevue, Washington.

Sacred Heart Medical Center has 412 staffed beds. Utilization data for 2007 show 26,036 total acute discharges, an ALOS of 4.38, and an average occupancy of 75.85%. As a Level 2 trauma center, the hospital may admit patients who live large distances away. The Medical Center employs hospitalists and currently uses a mixed model (registered nurses and social workers) to provide discharge planning.

Lane Individual Practice Association (Lipa), is a Medicaid Managed care plan under contract with Oregon’s Department of Medical Assistance Programs (DMAP). Lipa serves the majority of the target population in Lane County who are eligible for Oregon Health Plan benefits. Lipa includes approximately 860 providers practicing in approximately 175 physician offices. The total number of enrollees in May 2008 was 35,650. As part of its contractual agreement with DMAP, Lipa must provide exceptional needs care coordination (ENCC) and case management for its enrollees who have complex medical and psychosocial needs. ENCC/case management is provided by registered nurses and includes coordination of OHP covered services such as medical care and ancillary services. Linking enrollees with community resources is often part of the ENCC/case management function.

Lane Council of Governments (LCOG) is the designated Area Agency on Aging (AAA) for Lane County. It is one of five Type B Transfer AAAs in Oregon that is responsible for administering both Medicaid and Older Americans Act programs. It currently provides services to over 15,000 seniors and adults with disabilities through one site in the Eugene-Springfield area and five additional sites in the county. The AAA has had a memorandum of understanding in place for over ten years with Sacred Heart Medical Center to fund a 1.0 FTE Case Manager whose primary tasks are to determine Medicaid eligibility, expedite applications and implement an initial care plan for Medicaid consumers. Referrals come from the Discharge Planning staff and typically are individuals who require post-hospital skilled care and community waived services sooner than can be accommodated using the standard Medicaid intake process.

LCOG will also be the host site for developing and implementing a prototype ADRC/SEP.

Lane Independent Living Alliance (LILA) is a cross-disability, consumer-controlled organization operating a center for independent living (CIL) in Lane County with branch offices in Salem. LILA is a non-profit organization with 37 paid staff and five to seven volunteer staff. A majority of both staff and board members are people with disabilities. The four core services that LILA provides are advocacy, information and referral, independent living skills training, and peer mentoring. LILA offers state-funded training designed to provide Medicaid consumers who use home and community based services with the required tools to hire and manage their relationships with paid caregivers. LILA's peer mentors support persons with disabilities in gaining the skills and knowledge that allow for as much independence as possible.

Collaborative Partnerships

Each lead organization will contribute staff to participate on a local Care Transitions Task Force (CTTF). Using grant funds, SPD will provide a grant manager to staff and coordinate the CTTF's work. The CTTF charter will be to determine the feasibility of the proposed model by testing and evaluating each element and providing recommendations for how the elements should be organized, managed, and integrated with the prototype ADRC/SEP. These recommendations will form the basis for the Person-centered Hospital Discharge Planning Model Document required at month 24 of the grant period.

Expanding on the existing services that each lead organization provides, the proposed model will create a virtual Care Transitions Team (CTT) that crosses the boundaries between the hospital, community-based services, and primary care providers. Linkages will be created through ensuring timely handovers between team members at critical points in the discharge planning process (e.g., out-stationing the Medicaid Case Manager at the hospital) and shared protocols (e.g., criteria for post-hospital referrals to Options Counselors, criteria for Options Counselor referrals to Lipa ENCC/case managers). The proposed Local Assistance Center and its staffing model and on-line resources will provide critical infrastructure for the CTT, patients and their families/caregivers.

Underlying the model is SPD's overall philosophy of person-centered care which involves providers and consumers in a process of shared decision-making. Consumers are enabled to make informed decisions about balancing what is important TO them (e.g., independent living in the community) and what is important FOR them. That is, consumers also need to recognize how their age, chronic condition(s) or physical disabilities, and available caregiver supports may place limits on what will

constitute a safe post-hospital environment. At the same time, providers must not underestimate the consumer's capabilities. Providers must be willing to engage in finding creative solutions to a consumer's needs and ensuring adequate resources.

Strategies for Achieving the Vision

This section describes the care transitions process and the specific roles of staff from the lead organizations in achieving the vision.

Eliciting Consumers' Preferences and Promoting Customized Choices

As envisioned, Medicaid consumers will be identified on admission to Sacred Heart Medical Center. A Sacred Heart RN Clinical Coordinator or Social Worker will complete a risk assessment and screen for the consumers' goals and preferences for post-hospital care. Those members of the target population who indicate a post-hospital goal of independent living in the community will be referred to the Medicaid Case Manager, out-stationed at the Medical Center. This team member will be responsible for individualizing the consumer's preferences and engaging the consumer and his/her informal caregiver(s) in deciding how those preferences can be addressed in the post-hospital care plan. If the consumer has complex care needs and psychosocial issues, this team member will consult with hospital social workers. If appropriate, early referrals to LILA will be made at this point in the process.

The consumer's goals and preferences will be reaffirmed again by the staff nurses who are responsible for actual discharge from the Medical Center. At this point in time, staff nurses will also confirm the consumer's understanding of why they were hospitalized, what they should do and who they should contact if medical problems arise post-hospital, the lab tests/results they should discuss with their primary care provider, the proper use of the medications they are going home with, and other pertinent self-care information. If appropriate, the consumer's informal caregiver will be included in the discharge instructions.

Consumer goals and preferences will be affirmed a third time during the post-hospital discharge follow-up telephone calls. These calls will also be made by a Sacred Heart discharge planner (RN Clinical Coordinator or Social Worker) with access to consumers' inpatient medical records. This team member will assess the current status of active medical issues related to the hospitalization as well as the consumer's comprehension of how to take their medications and the presence of side effects, symptoms requiring immediate attention, and self-care protocols. This team member will also assess the extent to which the community services and caregiver supports the consumer requires to remain in their preferred living environment are in place and are adequate.

Consumers who meet agreed upon risk criteria (e.g., at-risk for re-hospitalization) will be referred to the ADRC Local Assistance Center for follow-up by Options Counselors (community health navigators). These team members will be available to complete an in-home assessment that includes the consumer's functional ability, caregiver supports, and overall safety in their home environment. They will reaffirm that the consumer has made an informed decision about their post-hospital care plan. They will be equipped to make the necessary referrals to community services such as LILA and the Family Caregiver Program, and they will work closely with the Medicaid case managers. In

urgent medical situations, the Options Counselors and the consumer will work with Lipa ENCC/case managers on the most appropriate steps to take.

Finally, to the extent possible under the OHP benefits structure, the Lipa ENCC/case managers will promote customized choices for consumers in regard to durable medical equipment, supplies, etc.

Required Training

The proposed model depends on staff having relevant knowledge and skills in at least three content areas: principles of person-centered care, assessing the individual's level of health literacy, and adapting verbal information and instructions to best meet the individual's needs. For example, staff nurses may use teach-back methods at the point of discharge to confirm that the consumer/caregiver understands their self-care requirements and the symptoms of complications that require immediate medical attention.

The Options Counselors/health navigators will need additional training in content areas such as completing a home safety evaluation and observing for signs and symptoms of potential medical conditions (e.g., dehydration, pressure ulcers).

Grant funds will be used to purchase technical assistance to help ensure that the training content and its delivery is effective, efficient, and addresses any scope of practice issues that may be present. SPD assumes that training will be delivered primarily through in-services and workshops using local experts. The training content and schedule for Sacred Heart Medical Center staff will be coordinated with their internal Education and Staff Development department.

Role of Hospital Discharge Planners as they relate to Medicaid Case Managers

In SPD's proposed model, hospital discharge planners and Medicaid case managers are members of the same care transitions team, with a mutual goal of ensuring that consumers make safe, timely transitions to their preferred discharge destination. Both will be involved in determining the criteria for the handovers during the care transitions process that has been described above. The model further reflects a collaborative team effort by out-stationing the Medicaid Case Manager at the Medical Center. The value of having this staff member in close physical proximity to the hospital discharge planners has already been demonstrated in the long-standing MOU between Sacred Heart and LCOG AAA, as well as in other sites.²

Outcome Measures

To evaluate the effectiveness of the proposed model, SPD has selected the following outcome measures. The first two measures are generally accepted as a proxy for evaluating the effectiveness of discharge plans. The third measure evaluates consumer satisfaction. Grant funds will be used to purchase technical assistance on refining the measures and collecting the data. The consultant will also assist in developing a set of process measures to evaluate the impact of the model on post-discharge to nursing facilities versus a community setting.

² See also, Promising Practices in Home and Community-Based Services, *Colorado – Hospital Discharge Fast Track*, updated 11/12/2004.

1. Reduction in the 30-day re-hospitalization rate for the target population, compared to a baseline.

Denominator = all Lipa/Medicaid admissions for a calendar month

Exclusions = all Lipa/Medicaid admissions for obstetrics

Numerator = all Lipa/Medicaid readmissions within 30 days of discharge

Data Source: Lipa Claims Data

2. Reduction in the number of target population ED visits within five days of hospital discharge, compared to a baseline.

Denominator = all Lipa/Medicaid discharges from Sacred Heart Medical Center for a five-day period

Numerator = all Lipa/Medicaid post-hospital ED visits for a five-day period

Exclusions = all Lipa/Medicaid patients discharged from Sacred Heart Medical Center to a skilled nursing facility or an intermediate care facility

Data Source: Lipa Claims Data

3. Medicaid Consumer satisfaction with discharge planning and care transitions

Survey results from a sample drawn from Lipa Enrollment and Claims Data. The survey will be conducted at the beginning of the Developmental Period to obtain a baseline and repeated at the end of the Implementation Period for comparison purposes. Survey questions will be drawn from the 15-item Care Transitions Measure³ and the Hospital-Consumer Assessment of Healthcare Providers and Systems (H-CAHPS) survey responses for discharge planning. The results from the baseline survey will inform the work of determining the organizational and system changes needed to support the model.

While not an outcome measure per se, SPD has determined that it will be important to compare the care transitions team and other providers' expectations for the model with their perception of how well it is working post-implementation. Key informant interviews will be conducted at the beginning of the Development Period and repeated at the end of the Implementation Period. Examples of question categories include integration of hospital and community services, confidence in the care transitions team's ability to delivery high quality services, and the impact of the model on the target population's health and quality of life.

Conclusions

SPD believes this is a superior proposal in several respects. First, the foundation for a strong collaborative effort among the lead organizations is already in place which will make it possible to conduct a pilot test of the model before the end of the Developmental Period. The pilot test will lead to a more successful implementation. We also anticipate being able to expand the model to one of Peace Health's critical access hospitals before the Implementation Period ends. This will provide an opportunity to observe what factors need to be in place to replicate the model, especially in rural Oregon.

³ Eric Coleman, et.al.

Second, the proposed model aligns with current initiatives to ensure access to health care for Oregonians, contain health care costs, and address issues of quality in health care that will be submitted to the Governor for review in October 2008. A comprehensive plan will be submitted to the 2009 Oregon Legislature in the Governor's budget. It will include a Policy Option Package for Integrated Health Homes (or medical homes), which assumes that post-hospital follow-up should reside with primary care and reimbursement should be available to support it. This has important implications for determining how the model could be sustained after Federal funds have expired.

Finally, Oregon's acute care system, coupled with its innovative community-based long term care system, provides a unique laboratory for demonstrating a care transitions model that may inform CMS and others on national policy regarding discharge planning.

A detailed work plan follows.

Work Plan and Timeline: Person-centered Hospital Discharge Planning Model

Phase 1: Developmental Period (October 2008 – September 2010)			
Major Activity	Key Tasks	Time Frame	Responsible Party
1.1 Project Start-up	Recruit and hire Grant Manager	Oct.-Sept. 2008	SPD
	Complete contracting process for technical assistance		SPD
	Formalize Care Transitions Task Force (CTTF) membership, establish meeting schedule and logistics		CTTF/Grant Manager
	Review and approve CTTF goals, objectives, time frames		
	Finalize stakeholder vision of the model	Oct. Dec.- 2008	CTTF/Grant Manager
1.2 Collect baseline data for outcome measures	Develop key informant interview questions; select and recruit key informants; conduct key informant interviews and collate results	Jan. – Feb. 2009	Grant Manager/Consultant
	Develop and test transitions satisfaction survey instrument	Jan. – Mar. 2009	Grant Manager/Consultant
	Conduct baseline transitions satisfaction survey and collate results	April – June 2009	Grant Manager/Consultant
	Begin collecting baseline data for re-hospitalization rates and ED visits	January 2009	Lipa
1.3 Determine organizational/system changes needed to support the model	Compare current discharge planning processes/tools with best practices (see, for example, Project BOOST recommendations).	Jan 2009-July 2009	Sacred Heart Medical Center staff
	Conduct gap analysis of existing protocols for referrals among lead organizations and determine requirements for revised processes (e.g., screening, handovers).		Grant Manager/CTTF
	Determine staffing model		Grant Manager/CTTF
	Determine training content and delivery models		Grant Manager/Consultant
1.4 Align care processes, staffing needs and competencies to support the Model	Draft new protocols for revised processes	Aug. 2009 – Jan. 2010	Grant Manager/CTTF
	Draft care transitions team members' job descriptions		Grant Manager/CTTF
	Recruit new staff as needed		Sacred Heart/LCOG
1.5 Complete orientation and training for staff.	Review processes, staff responsibilities with Care Transitions Team (CTT)	Feb. 2010 – June 2010	Grant Manager/CTTF
	Complete initial training for CTT and other key staff (e.g., hospital nursing staff)		Grant Manager/Consultant/CTTF
1.6 Test the Model with a pilot population	Define pilot population (e.g., Medicaid only/managed care)	July 2010 – Sept. 2010	Grant Manager/CTT/Consultant
	Define process measures for evaluating the pilot		
	Conduct the pilot, evaluate results. Use “lessons learned” to refine the model.		Grant Manager/CTT/Consultant

			Grant Manager/CTT/CTTF
1.7 Complete Person-centered Hospital Discharge Planning Model document	Prepare a draft for review and comment by CTTF, CTT, and other stakeholders Prepare final document and submit to CMS	Sept 2010	Grant Manager Grant Manager/SPD
1.8 Submit Progress Report		Sept. 2010	Grant Manager/SPD
Phase 2: Implementation Period (October 2010 – September 2011)			
2.1 Expand the model to include all members of the target population	Determine sequence and time frames for phasing-in target population segments (dual eligibles, etc.) Evaluate model's performance after each phase-in and make necessary adjustments	Oct 2010-Sept 2011	Grant Manager/CTT/CTTF Grant Manager/CTT/CTTF
2.2 Expand the model to one critical access hospital in Lane County	Recruit, orient staff from critical access hospital and Local Assessment Center Test and evaluate the model with a pilot population Phase-in target population	Oct 2010 Jan 2011 April 2011	CTTF/CTT/Grant Manager TBD TBD
2.3 Evaluate model based on baseline and re-measurement outcomes data	Conduct re-measurements for hospital readmissions and ED visits Repeat consumer satisfaction survey Repeat key informant interviews	April 2011 – Sept 2011	Lipa Grant Manager/Consultant SPD
2.4 Report out evaluation findings to key stakeholders	Prepare relevant documentation and support materials+	Sept.- Dec. 2011	CTTF/SPD
2.5 Submit Progress Report		Dec 2011	SPD

Proposal for the Development of an Aging and Disability Resource Center – Option 2

Problem Statement/Target Population

The Department of Human Services' (DHS) Division of Seniors and People with Disabilities (SPD) is responsible for administering programs for children and adults with developmental disabilities, seniors and people with physical disabilities. The overall mission of SPD is to assist seniors and people with disabilities of all ages to achieve well-being through opportunities for community living, employment, family support and services that promote choice, independence and dignity. The target population for this grant application is seniors and people of any age with a physical disability.

SPD serves as the single Medicaid agency for services to seniors and people with physical disabilities through long-term services, supports programs, and financial assistance programs. SPD is responsible for the licensing standards and inspections of care facilities including nursing homes, assisted living, residential care and adult foster homes. SPD provides oversight to homecare workers through training and maintenance of a worker registry. SPD serves as the Adult Protective Services agency for seniors and adults with physical disabilities.

Additionally, as the State Unit on Aging, SPD administers the Older Americans Act and Oregon Project Independence, a state-funded in-home services program targeting people over the age of 60 who are not receiving Medicaid-funded long term services and supports. Throughout the State of Oregon, SPD has designated 17 Area Agencies on Aging (AAA) to deliver services to local communities. Oregon Revised Statute, Chapter 410, allows AAAs to choose to serve seniors, or seniors and people with disabilities. It also allows AAAs to choose between administering only the Older Americans Act and Oregon Project Independence or also administering Medicaid programs. AAAs are designated as Type A (providing only Older Americans Act (OAA) and Oregon Project Independence (OPI) services) and Type B (providing Medicaid services in addition to OAA and OPI). In locations where the AAA chooses not to administer Medicaid services, SPD has state offices providing those services.

In many communities across the nation, navigating the complex system of long term services can be difficult and poses a barrier to independent living and personal choice. While Oregon's long-term services and supports system is more coordinated than many areas, individuals still face challenges accessing the information and assistance they need during critical transition points in their life. With 36 counties and 17 AAAs coupled with the regional differences in the organization of the service delivery system, access to information and coordination of services has not been consistently applied throughout the state.

Since 1981 Oregon has led the nation in the development of Medicaid funded lower-cost alternatives to institutional (nursing home) care. Although state Medicaid funding in Oregon for 2005 was almost equally split between nursing homes, community facilities and home care, more than 80 percent of clients received services in their own homes or in their communities.⁴ Continued success will require SPD to devise strategies to meet accelerated hospital discharges due to Medicare payment methodologies. Included in the strategies will be enhancement of nursing facility diversion and relocation efforts.

⁴ Department of Human Services – Ways and Means Presentation, January 23-24, 2007

The State of Oregon has clearly made an investment in creating community-based options within the Medicaid long-term services and supports program. However, for those not receiving Medicaid and over the age of 60 access to information and assistance is severely limited. For those individuals under the age of 60 with a disability, there is virtually no program outside of Medicaid to help. Without information, skills or supports to make informed decisions people often end up using more intensive and expensive levels of care than are necessary. To minimize confusion and enhance individual choice SPD must invest in services to people not eligible for Medicaid that are consistent and reliable across the state.

The need for long-term services and supports can impose significant financial hardship on individuals. In 2006, the average daily private rate charged for nursing home services in Oregon was \$213 a day, nearly \$6,400 per month or \$78,000 a year. Community-based services such as Assisted Living are costly as well. In 2006, the average monthly private cost for an assisted living facility was \$2,400 and \$2,700 for the Portland and Eugene markets respectively.⁵

Most people lack the financial resources to afford services for a significant period of time. When they exhaust their assets they often have to rely on Medicaid to fund their long-term services and supports. Approximately 27,000 seniors and people with disabilities access long-term services under Medicaid today. Without intervention SPD expects that 44,000 individuals will have Medicaid-funded services and supports by 2030. Additionally, Oregon is experiencing a reversal of a 30 year trend in declining nursing facility utilization funded by Medicaid. Between 1996 and 2006, Oregon Medicaid Nursing Facility utilization decreased each year for an overall decline of 29%, but since 2006 it has increased each year.⁶

The majority of seniors and consumers with disabilities face decisions related to long-term service supports for the first time following hospitalization for an acute event or decline in a chronic health condition. Most health care reimbursement systems create a strong financial incentive for hospitals to reduce the average length of stay for all patients. Oregon has one of the lowest hospital lengths of stay in the nation ranking 48 out of 50 states.⁷ This incentive creates pressure on the hospital discharge planners to move patients out of the hospital as quickly as possible. Nursing homes are equipped to admit people on short notice without significant planning work. In contrast, setting up a comprehensive package for in-home supports requires much more time and effort.

SPD together with the Area Agencies on Aging and other stakeholders embarked on an intensive planning process to evaluate our current system and recommend changes that would enable Oregon to more effectively meet the needs of seniors and people with disabilities. In May 2006 SPD in conjunction with a large stakeholder group and eight issue-specific subgroups issued a preliminary report entitled “Recommendations on the Future of Long-Term Care in Oregon.” In partnership with the Governor’s Commission on Senior Services, SPD and the Commission hosted public forums in 17 areas of the state to gather input on these recommendations. In November 2006 the Commission issued a follow-up report summarizing the results of the public forums and proposed additional recommendations. SPD, the Commission, and other stakeholders also discussed the details of these reports with several substantive committees of the 2007 Legislature, as well as the Joint Ways and Means Committee. At the conclusion of the 2007 session the Ways and Means Committee directed SPD to report to the Emergency Board by June 30, 2008 and to the 2009 Legislative Assembly on its

⁵ MetLife Market Survey of Nursing Home & Assisted Living Costs, October 2007

⁶ Data Source: Oregon Medicaid Management Information System (MMIS)

⁷ Oregon Association of Hospitals and Health Systems: [www.oahhs.org/data_comparisons](http://www.oahhs.org/data/state_comparisons)

comprehensive and on-going planning efforts for the long-term services and supports system for seniors and people with disabilities.

After the 2007 Session, SPD appeared multiple times before the Senate Interim Committee on Seniors and People with Disabilities and a House Subcommittee focusing on the same issues. In addition, the two committee chairs, Senator Bill Morrisette and Representative Jean Cowan, met several times with representatives of key senior and disability stakeholder groups to prioritize critical issues for potential inclusion in the long range plan. These efforts culminated in the passage of Senate Bill 1061 by the February 2008 Supplemental Session. The bill codifies planning directives to SPD related to the development of its long-range plan for a long term services and support system that:

- Is not funded by Medicaid;
- Is based on early intervention and prevention services; and
- Provides a single point of entry to the entire aging and disabilities network.

Since early fall 2007 Oregon's Area Agencies on Aging (AAAs) and Seniors and People with Disabilities (SPD) have been planning the development of a comprehensive and statewide network of resources to provide early support to individuals and their families. Each Oregonian who chooses will have easy access to long-term support resources, including comprehensive information, awareness, education, and guided assistance. The goal is to honor and support the desire of individuals with disabilities or who are aging to remain independent, healthy, safe and active in their home communities, and to avoid institutionalized forms of long-term services and supports, whenever possible.

The network envisioned will be known as Oregon's *Aging and Disability Resource Connection (ADRC)* and will serve any senior (60+) or younger person with physical disabilities without regard to income. It will include three major components:

- A Central Information Center for statewide access by a well publicized toll-free telephone number, supported by a robust online resource database and by a sophisticated web-based service system including e-mail for specific questions.
- A network of 17 Local Assistance Centers operated by the Area Agencies on Aging and Disabilities (AAAs).
- An expanded set of direct services and resources to help members of the target populations remain independent, healthy, safe and active. The AAAs will administer these expanded services and resources in collaboration with other DHS offices, community partners and providers.

SPD has developed a funding proposal for the first phase of the ADRC development. The proposal will be considered by the Department of Human Services and the Governor for inclusion in the budget recommended to the 2009 Legislature. If funded the Real Choice Systems Change grant proposal would jump-start those efforts and provide Oregon with an opportunity to pilot a Local Assistance Center in Lane County an area that serves both urban and rural communities. Additionally, the federal/state partnership established by this grant would add to the credibility of our budget proposal for state funds.

Proposed Interventions

This proposal is for the development of a statewide interactive online database of resources to be utilized by Information and Assistance programs in Oregon's 17 AAAs. The database would

initially be piloted in one region of the state, Lane County, and then deployed statewide. The second component is the development of a local Aging and Disability Assistance Center, serving both urban and rural residents of Lane County. The Assistance Center will be located in Eugene/Springfield, the urban center of Lane County, with staff out-stationed in five rural communities. The Lane County Assistance Center will be a prototype for replication statewide by the remaining 16 Area Agencies on Aging as funding becomes available.

1. Interactive Online Database

Oregon's AAAs have been working intensively over the last two years to populate the current long-term services and supports website with local resources. They have utilized an Alliance of Information and Referrals Systems (AIRS) compliant taxonomy and have adopted a set of front-end standardized categories.

This proposal will take our current efforts up to the next level by introducing systematic screening and assessment tools. These tools will support consumers in making better decisions on their own when choosing services and supports options, and quickly connect them to more intense assessment services as needed. Each time an individual logs in to the site they will be able to update their information (which will include ability-based information as well as their financial data). Based on their input consumers will automatically be provided information on services most suited to their needs.

As the consumer logs in and enters data, the information will be simultaneously transferred to a central database via the Web in real-time using data sharing protocols. Unlimited data can be stored. The database will equip AAAs with a consistent application for referrals and client tracking allowing for uniform follow-up and evaluation. Recognizing resource limitations an off-the-shelf software product will be customized to avoid intensive in-house processes to maintain.

The online tools will assist consumers and their long-distance caregivers who like to search the Internet for information before seeking more in-depth consultation from the AAA. For individuals who like to use the telephone first the tools will assist AAA staff to help them access appropriate resources quickly. In addition, it will be an easy method for other professionals (ex. health care providers, hospital discharge planners) to immediately assist consumers that seek advice at critical access points in entering the long-term services and supports system.

2. Local Assistance Center

The second major component of this proposal is to establish a Local Assistance Center in partnership with Lane Council of Governments (LCOG), Senior and Disabled Services, the designated AAA for Lane County headquartered in Eugene. The Local Assistance Center will be the linkage between and among the major pathways to long-term support. Specifically under this grant proposal, the Aging and Disability Local Assistance Center will help with the transition from acute hospital based care to community based care which will link people to the right information at the right time. Through web-based resources, phone contact, and home visits by a trained Options Counselor the Aging and Disability Local Assistance Center will offer personal and individualized help to the consumer.

Lane County was selected for this project because of its experience, diversity of populations, and area, which includes urban to very rural communities. Lane Council of Governments (LCOG) has expertise in several pertinent areas to this grant. LCOG is a voluntary association of general and

special purpose governments in Lane County. It is governed by a board of directors comprised of elected officials from twenty-seven (27) public agencies in the area. Among its many responsibilities, LCOG is the designated Area Agency on Aging and Disability Services for Lane County. Within LCOG operational responsibility for services for senior citizens and people with disabilities rests with Senior & Disabled Services (S&DS) and two citizen advisory councils – the Senior Services Advisory Council and the Disability Services Advisory Council. The by-laws of both Advisory Councils require that more than fifty percent (50%) of its members be consumers. Under contract with the State of Oregon S&DS is a “Type B Transfer Area Agency on Aging”. As such S&DS administers the Medicaid program for seniors and people with disabilities in Lane County including eligibility for long term services and supports. Additionally, S&DS receives Older Americans Act and State of Oregon funding to serve people over the age of sixty (60) who are not receiving Medicaid long-term services and are at risk of institutionalization. S&DS is a Single Entry Point for Medicaid, Older Americans Act services, and State funded services to seniors and people with disabilities.

Using Older Americans Act funds (Title IIIB and IIIE), S&DS has created the Senior Connections program, designed to offer personalized assistance by phone or through a home visit. By stationing staff in six communities throughout Lane County (including five offices in rural communities) the Senior Connections program has a presence in both urban and rural environments. However, the Senior Connections program has been restricted to serving people 60 years of age or older due to its funding through the Older Americans Act. Building on the success of this program the assistance centers will continue to serve seniors and begin offering services to younger adults with disabilities.

LCOG will partner with the Lane Independent Living Alliance to bring their expertise to the Local Assistance Center. Lane Independent Living Alliance (LILA) is a cross-disability, consumer-controlled organization operating a center for independent living (CIL) in Lane County with branch offices in Salem. LILA is a non-profit organization with 37 paid staff and 5-7 volunteers. A majority of both staff and board are people with disabilities. The LILA team is eager to partner in the Real Choices project since it is closely aligned with LILA’s four core services: peer mentoring, information & referral, advocacy, and independent living skills training. LILA offers state-funded training designed to provide Medicaid consumers who use home and community based services with the required tools to hire and manage their relationships with paid caregivers. LILA’s peer mentors support persons with disabilities in gaining the skills and knowledge that allow for as much independence as possible.

When a consumer (i.e. the care recipient, family member, care providers, or any other interested party) contacts the Assistance Center, a Resource Specialist will assist consumers in accessing services by using the online tool to identify resources and make referrals to local provider agencies. To assure a consistent standard of service across the centers Resource Specialists will be provided training and technical assistance to become Certified Information and Referral Specialists (CIRS) and Certified Information and Referral Specialists – Aging (CIRS-A) by the Alliance of Information and Referral Systems.

For consumers that are encountering more complex issues that are not easily addressed through phone or web-based referrals the Resource Specialist will offer the opportunity to access options counseling. To minimize confusion and ensure coordination of services a facilitated transfer between these two functions will occur.

The Options Counselor will assist consumers who have intermittent and short-term needs (especially at key or critical decision-making points in their lives) and provide education and outreach to help them understand their options. The Counselor will:

- Provide education, assistance, and advocacy tailored to meet consumers' specific needs;
- Provide information and resources to enable consumers to understand their options for immediate services and supports;
- Offer consumers and their families short-term and intermittent assistance over time as needed, developing long-term relationships as life events change;
- Conduct in-home assessment with consumers as appropriate to explore options and expedite access to services;
- Empower family caregivers to make informed decisions;
- Facilitate application to public assistance programs, such as Medicaid, for those interested and potentially eligible.

The Options Counselor will work as a consultant rather than as a long-term case manager. While the Counselor and the long term case manager work collaboratively there are important differences in eligibility, processes, and level of involvement with consumers.

Marketing, Outreach and Public Education

A professional marketing firm will be engaged to develop a marketing plan for external audiences including our target population, major employers, the health care community (health systems and plans), and the general public. A marketing plan targeted to our internal network will also be developed to educate people working for and with the ADRC on a regular basis. This includes training volunteers such as home-delivered meal drivers to provide information about the ADRC to people who are new to their services.

A toolkit will be developed for community partners and organizations to help promote the online database and the local assistance center of the ADRC. The toolkit will provide training materials, posters, signage, marketing materials, kiosk cards, and kiosk card holders. Kiosk cards will be developed on topics of interest to the target population such as falls prevention, planning for retirement, assistive technology, and benefits programs. The information will be culturally appropriate and directed to the preferences and needs of consumers. Kiosks will be set up in locations such as libraries, health clinics, hospitals, senior centers, athletic clubs, large employers, not-for-profit agencies, faith-based organizations, government agencies and shopping malls.

Facilitation of Person-Centered Hospital Discharge Planning Model

This portion of the grant proposal will facilitate the Person-Centered Discharge Planning Model in two ways. First, the online database of resources will assist hospital discharge planners in the development of options for post-hospital services and supports. The database will contain listings of all licensed care throughout the state with a description of the level of care provided and their current vacancy status. The database will also link with the Homecare Worker Registry to identify the availability and skill level of in-home care workers. Information packets about the services of the ADRC will be developed and made available to discharge planners for distribution to patients and their families.

Second, the Person-Centered Hospital Discharge Planning Model includes post-hospital follow-up by a hospital RN Discharge Planner or Social Worker initially by phone. As part of the post-hospital

follow-up referrals will be made to the Options Counselor for patients who are at risk of re-hospitalization and could benefit from further intervention and contact. Established protocols will be created to assure the target population will be served by the Local Assistance Center. The Counselor will conduct in-home visit(s) to assist the individual with any self-management supports or advocacy needed to assure that their preferences for long-term services and supports are met. In-home visits may also take place pre-discharge, as needed, to provide assistance to the patient's caregiver in assuring the home environment is adequate to support the post-discharge plan. This linkage will provide an important connection between acute and community based care facilitating a smooth transition.

Coordination of Programs

Oregon has been striving for a coordinated, single-entry system for services to seniors and persons with disabilities since passage of Oregon Revised Statute 410 in 1981. This law vested responsibility to SPD and the AAAs for services to this population whether supported by Medicaid, the Older Americans Act or state funds. As envisioned in the state-wide planning efforts to date the ADRC will further this endeavor by creating easy access to information and services for people regardless of income level or other eligibility criteria.

Advisory Council...Consumer Involvement

A state-wide ADRC Advisory Council will be established and provided staff support from SPD's State Unit on Aging program. Members will be chosen from across Oregon and will have a wide variety of experiences. More than half of the members will be consumers. The Council will also include consumer family members and representatives from advocacy and community based service providers. The goal is for balanced representation of public and private partners across the disability and aging communities, members who are from metropolitan, urban, and rural areas, culturally diverse and traditionally under-served communities including people of color, tribal nations and people who are low-income.

The Advisory Council will be engaged to steer this grant proposal and develop a multi-year strategic plan for the full development of *Oregon's Aging and Disability Resource Connection*. The Council will assist in the identification of unmet need and strategies to meet that need. It will guide the policies and procedures of the ADRC. The Council will be instrumental in the establishment of measurable performance goals for the ADRC and evaluate outcome data to determine progress toward meeting those goals.

Commitment of Partners

Key partners with SPD for this grant proposal are Lane Council of Governments (the AAA in Lane County) and the Lane Independent Living Alliance. Both entities have provided letters of support stating their commitment to the development of a Local Assistance Center. The following entities have provided letters of support for the proposal and offered to participate on the Advisory Council:

- Oregon Association of Area Agencies on Aging and Disabilities
- Governor's Commission on Senior Services
- Oregon Disabilities Commission
- Oregon Health Care Association, representing for-profit healthcare providers
- Oregon Alliance for Senior and Health Services, representing non-profit healthcare providers
- Seniors Serving Oregon Coalition, representing Senior Corps programs

- Senior Health Insurance Benefits Assistance, Oregon’s SHIP program
- Oregon’s Long-Term Care Ombudsman
- AARP
- Acumentra Health, Oregon’s Quality Improvement Organization
- Department of Human Services, Public Health Division, Health Promotion and Chronic Disease Prevention Section
- Oregon Homecare Commission
- Lane Independent Living Alliance, a Center for Independent Living
- Lane Council of Governments, an Area Agency on Aging
- Lane Transit District

Organizational Capacity/Key Project Personnel

The Department of Human Services (DHS) Division of Seniors and People with Disabilities (SPD) will serve as the lead agency and fiscal agent for the project. DHS as the Medicaid agency for the State of Oregon has demonstrated capacity to manage complex programs and has internal controls in place to assure compliance with applicable laws and regulation. The principle investigator/project coordinator will be Elaine Young, manager of the State Unit on Aging.

Evaluation, Formative Learning and Management Information System

For this project, an evaluation consultant will be retained to determine how to effectively measure the impact of the project model on the quality of life for participants. The consultant will work with the project manager, advisory council and project partners to develop the model of evaluation, determine data collection parameters and methods for data collection, and develop measurable goals for the project by the end of year one.

Preliminary Performance Goals will include: **Ease of Access:** Professionals and consumers will have access to the online resource database and local assistance centers. Consumers will experience less confusion and enhanced individual choice. **Visibility:** Implementation of the marketing plan will inform the public of the availability of information and assistance services resulting in an increase in the proportion of the target population being aware of how to contact the local assistance center and/or online resource database. **Trust:** Professionals and consumers will indicate confidence in the information provided by the local assistance centers and the online resource database. **Responsiveness:** Professionals and consumers will experience improved ability to connect to services and supports. **Efficiency:** The agencies involved in the project will create a collaboration that will result in expediciencies in referrals with more focused results. The online self-assessment tools will provide consumers with the ability to evaluate their needs and more clearly articulate the type of supports desired. **Effectiveness:** Consumers will choose services most suited to their needs.

Some of the quantitative indicators to measure progress toward the performance goals include: number of times the online resource database was accessed by consumers and professionals, the number of resources provided, impact on costs to publicly funded services such as nursing facility admissions, number of calls handled by the local assistance centers. Additionally, a combination of pre and post tests and consumer satisfaction surveys will be conducted.

Ongoing evaluation results will be used to monitor developments, learn from mistakes, and improve the project in a timely and effective manner. Monthly reports will be submitted by Lane County AAA, so that the project manager and advisory council members will be able to identify problems and seek solutions to these problems as they occur. Quarterly, the project manager and advisory council will review progress against work plan activities and identify modifications as needed to ensure that project milestones are being met. At the end of the three-year grant cycle, the Advisory Council and the program partners will measure the project's quality in terms of strengths, weaknesses, quality of the design, quality of the management, adequacy of resources, impact on target populations, impact on the community and potential to replicate.

Work Plan and Timeline: ADRC-Option 2

1. Professionals and consumers will have access to an online resource database and local assistance centers. Consumers will experience less confusion and enhanced individual choice.

Major Objectives	Key Tasks	Lead Person	Timeframe
1.1: Develop online resource database	Complete request for proposal/contracting process to secure a vendor	Grant Manager	Year One: October 2008 through December 2008
	Database design/testing	Grant Manager/IT Vendor	Year One: January 2009 through Year Two: March 2010
	Database Roll-out	Grant Manager/IT Vendor	Year Two: April 2010 through September 2010
1.2: Local Assistance Center	Complete Intergovernmental Agreement with LCOG for scope of work related to development of Local Assistance center	Project Director/Grant Manager	Year One: October 2008 through November 2008
	Planning/development of Local Assistance Center	Grant Manager/LCOG	Year One: December 2008 through March 2010
	Roll-out of Local Center	Grant Manger/LCOG	Year Two: April 2010
	Monthly reporting of planning/activity to Advisory Council	Grant Manager/LCOG	Year One: December 2008 through Year Three

2. Implementation of the marketing plan will inform the public of the availability of information and assistance services resulting in an increase in the proportion of the target population being aware of how to contact the local assistance center and/or online resource database.

Major Objectives	Key Tasks	Lead Person	Timeframe
2.1 Develop marketing plan for internal and external audience	Complete request for proposal/contracting process to secure a vendor	Grant Manager	Year One: July 2009 through September 2009
	Develop plan	Grant Manager/vendor	Year Two: October 2009 through March 2009
	Implement plan for internal/external audiences	Grant Manager/vendor	Year Two: April 2009 through Year Three
2.2 Establish kiosks	Complete request for proposal/contracting process to secure a vendor	Grant Manager	Year Two: July 2009 through September 2009
	Develop and print information cards for kiosks	Grant Manager/vendor	Year Two: October 2009 through March 2010
	Recruit kiosk locations and set up kiosks	Grant Manager/LCOG	Year Two: April 2010 though Year Three

3. The project will be evaluated to assure it is consumer-focused and can clearly demonstrate measurable outcomes.

Major Objectives	Key Tasks	Lead Person	Timeframe
3.1 Establish Advisory Council	Planning retreat and monthly meetings	Project Director/Grant Manager	Year One: November 2008 through Year Three
3.2 Evaluation	Contract with outside entity and develop evaluation plan/tools	Project Director/Grant Manager	Year One: July 2009 through December 2009
	Conduct evals and report outcomes to Adv. Council	Project Director/Grant Manager	Year Two through Year Three