Pathways To Community Living

# Illinois' Money Follows The Person Demonstration "Pathways to Community Living"

Stakeholder Committee Meeting
February 29, 2012

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# Presentation Overview

1. Overview and Background
2. Requirements and Current Status
3. Lessons Learned
4. Future Initiatives and Directions
5. Stakeholder Group
6. Next Steps

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# Overview and Background

# Long Term Care Re-balancing in Illinois

- Olmstead related lawsuits
  - *Williams v. Quinn* (SMI – IMD's)
  - *Ligas v. Quinn* (developmental disabilities)
  - *Colbert v. Quinn* (residents with disabilities and elderly in non-IMD nursing facilities in Cook County)
- State facility closures
- Long term care re-balancing continues to be a congressional, federal, and state priority

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# Money Follows the Person (MFP)

- Federal Demonstration Project – not a grant
- Authorized by the Deficit Reduction Act 2005 and extended until 2016 by the ACA
- Administration: Federal Centers for Medicare and Medicaid – CMS
- 43 states and the District of Columbia participate in MFP

# Illinois' MFP: "Pathways to Community Living"

- Illinois' MFP program, "Pathways to Community Living," targets four populations:
  - Individuals over age 60
  - Individuals with developmental disabilities
  - Individuals with physical disabilities
  - Individuals with serious mental illness
- Operational Protocol was approved in 2008, with transitions beginning in 2009

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# Program Objectives

- Reduce or eliminate barriers to receiving Long-term Care services in community settings
- Increase ability of state Medicaid programs to sustain the provision of Home and Community Based Services (HCBS) for individuals who transition from institutional settings
- Ensure continuous quality improvement in Medicaid HCBS service delivery

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# Operational Protocol Benchmarks

- Illinois' Operational Protocol was approved in 2008.
- Operational Protocol benchmarks include:
  - Annual increase in total long term care community spending
  - Increase in yearly transitions
  - Shift in balance of LTC spending to community based services and supports
  - Development of an Adult Serious Mental Illness (SMI) HCBS waiver(s)
  - Housing locator & referral network (joint project with Illinois Housing Development Authority (IHDA) taking the lead in its development)

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# Participating Departments/Divisions

- Department of Healthcare and Family Services (DHFS)
- Department on Aging (IDoA)
- Department of Human Services (DHS)
  - Division of Mental Health (DMH)
  - Division of Rehabilitation Services (DRS)
  - Division of Developmental Disabilities (DDD)
- Other partners include:
  - The Illinois Housing Development Authority
  - The University of Illinois at Chicago – College of Nursing
  - Stakeholders (consumers, providers, friends, family)

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# Requirements and Current Status

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# Eligibility Requirements

- Qualified institutional stay (nursing home) of 90 days or more
  - Change resulting from ACA – previously 6 months
- Medicaid beneficiary/recipient for a minimum of one day prior to community transition
- Nursing home level of care for IDoA, DRS, DMH and DDD participants, ICF/DD level of care for DDD
- Must be interested in transitioning to a qualified community setting

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# Qualified Community Settings

- Home owned or leased by the individual or a family member of the individual
- Apartment with individual lease, secure access & living, sleeping, bathing & cooking areas over which the individual or his/her family has control
- Community-based residential settings with no more than four unrelated individuals
- In Illinois, transition to a SLF is considered a qualified community setting

# Supports and Services

- Support with a move into the community including individualized assistance and available financial support
- Assistance from a qualified transition coordinator – 365 day follow up
- Development of a transition and care plan with linkage to community services
- Housing services including assistance in finding a home, rental assistance, and home modification
- Quality assurance and case consultation and review by the University of Chicago – College of Nursing

# Quality of Life Surveys (QoL)

## Background

- Survey completed three times for each individual that transitions
  - Prior to transition, 11 months after transition, and 24 months after transition
- Objective is to evaluate how well the program is meeting the needs of participating individuals

## Assess several areas

1. Freedom of choice and control over life
2. Overall satisfaction with life
3. Access to care and unmet needs
4. Feelings about being treated with respect and dignity
5. Ability to engage in and enjoy community activities
6. Health status
7. Living situation

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# Referral and Identification Strategies

- Targeted outreach referrals identified by Illinois Department of Healthcare and Family Services
- Identification by Ombudsmen (added to program)
- MDS 3.0 & Section Q "Participation in Assessment & Goal Setting" – Pending Federal Changes
- Coordination with lawsuits and consent decree implementation
- New referrals expected via enhanced marketing and outreach

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# Transitions Through 2011

| | IDOA | DRS | DMH | DDD | Total by year |
|---|---|---|---|---|---|
| 2009 | 12 | 18 | 27 | 0 | 57 |
| 2010 | 55 | 29 | 100 | 0 | 184 |
| 2011 | 75 | 67 | 95 | 0 | 237 |
| Total by division | 142 | 114 | 222 | 0 | 478 |
| 2012 (goals) | 86 | 77 | 144 | 50 | 357 |

***DDD is undergoing training and will begin transitioning individuals in 2012**

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# Lessons Learned

# Quality of Life Surveys Show Improvement

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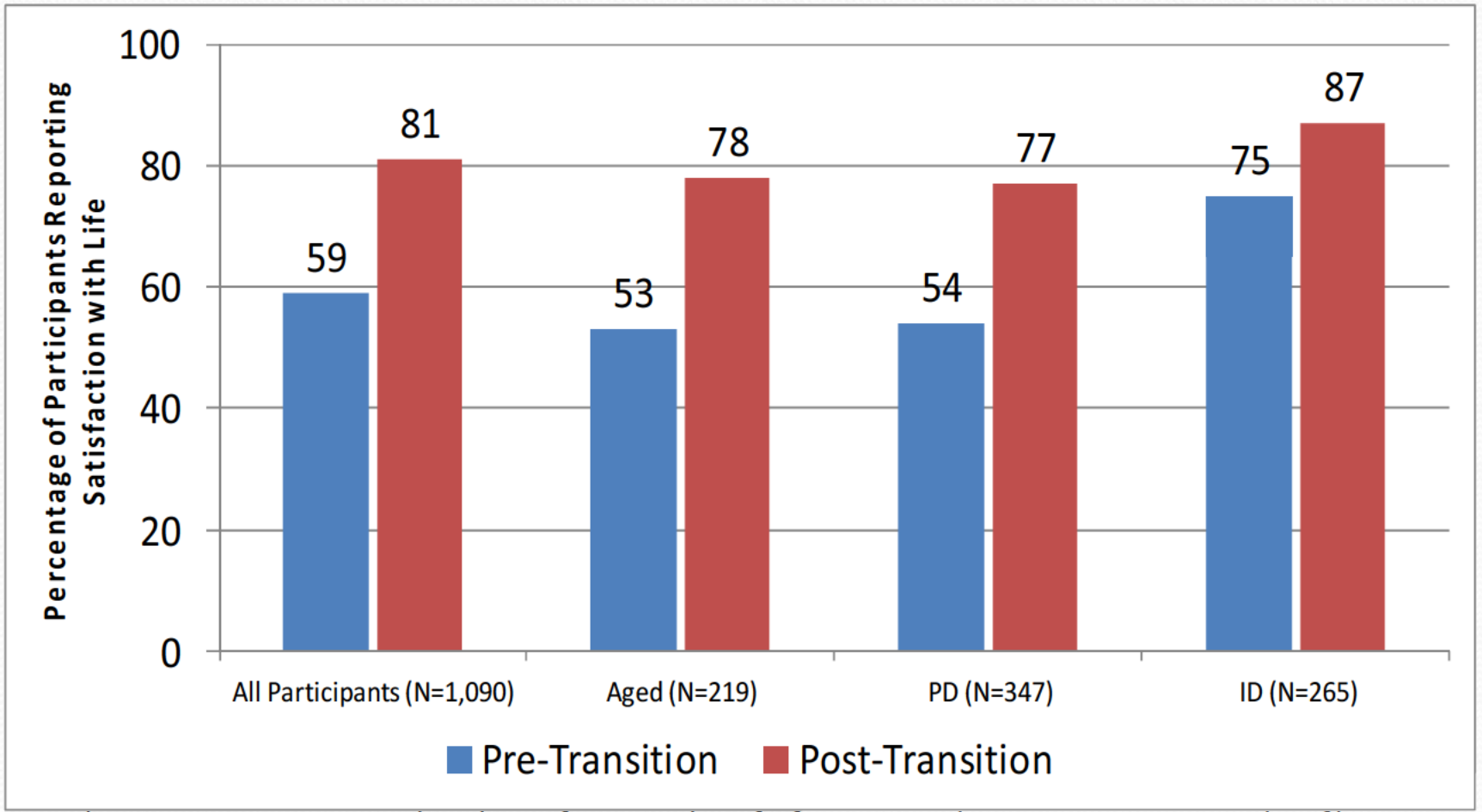
- **"Taking everything into consideration, during the past week, have you been happy or unhappy with the way you live your life?"**




Source: Mathematica Presentation and analysis of MFP-Quality of Life survey and Program Participation data files submitted through March 2011, representing pre-transition surveys conducted between January 2008 and March 2010.

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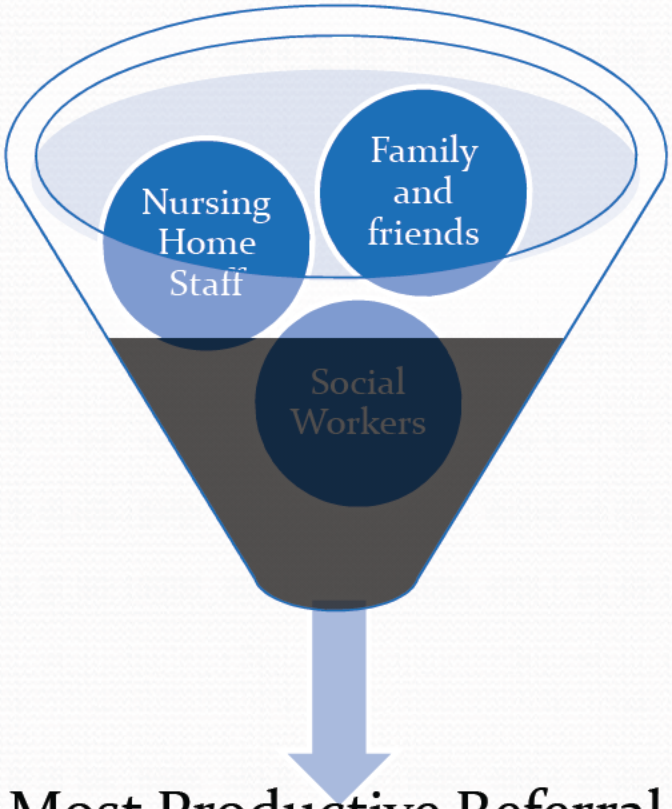
# Referral Sources

- HFS lists account for approximately 80% of all referrals
- Three sources stand out as the most productive referral sources (nearly 25% lead to successful transitions)
  1. Family and friends
  2. Nursing home staff
  3. Social workers




Most Productive Referral Sources

# Reasons for Not Enrolling

- Overall, the top 3 reasons for not enrolling in Pathways to Community Living accounted for 87% of responses
  1. Preference to live in nursing home (42%)
  2. Physical health needs were greater than Pathways services could provide (37%)
  3. Mental health service needs were greater than Pathways could provide (8%)
- These reasons are similar across stage agencies/divisions

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# UIC – College of Nursing Top Recommendations

- Integrated Care Model
- Participant Self-Management
- Transition Coordinator Quality Assurance
- Enrollment Improvement
- Referral Improvement
- Development of a “participant packet”

# UIC Recommendations Continued - Integrated Care Management Model

- Determining appropriate staffing model for integrated care management.
  - Registered nurse/social service professional teams with Advanced Practice Nurse consult
- Establishing and implementing an integrated care management model for a complex, co-morbid population by:
  - Defining the role of the Transition Coordinator, do they have ability to:
    - holistically assess multiple chronic health conditions (physical and mental),
    - complete a comprehensive risk/strength assessment,
    - develop a comprehensive mitigation plan which incorporates self-management of medications, chronic conditions, symptom/behavioral management, safety and ADLs/IADLs and
    - implement, monitor, evaluate and readjust plan based on change in participant's status and level of self-management abilities.
  - Enhancing health professional support for current Transition Coordinators;
  - Developing systems to monitor and evaluate Transition Coordinators ability to implement a comprehensive model.

Courtesy UIC College of Nursing

# UIC Recommendations Continued - Improve Participant Self-Management

- Reducing healthcare utilization (ED visits, hospital admissions), and re-institutionalization of participants by assisting participants to understand self-management of chronic conditions and appropriate use of primary care versus emergent care.
- Developing systems/mechanisms/protocols at division/agency level that support Pathways to Community Living and Transition Coordinators in:
  - Supporting and enhancing participant's self-management skill set via education, coaching, and modeling.
  - Evaluating participant's ability to implement self-management strategies for major chronic conditions, risks/problems, symptoms prior to transition that are monitored and evaluated for effectiveness and modified if needed post-transition.
  - Evaluating participant's ability to manage his/her medications along with having access to medications prior to and following transition.

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# Future Initiatives and Direction

# Pathways to Community Living- ADRC Collaborative Grant

- ADRC = Aging and Disability Resource Center
- Pathways re-balancing project –supplemental federal funding
- Engagement specialist at each site (3 sites)
  - Screen & engage nursing home residents regardless of age and population group
  - Develop a professional relationship with nursing home administrators and staff
  - Conduct bi-monthly meetings of all the stakeholders involved in assessment (education and case consultation)

# ADRC Project Goals

1. Build upon current strengths, infrastructure and capacity of three Illinois ADRC sites to support, enhance and increase the numbers of community transitions under Pathways
2. Promote the partnering between HFS; IDoA and its CCUs and Ombudsmen; DRS and its local CILs; DMH and its PASRR agencies and other community-based service providers; and the Division of Developmental Disabilities
3. Build upon current and create new processes to more effectively utilize and support the implementation of the Minimum Data Set 3.0, Section Q

# Division of Mental Health Expansion

- Pathways to Community Living Re-balancing Project
- Currently the Division of Mental Health (DMH) operates in Cook County
- Goal – hire 3 transition specialists at 3 mental health centers to expand DMH involvement outside Cook County
  - Springfield (MHCCI), Peoria (Human Services Center), DuPage (DuPage County Health Department)
- Expectation that mental health centers and ADRC's collaborate

# Housing Coordination

- Two housing coordinators hired
  - Several Goals
    - Increase housing coordination and referral practices
    - Improve linkages to qualified and accessible housing
    - Provide education and training on housing related issues and programs
  - Covered in part by Pathways to Community Living funds

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# Marketing and Outreach – Why?

- Improve communication with stakeholders
- Increase positive referrals that lead to successful transitions (i.e. family/friend, nursing home staff)
- Consistent representation across populations
- Meet UIC recommendation; development of a participant packet
- Meet MFP benchmark – increase in transition numbers

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# Marketing and Outreach Material

- Re-branding MFP as "Pathways to Community Living"
  - Better represents the intent of the program
- Participant Packet
  - Program Brochure
  - Fact Sheets
  - General FAQ
- Guidance to Nursing Home administrators and staff
- Fact sheets for specific populations
- Referral Form (print and online)

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# Website: www.mfp.illinois.gov

- Includes online referral, list-serve, and email contact
- Includes links to;
  - All participating agencies and divisions
  - All marketing and outreach material (i.e. brochure)
  - Housing Locator (IHDA)
  - Federal resources

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# Stakeholder Group

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# Stakeholder Committee

- Federal Requirement
- Purpose and Objectives
  - Consumer and stakeholder feedback
  - Program improvement
  - Development of new ideas and best practices
  - Public involvement
  - Enhanced Communication

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# Next Steps

- Questions?
- Feedback?
- Next meeting dates
- Thank you for participating!