U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

PASSAGES:

ARKANSAS'S NURSING HOME TRANSITION PROGRAM

December 2003

Office of the Assistant Secretary for Planning and Evaluation

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PASSAGES:
Arkansas's Nursing Home Transition Program

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MEDSTAT

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INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS), in association with Office of the Assistant Secretary for Planning and Evaluation (ASPE), sponsored the **Nursing Home Transition Demonstration Program** to assist states in providing transition options to nursing home residents who wish to move back to the community. CMS and ASPE awarded grants to 12 states between 1998 and 2000.[1]

The Demonstration permitted states to use grant funds for virtually any direct service or administrative item that held promise for assisting nursing home residents' return to the community. The grants provided targeted administrative or service resources to achieve the following objectives:

- To enhance opportunities for nursing home residents to move into the community by identifying nursing home residents who wish to return to the community and educating them and their families about available alternatives;
- To overcome the resistance and the barriers that may be in the way of their exercising this choice; and
- To develop the necessary infrastructure and supports in the community to permit former nursing home residents to live safely and with dignity in their own homes and communities.

This report, which describes Arkansas' Passages program, is one of a series of nine case studies presenting results from the Demonstration. The case studies, along with a final report summarizing results from all these states,[2] provide useful information as states consider nursing home transition efforts or implement nursing home transition programs. Lessons the demonstration states learned during this program are particularly important because CMS awarded a number of Nursing Home Transition grants in 2001 and 2002 under the Systems Change Grants initiative.[3]

During a June 2002 site visit, Medstat interviewed project staff from the state's Division of Aging and Adult Services (DAAS) and staff from two Area Agencies on Aging (AAAs) and two Centers for Independent Living (CILs) that implemented the grant at the local level. Medstat also interviewed staff from one nursing home involved in the program, and seven consumers who left nursing homes with the help of Passages, were in the process of transitioning, or were at risk of nursing home admission. The

[1] In 1998, Colorado, Michigan, Rhode Island, and Texas received grants between $160,000 and $175,000 each. In 1999, New Hampshire, New Jersey, Vermont, and Wisconsin received grants of $500,000 each. In 2000, Arkansas, Florida, Pennsylvania, and Nebraska received grants of $500,000 each.

[2] Eiken, Steve and Burwell, Brian. *Final Report of the Nursing Home Transition Demonstration Grants Case Study*. Medstat: publication pending.

[3] Twenty-three states and ten centers for independent living received nursing home transition grants in 2001 and 2002. More information is available at the following Web site: http://www.cms.hhs.gov/systemschange/default.asp.

State of Arkansas provided additional information for this report through unpublished documents provided by DAAS staff.

This case study report focuses on three common components of nursing home transition programs:

1. transition coordination or case management to help consumers access housing and services in the community;
2. a fund to pay for the up-front costs consumers may incur as they leave a nursing home, such as a security deposit for an apartment; and
3. a method to identify nursing home residents interested in transition.

The report also describes how three challenges common among the demonstration programs--coordinating with nursing homes, obtaining community housing, and obtaining home and community-based services--affected Passages and how state and local program staff addressed these challenges. Finally, the report presents data on the program's results and describes Arkansas' subsequent efforts to support nursing facility residents interested in transition.

PROGRAM DESCRIPTION

The Centers for Medicare and Medicaid Services (CMS) awarded a $500,000 Nursing Home Transition Demonstration Grant to the Arkansas Department of Human Services (DHS) in September 2000. The Division of Aging and Adult Services (DAAS) within DHS manages the grant. DAAS set a goal to transition 80 nursing home residents to integrated community settings during the grant period, which was originally one year. DAAS delayed the grant's implementation for five months because a statewide hiring freeze prevented it from hiring a project manager until February 2001. The grant ended in September 2003.

Transition Coordination

DAAS contracted with all eight AAAs and all four CILs in the state to provide service coordination for nursing home residents. The AAAs served nursing home residents age 65 and older, while the CILs served residents under age 65. Passages was available statewide. The AAAs already served the entire state and the CILs agreed to serve people outside their traditional service areas if necessary to ensure statewide coverage.

Each of these organizations designated an independent support coordinator for Passages. The coordinators performed community outreach to identify nursing home residents who wanted to move to the community, determined whether interested residents met the program's eligibility criteria, and worked with residents to develop and implement transition plans. DAAS trained all 12 support coordinators before the program began serving consumers.

Upon learning about a resident interested in transition, AAA or CIL staff first contacted the resident and verified that he or she was both eligible for Passages and interested in transition. DAAS made Passages available to nursing home residents age 21 or older who were enrolled in Medicaid and wanted to return to the community. DAAS set five additional criteria for residents:

- The person's medical needs could be met in the community (a physician's approval was required to meet this criterion);
- A safe and healthy physical environment could be provided;
- The transition plan was cost effective (i.e., the planned home and community-based services cost less than the person's nursing home residency);

- The person did not require skilled care 24-hours a day, which the state's Medicaid home and community-based services (HCBS) programs did not cover; and
- An adequate support system was available using formal and informal supports.

If the coordinator found the resident eligible, then the coordinator assessed the resident to learn his or her needs. After the assessment, the resident, his/her family, and the transition coordinator designed a transition plan that identified what support the resident required once in the community, the nature of the assistance, who would provide this assistance, and the approximate cost. After the plan was complete, the coordinator sent the plan to DAAS for approval.

If DAAS approved the plan, the coordinator helped the resident arrange for necessary housing and services, and periodically called the resident to keep informed of his or her health status. Sometimes the AAA or CIL assisted the resident during the actual move, such as driving the person to his or her new home or bringing over an initial supply of groceries. DAAS required monthly contact with the participant for at least three months after discharge in order to address additional needs as they arose. After three months, the coordinator and former resident completed a permanent placement plan that indicated the persons' ongoing services.

Arkansas paid for transition coordination on a fee-for-service basis, funding six tasks listed in Table 1. This approach was different from most grantees, which distributed lump-sum amounts to contracting organizations or hired transition coordinators directly. The fee-for-service approach allowed DAAS to pay some AAAs and CILs more for transition coordination if they served more people.

TABLE 1. Billable Transition Coordination Tasks

Task	Payment
Contact potential participant	$25
Visit potential participant in nursing home to discuss possible transition	$25
Complete Passages assessment	$50
Develop Passages transition plan	$50
Implement Passages transition plan (payable upon nursing home discharge)	$150
Monitor the transition, complete monthly progress reports, and complete permanent placement plan	$100

The maximum an AAA or CIL could receive for supporting a single person was $400. Some AAA and CIL staff said the payment was not enough for the work involved in coordinating a transition.

Payment of Up-Front Costs

DAAS separated transition expenses into two categories called transition services and supplemental services. Transition services were items secured before the person could move into his or her community home. Transition services included housing deposits, the first month's rent, utility deposits, furnishings, linens, durable medical equipment, kitchen items, home modifications, and other household items. DAAS limited transition services to $1,614 per participant.

Supplemental services were home and community-based services required once the resident moved into the community. The grant paid for these services under two scenarios:

- When people needed more than the maximum level of available Medicaid services for a short period of time (e.g., until they were comfortable with less assistance), and
- When people left a nursing home before eligibility for a Medicaid home and community based services (HCBS) waiver or for Medicaid state plan personal care was determined.

These services included attendant services, home delivered meals, personal emergency response systems, personal care, and chore services. Since determining eligibility for Arkansas' Medicaid HCBS waivers could take six to eight weeks, DAAS initially expected many former residents to use supplemental services. The per-person limit for supplemental service expenditures was $1,898.

CILs and AAAs paid for transition and supplemental services up-front and DAAS subsequently reimbursed them. According to one CIL, DAAS typically reimbursed the organizations within 60 days. This CIL said paying for transition services initially was a burden because the CIL had limited capital, but also acknowledged that it did not always bill the state promptly.

Identifying Program Participants

DAAS conducted statewide outreach for Passages. DAAS staff gave presentations or sent information to a variety of groups, including several advocacy groups for people with disabilities, an association of nursing home directors of nursing, and social workers at the University of Arkansas hospital. DAAS also sent informational materials about Passages to all nursing home administrators, including posters and brochures that the nursing home could post in their facilities. DAAS also sent a press release to local newspapers and placed Passages information in *Aging Arkansas*, the aging network newsletter in Arkansas.

Some local coordinating agencies also developed strategies to get information directly to consumers and their families. One CIL, working with nursing homes in its

area, formed peer support groups of nursing home residents preparing to transition. This CIL also wrote about Passages in its newsletter. Another CIL included information about Passages in public presentations about its services and programs. One AAA met with nursing home resident councils and asked resident council members to tell other residents about Passages. This AAA also operated the Long Term Care Ombudsman Program in the area, and the ombudsman informed residents about Passages during monthly visits to nursing homes.

DAAS established a statewide intake process for Passages. Anyone could refer a resident to Passages using an application form available at the Passages Web site (http://www.arpassages.com) or by calling the Passages 1-800 number. DAAS reported several residents used the Web site to refer themselves to Passages. Local coordinators also received referrals directly from nursing home staff or residents; this typically occurred when the coordinator is already working with one consumer in a nursing home and someone else in that facility approached the coordinator. As of August 2003, the two most common referral sources were nursing home staff (45 percent) and nursing home residents (32 percent). Residents' families (11 percent), nursing home ombudsmen (7 percent), and provider agencies (5 percent), including the AAAs and CILs, provided the remaining referrals.

Upon receiving a referral, DAAS program staff verified the person's Medicaid eligibility, collected location and demographic information about the resident, and entered the information into the Passages program database. DAAS then e-mailed this information to the local AAA or CIL for assessment.

Coordinating with Nursing Homes

DAAS contacted the state's nursing homes early in the program to encourage nursing home cooperation. The program manager met with the nursing home provider association's director and government relationship team to explain the program. DAAS also sent letters to nursing home administrators describing the program and encouraging referrals. DAAS did not perform additional statewide outreach until the spring of 2002, when it sent letters to nursing home social services and activities directors, the nursing home staff most likely to refer residents to Passages. Several people interviewed in June 2002 said many nursing home staff had little or no information about the program. Some local staff recommended that the state frequently send information about Passages to nursing home discharge planners to educate them about the program and remind them it still exists. Arkansas sent another letter to nursing home administrators and social workers in December 2002, which prompted additional referrals to Passages.

Reports of nursing home response varied from cooperation to resistance. Nursing homes were often partners in transition; nursing home staff referred two-fifths of Passages participants. In one region, several nursing homes allowed the local CIL to establish peer support groups for nursing home residents preparing to transition. The

peer support groups started at a large (nearly 1,000-bed) state-operated nursing facility that emphasized rehabilitation and preparing people for community living, according to the local CIL. On the other hand, one CIL reported encountering frequent resistance from nursing homes, and it often called DAAS so the state could encourage the facilities to cooperate. Consumers also described a variety of experiences with nursing homes: some nursing homes were not cooperative, while others supported their transitions.

Obtaining Housing

State and local people involved in Passages reported that a lack of affordable, accessible housing was one of the most significant barriers to transition for people under age 65. CILs said people in some areas needed to wait as long as a year for public housing. According to one CIL, some landlords and public housing authorities were reluctant to provide housing for former nursing home residents, citing liability concerns if a person became injured or his or her condition worsened. At the same time, CILs persuaded some local housing authorities to put Passages participants at the top of the waiting list. The AAAs said housing was not a barrier to transition, and DAAS said more public senior housing is available than public housing for people under age 65 with disabilities.

Obtaining Home and Community-Based Services

Most Passages participants used one of three home and community-based services programs after transition. DAAS operated two Medicaid HCBS Waiver programs--ElderChoices and Alternatives. ElderChoices served over 6,000 people age 65 and older in 2002. Alternatives served over 1,000 people with physical disabilities between the ages of 21 and 64. Neither of the waivers had a waiting list, so people leaving nursing homes were able to obtain waiver services quickly. In addition, DAAS provided personal care for 18,000 people (as of 2000) under a Medicaid state-plan option.[4]

Both AAAs and CILs reported effective continuity of case management. The AAAs provided case management for the ElderChoices waiver, and seven of the eight AAAs were also direct providers of Medicaid personal care services. Thus, continuity of case management was relatively easy for the AAAs. The transition coordinator was usually also a waiver case manager and often became the consumer's case manager. For people under age 65, CILs reported good working relationships with the state-employed case managers for Alternatives.

The AAAs reported older people had difficulty accessing the ElderChoices waiver, and mentioned participants who transitioned to the community but were denied waiver services. In at least one instance, the person later returned to a nursing home. The

[4] Mollica, Robert L. "Personal Care Services: A Comparison of Four States." AARP. March 2001.

AAAs also described people--including two interviewed consumers--who were determined functionally ineligible for waiver services but were admitted to a nursing home, reportedly without a change in functional capacity. One AAA said the difficulty in obtaining ElderChoices services was the most significant barrier to transition. CILs did not report similar challenges for the Alternatives waiver.

While Arkansas used the same criteria for nursing home and waiver eligibility, different people conducted the assessments. For waiver eligibility, state staff conducted the assessments: registered nurses assessed people for ElderChoices while social workers and counselors assessed people for Alternatives. The nursing homes themselves conducted nursing home eligibility assessments, using a different assessment tool than state staff used for the waivers. Anecdotal evidence from the AAAs suggested that the ElderChoices waiver assessments were more stringent than the nursing home assessments. During the grant, there was no data indicating a systematic problem.

The state is hoping to have that data shortly. DAAS contracted with a professional review organization, the Arkansas Foundation for Medical Care (AFMC), to evaluate the functional eligibility determination process. AFMC will review all the assessment forms used to determine eligibility for Medicaid nursing home payment and for the Alternatives and ElderChoices waivers. AFMC will also conduct face-to-face assessments with 10 percent of the newly approved people in nursing homes and in the waivers. As part of the state's 2002 Nursing Facility Transition Grant (see *Next Steps*), the state will develop a single, standard functional eligibility assessment for nursing facility services, Alternatives, and ElderChoices.

One CIL and some consumers reported that delays in the initial payment of attendants paid under Alternatives increases the difficulty in finding attendants. Alternatives is a consumer-directed waiver in which consumers select their own attendants (often with the CILs' assistance). Arkansas requires these required to enroll as Medicaid providers. Like many Medicaid providers, the attendants often provide services for one or two months before they are paid by Medicaid. The delay is particularly challenging for attendants, however, because they often do not have the resources to provide services for weeks before receiving payment. CILs often pay the attendants during this initial start-up phase, using either Passages supplemental service funds or their own funds.

PROGRAM RESULTS

DAAS developed a Microsoft Access database for Passages to provide quick information about the program. The database includes information on referrals, assessments, transition plans, the Medicaid costs for each consumer, and consumers' status after discharge. DAAS created several reports that provided useful data about Passages participants. The information in this report is current as of August 2003, two years and four months after Arkansas started serving people, and one month before the grants end in September 2003.

The Passages program received 149 total referrals. A majority of referred participants were approved for Passages and have left nursing facilities (88 people, 59 percent of referrals). Eleven referrals were pending approval, and 50 referrals were not approved. The most common reasons for denying nursing home transition assistance were lack of informal community support, lack of physician approval, and the need for around-the-clock skilled nursing care. Nine of the 88 transitioned residents (10 percent) returned to nursing facilities within three months.

More than 60 percent of people referred to Passages were under age 65, and people under age 65 were approximately two-thirds of participants who had left nursing homes through the program. State staff cited two possible reasons for why Passages was serving more people under age 65, even though most nursing home residents are older than 65. First, the CILs showed more interest in nursing home transition than the AAAs. They encouraged the state to apply for the grant and were more involved in the grant's development. Second, DAAS staff said Arkansas had a higher proportion of younger people in nursing homes than other states.

Over half of the referred residents were male (80, or 54 percent), while most nursing home residents are women. The high proportion of men among referrals may be explained in part by the high proportion of younger people. According to the 1999 National Nursing Home Survey, approximately half of nursing home residents under age 65 are male.[5]

Nearly three-fourths of the 88 transitioned residents received either the Alternatives or ElderChoices Medicaid HCBS waivers (63, or 72 percent). An additional person used Arkansas' HCBS waiver for people with developmental disabilities. Ten former residents (13 percent) received Medicaid personal care, while 14 participants (16 percent) received no Medicaid-funded support services. According to DAAS, some of these people qualified for services but refused them. These people may have relied on informal support, non-Medicaid services funded by the Older Americans Act, the Social Services Block Grant, or state and county-funded programs.

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[5] Jones, A. "The National Nursing Home Survey: 1999 Summary." National Center for Health Statistics. *Vital Health Statistics* 13 (152), 2002. Available online at http://www.cdc.gov/nchs/data/series/sr_13/sr13_152.pdf.

Passages consumers who left nursing homes moved an average of 87 days after their initial referral. One CIL, which had started nursing home transition assistance before Passages, said that funding for up-front transition services reduced time necessary to coordinate a transition from six months to three months. Before Passages, the CIL spent much of that additional time obtaining funding for housing deposits, furniture, household items, and other up-front costs.

During the June 2002 site visit, DAAS reported where Passages participants lived according to county. State staff noted that the areas with the highest populations were not the areas with the highest number of transitions. Rather, the areas with more transitions were near the organizations that devoted more effort to transition. These organizations were usually CILs. One DAAS employee said CILs tended to approach a Passages referral with the question "how can we do this?", while AAAs tended to ask "can we do this?" The difficulty older people had obtaining ElderChoices waiver services also may have influenced the lower number of transitions by AAAs. Staff from AAAs said they were reluctant to prepare people for transition because they believed residents would not receive sufficient services in the community.

DAAS spent an average of $2,219 in Passages funds per person discharged. This is the average fee-for-service cots of case management, transition services, and supplemental services for the 79 individuals who transitioned and who remained in the community for more than 90 days. This figure did not include the cost of program management, program outreach, or expenditures for people who did not transition.

Transitional services such as housing expenditures, furnishings, and durable medical supplies constituted more than half the Passages expenditures for transitioning individuals ($1,150 of $2,219, or 52 percent). Passages paid $669 per person (30 percent) for supplemental services such as home delivered meals, personal care, and chore services; and $400 per person (18 percent) for transition coordination based on the fee-for-service payment system. The state had expected that more funds would be required for supplemental and support services than for transitional costs, but actual expenditures showed otherwise. The results, however, mirror the experience of other demonstration states in which existing HCBS programs paid for supports after a person left a nursing home.

DAAS' database also recorded all Medicaid expenditures for Passages consumers in order to compare the cost of nursing home and community living. The average Medicaid costs for Passages in their first three months in the community was $1,303, 39 percent the Medicaid costs for the same consumers in their last three months in a nursing home ($3,301). These data include all Medicaid costs, not just long-term care costs, and suggest Passages is cost-effective. This cost information does not, however, include any non-Medicaid public funds the consumers used in their communities.

Arkansas surveyed all former nursing facility residents at least two months after transition to learn about participant satisfaction and quality of life. Of 42 respondents, 41 (98 percent) said their quality of life had improved since leaving a nursing home. Thirty-five respondents (83 percent) said their health had improved as well. Two-thirds of transitioned consumers (28) lived alone, while only one person lived in a group setting. Other consumers lived with family or friends.

NEXT STEPS

The federal grant period for Passages ended September 30, 2003. Arkansas plans to amend its Medicaid HCBS waivers to pay for transition services after the grant ends. As Passages ended, Arkansas implemented two new federal grants related to nursing home transition awarded in 2002.

ASPE awarded Arkansas a $410,557 State Innovation Grant to allow nursing home residents to use a cash allowance to purchase support services in the community. This project will follow the principle of money following the person: the cash allowance for former nursing home residents will be similar to the Medicaid expenditures paid to the nursing home before discharge.[6]

CMS awarded DAAS a $598,444 Nursing Facility Transition Grant as part of the Systems Change Grants Initiative. This grant, called "Passages 2," comprises several initiatives to support people leaving nursing homes or people at risk of nursing home admission. Arkansas will use the grant to establish a fund to pay for transition services. Arkansas also plans to develop a single assessment form to determine eligibility for both nursing homes and the Arkansas Medicaid HCBS waivers that serve older people and people with physical disabilities. State staff expect the single assessment to address the concerns about assessment consistency discussed earlier (See *Obtaining Home and Community-Based Services*).

Initiatives in Passages 2 to support people already in the community include developing an informational Web site on available long-term care services, establishing an ombudsman program for Medicaid HCBS waivers, and creating a process to expedite initial HCBS applications for people in hospitals. DAAS will also work with AAAs, CILs, and local housing authorities throughout the state to ensure that elderly persons and persons with disabilities--including people leaving nursing homes--are given high priority for new housing.

[6] More information about the State Innovation Grants is available at the following Web site: http://aspe.hhs.gov/state-innov02/intro.htm.

INTERVIEWS

Arkansas Department of Human Services, Division of Aging and Adult Services (DAAS)
- Herb Sanderson
- Sandra Barrett
- Jean Hecker
- Kris Baldwin

Area Agency on Aging of Southeast Arkansas (Pine Bluff, AR)
- Dixie Clark
- Carolyn Ferguson

CareLink: Central Arkansas Area Agency on Aging, Inc. (Little Rock, AR)
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- Scott Holladay

Delta Resource Center (CIL in Pine Bluff, AR)
- Billy Altom
- Randy Alexander
- Sandra Jasper

Spa Area Independent Living Services (CIL in Hot Springs, AR)
- Brenda Stinebuck
- James Capps

Davis Nursing Facility
- Linda Webb

5 Passages participants

2 people served by CareLink AAA who were denied eligibility for ElderChoices, but who were not Passages participants

CASE STUDIES OF NURSING HOME TRANSITION PROGRAMS

Complete List of Site Visit Reports

Community Choice: New Jersey's Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/NJtrans.htm
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Fast Track and Other Nursing Home Diversion Initiatives: Colorado's Nursing Home Transition Grant
HTML: http://aspe.hhs.gov/daltcp/reports/2003/COtrans.htm
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Michigan's Transitioning Persons from Nursing Homes to Community Living Program
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One-to-One: Vermont's Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/VTtrans.htm
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Partnerships for Community Living: Florida's Nursing Home Transition Program
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Passages: Arkansas's Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/ARtrans.htm
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Pennsylvania Transition to Home (PATH): Pennsylvania's Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/PAtrans.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2003/PAtrans.pdf

Project CHOICE (Consumers Have Options for Independence in Community Environments): Texas' Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/TXtrans.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2003/TXtrans.pdf

The Homecoming Project: Wisconsin's Nursing Home Transition Demonstration
HTML: http://aspe.hhs.gov/daltcp/reports/2002/WItrans.htm
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