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

FAST TRACK AND OTHER NURSING HOME DIVERSION INITIATIVES:

COLORADO'S NURSING HOME TRANSITION GRANT

December 2003

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-100-97-0019 between HHS's ASPE/DALTCP and the MEDSTAT Group. Additional funding was provided by the HHS Centers for Medicare and Medicaid Services. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Gavin Kennedy, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: Gavin.Kennedy@hhs.gov.

FAST TRACK AND OTHER NURSING HOME DIVERSION INITIATIVES:
Colorado's Nursing Home Transition Grant

Debra Holtz, J.D.
Steve Eiken

MEDSTAT

December 23, 2003

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-100-97-0019

This publication is based on research performed under Contract Number 100-97-0019, entitled "Case Studies of Nursing Home Transition Programs" sponsored by the Office of the Assistant Secretary of Planning and Evaluation (ASPE) and the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of ASPE, CMS or MEDSTAT. The authors gratefully acknowledge the many people in Colorado who generously gave us their time and insights for the preparation of this report.

TABLE OF CONTENTS

LIST OF TABLES

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 Colorado's grant, 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]

Unlike other Nursing Home Transition Demonstration Grants, Colorado's grant focused on preventing nursing home admissions, rather than assisting people who want to move into the community. This case study describes four interventions Colorado started to divert people from nursing homes to community living:

---

[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.

- Providing hospital-based case management and Medicaid financial eligibility determination, called the Fast Track program;
- Piloting an assessment designed to identify people at risk of nursing home placement early in a hospital stay;
- Developing a brochure to inform people about community options; and
- Surveying people with disabilities to identify specific challenges to community living, for people at risk of nursing home placement and nursing home residents.

The bulk of this report discusses Fast Track implementation. Colorado spent most funds from its October 1998 grant on Fast Track and project management (see Table 1). Project management included hiring a person to develop a data management system for Fast Track as well as management of all grant activities.

TABLE 1. Colorado Nursing Home Transition Grant Expenditures

	Cost	Percentage
Project management, including data management staff who developed a Fast Track data collection system	$68,889	43%
Contract for Fast Track case manager and runner	$60,000	37%
Contract to pilot screening instrument	$12,490	8%
Equipment for runner and data management staff	$11,000	7%
Survey to identify barriers	$ 5,000	3%
Informational brochure	$ 3,500	2%
Total	**$160,879**	**100%**

During a January 2002 site visit, Medstat interviewed staff from the Colorado Department of Health Care Policy and Financing, the state agency that administered the grant. Medstat also interviewed local Fast Track staff and their supervisors on-site at the Denver Health Medical Center, along with the medical center's director of clinical social work and two hospital social workers responsible for discharge planning. The State of Colorado provided additional information for this report through documents reporting Fast Track results.[4] Following a description of Fast Track, the report describes the other components of the grant and identifies components that continued after the grant ended.

[4] References for these reports can be found in the bibliography.

FAST TRACK

Before the Grant

The Fast Track program was first implemented in 1997, a year before Colorado received its Nursing Home Transition Demonstration Grant. Clinical social workers who coordinated discharge planning at Denver Health Medical Center (DHMC), a large, urban hospital that serves many Medicaid patients, noticed many people who may have been able to live in the community entered nursing homes after their hospital stay. Medicaid financial eligibility staff located at the local county agency, the Denver Department of Social Services (DDSS), saw the same problem. In 1996 DHMC and DDSS proposed a pilot to the state Medicaid agency, the Colorado Department of Health Care and Policy Financing.

The state agency met with DHMC, DDSS, and Home Care Management, the local agency that administered Medicaid home and community-based services (HCBS) waivers and a state-funded in-home services program, to brainstorm ways to prevent unnecessary nursing home admissions. They identified three main barriers that prevented people from successfully returning to the community:

- Hospital social workers did not know about HCBS
- Medicaid financial eligibility determination took a long time, often more than six weeks. Hospital patients often had to leave the hospital before this process was complete.
- Functional eligibility determination for HCBS sometimes was not complete before hospital discharge often taking three weeks.

The last two barriers were significant because nursing homes could begin serving people immediately after a hospital discharge, even if Medicaid financial eligibility and functional eligibility for HCBS had not yet been determined. If a person later was determined eligible for Medicaid, a nursing facility could bill Medicaid for up to three months worth of services it provided before eligibility determination. By comparison, Medicaid HCBS waiver services could not begin until after Medicaid financial and functional eligibility were determined.

The state and local agencies started a program entitled Fast Track to address these barriers. The three key components of this program were:

- a half-time case manager from Home Care Management working on-site at the hospital;
- a full-time financial eligibility technician assigned by DDSS to the hospital, to expedite financial and functional eligibility determinations; and

- DMHC clinical social workers working with the case manager during discharge planning.

DDSS and Home Care Management assigned staff to Fast Track at no cost, and the hospital donated office space for the case manager.

Fast Track began with the simple idea of everyone being at one place--the hospital--to improve the discharge planning process. Because the case manager was on-site, he or she could provide immediate information to patients, families, physicians, and hospital social workers about HCBS options. Because families were at the hospital, a case manager or hospital social worker could ask them about potential assistance that they could provide until all HCBS services were in place. The financial eligibility technician was the only person in the pilot not on-site, but worked closely with the hospital and case manager to determine Medicaid eligibility more quickly.

In addition to improved discharge planning, DMHC received added benefits from the working relationship between the hospital and the financial eligibility technician. The hospital could bill Medicaid sooner because the eligibility technician was able to track the patients and obtain faster eligibility information. This was particularly important for people who were hospitalized 30 days or more and thus became eligible for Medicaid through institutional eligibility criteria.

The social workers started the Fast Track process for patients by informing the case manager and the eligibility technician about people likely to enter a nursing home after discharge and likely to be eligible for Medicaid. If the patient was not already enrolled in Medicaid, the financial eligibility technician worked with the patient to determine Medicaid eligibility. The case manager assessed the patient's needs and worked with him or her to develop a plan for community living and to ensure the person received services immediately after discharge, regardless of whether Medicaid-eligibility was established. To obtain a better understanding of the person's situation, the case manager also worked closely with family members, physicians, the hospital discharge planner, and others involved in supporting the patient.

Even with the expedited eligibility process under Fast Track, eligibility for Medicaid and HCBS was often not determined before the patient left the hospital. When this occurred, the case manager, patient, and family identified other resources for community support until HCBS services could be put in place. If nursing home placement was necessary either for rehabilitation or for lack of temporary supports, the case manager continued to work with the person in the nursing home until he or she moved into the community with HCBS, Medicaid eligibility was denied, or the person chose to stay in the nursing home permanently.

State and local staff both considered the program a success, but the program ended in the fall of 1997 when Home Care Management concluded that it could no longer afford to donate the case manager's time.

During the Grant

Colorado restarted the program in October 1998 when they received a federal Nursing Home Transition Demonstration Grant. With the grant funds, the state paid for:

- a Home Care Management case manager to work at the hospital, with an increase from half time to three-quarter time;
- a "runner" hired by Home Care Management to assist people in completing the paperwork necessary to determine financial and functional eligibility; and
- data management staff to develop a database to show Fast Track's progress.

The runner was a basic, yet critical, addition to the program. The runner literally ran errands to places to collect documents and to complete the paperwork necessary for people to obtain HCBS services. With the patients' permission, the runner contacted family members, banks, attorneys, physicians, and other people the patients identified to gather information to determine Medicaid financial eligibility. The runner also visited provider agencies and obtained physician signatures when necessary to establish functional eligibility for HCBS. The runner's ability to collect documentation while the patient was hospitalized further expedited the eligibility determination process.

After a delay to hire staff and develop a contract between the state and Home Care Management, Fast Track started serving consumers again in March 1999. During the federal grant period, the financial eligibility technician was also located at the hospital, so now all the players were on-site.

Results

Approximately 115 patients were referred to Fast Track during its operation under the federal grant, from March 1999 through May 2000. During that time, 62 consumers (54 percent) received successful Fast-Track placements, defined as a hospital discharge in which a person avoided nursing home admission as a result of expedited Medicaid eligibility and development of appropriate community supports and services.

The state's Fast Track database provided demographic and functional data about program participants. People who used HCBS after their hospitalization had a wide range of ages, from 26 to 93 years of age. About half (52 percent) were between the ages of 50 and 69, and the average age was 62. A slight majority of people with Fast Track placements (54 percent) had deficiencies in all eight Activities of Daily Living (ADLs) measured in the case manager's assessment: transfers, bladder care, bowel care, mobility, dressing, bathing, hygiene, and eating. An additional 37 percent had deficiencies in six or seven ADLs.

For each consumer, the case manager listed the three most necessary services for community living after the service plan was developed. Food preparation was the most frequently identified service, followed by personal care, homemaker services, medication monitoring, and a personal emergency response system. Most Fast Track consumers received these services from Colorado's Medicaid HCBS waiver for older people and people with physical disabilities.

The program also tracked the reasons why some people referred to Fast Track did not move to the community. The most common reason was a consumer's refusal to receive Fast Track services. Nearly one-third of the 53 referred patients without successful placements (17 people) refused to participate; the discharge outcomes for these people are uncertain. Another twelve people moved to a nursing home or another hospital upon discharge. Other reasons included the patient dying in the hospital (seven people), functional ineligibility for HCBS (five people), and financial ineligibility for Medicaid (two people).

Colorado estimated Fast Track saved $407,012 in Medicaid expenditures during the grant period. This estimate is based on statewide data comparing average nursing home costs to the average cost of using HCBS. The estimate also assumes all Fast Track participants would have had a long-term nursing home stay without the program's intervention. State and local staff indicated they believe almost all Fast Track participants would have been admitted to a nursing home without the program.

Fast Track continued at DMHC after the grant, and is still in operation (See *Next Steps*). In addition to the number of people who used Fast Track, the staff interviewed said the program changed the way that DMHC social workers, and the hospital in general, approach discharge planning. DHMC clinical social workers now think of a nursing home as the last option, rather than the first option. Staff interviewed attributed this culture change to (1) better information sharing between social workers, the case manager, and the eligibility technician, and (2) the experience of helping people find supports in the community. Discussion of Fast Track is now included in the hospital's new employee orientation program, so all hospital personnel--not just social workers--are familiar with it.

EARLY SCREENING IN HOSPITAL

In an effort to increase Fast Track's effectiveness, Colorado used the grant to develop a user-friendly risk assessment tool, or adapt an already-developed tool, to identify which patients could benefit from Fast Track early in a hospital stay. Early identification of Fast Track participants could increase the success of the program by giving the case manager, eligibility technician, and runner more time to complete their work.

To achieve this objective, the state reviewed and analyzed current efforts and tools, and decided to use the Blaylock Discharge Risk Assessment Screen (BRASS), developed by Ann Blaylock and others.[5] The state then solicited the advice of DHMC social workers regarding information they used when making discharge-planning decisions. The state and the discharge planners then revised and adapted the BRASS tool for Fast Track. DHMC social workers used the revised assessment tool on a trial basis.

After the trial period, the state and hospital decided not to use the adapted BRASS tool. Social workers reported that it was easier to rely on their own judgment and experience to determine which patients might benefit from the Fast Track program, rather than taking the time to complete a screening tool. In addition, the many patients' conditions changed so rapidly that the results of an early assessment were not valid when planning a person's discharge.

The experience of DHMC social workers may have been one reason these social workers did not find the assessment tool useful for identifying Fast Track participants. According to state and DHMC staff, the social workers are more experienced than discharge planners at many other hospitals in the area, in part because DHMC serves a larger number of Medicaid patients than many facilities.

[5] Blaylock, A., Cason C. "Discharge Planning: Predicting Patients' Needs," *Journal of Gerontological Nursing*, 1992.

INFORMATION REGARDING HCBS

Initial research by the state suggested that many people did not know about options in the community and often chose a nursing home because of this lack of information. The state developed a brochure to inform consumers, families, providers, and hospital personnel about publicly funded long-term support options in the community. The state distributed the brochure to people both in hospitals and in the community.

State staff said the brochures were helpful in informing people about their options. The state did not print additional brochures after the grant ended, citing a lack of funding for printing. State staff said they did not believe a lack of brochures was a significant access problem because people learned about community options in many other ways.

SURVEY TO IDENTIFY BARRIERS

Colorado contracted with the Colorado Cross Disability Coalition to identify barriers to community living for people with disabilities at risk of entering a nursing home or attempting to return into the community. The coalition used focus groups, individual interviews, and written consumer surveys to identify barriers.

The coalition held three focus groups: one with consumers, one with independent living coordinators from Denver Center for Independent Living, and one with professionals from a variety of disciplines who work with people with disabilities. In addition, the coalition interviewed consumers, direct support providers, independent living specialists, case managers, family caregivers, Medicaid HCBS program administrators, and one physician.

The coalition mailed surveys to people under age 55 in the Denver metro area for whom there had been Medicaid nursing home claims within the past five years. Two sets of surveys were sent--one in the summer of 1999 to approximately 125 people, and one in the fall of 1999 to approximately 100 people. Only 30 people responded, including incomplete surveys. The coalition also sent approximately 400 surveys to people who used Denver-based home care agencies, and to people who used a popular medical equipment supplier. No consumers responded to this mailing in writing, but several called to provide input. The coalition did not report the number of respondents.

The information from the focus groups, interviews, and surveys has several limitations. The coalition only conducted surveys and individual interviews in the more populated areas of Colorado, so the interviews did not identify issues that only applied to the state's rural areas. Given the low survey response rate, the respondents' experiences may differ from the experiences of all people with disabilities in these areas. Acknowledging the limitations to the information, the coalition made the following recommendations to the state:

1. Improve mental health services and increase their availability. The coalition also recommended that an independent mental health expert with experience in both physical disabilities and mental health assess nursing home residents under age 65 on a regular basis. The coalition also recommended cross training of personnel between local agencies that administer Medicaid HCBS waivers and local mental health agencies.

2. Review and analyze Medicaid home care rules. Several ideas were combined in this area, including: (a) developing a short-term benefit that combines home health aide services with counseling to address mental health concerns, (b) reviewing home care utilization limits, and (c) using the Medicaid state plan option to provide personal care.

3. Increase the supply of affordable, accessible housing.

4. Develop a brochure for family caregivers and an outreach plan to inform caregivers about community options.

5. Provide case managers and independent living skills training to assist nursing home residents who want to move to the community.

6. Conduct an independent evaluation of equipment needs for nursing home residents.

7. Require a discharge plan and follow-up reviews by Medicaid HCBS waiver agencies or Independent Living Centers for people admitted to nursing homes for respite or rehabilitation.

8. Educate physicians and other medical professionals about HCBS.

9. Review the role of case managers to provide them with more flexibility and to require fewer routine activities.

10. Review the nursing home assessment tool.

Most of these recommendations have not yet been implemented because they require a number of actions such as federal regulation changes, and state legislative action. Colorado has implemented a new nursing home assessment tool and is taking steps to implement other changes such as a review of Medicaid home care utilization limits.

NEXT STEPS

Among the four components of the grant, the Fast Track program had the most tangible results in preventing nursing home admissions, and it was the only initiative that continued after the grant period. The state continued Fast Track with approximately $70,000 in Medicaid administrative funds--half federal and half state--starting in July 2000. The $70,000 continues pays for the three-quarter time case manager and a three-quarter time runner. In the first year after the grant, 122 patients were referred to the program, up from 115. The percentage of successful placements increased from 54 percent to 71 percent.

BIBLIOGRAPHY

Bell, Joan C.; Schleisman, Jacinda; Demmler, Jean; Reiskin, Julie. *Appropriate Use of Community Based Care for Persons Discharged from Hospitals*. Colorado Department of Health Care Policy and Financing. September, 2000. Final report to HCFA (now CMS) for the 1998 Nursing Home Transition Demonstration Grant.

Spaulding, Peggy and Clift, Heidi. *Appropriate Use of Community Based Care for Persons Discharged from Hospitals, Part II: Fast Track Program Fiscal Year 2000-2001*. Colorado Department of Health Care Policy and Financing. December 2001.

INTERVIEWS

Colorado Department of Healthcare Policy and Financing (DHCPF)
Peggy Spaulding
Heidi Clift

Location: Denver Health Medical Center (DHMC)
Meeting with Fast Track staff and supervisors

Don Burt, Denver County Department of Social Services
Kathleen Cordillo, Denver County Department of Social Services
Glenn Schweitzer, Home Care Management
Pauline Meyer, Home Care Management
Tandy Beckham, Home Care Management

Location: Denver Health Medical Center (DHMC)
Meeting with DHMC clinical social workers and director of clinical social work

Linda Lelander
Karen Brown
Dennis Heffrin

Four consumers

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
PDF: http://aspe.hhs.gov/daltcp/reports/2003/NJtrans.pdf

Fast Track and Other Nursing Home Diversion Initiatives: Colorado's Nursing Home Transition Grant
HTML: http://aspe.hhs.gov/daltcp/reports/2003/COtrans.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2003/COtrans.pdf

Michigan's Transitioning Persons from Nursing Homes to Community Living Program
HTML: http://aspe.hhs.gov/daltcp/reports/2002/MItrans.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2002/MItrans.pdf

One-to-One: Vermont's Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/VTtrans.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2003/VTtrans.pdf

Partnerships for Community Living: Florida's Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/FLtrans.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2003/FLtrans.pdf

Passages: Arkansas's Nursing Home Transition Program
HTML: http://aspe.hhs.gov/daltcp/reports/2003/ARtrans.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2003/ARtrans.pdf

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
PDF: http://aspe.hhs.gov/daltcp/reports/2002/WItrans.pdf

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

RETURN TO:

Office of Disability, Aging and Long-Term Care Policy (DALTCP) Home
[http://aspe.hhs.gov/_/office_specific/daltcp.cfm]

Assistant Secretary for Planning and Evaluation (ASPE) Home
[http://aspe.hhs.gov]

U.S. Department of Health and Human Services Home
[http://www.hhs.gov]