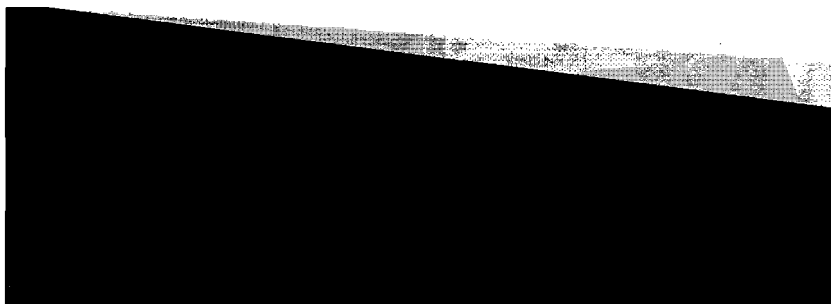# LONG-TERM CARE RIGHT-SIZING STRATEGIC PLAN
(AS RECOMMENDED BY THE LONG-TERM CARE RIGHT-SIZING STRATEGIC PLANNING RETREAT PARTICIPANTS)
STATE OF CONNECTICUT
JANUARY 15, 2012

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1

Introduction

According to the US Administration on Aging's Profile of Older Americans[1], the number of people age 65 and older is expected to grow to 19.3% of the population by 2030, marking a significant growth as a portion of the population nationally. This trend is evident in the State of Connecticut (State), where projections indicate a 40% growth in individuals age 65 and older between 2010 and 2025.[2] By 2025, demand for long-term services and supports (LTSS) is expected for more than 64,000 individuals in Connecticut – an increase of more than 24,000 individuals over current levels.[3]

The following graph displays the projected growth of the total demand for long-term care (LTC) services in Connecticut, as well as the expected change in the mix between home- and community-based services (HCBS) and nursing facility (NF) services. While the demand for LTC services is expected to grow to close to 64,000 users in 2025, the mix between HCBS and NF services is expected to move from the current HCBS/NF mix of 53%/47% to 83%/17% in 2025.[4] Changes in the HCBS/NF mix are largely attributed to interventions funded by the State's Money Follows the Person (MFP) Rebalancing Demonstration. Interventions are designed to eliminate barriers which prevent choice in where users receive their LTSS.

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[1] US Administration on Aging. A Profile of Older Americans: 2010 (updated February 25, 2011).

[2] Connecticut Long Term Care Planning Committee, "Long Term Care Plan: A Report to the General Assembly", January 2010, page 42, table 5.

[3] Jaramillo, Ernest ASA, MAAA, MBA; Medicaid Long Term Care Services and Supports Utilization and Cost Projection Model, State of Connecticut – Department of Social Services. November 30, 2011.

[4] Ibid.

Projected LTC Demand

Post Intervention-NF ■ Post Intervention-HCBS
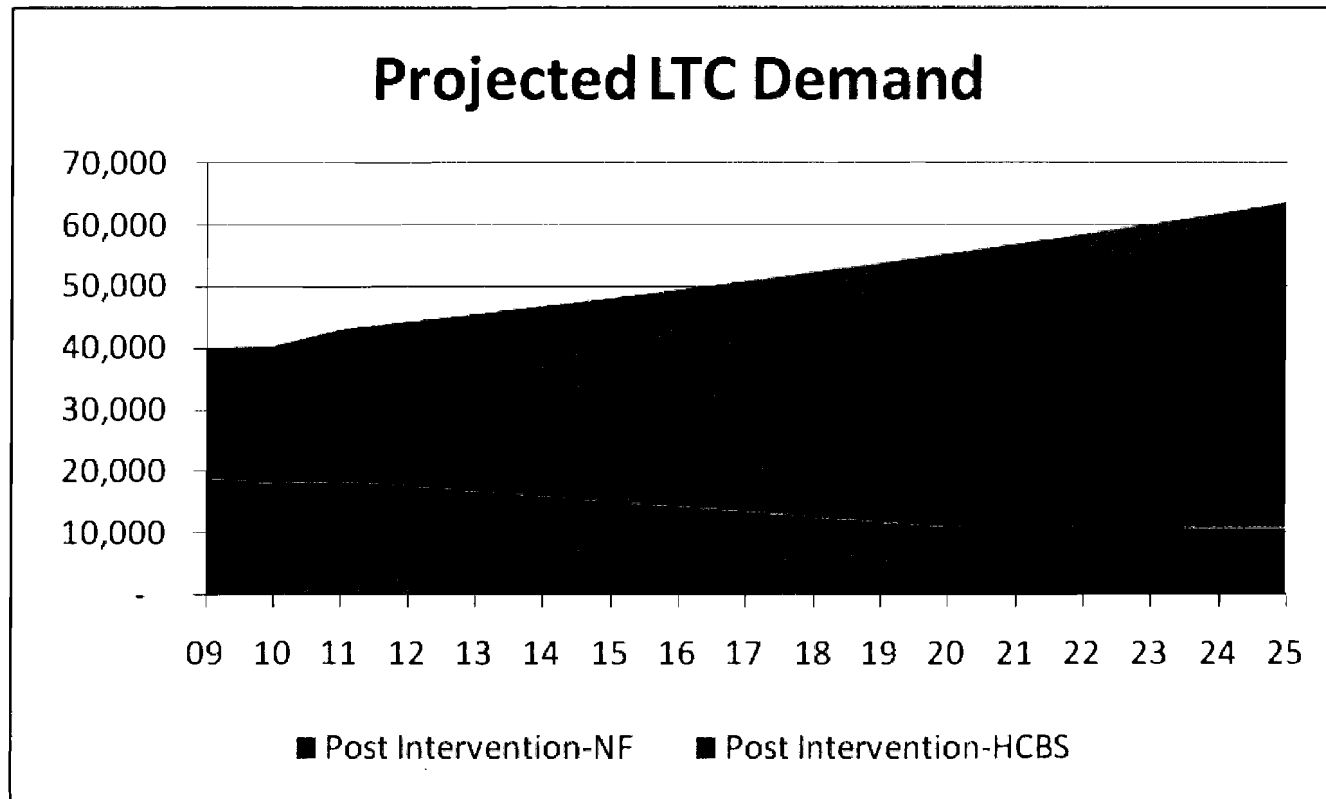
To structure a service delivery system to meet the anticipated needs for LTSS and improve person-centered care systems for individuals with disabilities and individuals who are aging, Connecticut has embarked on a LTC Right-sizing Initiative to identify system strengths and strategies to ensure the availability and service arrays preferred by and necessary to support the current and future users of LTC in the State. In partnership with individuals who are aging, individuals with disabilities, their families, community and institutional LTSS providers, advocates and other stakeholders, Connecticut seeks to align the supply of LTSS within the system with the anticipated demand for increased home- and community-based options.

Currently, Connecticut spends more than 78% of its associated LTSS dollars on institutional care for individuals who are aging and individuals with physical disabilities (excluding individuals with intellectual or developmental disabilities).[5] A 2011 analysis of adults age 31 and over using Medicaid LTC services shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and in 2008: Total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and older.[6] Offering greater options for community-based services as an alternative to the continued reliance on institutional care will enable the State to be more cost effective and more responsive to the preferences of the individuals likely to need services.

The right-sizing initiative will draw upon the strengths of the existing system, ensuring that the institutional providers within the State continue to serve an essential role in the care continuum while also diversifying and bringing their significant expertise to bear in other areas of the service system. The initiative further relies on the expert input of a wide array of stakeholders to ensure that the rebalanced LTSS system embodies the structures, philosophies and options necessary to meet the needs and preferences of individuals served for the coming decades.

Through a multi-month process of deliberate stakeholder briefing, engagement, data and system analysis, culminating in the LTC Right-sizing Strategic Planning Retreat, Connecticut has sought the input and expertise of those interested in building a sustainable LTSS system within the State. With an unprecedented level of partnership and collective work toward the common goals, the participants in these efforts have contributed heavily to this strategic plan which will be considered by the State to establish a LTC right-sizing strategic plan and LTSS system designed to meet the unique needs of the State's future.

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[5] Burwell, et. al. Medicaid Long Term Care Expenditures, FY 2008; December 2009; www.hcbs.org.

[6] _American Journal of Public Health_, September 2011, Vol. 101, No. 9; "Relations Among Home- and Community-Based Services Investment and Nursing Home Rates of Use for Working-Age and Older Adults: As State-Level Analysis", Nancy A. Miller, PhD.

Specifically, this plan addresses key elements within the LTC system that require further re-engineering in order to meet the State's LTC right-sizing goals such as:

- HCBS
- Workforce
- Housing and transportation
- Hospital transitions
- NF diversification and modernization
- MFP grants

While representing distinct features and challenges within the system, these elements are inter-related, and in some instances, interdependent – and all must be addressed to improve the LTSS system to ensure a strong and responsive person-centered care continuum and to establish State policies that maximize individuals' independence and control. Initiatives developed and implemented as a result of this plan will be aligned with the State's vision for a LTC continuum as defined by the LTC Planning Committee and MFP rebalancing demonstration; the vision is guided by the principles of individual participant choice, dignity and autonomy. The vision and principles are also aligned with the Department of Social Services' (DSS') mission of being committed to promoting and supporting the choice for individuals to reside in one's own home and community.

Throughout the process the level of engagement, interest and collaboration of the planning retreat participants in providing their time, expertise and candid comments have helped to shape the participants' LTC right-sizing strategy as it appears below. The State would like to recognize their efforts in support of developing the right-sizing vision.

2

Utilization and cost-projection model for Medicaid long-term services and supports

In order to assist in the development of the State's right-sizing strategy, a data model was developed to project the demand for LTSS at the State level. The purpose of this data model is to estimate the future demand for LTSS as well as the impact of changes in the mix of services between institutional and HCBS. As part of the model development, the State emphasized the necessity of ensuring the model illustrated the impact of honoring the choice of consumers.

The model construction is divided into two phases: First, a high-level model focusing on a macro view of LTSS over the next 15 years. In this first phase the model will use readily-summarized data from the American Community Survey as well as the historical Medicaid NF and HCBS participant information from State fiscal year 2004 to the present from the State's Office of Policy and Management.

The model construction during the first phase was broken down into three steps:

Projecting the overall demand for LTC services.
Examining the effect over time to the HCBS/NF mix if existing trends persist absent the impact of any new initiatives.
Factoring in the impact to the HCBS/NF mix if existing initiatives accelerate or new ones are introduced.

The second phase of the project is to construct a more detailed model to assess and address strategies at the local level. It is important to examine the issue at the macro level prior to the development of the more detailed local view so that potential systemic infrastructure issues which may exist can be taken into account. The more detailed model, which will use actual State Medicaid data, is expected to be completed in early February 2012.

3

Strategies for rightsizing

The workgroup that participated in the LTC right-sizing retreat and developed these strategies was comprised of a cross-section of individual HCBS stakeholders. Specifically, representation on this group included family members, advocates, ombudsmen, State staff, providers (community and institutional), academics and others. The strategies identified by this team are vital in achieving success and in building an equitable, objective and seamless system. Where the State recognizes that a robust set of strategies are necessary to realize the LTC right-sizing goals that have been established, it is also pragmatic in its approach: recognition that resources are limited. Thus, the final set of recommendations that will comprise the first phase of activity will be selected based on considerations relating to timing, resources and funding necessary to complete each strategy.

Home- and community-based service options
Overview
HCBS support individuals with disabilities to live in their own home, with family or in other community settings. A diverse set of community-based service options is critical to support individuals to live in the most integrated setting possible outside of NFs. As Connecticut develops these systems of support for community-based alternatives and improves the quality of the services, the State must consider how to best inform individuals of service choices and make new options available.

The strategies outlined below represent key steps to improve the home- and community-based system and its ability to support individuals based on their needs, regardless of diagnosis, including individuals with significant support needs and those who are returning to the community from institutional stays.

Strategies

Strategy	Tactic	Metric
Create parity across age and disability resources based on functional support	• Create a consolidated waiver for adult individuals who are aging or adults with	• System baselines were established for the following:

Strategy	Tactic	Metric
needs rather than diagnosis – Access, eligibility, payment, service availability, cost caps, age requirements or gaps.	physical disabilities that would blend existing waivers with expanded services to better meet the needs of people under the age of 65 • Make access to services and processes simpler, easier to understand and navigate • Increase understanding of Medicaid policy and spousal protections available under waivers • Address current discrepancies in rates for similar services • Eliminate waiting lists for services • Establish a seamless quality improvement strategy across waivers • Establish methods to share practices across target groups and programs to encourage and facilitate use of best practices across the system	— HCBS system performance (were the most robust segments of the system meeting needs or over-serving?) — Unmet needs (for individuals currently enrolled or awaiting waiver services) — Capacity (providers, State oversight, etc.) — Current processes (including process time/effort) and standards (access/eligibility, including cost caps) — Current complexity • Deliverables and timeframes for waiver consolidation and improvement were identified • System performance: Quality for individuals receiving service improved • Unmet needs decreased • Institutionalization or re-institutionalization of individuals eligible for HCBS demonstrated downward trends • Comprehension of all system facets increased: Eligibility (including protections for spouses in the community), access, services, providers, consumer protections and safeguards

Strategy	Tactic	Metric
		• Comparable rates for similar services rendered by similar providers were established
		• A seamless quality improvement strategy was established and in-place
Close service gaps and improve existing services to better serve the needs of all populations. Assess access to other services critical to success in community living.	• Undertake comprehensive review to ensure adequate, appropriate service availability within HCBS waivers and State plan (all services needed to support individuals in the community). For example: — Review and expand chronic disease education and self-management programs — Increase and improve physician access and physician understanding of community capacity to meet individual needs — Increase and encourage greater use of peers or caregivers in the delivery of service — Identify strategies to expand and grow successful, person-centered assisted living communities — Simplify and better inform individuals on availability of home modifications — Improve and promote importance of employment services (and debunk related eligibility myths)	• Baselines across all populations (using available service array and utilization patterns) were established • Services that demonstrated improved community retention or return (using available national data) were incorporated into the program

Strategy	Tactic	Metric
	— Improve care transitions and care management — Identify strategies to utilize HCBS as a tool for institutional prevention	
Build, improve and make provider networks accessible to wider array of individuals.	• Provide education around informed risk parameters and person-centered strategies for risk mitigation • Change legislation to allow for reduced liability to agencies if private providers are providing care inconsistent with agency care and for risk • Review and improve medication administration rules to enable wider opportunities for medication administration • Pay rates to enable livable wages and benefits (commensurate with NF pay and benefit levels) • Cross train and align provider qualifications across waivers and between agencies so that one provider can offer a package of services to all who need it • Ensure quality of care, through independent evaluation of provider — Identify strategies to support providers who care for complex and high-risk individuals to encourage, rather than discourage, provision of	• Baselines for providers of HCBS were established including: — Existing availability across waivers, measured over time, for increased capacity and quality • Legislation to address medication administration and risk/liability issues for HCBS provider entities was proposed • Consistent or reciprocal provider qualifications across all waivers were established and in place • Payment for similar services across the service system were aligned • Methodology to ensure provider quality was seamless and consistent across provider entities was developed

Strategy	Tactic	Metric
	care with significant support needs	
	— Ensure disaster preparedness, establish partnerships to meet individual needs in emergency situations/circumstances	

Challenges to success

Whether the strategies identified above are undertaken individually or as a package for comprehensive HCBS system reform, there are some challenges that must be overcome for successful execution. These challenges, though not unique to the efforts to ensure a rich HCBS service system, have direct implication on the ability or timeliness of possible implementation.

1. Affordable, accessible housing: Individuals are only able to avail themselves of HCBS if they are able to secure or retain housing in the community.
2. Fiscal considerations: Changes to rates and services (amounts, duration and scope) will have fiscal implications. Quantifying these considerations and identifying available resources will be key to moving forward.
3. Conflicting regulations between Medicare and Medicaid: Issues requiring resolution include formulary coverage or gaps for pharmacy benefits, disparate requirements for home health, homebound and others.
4. Transportation challenges: Availability of transportation as well as inability for personal care providers to provide transportation.
5. Availability of standard assessment that identifies needs objectively, based on need not diagnosis, and streamlined tools for service initiation and data collection.
6. Disparate rates and provider requirements across existing waivers. While noted above as an issue to address, changes will require engagement and negotiation with wide array of providers and individuals served.
7. Lack of disaster preparedness strategies, such as utilization of NFs to house and care for consumers when provision of HCBS services is not possible due to short-term catastrophic events.

Other strategies

The strategies noted above represent those identified by the group as being the highest priority; however, other critically important steps and considerations were raised during this dynamic stakeholder retreat. The items noted below should be addressed as a part of the broader overall strategies addressed above or should be sequentially addressed once the broader strategies have been implemented:

1. Deliberately incorporate employment discussions/plans into all service planning discussions with people seeking services.
2. Undertake deliberate, comprehensive support effort for informal caregivers: Education, support services, respite, linkages with peers, etc. Expand understanding of existing informal caregiving network (and its likely expansion with expanded HCBS utilization).
3. Provide one-stop shopping or informed choice about all resources available across populations/communities (no wrong door approach). ADRCs have been helpful but many people are not yet aware of ADRCs and these are not available across the State.
4. Provide comprehensive, concise education of providers, families and potential service recipients of what is available and how to access it.
5. Increase access to advocacy and protection while residing in the community. Ensure quality of care.

Workforce
Overview

As the State begins to operationalize its efforts to rightsize its balance of LTC services between NFs and HCBS, there are many important perspectives to consider. Chief among them is assessing the workforce capacity needs as a result of rebalancing the delivery system. As demand for HCBS services increases, existing labor, incoming labor and informal caregivers supply will also need balancing. The State is expected to have a substantial increase in the 65-and-older population, along with a decrease in the under-65 population[7], which is going to decrease the supply of informal caregivers as well as the pool of paraprofessional candidates. Understanding and leveraging the informal caregiver supply while making the paraprofessional field an attractive option for job seekers is a key component of the issues related to workforce as related to LTC rightsizing.

Strategies

Strategy	Tactic	Metric
Increase the labor force to adequately supply the future demand for LTC services. There is expected to be an increase of close to 20,000 LTC users over the next 15 years, with the bulk of the increase focused on HCBS.	• Develop a clearinghouse and job board to identity all LTC providers in the State, and any accreditations they may have so a potential LTC consumer can evaluate them as a potential provider (The job board is where providers and users can connect on the basis of a number of criteria, such as desired work schedule) • Revise State regulations as needed to allow NFs to become hubs of community service for HCBS users • To attract more workers reform the pay structure, including benefits, of LTC industry workers	• A clearinghouse and job board established within 18 months • Legislation to address State regulations related to NFs as hubs of care, medication administration and risk/liability issues for HCBS provider entities proposed within 18 months • A committee to examine/reform the pay structure of providers taking into account the demand for care in conjunction with the practical costs and infrastructure of living in Connecticut established within 12 months • A proposal to partner with existing or new educational outlets in response to

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[7] Connecticut Long Term Care Planning Committee, "Long Term Care Plan: A Report to the General Assembly", January 2010, page 46.

Strategy	Tactic	Metric
	• Restructure the waivers to allow for a more streamlined approach of entry into the HCBS waiver programs and to provide for a more uniform approach for the access to services	the need for education of the workforce (new, existing and future) established within 12 months
	• Develop training programs for new and existing entrants into the field (The training programs will be geared toward those with experience in the LTC industry, looking to transition into work more heavily focuses on delivering home-and community-based services, as well as ground up training for those with no experience at all)	• Enrollment and post-training job statistics tracked and demonstrated dwindling gap in workforce needs • The number of new workers increased from X to Y
	• Develop a marketing plan to make others aware of the opportunities for direct care (in-home) workers (The flexibility of the job might be more attractive to those with desire for a more flexible schedule such as part time, college students, etc.)	
	• Offer continuing mentoring and peer support to formal and informal caregivers.	• An online education forum to current informal and formal caregivers in place

Challenges to success

The ability to develop a strong HCBS workforce to support right-sizing efforts represents a critical imperative for the State. Although not insurmountable, there are some challenges that must be overcome for successful execution. These challenges, though not unique to the efforts to ensure a rich HBCS service system, have direct implication for the timeliness in meeting the State's right-sizing goals.

After discussion about the primary challenges for success identified by the group, two basic issues were identified. First, the Connecticut waiver structure and the second, regulatory issues surrounding nurse delegation. These issues were viewed to seriously hamper the ability to achieve a more efficient and standardized structure and workforce. In short, the workgroup felt that regulatory changes could result in greater workforce efficiencies through more encompassing authority to perform a greater variety of HCBS services. If these systemic issues cannot be examined and rectified at the State level, workgroup participants felt there would be little that could be done to meet the demand for an increased workforce.

In addition, participants agreed that another challenge to meeting the workforce demand included the economics behind living in Connecticut where the cost of living compared to the wage earned presented a unique barrier. The current HCBS pay structure does not offer enough incentives to attract new workers. While the group also identified the supply of adequate housing and transportation for workers as a challenge, the group feels that the influx of workers through pay reform will spark subsequent movement in housing and transportation.

Other strategies
As noted earlier, many of the distinct features and challenges within the system have elements that are inter-related, and in some instances, interdependent. The group discussed the impact of housing and transportation on workforce development; however, the discussion remained targeted on workforce development.

Housing and transportation
Overview
Housing
Provision of affordable, safe and accessible housing plays a critical role as Connecticut assists Medicaid consumers to either remain in or return to the community. Appropriate housing opportunities for HCBS consumers can vary greatly and are frequently the primary barrier for LTC consumers to receive HCBS. In order for the State to accomplish its LTC right-sizing goals, it will be necessary to have an adequate supply of housing so the rebalancing targets that have been established may be accomplished.

Housing options include a person's own home (owned, leased, shared), supportive housing, shared living arrangement, congregate housing, assisted living services/managed residential communities and residential care homes. Finding adequate housing can be more challenging than developing the array of services needed to assist consumers to remain in or return to the community.

Transportation
Transportation becomes central in providing Medicaid consumers access to the community. Additionally, transportation plays a pivotal role in bringing caregivers to HCBS consumers to provide the necessary care that facilitates a consumer to successfully remain in or return to the community. Transportation is frequently acknowledged to be one of the greater unmet needs in communities. Transportation (when available) is frequently not accessible or affordable, leading to additional challenges to bring the consumer and the service providers together.

Strategies

Strategy	Tactic	Metric
The State should foster greater partnership and cross-agency collaboration needs between agencies focused on housing and transportation.	• Establish a strategic partnership between DSS, Connecticut Housing Finance Authority (CHFA), Department of Economic and Community Development (DECD)/Office of Housing Development & Finance (OHDF), Department of Transportation (DOT) and the US Housing and Urban Development (HUD)	• A formal partnership between DSS and HUD, DECD, CHFA and DOT established • A housing and transportation unit within DSS established • Available housing options from X to Y expanded • Guidelines to allow caregivers to

Strategy	Tactic	Metric
	• DSS should establish a housing and transportation unit to specifically build relationships with partners in order to provide more housing and transportation opportunities	provide transportation revised
	• Leverage new relationships to access additional housing vouchers via grants, and identify project-based housing units that are currently vacant for housing of transitional clients	
	• Foster collaboration with DOT to establish different guidelines for caregivers providing transportation which enables an increase in pay	
Provide natural supports and caregivers with assistance with transportation and housing.	• Provide caregivers and clients priority with tenant-based and project-based housing vouchers as well as help to establish community coalitions to assist in transportation	• Workforce survey on perceived transportation barriers improved from X to Y
	• Analyze additional means to establish how home sharing could assist family and caregivers with respite	• Expansion of shared housing increased from X to Y
	• Establish coalitions for community transportation to assist with ride shares	• Ride share use increased from X to Y
	• Explore the use of Zip car-like rentals service	• 202 housing units increased from X to Y
	• Explore the use of school buses during the day	
	• Develop more opportunities to utilize the 202 housing structures to assist in	

Strategy	Tactic	Metric
	housing shortage	
Preserve system funding that is the result of savings from rebalancing by allocating funds specifically to housing and transportation.	• Establish a housing trust to hold funds from cost savings of transitions in order to reuse savings specifically toward housing and transportation instead of allowing funds to go back to general funds in State budget	• Calculated savings placed in trust improved from baseline to X%
Improving financing dollars for housing.	• CHFA to obtain new bonding dollars for affordable housing to allow NFs to modernize and introduce culture change (e.g., greenhouse concepts, home-like environments, more common space, designs for more space and environmental efficiencies)	• Bonding funds increased from X to Y
Convert select NFs to assisted living.	• Support the development of assisted living communities through the conversion of skilled nursing home buildings and on the campuses of skilled nursing homes	• X many conversions over Y many years

Challenges to success

During the course of discussion the workgroup observed the following challenges to affordable housing and transportation:

1. Current housing options require significant retrofitting/restoration.
2. There is considerable fragmentation between State agencies such as DOT, DSS, CHFA and DECD/OHDF.
3. There is a lack of data preventing an understanding of issues by geography.
4. There are considerable regional differences throughout State-related to housing needs.
5. Transportation is not available for the community workforce to reach clients.
6. Financing fragmentation caused by systems/agencies not working in conjunction with each other (i.e., DOT and DSS).
7. The bias against assisted living and campus of care settings in MFP grants.
8. Housing requires considerable development funding and the operating subsidy for the actual affordable housing site which requires a federal and State collaborative effort.

Other strategies

The follow-up comments supported the following additional strategies:

1. Foster and improve ability to use assisted living communities.

Hospital discharges
Overview

Hospital discharge planning activities often drive patients to NFs in order to provide a safe discharge environment and act as an effective mechanism in transitioning consumers along the continuum of care to ensure that they receive the appropriate follow-up care and services they require. However, data shows that 65% of all individuals who enter NFs are still there after six months.[8] Thus, for vulnerable populations, entry into a NF can often lead to permanent institutionalization and loss of community ties and individual freedom of choice. Additionally, health services research indicates NFs could provide viable alternatives to acute inpatient (re-)admissions, effectively bypassing emergency departments (EDs) and subsequent inpatient stays through direct NF admissions. From this perspective, NFs can ensure that patients receive the right care in the right place at the right time and can be quickly transitioned back into their community.

The strategies outlined below represent those steps the Hospital Discharge workgroup identified as being critical in the State's efforts to promote a more efficient and effective hospital discharge planning processes. Through more integrated and streamlined processes and with greater collaboration and education it was felt that more effective transitions of care could be obtained. Thus, as consumers need to access acute care services, hospital case managers, assistive personnel and physicians could promote home- and community-based support and service alternatives when appropriate effectively reducing potentially inappropriate NF admissions that can lead to long-term institutionalization, and targeting and reducing inappropriate ED and subsequent inpatient admissions through either a direct NF admission process or home health service delivery options.

Strategies

Strategy	Tactic	Metric
Convene a statewide Person-Centered Community Care Collaborative, focused on the development and dissemination of educational tools and materials and promotion of the State's right-sizing strategy through support of the cultural change	• Develop statewide definitions for key HCBS terms such as "choice", "person-centered plan" and "dignity of choice" that will have drive cultural change • Devise and implement a global communication plan raising awareness	• Established systems baselines: — What was the hospital community's understanding of HCBS options? — What barriers existed for hospital case managers in promoting HCBS

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[8] Connecticut Commission on Aging Strategy Paper, December 2010, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCkQFjAA&url=http%3A%2F%2Fwww.cga.ct.gov%2Fcoa%2FPDFs%2FFact%2520 Sheets%2FCoA%2520LTC%2520strategies%252012-7-10.pdf&ei=WIThTt2NLKHm0QG_mdCJBg&usg=AFQjCNFzEWtVJVgGcjMgOiDc5Rs0NHNTzw&sig2=1HNf3nghsWUNuxCZBopnlQ, last accessed December 9, 2011.

Strategy	Tactic	Metric
necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health (PH) and behavioral health (BH) issues.	of LTC options • Continue to build on a centralized, web-based repository for LTC information, making it meaningful and relevant to the medical/hospital community • Build greater synergies between the various State, regional, county and city organizations that all have a role in promoting LTC and HCBS options	options? — How could the current pre-admission screening process have been revised to promote options for HCBS services? Were there screening tools that could've been employed to better stratify at-risk individuals? — Assessed current fragmentation or available options in obtaining services for individuals with BH conditions • Satisfaction measures related to knowledge, resources and ability to access services by the health care community • Satisfaction measures related to knowledge, resources and ability to access service by consumers • Number of "hits" on centralized website • Employed survey for individuals accessing the website • Used data to re-design/update web content as appropriate
Develop and implement a Transition of Care model specific to individuals who are receiving or are at risk for receiving LTC services (Note: This was viewed by the workgroup to be separate strategy to be employed in	• Develop and deploy a comprehensive educational program targeted at hospital case managers and hospital physicians that provides information on the options available to care for individuals in the community setting and	All measures were for those individuals, new or existing, that received LTC services: • Readmission rates — To hospital from community — To hospital from NF

Strategy	Tactic	Metric
tandem with the Person-Centered Community Care Collaborative)	assists the medical community in becoming more person-centered and less paternalistic. — Web-based training program globally accessed by all hospital case management staff providing basic training on LTC options — Increase and improve understanding of key HCBS terms and how that effects care planning and discharge efforts • Implement a tool that assists hospital case managers in determining at-risk patients for LTC services • Tool could be web-based and algorithmic, allowing for LTC options to be displayed based on what the individual's needs were, promoting individualized and person-centered planning • Hire and train LTC ED coordinators who could be responsible to more effectively identify and engage resources to assist in transition of a person back into a community setting or minimize the length of stay in a NF through effective care planning	— To NF from community — To NF from hospital • For those who required LTSS upon discharge from hospital, X percent increased in discharges to community versus institutions • Reduction in length of stay (LOS) — Acute inpatient LOS — NF LOS • The overall community tenure of individuals who received HCBS services increased • Standardized discharge planning survey assessed: — Patient/caregiver understanding of discharge plan — Support in successfully implementing the discharge plan and engaging LTC services — Timeframe for follow up with primary care provider or specialty care provider post discharge • Understood long-term options that were available to the consumer

Challenges to success

Whether the strategies identified above are undertaken individually or as a package for comprehensive HCBS system reform, there are some challenges that must be overcome for successful execution. These challenges, though not unique to the efforts to ensure a rich HCBS system, have direct implication for the ability or timeliness of possible implementation:

1. State/Department of Public Health regulations have not kept pace with the times:
   a. The medical concept of a "safe discharge" is often at odds with the LTC mantra of "dignity of choice", making the necessary health care community's culture change to support rebalancing difficult
   b. Direct admission to a NF requires an order by a hospital physician/practitioner effectively delaying or minimizing the ability to utilize NFs in the most efficient and effective manner
2. Medicaid and waiver structure:
   a. When trying to coordinate service planning for individuals with BH issues, provider qualifications and low reimbursement rates make it difficult to recruit and retain providers (i.e., mid-level mental health (MH) nurse practitioners are not recognized by some waivers as viable providers of service)
   b. Disparity in provider reimbursement between PH and their MH counterparts undervalues the provision of MH services
   c. The varied structure, service packages and eligibility process make accessing services difficult and those delays contribute to institutionalization where the six-month wait period for MFP options then kicks in and delays community discharge even further (It should be noted that in a post-workgroup meeting, it was validated that MFP requirements under the Affordable Care Act have resulted in the waiting period dropped to 90 days, improving the turnaround time but still posing barriers to a more timely NF discharge)
3. The Centers for Medicare & Medicaid Services (CMS)/federal regulations:
   a. The use of observation stays muddies the waters when trying to directly admit into a NF for individuals with dual eligibility, as current regulations require a three-day acute inpatient hospital stay
   b. The definition of "community setting" makes it difficult for LTC providers wishing to diversify their business model to enact timely and efficient change to their service delivery array

Other strategies

The strategies outlined above represent the culmination of a robust discussion amongst the workgroup participants. The group did take several forays into other topics outside the scope of the hospital discharge arena. However, those discussions were tabled as they were considered outside the workgroup scope and/or covered under the five other workgroup topics.

Nursing facility diversification and modernization
Overview

The current State LTC institutional landscape includes 238 NFs with a total of 28,780 beds and an average occupancy rate of 92%. The State ranks number three in the country for the number of facility residents per 100 State residents over age 65 at 5.8 compared to the national average of 3.8. The State also has ranked high in the proportion of low-acuity residents that live in NFs. According to data from the CMS *2008 Online Survey, Certification and Reporting* database, the average activity of daily activities of daily living score of a Connecticut NF resident was 3.7 while the national average was 4.0. Four states tied with Connecticut and only two states had a lower acuity score, demonstrating Connecticut's opportunity to transition or maintain more individuals to the community setting.

NFs are a critical component to any State's Medicaid LTC program. Recent studies, however, conclude that consumers increasingly want to remain or return to their own home[9]. In response to consumer desires, the State has implemented initiatives that are designed to result in an increased proportion of the Medicaid LTC consumers residing in the community. Regardless of the shift to provide supports and services for consumers to remain in or return to the community, NFs will continue to be a vital component to any LTC program. NF operators will however need to consider what their presence in the local community will look like in the future: Will it be a smaller facility? Will it provide specialized care? Will it be an operation that also provides supports and services to consumers who reside in the community?

This group is tasked with identifying different strategies NFs might consider in order to diversify and modernize their health care operations so that they may effectively react to the changing LTC environment.

Note: CMS has proposed rules regarding what conditions must be met to qualify as a home- and community-based setting (e.g., assisted living). What impact that may have on options for NF operators who wish to diversify is not fully known at this time since CMS is reviewing a significant number of comments before it can finalize the rule.

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[9] Connecticut Long-Term Care Needs Assessment Part I: Survey Results, June 2007 (REVISED March 2010), Page 56, Table III-10.

Strategies

Strategy	Tactic	Metric
Transform NFs into comprehensive assessment centers for all LTSS.	• Adoption of a common assessment tool that addresses all LTSS and related conditions and disabilities. The tool should be person-centered, include collaboration with hospital discharge planners and MFP initiatives, and consider available community resources and make recommendations when community supports are lacking. • Redefine the Certificate of Need (CON) process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports the transformation process. • Determine a payment rate for the assessments and how such payments will be funded. • Change community interaction (e.g., communication channels, means of obtaining information, requests for assistance, grievances, etc.) with NFs to support person-centered care.	• Identified a single assessment tool • Number of assessments • Number of referrals for community-based services increased from X to Y • MFP payments for an assessment tool or conversion of NF building/ operational/workforce to assessment centers developed • Consumer surveys • CON policies and procedures revised • Payments for assessments at the State level included MFP payments • Revenue and units of service at the facility level • NF operational changes reflected focus on person-centered care • Ombudsmen surveys
Develop NF services to include transitional programs that support the movement of individuals from the facility back into the community.	• Expand Medicaid- and Medicare-covered therapies to support rehabilitation and training for community living (e.g., occupational therapy, etc.) • Create additional transitional training programs within NFs (including possible transitional units), including training and	• Changes to Title XIX and Title XVIII supporting community living therapies • Revenue/billed units for identified therapies • Repurposed square footage to support transitional programs

Strategy	Tactic	Metric
	support for caregivers • Revise NF licensure and regulatory requirements to allow for transitional programs and new levels of care (LOCs) • Develop Medicaid rates for transitional services • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports transitional services	• Revenue/billed units for identified services • MFP payments for development of transitional program or NF building/ operational/workforce changed for addition of transitional services • Number of educational programs for caregivers • Consumer surveys • Changes to Title XIX and Title XVIII supported transitional living services • Statutory and regulatory revisions • Medicaid (or MFP) fee schedule or rate methodology • CON policies and procedures revised
Transform NFs into continuing care providers that allow individuals to receive a continuum of services from the same entity.	• Reissue business plans and financial projections. • Provision of community-based services through NFs, including but not limited to therapies, home health, personal care, home-delivered meals, hospice (facility and home), respite, memory impairment, transportation, concierge, adult day and assisted living, etc., MFP, care follows the person and caregiver follows the person; facilities will become similar to ADRCs and centers for coordination and support • Development of community space at	• MFP payments for strategic assessments/feasibility analyses and development of business plans • Number of business plans included continuing care programs • Units of non-NF services provided by NF entities • Non-NF revenue paid to NF entities • Non-NF individuals served • Changes in licensure of NF square footage • Changes in licensure allowed hospice services in individual rooms within a NF

Strategy	Tactic	Metric
	NFs	and coverage by Medicaid/Medicare
	• Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports transitional services	• MFP payments for development of community based services or NF building/operational/workforce changed for addition of community services
		• MFP or other grants for development and implementation of electronic health records for LTC services
		• Consumer surveys
		• Changes in licensure of NF square footage
		• CON policies and procedures revised

Challenges to success

The current bias for NF care has evolved based upon historic Medicare and Medicaid policies, which have then influenced a host of other issues, including workforce development, financing, licensure/certification and other federal and State policies. For the above strategies to be successful, action will be needed to revise how LTSS are typically provided, including challenges inherent in the current system such as those discussed below:

1. CON policies and decisions that restrain the transformation of NFs or deter closure/de-licensing of beds.
2. Lack of funding for development and adoption of a single assessment tool that reflects person-centered planning.
3. Lack or insufficient funding for assessment payments; rates too low to support such services.
4. Coordinating BH and substance abuse services with LTC assessments and services.
5. Three-day hospital stay requirement under Medicare, which limits NF utilization in place of hospital services.
6. Resistance to changes in revenue projections and business plans that may require the approval or notification of financing entities (e.g., mortgage holders, bond trustees, banks, etc.).
7. Funding for building and property changes to support comprehensive assessment services, and adequacy of revenue to support costs of such changes.
8. Resistance to changes in hourly rates, job classifications and available positions that may require approval or negotiations with the Service Employees International Union.
9. Funding for training and workforce development for comprehensive assessment, transitional and other community-based services.
10. Lack of coordination with other MFP initiatives, resulting in competition and duplication of services and costs.
11. Lack of changes to statutory and regulatory governance of Medicaid (Title XIX), Medicare (Title XVIII), CON and licensure programs to support transitional services and mixed-facility use.
12. Lack of funding (MFP, Medicaid or Medicare payments) for transitional and community service development (e.g., direct funding, loan guarantees, etc.).
13. Lack of inclusion of occupational therapy as a covered MFP, Medicaid and/or Medicare service.
14. Coordination/collaboration with existing HCBS providers and financial viability of new and existing services.
15. Failing to determine how hospice services can be delivered within the NF (or space formerly used as NF).
16. Exclusion of LTC providers for grants for electronic medical records.

Other strategies

Strategies that were discussed but considered lower priorities than those identified above:

1. Add other community services at NFs to make them more attractive for community involvement.
2. Support coordination between NF and other HCBS so the NF is a community backup when other HCBS providers have difficulty meeting individuals' needs.
3. Enhance NFs as centers for community and family support for LTC services and education rather than as the last and least desirable option. Focus should be on the individual's needs and desires, and how coordinated with the community and family.

4

Money Follows the Person grants
Overview

As the State moves forward with their LTC rebalancing initiatives, there is no doubt that the State's LTC system will look very different in the future. To assist in this transformation effort, the State has secured approximately $20 million in funding from CMS so that "institutions will begin to redefine their role in the delivery of LTC from 'final placement' to an environment that supports long-term living". This funding will provide the opportunity for financial assistance to NF providers that desire to transform their current business model in a way that will expand the opportunities for individuals to reside in the community setting of their choice.

The State will develop grant opportunities for the planning and implementation of LTC right-sizing initiatives for which NF providers may apply. In order to evaluate proposals and fund diversification plans the MFP Grant workgroup was tasked with developing strategies to assist the State to achieve the short-term objective of issuing a request for grant proposals. The MFP Grant workgroup was also tasked with developing guiding principles and criteria that the State could use to evaluate and fund the various plans that may be submitted.

Per the State's current MFP Operational Protocol (revised February 10, 2011) this funding will be divided into two phases: Phase I for planning activities for potential diversification and Phase II for funding viable plans that the State selects. The funds for Phases I and II will be targeted to NFs interested in diversifying their operations by providing community services or serving in another capacity that supports the successful provision of services to individuals in the community while also decreasing the number of NF beds. Phase II funding may go towards paying a NF for each person they return to the community, in order to compensate the entity for both their effort to support the individual during the transition and for the revenue decrease as a result of the transition. Funding from Phase II can also go towards infrastructure costs associated with the development of a HCBS business model. Examples of infrastructure costs CMS can cover include:

- Technical assistance/consulting
- Legal fees for establishing separate home health agency structure and other start-up costs
- Fees for becoming a certified adult day provider
- Business interruptions costs during conversion

- Licensure costs
- Meetings costs
- Infrastructure costs associated with information technology
- Training and professional development
- Travel
- Community market research
- Outreach activities
- Print materials for adult day center or home health agency

In addition, for facilities wishing to develop community housing, expenses attributed to accessibility modifications can be covered. However, costs associated with renovating on institutional grounds for the purpose of creating housing on institutional grounds will not be covered.

If the final MFP grant program differs from what the current MFP Operational Protocol would allow, the State may amend the current protocol to align with the program adopted by the State and request CMS approval.

Note: CMS has proposed rules regarding what conditions must be met to qualify as a HCBS setting (e.g., assisted living). What impact that may have on options for NF operators who wish to diversify is not fully known at this time since CMS is reviewing a significant number of comments before it can finalize the rule.

Strategies

Strategy	Tactic	Metric
Determine the interest of NFs regarding grants for planning and implementing LTC right-sizing initiatives.	• Develop a survey and survey NFs regarding their interest in grants for planning and implementing LTC right-sizing initiatives; questions could include but not be limited to interest in grants, interest in receiving technical assistance and what would be appropriate amounts for grants; this information can be used to determine how the grant funds should be allocated between Phase I and Phase II	• Survey developed • The number of NFs that completed the survey • A report that summarized the results of those NFs that completed the survey

Inform the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives.	• Develop a training module to educate the NFs about the opportunities to apply for and receive grants from planning and implementing LTC right-sizing initiatives
	• Educate the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives; provide these through one or more of the following:
	  — Meetings
	  — Webinars
	  — Web page
		• Training module developed
		• The number of education meetings and webinars, including the number of participants and locations of meetings
		• A webpage where all information about the grants and background material on the LTC right-sizing initiative is accessible was developed

Strategy	Tactic	Metric
Make technical assistance available to NFs in preparation for submitting their proposals for planning grants and implementing LTC right-sizing initiatives.	• Arrange with CMS MFP technical advisory contractor to provide 1:1 technical assistance with NF providers who want to submit proposals for planning grants and implementing LTC right-sizing initiatives	• State established formal arrangements for 1:1 technical assistance • The number of NF providers that received 1:1 technical assistance for planning grants • The number of NF providers that received 1:1 technical assistance for implementing initiatives

Strategy	Tactic	Metric
Provide to NFs grants for planning and implementing LTC right-sizing initiatives.	• Develop and issue a grant proposal that is based on the input provided at the State's LTC Right-sizing Strategic Planning Retreat, a utilization and cost-projection model to identify where grants are needed, NF survey results and any other comments that the State may receive from providers, advocates and others • Develop the associated data that can be used by NF providers in preparing for their grant proposal and also utilized by the State in the evaluation of proposals	• A grant proposal was developed and issued • Data was available for use by the NF providers and the State (data and other right-sizing-related documents made available on a State website/page) • The number of NF providers that submitted proposals and received planning grants; included the amount requested and amount awarded • The number of NF providers that received grants for implementing initiatives; include the amount requested and amount awarded • The number of home health agencies created • The number of NFs that provided emergency back-up support in the community • The number of affordable housing units created • Increased percentage of Medicaid LTC participants living in the community compared to institutions

Guiding principles and evaluation criteria

The MFP grants workgroup identified several principles that the State should follow when developing the MFP grant proposals and awarding grants. The following are these guiding principles:

1. The criteria must align with the State's LTC right-sizing strategic plan and MFP operational protocol.
2. The MFP grant expectations must align with the funding that is available.
3. The evaluations criteria should be transparent. In other words, providers should know exactly how they will be evaluated and what priorities (i.e., one region versus another region of the State, two NFs with equal proposals) the State will establish when awarding a grant.
4. There should be the ability to skip Phase I (planning) if the provider has already completed their planning without any funding. This would require the State to issue Phase II opportunities should they be made available. Don't delay phase II for providers.
5. The grants that are made available should be based on regional needs and not on statewide criteria.
6. Criteria for the evaluations must align with needs of the community.
7. Facilities should develop relationships with and partner with existing HCBS providers/agencies.
8. Phase I planning grant criteria should be more flexible than Phase II implementation of LTC right-sizing initiatives.

The MFP Grants workgroup believes that before the grant proposals are developed, in addition to the guiding principles, there should also be a list of basic evaluation criteria to guide the authors of the grant proposal. The workgroup identified several criteria that should be considered when establishing how grant applications will be evaluated. The following is the list of evaluation criteria for the State's consideration:

1. The provider should be able to demonstrate that they have been in compliance with State licensure and CMS certification requirements.
2. A NF's low occupancy rate does not mean that they would have a higher priority for receiving a grant.
3. A provider should be able to demonstrate its successes with its current NF workforce.
4. A quality provider should not necessarily have to reduce its beds if their grant request demonstrates the ability to meet a community need.
5. The provider must demonstrate that their project has a demonstrated need in the community.
6. A provider must demonstrate that it has supported efforts to inform consumers of their choices (informed choice) regarding all LTSS that are available.
7. A provider must demonstrate its support of and competency at delivering a person-centered approach to providing LTSS.
8. A provider must demonstrate how it has undergone or begun to undergo a culture change in their NF (e.g., Greenhouse).
9. A provider must demonstrate that it is currently financially viable.
10. A provider must demonstrate that their proposed project is sustainable.
11. A provider must demonstrate how the project will be aligned with the other community providers and supports (e.g., Memorandum of Understanding to demonstrate a commitment to collaboration).

Data

MFP grants will be targeted towards alignment of estimated demand for LTSS, including the NF bed supply. NF bed supply will be addressed through grant incentives to adjust capacity where needed. NF bed capacity will be decremented by grant awards for those providers who seek the opportunity. The State will take a pragmatic approach in grant evaluation.

Numerous workgroup members discussed the need and desire to have a more robust dataset to understand and analyze the effects of rebalancing. To address that need, the State is in the process of establishing a "live" data book for the primary purpose of providing reliable data on which the State can base decisions to ensure the appropriate balance of supply and demand. While the NF bed supply will be adjusted primarily through grant incentives and the development of additional HCBS capacity, decreasing NF bed utilization will likely impact the delivery of LTSS in many ways, including ones that are significant and unpredictable at this time.

The data book may be used by the NF providers who may submit grant proposals to ascertain information regarding capacity within their area.

The next phase of development of the strategic plan will consider how the data, maps and adopted strategies will affect supply and demand in the coming years. As the initiative unfolds, this information (in conjunction with the experience of providers and local communities) will be reviewed and analyzed to understand the interactions between the implemented programs, changes to the market (population, workforce, regulation, etc.) and provider experience. This view of the State's LTSS will continue to evolve as the variables change, but regular evaluation should provide an appropriate context for determining next steps in the process.

The data book will be located on a Connecticut Department of Social Services webpage: http://www.ct.gov/dss/xxxxx. The data book will be refreshed on a minimum of an annual basis so that it can be relied upon as a valid source of information. The State will also be adding additional information that might be useful to NF providers, the State and others.

The current data book will have the following information available:

- NF performance and rates matrix. (This document includes individual information on all Connecticut NFs. Some of the information included is regarding the number registered nurse hours per resident day, quality measures star rating, overall star rating and percent of beds occupied.)

- Maps that show the location of NFs, residential care homes, assisted living services agencies, home health care agencies and homemaker/home health aide agencies. These maps are by county and also include regional population density information.
- Maps by county that show the locations and bed size of NFs and residential care homes.
- Maps by county that show the occupancy rates of NFs and residential care homes.
- Several NF and residential care home bar charts that indicate type of ownership (e.g., for profit – not multi-ownership), number beds per facility, percent of beds occupied, rates (per diems) ranges and overall star ratings.

Challenges to success

There will be challenges in developing a fair and comprehensive MFP grant request for proposals. The development of this document will be guided by the principles and evaluation criteria noted above. A fair and comprehensive document can be developed by also understanding some of the challenges related to the MFP grants. The challenges that were identified by the MFP Grant workgroup include but are not limited to the following:

1. Providing adequate funding for the planning and implementation of LTC right-sizing initiatives grants.
2. CMS' MFP funding restriction of providing assisted living through HCBS waivers on institutional grounds.
3. Criteria for being awarded a grant could be too limiting to be creative.
4. Not having the available community/HCBS workforce to align with a LTC right-sizing initiative.
5. Availability of appropriate data to fairly evaluate where rightsizing should occur.
6. Availability of appropriate data to fairly evaluate providers applying for a right-sizing grant.

5

Conclusions

The recommended strategies identified within this plan for each of the key system elements represent important steps toward building a strong system of LTSS. Collectively, they provide direction to the State when developing a redesigned service system that will afford individuals, even those with significant support needs, maximum choice and control over the type and location of their services. The Planning Retreat participants identified these strategies to represent the very important efforts necessary to reconfigure the infrastructure as well as needed improvements to services and processes used within that frame.

Through this stakeholder process, some common themes emerged across the strategies and system elements:

Partnership and collaboration – across all stakeholders – are key to all of the strategies. Leveraging existing relationships and forging new partnerships will be essential to make the system changes that will form the backbone of a right-sized system.
Simplifying, streamlining, educating and using resources strategically also emerge as themes across the issue areas. This emphasis is represented at the macro or systems level with strategies identified to utilize budgeting techniques and resource decisions that will incentivize the needed system movement. The strategies also emphasize individual-level considerations, as strategies encourage the State to make service and individual resource allocation decisions based upon objective assessments of individual needs and not solely based on diagnosis. The encouragement toward streamlining is to make the system efficient, cost effective and understandable to the individuals who use it and their families.
Supporting informal and formal care providers to ensure a quality workforce also emerges across many strategies. The compensation, supports and learning opportunities for this increasingly critical network is key to any strong HCBS system.

Additionally, there were commonalities in the identified challenges which Connecticut must overcome. Some of these challenges are posed by federal program requirements, in Medicaid for HCBS and MFP, particularly as they relate to assisted living, and the interface between Medicare and Medicaid. Others are State requirements such as rules around nursing delegation, direct admission to NF requirements and safe discharge standards, differences across various agency requirements (around LOCs and financial eligibility) and service fragmentation that must be smoothed in order for seamless transitions and access to services can occur. A stark challenge also identified in each area is

the lack of affordable, accessible community-based housing and transportation. Additionally, the adequacy and training of the needed network of support workers is a concern across the issues areas. Finally, fiscal considerations will be important as the State determines the extent and timing of expanded HCBS opportunities, any changes to provider reimbursement or the implementation of other strategies that may require resources. These challenges and others are not insurmountable but will require thoughtful deliberation and creativity to overcome.

As the recommended strategies identified within this report reveal, significant work on the part of the State to prioritize resources and develop timelines to address what are determined to be the critical needs necessary to realize the State's LTC rebalancing goals. Through application and consideration of the projected LTC needs at the State and local level and informed by data book, the State can make pragmatic choices in determining where to allocate resources. Current and future LTC service users should be invigorated by the dedication and long-term vision of the State.

The next phase of development of the strategic plan will consider how the data, maps, and adopted strategies will affect supply and demand in the coming years. As the initiative unfolds, this information in conjunction with the experience of providers and local communities will be reviewed and analyzed to understand the interactions between the implemented programs, changes to the market (population, workforce, regulation, etc.) and provider experience. This view of the State's LTSS will continue to evolve as the variables change, but with regular evaluation; should provide an appropriate context for determining next steps in the process. Through the continued level of engagement and commitment of the State and the stakeholders, the goals of the initiative are achievable.

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Appendices

The list of LONG-TERM CARE RIGHT-SIZING STRATEGIC PLANNING RETREAT PARTICIPANTS will be inserted here.

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