STRATEGIC REBALANCING PLAN: A PLAN TO REBALANCE LONG TERM SERVICES AND SUPPORTS

2013 - 2015

State of Connecticut
Department of Social services
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Executive Summary

Connecticut's Strategic Rebalancing Plan is the culmination of a multi-month process which aims to increase choice in where people receive long-term services and supports, while supporting cost efficiencies in the Medicaid program. The planning model is part of an initiative by Governor Dannel P. Malloy and the General Assembly to expand long-term care options and help the nursing home industry diversify its business model to meet changing service needs. It represents exemplary collaboration and coordination across multiple state departments, the federal government, home health providers, nursing home administrators, consumers and other stakeholders. The initial three-year plan for 2013-2015, which will be updated annually, reflects Connecticut's proactive approach to address the anticipated, unprecedented demand for Medicaid-funded long-term care through 2025.

In essence, the plan is **using census and demographic data to develop 'supply-and-demand' projections for long-term care needs on a town-by-town basis. This, in turn, will help target services that support quality of life and cost-effectiveness in specific areas of the state -- while aiding the nursing home industry in diversifying and focusing its business model to meet coming trends rooted in Connecticut's aging demographic.**

Strategies and tactics for 2013-2015 include:

- Connecting people to information about long-term care services and supports;
- Increasing transitions of long-term nursing home residents to the community;
- Closing service gaps, improving existing services, identifying new services;
- Ensuring quality of care;
- Building capacity in the community workforce to sustain rebalancing goals;
- Focusing on housing and transportation supports;
- Helping transform nursing facilities into continuing care providers across a continuum of needs.

As provided under Public Act 11-242 and coordinated by the Department of Social Services, the plan is designed to rebalance Connecticut's Medicaid long-term services and supports, including, but not limited to, those supports and services provided in home, community-based settings and institutional settings. Given the aging demographic, there is an urgent need for systemic reform. In addition, the 1999 Olmstead vs L.C. U.S. Supreme Court decision required states to provide community choices in lieu of institutional care. On the average, community choices are more desirable and less costly when they can be provided safely and appropriately. 'Rebalancing' to serve people in less costly and preferred community-based alternatives results in greater efficiencies for Medicaid, as more eligible people can be served with

hard-pressed public funding. At the same time, the planning process will benefit the public in general by focusing long-term care services and supports in a manner that best anticipates the degree and nature of needs in specific areas of the state..

Overall, the plan establishes a framework for change to the design of home- and community- based services, housing and transportation, workforce development, discharges from institutions to community, and nursing homes. It also optimizes federal funding opportunities under the Money Follows the Person Rebalancing Demonstration and the most recent award for the State Balancing Incentive Payments Program, which projects an additional $72.8 million in revenue through September 2015, supporting strategic planning efforts.

While the Plan includes multiple strategies and tactics, none is more important than the overarching strategy of partnership. The state aims to lead change in partnership with local communities and other stakeholders. To support partnerships with towns, local data maps were developed, projecting supply and demand for long-term services and supports through 2025. As community long-term services and supports are developed, the data maps anticipate that more people will choose to remain in the community and that demand for institutional care will decrease. For this reason, the plan also seeks to partner with nursing home administrators who, working in collaboration with local towns, choose to diversify their business model and build capacity to support people with services in the community.

Connecticut has made great progress in the development and implementation of community long-term service and supports over the past 20 years. The Money Follows the Person Demonstration has proven that long-term residents of institutions can be served in the community at less cost and higher quality of life. Venerable services like the Connecticut Home Care Program for Elders and Medicaid waiver programs have made a huge difference in the lives of elders and younger adults with disabilities.

The pace of change in preference from institutional care to community care is increasing exponentially, and the need for a strategic plan is imperative. Implemented in partnership with stakeholders, the Strategic Rebalancing Plan will guide state efforts to increase choice in where people receive long-term services and supports, while increasing the efficiency of the Medicaid program for taxpayers in general.

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Introduction

The State of Connecticut (State) is committed to creating a more efficient and effective long-term services and supports (LTSS) system aligned with the principles of choice, autonomy and dignity. The envisioned system will allow Medicaid recipients who need LTSS to choose whether they want to receive these services in a nursing facility (NF) or in a community setting. In order to attain the vision of enhanced qualify of life and increased choice for individuals across all disabilities to live, work and age within their own communities, the concept of a town-based LTSS compendium was developed. Honoring the autonomy and local governance authority of the towns within Connecticut, the individually tailored, town-based approach to LTSS will provide choices ranging from various types of supportive housing options to care provided in a nursing facility; these options will reflect the preferences of the persons they are designed to serve and support a seamless transition from hospital to short-term rehabilitation and back into the community.

Design and implementation of a strategic plan within the time frame anticipated by this plan is imperative given that over the next several years the number of people estimated to need LTSS will increase dramatically due to the aging population. According to the U.S. 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 in the portion of this population nationally. This trend is even more compelling in Connecticut, where projections indicate a 40% growth in individuals age 65 and older between 2010 and 2025.[2] Notably, in the November 2011 report entitled *90+ in the United States: 2006-2008*[3], Connecticut ranked second among states with the highest percentage of the population in both the 'Aged 90 and Over' and 'Aged 65 and Over' categories. The report also notes that age is positively associated with incidence of physical limitations, and the oldest have the highest levels of physical and cognitive disability. By 2025, more than 48,600 individuals in Connecticut are expected to need Medicaid LTSS – an increase of more than 9,800 individuals over current levels[4]. Estimating future demand, building sufficient supply with quality

[1] U.S. Department of Health and Human Services 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] Wan He and Mark N. Muenchrath, US Census Bureau, American Community Survey Reports, ACS-17, *90+ in the United States: 2006-2008*, U.S. Government Printing Office, Washington, DC, 2011.

[4] Medicaid Long Term Care Services and Supports Utilization and Cost Projection Model, State of Connecticut – Department of Social Services. November 30, 2011.

assurances, and eliminating policy and procedural barriers that prevent choice are all key to the State's Strategic Rebalancing Plan.

The projected increase in the aging population is especially relevant to the design of benefit and eligibility in the State's Medicaid program. Since 42% of the costs associated with LTSS in Connecticut are paid by the Medicaid program, it is essential that the Medicaid LTSS cost structures be modified with the aim of not only assuring choice, but also controlling costs. In SFY 2009, Connecticut spent 65% of its Medicaid LTSS dollars on institutional care for individuals who are aging and individuals with disabilities.[5] A 2011 analysis of adults age 31 and over using Medicaid LTSS 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 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] The State's high utilization of nursing homes for persons receiving LTSS is a statistic that stands in contrast to surveys completed by LTSS users where 75% indicate their preference for services in the community.[7] In addition, the average cost of serving a Medicaid participant in the community is approximately one third[8] of the average cost of serving someone in an institution. Serving people in the community when it is preferred, safe and on average more cost effective, will result in more people served for each LTSS dollar spent. Procedural, capacity and policy barriers driving costs and resulting in unnecessary institutionalization must be addressed. Barriers include:

- Lack of sufficient services, supply, and information about home and community-based services (HCBS),
- Inadequate support for self-direction and person-centered planning,
- Lack of housing and transportation,
- Lack of a streamlined process for hospital discharges to the community rather than nursing homes for persons requiring LTSS,
- Lengthy process for accessing Medicaid as a payer, and
- Lack of a sufficient workforce

It is essential that the Strategic plan address the aforementioned barriers in order to advance true choice regarding where persons receive their LTSS as well as more efficient distribution of LTSS dollars. The report that follows details specific strategies that are intended to support this result.

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[5] Connecticut Long Term Care Planning Committee; Long Term Care Plan: A Report to the General Assembly; January 2010; p. 54, Table 15.

[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.

[7] "Raising Expectations, A State Scorecard on LongTerm Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers" September 2011, Susan C. Renhard, Enid Kassner, Ari Houser, and Robert Mollica, p. 1. AARP Public Policy Institute

[8] Across the States, Profiles of Long-Term Services and Supports, Executive Summary, State Data, and Rankings, Ninth Edition, 2012, Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, p.14 AARP Public Policy Institute

It is also essential for the strategic plan to continually evaluate and estimate the impact that the strategic initiatives have on supply of both HCBS as well as institutional services. The plan aims to evaluate supply and demand trends and projections every 6 months. The current model detailed in Section 2 of this report projects a surplus of 5,000 institutional beds assuming barriers that prevent choice are removed. As demand for institutional care decreases, the plan details a proactive approach to reducing unneeded beds and building community capacity. Key strategies focus on partnerships with institutional providers who are interested in diversifying their business models to provide community LTSS where need is identified in town level supply and demand data maps. The State's strategic plan includes competitive procurements targeted to institutional providers for the purpose of building community LTSS which reflect the needs and preferences of the town.

Through a multi-month process of deliberate stakeholder briefing, engagement, data and system analysis, culminating in the November 2011 Long-Term Care Right-Sizing Strategic Planning Retreat, the State has sought the input and expertise of those interested in building a sustainable LTSS system within the state. Stakeholders participating in the strategic planning process included individuals with LTSS needs, family members, advocates, ombudsmen, State staff, providers (community and institutional), Money Follows the Person Steering Committee members, academics and others. Recommendations from the right-sizing retreat (Appendix B) provided a foundation on which this plan was developed. With an unprecedented level of partnership and collective work toward the common goals, stakeholders will continue to play a key role in the implementation and evaluation of LTSS strategic initiatives.

The plan, guided by the vision of choice, autonomy and dignity for the people we serve, aims to achieve a rebalanced system by: 1) removing barriers that prevent choice in where people receive LTSS at a state policy and systems level; and 2) partnering with nursing homes, communities, and existing community providers to implement change at a local level. **After careful review, the recommendations included in this document were selected to comprise the first phase of Connecticut's Right-Sizing Plan based on considerations related to the timing, resources and funding necessary to complete each strategy.**

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

Projecting future demand for Medicaid LTSS and funding appropriate supply is a critical component of Connecticut's Strategic Right-Sizing Plan. Future demand projections are based both on existing trends in distribution of LTSS dollars and preferences between institutional and HCBS settings as well as assumptions about future trends. Future trend assumptions take into consideration the impact of the various strategies and tactics outlined in this plan. As barriers that prevent choice are eliminated, it is assumed that there will be an exponential shift towards HCBS LTSS. This shift is reflected in the model which will identify areas of the state where there is an excess of NF beds, areas where there may not be enough beds, and areas where transitional programs and additional community LTSS are needed. The model will inform the planning process for State and town level rebalancing efforts supporting consumer preferences.

The model was developed by Mercer actuaries through implementation of the following process:

1. Project the population of the State by age and gender.
2. Project the proportion of the State population that is Medicaid eligibility Aged, Blind and Disabled (ABD).
3. Project the proportion of the ABD population that is nursing facility level of care (NFLOC)
4. Project the proportion of the NFLOC population using HCBS services.

The process was conducted at the Labor Market Area Level and projected on the individual towns in the labor markets, then aggregated at the statewide level.

Mercer actuaries utilized population projections developed by the Connecticut State Data Center by age, gender and by town, through 2025. These projections included town-by town, in-migration and out-migration. Mercer assumed, by town, a constant ABD and NFLOC incidence rate by age and gender. As the projection goes toward 2025, the natural aging of the population leads to a higher proportion of the town population expected to by NFLOC.

Historically the NF/HCBS mix in the State has been moving toward HCBS at approximately 0.50% to 0.75% per year, absent the impact of State-led initiatives. This shift, combined with the aging population and higher NFLOC incidence rates which act against NF/HCBS mix, leads the State to a projected NF/HCBS mix of 57.6% in 2025, absent the impact of State-led initiatives.

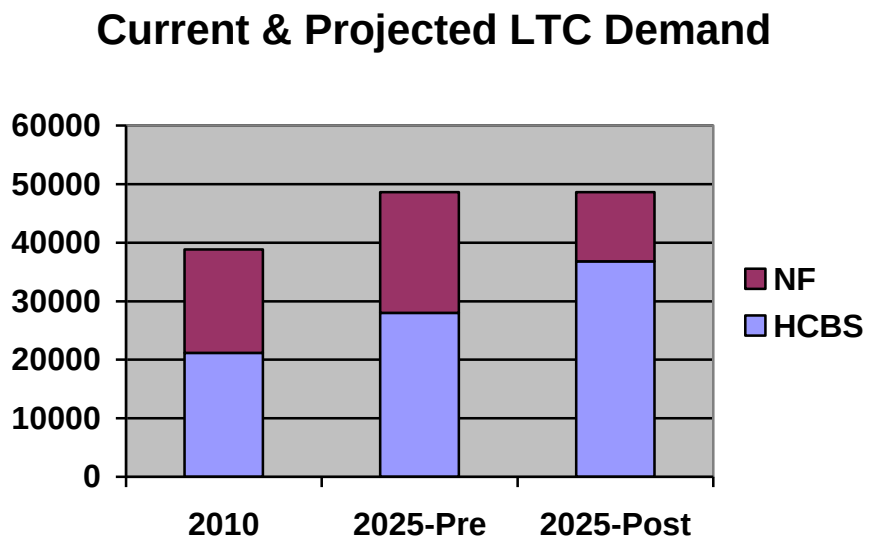
In examination of the historical data, Mercer found that beginning in early 2011, there was a significant acceleration in the NF/HCBS mix as a result of the following State led initiatives:

- Transitions under the Money Follows the Person (MFP) Grant
- Hospital Discharge Planning
- NF Closure Model
- Long-Term NF Diversion
- Pre-Admission Screening Resident Review

By incorporating the impact of these initiatives into modeling the projected NF/HCBS mix at the statewide level, it is expected to increase proportionately to 75.7% by the year 2025. The final HCBS/NF mix is consistent with HCBS level currently being achieved in other states. The proportionate increases were developed at the age, gender and cohort level. The projections of future HCBS/NF levels presume the State will continue to use current initiatives and will utilize additional initiatives in future years in order to achieve the projected 2025 HCBS levels. In addition, the model does not take the current expansion of the MFP transition initiatives into consideration. Expansion initiatives such as this have the potential to accelerate movement from NF to HCBS beyond what is modeled.

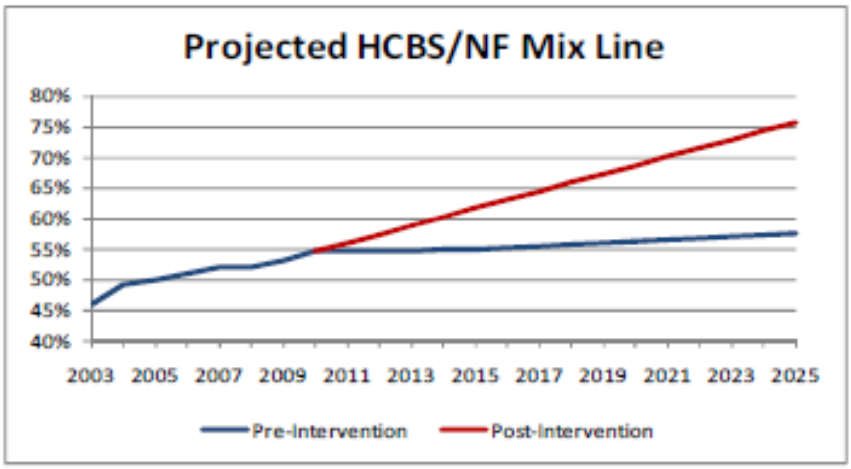
Another element of the modeling includes projecting the demand for NF and HCBS workers as this shift in NF/HCBS mix occurs. The worker supply and demand reported assume a constant proportion by town of NF/HCBS highlighted workgroups throughout the projection. As the population ages and the number of users shifts from NF to HCBS, the worker supply and demand shifts accordingly by town based on the number of people expected to need care under the specific settings.

The accompanying charts highlight the number of LTC users and the corresponding NF/HCBS mix pre and post State-led initiatives.



As reflected in the chart above, Connecticut anticipates a 25% increase in the number of LTC users from the current rate of approximately 38,800 users to a rate of 48,600 users in 2025,

The impact of interventions on the existing trends towards HCBS is reflected in the chart below. As demonstrated in the trend analysis, interventions at the DSS are having a significant impact. As barriers that prevent choice in where people receive LTSS are eliminated, more people are choosing HCBS rather than NF options.



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Strategies for right-sizing

Home- and community-based services options
Overview

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 maximize opportunities available through the Affordable Care Act9 that both increase revenue to the State and begin to address the fragmentation that currently exists in Connecticut's HCBS systems.

Initially, strategies relate to ensuring that people have access to information through action steps including implementation of a global communication plan. While the global communication plan will include multiple outreach methods, the new LTSS website will be the primary communication tool. The State plans to build an interactive website using the existing LTSS website as a foundation.

Not only do consumers and caregivers need information, but they need streamlined means of accessing supports. Further, the State needs a means of comparing utilization and expenditures across populations. Standardizing assessment is the key first strategy in creating parity across age and disability and assuring fiscal controls supporting comparative analysis across the various LTSS settings, including nursing homes. Standardizing assessment will result in standard levels of need which will be linked to standard budget allocations. Needs assessment data will be linked to the Medicaid Management Information System so that level of need data, individual budgets and expenses across LTSS can be analyzed easily with common metrics Development and implementation of a common core needs assessment is an important SFY 2013 tactic which addresses the need for standardization.

With a common core needs assessment and stronger financial controls in place, the State can begin to explore some of the fragmentation that exists within the community LTSS. The strategic plan explores implementation of the Community First Choice option. This option has the potential of not only

[9] Patient Protection and **Affordable Care Act**, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).

serving cross disability and age populations but also increasing revenue through a 6% enhanced federal match. The Community First Choice option would add personal care assistance to the Medicaid State plan, serving persons currently served under waivers at nursing home level of care, and offering coverage to those currently on waiting lists. Further analysis is needed to determine whether these additional costs would be offset by the additional revenue. Throughout the three years of the plan, other options to address fragmentation in the system will also be explored such as the implementation of a 1915(i) state plan amendment to cover the service component in supportive housing and qualifying rest homes. Through Section 1915(i) of the Social Security Act, states are permitted to offer HCBS to persons not yet at NF level of care through a Medicaid state plan amendment. Examples of supportive housing services include supported employment, psycho-social rehabilitation and clinical services. Before the State can move forward with the Community First Choice option or the 1915(i) option, the State will need to model the benefit design and eligibility criteria and conduct an impact analysis reflecting costs associated with projected increases in demand and determine the extent to which these costs are offset by projected increases in revenue. Finally, the State will evaluate the feasibility of implementing a consolidated HCBS waiver for older adults and individuals with disabilities.

The strategic plan addresses several key service gaps in HCBS waiver services, most notably a redesign of respite for informal caregivers. The economic value of family care giving was estimated at $450 billion in 2009 based on 42.1 million caregivers age 18 or older providing an average of 18.4 hours of care per week to care recipients age 18 or older, at an average value of $11.16 per hour. 10The Department plans to convene a focus group of caregivers to discuss and make recommendations on the redesign in the first year of this plan. Current considerations include the design of a flexible individual budget that would provide the caregiver with respite options – from a short NF stay for the participant to short-term in-home support. Redesign of this benefit not only supports family caregivers desperately trying to keep their family member at home, but also is a cost effective intervention since it reduces reliance on the formal system. Often family members ‘burn-out’ and turn to institutional care since they see no other viable option. This strategic plan aims for Connecticut to lead the nation in supporting family values by providing the support families need while caring for a family member at home. UCONN will evaluate the respite options as part of the MFP demonstration and produce a report in year 3 for the purpose of incorporating improved respite into HCBS waivers.

[10] Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving, Feinberg, L, Reinhard, S, Houser, A, and Choula, R, AARP Public Policy Institute

Another major focus of the HCBS strategy is the philosophical shift from a LTSS system primarily medical in orientation to one that is person-centered. Within the context of this strategy, policies and practices of the system will be analyzed to assure that they reflect a person-centered service delivery and decision making model. The discussion of risk and liability is central to this shift. Year one of the strategy begins with implementation of new policies regarding the administration of medication in support of nurses delegating to certified home health aides.

Goal: To improve effectiveness and efficiency of Connecticut's HCBS system

Metric: 58% of Medicaid LTSS participants are receiving HCBS

SFY 2013 – 2015 Strategies and Tactics

Strategy: Connect people to LTSS information and services

- Create global communication plan integrated with workforce communication plan
- Develop tools, including a LTSS website that builds upon existing sources, to educate public regarding HCBS, employment, spousal assessment, etc.

Metrics:

1. **Increase in the number of 'hits' on the website;**
2. **Increase in the number of physician offices and other target locations, such as libraries and hospitals, with information regarding community LTSS;**
3. **Increase in the number of callers to Connecticut Aging & Disability Resource Centers (ADRCs) who identify the place they heard about services as the LTSS website or other education initiative;**
4. **The percentage increase in the targeted population aware of community LTSS options.**

Strategy: Create parity across age and disability resources based on functional support needs rather than diagnosis

- Create and implement a common core needs assessment and budget allocation methodology for standardization across LTSS.
- Explore methods to link needs assessment data to MMIS so that level of need data, individual budgets and expenses across LTSS can be analyzed easily with common metrics;

- Review consolidation of existing personal care assistance services across all waivers into a Community First Choice State Plan amendment, reducing fragmentation across populations and qualifying for an additional 6% FMAP;
  - Initiate the common core assessment tool and methodology with the Community First Choice cross disability population.
- Streamline eligibility, payment, service availability, rates, cost caps, age requirements or gaps.
- Consider design of a consolidated waiver for adult individuals who are aging or adults with physical disabilities and analyze cost implications
- Train staff on all systemic changes.

Metrics:

1. **Increase in the number of HCBS serving cross disability populations;**
2. **Decrease in the variance in funding levels and services provided across LTSS for people at the same level of need;**
3. **Increase in self-reports of access to services and met needs;**
4. **Progress on stated goals of the Integrated Care Demonstration for Medicare and Medicaid Eligibles (MME).**

Strategy: Close service gaps and improve existing services or identify new services to better serve the needs of all populations.

- Coordinate with MME Demonstration to assure alignment and synergy;
- Undertake comprehensive review of all closed MFP cases to understand reasons for closure and what solutions can be implemented to reduce the frequency of case closure;
- Produce report on reasons for MFP case closures to define gaps in HCBS services or process;
- Provide additional flexibility and cost effective services by integrating adult family home model, independent support broker, alcohol and substance abuse, and peer support services;
- Build new service provider networks to assure capacity;
- Simplify home modification process;
- Integrate employment into MFP and HCBS;
- Explore a 1915(i) amendment to fund supports for Supportive Housing and for qualifying rest homes;
- Explore current NF level of care within the context of LTSS and make recommendations to improve access to services;

- Implement respite service reform in support of family caregivers.

Metrics:

1. **Decrease in the percentage of closed MFP cases.**
2. **Increase in number of care-givers reporting satisfaction with respite services;**
3. **Increase in the number of participants using adult family homes, alcohol and substance abuse treatment and peer support**
4. **Increase in number of participants who are employed**

Strategy: Create mechanisms to ensure quality in the care provided through HCBS

- Establish a quality improvement committee to ensure sound discovery and remediation techniques and to identify and fix issues quickly within the community;
- Establish a seamless quality improvement strategy across waivers, MFP and State Plan HCBS including adult family homes;
- Develop strategies to assure conflict-free case management;
- Increase ability of LTSS consumers to access long-term care ombudsman advocacy and services.

Metrics:

1. **Increased number of case management agencies with no conflicts;**
2. **Decreased number of critical incidents;**
3. **Increase in the number of LTSS complaints resolved satisfactorily.**

Strategy: Build, improve quality of provider networks aligned with the principles of person centered planning

- Educate providers regarding informed risk;
- Cross train HCBS waiver providers;
- Analyze policies and regulations and recommend change based on principles of person-centered decision making;
  - Implement systemic changes to advance nurse delegation of medication;
  - Develop nurse leadership institute for the sharing of best practices in person-centered care and nurse delegation;
  - Provide training to certify staff in medication administration;

  - Explore legislation to allow for reduced liability to agencies who may be caring for individuals with significant support needs who are willing to undertake some informed risk for needs that extend beyond the care traditionally provided by agencies;
  - Explore legislation to enable home health agency-affiliated nurses to train PCAs without incurring liability related to ongoing supervision;
- Ensure disaster preparedness, establish partnerships to meet individual needs in emergency situations/circumstances;
- Ensure quality of care through independent evaluation of providers.

Metrics:

1. **Increase in the number of people/agencies utilizing risk agreements;**
2. **Increase in the acuity level of community LTSS participants;**
3. **Increase in the number of trained and certified home health aides.**
4. **Increase in the number of certified home health aides administering medication;**
5. **Increase in the number of electronic devices dispensing medication.**

Workforce

Overview

As the State begins to operationalize its efforts to right-size its LTSS services between NFs and HCBS, there are many important issues to consider. Chief among them is assessing the workforce capacity as a result of rebalancing the delivery system. As demand for HCBS increases, the demand for paid and unpaid direct care workers will also increase. Between 2006 and 2030, the population over the age of 65 is expected to increase by 64%, while the working-age population is expected to decrease by 2%. This gap will decrease the supply of informal caregivers as well as the pool of direct care workers. Understanding and leveraging the informal caregiver supply while making the direct care field an attractive option for job seekers is a key component of LTSS right-sizing. As Connecticut aggressively pursues Medicaid rebalancing goals, the need for focused efforts to recruit, train, retain and support paid and unpaid caregivers is essential. Without a focused, coordinated approach, lack of caregivers will stall rebalancing efforts and Connecticut will fail to meet its goals. The State will begin its strategic approach by developing a comprehensive workforce development communication plan.

Goal: To build capacity in the community workforce sufficient to sustain rebalancing goals

Metric: Increase in number of direct care workers as reported by Department of Labor and fiscal intermediaries

SFY 2013 – 2015 Strategies and Tactics

Strategy: Continuously promote workforce initiatives that are proven to support consumer choice, self direction and quality while enhancing recruitment, retention, productivity and training of the paid and unpaid direct care workforce

- Create statewide inventory of the existing workforce needs, future demand and national and local initiatives that show promise and scalability;
- Track national policy and practice trends to ensure Connecticut's workforce development strategy is synergistic with responsible national goals;
- Create statewide inventory of Connecticut's workforce activities embedded in state-funded and Medicaid waiver programs.
- Promote model re-training programs that would allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community;
- Promote employer/employee training models in a variety of community-based workplace settings, including self-directed employment arrangements and informal care giving training models;
- Seek to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor. The development and use of technology is proven to increase productivity of the direct care worker as well as increase the independence of the consumer;
- Identify similarities between the paid workforce and unpaid caregivers and coordinate development initiatives to leverage resources and avoid overlap;
- Inform the work of the Personal Care Attendant Quality Home Care Workforce Council.

Metrics:

1. **Increase in the percentage of institutionally based staff completing community LTSS training, including person-centered planning;**
2. **Decrease in turnover of paid direct-care staff;**
3. **Decrease in number of unpaid caregivers reporting burden.**

Strategy: Increase synergy with Connecticut's workforce system and support their efforts to create a pipeline of direct care workers with opportunities for career ladders to health and human/social services professions

- Orient workforce leaders to the demand and the guiding principles for long-term care in Connecticut;
- Partner with state and local workforce systems such as workforce investment boards (WIB's) and Connect-Ability to align recruitment and training efforts towards the demand for community-based direct care workers.;
- Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to health care reform of the need and conditions of the direct care workforce and unpaid caregivers;
- Create and endorse a common set of core competencies with emphasis on communication, relational skills, and understanding risk that helps paid and unpaid workers deliver person-centered care. *These core competencies should enhance consumer self-direction and should be careful not to infringe on the right of the consumer to train and direct their care;*
- Identify additional competencies and advanced competencies needed to create clearer career pathways in health and human/social service professions;
- Collaborate with the community college system to design direct-service curricula using a foundation of person-centered care;
- Foster training or re-training programs at multiple venues including community colleges, employers, and private/public partnerships.
- Increase and streamline ability to hire family members as paid caregivers.

Metrics:

1. **Increase in the number of direct care workers achieving competency;**
2. **Increase in the number of persons graduating from training programs;**
3. **Increase in family members hired as paid caregivers.**

Strategy: Create equity across state systems

- Identify, analyze and catalog variations across state departmental practices, policies and regulations that affect the paid and unpaid direct care workers;

- Identify, analyze and catalog systemic similarities and differences among state agencies with regards to wages of direct care workers and make recommendations to produce more equity;
- Identify, analyze and catalog systemic similarities and differences among state agencies in the handling of workers' compensation and unemployment claims and make recommendations to produce more equity;
- Identify, analyze and catalog systemic similarities and differences among state agencies in their policies and procedures related to use of assistive technology in care planning and make recommendations to produce more equity.

Metrics:

1. **Increase in the number of publications;**
2. **Changes in state agency policies/procedures to carry out recommendations.**

Strategy: Raise awareness of the importance and value of the direct care worker and unpaid caregiver

- Create workforce communication plan;
- Increase connectivity, networking, and training among both paid and unpaid caregivers;
- Increase awareness of support programs available to unpaid caregivers;
- Research and identify national best practice models that address wages and benefits;
- Promote flexibility in workplace employment policies and practices to accommodate the circumstances of unpaid family caregivers.

Metrics:

1. **Increase in the number of website inquiries regarding workforce;**
2. **Increase in the number of job seekers accessing new LTSS website;**
3. **Increase in the percentage of job seekers obtaining employment through new LTSS website;**
4. **Increase in the number of companies with unpaid caregiver support programs and number of employees using them.**

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 LTSS consumers to receive HCBS. In order for the State to accomplish its LTSS right-sizing goals, it will be necessary to have an adequate supply of housing so the established rebalancing targets may be accomplished.

Housing options include a person's own home (owned, leased, or shared), supportive housing, shared living arrangement, congregate housing, assisted living services/managed residential communities and residential care homes (rest 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. Key to the State's strategy is the establishment of a Medicaid housing plus supports specialist to assure coordination between the Department of Housing and Medicaid LTSS.

Transportation

Transportation becomes central in providing Medicaid consumers access to the community. Additionally, transportation plays a pivotal role in bringing caregivers to HCBS consumers in order to provide the care needed for consumers to successfully remain in or return to the community. Frequently acknowledged as one of the greater unmet needs in communities, it is frequently not accessible or affordable.

Goal: To increase availability of accessible housing and transportation

Metrics:

1. **Increase in the number of subsidized units in the State;**
2. **Increase in number of towns with affordable, flexible transportation options.**

SFY 2013 – 2015 Strategies and Tactics

Strategy: Foster partnership and cross-agency collaboration between agencies focused on housing and transportation.

- Establish a strategic partnership between DSS, the new Department of Housing, Connecticut Housing Finance Authority (CHFA), Department of Economic and Community Development (DECD), Department of

Transportation (DOT) and the U.S. Housing and Urban Development (HUD);

- Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to development of housing plus support models;
- Establish a housing and transportation unit to specifically build relationships with partners in order to increase available units, increase resources for housing and transportation, and increase coordination of services and supports with housing;
- 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 Connect-Ability transportation initiatives.

Metrics:

1. **Increased number of housing committees with Medicaid representation;**
2. **Increased number of grants submitted to access housing funds;**
3. **Increased number of Medicaid staff assigned to housing and/or transportation.**

Strategy: Provide natural supports and caregivers with transportation and housing assistance

- Establish coalitions for community transportation to assist with ride shares;
- Explore the use of Zip car-like rentals service, school buses or NEMT transportation brokers, negotiated transportation rate and network available as a service under HCBS ;
- Develop more opportunities to utilize HUD’s Section 202 housing program to assist in housing shortage;
- Analyze additional means to establish how home sharing could assist family and caregivers with respite.

Metrics:

1. **Increase in the number of 1915(c) waivers with non-medical transportation as a service option;**
2. **Increase in numbers of community transportation coalitions and alternative transportation options (zip cars, school buses, IT-N I);**
3. **Increase in number of Section 202 subsidized units.**

Strategy: Improve financing dollars for housing

- Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes;
- Provide competitive low cost loans to finance adult family homes or to convert rest homes to adult family homes;
- Establish new bonding dollars for affordable housing and, to the extent permissible under the funding stream, to allow NFs to modernize and introduce culture change and for capital improvements/conversions (e.g., more home-like environments, more common space, designs for more space and environmental efficiencies).

Metrics:

1. **Increase in bond funding;**
2. **Increase in tax credits.**

Hospital and Nursing Home 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. For Medicaid participants discharged from a hospital to a nursing home, the risk of long-term institutionalization is significant. Data shows that 65% of all Medicaid participants who enter NFs are still there after six months.[11] 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 admissions/re-admissions, effectively bypassing emergency departments (EDs) and subsequent inpatient stays through direct NF admissions. From this perspective, NFs can help to ensure that patients receive the right care in the right place at the right time and can be quickly transitioned back into the community.

Barriers that impact discharges from both nursing facilities and hospitals are addressed in this strategic plan. The primary barriers include lack of streamlined access to community supports, lack of standardized process for transitions between care settings, and lack of an expedited eligibility

[11] 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%2520Sheets%2FCoA%2520LTC%2520strategies%252012-7-10.pdf&ei=WIThTt2NLKHm0QG_mdCJBg&usg=AFQjCNFzEWtVJVgGcjMgOiDc5Rs0NHNTzw&sig2=1HNf3nqhsWUNuxCZBopnlQ, last accessed December 9, 2011.

process. Key strategies in this plan focus on the establishment of a single point of entry that will result in quick linkages to community LTSS and transitional services and supports under MFP.

Goal: 1) Decrease hospital discharges to nursing facilities among those requiring care after discharge

2) Transition 5,200 people from nursing homes to the community by 2016

Metrics:

1. **884 persons transitioned from nursing homes under MFP per year;**
2. **52% of persons discharged to community from hospitals.**

2013 – 2015 Strategies and Tactics

Strategy: 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 necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health and behavioral health issues.

- Develop Single Point of Entry and web-based resource for discharge planners;
- Develop strategies to promote electronic health records in LTSS settings (NF and HCBS);
- Coordinate activities with other ACA initiatives such as the MME Demonstration
- Build greater synergies between the various State, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings.

Metrics:

1. **Increased number of target populations (providers, consumers) satisfied with single entry point;**
2. **Increased number of people satisfied with town meetings;**
3. **Increased number of town meetings;**
4. **Increased number of consumers who use the single point of entry to (a) submit a prescreen, and (b) link to services.**

Strategy: Develop and implement standards in Transition of Care in coordination with other health care initiatives

- Improve collaboration to develop more definitive “handoffs” between hospitals, community resources, and other services and settings;
- Build on work currently underway relating to the transition model of care as well as develop a cohesive approach that encompasses various State initiatives currently underway such as the Integrated Care Demonstration for dual eligibles;
- Collaborate with state Community-Based Care Transition Program (CCTP) efforts.

Metrics:

1. **Decrease in variance between state transition processes;**
2. **Reduction in 30 day hospital readmissions among Medicaid LTSS users.**

Strategy: Improve process for LTSS eligibility.

- Participate in DSS internal process review to streamline LTSS eligibility ;
- Research other state practices and report recommendations on 5 year look-back options, exploring the underwriting risk of an expedited look-back process as compared to the cost of the existing process;
- Consider piloting new process for expedited look-back with MFP unit and select regional units and produce cost-benefit analysis to inform broader systemic change;
- Work to create and implement streamlined process for 5 year look-back statewide based on recommendations from above;
- Provide staff training;
- Provide incentives to local service providers (ADRCs, senior centers, municipal agents) to submit complete and accurate Medicaid applications.

Metrics:

1. **Decrease in length of time from initial contact with entry point to services in the community;**
2. **Increase in number of incentive payments to local service providers.**

Strategy: Provide MFP transitional and community services and supports to qualified persons who are institutionalized

- Partner with local organizations to provide transitional services to persons who are institutionalized;
- Determine core competencies and educate transition coordinators;
- Implement performance outcome payments;
- Continually improve housing plus supports model.

Metrics:

1. **Decreased length of time in transition;**
2. **Decreased rate of critical incidents;**
3. **Increased number of performance outcome payments.**

Nursing Facility Diversification and Modernization

Overview

The current State LTSS institutional landscape includes 235 NFs with a total of 26,467 beds and an average occupancy rate of 90.8%. 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 activities of daily living (ADL) 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 in community settings.

As barriers that prevent Medicaid participants from having a choice to receive services in the community are diminished, demand for the current model of institutional care is projected to decrease. The State plans to use town level data maps referenced in Section 2 to identify high need areas of the state and to guide decision making. Criteria defining high need areas will include, but not be limited to, current nursing home census compared to current and projected demand for institutional care at a local level and current and projected demand for community LTSS compared to supply. Competitive grant funds will be available to nursing homes who work in partnership with their communities. The State acknowledges that the vision of local LTSS compendiums includes new models of institutional care. These institutional settings will reflect a stronger culture of person-centered care than is currently the norm in Connecticut and be more 'home-like' in orientation than many of the current models. While different nursing home models of care are an important consideration, the strategic priority for this 3

year plan is the development of community LTSS. During the first phase of this strategic plan, funds will be prioritized for high need areas and for those nursing homes who are interested in diversifying for the purpose of providing community LTSS.

Goal: To adjust supply of institutional beds and community services and supports based on demand projections

Metric:

1. **Increase in satisfaction of town members with local LTSS**

SFY 2013 – 2015 Strategies and Tactics

Strategy: Develop NF services to include transitional programs that support the movement of individuals from a variety of care settings back into the community

- Review the impact of expanding Medicaid- and Medicare-covered therapies to support rehabilitation and training for community living (e.g., occupational therapy, etc.);
- Explore transitional training programs within NFs (including possible transitional units), including training and support for caregivers;
- Revise NF licensure and regulatory requirements to allow for transitional programs and new levels of care (LOCs);
- Explore rates for transitional services;
- 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; transitional services;
- Coordinate with other integrated care and home health initiatives.

Metrics:

1. **Decrease in average length of stay at facility;**
2. **Decrease in length of transition process;**
3. **Increase in percent of persons who can self-administer medication upon discharge;**
4. **Decrease in critical incidents during first 30 days post discharge;**
5. **Increase in employment rate within 6 months post discharge.**
6. **Alignment of the number of LTSS Medicaid NF beds with demand.**

Strategy: 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, such as those supporting financing arrangements, debentures and investor communication (i.e. annual reports, board meetings, etc.);
- Support nursing homes working in collaboration with community stakeholders to build a town-based LTSS compendium consistent with the State's strategic plan;
- Explore NF as part of the town's emergency back-up and expanded respite system;
- Develop capacity to provide HCBS 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, assisted living, etc.;
- Support transformation of NFs into community housing;
- Coordinate with HUD to explore flexibility with existing NF financing;
- Develop community space at NFs;
- Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports community services;
- Promote person-centered care in nursing homes.
- Promote increased quality of care in nursing homes.

Metrics:

1. **Increase in number of nursing homes offering community LTSS;**
2. **Decrease in number of nursing homes with public health violations.**
3. **Decrease in the number of nursing home Medicaid beds statewide.**

5

Conclusions

The strategies identified within this plan for each of the key system elements represent important steps toward building a strong system of LTSS. Collectively, they will result in 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 State stands ready to make the very important efforts necessary to reconfigure the infrastructure as well as needed improvements to services and processes used within that framework.

Throughout the implementation of the strategic plan, Connecticut will continue to 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, they 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.

Appendix A

Home and Community-Based Service Strategies and Tactics

SFY 2013 - 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Connect people to LTSS information and services	• Create global communication plan integrated with workforce communication plan		• Continue communication plan • Develop tools to educate public regarding HCBS, employment, spousal assessment, etc.	Web budget/WF budget	• Continue communication plan	Web budget/WF budget
Create parity across age and disability resources based on functional support needs rather than diagnosis –	• Analyze needs assessment and budget allocation methodology with respect to creating a common core for standardization across LTSS • Streamline, eligibility, payment, service availability, cost caps, age requirements or gaps • Analyze impact of consolidating existing personal assistance services into a Community First Choice State Plan amendment • Study the impact of a consolidated waiver for adult individuals who are aging or adults with physical disabilities and analyze cost implications	$300,000 MFP TA	• Select a common core tool and methodology and develop for use in Connecticut's LTSS ▪ Assess feasibility of incorporating needs assessment tool with EMS, MSIS or other common platforms • Conduct impact analysis of Community First Choice option and if indicators support implementation: — Develop State Plan amendment adding Community First Choice Option — Implement Community First Choice Option utilizing standard common core assessment tool for all populations • Provide tools and training on	$300,000 $1,000,000 Revenue projection	• If applicable, modify common core assessment tool across all LTSS and budget methodology based on experience with Community First Choice implementation • Provide training on new common core tool • Continue integration on to common platform	$25,000 $1,000,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
			common core assessment tool	$50,000		
Close service gaps and improve existing services or identify new services to better serve the needs of all populations	• Undertake comprehensive review of all closed MFP cases to understand reasons for closure and what solutions can be implemented to reduce the frequency of case closure	$100,000	• Continue comprehensive review in partnership with UConn; use SFY 2013 report to inform waiver and State Plan changes	$100,000	• Continue to evaluate UConn reports and integrate findings into LTSS system	$100,000
			• Conduct impact analysis of a 1915(i) amendment to fund supports for Supportive Housing and for qualifying rest homes	Revenue	• If applicable, evaluate 1915(i) implementation and modify if necessary	
			• Analyze and report on raising NF levels of care (eliminating ICF) and replacing with 1915(i)	Rev	• Modify LOC based on report	
			• Design, implement, and evaluate peer support model as MFP Demonstration	$100,000	• Expand peer support to entire system based on evaluation	$100,000
			• Design, implement and evaluate improved respite and other supports for informal caregivers under MFP	$250,000	• Continue to demonstrate respite and other supports to informal caregivers and publish findings	$250,000
	• Design and implement adult family home model and independent support broker – design/fund outreach strategy to build provider networks	$125,000	• Implement outreach for adult family homes and independent support broker to build provider networks	$25,000	• Evaluate and modify outreach developing adult family homes – continue to build network	$25,000
	• Simplify home modification		• Design, implement and evaluate alcohol substance abuse	$250,000	• Design, implement and evaluate alcohol substance abuse demonstration under MFP	$250,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	process • Integrate employment into MFP and HCBS		demonstration under MFP			
Create mechanisms to ensure quality in the care provided through HCBS	• Establish quality improvement committee to ensure sound discovery and remediation techniques and to identify and fix issues quickly within the community.	Align existing resources to assign FTE to QA	• Establish a seamless quality improvement strategy across waivers, MFP and State Plan HCBS including adult family homes • Develop strategies to assure conflict-free case management	•	• Continue quality improvement discovery and remediation • Increase ability of LTC Ombudsman to review homecare • Promote conflict-free case management	•
Build, improve quality of provider networks aligned with the principles of person centered planning	• Continue education to providers regarding informed risk	$25,000	• Continue education to providers regarding informed risk	$25,000	• Continue education to providers regarding informed risk	$25,000
	• Cross train HCBS waiver providers	$5,000	• Continue cross training waiver providers	$10,000	• Continue cross training waiver providers	$10,000
	• Improve medication administration regulation and training · Develop nurse leadership institute for the sharing of best practices in person-centered care and nurse delegation	$20,000	• Continue education and outreach to home health agencies and support of nurse leadership institute	$15,000	• Continue education and outreach to home health agencies and support of nurse leadership institute;	$15,000
	· Explore grants to HH for participation in Nurse Delegation Evaluation	50,000	• Explore grants to HH for participation in Nurse Delegation Evaluation	$50,000	• Explore grants to HH for participation in Nurse Delegation Evaluation	$50,000
	· Provide training to certify staff in med admin	$40,000	· Expand network of medication certification trainers and certify additional staff	$80,000	· Expand network of medication certification trainers and certify additional staff	$80,000
	· Evaluate nurse delegation model	$50,000	· Continue evaluation of nurse	$100,000	· Continue evaluation of nurse	$100,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
			delegation		delegation	
	• Ensure disaster preparedness, establish partnerships to meet individual needs in emergency situations/circumstances		• Explore legislation to allow for reduced liability to agencies who may be caring for individuals with significant support needs and who seek to undertake some informed risk beyond the care typically provided by the agency • Explore legislation to support home health agency nurses training PCAs • Ensure quality of care through independent evaluation of providers			

Workforce Strategies and Tactics

SFY 2014 and 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Continuously promote workforce initiatives that are proven to support consumer choice, self direction and quality while enhancing recruitment,	• Create statewide inventory of the existing workforce needs, current activities, future demand and national and local initiatives that	MFP TA	• Prioritize and promote promising practices across the state	Included in website development budget	• Prioritize and promote promising practices across the state	Included in website development budget

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
retention, productivity and training of the paid and unpaid direct care workforce.	show promise and scalability. • Track national policy and practice trends to ensure Connecticut's workforce development strategy is synergistic with responsible national goals. • Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community. • Seek to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor. *The development and use of technology is proven to increase productivity of the direct care worker as well as increase the independence of the consumer.* • Identify similarities between the paid workforce and unpaid caregivers and coordinate development initiatives to leverage resources and avoid overlap. • Inform the work of the Personal Care Attendant Quality Home Care Workforce Council	$175,000	• Create Connecticut report card regarding direct care workforce strategies • Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community. • Continue to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor • Continue to coordinate development of initiatives related to paid and unpaid caregivers • Inform the work of the Personal Care Attendant Quality Home Care Workforce Council	$175,000	• Continue Connecticut report card regarding direct care workforce strategies • Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community. • Continue to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor • Continue to coordinate development of initiatives related to paid and unpaid caregivers • Inform the work of the Personal Care Attendant Quality Home Care Workforce Council	$175,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
			• Identify employer/employee training models in a variety of community-based workplace settings, including self-directed employment arrangements and informal caregiving training models.		• Prioritize and promote identified employer/employee training models in a variety of community-based workplace settings, including self-directed employment arrangements and informal caregiving training models.	
Increase synergy with Connecticut's workforce system and support their efforts to create a pipeline of direct care workers with opportunities for career ladders to health and human/social services professions	• Orient workforce leaders to the demand and the guiding principles for LTSS in Connecticut. • Partner with state and local workforce systems such as workforce investment boards (WIB's) and Connect-Ability to align recruitment and training efforts towards the demand for community-based direct care workers. • Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to health care reform of the need and conditions of the direct care workforce and unpaid		• Orient workforce leaders to the demand and the guiding principles for LTSS in Connecticut. • Identify priority recruitment and training goals and incorporate into workforce communication plan • Assure MFP representation on key workforce councils and committees		• Orient workforce leaders to the demand and the guiding principles for LTSS in Connecticut • Identify priority recruitment and training goals and incorporate into workforce communication plan • Assure MFP representation on key workforce councils and committees	Included in website development budget

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	caregivers. • Create and endorse a common set of core competencies with emphasis on communication, relational skills, and understanding risk that helps paid and unpaid workers deliver person-centered care. *These core competencies should enhance consumer self-direction and should be careful not to infringe on the right of the consumer to train and direct their care.* • Identify additional competencies and advanced competencies needed to create clearer career pathways in health and human/social service professions • Collaborate with the community college system to design direct-service curricula using a foundation of person-centered care. • Foster training or re-training programs at multiple venues including community colleges, employers, and private/public partnerships.	$25,000	• Integrate competencies within LTSS system • Assure curricula for direct workforce is consistent with person-centered planning; • Prioritize and promote training or re-training needs and support development at community colleges • Increase and streamline ability to hire family members as paid caregivers		• Strengthen QA systems to assure compliance with competencies • Prioritize and promote training or re-training needs and support development at community colleges	

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Create equity across state systems.	• Identify, analyze and catalog variations across state departmental practices, policies and regulations that affect paid and unpaid direct care workers. • Identify, analyze and catalog systemic similarities and differences among state agencies with regards to wages of direct care workers, make recommendations to produce more equity. • Identify, analyze and catalog systemic similarities and differences among state agencies in the handling of workers' compensation and unemployment claims, make recommendations to produce more equity. • Identify, analyze and catalog	MFP TA	· Publish prioritized report re: identification, analysis and cataloging of SFY 2013 tactics including recommendations for change in procedure, policy or practice in SFY 2015; · Identify key leverage points for change based on the report		• Address top leverage point from SFY 2014 report and advance implementation	TBD

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	systemic similarities and differences among state agencies in their policies and procedures related to use of assistive technology in care planning, make recommendations to produce more equity.					
Raise awareness of the importance and value of the direct care worker and unpaid caregiver.	• Create workforce communication plan • Increase connectivity, networking, and training among both paid and unpaid caregivers. • Increase awareness of support programs available to unpaid caregivers.	$350,000	• Continue workforce communication plan phase 2 • Develop a local repository or clearinghouse that provides opportunities for linkages at a local level and allows consumers to identify providers of services and supports with website • Research and identify national best practice models that address wages and benefits. • Promote flexibility in workplace employment policies and practices to accommodate the circumstances of unpaid family caregivers	$150,000	• Continue workforce communication plan phase 3; • Publish report on national best practice models that address wages and benefits; • Promote flexibility in workplace employment policies and practices to accommodate unpaid family caregivers	$150,000

Housing and Transportation Strategies and Tactics
SFY 2013- 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Foster partnership and cross-agency collaboration between agencies focused on housing and transportation	• Establish a strategic partnership between DSS, the new Department of Housing, Connecticut Housing Finance Authority (CHFA), Department of Economic and Community Development (DECD), Department of Transportation (DOT) and the U.S. Housing and Urban Development (HUD) • Establish a housing and transportation unit to specifically build relationships with partners in order to increase available units and resources for housing and transportation • 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	FTE MFP Staff	• Foster collaboration with DOT to establish different guidelines for caregivers providing transportation with a goal of increasing pay • Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to housing plus supports	•	• Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to housing plus supports	•
Provide natural supports and caregivers with transportation and housing assistance	• Analyze additional means to establish how home sharing could assist family and caregivers with respite	(Analysis taking place under	• Provide competitive low cost loans to finance adult family homes or to convert rest homes to adult family homes	$1,000,000	• Provide competitive low cost loans to finance adult family homes or to convert rest homes to adult family homes	$1,000,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
		Adult Family Home Model under HCBS strategy)	• Establish coalitions for community transportation to assist with ride shares • Explore the use of Zip car-like rental services, school buses or NEMT transportation brokers, transportation rate and network available as a service under HCBS • Develop more opportunities to utilize the Section 202 housing program to reduce housing shortage			
Improve financing dollars for housing.	Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes	$1,000,000	• Establish new bonding dollars for affordable housing and, to the extent permissible under the funding stream, to allow NFs to modernize and introduce culture change and for capital improvements/conversions (e.g., more home-like environments, more common space, designs for more space and environmental efficiencies) • Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes	$1,000,000	• Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes	$1,000,000

Hospital/ Nursing Home Discharge Strategies and Tactics

SFY 2013 - 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
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 necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health and behavioral health issues.	• Devise and implement a global communication plan raising awareness of LTSS options	$125,000	• Promote global communication	$250,000	• Promote global communication	$250,000
	• Communicate progress on rebalancing efforts through statewide event	$30,000	• Communicate progress on rebalancing efforts through statewide event	$30,000	• Communicate progress on rebalancing efforts through statewide event	$30,000
	• Develop Single Point of Entry and web-based resource for discharge planners	$275,000	• Continue phase 2 of website	$500,000	• Continue phase 3 of website	$250,000
	• Develop strategies to promote electronic health records in LTSS settings (NF and HCBS).					
	• Build greater synergies between the various state, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings		• Continue to build greater synergies between the various state, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings	$25,000	• Continue to build greater synergies between the various state, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings	$25,000
Develop and implement standards in Transition of Care in coordination with other health care initiatives	• Improve collaboration to develop more definitive "handoffs" between hospitals, community resources,		• Design, develop and implement training for transitions of care	$25,000	•	•

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	and other services and settings • Build on work currently underway relating to the transition model of care as well as develop a cohesive approach that encompasses various State initiatives currently underway such as the Integrated Care Demonstration for dual eligibles					
Improve process for LTSS eligibility	• Inform DSS LEAN process • Create and participate in national task force • Research and report recommendations on 5 year look-back options • Explore underwriting risk of expedited look-back process compared to cost of existing process; • Work to create and implement a streamlined process for 5 year look-back statewide	•	• Continue SFY 2013 activities • Pilot new process for expedited look-back with MFP unit and select regional units and produce cost-benefit analysis to inform broader systemic change; • Provide staff training • Provide incentives to local service providers serving as single entry points to submit complete Medicaid applications	•	• Continue SFY 2014 activities	•
Provide transitional and community services and supports through MFP to persons who are institutionalized	• Partner with local organizations to provide transitional services to persons who are institutionalized; • Determine core competencies and educate transition coordinators; • Provide performance outcome	$100,000	• Partner with local organizations to provide transitional services to persons who are institutionalized; • Determine core competencies and educate transition coordinators; • Provide performance outcome	$100,000	• Partner with local organizations to provide transitional services to persons who are institutionalized; • Determine core competencies and educate transition	

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	payments; • Continually improve housing plus supports model • Increase capacity to transition persons under 65 by hiring 3 CCT social workers • Continue implementation of MFP Demonstration	$195,336 $6,710,375	payments; • Continually improve housing plus supports model • Continue implementation of MFP Demonstration	$6,478,747	coordinators; • Provide performance outcome payments; • Continually improve housing plus supports model • Continue implementation of MFP Demonstration	$100,000 $6,518,715

Nursing Facility Diversification and Modernization Strategies and Tactics

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Develop NF services to include transitional programs that support the movement of individuals from a variety of care settings back into the community	• Review the impact of expanding 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 support for caregivers, alcohol and substance abuse, independent living skills and pre employment skills • Revise NF licensure and regulatory requirements to allow for transitional programs and new levels of care (LOCs) • Develop rates for transitional services as pre-discharge community service • Establish authorization process for services and individual plan requirements • Redefine the CON process for		▪ Review SFY 2013 tactics and revise as necessary; ▪ Modify receivership legislation to integrate MFP informed choice process;		Review SFY 2014 tactics and revise as necessary	

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	determining how NF space can be used for non-NF services, including de-licensure, so that it supports transitional services • Coordinate with other integrated care and home health initiatives					
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, such as those supporting financing arrangements, debentures and investor communication (i.e. annual reports, board meetings, etc.) • Develop capacity to provide 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, assisted living, etc. • Development of community space at NFs • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports community services	RFP $13,000,000	• Review implementation of SFY 2013 tactics, revise as necessary; • Develop RFP for funding of additional proposals from nursing homes; • Review statutes and recommend changes aligned with advancing the strategic plan; • Explore close-out rate for nursing homes	RFP $15,760,000 ($10M in bonds)	• Review implementation of SFY 14 tactics, revise as necessary; • Review statutes and recommend changes aligned with advancing the strategic plan	RFP $15,760,000 ($10M in bonds)

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	• Develop RFP for nursing facilities interested in diversifying to provide community supports as identified in town level data maps • Develop prioritization for awards based on NF quality, unneeded institutional beds and need for additional community services and supports at a town level • Analyze local supply and demand trends and produce 6 month updates	$50,000	• Analyze local supply and demand trends and produce 6 month updates	$100,000	• Analyze local supply and demand trends and produce 6 month updates	$100,000

Appendix B

Report from the Long-Term Care Right-Sizing Strategic Planning Retreat: Participant Strategies to Address Long-Term Care Rebalancing Efforts State of Connecticut April 16, 2012

Acrobat Document