BUILDING A SUSTAINABLE NURSING FACILITY TRANSITION PROGRAM

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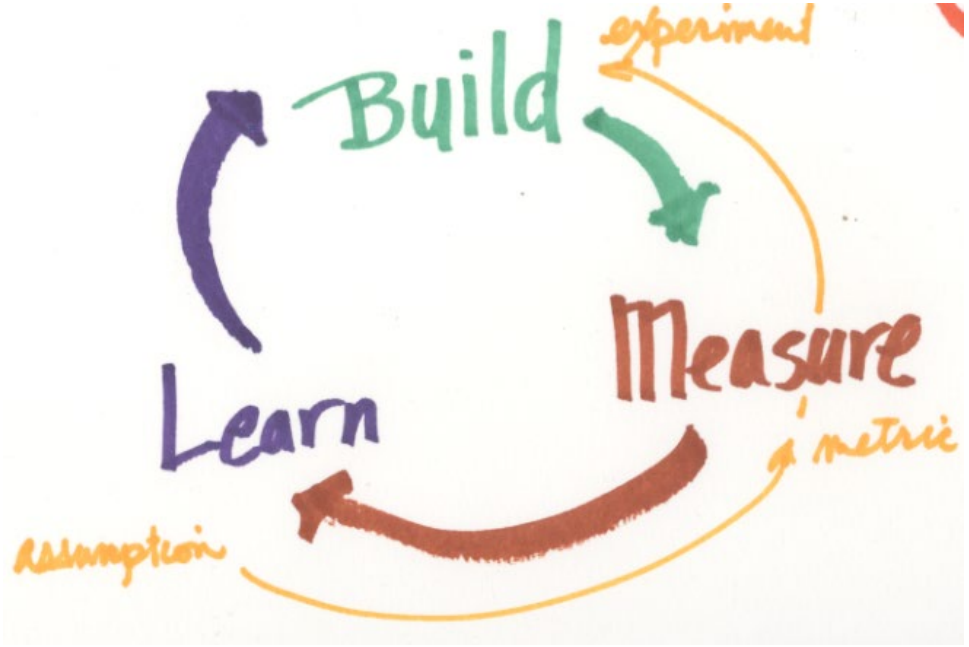


Objectives

- Michigan's CIL Network- Disability Network
- Why Michigan re-designed the Nursing Facility Transition (NFT) program
- The Process
- The New NFT Program
- Lessons Learned
- Questions & Answers
- Dialogue – How are other states funding the 5th core service

Disability Network

- 15 Centers for Independent Living
- Disability Network- where the collective work occurs
- Focus:
  - Relationships
  - Credibility
  - Staff Development
  - Resources

WHY REDESIGN?

Why re-design NFT

Funding was not sustainable- Money Follows the Person (MFP)

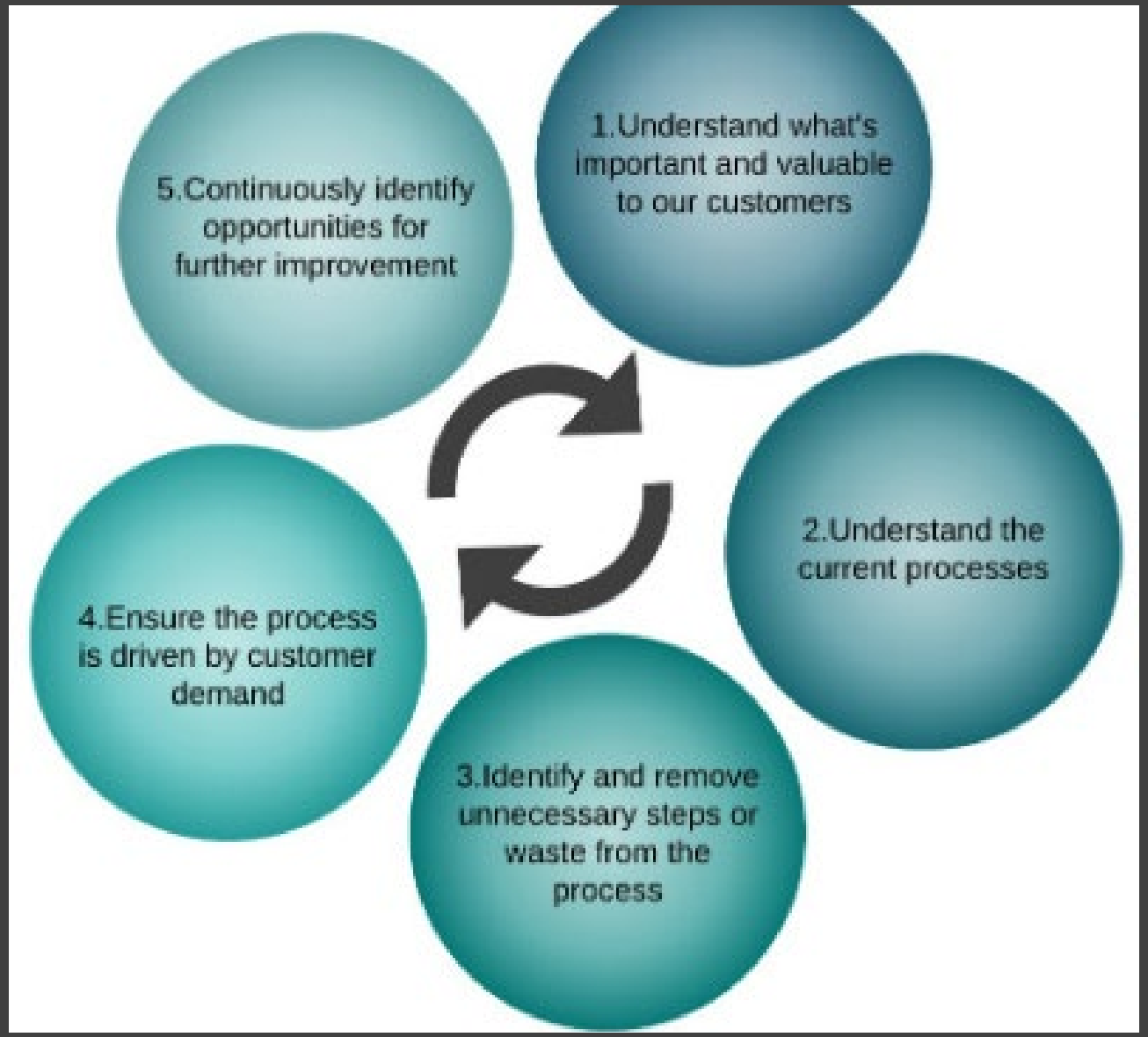
MFP had many rules and restrictions

Bundled payment in previous model

We asked for it!

THE PROCESS

LEAN PROCESS



LEAN Process

1. What is important to your consumers?
2. Study your current processes
3. Eliminate unnecessary steps in your process- where is there waste or inefficiencies?
4. Ensure the process is driven by consumer demand
5. Continue to identify opportunities for improvement

Modified Process in Michigan

1. Established our re-design values through stakeholder and consumer input
2. Developed the Value Stream Map- ‘the what is’
3. Addressed barriers, waste and inefficiencies
4. Created our NFT Idealized Design- ‘our dream’
5. Conducted Plan-Do-Study-Act (PDSA’s) cycles on all new processes
6. Revised Idealized Design based on the PDSA’s
7. Sought stakeholder and consumer feedback on revised NFT Idealized Design
8. Implemented re-designed NFT program (October 2018)
9. Evaluation of first year (scheduled for early FY 2020)

PDSA- What & Why

- **What**- It is a framework for testing whether the change you want to make is an improvement
- **Why**- Changes to the system can only be made if they can be supported with data as an improvement

Inclusiveness was critical!

NFT Re-design Leadership Team

NFT Re-design Operational Team

NFT Issue Specific Workgroups

- Pre-transition
- Transition Implementation
- Post Transition
- Policy

OUR NEW NFT PROGRAM

Our Values

1. Be based on providing a continually better customer experience for people who are transitioning.
2. We built on a person-centered foundation that promotes maximum personal choice.
3. Design a process that allows participants to communicate with only one person, to eliminate confusion.
4. Respect of the person's right to take risks.
5. Include flexible timelines – each individual needs their own individual timeline to transition.
6. Respect participants' need to try multiple times to transition successfully.
7. Include additional support for the person so that they can be successful in their transition through such efforts as a mentoring program and other supports.
8. Include well-trained and qualified staff at all levels, using a reimbursable training system for aides, caregivers, relocation specialists, etc.
9. Respect and trust contractors to make good and responsible decisions.

Our Values

10. Include clear, concise and consistent two-way communication.
11. Ensure collaboration over competition.
12. Include consensus on operational definitions for terms, data, metrics and measurements.
13. Include a continual, two-way feedback loop into the system.
14. Include purposeful reporting.
15. Be cost-effective and cost-saving overall, with an eye to low administrative costs.
16. Build continual quality improvement into the system.
17. Promote rebalancing of funding from institutional to community-based living.
18. Create a future where it is as easy to get out of the nursing home as it is to get into one.

Providers and Payment

Providers:

- Area Agencies on Aging (AAA)
- Medicaid Waiver [1915 (b) and (c)] Agencies (non-AAA)
- Centers for Independent Living

Payment:

- Medicaid
- State Plan Amendment
- 1915 (i) (iSPA)

Provider Qualifications

Transition Navigators are qualified as a:

1. Registered Nurse licensed in the State of Michigan, or
2. Social Worker licensed in the State of Michigan, or
3. Non-licensed or other licensed health care professionals with the following qualifications:
    1. Possess a bachelor's degree in a health or human services field or **Community Health Worker certification**, and
    2. At least three years of experience in the provision of health or social services.

Transition Navigators must be knowledgeable in:

- Person-centered planning,
- How to access long-term and HCBS services and supports within the community they serve,
- How to address barriers to discharge, and
- Eligibility requirements for HCBS services and supports.

State Plan Amendment [1915 (i)]

- States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit.
- People must meet state-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications) in home and community-based settings.

State Plan Amendment [1915 (i)]

- Target the HCBS benefit to one or more specific populations- **Michigan= nursing facility residents**
- Establish separate additional needs-based criteria for individual HCBS
- Establish a new Medicaid eligibility group for people who get State Plan HCBS
- Define the HCBS included in the benefit, including state- defined and CMS-approved "other services" applicable to the population
- Option to allow any or all HCBS to be self-directed

Transition Navigator Services

- Definition provided to the Centers for Medicaid and Medicare Services (CMS)
- Transition Navigator services are provided to assure the delivery of supports and services needed to meet the individual's goals for living in the community after an institutionalization.
- Without these supports and services, the individual would otherwise remain institutionalized.
- The Transition Navigator functions to be performed and the frequency of face-to-face and other contacts are specified in the individual's person-centered service plan.
- The frequency and scope of Transition Navigation contacts must take into consideration health and safety needs of the individual.
- Transition Navigation does not include the direct provision of other Medicaid-funded services.

Community Transition Services

- Definition Provided to CMS
- Community Transition Services are non-recurring expenses necessary to enable an individual who is transitioning from a nursing facility or other institutional setting to the community to establish a basic household and do not constitute room and board.

  These services include the following:
  - Security deposits required to obtain a lease on an apartment or home,
  - Set-up fees for utilities or service access, including telephone, electricity, heating and water,

Services & Payment

Targeted Case Management Services

Referred to as Transition Navigation Services

Based upon person-centered plan

$20 per 15 minute unit

HCPCS: T1017

Services include:

Community Transition Assessment

Transition to community

Securing housing

Shopping for household goods/services

Follow-along

Services & Payment

Community Transition Services

Based upon person-centered plan

Payment- based on fee screen established by State of Michigan

HCPCS: Varies

Services include:

Home modifications

Household items

Durable Medical Equipment

Security Deposits

Rent*

Documentation (Drivers license, birth certificate, etc.)

Utility set-up*

*funded with non-federal funds

Other Program Aspects

Unified approach to marketing

800 #

Subcontracting & Collaboration

LESSONS LEARNED

Lessons Learned

- PDSA- Transition Navigation Service rate
- Anticipated service volume & staff capacity
- Documenting in a Medicaid world
- Transition to the new business model
- Outreach and promotion is key
- Market saturation

QUESTIONS?

HOW ARE YOU FUNDING THE 5TH CORE SERVICE?

Open Dialogue

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