Money Follows the Person – Getting it Done in Nevada

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Introduction

This report was developed at the request of the Northern Nevada Center for Independent Living (NNCIL) pursuant to a grant by the US Department of Health and Human Services, Commission on Medicare and Medicaid Services (CMS). The purpose of this report is to provide recommended action steps for the state of Nevada to establish structural, programmatic and funding mechanisms to facilitate a balance in resources for people with disabilities moving from institutions to community living.

The Money-Follows-the-Person (MFP) initiative in Nevada began through a systems change grant by the Nevada Office of Disability Services with the United States Department of Health and Human Services, Commission on Medicare and Medicaid Services (CMS). Nevada defines MFP as the restructuring of state and federally funded programs, procedures and policies for long term services in order for resources to move with a person with a disability to the most integrated setting appropriate. These supports and services should be flexible in order to meet the individual needs.

The primary principle of Money-Follows-The-Person is simple and straightforward - - People with disabilities should be able to decide where and how their services and supports should be provided. The state should enable and facilitate this decision through a flexible method of funding. CMS, the federal agency that administers the Medicaid program, has made a commitment to work with states to develop programs that embrace the Money-Follows-The-Person principles. Through the design of various MFP mechanisms, Nevada can facilitate the portability in funding necessary to ensure that

people with disabilities are supported in the most integrated setting in accordance with the Americans with Disabilities Act (ADA) and the requirements set forth in the *Olmstead* decision.

This report contains eleven recommendations for consideration by decision-makers and stakeholders in Nevada. These recommendations are offered in the spirit and intent of the MFP principles and the ADA. The recommendations are also designed as a cost effective approach to a service system with community living as its foundation. If implemented effectively, the recommendations can also be investments toward significant long-term savings in state funds and increased federal resources.

Through various federal initiatives, similar systems reform is taking place across the United States. In fact, effective models for long term supports and services are abundant, including in Nevada. Some examples of practices in other states or jurisdictions are included in the discussion and rationale statements for many of the recommendations. It is important for Nevada to take full advantage of successes of other experiences across the country. If recommendations contained herein are accepted, consultation with other states and jurisdictions regarding implementation could enhance effectiveness.

Report Methodology

This report was developed through multiple tasks of obtaining information, seeking input and feedback from key stakeholders and analyzing the information provided. A voluminous amount of county, state and federal documents and reports were reviewed and analyzed. Nevadans with disabilities were interviewed. State and county administrative, management and program staff were interviewed. Information was also taken from training opportunities with nursing facility transition staff and presenters. Numerous conference calls with staff from the Nevada Office of Disabilities and Northern Nevada Center for Independent Living were also conducted in order to clarify and verify information received.

Impact of the Olmstead Decision

In 1999 the United State Supreme Court affirmed in *Olmstead* that the inappropriate institutionalization of qualified individuals with disabilities is discrimination under the Americans with Disabilities Act (ADA) because such institutionalization segregates individuals with disabilities from everyday life activities and diminishes individual opportunity. The Court made clear that, under certain circumstances, states and public entities are required to provide community-based services to people with disabilities and to make reasonable modifications in policies, practices or procedures when modifications are necessary to avoid discrimination on the basis of disability. The Court also suggested that a state could establish compliance with the ADA's reasonable modification requirement if it demonstrates that it has: a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings; and a waiting list that moves at a reasonable pace not controlled by the state's endeavors to keep institutions fully populated.

Since then President Bush has called upon states to swiftly implement the *Olmstead* decision and has directed federal agencies to assist states through coordinated technical assistance. The great majority of states are working to implement components of the decision. According to the National Conference of State Legislatures, in the six years since the *Olmstead* decision, at least 46 states and territories are engaged in major planning efforts to increase community options for people with disabilities.

Nevada initiated a major statewide planning effort that resulted in the development of the *Nevada Strategic Plan for People with Disabilities.* This plan, which was first issued in October 2002, is a working document utilized by the disabilities leadership and stakeholders across the state. This plan incorporates nine primary goals and numerous activities designed to support each goal. Goal number eight specifically states: *The state system of service delivery and long-term care will be managed and monitored so services*

in the most integrated settings become the norm throughout Nevada. Effective MFP structures and mechanisms assist in making this goal a reality.

Current Institutional Bias

For people with severe disabilities in Nevada today it is simply much easier to receive comprehensive services in a nursing facility than in the community. You apply or you are referred by a hospital – if found eligible, you are accepted – you move in - and you can stay as long as you like. For nearly all people with disabilities in nursing facilities in Nevada, Medicaid foots the bill.

Obtaining community services is much more complicated. Waiting lists exist for most community services and if one needs comprehensive services due to the complexity of his or her disability, spending caps and limits on available resources often stand in the way. The state agencies, in conjunction with the disability community, have recognized these barriers and have worked steadfastly over the past six years to ameliorate each of the primary barriers.

Many other states have also recognized the institutional bias and have taken actions to rebalance the long term services and supports system to offer services in the most integrated setting. These rebalancing efforts include changes in policies and procedures, public information initiatives, legislative actions and budgetary restructuring. These efforts are not uncomplicated and require leadership and ongoing collaboration between the executive and legislative branches of state government.

The recommendations set forth below are designed to assist in the transition from a system with an institutional bias to a system where services in the most integrated setting are the norm, as stated in the state's strategic plan.

Recommendations

In addition to the current initiatives and activities undertaken through the Nevada Strategic Plan for People with Disabilities, the following steps are recommended.

1. **Development of a self-directed model of funding for people transitioning from institution to community that maximizes consumer control.**

Since the Olmstead decision, Nevada has recognized the need for adults with disabilities to control their own services and supports while at the same time maintaining an acceptable level of accountability. In order to facilitate this principle, mechanisms need to be put in place, which allow people with disabilities to make meaningful choices about how their services and supports will be provided. These choices must then be respected through a responsive mechanism.

   a. **Modification of HCBS Waiver Services to Allow for Individual Budgeting, Fiscal Intermediary and Independent Support Broker Services.**

As more state systems of long term services and supports are converting to a self-directed model, the feedback from recipients has been overwhelmingly positive. Report after report has demonstrated that people who have a high degree of choice and control also exercise a higher degree of responsibility – resulting in improved quality, satisfaction and cost containment.

The experience in Oregon is exemplary of this principle. Authorized by an 1115 Medicaid waiver, Oregon's Independent Choices Program provides persons who meet the state's financial and functional Medicaid criteria for nursing home placement with a monthly cash payment equivalent to the cost of services they would have received if they were enrolled in Oregon's HCBS waiver program. Under this five-year demonstration project, which began in 2001, participants receive a monthly cash payment that is

electronically deposited into the individual's bank account. Receipt of the cash does not impact any other benefits available to participants such as HUD, SSI and food stamps.

Individuals use their monthly allotment to pay directly for services and are fully responsible for the mechanics of payroll and budgeting for needed services. Services include homemaker, personal care, chore, companion, attendant care and transportation. Consumers have the flexibility to utilize services as needed. For example, if the need for transportation is greater in one month than in another, they can easily arrange for this to take place by making these arrangements directly.

Each participant or his/her surrogate is responsible for hiring, training, supervising and, if necessary, firing employees. Participants/surrogates must complete a ten-hour training session and pass an exam to be eligible to conduct payroll tasks. If a person or the designated surrogate fails to pass the exam, the person must use a fiscal intermediary, the cost of which is covered by the program. If, on the other hand, the individual or surrogate is capable of handling the financial aspects of being an employer and chooses to use a fiscal intermediary, the costs are the participant's responsibility. Two centers for independent living and two senior service centers provide training and technical assistance services.

Investment

Since this recommendation is proposing to modify existing structures and not add services, there would be no new program funds required. Modification of existing waivers and/or application for new Home and Community-Based Waivers is an administrative function, however, that would require staff time and administrative support to design and administer the restructured waivers. Once waivers were modified, standards for self directed supports would also need to be developed and incorporated into policy.

b. Consideration of application for Independence Plus Waiver

In 2002, CMS unveiled the *Independence Plus* initiative in response to Executive Order 13217, in which the Department of Health and Human Services (DHHS) promised to provide states with simplified model waiver and demonstration application templates that would promote person-centered planning and self-directed service options.

Independence Plus is based on the experiences and lessons learned from states that pioneered the philosophy of consumer self-direction. Specifically, two national pilot projects demonstrated the success of these approaches in the 1990s: (a) the Self-Determination project in nineteen states, focused primarily in the Home and Community-Based Services § 1915(c) waivers, and (b) the "Cash and Counseling" project in three states, focused on the § 1115 Demonstrations. These programs afforded service recipients or their families the option to direct the design and delivery of services and supports, avoid unnecessary institutionalization, experience higher levels of satisfaction, and maximize the efficient use of community services and supports.

CMS defines a self-directed program as "a state Medicaid program that presents individuals with the option to control and direct Medicaid funds identified in an individual budget." The CMS requirements for a comprehensive self-directed program, or Independence Plus, include person-centered planning, individual budgeting, self-directed services and supports as well as quality improvement components.

CMS developed two optional electronic templates under *Independence Plus.* The templates provide guidance through design features for self-directed programs, and use a streamlined application process intended to facilitate a faster federal approval of state proposals.

- Section 1115 Demonstration Template - Allows Medicaid beneficiaries to manage their cash allowance directly and to hire legally responsible relatives.

- Section 1915(c) Waiver Template - Allows Medicaid beneficiaries to self-direct a budget and a wide array of services necessary to keep a person from being institutionalized in a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded.

CMS is consolidating the existing *Independence Plus* template into a new web based Section 1915(c) application with instructions. The consolidation enables: the expansion of a variety of self-directed options in existing waivers; consistent participant protections across all waiver programs; minimal administrative burden to states; an easier Waiver amendment process; and improved communication of expectations for quality.

Currently, there are eleven approved Independence Plus waivers in ten different states, which include New Hampshire, South Carolina, Louisiana, North Carolina, Florida, Maryland, California, Delaware, New Jersey and Connecticut.

The impact of implementation of an Independence Plus waiver would serve several functions, including:

- ✓ Implementation of an Independence Plus waiver would allow for the promotion of family members as caregivers;
- ✓ Providing for development of standards and criteria for independent support brokers;
- ✓ Providing a mechanism for expansion of person-centered planning; and
- ✓ Providing a mechanism for development of an individual budgeting process.

2. **Continue efforts to ameliorate institutional bias in county match administration.**

For years, there have been administrative encumbrances within the county Medicaid match process that have prevented the transfer of equitable resources from nursing facilities to community living. Since *Olmstead*, a heightened awareness of this issue has led to continuous dialogue and preliminary proposals to address the issue.

Several county human services administrators have met with state officials and advocacy organizations on numerous occasions to come up with various solutions to the problem. Simply stated, counties draw match funds from their indigent health care funds for people in nursing facilities. When people move from nursing facilities to the community, many of them are no longer eligible for county indigent health care funds due to the different criteria for these funds. If the counties use general funds for people who have transitioned to the community, costs are too high and unsustainable as well as ineligible for county matching monies.

One of the associated issues to this problem has been the untimely and confusing data that has been traditionally provided to the counties by the state regarding individuals with disabilities in nursing facilities. Counties have had difficulties tracking people and their funding, making it even more challenging to plan for resources as people move to the community. Since this problem has been articulated by the counties, there have been improved methods of transmitting and interpreting this data. The Nevada Association of County Human Services Administrators has continued to work with state officials to remedy this issue.

To effectively address the county Medicaid match issue, it may be necessary to change the eligibility criteria for Medicaid so that individuals who are currently in this category

will have the same access to state-funded community services as other Medicaid recipients. A costs analysis will be necessary to ascertain its fiscal feasibility. The amount investment into resolution of the county/state match issue is unclear as specific recommendations from the county/state workgroup would dictate possible costs.

3. Implementation of a Budget Consolidation Model (similar to Rider 37 in Texas)

Nevada should consider the adoption of an approach to rebalance its budget to ensure appropriate resources for community services as people with disabilities leave nursing facilities. This initiative provides Nevada an opportunity to transition people from nursing facilities to community residential settings without increasing Medicaid costs to the state. One successful method that has been utilized has been a budget consolidation model, presently utilized in Texas.

Background

Immediately following the Olmstead decision, Texas recognized an overwhelming challenge in addressing the realization of having more than 62,000 people in nursing facilities throughout the state. To address this issue, the Texas state legislaturemade nursing facility transition to the community a priority. This was accomplished in 2001 through the passage of Rider 37, which permitted the state Department of Human Services to transfer funds from the nursing facilities' budget to the community services' budget as people moved to the community. The Rider was once again authorized in 2003 (as Rider 28) and in 2005 was codified into the state statute.

The principle benefit of Rider 37 and subsequent legislation is that anyone in a nursing facility who has been determined appropriate for community supports can move without waiting for available funding. The transfer of aggregate funds from the nursing facility budget to community services' budget is made on a quarterly basis, thus allowing for ongoing cash flow and transfer to the community immediately upon the identification of

community supports. In less than two years after the enactment of Rider 37, more than 3,000 Texans with disabilities have received funding for community services through this rebalancing of financing.

It is important to note that Rider 37 cannot be used to prevent people from going into nursing facilities who can also be served in the community. In fact, during the process for eligibility for services, the individual with a disability must remain in the nursing facility to remain qualified for the Rider. If the individual leaves the nursing home during the eligibility process, he or she will forfeit their Money-Follows-the-Person status and will be placed on the regular waiting list for services.

Texas has used several methods to implement Rider 37 and its successor legislation. One method was the utilization of contractors known as "relocation specialists" to identify people with disabilities in nursing facilities who are viable candidates for community transition and support them through the transition process. The state also contracts with four Independent Living Centers to provide transition supports to people with disabilities in nursing facilities. Texas has also developed Nursing Facility Transition Workgroups in all regions of the state to address transition issues in their respective region.

The state of Utah also created a budget rebalancing initiative known as the Portability of Funding for Health and Human Services law. This legislation provided for an open enrollment process that permitted individuals in ICF/MR facilities to move to the community utilizing Home and Community Based Waiver services. As a person moved to the community, funds were shifted from the institutional budget to community funding. This initiative lasted for four years (1998-2002) and resulted in a 6% decrease in the ICF/MR population.

Vermont also has a budget appropriations process for long term supports and services that connects transition from nursing facilities to new community resources. Through

this legislation (Act 160) for every dollar that is saved in nursing facility costs, the same amount of funds is reallocated to community services. This reallocation process has been in place for ten years.

Benefits

The principle benefit of a budget consolidation model is that it is a cost neutral initiative for the services to the recipients. It also incrementally shifts resources toward the preferred venue – community supports and services.

Nevada already has in place an active in-reach and transition support system through its FOCIS program as well as assistance from its Centers for Independent Living. The identification of candidates for transition, therefore, is a function that already exists for Medicaid recipients.

Limitations

While Nevada should strongly consider enacting legislation similar to Rider 37, it would be somewhat unlikely that results similar to Texas would occur as quickly. The primary reason is that, historically, Nevada had not invested as heavily in nursing facilities as a method of serving people with disabilities. As a result, there is a proportionately higher number of people waiting for long term supports and services who are not presently in nursing facilities (although they are at risk of unnecessary institutionalization if community services are not available).

Investment

There would be no new program costs because the initiative simply shifts funds. No new funds are added. In fact, since community programs are typically less costly than nursing facility services, the state is likely to save money over a period of time. There would be some minimal costs to initially set up the administrative structure for budget consolidation. Once the structure is established, administrative costs would be minimal.

4. Development and Utilization of Uniform Data and Community-Friendly Assessment Process

Nevada Medicaid staff, through the guidance from the *Nevada Strategic Plan for People with Disabilities,* has developed and utilized a setting-neutral assessment for people who receive services through the FOCIS program. It has been reported that this assessment instrument has produced meaningful, positive outcomes in assisting people with disabilities through the identification, assessment and transition process.

Unfortunately, neither this assessment nor any similar assessment process has been made operational on a statewide basis. This type of assessment is also not being used outside of the Medicaid program for people who are at risk of nursing facility placement and need long term community supports and services. In addition, there is no data collection system or depository where assessment information can be utilized for analysis and planning. In other words, Nevada lacks the specific needs assessment data to effectively plan for people with disabilities who are unnecessarily institutionalized or those who are at risk of unnecessary institutionalization.

It is, therefore, imperative that Nevada adopt an assessment tool and process that can be used on a statewide basis by multiple entities. This uniform assessment process should also be enhanced through consistent training and technical assistance. Once the assessment is in use, the state can implement a data development and collection system as well as conduct an evaluation of its effectiveness.

The investment in a uniform assessment process would be relatively minimal as some assessments are already in place that could be replicated or expanded.

5. **Utilize Data from Individual Assessments to Develop a Statewide Needs Assessment.**

Good planning requires good data. Nevada state legislatures as well as state government officials must have the tools and information necessary to effectively plan and allocate resources where they are needed. Once recommendation #5 above is implemented, it will be important for Nevada to establish a process for receiving information and incorporating it into its decision-making process. One suggestion would be the establishment of an annual *Olmstead* Compliance Report, which would include baseline information, interpretation of this information and recommendations to address issues identified.

The state of Oregon developed its ACCESS system. This is an automated assessment system with algorithms that assigns an individual's information and connects need level with service priorities and eligibility. Originally designed to streamline eligibility, this system can now provide data on eligibility, funding authorization, reassessment schedules and cost projections. Most importantly, this system collects information and produces reports that can be utilized by state leadership for planning and resource development.

6. **Establish a statewide resource center on consumer self-direction.**

Self-directed supports, in and of itself, does not constitute a money-follows-the-person policy. It is a tool, however, that embodies the principle of money-follows-the-person and has been a mainstay request of individuals with disabilities in Nevada for many years. At least thirty-five states, including Nevada, have undertaken some public policy action(s) related to self-directed services. Twenty states have either modified their existing HCBS Waivers or applied for demonstration waivers to operationalize, at least in part, a self-directed model. Converting to a self-directed model is no longer considered

out-of-the-box thinking and has become the current best practice in supporting people with disabilities.

Converting to a self-directed model, however, requires cultural and administrative changes that will take time and significant effort. One way to initiate this effort would be to establish a statewide center on self-direction. This center could be the fulcrum point for information, training, technical assistance, coordination, evaluation and policy development regarding the conversion efforts. During the conversion process, access to information about service and funding options, new procedures and the mechanics of the evolving infrastructure will be critical to people with disabilities who are "caught in the shuffle."

The statewide center on self-direction could have numerous functions, to include:

- Serve as a central point of information on self-direction for consumers, families, providers as well as state and county staff;
- Development of educational materials on self-direction
- Identify resources that could facilitate self-direction;
- Coordinate and conduct ongoing training on self-directed supports statewide.
- Provide technical assistance to state and county staff on conversion to self-direction; and
- Provide an annual report to the state legislature on progress regarding development of self-directed supports.

There would be some investment of resources for this statewide center. Since it would be important for this center to have an independent status, a Request for Proposal would be necessary to include qualifications of providers and desired outcomes. Costs for a center are estimated to be approximately $250,000 per year.

7. Development of a Statewide Person-Centered Planning Process

Person-centered planning involves the development of a variety of methods and resources that enable people with disabilities to choose their own direction to success. In the person-centered planning process, the planning team plays a supportive role in assisting the person with a disability in determining where they want to go and how best to get there. Person-centered planning is vastly different than the traditional interdisciplinary or treatment team planning models that are most often used in institutional settings. While health and safety issues are still priority considerations, individual choice is the foundation of the person-centered approach. Across the country, particularly regarding to people with developmental disabilities, person-centered planning has taken hold.

In Nevada, person-centered planning is being partially implemented throughout community services for people with developmental disabilities. Through a gradual process of training, plan structure development and evaluation, the individual planning process is being converted from the interdisciplinary process to a person-centered planning approach. For most long-term care services in Nevada however, the traditional treatment plan structure is still in place.

Nearly ten years ago, the state of Michigan passed legislation amending their mental health code to establish the rights of people with developmental disabilities and mental illness to a person-centered planning process. This was done in combination with the development of a capitated payment system that allows the state to offer a full array of services while determining how to control costs at the local level. This initiative has been a cost neutral process facilitating a rare combination of a new manner of individual planning with cost containment.

The state of Oregon also incorporated person-centered planning into its nursing facility transition structure. Through the Client Assessment Planning System (CA/PS) the documented needs generate an individual authorization for home and community-based services. Once funding levels and the type of setting are authorized, a consumer-directed service plan is developed with the individual and community case manager.

8. Revise Health Care Statute to Develop a Central Identification Registry for People Going Into Nursing Facilities from Hospitals

While efforts within the Nevada Division of Health Care Financing and Policy (DHCFP) have created some system change, more needs to be done to swiftly identify individuals to assure a successful transition out of an institution. Because DHCFP staff are only able to assist eligible Medicaid recipients, there is no entity currently available to assist people with disabilities who are not Medicaid eligible. Generally, it takes a period of thirty to ninety days to become eligible for Medicaid. In the meantime, individuals may be identified as someone desiring assistance to transition back into a more integrated services setting. Therefore, time is lost in the discharge planning process and often becomes a barrier to discharge as the individual loses belongings and housing while in an institution. Best practices support the notion of early identification and assistance as a means to improve successful transition out of a nursing facility. Early identification of individuals would allow for an opportunity to increase awareness of available community options, expedite eligibility for community-based services; and increase the coordination of services early in the institutional placement process.

Nevada Revised Statutes include Chapter 439B-Restraining Costs of Health Care, which should be amended to include a reporting requirement for any health care facility discharging or transferring an individual to a nursing facility. Currently, hospitals are required to report quarterly on the care and treatment of patients, specifically those who may be considered indigent (those not covered by a health care policy and those who are not currently eligible for public benefits). Chapter 439B should be expanded to include

reporting of those individuals who are being discharged or transferred to a nursing facility as soon as this information is known. This information can be added to the current reporting repository for applicable analysis and distributed to an appointed entity responsible for disseminating information regarding long term care supports and options to those individuals recently placed into nursing facilities. This entity should also be made responsible for making referrals to DHCFP, counties of origin and other sources of assistance that could potentially assist in making community supports available as desired.

There are minimal administrative costs associated with this recommendation as much of the cost would be included in the expansion of reporting capabilities in the data recommendation above.. In fact, responsible utilization of a comprehensive registry of people as they go into nursing facility may prevent costly long term unnecessary stays in those facilities.

9. Establish a Requirement that Community Long Term Services Options be presented by knowledgeable individuals during Discharge Planning

People with disabilities who require long term supports and services must know what their options are in order to exercise meaningful choices. In Nevada, discharge planning for people with disabilities in nursing facilities is often conducted only with the individual and nursing facility staff. Many times, nursing facility staff may not be aware of options for community supports that are available or possible funding mechanisms.

The state of Utah, which faced a similar situation, developed multiple strategies to address these challenges. First, Utah Medicaid developed training and educational materials outlining community options. Secondly, the state developed targeted contracts in specific counties to train community educators. The community educators were commissioned to go to nursing facilities and train staff on community resources and

methods of referral for community supports. Third, Utah issued a requirement that a independent third party be present at all education sessions in nursing facilities. As a result of these efforts, there has been a significant increase in the number of people with disabilities who have transitioned from nursing facilities to the community.

Similarly, the state of Maryland recently enacted legislation (HB 794) requiring an independent "community resource specialist" to attend all annual planning meetings at State Residential Centers for people with developmental disabilities. The community resource specialist cannot be an employee of the facility and must have the knowledge and experience to share information with the individual and planning team regarding options for services in the most integrated setting.

New Jersey, through its Community Choice program, provides people with disabilities who live in nursing facilities with information about community options. This was accomplished by the employment of more than forty Community Choice counselors statewide (registered nurses and social workers with community knowledge and experience) to perform this task. These counselors receive extensive initial and ongoing training on a biweekly basis over a six month period. Training is provided in areas such as Medicaid services, aging services, individual rights, housing, transition planning and provider resources. It is important to note that this program started with only 10 Community Choice counselors the first year of implementation and expanded over the next five (5) years.

Consumer-driven supports begin with the knowledge and understanding of what services are available to an individual so that informed decisions can be made. Currently in Nevada, information regarding long-term care services is fragmented, and information regarding eligibility criteria for Medicaid programs is not readily accessible to consumers and providers. Although Medicaid has a website that provides some information regarding the various programs, there is no centralized source that provides information

on all the various services, program eligibility criteria and how to access pertinent information. Individuals often need to contact several agencies to secure complete information regarding financial and non-financial criteria. The Nevada Strategic Plan for People with Disabilities established goals to address the need for education of consumers so that people can appropriately choose, direct, and access services they need to divert from institutionalization (Refer to Goal 6 & 7). SCR 11 was also passed during the 2003 legislative session in support of a 211-dialing plan for access to social services. These initiatives will provide written information and a referral system on available programs, eligibility criteria and other matters.

For the educational and outreach process to be effective, however, policies need to be developed to ensure that individuals with disabilities, including those in nursing facilities, have access to needed information. Currently, Nevada has no policy mandating agencies that assist consumers with long-term care services to develop and provide outreach and in-reach services.

Individuals in nursing facilities are dependent upon nursing facility staff to assist with identifying community-based services and informing them of service options. NNCIL staff and consultants interviewed staff and consumers at six nursing facilities in Northern Nevada and five in Southern Nevada. Staff interviewed stated that the lack of training and a formal process to keep current on available community resources is a major barrier to effective transition. Nursing facility staff also reported that, because information is not readily accessible and there are a limited number of social service staff, researching service information is not considered a high priority. As a result, residents in these facilities do not receive appropriate information. FOCIS is one of the mechanisms that is designed to assist recipients to prevent admission or discharge from a nursing facility. Consumers are often unaware of this service unless informed by the nursing facility staff. Facility staff have a tendency to inform consumers they are referring for transition assistance, not those who have yet to be identified as candidates for transition. In

Southern Nevada, nursing facility discharge planners and advocacy providers sometimes perceive FOCIS as a referral service that assists nursing facility staff and consumers with information but does not provide hands-on assistance with the transition process.

During the diversion and transition process, program eligibility is important for coordinating community-based services. Due to staff turnover and the fact that the Welfare Division determines eligibility, Medicaid staff are sometimes not well trained on various eligibility issues. This puts the consumer at a disadvantage as they try to access complex Medicaid programs for home and community-based supports.

Investment

A statewide project of this nature would require a contractual arrangement with an independent entity. This entity would provide community resource specialists to be available for people in nursing facilities as they are identified through the assessment process as candidates for community long term supports and services.

As mentioned in Recommendation #3, the Texas Department of Human Services (DHS) implemented a project that provides relocation services to eligible nursing facility residents and increases community awareness for individuals with physical disabilities at risk of nursing facility placement. Through a request for proposal process, three Independent Living Centers (ILCs) were selected to operate five pilot sites. The ILCs not only provided transition specialists to assist CARS participants, but also disseminated information to individuals in the community regarding long-term care options. The ILC's also referred consumers to DHS for community care services. Nevada should consider a similar model to ensure that information is provided by an independent entity that has first hand experience in obtaining community supports.

10. Establish Contracts for Continuous Transition and Follow-Along Supports

Transition supports for people with many disabilities do not end when they leave the nursing facility. So far, the Nevada FOCIS program has been instrumental in assisting hundreds people with disabilities through identification, assessment and effective transition planning. The limited staffing resources of the FOCIS program, however, preclude their ability to provide the necessary face-to-face visits and follow-up to ensure that transition supports are effectively implemented.

Across the country, states have learned the hard lesson of inadequate transition follow-up. Living in the community does not guarantee quality services. What is written in a perfectly crafted transition plan does not always happen as planned. People with disabilities who have transitioned from nursing facilities to the community have reported many complications after their move that have resulted in serious negative consequences. These unexpected complications have occurred in areas that include pharmaceutical services, transportation, durable medical equipment, home modifications, personal assistance and psychiatric services. In some instances, there have been serious health and safety problems as a result of these complications. In other instances, the person needed to return to the nursing facility until the problematic issue was resolved.

As the possible consequences of inadequate follow-up up are serious, Nevada should place high priority on ensuring that resources are invested to prevent health and safety concerns or unnecessary re-institutionalization. A contract should be provided to an entity to work closely with FOCIS to monitor and document follow-up and full implementation of community transition plans. The specific costs of such an investment warrants further review as it may be possible to utilize Medicaid funds to fulfill this function as targeted case management or, alternatively, as a support broker function if the person is utilizing self-directed supports.

11. Initiate ongoing fiscal audit and analysis designed to evaluate cost comparisons between nursing facility and community living in Nevada

It is often stated that, in long term care, community services and supports are less costly than institutional services. Close examination of this issue supports this perception. A recent (February 2006) study of Delaware's long-term services system conducted by The Lewin Group projected that implementation of a shift from nursing facility services to community would save the state from $126 million to $207 million over a ten year period. These savings were projected even after deducting the investment costs of transition, outreach and information such as those incorporated in the recommendations above. The projections also concluded that the cost savings would enable Delaware to serve an additional 288 to 478 people with disabilities per year in the community.

The state of Indiana has developed the Quality Improvement Process (QIP). This was accomplished though a collaborative effort of people with disabilities, state officials, case managers, services providers and local agencies. QIP is a survey process that evaluates consumer choice, timeliness, respectfulness, consistency and task performance. After the initial phase of pilot testing, the survey process was expanded to become statewide. Data and feedback information from these surveys is used in a variety of ways, including provider evaluation reports, program enhancement, training and, in serious situations, provider investigations. Aggregate and summary data are also provided to state leadership for planning purposes.

Nevada is now at the threshold of a broad-based initiative to support community living as the preferred alternative over nursing facility living for many people with disabilities. An opportunity has presented itself for Nevada to demonstrate through empirical data how

community living is not only the preferred approach, but also is fiscally responsible. In executing a public policy of money-follows-the-person, it is important that Nevada establish its ability to track and analyze how resources are being rebalanced in order to permanently remove the institutional bias.

The investment in a financial review of funds would be minimal, as administrative supports are already in place. The legislature, however, should work with people with disabilities and other stakeholders to ensure that the review is designed and structured to be meaningful and comprehensive as well as useful for planning purposes.