



**Division of Long Term Care  
Sustainability Initiatives**

Pris Boroniec  
November 29, 2012

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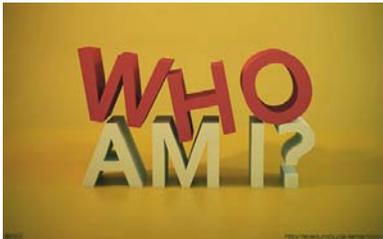
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**Introduction**



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**Agenda - LTC Initiatives**

- Falls prevention initiative in nursing homes
- Connections to community Living - NH residents interested in community placement
- Residential services initiative
- Managed care efficiencies
- Nursing home quality and performance improvement initiative
- Crisis intervention and stabilization
- Nursing home modernization initiative

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## NH Falls Prevention Initiative



A yellow triangular warning sign with a black border, depicting a black silhouette of a person falling backwards. The sign is centered on a white background within a larger rectangular frame.

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## Key Findings (The Burden of Falls in WI)

- Falls have surpassed motor vehicle crashes as the most common cause of injury related death
- A large majority of fall-related deaths (87%) and inpatient hospitalizations (70%) involve people age 65 or older.
- Hospitalizations and emergency department visits due to falls result in \$800 million in hospital charges each year in Wisconsin.
- Over 70% of the costs for fall-related hospitalizations and emergency department visits are paid by government insurance programs such as Medicare and Medicaid.
- The majority of falls that result in death occur in a person's home.
- Approximately 40% of those admitted to a nursing home had a fall in the 30 days prior to admission.

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## Fall prevention to ...

- Decrease hospitalizations
- Decrease staff time
- Increase independence
- Improve quality of life!!

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Division of Long Term Care  
Division of Quality Assurance  
Division of Public Health

**CHSRA**  
Center for Health Systems Research & Analysis

**METASTAR**

**LeadingAge**  
Wisconsin  
formerly WAHSA

**WHCA / WiCAL**  
Wisconsin Health Care Association Wisconsin Center for Assisted Living

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### NH Falls Prevention Project

- DHS Initiative – DLTC, DQA, DPH
- Collaboration with LeadingAge WI and WI Health Care Association
- Collaboration with CHSRA using CMP \$ funds
- Collaboration with MetaStar for training

Four yellow triangular warning signs with black borders, each depicting a stylized human figure falling from a different height and direction: top-left (falling from a ledge), top-right (falling from a height), bottom-left (falling from a height), and bottom-right (falling from a height).

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### NH Falls Prevention Project

- Find leaders within the provider community and those with background in fall prevention
- Study what's working
- Match what's working to those needing improvement

Four yellow triangular warning signs with black borders, each depicting a stylized human figure falling from a different height and direction: top-left (falling from a ledge), top-right (falling from a height), bottom-left (falling from a height), and bottom-right (falling from a height).

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## NH Falls Prevention Project

- Study the effectiveness
- Publish successful models
- Increase effective falls prevention across the provider communities
- Goal – decrease falls; decrease citations; decrease cost to system; improve Quality of Life!!



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## Connections to Community Living



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## Successful community living by:

- Integrating long-term services and supports with health care and housing;
- Building on full community participation for everyone.



Wisconsin's continued efforts to assure sustainable long term care program, to assure that people can remain safely at home, and to promote community connections.

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## Key events related to community living

- 2001 – President Bush New Freedom Initiative  
<http://www.hhs.gov/newfreedom/init.html>
- 2008 – Money Follows the Person (MFP)  
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>
- 2009 - President Obama “The Year of Community Living”  
[http://www.whitehouse.gov/the\\_press\\_office/President-Obama-Commemorates-Anniversary-of-Olmstead-and-Announces-New-Initiatives-to-Assist-Americans-with-Disabilities](http://www.whitehouse.gov/the_press_office/President-Obama-Commemorates-Anniversary-of-Olmstead-and-Announces-New-Initiatives-to-Assist-Americans-with-Disabilities)
- 2012 - Secretary Sebelius establishes the Administration for Community Living (ACL)  
<http://www.hhs.gov/news/press/2012pres/04/20120416a.html>

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## Connections to Community Living - Project Goals

- Ensure that individuals living in nursing homes are aware of the supports and options available to live in less restrictive settings in the community.
- Increase relocation of people residing in nursing homes to home and community based settings through:
  - *Diversion.* Provide early intervention to help people admitted for short term rehab avoid becoming long term residents.
  - *Relocation.* Assist people in Nursing Homes on a long-term basis who wish to relocate to a community setting.
- Reduce Medicaid expenditures by assisting individuals living in nursing homes to live in more cost-effective home and community based settings, where appropriate.
- Increase participation in the Money Follows the Person (MFP) demonstration and enable enhanced federal match claiming.

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## Strategies

- Articulate mission, goals and areas of mutual benefit.
- Outreach to stakeholders to inform them of the initiative and seek cooperation.
  - External stakeholder input group/meetings
    - Members and families
    - Nursing Home provider community;
    - Ombudsmen;
    - Managed Care Organizations (MCOs);
    - IRIS;
    - Aging and Disability Resource Center (ADRCs);
    - Hospitals; and
    - Home care and other community service providers.
- Develop informational materials geared toward people living in Nursing Homes and their families.
- Develop materials geared towards hospital discharge planners and Nursing Home staff.

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## Strategies

- Work with the Division of Quality Assurance (DQA) and facilities to increase appropriate referrals for possible relocation (based on responses to the MDS-Q).
  - DQA membership on DHS Steering Committee.
  - Define role for DQA in increasing referrals:
    - Survey process; and
    - Training and communication with providers.
  - Clarify role of NH admissions and discharge planning related to initiative.

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## Strategies

- **Deploy Community Living Specialists**
  - Target areas identified through data analysis. Cover 10 counties (primarily in East and Southeastern WI); based on concentrations of MA-funded Nursing Home residents.
  - Recruit five community living specialists beginning September 1, 2012. Full implementation expected by November 1, 2012.
  - Responsibilities include:
    - Outreach to people residing in Nursing Homes
    - Outreach to Nursing Home staff
    - Problem solve/overcome barriers and coordinate relocations for people.
    - Work with partners to ensure smooth/timely relocations.

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Areas with High # of NH Residents on Medicaid (non-DD)



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## Case Study



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## Residential Services Initiative



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## Residential Services Project Goals

- Ensure that people with long-term care needs are safe and cared for in their own homes and community settings as long as possible.
- Provide services in residential settings when it is the least restrictive, most integrated and cost-effective location to meet the person's needs.
- Provide further guidance for residential care as an allowable service within the Family Care benefit package.

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## Strategies

Vision  
All people - including people with disabilities and seniors - should be able to live at home with the supports they need and participate in communities that value their contributions.  
Integrated community is a core value, and is not a new direction for Wisconsin's long term care programs.

Communications – Outreach and Discussion with:

- Members and Families
- Providers
- ADRCs
- MCOs
- Advocates
- Other Stakeholders
- Division of Hearing and Appeals

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## Strategies

Update Messages about the role of Family Care related to long-term supports by:

- Focusing on living at home, with family or friends;
- Building on and strengthening community connections and support; and
- Developing program materials such as:
  - Options and Enrollment Counseling
  - Pre-admission information
  - Member Handbooks
  - Full Partner in Family Care brochure
  - Contract Language
  - Websites

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## Strategies

Program Guidelines and Best Practices

- Care management team guidelines for use with RAD;
- Placement and relocation specialists and expertise in MCOs;
- Use of technology to support independent living; and
- Support and enhance community connections and relationships.

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## Strategies

### Guidelines

- Strength-based assessments
- Independent living plans
- Identify and remediate challenges to living in one's own home
  - Clinical or health needs
  - Mental health
  - Functional
  - Cognitive
- Technology and other resources such as:
  - Medication administration devices
  - Home modifications
  - Remote monitoring

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## Opportunities

- Supportive Housing Model
- Residential model serving individuals with significant behavioral challenges or higher medical acuity



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## Paradigm Shift



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## What does this model look like?

- Terms – Permanent Supportive Housing; Consumer-controlled Housing; Community Supported Living
- Key characteristic - integrated permanent housing (typically rental apartments) linked with flexible community-based services that are available to people when they need them but are not required as a condition of occupancy. Philosophy that supports consumer choice and empowerment, rights and responsibilities, and appropriate, flexible, accessible, and available supports that meet each person’s changing needs.

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## Paradigm Shift in Supportive Housing

Residential Services Paradigm	Permanent Supportive Housing /Community Supportive Living Paradigm
Residential services and treatment setting (CBRF, AFH)	Home (single family house/apt)
Placement with some choice	Choice
Role as client, resident, patient	Role as tenant, citizen
Staff control	Consumer control
Grouping by disability	Social integration
Learning in transitional, preparatory settings	Learning in real life settings
Standardized levels of service	Individualized, flexible supports
Most facilitative environment	Least restrictive, most integrated

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## Residential Services “Plus” Model

- CBRF serving resident’s needing a ventilator
- Facility serving residents with bariatric services
- RCAC serving people with mental health challenges
- Adopting the Wisconsin Star Method
- Facility functioning as a Chapter 55 placement (WI Supreme Court Decision related to Helen E.F.)
- Other complex medical challenges
- Creating new or remodeled environments to better support these individuals

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### MC Efficiencies related to Residential Communities

- MCO/Residential Plan of Care/Care Coordination Practice Guidelines
  - Develop system for facility plan of care and MCO member centered plan to concurrently be reviewed, so member has “one” plan of care addressing his or her needs.
  - Care planning/conferencing occurs with member, guardian, and others that the member identifies as part of the team along with the MCO and the facility.

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### MC Efficiencies related to Residential Communities

- MCO/Residential Plan of Care/Care Coordination Practice Guidelines
  - As member agrees:
    - MCO staff to work closely with facility staff related to member needs;
    - MCO staff ensures that when visits occur at facility, staff is included in updates and visit progress; and
    - Facility receives copies of pertinent member assessment and member centered plan.
  - For members requiring risk plans, develop these together and ensure that all MCO and residential staff have shared understanding of the person's needs and the communication regarding changes.
  - When possible, MCOs will limit the number of IDT staff teams working with specific facilities.

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### MC Efficiencies related to Residential Communities

- MCO/Residential Quality Oversight
  - MCO has contractual requirements for member quality and provider quality oversight.
  - In 2013, areas will be identified that offer efficiencies and reduce duplication of certain areas of quality oversight. Through collaborative work with the MCO Provider Network Work Group, Care Management Work Group, DQA and assisted living provider community.

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### MC Efficiencies related to Residential Communities

- Role of NP/RN
  - Continue to explore the role of the Nurse Practitioner (especially in SNF).
  - Identify ways that the role of the RN can be less duplicative in settings where a RN is readily available.

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### Nursing Home Quality and Performance Improvement Initiative



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## Using data to improve quality

- Nursing homes are an integral and vital part of Wisconsin's long term care continuum .
- Nursing homes are now serving more complex and more acute residents.
- WI needs high quality nursing homes to meet the needs of some of WI most vulnerable citizens.

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## Strategy

- Define quality and determine how to measure it.
- Capture and analyze data.
- Create a Nursing Home quality performance measurement system.
- Define quality performance based on selected risk-adjusted clinical measures.
- Use CMP grant to fund the project.
- Work with CHSRA to design.



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## Crisis Intervention and Stabilization



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## Project Goal

- Improve the capacity of MCOs and community-based providers to support individuals with long term needs as well as complex mental health needs and challenging behaviors.

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## Strategy

- Develop the capacity for comprehensive community crisis response.
- Increase capacity and expertise of MCOs to develop and maintain effective behavior support plans and stable community settings.
- Develop resources to support relocation planning from institutional to community based settings.
- Explore partnering with the Waisman Center for Excellence in Developmental Disabilities to provide training and technical assistance to Family Care, IRIS and Partnership staff, and to provide assistance with relocation teams.

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## Nursing Facility Modernization



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## Strategy

- Average age of a nursing home building in WI is 33 years old.
- Improve resident outcomes by incentivizing new innovative construction and remodeling to aging physical plant nursing homes and increase occupancy.
- Collaboration with NH provider Community for creative ideas.

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## Innovative Construction

- Small scale living units with household identity;
- Peaceful atmosphere – Home-like;
- Private bedrooms and bathrooms;
- Inviting common areas;
- Freedom of movement and access to the outdoors;
- Personalized space-enhanced dining, bathing and activity programs;
- Opportunity for community and family involvement;
- Strengthened relationship between residents and staff;
- Incorporate aspects of “culture change” and “person centered care”; and
- Workspaces designed for efficiency.

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## Status of this Initiative

- 2008-2010 – 23 projects approved with almost half completed.
- Revising the incentives and process for the next approval phase.



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## Resources

### Division of Long Term Care

- <http://www.dhs.wisconsin.gov/aboutdhs/DLTC/>

### DLTC Sustainability

- <http://www.dhs.wisconsin.gov/lcreform/>

### Family Care

- <http://www.dhs.wisconsin.gov/lcare/>

### ADRCs

- <http://www.dhs.wisconsin.gov/lcare/adrc/professionals/index.htm>

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## Questions?



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