



## **Final Report**

# **Nursing Home Transition 2000 Grant**

*CMS Grant # 11-P-91191/3*

March 2004

P E N N S Y L V A N I A  
Intra-Governmental  
**COUNCIL ON LONG TERM CARE**

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## Final Report on Nursing Home Transition 2000 Grant Table of Contents

Introduction	3
Program Description	3
2000 Federal Grant	3
Purpose of Final Report	4
General Overview	4
Community Education and Outreach	5
Presentations about the Project	5
Referrals	6
Minimum Data Set Indicators	7
Individual Contact with Nursing Homes	8
Short-Term to Long-Term Stays	9
Public Relations Campaign	9
Best Practices for Outreach	9
Program Operations	10
Procedures	11
Lessons Learned about Home and Community Services	16
Common Barriers and Systems Reform Efforts	17
Lessons Learned about Housing	19
Common Barriers	19
System Reform Efforts	22
Waiver Amendments	22
Community Choice and Home Modification	23
2003 Systems Change Grants	23
HUD Project Access Voucher Program	23
Additional Lessons Learned	24
Future of Nursing Home Transition in PA	26
PATH Technical Support	26
Waiver Amendments	26
New State Initiative	27
Related Initiatives	27
Conclusion	27
List of Appendices	28
Appendices	29

# **Final Report on Nursing Home Transition 2000 Grant**

*CMS Grant # 11-P-91191/3*

## **Introduction**

The Pennsylvania Nursing Home Transition Grant 2000 was a collaborative effort of the Pennsylvania Intra-Governmental Council on Long-term Care. It began in April 2001 using state discretionary funds, and continued through September 2003 as a demonstration project funded by a Federal Centers for Medicare and Medicaid Services (CMS) grant. The project became known as Pennsylvania Transition to Home, or PATH, and it involved consumers, the Pennsylvania Departments of Aging, Public Welfare and Health, community-based service providers, nursing home associations, advocates, and other interested stakeholders.

The overarching goal of PATH was to assist people to transition from nursing homes into the community learn about perceived or real barriers that nursing home residents face when considering alternatives to living in a nursing home. It successfully strengthened the Commonwealth's overall efforts to expand and improve home and community-based options for both older Pennsylvanian's and Pennsylvanians with disabilities. As a demonstration, it operated initially in Dauphin, Cumberland, Lehigh and Schuylkill counties, and in January 2003, with the addition of state resources, it expanded to include Washington, Fayette, and Greene counties.

## **Program Description**

### ***2000 Federal Grant***

The Pennsylvania Departments of Aging, Public Welfare, and Health each played a role in the implementation and oversight of the PATH project, and all three state agencies closely monitored the operation and outcomes of the project through staff assigned to participate on the PATH Advisory Committee. Primary oversight responsibility was within the Department of Aging, under the supervision of the Executive Director of the Intra-governmental Council on Long-term Care. In November 2002, the Council issued a progress report on the PATH project, which detailed the initial start-up of the project, including staff orientation, nursing home outreach and consumer identification activities, and specific statistical information on what variables affected successful transition. A variety of issues related to lessons learned about barriers and their effect upon nursing home transition were covered as well. The progress report can be viewed on the Commonwealth website at:

<http://www.aging.state.pa.us/aging/lib/aging/FallProgressRpt.doc>

## ***Purpose of Final Report***

While the Progress Report was an interim report made available to the public via the Internet, it provided a valuable tool by which to educate the state officials as well as local providers, consumers and family members, and a variety of stakeholders interested in the progress of PATH. The final report will focus more generally on lessons learned by the PATH project, and what systems change activities have occurred as a result, in part, of the project. It will not however, provide the specific details contained in the preceding progress report.

## ***General Overview***

### **ADVISORY COMMITTEE**

This committee was formed at the initial stages of the grant, to provide feedback and advice on the implementation and progress of the project. The committee consisted of the Departments of Health, Public Welfare, and Aging, and as well as a wide variety of other interested participants. Consumers were invited to participate, and several people who had lived in a nursing home were on the committee. As the project moved forward, and began moving people out of institutions, additional consumers were invited to join and provided valuable feedback to the committee. Other Advisory Committee participants included representatives from Centers for Independent Living, participating Area Agencies on Aging, the Pennsylvania Protection and Advocacy agency, PA Association of Non-profit Homes for the Aging, PA Health Care Association, and PA Association of County-affiliated Homes, the Developmental Disabilities Council, the Statewide Independent Living Council, provider groups, the Ombudsman, housing advocates, and other interested stakeholders.

### **STAFF**

During the first full year and a half, the project was staffed by 2 Transition Coordinators and one Project Director, and was increased to three Transition Coordinators at the beginning of 2003. All staff members were independent contractors. By the end of the CMS funded project, PATH was in seven of the Commonwealth's 67 counties: Cumberland, Dauphin, Fayette, Greene, Lehigh, Schuylkill, and Washington. Laptops and cell phones were critical to effective communication and efficiency. Voicemail and email were also useful tools as much of the staff work was accomplished in the field. The Transition Coordinators worked flexible hours, including weekends and evenings at times, to be able to meet with consumer and family needs.

From July 2001 to October 2003, the PATH project operated as a CMS funded project, and in October 2003, the Department of Aging took over responsibility for staffing and funding nursing home transitioning as a service provided by the Area Agency on Aging. Currently, two of the three Transition Coordinators are on contract with Area Agencies on Aging, while the third Transition Coordinator has become a staff member of the AAA. The Project Director continues to manage the project, working closely with Program Management of PA Department of Aging to transform nursing home transition into an AAA-based program. Throughout the project, the Executive Director of the Intra-governmental Council

on Long-term Care provided extensive technical support, including project oversight, committee facilitation, as well as coordination between departments and stakeholders. In addition, administrative support was provided by PDA staff.

### **DATA MANAGEMENT**

A customized Microsoft Access database was developed for the project, and used to track nursing home and community-based services information, as well as consumer contacts and records (see Appendix A for screenshots). The database was used for three important project functions:

- Administration: Staff maintained case records, contact records, nursing home information, and as well as for planning daily consumer visits.
- Supervision: The Project Director used the database to manage the program and supervise Transition Coordinators.
- Evaluation and reporting: The database was used to prepare reports for the Advisory Committee, the Intra-governmental Council on Long-term Care, and CMS.

The data management program was flexible and able to be revised and refined as needed, and fully secure via password protection. Initially the project was able to transfer files via email, but as the database became too large it was necessary to use a dedicated server and internet-based synchronization.

### **Community Education and Outreach**

PATH tested several consumer identification techniques, and determined that some were more effective than others. The techniques included outreach, referrals from a variety of sources, and the use of MDS data.

### **PRESENTATIONS ABOUT THE PROJECT**

The PATH staff presented to a number of statewide and local groups, describing PATH, nursing home transition in general, informing participants about the availability of community-based services and how people can move into the community. These presentations yielded new referrals, as well as clarifying the role of PATH. Formal presentations about PATH were made to:

- Schuylkill County Ombudsman Residents Council meeting
- Regional Council on Aging and state Council on Aging meetings
- Area Agency on Aging staff meetings in all seven counties
- Centers for Independent Living in all 7 counties
- Brain Injury Association of PA, as well as several local brain injury coalitions
- Schuylkill County Office of Senior Services County HCBS luncheon
- Cumberland County Quarterly NH/Hospital administration meeting
- Pottsville Hospital Warne Clinic CHAT program
- Intra-governmental Council on Long-term Care Quarterly meetings
- DPW Stakeholders Planning Team meetings
- Dauphin County MH/MR staff meeting

- DPW CSPPPD contractors meetings
- PA Statewide Independent Living Council quarterly meetings
- DPW staff: OMAP, OMHSAS, Bureau of LTC, Policy, and OSP
- Balancing Fellows project, a nationally recognized forum.
- The National Council on Independent Living, 2003 Annual meeting
- PDA Enrichment Conference
- PA DomCare providers annual meeting
- Nursing home and hospital social workers meetings
- MH/MR providers in several counties
- Resident/family meetings for Susquehanna Center closing
- Department of Health LTC state meeting
- Pennsylvania Culture Change Coalition conference
- Project Access Housing Conference
- PA Ombudsman meetings
- Housing Authorities and HUD Project Access Committee meetings

In addition to presentations about the project to the various entities within the state, the project had numerous inquiries about its experience. This includes providing information such as outreach materials and other collaterals, to data element questions. The PATH staff provided technical assistance to many states starting up their nursing home transition project, including Ohio, Oklahoma, North Carolina, Georgia, South Carolina, Alaska, and Nebraska.

**REFERRALS**

PATH Transition Coordinators began responding to referrals following 2 months of orientation and training, and for 22 months under the CMS funded project. Throughout the project, Transition Coordinators actively worked in the 82 nursing homes located in the seven counties, with the bulk of referrals coming from nursing home personnel in these facilities.

**Referral Sources**

Table 1

<b>Who makes referrals</b>	<b># received</b>	<b># transitioned</b>
Nursing facility staff	84	34
CIL Staff	4	2
Self-referral	7	4
Area Agency on Aging/Ombudsman	15	7
Public Housing Authority	2	1
Friend	2	0
Family	1	1
PA Protection & Advocacy	1	0
CSPPPD	2	2
Other	1	0
<b>TOTAL</b>	<b>119</b>	<b>51</b>

## Referrals and Outcomes by Year

Table 2

	Year 1	Year 2
Number of I&R cases	19	41
Number of referrals to PATH	74	45
Number of referrals resulting in transition	36	15
Number of referrals closed without transition	38	23
<i>Consumer died</i>	6	0
<i>Severe decline in health</i>	2	0
<i>Housing unavailable</i>	1	0
<i>Services nonexistent</i>	1	0
<i>OSP provider took over transition</i>	2	3
<i>Consumer changed mind</i>	14	6
<i>"Transfer to community not appropriate"</i>	0	1
<i>"Transition and service plan failed"</i>	1	0
Number of cases that are still active	0	7

*Year 1 refers to the period prior to October 1, 2002. Year 2 is the period between October 1, 2002 and September 30, 2003.*

## Referrals and Outcomes by Consumer Age

Table 3

Description	Total Number
<b>Total referrals</b>	119
• 60 and over	72
• Under 60	47
<b>Total transitioned</b>	51
• 60 and over	24
• Under 60	27
<b>Unable/unwilling to transition</b>	61
• 60 and over	41
• Under 60	20
<i>Note: 7 referrals are still active (being processed) and are therefore counted neither in the "total transitioned" group nor in the "unable/unwilling to transition" group.</i>	

Although PATH received fewer referrals for actual PATH consumers the second year, it received far more Information and Referral calls. As coordinators worked closely with facilities, they educated social workers and other professionals. As a result, rather than simply refer a consumer to PATH, many social workers actively planned a discharge and involved PATH only for specific barriers such as housing or home modifications. Moreover, many of the second year referrals closed without a transition were in the newly added counties of Washington, Fayette, and Greene. As facilities in those areas become more accustomed to working with PATH and transitioning consumers, a smaller proportion of the referrals from there should close without transitions.

### MINIMUM DATA SET INDICATORS

PATH staff worked with DPW and PDA data analysts to develop a program using the Minimum Data Set (MDS), to identify individuals who are in nursing homes

that could move back into the community. The following data elements were selected for the analysis.

- Occupational Therapy Days
- Short-term memory
- Age
- Payment Source
- Expressed a desire to Return to Community
- Has a support person for discharge

A Data Use Agreement (DUA) from CMS was required to be able to use MDS. Once this was approved, the program allowed the analysts to produce a list of individuals in the counties, including consumer name and facility. The data run was more than six months old, and did not yield significant results for identification. The Commonwealth is currently exploring ways to obtain more current data from MDS. The question “Expressed a desire to return to community” should be considered the primary element requested in any future MDS use for identification.

### **INDIVIDUAL CONTACT WITH NURSING HOMES**

Individual contact with people living in nursing homes and nursing home staff proved to be one of the most effective means of identifying people who wished to move into the community. In those facilities where social work staff identified PATH as an asset to the people who live in the nursing home, Transition Coordinators were contacted frequently for both information and referrals. There were some nursing homes in the seven counties, which were not interested in referring people to PATH, and chose not to participate. PATH staff, however, contacted the facility when appropriate, to market nursing home transition—visit consumers, provide brochures or the poster, drop off the newsletter, meet with new staff or drop by and visit the administrator.

By the end of the project, it became clear that a handful of nursing facilities were willing participants in the project. Those facilities not interested in PATH involvement informed transition coordinators that the people who entered their nursing facility needed 24 hour care and would not be returning to the community. It was necessary to implement other means of identifying people in those facilities who wished to leave these facilities, and creative outreach strategies were developed. For example, staff involved a nursing home association to work with its members, requested Center for Independent Living staff to assist, or recruited support from ombudsman.

The outreach efforts to nursing homes have yielded several significant results:

1. The Transition Coordinators have developed a positive working relationship with the social workers responsible for discharge planning, in some of the facilities.
2. The Transition Coordinators understand and adhere to the individual nursing home visitation policies, and other policies related to discharge.
3. Referrals by nursing home staff were the most frequent source of consumer identification.

## **SHORT-TERM TO LONG-TERM STAYS**

While PATH did not originally target people who were assessed for a Medicare short-term stay, it has been identified as an activity the Commonwealth's Departments of Aging and Public Welfare are interested in pursuing more aggressively. During the last 9 months of the PATH grant, Transition Coordinators worked more closely with the Assessment units at the AAAs to assure that all people who have been assessed for a short-term nursing home placement are provided with information about home and community based services, and receive a follow-up visit from a Transition Coordinator to assure that the person has access to an advocate if necessary. Letters explaining the Transition Coordinators' role with regards to people assessed for short term placement were sent to nursing homes in the seven counties, from the Office of Medical Assistance, which is responsible for payment, and the Department of Health, which is responsible for licensing.

### **Length of NF Stay for Transitioned Consumers**

Table 4

Average length of NF	18 months*
Median length of NF	11 mo. 8 days

*\*A few PATH consumers had NF stays of several years, one of 18 years. Removing the 18 year stay lowers the average to 15 months 7 days.*

## **PUBLIC RELATIONS CAMPAIGN**

A number of collaterals were developed in the public relations campaign. These have been effective in getting the word out to people and their families. A logo was created, brochures with inserts explaining specifics of available home and community based services, business cards for all staff, and a poster. The poster is being used in health facilities such as clinics and hospitals, doctors' offices, and those nursing homes that are willing to display the poster. In addition, they were made available to the community service providers, including home-health agencies, AAAs, and CILs in the seven county regions. Materials were printed to assist with statewide expansion of the program. See Appendix I for more information.

## **BEST PRACTICES FOR OUTREACH**

PATH Transition Coordinators report that the best method of outreach is in-person contact on a regular basis. This involves frequent visits to nursing homes, dropping in on consumers and staff, and follow up by telephone and e-mail. While the PR materials provide information to hand out, regular, frequent visits to nursing homes and home and community-based services agencies are necessary to keep the concept of transitioning in the forefront of the minds of consumers and families, as well as nursing home staff.

PATH also found that large group presentations in the community are excellent methods for getting the word out about the concept. Nursing homes and long-term care have traditionally been considered synonymous, and the PATH project has worked to shift the paradigm, to help consumers, family members, medical professionals, and consumers think of other options in long-term care and services. These types of presentations generate new referrals, but also work

towards a better understanding by the general public of the role of home and community based services and the availability of nursing home transitioning. Word of mouth also generates referrals, and increases the incidence of information & referral calls.

## **Program Operations**

The PATH Project was fully operational by the end of the first year of the CMS grant. The Commonwealth applied for and received authorization from CMS to extend the project into a second and third year of operations, with no additional federal funding. These no-cost extensions allowed the program to become fully operational and fulfill the goals it had set out to achieve in the proposal to CMS. The Commonwealth's Departments of Aging and Public Welfare supplemented the project with state funding to assure the continued operation of the project during the final year.

The original target population included both younger people with disabilities and older Pennsylvanians living in nursing homes. During the 22 months of the project while two Transition Coordinators (note: an additional TC added during the last nine months of the project) were actively working with consumers, 51 people were transitioned from nursing homes. Other outcomes included the development of procedures to effectively support consumers moving out of nursing homes, design of forms to use when transitioning people, establishment of several financial mechanisms including a transition account with a funding requisition process to efficiently support moving out of institutions, and participation by PATH staff in a variety of the Commonwealth's systems change efforts.

At the beginning of the second full year of operations, the Commonwealth Departments of Welfare (DPW) and Aging (PDA), and the Advisory Committee, recommended a shift in the target population. For the remainder of the project, it was decided the focus would be to develop nursing home transition as a service for people sixty and over, and coordinated through the Area Agencies on Aging. The justification was that several Waivers operated by DPW office of Social Programs (OSP) were already working to transition younger people with disabilities, and an appropriation of state dollars to add nursing home transition as a service to the Independence Waiver, created an opportunity for the DPW programs to focus on younger people. However, younger people continued to be referred to PATH staff. After an initial visit to the consumer, they would be referred onto the DPW programs, or if the person did not fit neatly into the DPW Waiver, PATH continued to work with them.

## Basic Characteristics—Transitioned Consumers

Table 5

Description	%
<b>All</b>	N=51
<b>Percent female</b>	55% (N=28)
<b>Age</b>	
<ul style="list-style-type: none"> <li>• Percent age 60 and over</li> </ul>	47% (N=24)
<ul style="list-style-type: none"> <li>• Mean age=58.1 years</li> </ul>	
<b>Family Involvement</b>	
<ul style="list-style-type: none"> <li>• Percent with family member involvement</li> </ul>	47% (N=24)
<b>Medicaid Status in Nursing Home</b>	
<ul style="list-style-type: none"> <li>• Percent Medicaid Eligible</li> </ul>	71% (N=36)
<b>Type of Disability*</b>	
<ul style="list-style-type: none"> <li>• Mobility</li> </ul>	69% (N=35)
<ul style="list-style-type: none"> <li>• Sensory</li> </ul>	2% (N=1)
<ul style="list-style-type: none"> <li>• Other physical</li> </ul>	18% (N=9)
<ul style="list-style-type: none"> <li>• Cognitive</li> </ul>	8% (N=4)
<ul style="list-style-type: none"> <li>• Mental health</li> </ul>	10% (N=5)
<ul style="list-style-type: none"> <li>• None</li> </ul>	8% (N=4)
<i>*Note that a consumer can have more than one type of disability</i>	

### **Procedures**

The guidelines and procedures, which were developed and tested in the PATH Project, were reviewed at bi-monthly Advisory Committee meetings. They evolved as needed over the course of the project. The following is a description of those guidelines and procedures, which were significant to the success of the project.

#### **PROCESS WITHIN EXISTING SYSTEM**

One key element of the PATH Project is that it was not intended to replace any of the Commonwealth's existing service delivery programs. The intent was to have home and community based services system respond to and support people who live in institutions who wish to leave, and assist people with moving out of institutions. In an effort to educate the existing service delivery system about how PATH would work within their service delivery process, a flow chart was developed and used in speaking with service providers during an initial series of community meetings in the counties in which PATH would operate.

The Flow Chart (see Appendix B) explained that the Transition Coordinator would be the primary contact with individuals identified as potential candidates, and once the consumer indicated that they indeed were interested in and wanted to work on moving out, the primary contact role switched to service or care

manager in the appropriate service delivery system. In practice, the PATH Transition Coordinators remained extremely involved in the process, particularly in the area of locating appropriate housing, and setting up the household. As PATH staff became more integrated into the Area Agency on Aging (AAA) in the counties in which they operated, the AAA's developed, in conjunction with PATH staff, local procedures that were appropriate for the local agency structure. Appendix C is an example of a local procedure implemented to assure effective communication.

While PATH did not replace any existing systems or services, transitions required significant coordination to ensure that the needed services started at the needed time. Often matching up a service start date with a move-in date on an apartment took a great deal of effort. Table 6 shows the community services that PATH consumers who successfully transitioned needed.

### Community Services Needed—Transitioned Consumers

Table 6

Services Needed*	% Of Consumers
Attendant Care Waiver	16% (N=8)
Independence Waiver	14% (N=7)
OBRA Waiver	6% (N=3)
PDA Waiver	20% (N=10)
Para Transit	6% (N=3)
Ambulance Transport	2% (N=1)
Shared Ride	6% (N=3)
Public transit	55% (N=28)
Community MH	2% (N=1)
VNA	2% (N=1)
Home Health Care	8% (N=4)
Personal Care Assistance	4% (N=2)
PA Family Caregiver Program	2% (N=1)
Meals on Wheels	4% (N=2)
Food stamps	2% (N=1)
Rental Assistance	25% (N=13)
Subsidized Housing	69% (N=35)
LHEEP (utility bill subsidy)	2% (N=1)
Skills training	6% (N=3)
DPW Cash Assistance	4% (N=2)
MOW	4% (N=2)
Medical Assistance	4% (N=2)
Pharmacy Delivery	2% (N=1)
Case management	8% (N=4)
Advocacy	4% (N=2)
None	6% (N=5)

- *Services are not mutually exclusive*

## TRANSITION FUNDING

Transition funds were available to PATH consumers who needed help with transitional costs. Initially, all funding requests were processed through United Disabilities Services, the fiscal agency for PATH. Quickly into the program, however, it became apparent that billing UDS and waiting up to 30 days for payment was causing a delay and adding another obstacle to transitions. Consumers were not always able to wait the month to pay some expenses; for example, security deposits on apartments had to be paid as quickly as possible or the apartment would be lost. In addition, most consumers did not have personal funds available to cover their expenses until UDS could reimburse them and many items needed to be purchased at stores that could not bill UDS. Table 3 illustrates number of transition expenses by category, and the total cost. For a detailed breakdown of these expenses, see Appendix D. Categories include:

- a) **Invoiced:** These expenses could be billed by a provider, and paid in sufficient time by administrative entity.
- b) **Immediate pay:** These expenses required payment at the time of purchase or service.
- c) **Promise of payment:** These are expenses that a provider can submit an invoice for but which needed immediate payment. E.g. Security deposit.

### Total Expenditures by Category

Table 7

Category	# Times Needed	Total Expenditure
Invoiced	44	\$43,557
Immediate pay	47	\$9,679
Promise of payment	75	\$26,255

Payment issues were addressed by setting up a checking account that the project director could access for funding requests that could not be billed or could not wait the billing period. The transitional funds needed to be flexible and easily accessible, and several alternative methods were implemented:

- a) Purchased gift cards to local department or grocery stores, allowing consumers to obtain needed household items quickly without handling cash funds;
- b) Set up accounts at several local businesses and consumers were able to make purchases against that account and PATH was billed;
- c) Project director gave transition coordinators a check (signed and made out to the appropriate business) that they could fill in with the actual amount at the time of purchase. *This was done after the coordinators had received an estimate from the business and submitted that estimate for funding.*

- d) To ensure that costs were as minimal as possible but still provide consumers with everything they needed, spending guidelines were developed (see Appendix D).

### **CASE REVIEW**

With PATH expansion, successful and unsuccessful transitions, and an increasing number of referrals, the need for a case review process was identified. A subcommittee of the Advisory Committee was assigned the task of developing both the standards for this process and any forms or written material that would be necessary. The case review process was finalized. Appendix E shows the materials generated to introduce a consumer to the review process.

### **SHORT TERM ASSESSMENTS**

In reviewing all PATH consumer referrals on the database, it was noted that a number of individuals had originally been short-term admissions but found themselves having to convert to long term because they had not received any assistance with transitioning to the community within the first six months of their stay at the nursing home. As a result, these consumers lost their community infrastructure, including monthly income, housing and/or community based service connections. Once a consumer had lost such community supports it became difficult and time consuming to put everything back in place again. Several months were added to a transition plan if housing and services needed to be set up whereas it would have taken less time if the supports had not been lost in the first place. The PATH Transition Coordinators reported this trend to the PATH Advisory Committee.

During the final phase of the project, Transition Coordinators were asked by the Departments of Aging and Public Welfare to explore whether or not a system was in place, at each PATH county AAA, to provide consumers assessed as short-term stays, with information on HCBS and/or advocacy to achieve an eventual return to community living. The goal of following short-term admissions is to get the information out to people, begin transition efforts before they lose supports (housing, income, services) and enable the transition process to be as seamless as possible.

PATH determined that the local Area Agencies on Aging (AAA), responsible for pre-admission assessment, have a system in place to provide consumers or their families with information on HCBS at the time of the initial nursing home placement assessment. Transition Coordinators work with assessment staff at the AAAs to determine who may benefit from a follow up visit exploring community service options. The role of the PATH Transition Coordinators, with these consumers, is to act as an information and advocacy safety net and to coordinate a seamless transition to community living before essential supports are lost. A general procedure form was developed by one of the demonstration AAAs (see Appendix F). The other AAAs then used the procedure as a model and modified the procedure to fit their office process.

Nursing home social workers and administrators who have a good working relationship with the PATH Transition Coordinators understand the purpose of following short – term admissions and are fully cooperating with this activity. Other nursing homes remain ambiguous about their commitment to assisting individuals with transition to the community. As discussed earlier in this report, letters from the Office of Medical Assistance and the Department of Health, explaining the role of the Transition Coordinators with people who are assessed for short-term placement were sent to nursing homes in the seven PATH counties. The purpose of the letters is to provide official written support, from the entities that are responsible for nursing home payment and licensing, for the Short – Term Stay initiative.

**INTAKE AND REFERRAL**

Once the project got underway, transition coordinators began receiving calls from professionals, family members, and consumers with questions on specific issues about transitions. These calls did not result in new PATH consumers, because PATH assistance was not needed beyond a question on a specific issue. PATH coordinators also received several queries from professionals in adjacent counties and were able to guide them through the transition process. As the project progressed, these calls became more numerous and often were from social workers local to PATH who were planning transitions and asking PATH to assist them only when they did not know how to overcome an obstacle.

**Time Spent on Information and Referral Contacts**

Table 8

Average time spent on an I&R call	33 mins.
Median time spent on an I&R call	27.5 mins
Total number of recorded I&R calls	83

*This table reflects only the time spent after PATH began tracking I&R calls in a separate section of the database, late in the first year of the project. Prior to this, I&R contacts were tracked with PATH consumers and the time per contact is measured differently.*

**FORMS**

Throughout the duration of the project, the main forms used by coordinators were modified several times. The forms that were used for the PATH project fall into three general categories: staff forms, consumer forms, and miscellaneous PATH forms. See Appendix G for copies of these forms.

**STAFF FORMS**

- *Transition coordinator funding forms* were used to pay for coordinator costs, such as trainings.
- *Time sheets* were used to record coordinator hours from week to week.

### CONSUMER FORMS

- *Intake forms* were used to collect consumer information during the first meeting with a coordinator.
- *Releases of information* were used to protect consumer confidentiality.
- *Consumer visit forms* were used to document visits with consumers and develop concise lists of any follow up action needed.
- *Short-term visit forms* were used to document visits with consumers who were assessed for short-term stays.
- *Household items checklists* were used to make sure each consumer had everything they needed in their home.
- *Transition checklists* were used to ensure that every aspect of a transition was appropriately taken care of.
- *Consumer funding forms* were used to request transitional funding for consumers.

### MISCELLANEOUS FORMS

- *Photo release forms* were used to get permission to use consumer photos in PR material.
- *Requests for a case review and descriptions of a case review request* were developed to start the case review process for consumers.

## **Lessons learned about Home & Community Services**

The PATH project did not replace programs but rather worked within the existing structures, because Pennsylvania already had an extensive HCBS system. Transition coordinators helped consumers connect to the services they needed and facilitated the move from institutional living to community living. In the Commonwealth, HCB services are provided through waivers, state-funded programs available through the Department of Aging, or local programs that serve a specific population. The HCBS programs for consumers who are 60 years old or older are available through local Area Agencies on Aging. For these consumers, the available services are offered through programs that use a consumer's functional level to partially determine eligibility, with pre-admission assessment being a hallmark of the effort to support people in the community.

The HCBS system for younger consumers with physical disabilities is administered by DPW Office of Social Programs, delivered at the county level by local providers. These programs use functional level, type of disability, and financial indicators to determine eligibility.

Consumers who fit neatly into the categories defined in each of the waivers have an extensive support network available to them through the program offices. However, those with multiple disabilities, particularly those with mental health or other cognitive disabilities, may have a difficult time accessing services, which

prevents a smooth transition from a nursing home. Common barriers were identified by PATH.

## **COMMON BARRIERS & SYSTEM REFORM EFFORTS**

Barriers were identified through the course of the project, and a number of system reform efforts were implemented as a result, in part, of the PATH experience. These include efforts to address cost limitations, non-existent or lack of transition services in waiver, communication difficulties, slow intake process and follow through by facilities, and waiting lists. Table 9 below lists the numbers of PATH consumers experiencing these barriers.

### **COSTS HIGHER THAN WAIVER LIMITS**

Several consumers needed care plans that would have cost more than the limits set under the waiver program they qualified for. The PDA Waiver currently has an individual cap that can be covered for each consumer. If someone needs a service plan that would cost slightly more than this individual cap, they are asked to private pay if they can afford it, or denied if they cannot. Several other waivers run by the Commonwealth operate with an aggregate cap that allows some consumers to have more expensive care plans as long as they are balanced out by less costly consumers and the overall average expenditure per consumer does not exceed their limit. PDA is in the process of examining this option, and amend the PDA Waiver to include an aggregate cap in the future. PDA and DPW are in the process of amending the PDA Waiver to utilize an aggregate cap.

### **SERVICES DO NOT EXIST**

Many consumers experienced difficulties finding services because they were too high functioning, had multiple disabilities, or did not fit into the waiver programs available to them. If a consumer is under 60 and can do their own personal care, they are forced to rely on local or county service options since no statewide programs currently exist. These smaller programs vary widely in their availability and usually have a long waiting list associated with them. Consumers who have a dual diagnosis or a disability that is not served by one of the waiver programs experience delays in obtaining services. Availability of HCBS to these consumers is dependent upon several factors including: provider willingness and creativity, consumer persistence, and appeals processes leading to obtaining a waiver. Systems reform efforts include adding nursing home transition to the waivers, as well as variety of consumer advisory committee recommendations around expanding availability of services.

### **WAITING LISTS**

Several PATH consumers have been placed on a waiting list for service programs. Others have had to wait because attendants could not be found in their area. At least two consumers discontinued their involvement with PATH or changed their original transition plan due to waiting lists. Efforts to expand HCBS programs will be ongoing through the Commonwealth budgeting and procurement process.

#### DIFFICULTIES OBTAINING AN INCOME

Some consumers did not have an income when PATH first became involved; typically, this was the case in younger consumers who had been working prior to institutionalization and were used to relying on employment income. In many cases, they wished to remain in the facility, where Medicaid covers most of their daily costs, rather than go back to the community. Other consumers, however, did wish to continue with a transition back to the community. In these instances, PATH transition coordinators assisted consumers with the necessary paperwork to apply for an income. Several consumers have also had to delay their transition while they appealed a decision that affected their financial situation. In either case, these individuals have few choices: wait for an SSI or SSD approval while in the facility, go on cash assistance short term (while waiting for SSI or SSD approval), or rely on informal supports to provide them with the financial resources they will need in the community. Although not the best solution, some consumers did transition before they were approved for an income. They found subsidized buildings that would allow free rent if they had no income, obtained food stamps, and had family and friends willing to help out with their finances.

#### SPECIALIZED EQUIPMENT

Delays in obtaining specialized equipment have caused consumers' transitions to be prolonged. PATH transition funding supported several purchases of this equipment, in order to assure a safe discharge in some cases, and in other cases to supplement with equipment not available through Medical Assistance (e.g. specialized lifts.)

#### COMMUNICATION DELAYS

Difficulties contacting the assessor or care manager could delay consumers needlessly. However, the PATH program has worked with local AAAs to integrate PATH into the AAA system. In the southwestern area, the transition coordinator became an employee, rather than a sub-contractor, of that AAA. By integrating the PATH project even further into the existing HCBS system, many of these difficulties have been resolved since transition coordinators are now seeing assessors and care managers on a regular basis. DPW has also addressed this issue for their consumers under age 60; by incorporating nursing facility transitions into their own HCBS system they have also ensured that the professionals handling those transitions are working within a provider agency. The number of communication barriers was reduced from 4 in the first year to 0 in the second year of the project.

#### SLOW INTAKE PROCESS

Delays in the waiver intake were commonplace and could occur at numerous times during the process. During the last few months of the PATH project, the Commonwealth, under the leadership of the Office of Health Care Reform, undertook a significant effort to eliminate barriers and enhance access to HCBS. It began in October 2003 as a pilot in the southwestern part of the state, using the PATH participating counties, in part because of the PATH experience and presence there. Known as Community Choice, this program calls for services to start within 72 hours of a consumer's initial contact to the provider agency. It expanded to the Philadelphia area in January 2004 and is expected to go statewide around July 2004. Although Community Choice is only offered for

certain waivers, is has been a change that has helped many consumers and can help even more in the future.

**SLOW FOLLOW THROUGH BY FACILITIES**

Some nursing facilities were slow to provide paperwork or follow through that they had said they would do. Several PATH consumers waited months for an MA51 form to be sent out to their local AAA. As part of the Community Choice program, this form will become optional and a simple prescription will suffice instead. Although this won't help every consumer in every situation, by reducing the paperwork that a facility needs to complete for a transition, Pennsylvania has eliminated this delay for some people.

**HCBS Barriers**

Table 9

<b>Barrier</b>	<b>Number of transitioned consumers affected</b>
Costs higher than waiver limits	5
Services do not exist	9
Waiting lists	5
Difficulties obtaining an income	3
Specialized equipment	5
Communication delays	4
Slow intake process	24
Slow follow up by facilities	7

**Lessons learned about Housing**

As PATH consumers prepared themselves for moving into the community, they discovered that applying for, locating and securing affordable and accessible housing was a challenge. The need for housing often added several months to the transition process due to housing barriers. PATH consumers encountered numerous housing barriers that can be placed into four primary categories: Local Housing Authority/HUD Programs and Processes, Security Deposits and Rent, Home Modifications, and Consumer Issues. Table 11 below provides number of consumers and the type of housing barrier they experiences. Each category is described in more detail.

**COMMON BARRIERS**

**HOUSING AUTHORITY/HUD PROGRAMS AND PROCESSES**

The overall lack of affordable and accessible housing was identified the foremost problem faced by consumers needing an apartment. In several of the counties included in the PATH demonstration project, there were waiting lists (some more than a year long) for accessible units. Also, some housing authorities refused to provide a listing of their individual Section 8 landlords (other than the large

apartment buildings), therefore making it difficult for a consumer to search for accessible units and limiting consumer choice.

### Housing for Transitioned Consumers

Table 10

<b>Consumer Housing and Informal Support Status</b>	<b>% Of Consumers</b>
<b>Housing Situation before Transition</b>	
Percent who already had housing	46% (N=23)
<b>Housing Type after Transition</b>	
Apartment	78% (N=40)
House	20% (N=10)
Group housing	2% (N=1)
<b>Need for Accessible Housing</b>	
Percent who needed accessible housing	69% (N=35)
<b>Informal Caregiver Availability</b>	
Percent who live with spouse or other adult	33% (N=17)
Percent who live alone--informal caregiver visits	31% (N=16)
Percent living alone & lack an informal caregiver	35% (N=18)

In Pennsylvania there is no statewide coordinating housing entity to promote the exchange of information between local housing authorities or to provide effective outreach to consumers, regarding general housing issues, reasonable accommodation and accessibility. PATH Transition Coordinators found that housing authorities and consumers generally were not aware that reasonable accommodations on such things as the rent payment standard were an option. Once the housing authorities were given some information, they made the change to accommodate the individual consumer's income level and make the apartment affordable.

#### SECURITY DEPOSITS AND RENT

Funding for security deposits and rent was a common barrier experienced by PATH consumers. Of the fifty-one consumers who transitioned, exactly 50% of them needed assistance with rent. Twenty-one consumers also needed funding for security deposits. Rent and security deposits were paid by PATH in order to hold an apartment for a consumer while waiting for one or more of the following: approval of waiver services, completion of home modifications, Section 8 income verification and criminal background checks. PATH was only able to identify a few programs, which would pay for security deposits and/or rent. (e.g. Salvation Army and Shining Light, and local county rental assistance programs) Such resources are not advertised and they may be difficult to obtain. Funding from PATH was the only funding option available to resolve this issue. Without it, many of the PATH consumers would not have been able to transition to the community.

## HOME MODIFICATIONS

Some PATH consumers needed home modifications in order to return to either their own home or to a subsidized apartment. Types of home modifications included ramps, stair glides, grab bars, accessible showers, and wider doorways. All of the barriers associated with home modifications had to do with funding issues. A brief description of each is listed below.

Lack of presumptive eligibility in the waiver programs was the primary barrier to getting home modifications approved and completed before a consumer returned home. The Pennsylvania Department of Welfare does not reimburse the HCBS waiver providers for any home modification expenses until the consumer has moved into the community. If home modification funding is provided and the consumer does not transition to home, the service provider is not reimbursed by DPW. Therefore, some service providers are unwilling assume the financial risk of presumptive eligibility. Advocacy from both the consumer(s) and the PATH Transition Coordinator(s) was necessary in order to convince individual service providers to consider presumptive eligibility and pay to have modifications completed before the consumer transitioned.

Non-waiver eligible consumers were left with very little options. There were quite a few PATH consumers who either did not need personal care services provided through a waiver or who were marginally over the financial qualification limits but still required home modifications to be able to live independently. If an individual was not a waiver consumer, they were left with very few or no funding options for home modification projects. PATH transition funds filled this system gap.

A few of the home modification projects were extensive and the costs were too high for one single funding source. The consumer transition process was delayed (for up to six months) while funding sources were pieced together and construction was completed. For example, the Transition coordinator pieced together funding from PATH, the PDA Caregiver Support program, and the Lowe's Heroes Program, a program at a home improvement store to, facilitate a very extensive bathroom and bedroom alteration.

HUD home modification resources were limited and difficult to obtain. HUD programs offering funding assistance excluded most PATH consumers because of qualifications such as home ownership and/or having to be a family unit with a child. Furthermore, the Department of Community and Economic Development (DCED) Access grant program, which would have been an excellent resource for PATH consumers, had long waiting lists in each PATH County. Additionally, each county that had the DCED Access grant money distributed the funds in a different method. Finding out where and how to apply for the funding was frustrating and tedious. PATH consumers were not able to utilize any HUD funding for home modification projects.

## CONSUMER ISSUES

Several consumers had bad credit histories that could not be eliminated in order to obtain Section 8 or Public Housing. Other consumers had poor credit, in some

cases due to their disability. Advocacy and counseling with the consumer was necessary to clear up credit problems and enable housing to be obtained.

A few consumers had criminal backgrounds that prohibited them from applying for any type of subsidized housing. Some of them managed to find private landlords who did not check backgrounds. These consumers had to private pay for the entire rent, since they couldn't get any rental subsidy. Just finding a low cost apartment that they could afford became a barrier for those people who were not able to get a subsidy. The extent of the criminal background check is at the discretion of each local housing authority. Some agencies will only look to their local records while others check local, state, and federal records. Consumers moving into another housing authority's jurisdiction often face the added delay of waiting for an extended criminal check. If they have lived in other states, it can take as long as six to ten weeks for a clean criminal background to be returned; if they do have a record, that time period is even longer.

Some individuals did not have the adequate information or documentation necessary to complete a housing application. In most instances it took at least a month and sometimes longer, for the consumer to obtain these items before the housing application could be submitted or reviewed.

### **Housing Barriers**

Table 11

<b>Barrier</b>	<b>Number of transitioned consumers affected</b>
Lack of housing	13
No statewide HA	2
Security deposits/rent	29
Lack of presumptive eligibility in waiver	2
Limited funding for non waiver	6
Costs exceed limits for one source	3
Limited HUD programs	1
Bad credit	7
Criminal background	3
Lack of documentation	9

## **SYSTEM REFORM EFFORTS**

### **WAIVER AMENDMENTS**

At this time Pennsylvania is in the process of amending waivers to include community transition service funding. Both the Office of Social Programs and the Department of Aging have MA waivers that will be amended. Transition service funding could include security deposits that are required to obtain a lease on an apartment or home.

#### COMMUNITY CHOICE & HOME MODIFICATION

In January 2003, newly elected Governor Rendell established the Governor's Office of Health Care Reform (OHCR). As part of the OHCR Community Choice demonstration, and in response to consumer input, one of the activities this office has undertaken is working to determine how home modification barriers can be overcome. During this process, a collaborative relationship encouraging the exchange of information between housing entities, such as the PA Housing Finance Agency and the Department of Community and Economic Development and waiver and service providers from DPW, Aging, Vocational Rehabilitation, and Assistive Technology, is being fostered. The goal is to enable necessary home modifications to occur in a timely manner in conjunction with the prompt approval time line provided to consumers by the Community Choice Program.

#### 2003 SYSTEMS CHANGE GRANTS

The Commonwealth of Pennsylvania received three CMS funded Real Choice Systems Change grants in late September 2003. These grant projects shall include significant housing components that will address issues such as presumptive eligibility for home modifications, rental assistance, landlord education, and more.

#### HUD PROJECT ACCESS VOUCHER PROGRAM

Pennsylvania received 50 Project Access vouchers from The U.S. Department of Housing and Urban Development (HUD). The voucher program was designed to assist non-elderly persons, age 62 or younger, with a disability, to transition from a nursing home to the community. While the HUD program was intended to support nursing home transition, it was not a good fit in a state that was targeting older people, as was the case for Pennsylvania. Since the Project Access vouchers were to be used only by nursing home consumers who wished to transition to the community, individuals were provided with an expedited means of obtaining a housing voucher in counties that had lengthy waiting lists for Section 8 vouchers. PATH staff spent a great deal of time working with a Pennsylvania Project Access Housing Voucher coalition to implement the program and assure that these vouchers would be available to any PATH consumers who could use them. Many meetings, dialogues with local housing authorities, memorandums of understanding, etc were necessary to implement the program. Fifteen PATH consumers have benefited from receiving a Project Access voucher. Other consumers qualified for this type of voucher, but due to other delays found alternative housing subsidies that offered a quicker housing solution in their situation. Table 12 shows the PATH activity with the HUD Project Access Voucher Program.

## HUD Project Access Housing Voucher Project

Table 12

<b>PATH consumers &amp; Project Access</b>	
Approved	23
Denied	7
Pending when PATH case closed	6
Total	36
<b>PATH consumers approved for Project Access</b>	
Leased up and used their voucher*	15
Will not use	4
Transition still pending	4
Total	23

*\*Due to other housing authorities absorbing these vouchers or couples moving in together, this number does not reflect the total number of Project Access vouchers used but rather the total number of PATH consumers to use them.*

Finally, the PATH staff learned numerous lessons as they were assisting consumers with overcoming barriers to housing. PATH staff has actively pursued continuing education on housing trends and initiatives by regularly, attending collaborative project meetings as well as conferences and presentations by housing entities. It will be critical, as the Commonwealth expand availability of nursing home transition to other counties, to include the lessons learned in both housing and HCBS.

### **Additional lessons learned**

#### LACK OF FACILITY SUPPORT

A lack of facility support has continued to be a concern and delay for consumers. The PATH staff had no authority, which compounded the problem and was addressed by various means including letters from Departments of Health and Public Welfare. Transition coordinators and others involved in nursing home transition frequently educate facilities about the concept and availability of HCBS and other independent living options, staff in some facilities did not cooperate with transitions they were involved with. It became clear that PATH staff could not rely on these facilities to make referrals. This uncooperativeness included:

1. Processing paperwork. Some facilities simply did not do their tasks for a transition in a timely manner,
2. Withholding information, particularly if the facility staff felt that it was an unsafe or inappropriate discharge.
3. Lack of clear understanding or confidence in HCBS system
4. Open hostility or aggressiveness. Most of these unsupportive situations were caused by one or two professionals, rather than entire staff. In one case, PATH transitions went smoothly with some staff, but not others.

### LACK OF CONSUMER FOLLOW THROUGH

Consumers who did not follow through with things they agreed to do could delay their own transitions. Both the PATH transition coordinators and other people involved offered consumers the assistance they needed, and ensured that they understood their responsibilities, yet some consumers simply were unwilling and in some cases unable to follow through. This barrier was effectively addressed using services of a Center for Independent Living, which was able to provide independent living skills training and peer support.

### FAMILY CONCERNS

Many consumers had families with objections or who were hesitant about a move back to the community. Although in most cases, these concerns were easily dealt with, family fears caused many delays as Transition Coordinators and other social service staff tried to educate family members about the HCBS options available. PATH and several other programs have increased their PR efforts and tried to reach more family members before they need services. Also, transition coordinators have begun working with consumers assessed as a short-term nursing home stay; as part of these meetings, Transition Coordinators are reaching out to educate family members as well.

### LACK OF KNOWLEDGE ABOUT HCBS SYSTEM

Many family members, consumers, and professionals simply do not know about Pennsylvania's HCBS system, nor are they aware of how to access it. By reaching out to more consumers (through short term visits and other increased efforts) and by continually educating social workers, PATH and other agencies have enabled more consumers to bypass the confusion and misdirection that early transitions experienced.

### CONSUMER CONCERNS

Consumer fear will always be an obstacle to transitions, and any person trying to help someone back into the community needs to be sensitive to these fears. However, with increased outreach and successful PATH consumers who have gone back and become peer counselors for other consumers, this delay has also been minimized. Peer counseling may be the most effective method to address this issue, and peer counseling efforts by centers for independent living have had significant results with certain PATH consumers.

### Other Barriers

Table 13

<b>Barrier</b>	<b># transitioned</b>
Family concerns	6
Lack of knowledge about HCBS system	12
Consumer concerns	4
Lack of facility support	6
Lack of consumer follow through	6

## **Future of Nursing Home Transition in PA**

The CMS funded nursing home transition grant enabled the Commonwealth of Pennsylvania to test the effectiveness of two models of nursing home transition: a model which utilized nursing home transition coordinators in a flexible, cross-systems/cross age approach, and a second model in which the transition coordinator became part of the AAA service delivery system. The demonstration found that unless the transition coordinator was a part of a system, the role was sometimes viewed as adversarial to the existing service providers. During the course of the demonstration, the state Office of Social Programs, which manages 4 critical HCBS Waivers that support primarily younger people wishing to return to or remain in the community, was able to secure state funding to provide nursing home transition service to people who participated in the Independence Waiver. At that time, the PATH project was instructed by the DPW Policy Office to serve the over 60 population only, as the OSP programs would be serving younger people. However, developing two separate programs to transition people based on age is not ideal, and the PATH project staff and Advisory Committee recommend that these activities be coordinated between departments, for people of all ages.

The CMS grant supported the Commonwealth's efforts to identify existing gaps in service, and barriers to receiving service. The Commonwealth is committed to expanding options for Pennsylvanians with disabilities and older Pennsylvanians. The PATH project provided state officials with information about what works in the system, gaps or barriers to receiving services, and it demonstrated that nursing home transition is an essential component to a comprehensive home and community –based services system. A number of new initiatives are, in part, due to the groundwork laid by the PATH project demonstration. These include a plan to apply to CMS for several Waiver amendments to expand and include NHT as a service, a new initiative in the Governor's budget for 2004-05 to add nursing home transition to the services delivered through Department of Aging programs, and inclusion of a nursing home transition component to the Community Choice demonstration programs occurring in the Southwestern PA counties (Washington, Fayette, and Greene) and in Philadelphia.

***PATH Technical Support*** The PDA will retain the PATH staff, including PATH Project Director and three Transition Coordinators, for a minimum of nine months to continue to operate the project in the seven counties, and to assist with planning and technical support. The goal is to expand the capacity so that nursing home transition is available at all AAAs across the Commonwealth.

***Waiver Amendments*** The Commonwealth developed a plan, including a template to be used across the waivers, to submit amendments to several of the eleven waivers. PATH staff was involved in developing the language, which will be included in amendments to the PDA, Independence, Attendant Care, COMMCARE, and OBRA Waivers. The amendments would expand these waivers to include nursing home transition services as allowable waiver services. In addition, an aggregate cap will be sought for the PDA Waiver.

***New State Initiative*** The PA Department of Aging plans to continue the existing demonstration counties, and then expand nursing home transition to additional Area Agencies on Aging, ultimately making this available statewide. Funds will be secured to continue and expand the nursing home transition capacity in the Commonwealth.

## Related initiatives:

***Community Choice*** In August 2003, the Governor's Office of Health Care Reform, in collaboration with the Departments of Health, Public Welfare, and Aging initiated a demonstration project called Community Choice. The purpose is to remove the barriers to access to home and community based services, enabling Pennsylvanians with disabilities, regardless of age, to be seen by HCBS providers within 24 hours and to receive services in their homes as quickly as within 72 hours, based on urgency of need. Three critical components of this demonstration are presumptive eligibility, consumer self-declaration of income information, and a shortened assessment. The initial demonstration site, the three county region of Washington, Fayette, and Greene counties, was chosen in part due to the PATH project experience there. It was expanded to Philadelphia County in January of 2004. The AAA in Philadelphia will receive technical support from PATH staff.

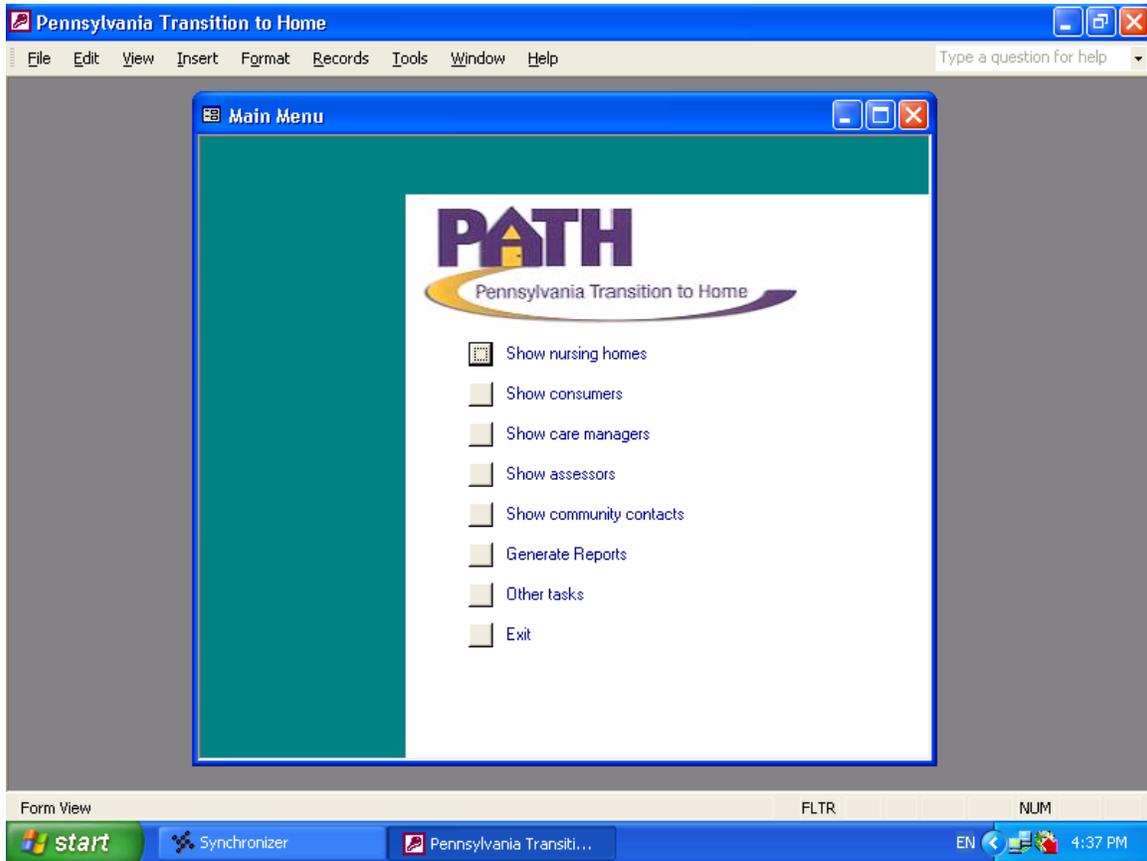
***2003 CMS Grants*** The Commonwealth applied for five 2003 Real Choice Systems Change grants and was awarded three of the five grants: Money Follows the Person, Quality Assurance/ Quality Improvement, and Aging and Disability Resource Center. All three of these grants consider nursing home transition as a part of the HCBS continuum. These grants will be used, along with the lessons learned in nursing home transition, to test out a multitude of initiatives and result in enduring systems change.

## **Conclusion**

The Commonwealth of Pennsylvania thanks the many stakeholders, participants, and dedicated staff that contributed to the success of the 2000 Nursing Home Transition Grant, known as the PATH Project. The Commonwealth would also like to thank CMS for the grant, which enabled the state to test and experiment with a variety of systems change efforts. The grant support has provided the Commonwealth with an opportunity, which has resulted in enduring systems change. Nursing home transition will now be a part of the HCBS system in Pennsylvania.

## ***List of Appendices***

- a) Screenshots from PATH database
- b) Flow Chart
- c) Procedure checklist/guidelines (for Schuylkill)
- d) Spending guidelines
- e) CRC handouts
- f) Short term procedures (SWPAAAA)
- g) Forms
- h) Large barrier chart
- i) Brochure and poster



**Pennsylvania Transition to Home**

File Edit View Insert Format Records Tools Window Help

Type a question for help

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**Consumers**

**PATH** *Consumers* **Action needed:** Help

TC: [ ]

**Basic Information**

Guardian: [ ] Show guardian Case status: [ ]

DoB [ ] Current status: [ ]

Nursing home: [ ] Show nursing home info

Initial transition information

**Milestones** Barriers

First contact date: [ ]

Decision date: [ ]

Date sent to assessor: [ ] New assessor

Assessor [ ] Show assessor

Date assessment completed: [ ]

Date sent to care manager: [ ] New care manager

Care manager: [ ] Show care manager

Date care plan approved: [ ]

Date implemented: [ ]

Date consumer moved into the community: [ ]

Housing: [ ] [ ] [ ] Update

Uses MAHCBS: [ ] If yes, type of waiver: [ ]

Community services used: [ ]

Entities involved: [ ]

Was a family member involved: [ ]

Show notes Funds Allocation

**Contacts** Show details

Date	Type	With
▶		

Record: [ ] of 1

**Notes/comments**

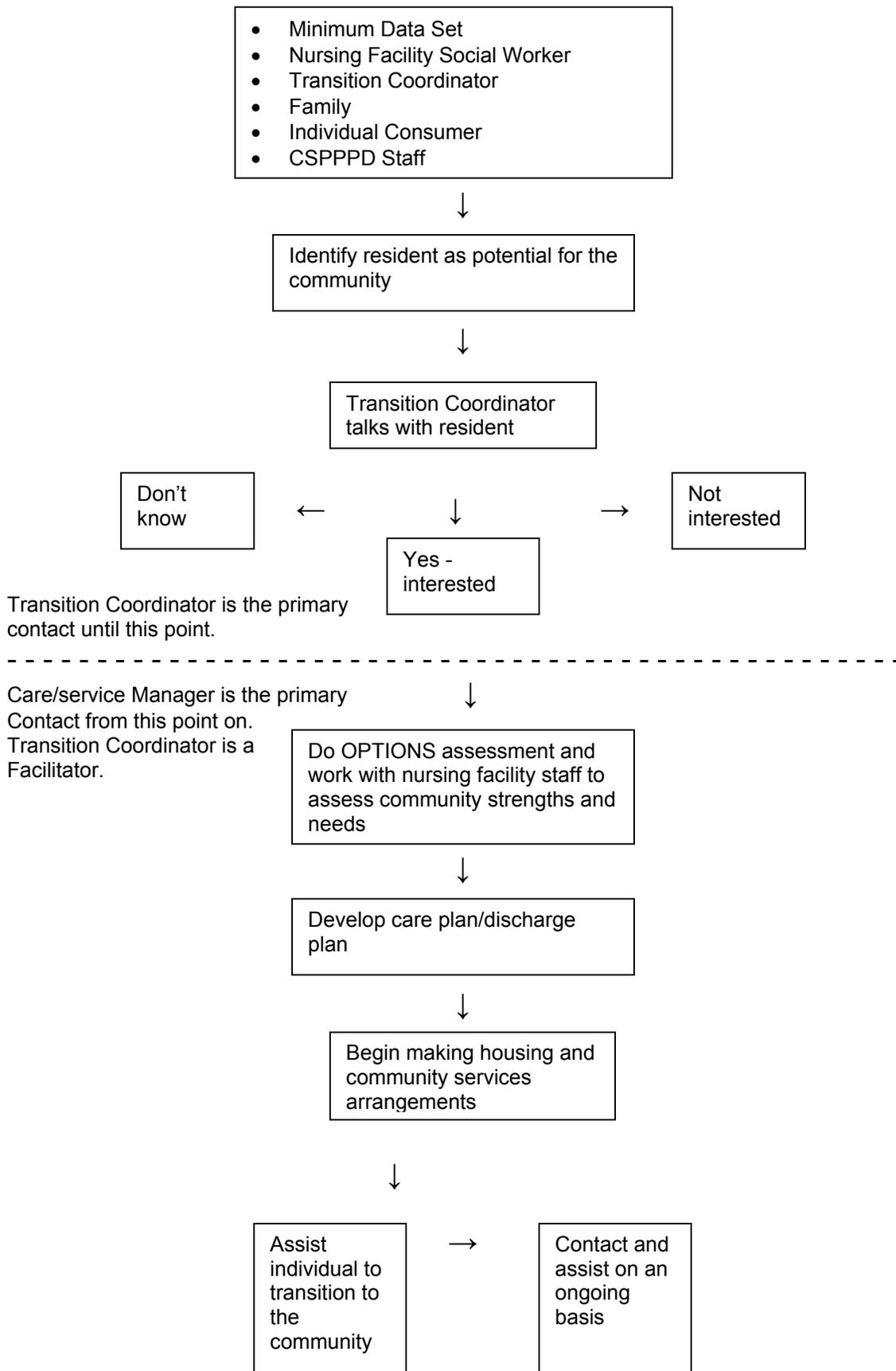
[ ]

Record: [ ] of 144

Form View

NUM

## Pennsylvania Transition to Home Process



## ***PATH Consumer Checklist***

**Consumer:**

<b>Checklist Item</b>	<b>Date Completed</b>
Referral to PATH	
First Contact by PATH Transition Coordinator	
Decision to become a PATH consumer	
Referral to I & R Department by PATH ( <i>within one week of decision date</i> )	
Assessment by Office of Senior Services	
Assigned to Case Manager	
First Care Conference ( <i>consumer, family, nursing home staff, etc</i> )	
Home Evaluation ( <i>joint visit by Case Manager and PATH</i> )	
Care Plan Approved	
Visit with Consumer ( <i>one week prior to discharge date</i> )	
Consumer moved to community	
Case Manager visit to consumer	
Care Plan implemented	

**PATH Transition Coordinator:**

**Office of Senior Services Care Manager:**

### **Consumer Expenditures by Category**

<b>Invoiced</b> (These expenses were billed by a provider and enough time was allowed for payment through normal funding streams)		
<i>Expenditure for</i>	<i>Number of times needed</i>	<i>Total Expenditure</i>
Home modifications including ramps and lifts	19	\$40,053
Assistive equipment	10	\$2,794
OT evaluations	2	\$127
Utility bills	13	\$583
<b>Total</b>	<b>44</b>	<b>\$43,557</b>
<b>Immediate Pay</b> (These expenses required payment at the time of purchase or service)		
<i>Expenditure for</i>	<i>Number of times needed</i>	<i>Total Expenditure</i>
Furniture	18	\$5,204
Household goods	19	\$3,535
Groceries	9	\$899
Transportation	1	\$41
<b>Total</b>	<b>47</b>	<b>\$9,679</b>
<b>Promise of Pay</b> (These are expenses that providers can submit an invoice for but which needed payment quicker than regular funding streams allowed)		
<i>Expenditure for</i>	<i>Number of times needed</i>	<i>Total Expenditure</i>
Rent and security deposits	68	\$25,945
Apartment application fees	4	\$130
Moving expenses	3	\$180
<b>Total</b>	<b>75</b>	<b>\$26,255</b>

\*Number of times needed represents each time PATH provided funding; individual consumers may have needed funding for the same category more than one time.

**PATH Spending Guidelines List**

PRODUCT	COST	SUGGESTIONS & COMMENTS
<b>KITCHEN</b>		
Pots and Pans *	\$30	* these items can be purchased as part of an 83 piece set at Walmart
Glasses *	X	<b><i>the entire set is \$30</i></b>
Mugs *	X	
Dishes *	X	
Bowls *	X	
Silverware *	X	
Cooking Utensils *	X	
Hot Pads/Oven Mitts	\$1	each
Dish Towels	\$1	
Dish Cloths	\$1	
Scrubbing Pad	\$1	
Dish Rack	\$5	
Trash Can	\$3	Should we up this to \$5? I haven't bought one in a long time
Microwave	\$40	
Coffee Maker	\$15	
Electric Can Opener	\$15	I'd lower this to \$10 and...
Toaster	\$8	raise this one to \$10
<b>DINING AREA</b>		
Table*	\$150	if consumer uses a wheel chair, make sure it will fit under the table
Chairs*	X	\$150 for a 5 piece set at most Walmarts/Kmarts, w/c's fit
<b>BEDROOM</b>		
Metal Bed Frame	\$10	at thrift store or free with mattress purchase
Mattress & Box Spring	\$600	
Sheets & Pillowcases *	\$12	*could buy in a complete bed set for \$40
Blanket / Quilt *	\$30	
Pillow	\$5	
Mattress Protector Pad	\$20	
Nightstand	\$40	
Lamp	\$10	
Hangers	\$1	13 pack
Mirror	\$10	
<b>LIVING ROOM</b>		
Sofa	\$150?	this assumes you can find one used; new, probably \$500 as a low cost
Coffee Table	\$50	Walmart/Kmart; usually can find this at a thrift store
Chair with arm rests	\$75	this would be a chair with cushion seating (not a wooden table chair)
Lamp	\$10	
Television	\$100	
TV Stand	\$150	Walmart/Kmart; usually can find this at a thrift store

### ***PATH Spending Guidelines List***

<b>PRODUCT</b>	<b>COST</b>	<b>SUGGESTIONS AND COMMENTS</b>
<b>BATHROOM</b>		
Bath Towels	\$5	each
Hand Towels	\$4	each
Washcloths	\$5	3 pack
Soap Holder	\$1	Dollar store
Toothbrush Holder	\$2	Dollar store
Toilet Brush	\$1	Dollar store
Laundry Basket	\$2	Dollar store
Trash Can	\$3	
Shower Curtain	\$10	or buy a liner for \$2; liners at Dollar Store
Shower Curtain Hooks	\$1	Dollar store
Night Light	\$1	Dollar store
Non-skid tub mat	\$3	Dollar store sells the stick on things, don't know about the mats though
<b>MISCELLANEOUS</b>		
Clock	\$10	
Portable Phone	\$15	convenient if consumer is not able to get to phone quickly
Regular Phone	\$10	
Vacuum	\$85	for Vacuum and a pack of bags
Blinds	\$5	each
Curtains	\$10	per set
<b>GROCERIES</b>		
Food	\$100	meals, condiments, juice, milk, snacks
Cleaning Supplies	\$20	laundry soap, dish detergent, liquid cleaner, paper towels, mop, etc.
Toiletries	\$20	personal care items, toilet paper, tissues
Other	\$10	trash bags, storage bags, plastic wrap, batteries, light bulbs
Total	\$1716	

The chart provides some spending guidelines and suggestions. Please note that consumers, along with the transition coordinator, should seek out donated or discounted items from family, friends and other community resources (Salvation Army, Goodwill, churches, AAA supplies, etc.) before making new purchases. *Price guidelines listed on the chart are for new items unless otherwise noted.*

Most consumers will not need to purchase everything on the chart. The total listed at the bottom is the maximum amount for household apartment set-up items. Consumers should be directly involved with the shopping and given the opportunity for choice and personal preferences. Some consumers may prefer to spend more than the suggested guideline on one item (ie: a TV) and less on others (ie: kitchen & bathroom items), thereby still shopping within the projected budget guidelines and limits.



DRAFT

Dear PATH Consumer,

We understand that you disagree with a PATH decision and are interested in a Case Review. This letter and the attached information will help you understand what you can expect and what you need to do to request a PATH Case Review.

When you disagree with a decision made by PATH, you may request a Case Review from your Transition Coordinator. Requesting a Case Review should only be done after you have tried other means of setting your disagreement with PATH. Upon receipt of this letter and the attached form, you will need to fill this form out, or have someone help you fill it out. You should then send your completed form to me to initiate the Case Review Process. Receipt of your request for a Case Review will be confirmed by a phone call, and all information you provide will remain confidential. Once I have received your form, please direct all questions about this to me rather than to your Transition Coordinator.

The Case Review process will take approximately four weeks to complete. When I receive your form, I will contact the members of the Case Review Committee and schedule a meeting within two weeks. I will also contact your Transition Coordinator. Following the Case Review Committee meeting, you will receive a written explanation of the Committee's recommendations.

The Committee may recommend a change, or recommend that the PATH decision was appropriate given the circumstances. Your Transition Coordinator will discuss the outcome of the Committee recommendations as well as taking further steps necessary. If you have any further questions, please feel free to contact me at (717) 335-3340.

Sincerely,

Jennifer Burnett  
PATH Project Director



## Questions and Answers about a Case Review

### **What can I do if I disagree with a PATH decision or action?**

- Have an open discussion with your Transition Coordinator about the status of your transition.
- You have the option to ask someone else to support you and participate in this discussion.
- During this discussion you will:
  - Review concerns
  - Identify barriers to transitioning
  - Seek a solution

### **If I still disagree with a PATH decision, what do I do next?**

Request a Case Review.

### **Should I include additional information?**

Additional information that helps to explain your viewpoint can be sent with your form. You can include such things as nursing home or medical records, letters, or any other paperwork you feel is important.

### **Can I have someone else help me fill out my form?**

Yes. Anyone can help you fill out your form.

### **Will my information be kept confidential?**

Yes. All information that identifies you will be removed before your case is reviewed.

### **What happens after the form is sent to the PATH Project Director?**

- The Case Review Committee will meet within three weeks of receiving your request.
- You will be notified in writing of the Case Review Committee's recommendations within one week of their meeting.
- The final recommendation may be a different course of action or the PATH decision may remain in place.

### **Who should I contact if I have more questions about the process?**

You should contact Jennifer Burnett, PATH Project Director (888-841-7673), if you have more questions about the Case Review process.

## **Tracking of Short Term Nursing Facility Determinations by PATH Transition Coordinator PROCEDURE**

The procedure for the Pennsylvania Transition To Home (PATH) Transition Coordinator to track and follow-up on all consumers determined, by the Southwestern Pennsylvania Area Agency on Aging (AAA) Assessment Unit, to need short term nursing facility care (under 6 months) is as follows:

1. The AAA Assessment Unit will mail a completed Short Term Nursing Facility Tracking Form to the PATH Transition Coordinator each Friday.
2. The Transition Coordinator will contact the nursing facility in which each consumer is located. During this contact the Transition Coordinator will inform the nursing facility of the referral from the AAA Assessment Unit. The Transition Coordinator will initiate the PATH intake procedure at this point.
3. The Transition Coordinator will make a follow-up visit to the consumer in the nursing facility after the receipt of the referral from the AAA Assessment Unit.
4. With the consumer's consent, the Transition Coordinator will contact the consumer's informal supports to inform them of the referral and the involvement of PATH.
5. The Transition Coordinator will complete the outcome section of the Tracking Form and mail it to the AAA Assessment Unit each Friday.
6. The Transition Coordinator will continue to monitor the consumer's progress in the nursing facility and assist in planning for potential discharge back into the community.



### Funding Request for Transition Coordinator Expenses

**Section 1** *(to be completed by the PATH TC)*

Transition Coordinator:

County:

Total Amount Requested:

Date Needed By:

Payable To: *(name of business or person, address, phone number)*

Send Check To: *(complete this if different than "payable to")*

Description of how dollars are being spent:  
*(For example: "conference registration fee" or "reimbursement for...")*

Date request submitted:

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**Section 2** *(to be completed by the financial department)*

Date Approved:

Date Check Dispersed:

Amount Expended:

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**Section 3** *(to be completed by the financial department after receiving receipts from PATH TC)*

\_\_\_\_\_ Receipts for expenditures received      Date: \_\_\_\_\_



**PATH Intake Form**

Name: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_

Date of First Contact: \_\_\_\_\_

\_\_\_\_\_

Date of Admission: \_\_\_\_\_

Phone: \_\_\_\_\_

County: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Facility: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

MA Eligible?    Yes    No

Address: \_\_\_\_\_

\_\_\_\_\_

Facility Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Reasons for entering nursing home

Self-report: \_\_\_\_\_

\_\_\_\_\_

Other Source: \_\_\_\_\_

\_\_\_\_\_

Current Health Status

Self-report: \_\_\_\_\_

\_\_\_\_\_

Other Source: \_\_\_\_\_

\_\_\_\_\_

Housing Needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Service Needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there informal supports who can take care of any of the above needs? Yes No

If Yes, explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PENNSYLVANIA TRANSITION TO HOME  
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL  
INFORMATION**

I, \_\_\_\_\_,  
authorize and consent to the release of any confidential information you may possess,  
regarding my medical and/or financial affairs, to the Pennsylvania PATH Program. I  
understand that this information will remain confidential. I understand that I may  
withdraw this consent, in writing, at any time.

**SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE**

\_\_\_\_\_

**DATE:** \_\_\_\_\_

**REASON CLIENT UNABLE TO SIGN:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF PATH PERSONNEL**

\_\_\_\_\_

**DATE:** \_\_\_\_\_

**PATH Consumer Visit Form**

Consumer: \_\_\_\_\_

Date: \_\_\_\_\_

Transition Coordinator: \_\_\_\_\_

Next Visit: \_\_\_\_\_

**Issues Discussed:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Follow – Up for Next Visit**

Consumer Will Do: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Coordinator Will Do: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Others Will Do (Specify who): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signatures of Attendees:**

Consumer: \_\_\_\_\_

Coordinator: \_\_\_\_\_

Others: \_\_\_\_\_

**PATH Short Term Visit Form**

Name: \_\_\_\_\_ Admission Date: \_\_\_\_\_  
 Facility: \_\_\_\_\_ Short Term Ending Date: \_\_\_\_\_  
 Room Number: \_\_\_\_\_ Age: \_\_\_\_\_  
 Social Worker: \_\_\_\_\_ Date of First Contact: \_\_\_\_\_

Reason for entering facility: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Desire or plan to return to the community? Yes No

If yes:  
 Estimated discharge date: \_\_\_\_\_  
 Any outside time constraints? \_\_\_\_\_  
 \_\_\_\_\_

Any community services received prior to admission? \_\_\_\_\_  
 \_\_\_\_\_

New services that would be needed in the community (including transition services): \_\_\_\_\_  
 \_\_\_\_\_

Family member or emergency contact information:  
 Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Other Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Transition Coordinator: \_\_\_\_\_  
 County: \_\_\_\_\_  
 Family follow up completed: \_\_\_\_\_  
 Consumer follow up needed: \_\_\_\_\_

**PATH Household Items Checklist**

**Kitchen**

- Pots and pans
  - Glasses
  - Mugs
  - Dishes
  - Bowls
  - Silverware
  - Cooking Utensils
  - Hot pads
  - Towels
  - Washcloths
  - Microwave
  - Toaster
  - Other appliances
- Specify: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Living Room**

- Sofa
  - Coffee table
  - Chair
  - Lamp
  - Other
- Specify: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Dining Room**

- Table
  - Chairs
  - Other
- Specify: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Bedroom**

- Bed
  - Dresser
  - Nightstand
  - Lamp
  - Sheets
  - Pillow
  - Blanket
  - Hangers
  - Other
- Specify: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Bathroom**

- Rugs
  - Bath towels
  - Hand towels
  - Washcloths
  - Soap holder
  - Toothbrush holder
  - Toilet brush
  - Hamper
  - Other
- Specify: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Miscellaneous**

- Other
- Specify: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Consumer Signature: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

**PATH Transition Planning Checklist****Consumer:** \_\_\_\_\_

<b>Need</b>	<b>Date Addressed</b>	<b>Date Completed</b>	<b>Need</b>	<b>Date Addressed</b>	<b>Date Completed</b>
<i>Health</i>			<i>Housing</i>		
Evaluations Needed for Discharge			Furniture or Household Items		
Adaptive Equipment			Utilities Turned On		
Insurance			Find a Home		
Community Doctors			Change of Address		
Community Pharmacy			Rental Assistance		
Medications at Discharge			Home Modifications		
Medical Supplies			Moving Items to New Home		
Community MA Activated					
<i>Daily Living</i>			<i>Finances</i>		
Personal Assistance			Determine Income		
Housework			Obtain Income		
Skills Training			Current Bills or Debts		
Mobility Assistance			Food Stamps		
Shopping			Bank Account		
Meal Preparation			Budgeting Training		
Start up Groceries					
Back Up Plans			<i>Transportation</i>		
Emergency Information			Home From Facility		
			Public Transportation		
			Accessible Transportation		
			Bus Schedules		

Note specific details on the consumer visit form as they are addressed.



Date :

**Request for Transitional Funding**

Name of PATH Consumer:

County:

Transition Coordinator:

Total Amount Requested:

Date Needed By:

Specific Breakdown of Request:

- Cash       Check      \$

To Be Paid to Consumer:       Yes     No

If no, payable to whom?

Approved \_\_\_\_\_

Disapproved \_\_\_\_\_

See Project Director \_\_\_\_\_

Date Check/Cash Disbursed: \_\_\_\_\_ Amount Expended \$ \_\_\_\_\_ Date: \_\_\_\_\_

For What Were Dollars Used: \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_



**PHOTO RELEASE FORM**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

- I understand and consent to videotaping and/or my photograph being used by Pennsylvania Transition to Home (PATH) for use in training and educational materials about community-based living and nursing home transition.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_





### ***Barriers Encountered for Transitioned Consumers***

<b><i>HCBS Barriers</i></b>	
<b>Barrier</b>	<b>Number of transitioned consumers affected</b>
Costs higher than waiver limits	5
Services do not exist	9
Waiting lists	5
Difficulties obtaining an income	3
Specialized equipment	5
Communication delays	4
Slow intake process	24
Slow follow up by facilities	7
<b><i>Miscellaneous Barriers</i></b>	
Lack of facility support	6
Lack of consumer follow through	6
Family concerns	6
Lack of knowledge about HCBS system	12
Consumer concerns	4
<b><i>Housing Barriers</i></b>	
Lack of housing	13
No statewide HA	2
Security deposits/rent	29
Presumptive Eligibility in waiver	2
Limited funding for non waiver	6
Costs exceed limits for one source	3
Limited HUD programs	1
Bad credit	7
Criminal background	3
Lack of documentation	9

PATH Brochure and poster

For copies of the PATH brochure and poster, please contact  
PA Department of Aging (717) 783-1550.

