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OLDER ADULTS COMMUNITY CONSORTIUM: PRELIMINARY FINDINGS AND RECOMMENDATIONS

Aging and Adult Services Division

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Legislative Report

Minnesota Department of **Human Services**

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INTRODUCTON

Minnesota Laws Chapter 338, Section 3, Subdivision 8 requires the Commissioner of the Department of Human Services (DHS) to provide a report of preliminary finding and recommendations on whether the Older Adults Community Consortium (Consortium) demonstration projects should be continued and whether the number of demonstration project sites increased. The report must include: (1) a comparison of the performance of demonstration sites relative to non-consortium communities on the quality measures specified in the statute; (2) an assessment of the extent to which the demonstration project can be successfully expanded to other parts of the state; (3) legislative changes necessary to improve the effectiveness of the demonstration project and to expand the projects to other parts of the state; and (4) any actions taken by the commissioner of health under the statute.

BACKGROUND

The Consortium framework was conceived in the fall of 2007 and was developed through the 2008 Legislative Session. It was intended to encourage projects that were large-scale, vertically and horizontally integrated and flexible as needed to meet local conditions. The involvement of the Minnesota Departments of Human Service (DHS), Health (MDH), Transportation (MnDOT), and the Housing Finance Agency (MHFA) in the development of the proposal indicated the breadth of the conceptual basis of the proposal.

These departments administer a number of grant programs intended to meet the challenge of the coming "Age Wave:"

- Community Service and Community Services Development (CS/SD) grants fund a variety of systems change projects that involve health care, community-based service and other long-term care providers.
- Nursing Facility Performance Improvement (NF PIPP) grants provide incentives for nursing facilities (NF) to change how they provide services within the facility and in their communities.
- Nursing Facility Moratorium Exception grants permit necessary capital improvements.
- MHFA provides financing incentives for subsidized housing projects.
- MnDOT administers grants to address the transportation needs of Older Minnesotans.

There have been efforts to coordinate these programs but they have been limited by a variety of statutory and administrative constraints.

The Long-Term Care Imperative, a collaborative of Aging Services of Minnesota and Care Providers of Minnesota, proposed to the Governor and the Legislature that a portion of these State grant programs, programs with similar ends but differing application processes, project requirements and timelines, be coordinated to make application simpler and to achieve project synergies. This would further the over-arching goal of increasing the supply of home and community-based services for Older Minnesotans and changing the long-term care system to better meet the challenges of increasing demand and finite resources. DHS and the other departments provided technical assistance in drafting the bill and to the selected Consortiums to ensure the success of the projects.

The funding sources for the Consortium projects were identified in the 2010/2011 Biennial budget. They were: 10% of NFPI grants, 10% of CS/SD grants, and 10% of Nursing Facility Moratorium Exception grants. Selected projects were also made eligible for a preference for MnDOT grants including Elderly Persons and Persons with Disabilities (5310), Job Access and Reverse Commute (JARC) and New Freedom, and for MDH Electronic Health grants.

The statute also gave the Commissioner of Health the authority to waive both rule and statute for consortium projects. The legislature made budget reductions during the 2009 session that reduced the amount of CS/SD grants and did not include funding for Moratorium Exceptions, but other than funding reductions, the intent of the 2008 Consortium legislation remained unchanged.

The Consortium grants were intended to rebalance Minnesota's long-term care supports and service delivery system in a more comprehensive way, increase its capacity to help people age 65and older stay in their own homes and communities and demonstrate the utility and replicability of each Consortium's approach. The grants are directed to programs that serve individuals 65 years of age or older who are at risk of nursing home placement and "spending down" to Medical Assistance.

Most older adults prefer to have the supports that they need to remain independent provided in their own homes. In most cases this is the best alternative in terms of cost, whether the supports are directly paid for by the consumer or their families or by other third-party payers. The State supports market-based solutions that increase consumer choice, promote least restrictive alternatives and minimize the impact of expensive service delivery options on publicly funded programs both in the short and long-term. System development that maximizes the use of safe and effective lower cost service options in consumers' own homes is vital[1].

The State has a broad role in providing care and services to older Minnesotans through Medical Assistance (Medicaid) and its waivers, the Alternative Care (AC) program and Group Residential Housing (GRH) program. In addition, the DHS Aging and Adult Services Division (AASD) work in partnership with the Minnesota Board on Aging (MBA) in administering programs funded by the Older Americans Act (OAA). The Consortium grant program explicitly added MDH and MnDOT grants that have been designated to serve older Minnesotans as additional potential resources.

Consortium projects were required to serve low and moderate-income persons by providing services through and paid by the Elderly Waiver, AC, other public programs as appropriate (for example, Older

[1] "Reshaping Long-Term Care" Final Report of the Minnesota Long-Term care Task Force, January 2001

Americans Act, Community Services Block Grant, Food Support, etc.) and using other sliding fees scales for persons who are not quite eligible for those programs.

Each Consortium project was also required to support families and other informal caregivers, strengthen the long-term care system, better coordinate with the health care system, integrate consumer services and maximize the use of limited funding resources. This work requires collaboration among long-term care stakeholders, the health care system and communities and re-imagining both relationships and services.

Changing the long-term care system also involves identifying state and federal policies that may be barriers to the creation and support of this re-imagined home and community-based service system. The Consortium grant program directed that policy barriers and a mechanism to resolve them, if possible, be identified.

PROCESS DESCRIPTION

DHS used the extended time between the formulation and legislation of the Consortium policy in 2007-2008 and selection of projects in 2009 to:

- Publicize the Consortium concepts to interested potential applicants and state policy staff not directly involved developing the statute;
- Solicit public comment on the development of the Request for Proposals (RFP) for projects that were broader in scope than previously attempted; and
- Provide sufficient time for the extensive preliminary work necessary to:
    - develop professional and financial relationships,
    - assemble the necessary expertise, and
    - develop and write a complex application.

DHS changed the typical RFP process at the recommendation of stakeholders to include an informational session about the legal requirements of RFPs, how those requirements shape the selection process and the specific requirements of the Consortium statute. It also provided external parties an opportunity to make suggestions about the content and timing of the RFP. These suggestions led to an extended, five month period between the publication of the RFP and the deadline for applications. It included a preliminary applicant conference that was held immediately after the initial publication of the RFP in November 2008 that provided an overview and explanation of this large, complex RFP. That was followed by a second applicant conference in March 2009 which provided additional clarification as groups prepared to complete applications. The RFP was written to require applicants to articulate what the goals, activities, and location of the project were, and how the applicant proposed to meet the legislatively mandated evaluation requirements. The RFP also required evidence of joint governance and concrete financial commitments from all partners.

The principal deliverable of each Consortium grant was a demonstration of the measurable impact of its activities in its chosen location compared to a similar location without Consortium-related activity. The measurement include persons served, individual outcomes, level of service access, service delivery including units of service, service coordination, customer satisfaction and measures related to the appropriate use of technology. Applicants could include additional measures as appropriate to the goals of its Consortium project.

Given the broad range of possible Consortium projects and locations, precise definition of the deliverables beyond these broad directives was the responsibility of the applicant. The aptness of the measures selected and their relation to the Consortium's activities, as well as the degree that these measures were quantifiable and comparable, was a central element of the Consortium RFP evaluation.

Each Responder was asked to:

1. Articulate the challenge or opportunity that the Consortium intended to address. This challenge needed to be tied to clearly identified, objective information. The challenge or opportunity needed to be directly related to the measures that will be used to demonstrate the impact of Consortium activities.
2. Describe the Consortium's activities. These activities needed to be relevant to the challenge or opportunity the Consortium intended to address and generate data to help measure the impact of the activities of the Consortium. The activities also should generate process measures which are important elements for understanding both the Consortium's demonstration and how structural or corporate relationships and changes to those relationships affect the ability of the Consortium's model to be replicated. The activities themselves and process measures are used as deliverables.
3. Describe both the outcome and the process measures used by the Consortium to measure the impact of its activities.

The responder was also required to demonstrate an understanding of how the activities could be measured and compared to a comparable non-consortium site, and how the Consortium functions and processes could be understood and reproduced. Applications were assessed based upon the Consortium's understanding of the measures it proposed and the relevance of those measures to its activities.

DHS contracted with an outside evaluator separately for an evaluation. The project evaluation was developed as part of a larger evaluation that includes other Reform Initiatives from the 2009 Legislative session including: NF PIPP strategies and evaluation of the Return to Community initiative. This deliverable was more completely defined through contract negotiations and was included as part of the on-going work of each grant.

RFP EVALUATION

Nine applications were received; two were non-responsive because they failed to meet the minimum requirements to be reviewed. No application adequately addressed the evaluation component of the RFP. That challenge developed from the necessity of intentionally writing an RFP that was not overly prescriptive so that the applicants had the ability to innovate. It was also a function of the challenge of designing both a project and its evaluation. And it was due, in part, to difficulty in articulating the goals of projects which made it more difficult to outline methods of measuring their impact.

The legislative evaluation requirements are being met by creating or modifying tools to capture information about participants and the goals of each project that have evolved in negotiations and initial implementation. Evaluators from the University of Minnesota and University of Indiana are assisting in more clearly articulating the projects' activities and measuring the impacts of the activities on participants and comparing those to similar non-project areas. The assessment will address the work of the consortia and their partnerships and the utilization, cost and clinical outcomes for participants.

The review committee recommended the selection of two applications to enter negotiations. They were:

- The Carondelet Village Consortium (CVC), principally a partnership between the Sisters of St. Joseph Carondelet-St. Paul Province and Presbyterian Homes and Services, and
- The Northern Consortium (NC), which now consists of Northern Pines Medical Center, Aurora; Virginia Regional Medical Center hospitals with nursing facilities, and two additional nursing

facilities - St. Raphael's Health and Rehabilitation Center, Eveleth and St. Michael's Health and Rehabilitation Center, Virginia-.

The two Consortiums had previously existing business relationships among their members and had been engaged in substantive discussions that involved significant joint capital commitments or combined operations. The grant provided an opportunity to expand both the range and scope of their previous work. Both Consortium groups were actively pursuing systems change initiatives in their areas and were motivated by clear strategic visions that correlated with the goals of the grant.

Both projects took considerably longer than anticipated to begin. The CVC contract was not completed until December 2009, five months after initial negotiations began. The NC contract was not completed until May 2010 and involved changes both in the lead partner and service area. In both cases, the challenges lay in the actual implementation of a complex project that involved financial integration and administrative reorganization.

Both projects participated in business process mapping exercises with DHS staff to help clarify project goals, define work processes and firm up timelines. Even with pre-existing working relationships and lengthy contract negotiations, the Consortiums needed additional time during initial implementation to develop a solid plan. The strengths of both Consortiums have been their abilities to constructively adjust to the almost continuous changes to Health Care and Long-term Care that have been occurring as uncontrolled external variables over the term of the project.

PROJECTS

CARONDELET VILLAGE CONSORTIUM

Carondelet Village Consortium (CVC) is a collaborative effort to serve individuals 65 years and older in the Highland Park, Macalester/Groveland, West 7th, Summit Hill, Summit University and Union Park neighborhoods of St. Paul (and the corresponding zip code areas). It will build and operate Carondelet Village in Highland Park. Carondelet Village includes a full continuum of care and services including market rate and subsidized senior housing, assisted living and memory care units, and a skilled nursing facility. It will open in November 2011. CVC will support seamless continuity of care through improved care coordination and promote meaningful engagement for older Twin Cities' residents by fostering connections and building on community social capital. To do this, CVC has entered into partnerships with Jewish Family Services, the Metropolitan Area Agency on Aging, Inc. and three Living at Home Network programs to offer expanded services to older adults in its target area.

The heart of the initiative is a holistic care management and coordination model that integrates long-term care and primary healthcare services in a better way improving outcomes associated with standard case management. Key aspects of the model include: earlier connection with and assessment of elders in the community; elder engagement for active community involvement, preventative health activities, and well-informed self-care; early and ongoing support by a nurse practitioner, improved medication management; use of the latest technology to assist with transportation, referrals, and the management of care records; and stronger collaboration between social services and health staff.

CVC has enrolled approximately 90 clients. Half of the participants are UCare enrollees whose residences are scattered across the Twin Cities Metro area. These clients are eligible for services under both Medicare and Medicaid (dual-eligible clients). The other clients were enrolled within the neighborhoods served by CCV (often self-referred).

Participants are evaluated using the Live Well at Home Rapid Screen© tool and level of need is determined based on ADL impairments and chronic conditions, psychosocial needs and professional judgment. Those identified as higher need (classified as Level II or Level III) receive more frequent routine contact, and those identified as lower risk (Level I) are contacted at least once each quarter.

The Rapid Screen and other assessments are used to match clients with the appropriate intervention including: chronic disease self-management and evidence-based health promotion classes, a social engagement program based on participant's strengths, access to volunteers, care transitions management and transportation review. Each client reviews his or her assessment and plan as part of the interdisciplinary team within 30 days to validate the level of need and to ensure appropriate assessments and interventions are in place. Clients are routinely reassessed to evaluate the efficacy of their plans and physical changes. CVC also coordinates an enrichment calendar of classes, programs and activities offered by partnering organizations.

CVC uses electronic tools to record and manage information about clients. They include Salesforce (inquiries, participants, volunteers), Practice Fusion (care coordination), and HomeMeds (medication management). The CVC partners use Revation Systems, Inc., LinkLive secure messaging technology, to ensure HIPAA compliant conference calling, chat and document exchange.

NORTHERN CONSORTIUM

The Northern Consortium (NC) includes Northern Pines Medical Center, Aurora and Virginia Regional Medical Center, two medical centers (both part of the Essentia system) and their associated NFs and two Benedictine Health System long-term care facilities -- St. Raphael's in Eveleth, MN, and St. Michael's in Virginia, MN. One element of the project is to set up a new organizational structure to combine the nursing facilities administratively. A second is to provide care coordination services to identified clients when discharged from one of the consortium facilities or those identified through the two medical centers' Health Care Homes. The Arrowhead Area Agency on Aging is an active participant providing technical assistance and training.

NC targets clients who are patients at the clinics' Health Care Home and live within a 25 mile radius of Virginia, Aurora and Eveleth. They must be 65 years or older and have one or more of the following conditions: depression, diabetes and hypertension. Targeted clients also have had an emergency room visit, hospitalization or nursing facility stay within the past three years.

Clients who meet the target criteria are invited to receive care coordination services. The care coordination helps clients remain in their homes and decrease emergency visits, hospital admissions and transfers to skilled nursing facilities. The consortium's care coordinators and Health Care Home RNs work in collaboration, doing a series of assessments beginning with the Live Well at Home Rapid Screen© tool, care planning and identifying services to assist clients remain at home. After the client's needs are assessed, the NC interdisciplinary care coordination/health care home team creates and implements individual care plans that use other organizations to provide home and community-based services including: meals, chores, transportation, education, transitional support and companionship. It also coordinates behavioral health services as needed and provides on-going monitoring and intervention

when necessary.

NC's tracking and assessment systems, in addition to the Rapid Screen, include the Health Care Home Complexity Tier tool and the Community Planning tool. Other tools available on Web Referral may also be used including the Brief Interview of Mental Status, Activities of Daily Living/Instrumental Activities of Daily Living and the Geriatric Depression Scale. The Health Care Home and Consortium coordinators use Essentia's Electronic Health Record (EHR), Epic, to track clients and exchange information. The NC partners use the secure Revation voice-over internet protocol tool for HIPAA-compliant conference calling, chat and document exchange. NC began inviting participants October 1, 2011 and is now serving 15 persons.

The NC partners are currently investigating further use of the Community Health Information Collaborative (C.H.I.C.), Epic, and MDI Achieve (the EHR used by NFs to improve care transition and information exchange between clinic, hospital, NF and home).

FINDINGS AND RECOMMENDATIONS

The statute requires a comparison of the performance of demonstration sites to non-consortium sites on the measures listed. CCV has been serving clients for nine months; NC has been serving clients for two months. The number of persons served to date is relatively small but growing. Assessing the projects' performance using their own internal metrics indicates positive results. However, there currently is insufficient information to compare their performance outcomes to non-consortium sites. Additional time providing services will provide more data and on-going work with the external evaluators will permit the comparative evaluation in the report due in November 2012.

The statute also requires an assessment of the extent to which the demonstration project can be successfully expanded to other parts of the state. The Consortium project has permitted CVC and NC to test practices and processes that align with other larger health care initiatives and to position them to take a leading role in these efforts. Both are actively engaged in the development of Health Care Homes as part of the Medicare Advanced Primary Care Practice demonstration which began October 1, 2011. They are well positioned to pursue better integrated, more comprehensive care coordination for a broader range of clients and more types of care transitions. Changes in Medicare reimbursement policy that create disincentives for avoidable hospital readmission have also led to the addition of new partners and to a larger pool of program participants. These projects are currently expanding by accretion. The ability to expand to more Consortiums is unclear not only because of current resource constraints, but also because of the preliminary nature of the results of NC and CVC.

The Commissioner of Health waived Minnesota Statutes 144A.073, subd. 3c, in February 2010 permitting Presbyterian Homes and Services to move 45 lay-away beds from two other projects to Carondelet Village to build the NF portion of the project (using the authority provided in the Consortium Statute). Neither project has requested additional waivers. As these projects explore better use of the EHR and other electronic tools across care settings and involve a broader range of partners, maintaining the ability for the Commissioner of Health to waive either rule or statute may be very beneficial.

The legislation directed that Consortium projects be given a preference for certain MnDOT and MDH grants. Coordinating the timing of and defining the preference for grants across Departments has been an on-going challenge because of the diffuse nature of the grant making process and perceived responsibility for the Consortium project. The work that both CVC and NC are doing to expand the use

of EHR and other electronic tools into home and community-based services has the potential to provide valuable opportunities to use the additional resources the statutory preference for grants might provide.

Because of the length of time it has taken to implement both projects, the legislative changes necessary to improve the effectiveness of the demonstration include extending the Consortium preference for MDH and MnDOT grants and an extension of the Commissioner of Health's ability to waive rule and statute.

In any future expansion of the Consortium legislation and for any similarly complex RFP, the use of a preliminary informational meeting before the publication of the RFP would be a helpful. In addition, having one applicant conference immediately after publication and a second applicant conference about six weeks before the application deadline is also a helpful practice. Allowing the entire process to take nearly nine months did not significantly improve the quality of the applications. However, more time should be budgeted for contract negotiations for these complex RFPs.

Both projects have collaborated willingly and constructively with DHS staff and their other partners. They have expanded the scope of their work to meet the significant changes in State and Federal Health Care Policy over the last three years. Because of the work of these partners and the Consortium grant, these projects are well-positioned to help demonstrate the use of Health Information technology; technology that has recently become sufficiently developed to be operable across a variety of settings.

Projects of this magnitude require greater overall grants management and monitoring to ensure return on investment and also require dedicated project managers for the grantees.

The Community Consortium legislation has provided an important opportunity to test new models of service delivery in a rapidly changing Health Care and Long-term Care environment. If additional funding were available in the future, investing in another Consortium process would be a valuable additional tool to expand Consortiums to new regions and partners.