

Strategy Brief:

**Ombudsman Program Involvement in
Nursing Home Transition Activities**

Report on National Dialogue Forum #2

Prepared by the National Association of State Units on Aging

National Long-Term Care
Ombudsman Resource Center

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**Ombudsman Program Activities in
Nursing Home Transition Efforts**

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Foreword

The National Association of State Units on Aging (NASUA), as part of its work in support of the National Long-Term Care Ombudsman Resource Center (NORC), is convening a series of national dialogue forums on issues of importance to long-term care ombudsman programs and state units on aging (SUAs). The National Dialogue Forums will provide a venue for state aging directors and state long-term care ombudsmen (SLTCOs) to discuss challenging issues and identify promising practices to more effectively serve long-term care consumers.

NASUA has developed a process for convening the National Dialogue Forums consisting of the steps described below.

Step 1. Convene the Advisory Committee to identify topic areas on which the forums will focus in the coming year. The Advisory Committee consists of equal representation of SUAs and SLTCOs (the membership of the Advisory Committee is listed in Appendix A). At the Advisory Committee's first teleconference in September 2003, three topic areas were identified:

- Ombudsman program connections to home and community based services.
- Ombudsman program involvement in nursing home transition efforts.
- Reaching and serving diverse populations.

Step 2. Convene an Issue Identification Panel (IIP) focused on each topic. The IIP will help identify the primary questions for discussion during the National Dialogue Forums. Each IIP consists of approximately 10 representatives of SUAs, state ombudsman program and other areas germane to the topic (e.g., Adult Protective Services, Centers for Medicare and Medicaid Services, Independent Living Centers, home and community based services, etc.).

Step 3. Identify promising practices. Promising practices and information on strategies ombudsman programs use to address the dialogue topic will be solicited from SLTCOs via email prior to each dialogue forum. Additional promising practices will be identified during the dialogue forum.

Step 4. Invite all SUAs and SLTCOs to participate in the National Dialogue Forums.

Step 5. Convene the National Dialogue Forum, consisting of a series of teleconferences on each dialogue topic.

Step 6. Develop a strategy brief. Strategy briefs will provide highlights of the ideas, challenges and promising practices presented during the dialogue forums and obtained via email from state ombudsman programs. A strategy brief for each dialogue topic will be prepared and disseminated to all SUAs and SLTCOs.

Strategy Brief:

Ombudsman Program Activities in Nursing Home Transition Efforts

Report on National Dialogue Forum #2

Introduction

This strategy brief presents promising practices and strategies used by ombudsman programs to assist nursing home residents to transition back to their communities and homes, including:

- providing residents and their families with information about home and community based services (HCBS) and other options available to them;
- informing residents of their right to leave the nursing home and receive care in their home or community; and
- linking residents and their families to the appropriate agencies or persons for assistance with moving back to the community.

The information presented here is based on promising practices identified by state ombudsmen in response to an email solicitation sent to all programs initially on May 14, 2004 and information provided during the National Dialogue Forum. The National Dialogue Forum consisted of two teleconferences held on June 2 and 4, 2004.

An Issue Identification Panel (IIP) comprised of state ombudsmen, state aging directors, and representatives from the Centers for Medicare and Medicaid Services (CMS), the Centers for Independent Living (CILs), and the Administration on Aging (AoA) helped develop a set of questions for this National Dialogue Forum on *ombudsman program activities in nursing home transition efforts*. See Appendix B for the list of IIP participants.

A total of 41 individuals from 23 states and the District of Columbia participated including:

- 5 representatives from state units on aging.
- 33 state ombudsman program representatives.
- 3 participants representing the Administration on Aging and the National Ombudsman Resource Center.

In two of the states that participated, both the state unit on aging (SUA) and the ombudsman program were on the calls.

National Dialogue Forum participants are listed in Appendix C.

The questions, listed below, were emailed to all state aging directors and state ombudsmen prior to the calls, and were used to guide the discussion during the teleconferences.

Primary question:

What **role** does or should the long-term care ombudsman program play in identifying and assisting nursing home residents who want to return to their homes or communities?

Secondary questions:

How does the ombudsman program effectively **coordinate** with other agencies (e.g., Medicaid, Centers for Independent Living, etc.) to assist nursing home residents' transition to the community? Is this coordination part of a formal transition initiative?

Promising Practices and Discussion Highlights

The promising practices and discussion highlights are organized by state under the following sections:

- I. The **role** of the long-term care ombudsman program in providing information and support - what ombudsman programs do when a resident says "I want to go home."
- II. Ombudsman program **coordination** with community agencies and nursing home transition initiatives.

Section I addresses the primary question of the ombudsman program's role in assisting residents with returning to the community, while Section II examines the secondary questions regarding program coordination with community agencies and formal transition initiatives.

All long-term care ombudsman programs encounter nursing home residents who express a desire to return to their homes or communities. These situations occur frequently and are routinely handled by providing residents and their families with information about alternative long-term care options, including home and community based services. In some instances, the ombudsman program refers the resident or family to another agency and/or the facility social worker for assistance with moving back to the community. These ombudsman program activities may or may not be part of a formal

nursing home transition effort such as a Real Choice Systems Change Grant, Nursing Facility Transitions grant or Olmstead state initiative.

1. The role of the long-term care ombudsman program in providing information and support - what ombudsman programs do when a resident says “I want to go home.”

Key discussion points:

- ❑ Ombudsman programs primarily respond to individual requests about leaving the nursing home, rather than proactively identifying residents for transition back to the community.
- ❑ Ombudsman programs provide residents and their families with information about home and community based services and in some cases monitor the discharge planning and transition process.
- ❑ A lack of home and community based services, particularly housing, and facility resistance were identified as the biggest barriers for residents wanting to return to the community.

The consensus among dialogue participants was that the ombudsman program’s role in nursing home transition efforts is generally one of responding to individual residents’ and families’ questions about leaving the facility and returning to the community, rather than proactively identifying and approaching residents who are likely candidates for transitioning back to their homes or communities. Ombudsmen identified two considerations influencing the program’s role in transition efforts. First is a concern about damaging their working relationships with nursing homes if the program is perceived as systemically and routinely identifying residents for potential transition back to the community. Second is a desire to let residents raise issues that are important to them rather than predetermining the focus of the conversation on transition.

Our primary role is to make sure the social worker at the facility talks with the resident about their discharge potential and helps with a discharge plan if appropriate.

Mary McKenna
State Ombudsman, Massachusetts

Through the normal course of developing relationships with residents during scheduled visits, conversations about leaving the nursing home sometimes come up. In these cases, ombudsmen give residents and their families information about home and community based services (HCBS) and housing options that may be available. Ombudsman programs also make referrals to HCBS agencies or nursing home transition programs, advocate for an individual resident’s right to move back to the community and in some cases, monitor the transition process.

A lack of family supports, limited availability of home and community based services and housing options, and resistance by some facilities to educating residents and families about their rights and alternatives to nursing home care were identified by

ombudsmen and SUAs as significant challenges to the successful transition of residents from nursing homes back into the community. However, ombudsmen agreed that it was their role to assist individual residents to overcome the barriers to returning to their homes and communities by providing information about community based care options and when appropriate, by monitoring the discharge planning process. The ombudsman programs in **Minnesota**, **Nevada** and **Wisconsin** put this in practice by monitoring the transition process when necessary to ensure the resident's wishes and concerns are heard and addressed during discharge planning. It is important to note that not all nursing homes resist assisting residents to transition back to the community. In **North Carolina**,

To promote successful transitions the Nevada Ombudsman Program recommends "trial runs" to help the resident make a final decision about returning to a particular community setting. Depending on the outcome, the resident's services needs may require reevaluation.

for example, the nursing home industry is supportive of transition efforts. The state ombudsman there described two recent situations in which a nursing home social worker contacted the program to find resources for residents seeking information on options for returning to the community. In

addition, some states such as **Georgia** actively educate residents about alternatives to nursing home care. For instance, the Georgia Medicaid agency developed a booklet about home and community based services available to Medicaid recipients that nursing homes are required to give new residents upon admission and distribute to all residents in the facility at least yearly. Ombudsmen also have a supply of these booklets.

Dialogue participants pointed out the need for careful discharge planning and monitoring to ensure that former nursing home residents receive adequate, quality services in the community. Below are examples of ombudsman program activities that support individual resident's transition from nursing homes back to their communities.

"It's one thing to help people get out; it's another to make sure they receive the quality services they need in another setting.

Becky Kurtz
State Ombudsman, Georgia

Georgia:

Nursing home residents who are SSI eligible have experienced significant lag time in getting their SSI payments once they return to the community. State Ombudsman, Becky Kurtz, reports that the Social Security Administration (SSA) has "pre-release procedures" which are used for SSI eligible persons coming out of the prison system. These same procedures can be implemented for nursing home residents prior to discharge, which means they can get their SSI checks more quickly after returning to the community. The ombudsman program has educated nursing home social workers and discharge planners about these procedures and works to ensure this process is used in individual situations.

Minnesota:

The ombudsman program has found that county social service programs having close working relationships with nursing homes can sometimes work against a resident wishing

to transition back to the community. In some instances, nursing homes have tried to discourage a discharge by telling the resident or family that they will have to contact Adult Protective Services because the resident will be at risk in the community, without making an effort to address concerns through the discharge planning process. The ombudsman program becomes involved in such cases by offering education and assistance and monitoring the discharge process as needed.

Nevada:

Facilities often express concern to the ombudsman program that residents who want to leave the facility are unable to do so. The ombudsman program has successfully facilitated meetings between residents and facilities to reaffirm the resident's right to consider other care options and to address the barriers to discharge. The ombudsman strives to convene all the appropriate staff for an interdisciplinary discussion of the resident's needs and options for addressing those needs. In one instance the barrier to transitioning was the resident's inability to manage his own insulin shots. With training, the resident was taught to self-administer the shots and was able to return to the community. The ombudsman also monitors certain situations in which the facility is resistant to the resident leaving to ensure the facility is taking responsibility for discharge planning.

For successful transition back to the community, discharge planning must start from the very beginning when the resident enters the nursing home.

Gilda Johnstone
State Ombudsman, Nevada

The ombudsman program routinely provides information about community care alternatives to resident councils. The program reaffirms the residents' right to return to their home or community and receive appropriate assistance from the nursing home to address any barriers to such a transition. This includes: development and implementation of a care plan aimed at that goal and a realistic discharge plan with coordination of the community services necessary for a successful transition.

The ombudsman program suggests that to check his/her potential for successfully transitioning from the nursing home, the resident may want a "trial run" to test living in the community for a day, a weekend, or even a week. Short-term services can be arranged when the resident returns home, to a relative's home, or other location. (Depending on the state, residents who are Medicaid recipients may be able to request "therapeutic leave" for a specified period of time and have their nursing facility bed held for them.) Residents who do this may find barriers in their own home that they had not considered or discover that living at home is not what they imagined. The experience of the Nevada State Ombudsman is that residents are often the first to face the reality that they need care in a safer environment. Even if the resident remains at the nursing home, the fact that the request was addressed and they were given an opportunity to try living in the community is appreciated.

Texas:

The ombudsman program encounters many residents who were not initially offered other community options such as assisted living, before being admitted to the nursing home. The program has helped many of these residents transition back to the community by offering information and referral assistance.

I recently met a woman in a nursing home. She was fully cognitive, could dress herself, and needed only minimal assistance. She was never offered any options but a nursing home.

Margaret Matthews
Regional Ombudsman, Texas

West Virginia:

The ombudsman program works to ensure that consumers who want home care services, particularly those consumers who are in long-term care facilities, receive a full explanation of options available to them. As ombudsmen make routine visits to residents in long-term care facilities, residents frequently ask about the possibility of leaving the nursing home, going to an assisted living facility or returning to their own home or the home of a relative or friend. When this happens, the ombudsman typically refers the resident to the nursing home social worker to explore the possibility of discharge and develop a realistic discharge plan when appropriate. The ombudsman may also make a referral to community resources such as the Medicaid Waiver Program, county agency on aging or assisted living facilities. In these instances, the ombudsman checks back with the resident to ensure that a discharge plan was formulated.

Wisconsin:

The ombudsman program has assisted nursing home residents transition back to the community since the early 1980s when the state began implementing two Medicaid home and community based waivers: the Community Options Program (COP) for seniors and the Community Integration Program (CIP) for persons with developmental disabilities. State statute requires the ombudsman program to serve COP participants. When an ombudsman encounters a resident who wishes to relocate to the community, the program provides the resident and his/her family or support system with information to foster an informed choice. When necessary or requested, the ombudsman program monitors the transition process to ensure the resident's choices are honored to the greatest extent possible and that appropriate arrangements for discharge are made.

II. Ombudsman program coordination with community agencies and nursing home transition initiatives.

Key discussion points:

- ☐ Many ombudsman programs serve on committees or coalitions working on nursing home transition initiatives.
- ☐ Ombudsman programs generally refer residents and families to nursing home transition programs when available.
- ☐ Since knowledge of community resources is important for making appropriate referrals, several ombudsman programs have received training regarding transition initiatives to increase their knowledge of service options.
- ☐ Coordination among a variety of agencies is a key component for ensuring the successful transition of residents back to the community.

Many ombudsman programs serve on committees and coalitions working on nursing home transition initiatives. Becky Kurtz, **Georgia** State Ombudsman, emphasized the need to “advocate at a macro level to put the infrastructure in place” so that community care options are available to support residents capable of returning to the community with assistance. As reported in Section I, dialogue participants frequently noted that the lack of sufficient home and community based services, including housing, is the primary barrier to residents wanting to transition out of nursing homes.

While most ombudsman programs that participated in the dialogue are not formally involved in nursing home transition initiatives, all reported acting as referral and resource points to guide residents and families to assistance. In fact some ombudsman programs, including **Kentucky** and **Ohio**, have received training regarding transition initiatives being implemented in their states so that program staff know about service options.

Regional ombudsman programs frequently make referrals to home and community based service (HCBS) programs and have developed relationships through routine meetings. In **Colorado**, for example, the ombudsman program coordinates informally yet effectively with the single entry point agencies, independent living centers and other organizations in the home and community based services system to help residents leave the nursing home and return to the community. Coordination between the ombudsman program and HCBS programs is most likely when the two programs are housed in the same agency. Such is the case in **New York**, where about half of the state’s local ombudsman programs are housed in area agencies on aging (AAA). These local ombudsmen coordinate with AAA staff when they encounter a resident who wants to transition back to the community.

Ombudsmen agreed that a key component to a resident's successful transition back to the community is good coordination among a variety of individuals and agencies --- social workers, case managers, home care providers, area agencies on aging, family caregivers, etc. The support system that helps a resident to leave the nursing home is typically comprised of a carefully crafted patchwork of providers, family and neighbors, working in concert to execute an individually tailored care plan. Therefore, the ombudsman's knowledge of community services and resources is especially important for assuring that appropriate referrals are made for the resident's benefit.

Many states are implementing their own transition efforts under their state's Olmstead plan or under a Real Choice Systems Change Grant as part of the federal New Freedom Initiative. These initiatives promote the development of community services and support systems with which the ombudsman program can coordinate in order to assist nursing home residents to return to their homes and communities. However, even in states without a formalized transition initiative, ombudsman programs have identified ways to coordinate with state and local agencies and service providers on behalf of residents seeking to transition out of nursing homes. An example of this is in **Montana**, where the ombudsman program works with the state's Medicaid Waiver Program, home and community based service providers and nursing homes to assist nursing home residents to successfully return to their homes. Typically the ombudsman program is involved in cases where the resident's multiple physical and mental health needs require numerous planning meetings and a careful delineation of the services to be provided by each agency to ensure that the individual's needs are met. The ombudsman program monitors such situations to ensure successful transition.

Real Choice Systems Change Grants

In 2001, President Bush issued Executive Order 13217 launching *The New Freedom Initiative*. The goal of this national initiative is to remove barriers to community living for people of all ages with disabilities and chronic illnesses. To help achieve this goal, the Centers for Medicare & Medicaid Services (CMS) awarded “Real Choice Systems Change Grants for Community Living” in 2001, 2002, 2003, to support states’ efforts to design and implement lasting improvements in the home and community services support system. A total of \$158 million has been awarded to 49 states, the District of Columbia and two territories. In 2004, CMS made available an additional \$31 million in Systems Change grants.

In 2001 and 2002, Nursing Facility Transitions (NFT) grants were awarded for up to three years to help states transition eligible residents back into the community. There are two types of NFT grants: one for state program initiatives and the other for Independent Living Centers to promote partnerships with the states (ILP). States that received NFT grants in 2001 and 2002 include: Alabama*, Alaska, Arkansas, California, Colorado, Connecticut, Delaware*, Georgia*, Indiana, Louisiana, Maryland*, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey*, North Carolina, Ohio, Rhode Island, South Carolina, Texas, Utah, Washington, West Virginia, Wisconsin* and Wyoming. States with an asterisk (*) received grants for both state program initiatives and ILPs.

Information about the New Freedom Initiative is available at:
<http://www.cms.hhs.gov/newfreedom/>.

The examples of ombudsman program activities highlighted below are from states that are implementing nursing home transition initiatives under a Real Choice Systems Change Grant and/or a state initiative under an Olmstead plan.

Alabama:

The state’s Nursing Home Transition Initiative, currently being piloted in two regions, targets nursing home residents with dementia and Alzheimer’s Disease. A critical element in transitioning such residents is planning for the safety of the older adult and the caregiver. Designated Nursing Home Transition coordinators located in two area agencies on aging help identify and assist residents and families with logistics such as setting up home and community services. The ombudsman program’s role is to provide residents and families with information about options and refer them to the Transition Program when appropriate.

California:

The Contra Costa County Ombudsman Program participates in “Providing Assistance to Caregivers in Transition” (PACT), a three-year pilot project funded by the Administration on Aging (AoA) that supports, educates and empowers caregivers in

moving their loved ones out of an institutional setting.¹ Assistance is also provided to caregivers in advocating for quality care for those remaining in an institutional setting. The PACT program team of health care professionals includes a case manager, public health nurse, Independent Living Specialist and Long-Term Care Ombudsman.

The PACT program strives to:

- Increase the caregiver's knowledge of the care recipient's current situation and available options and alternatives for meeting the resident's needs so that informed decisions can be made about the best options for addressing each individual's situation.
- Increase caregiver support and empowerment during the first three months of a loved one's placement in a skilled nursing facility and/or during the transition to a more independent setting.
- Increase the number of persons who transition to the community within three months of being placed in a skilled nursing facility.

If the care receiver will be transitioned home, the PACT team assists in obtaining the necessary services and/or equipment for the home prior to the transition. The team continues to monitor and support the caregiver once the care receiver comes home. If the care receiver is unable to transition home, PACT team members work with the caregiver within the facility setting to ensure that needed services are provided. The team continues to monitor and support the caregiver in this setting as well.

Caregivers may qualify for PACT services if they meet one of the following criteria:

1. Has a loved one aged 60+ who is currently residing in a skilled nursing or intermediate care facility in Contra Costa County and is able to provide adequate care at home.
2. Would like assistance in advocating for quality care for a loved one who needs to remain in a care facility.

Kentucky:

The state ombudsman serves on the state's Olmstead Advisory Committee and a workgroup developing a training curriculum for direct care workers under a Real Choice Systems Change Grant. Local ombudsmen have received training on the state's transition initiative and are knowledgeable about the services that are available in individual communities. As a result, ombudsmen are effective in assisting residents who express a desire to transition back to the community to connect to community resources.

¹ Funding for PACT comes from Older Americans Act, Title III-E funds. A report entitled "Nursing Home Transition: Implementing the Program Providing Assistance to Caregivers in Transition (PACT)" describes the project's accomplishments in the first 24 months. The report is available from:

http://pascenter.org/publications/publication_home.php?id=66.

Kentucky's Transition Housing Initiative for Nursing Facility Residents (currently being piloted in two counties) has developed a brochure, titled *It's Your Move*, that has been distributed to nursing facilities, senior centers, libraries and other strategic locations to inform people of the transition assistance that is available in those areas. This initiative is administered by the Center for Accessible Living, an independent living center. (A copy of the brochure *It's Your Move* is in Appendix D.)

North Carolina:

The state ombudsman program staff participates in the Nursing Home Transition Work Group designed to assist Medicaid eligible nursing home residents who want to return to the community. The ombudsman program helps residents find the right community resources, empowers them to develop and carry out their own plan for meeting their needs once they are back in the community, and educates families about the resident's right to choose where s/he lives. In some situations, the ombudsman program makes a referral to the Family Caregiver Specialist at the area agency on aging to assist caregivers in finding and using community resources.

North Carolina's "Transitions Program" has created a fact sheet for nursing home residents and families about transitioning back to the community. The fact sheet lists the ombudsman program as a partner and a resource, along with the Centers for Independent Living, the Housing Finance Agency, Vocational Rehabilitation, the Department of Health and Human Services, and facility staff. (A fact sheet on the *Transitions Program* is in Appendix E.)

Ohio:

Ombudsmen have been trained on the two transition projects currently underway in the state in order to raise their awareness of the types of persons the projects are trying to assist and how to make referrals. The state ombudsman serves on the advisory work group for one of the projects, developed under a Real Choice Systems Change Grant.

Texas:

Texas has a "money follows the client" program established by state statute. According to John Willis, State Ombudsman, this program makes a big difference in Texas. Simply put, when nursing home residents choose to be served in another setting (e.g., assisted living, with family, adult foster care, etc.) the money that would have paid for their stay in the nursing home follows them and pays for care in the alternative setting. When the individual no longer needs care or dies, the money reverts back to the state's nursing home budget and is used to fund additional residents wanting to transition out of the nursing home. Currently, there are 60,000 people of all ages in nursing homes statewide on waiting lists for community based alternatives. The ombudsman program does not actively seek out residents with a potential to transition; however, ombudsmen respond aggressively to residents' requests for assistance to return to the community, by providing information about options and making referrals, mainly to the independent living centers

(ILCs). ILCs assess the resident's needs and the appropriateness of various transition options. In Texas, the ombudsman program partners with the independent living centers to inform nursing facilities about the availability of transition assistance for residents. Some facilities now make referrals directly to the ILCs when they identify residents who could function in the community with support.

During the first six months of 2004 almost 1,400 persons were transitioned from nursing facilities to alternative living arrangements in the state. Most of these transitions were the direct result of coordination between the transition team and the facility staff and/or the ombudsman program. (A copy of the brochure *Home by Choice*, which describes the transition program operated by the Heart of Central Texas ILC, is in Appendix F.)

"The ombudsman program nationwide has been working with residents to transition to the community even before the Olmstead decision. ... The ombudsman program has been doing this for a long time."

John Willis
State Ombudsman, Texas

West Virginia:

The ombudsman program recently established a formal agreement with the West Virginia University Center for Excellence in Disabilities, which provides nursing home transition assistance under a Real Choice Systems Change Grant. As part of the agreement, the ombudsman program will educate persons involved with transitioning efforts at the Centers for Independent Living, ADAPT and others about nursing homes, care issues, and the types of support services residents may need to successfully transition back to the community. The program has already connected several residents to the Center. In these situations, the ombudsman works with the residents until they return to the community or their own homes.

Wisconsin:

It's hard to change the mindset that nursing homes are the only option. Families want their loved ones safe, and they think the nursing home is the place they will be safe.

Claudia Stine, Director
Ombudsman Services, Wisconsin

Wisconsin began working on nursing home transition in 1985 and received its first "Homecoming" grant in 1999. Regional ombudsmen periodically meet with county home and community based waiver program staff to share information

about what their respective programs are doing. Because of this relationship, when the ombudsman program finds a resident who wants to transition back to the community, referrals can be quickly made to the appropriate people. According to Claudia Stine, Director of Ombudsman Services, very little is done by hospitals in the state to make elders aware of their long-term care choices. To address this, state ombudsman staff met with the State Discharge Planners Association to begin changing the mindset that there are no other places people can go for rehabilitation and supportive living except a nursing home.

Wyoming:

Under the “Project Out” transition initiative, the state unit on aging partners with the ombudsman program to explain the community care options that are available for those wishing to move back into the community at resident and family council meetings in nursing homes. (Information about “Project Out,” presented in a PowerPoint format, is in Appendix G.)

Summary

A lack of community based services, including housing, was identified by dialogue participants as the primary barrier to residents transitioning back to the community. Other challenges discussed during the teleconference calls included nursing homes that are resistant to transition efforts and a lack of information provided to residents and families about long-term care options in addition to nursing home care.

Ombudsman programs that participated in this National Dialogue Forum perceive their primary role in nursing home transition efforts as providing information and assistance to residents who ask about returning to the community, rather than proactively identifying and approaching residents about transitioning back to their homes or communities. Many ombudsman programs coordinate with community agencies to assist residents with transitioning back to the community. However some programs described more active involvement in nursing home transition initiatives, such as Real Choice Systems Change Grants, state-funded transition programs and Olmstead-related initiatives. A number of state ombudsmen participate in state level coalitions and advisory committees that oversee nursing home transition initiatives, while regional ombudsman programs in some states have received training about nursing home transition initiatives to enhance their awareness of services and referral options.

APPENDIX A

Advisory Committee Members

National Dialogue Forum Advisory Committee

Advisory Committee Members

SUA Representatives:

Kentucky

Jerry Whitley
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Maine

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APPENDIX B

Issue Identification Panel Members

Ombudsman Program Activities in Nursing Home Transition Efforts

Issue Identification Panel Members

Panel Task: Identify primary questions of interest to address during the National Dialogue Forum on Ombudsman Program Activities in Nursing Home Transition Efforts.

SUA Representatives:

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Ohio

John Saulitis
Local Ombudsman

Maine

Chris Gianopoulos
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Kathy Leitch
Assistant Secretary
Aging & Disability Services

Administration on Aging

Sue Wheaton
Ombudsman Program Specialist

Ombudsman Program Representatives:

California

Joe Rodrigues
State Ombudsman

Centers for Medicare & Medicaid Services

Deidra Abbott
Center for Medicaid & State Operations

Maine

Brenda Gallant
State Ombudsman

Minnesota

Mary Kennedy
Director, State Medicaid Agency

National Ombudsman Resource
Center

Alice Hedt
Director

Texas

Richard Petty
Independent Living Resource Unit

APPENDIX C

National Dialogue Forum Participants

Ombudsman Program Activities In Nursing Home Transition Efforts

National Dialogue Forum Participants

Alabama

Virginia Bell
State Ombudsman

Caprice Chattom
Nursing Home Transition Coordinator
Department of Senior Services

Arizona

Robert (Bob) Nixon
State Ombudsman

Cindy Skalsky
Local Ombudsman

Arkansas

Kathie Gately
State Ombudsman

Carolyn Singleton
Adult Protective Service/Ombudsman
Program

California

Joe Rodrigues
State Ombudsman

Colorado

Pat Tunnell
State Ombudsman

District of Columbia

Zita Dresner
Ombudsman Program

Georgia

Becky Kurtz, Esq.
State Ombudsman

Kentucky

John Sammons
State Ombudsman

Massachusetts

Mary E McKenna
State Ombudsman

Jenny Beaujean
Amanda Lutze
Michele Gaythwaite
Ombudsman Program

Minnesota

Sandra Newbauer
Ombudsman Program

Mississippi

Anniece McLemore
State Ombudsman

Missouri

Andy Petti, Community
Independence Coordinator
Department of Health & Senior Services

Julie Wilson
Carrie Eckles
Ombudsman Program

Montana

Kelly Moorse
State Ombudsman

Robin Homan
Office on Aging

Nebraska

Cindy Kadavy
State Ombudsman

Nevada

Gilda Johnstone
State Ombudsman

New York

Martha Haase
State Ombudsman

Daniel Degnan
General Counsel
Office for the Aging

North Carolina

Sharon Wilder
State Ombudsman

Denise Rogers
Ombudsman Program

North Dakota

Linda Wright
Lynne Jacobson
Ombudsman Program

Ohio

Beverley Laubert
State Ombudsman

Texas

John Willis
State Ombudsman

Margaret Matthews
Local Ombudsman

Utah

Helen Goddard
Director, Division of Aging
& Adult Services

Chad McNiven
State Ombudsman

Washington

Louise Ryan
Assistant State Ombudsman

West Virginia

Suzanne E. Messenger, Esq.
Ombudsman Program

Wisconsin

Claudia Stine
Director, Ombudsman Services

Vickie Bergquist
Ombudsman Program

Wyoming

Dorothy Thomas
Marcia Harvey
Division on Aging

Others

**National Ombudsman Resource
Center**

Julie Meashey
Deanna Okrent

Administration on Aging

Sue Wheaton
Ombudsman Program Specialist

APPENDIX D

Kentucky: *It's Your Move* (brochure)

Contact:
John Sammons
State Ombudsman
Office of Aging Services
Johnm.sammons@KY.gov
(502) 564-6930

APPENDIX E

North Carolina: *Transitions* (fact sheet)

Contact:
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LTC Ombudsman/Elder Rights Specialist
Division of Aging and Adult Services
Denise.Rogers@ncmail.net
(919) 733-8395

Transitions

*Creating Community Living Options
for Residents of Nursing Facilities.*

Moving out of a nursing home back into the community is challenging—with many obstacles and responsibilities to consider. A new federal program is working to assist nursing care residents in living independently again.

The “Transitions Program” takes advantage of the experience and expertise of counselors with the state’s Independent Living Program (or IL). The IL staff assist with the development of *transition plans* and coordinate the supports and services needed for a successful transition.

Are You Eligible?

You are eligible if you are a nursing facility resident in North Carolina and have the desire to live independently in the community. Your transition will depend on availability of community resources. The program can help you explore options about where you can live and what services and supports are available to meet your needs. There is no cost to you for this assistance.

What Is Required of Participants?

Most important are your cooperation and a willingness to accept the challenges and responsibilities associated with the transition.

We will need to discuss the types of services, supports, and benefits you will need in order to live independently in the community. You will be asked to sign a release permitting the Transitions staff to review your records or you may review your records with our staff.

Can Family & Facility Staff Assist?

Absolutely. We encourage anyone you feel can help to participate in the planning—including nursing facility staff, friends, family members and others involved in your care.

Will You Be Able to Return to a Nursing Facility If Necessary?

If you change your mind or if your needs change, you may return to a nursing facility as long as you still meet the requirements for admission.

How Do You Get Started?

We will be happy to meet with you, and you are welcome to invite family and friends to join us. Also, you may ask your social worker at your nursing facility or contact your Regional Long Term Care Ombudsman. They can let us know about your interest in transitioning, and we will follow up by contacting you.

**To apply or to receive more information—
contact Michael Howard at (877)512-0022
or e-mail Michael.Howard@ncmail.net.**

More About the Transitions Program

The US Centers for Medicare and Medicaid Services has awarded these grants since 1998. North Carolina received its grant in October 2002.

The principal goals for the program are to: design and implement a program to transition 80 to 100 nursing facility residents who wish to live outside an institutional setting and build a statewide network that can sustain a transition program beyond the grant period.

The program has partners throughout the state’s communities to facilitate successful transitions. These include staff at Centers for Independent Living, the NC Housing Finance Agency, NC Department of Transportation, NC Department of Health and Human Services, the LTC Ombudsman Program, and nursing home administrators and staff.

NC Vocational Rehabilitation



Transitions Services • Independent Living Program
2801 Mail Service Center • Raleigh, NC 27699-2801
(877) 512-0022 • Fax (919)733-1628 • TDD (919)855-3579
<http://dvr.dhhs.state.nc.us/DVR/faqs/ilfaqs.htm>

APPENDIX F

Texas: *Home By Choice* (brochure)

Contact:
Margaret Matthews
Regional Ombudsman
Area Agency on Aging of
Central Texas
Omb12@centexaaa.com
(254) 939-1886

APPENDIX G

Wyoming: *Project Out* (PowerPoint slides)

Contact:
Keith Hotle
State Program Manager
Project Out
Independent Living Rehabilitation
kholte@trib.com
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"Going Home"



Wyoming's Nursing Home Transition Program

Project Out

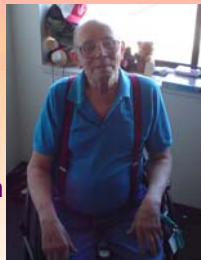
Wyoming Independent Living Rehabilitation

Keith Hotle State Program Manager

This document was developed under grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Dept. of Health and Human Services, and you should not assume endorsement by the federal government.

Project Out Mission

To assist Wyoming nursing home residents who choose to transition to the community



Project Out - Program Overview

- Program Began on September 1, 2002
- Funded for 3 Years
- Goal is 85 Nursing Home Transitions
- WILR Responsible for Entire State of Wyoming
- 3 Transition Specialists & Program Manager
- Coordinate With Other WILR Independent Living Specialists
- Over 100 Referrals
- 15 Transitions in FY 2002-2003
- 35 Transitions to date in FY 2003-2004
- 4 Consumers Returned to Nursing Homes
- Transitioned Consumers range from 28-84 years old
- Average age is 62
- Almost 40% were under 60
- Evenly divided among men and women
- Average monthly income of transitioned consumers was \$806 -- low was \$164

Project Out Program Criteria

To Qualify for Financial Assistance: Medicaid Eligibility

The individual must be on Medicaid or be Medicaid eligible

Disability

The individual must have a significant physical or mental disability which for that individual constitutes or results in a substantial handicap to functioning independently in family or community

Desire and Ability to Return to the Community

There must exist a reasonable expectation that transition services may enable the individual to make significant movement toward greater functional personal independence in family and/or community

Project Out Transition Services



- Information & Referral
- Housing Location
- Rental Assistance
- Utility Deposits
- Moving Expenses
- Furniture
- Home Modifications
- Assistive Technology
- Transportation Vouchers
- Locate Personal Care Attendants
- Benefits Counseling (SSI/SSA)
- Coordinate Waiver Assistance

The Transition Process

- Referral
- Intake
- HIPPA Release
- Client Interview
- Assessment
- Independent Living Plan
- Coordination of Services
- Financial Assistance
- Team Meetings
- Eligibility Determination
- Transition
- Aftercare
- Evaluation



Barriers to Transition

- Safe & Affordable Housing
- Transportation Services
- Lack of Personal Care Attendants
- Lack of Family and/or Community Support System
- Nursing Home Staff Cooperation
- Funding Major Home Modifications
- Waiver Waiting List
 - ALF Waiver
 - LTCHCBS Waiver



More About Waivers

Project Out Utilizes 2 Waiver Programs:

- Long-Term-Care Home & Community-Based Services Waiver (LTC/HCBS)
 - 1000 Waiver Slots Authorized
 - Services Provided in the Home
 - Includes Self-Directed Care
 - 4-5 Month Waiting List
 - Nursing-Home Residents for At Least 1 Year go to the Top of the List
- Assisted Living Facility (ALF) Waiver
 - Facility provides waiver services
 - Home Health Agency caseworker
 - Assisted Living Facility (ALF) Waiver
 - 8-9 Month Waiting List



Credit: ADAPT

Project Out - 2 Success Stories

“Jane B.”

- 53-year-old diabetic
- Went into nursing home for rehabilitation after leg was amputated
- Intended to stay a week or two, but remained a year
- Project Out helped her move into handicapped-accessible apartment
- Provided electric wheelchair and transportation funds
- Looking for computer so she can retrain and begin working

“Wilma F.”

- 72-year-old widow
- Suffers from diabetes and mental conditions
- Health is manageable with proper medication monitoring
- In and out of nursing home for over a year due to self-neglect
- Located assisted-living facility & coordinated waiver services
- Provided furniture and rental assistance
- Currently working at local food bank and thriving in new home

Nursing Home Transitions in Wyoming -- What Does the Future Hold?



- **Real Choice Systems Change**
 - Complete Overhaul of State Long-Term Care System
 - Requires Commitment of Wide Range of State Agencies
- **Money Follows the Person**
 - Federal Program
 - Medicaid Dollars Follow Individual From Institution to Community
- **Legislative Initiative**
 - (Rider 37 The Texas Experiment)
 - Requires Educating Legislators
 - Program is fiscally desirable
 - Olmstead requires community-based services for the disabled

Project Out

Wyoming Independent Living Rehabilitation

Keith Hotle
State Program Manager

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