



Changes to the Community-Based Service Delivery System

**Prepared by
Nevada Senior Corps Association
with the assistance of
For Profit, Non-profit and Public Sector Providers
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For more information

Please Contact

Nevada Senior Corps Association * PO Box 20354 * Reno, Nevada 89515 * (775) 829-0870 (Work) * (702) 275-6530
* nasca@nevadaseniors.org



PO Box 20354 * Reno, Nevada 89515 * (775) 829-0870 (Work) * (702) 275-6530 (Cell) * nsca@nevadaseniors.org

Suggestions

The following are the suggestions discussed in detail in the report. These are designed to improve the service delivery system for customers of state senior services. This is becoming more important given the severe financial situation the State and local governments are facing. The suggested changes are:

- **Contract to the private sector all direct services.**
- **Bid out Direct Service Case Management and Social Worker services with the exception of Elder Protective Services.**
- **Reorganize the Aging Division and Adults with Disabilities.**
- **Maximize federal and other outside funding opportunities.**
- **Consolidate the grant development functions.**
- **The Medical Homes Collaborative program should bypass the pilot program phase.**
- **Start the regulatory process for a self-directed care program.**
- **Finish development of the PACE (Program of All inclusive Care for the Elderly) program.**
- **Consolidate all agency compliance audits / surveys.**
- **Enter into cooperative agreements between the various transportation funding agencies for vehicle inspections.**
- **Merge the ADSD Aging and Disabilities Resource Centers (ADRCs) with the Family Resource Centers (FRCs).**



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Purpose and Background

The Nevada Senior Corps Association started a study in September 2009 of programs that are serving seniors in the state of Nevada, excluding housing. Initially the study was attempting to provide the Legislature with a list of policies that could be applied to the current system. However, it is now apparent that due to the financial issues facing the State, looking towards solutions that will fine tune the system are not going to be sufficient. Further, the National effort to restructure the health care system will cause major changes in the way services are delivered, who is eligible for the services, and the level of those services. Health care is one of the three primary issues facing the senior population.

The current delivery system is not adequate to provide the services needed to address the current retired low-income population, much less the wave of “baby-boomers” that will enter the system in the next few years.

Over 200 agencies were asked to respond to a survey. 61 were returned, and 30 were contacted for additional information. Initially, the intention was to contact all the respondents, but it became clear that the issues and comments were substantially the same. While the survey was limited in its responses, the issues that were identified were remarkably similar. The inventory phase of the study was completed during December 2009.

2010 Special Session

With the call for the Special Session, NSCA, through Nevada Senior Advocates (NSA), an organization which lobbies for NSCA, decided to redirect the efforts of the study to improve the efficiency of State programs that provide services to seniors and people with disabilities. The suggestions were developed with some of the service providers, public and non-profits, as well as local government units that provide services to seniors. The suggestions developed and submitted to the Legislature and the Administration parallel several of the service improvement recommendations obtained from the service providers during the inventory phase of the study discussed above.

The providers that participated in the development of the recommendations are committed to the provision of community-based services for seniors, people with disabilities and other Nevadans with needs. Community-based services are designed to keep people out of more expensive care alternatives i.e. local hospitals, emergency rooms, assisted living facilities and nursing homes.

The following is provided to give you an idea of the costs to provide services in various categories in Nevada. The figures are annual and private pay rates. They are taken from a study by MetLife done in October 2009 and assume care for 365 days. This overstates the cost of Home Care and Adult Day Care, since these programs generally do not provide 365 days of service, and overstates the Medicaid and Medicare reimbursement rates. What is important are the ratios between them.

Nursing Homes	Assisted Living	Home Care	Adult Day Care
\$71,540 (semi-private)	\$35,992 50% of Nursing Homes	\$7,665 Home Health Aide \$6,935 Homemaker 9% to 11% of Nursing Homes	\$26,280 37% of Nursing Homes

The State through the Aging and Disabilities Services Division (ADSD) has embraced the community-based services goal in its planning. However, the administrative structures need strengthening to better implement community-based services.

Between July 2009 and February 2010, the Division of Health Care Financing and Policy (DHCFP) according to the FOCIS (Family Outreach Community Integration Services) report, moved 73 customers into a community-based setting that were at risk of becoming institutionalized within 30 days, or who had been in nursing homes for 30 days or less. Additionally, during the same period, 102 customers who had been in nursing homes for over 30 days, were moved into a community setting.

There will be additional changes to the Medicaid program brought about as a direct result of the recently passed *"Health Care Reform Act"*. It is premature to determine what the impact will be, but as with the ADSD programs, which are the primary focus of this report, the DHCFP will have to look at different ways of providing services.

With the fiscal conditions facing the State, now is the time for Nevada to move from pilot projects to establishing programs that work, and save money in the Medicaid arena. For instance, the Division of Mental Health and Developmental

Services recently approved regulations to start a pilot project for a self-directed waiver program for a limited number of clients in rural Nevada. It has taken almost a year to reach this point, and will likely take another one to two years for this to move out of the pilot phase and into the mainstream.

The vision is to provide a process by which Nevadans with needs will move seamlessly between the levels and types of care they need, as well as in and out of the system, referred to as “continuum of care”. Within the continuum of care, coordinating and consolidating the services will eliminate the “silo effect” where each service or program is administered as a stand alone activity. The current system, based on stand alone programs, is inherently duplicative which is difficult to navigate for the customer as well as the service agencies.

An alternative approach would be to adopt necessary regulations, and in the process, combine common elements between existing programs. This would eliminate some of the duplication created with new stand alone programs. As part of the regulatory development process, an implementation schedule for the various components should also be established. The intent is to accelerate the regulatory process while maintaining state control of the program, eliminating the potential for creating additional service delivery silos and placing Nevadans in need with either more say over the services they need, and/or contributing to the cost of their own care.

The following policies were developed to provide a basis for developing the suggestions. The policy numbers that relate to each suggestion are included with the suggestion.

➤ **Policy 1**

Not fund or create programs for Nevadans with needs that do not actively collaborate with other agencies so as to coordinate services and assure that customers get their needs met in the most cost effective manner possible.

➤ **Policy 2**

Fund programs that are part of care coordination efforts with other community-based and State agencies.

➤ **Policy 3**

Use a self-directed model of service delivery to assure that Nevadans with needs have as much control over the services they choose as possible, to assure greater personal ownership for those needing services, and provide consequences for those who misuse the funding or services.

➤ **Policy 4**

Organize administrative functions in the most cost-efficient way possible to reduce the operating costs of its programs and those of contractors, utilizing the collaborative / continuum of service delivery model, thereby assuring non-duplication of services and funding high quality, productive, and cost-efficient services, programs, and agencies.

Suggestions

Nevada Senior Corps Association offers the following suggestions which reflect the commitment to community-based services through care coordination, with oversight from the State. Several of these were presented previously, and others were developed during and subsequent to the Special Session. It is recognized these suggestions cover a wide range of actions, and cannot be implemented all at once without disrupting current operations. DHHS and ADSD have reviewed these suggestions and provided valuable input and suggested changes, most of which have been incorporated. This is not to be considered an endorsement by either DHHS or ADSD of the suggestions.

Note that where possible, the recommendations have time frames attached. This is done to provide a basis to measure progress. Further, some of the service providers have offered to assist the State in implementing the suggestions. We are not suggesting the creation of another committee. We are willing to sit with the affected personnel, and participate in the design and implementation. In some respects, this is an extension of the SAGE Commission report, bringing to the table those that have expertise at the service delivery level to assist in designing a new safety net.

Aging and Disability Services Division Suggestions

1. **Contract to the private sector all direct services** through an open competitive bidding process by July 1, and not undertake any new direct services without first attempting to secure the service through an open competitive bidding process. The process has started with the Title XX Homemaker program, as well as various Medicaid waiver programs administered by the Division. The Homemaker program has reduced the number of Homemakers on the State payroll to one person. Homemaker services are for all intents and purposes, transitioned.

As part of this effort, place all outsourced services up for a competitive bidding process for the next grant cycle. The first step in this process was the development of the report entitled “*ESSENTIAL SERVICES Nevada Service Delivery*”, dated April 2009. Subsequently, the Division issued a list of essential services that identified 16 essential services designed to keep low-income, minority and rural senior customers out of nursing homes, the primary goal for services provided by the Division. Priorities amongst the essential services were not formally identified for the grant cycle ending in FY 2011. Some grantees were told that the Division would only consider funding projects in a subset of the essential services during the grant cycle that ends in 2013. While this is consistent with the “*ESSENTIAL SERVICES Nevada Service Delivery*” report, it is not clear if this was shared with all the potential grantees.

As important, there does not appear to be any involvement by anyone outside of the Division in determining the priorities. Without questioning the priorities, it points to a lack of clarity. If the grant processes were restructured to include providers and others in the establishment of the funding priorities, and structuring the applications to reflect the priorities as well as the policies, this issue could be corrected. **Policy 1 and 5.**

2. **Bid out Direct Service Case Management and Social Worker services** (except for Elder Protective Services (EPS), leaving ADSD with oversight, planning, grant monitoring and intervention functions. The State and Clark County have worked for the past two or three years to consolidate all the elder protective services within ADSD effective July 1, 2010. This will lead to more accountability, and more importantly, the customers requiring this



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service will receive service from one agency. This is an excellent accomplishment for which both ADSD and Clark County are to be congratulated.

ADSD will need over time, to increase the social workers assigned to EPS. Through the use of contracted Direct Service Case Management social workers, for The Community Home-based Initiatives Program (CHIP), Waiver for Elderly in Adult Residential Care (WEARC), Assisted Living Waiver (AL) and Community Options Program for the Elderly (COPE), ADSD may be able to transfer some of the Social Workers to EPS. Under the provisions of the various Medicaid waivers, social workers are responsible for eligibility determinations, and other administrative duties associated with the programs. In other programs that have both social workers and case managers, the administrative duties are assigned to case managers and the social workers are responsible for dealing with hard to place customers or those with problems that require the skill sets that social workers have. **It is suggested that the Division consider amending the waivers to align the duties more closely with those in other programs that have both social workers and case managers such as the Welfare Division.**

The private sector can provide the same level of service at a lower cost than the State can. It is much easier to adjust caseloads through contracted services than using State employees. The Division will under any restructuring, need to maintain final decision making to assure accountability. **Policy 5.**

3. **Reorganize the Division along functional lines.** This effort is underway. It needs to be completed as part of the next budget cycle. It is suggested that by July 1, a detailed recommendation on the proposed reorganization be developed, and then discussed with the various interest groups impacted, so their concerns can be considered as the next biennium budget is developed.

As part of this effort, all advisory committees should be either abolished or consolidated, with the goal of achieving one advisory committee for ADSD. As noted above, there have been steps to accomplish this. ADSD should consider replacing the various advisory committees with statewide provider

and consumer listening sessions (via electronic methods) to gather ongoing information regarding the effectiveness and efficiencies of service provision. **Policy 1 and 2.**

- 4. Maximize federal and other outside funding opportunities** by appointing a skilled grant specialist or contracting with grant development specialists or organizations to research, produce, implement, and evaluate innovative and high quality, cost beneficial services. It is recognized that creating a grants specialist or hiring an outside firm to perform this function impacts the budget. Further, there are restrictions on the amount of Federal funding that can be utilized for this purpose, and State funding is being utilized for other priority funding areas. Perhaps ADSD could partner with community partners to develop proposals that increase funding opportunities.

As a start, the Division should appoint one person who will be responsible for coordinating, applying for, and researching opportunities. Currently the grant writing, and pursuit of new sources of funding is spread amongst the entire Division. With everyone involved, there is no real focal point for this important activity. *The intent of this is to emphasize and support the need for the Division to secure additional funds for their customers.* **Policy 1, 4 and 5.**

- 5. Consolidate the grant development functions** either within the Division or with other similar functions within the Department during the next budget cycle. Given the current shortage of staff, this suggestion will not reduce overall staffing requirements, or provide additional funds for services. The primary benefit of this is to provide consistent policy and administrative direction to the efforts to secure additional funding from all sources. As noted above, if the previous suggestion is implemented, this could be done in collaboration with existing community-based providers and interest groups.

One of the major issues facing ADSD is securing an adequate revenue stream for its base programs. Most grants are primarily available for innovative or pilot projects which do not address this basic issue. They are however, extremely important in allowing the Division to experiment with

new and innovative service delivery alternatives, which will become more important as the next generation of seniors enters the system. **Policy 5.**

Division of Health Care Financing and Policy Suggestions

1. **The Medical Homes Collaborative program should bypass the pilot program phase.** DHCFP has a Request for Information to solicit comments on a Medical Homes Collaborative program. The proposal is to apply the program to those most at risk. There are many elements of this initiative that apply to several other stand alone programs that are in place. These are all directed towards capping payments, providing for the envisioned self-directed model of services with client involvement in the decisions that impact their care, discussed below, and to some extent, diverting Nevadans with needs from nursing homes. The only concern with the approach is that it appears DHCFP is proposing a pilot program. While this was appropriate when there was little experience with the program, the Medical Home Collaborative Program is now in place and operating successfully in other states. It is suggested the pilot program phase be replaced with a schedule for implementation. **Policy 1, 3, and 5.**
2. **Start the regulatory process for a self-directed care program** based on a fixed budget for those on Medicaid who choose this alternative, so that it could be incorporated in the next budget cycle for presentation to the Legislature. The self-directed care program enables the recipient the flexibility to shop for the best value of services to support their needs. There are several models of this program, such as the Wisconsin Family Care Model, that appear to be operating successfully. The benefit to the state is they are better able to manage Medicaid expenditures and their overall budget. **Policy 1, 2, and 4.**

Suggestions that cross division / department lines

1. **Finish development of the PACE (Program of All inclusive Care for the Elderly) program** with plan amendment and regulations so the program can be incorporated in the next budget cycle. This program contains components of the Medical Homes Collaborative and the self-directed care program. Perhaps the regulations for this program could be incorporated in the Medical Homes Initiative, to avoid the creation of another service silo. Apparently legal questions have been raised as to



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whether or not the State can undertake the PACE program because of statutory language in the insurance statutes. This issue was raised during the last session, but not resolved, and will need to be addressed before the PACE program can be implemented. The Insurance Division recently determined they do not have a role in this program.

There are some concerns that the roll-out costs are not budgeted, however, the Association has members with expertise in the PACE program that have volunteered to assist the State in the plan and regulatory process. Further, 427A.260 (1) would permit the State to include these costs in a RFP or RFQ that is written to solicit potential providers. Using either approach discussed, could at least complete the necessary plan amendment and regulations before the next session of the Legislature, clearing all the procedural hurdles. The Federal government still would need to approve the plan amendment and regulations, however, the State would be in a position to implement the program as soon as the Federal government approved them. **Policy 1, 2 and 4.**

2. **Consolidate all agency compliance audits / surveys** into one for ADSD, Blind and Disabled service providers. As it stands today these agencies can be audited by as many as four different groups – ADSD (CHIP/WEARC and grantees), Medicaid (PCA / WIN), Bureau of Health Care Quality & Compliance (PCA Licensing) and Disability Services (ISO). Most of the regulations are similar and each group could receive a separate addendum addressing their unique requirements. This suggestion is being considered for inclusion in the next budget cycle.

Policy 5.

3. **Enter into cooperative agreements** to consolidate vehicle inspections and operating criteria so that providers are able to more efficiently provide transportation services. If this is implemented, there may not be huge savings, but there will be an improvement in service delivery, less confusion to the operators and the customers they serve. **Policy 5.**
4. **Merge the ADSD Aging and Disabilities Resource Centers (ADRCs) with the Family Resource Centers (FRCs).** Over the past 8/10 years, DHHS has been funding these two efforts, which have essentially the same mission – provide information and assist customers' to access state



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services. The Family Resource Centers are managed out of the Grants Management Unit in the Directors Office, and the ADRC's are managed as a unit within ADSD. The funding for the FRCs is from the General Fund, supplemented by a foundation grant the Grants Management Unit secured when the General Fund allocation for the FRCs was reduced. When the FRCs started, they were non-profit entities, local governments or school districts. As the system matured, the non-profit FRCs expanded their role into additional service delivery programs geared for the customers they were primarily serving. The result is that every FRC is different, and is geared to the primary population they serve. The State has begun to ask the FRCs to take on additional responsibilities as public funding has become tighter. This is resulting in the FRCs moving more towards service providers in addition to information and referral entities.

The ADRCs during this same time frame were primarily focused on the development of a computer based information and referral system called the "Nevada Care Connection". Recently DHHS started looking at combining the 211 information system with the ADRC system. Because ADSD recently completed implementing the SAMS system, it will be difficult to merge the client side of the systems, however there does not appear to be any technical or policy reason why the information side of the systems could not be merged, resulting in a savings to both programs.

Funding for the ADRCs was obtained from the Federal government in a series of projects, which limited the ability of the ADRCs to develop rapidly. In fact, the program was eliminated in the Executive Budget presented to the 2009 Legislature. It was continued through Federal stimulus funds. ADSD in the past two years has created three centers – two in Washoe County and one in Clark County. They are following the same model as the FRCs in that the ADRCs are located in existing non-profits or local governmental units. The information and referral services offered by the ADRCs are the same as the FRCs, except they are limited to senior programs and adults with disabilities. Additionally, the ADRCs, serve as a continuing point of contact for the customers as they enter the social network. ADSD is soliciting proposals to add an additional two pilot sites located in the rural areas.



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The concern is that ADSD is on the verge of creating a duplicative resource center program. The alternative is for DHHS to administratively merge the two programs. It is understood that the funding flexibility that exist with the FRCs does not exist within the ADRCs. It is also clear, given the experience of the FRCs, that the primary population served is determined by the community they serve, more than funding. If the resource centers are administered through one state entity, the State would be in a position to better marshal scarce resources avoiding the potential of creating centers that in time would compete for the same resources. Potentially, customers will also be lost through the inevitable problem of someone being told to go to the other center across town, or across the street for assistance. There is also the opportunity to create an information and referral system for social services similar to the “Job Connect” program that the Department of Employment and Rehabilitation has established.

Where to from here

The next step is to discuss the suggestions with State policy makers, come to agreement on which ones can be pursued and refine the proposals to assure they can be implemented within agreed upon time frames.

Whatever is undertaken needs to be shared with the Legislative branch because the Legislature will be asked to fund the selected solutions, may be required to adopt Legislation in some cases, as well as approve regulations that will result from the implementation activities.