



Recommendations to Balance Arkansas's Long-Term Care System

Prepared for: Division of Aging and Adult Services
Arkansas Department of Human Services

Date: April 24, 2009

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Acknowledgements

As part of a Centers for Medicare and Medicaid Services (CMS) State Long-Term Care Profile Grant, the Division of Aging and Adult Services (DAAS) convened outside experts in long-term care systems reform to make recommendations regarding actions to pursue in order to balance Arkansas's long-term care system.

The consultant team included:

Charles Reed*President, C.E. Reed and Associates*

Penny Black*Partner, C.E. Reed and Associates*

Denise Gaither*Partner, C.E. Reed and Associates*

Carol O'Shaughnessy*Consultant*

Lisa Alecxih*Senior Vice President, The Lewin Group*

Ray Scott*President, Ray Scott Associates*

We would like to thank Suzanne Bierman, Connie Parker and Krista Hughes of the Division for Aging and Adult Services, as well as many members of the Department of Human Services' leadership and provider and constituent representatives for their time and input helping us to understand Arkansas's long-term care system.

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Executive Summary

Arkansas has made major strides towards developing a more “balanced” system of long-term care services. The Division of Aging and Adult Services currently administers three home and community-based services (HCBS) waiver programs, including *ElderChoices*, to meet the needs of the frail elderly; *Alternatives*, to provide consumer-directed services for adults with physical disabilities; and *Living Choices*, the state's assisted living waiver to allow adults 21 and older to live in apartment-style housing where support services, personal health care and 24-hour supervision are provided. The *Independent Choices* program originated as a 1115(c) “Cash and Counseling” Demonstration waiver and has since been expanded as a Medicaid optional state plan service. It provides consumers with a cash allowance that may be used to hire caregivers to help with personal care needs.

In addition, different divisions within Arkansas's Department of Human Services have successfully tapped various federal and foundation resources to improve and balance its long-term care system by providing a broader array of choices and options for consumers and their families. Despite these accomplishments, Arkansas's long-term care system remains heavily invested in expensive institutional care. Arkansas devotes a much greater percentage of its Medicaid long-term care budget to institutional care than most other states; 73% for all Medicaid populations in Arkansas versus 61% nationally.

Between FY 1999–2008, Arkansas Medicaid spending in nursing homes increased by 93%, due at least in part to an effort to improve the quality of care. It should be noted that during this same period of time, the number of individuals in nursing homes decreased by 9%, while the budget for the *ElderChoices* waiver and most other home and community-based services remained essentially flat. In addition, an analysis of available data indicates that individuals living in nursing homes in Arkansas have lower disability scores than nursing home residents in other states.

Many potential consumers and their families experience difficulty accessing the long-term care services they want and need. These consumers will often unnecessarily enter nursing homes, the most expensive service in the long-term care system, because they cannot navigate the fragmented system to obtain a more preferred and often less expensive long-term care service.

Arkansas's currently fragmented system of long-term care services significantly impacts the ability of the state to strategically plan for and administer the long-term care services for an increasing number of vulnerable individuals who will require these services over the next several years.

This report recommends the following major improvements be made to Arkansas's long-term care system and those items listed with a red star (★) are initiatives the Consultant Team believes should be implemented immediately:

Common Philosophy and Shared Core Values

States that have been most successful in balancing their long-term care systems developed a set of core values that drive the planning and development of the long-term care system, some stipulated in state legislation.

- ★ *Continue to engage consumers, advocates, providers, state employees and legislators in establishing a common DHS and statewide philosophy and shared core values.*
- ★ *Establish ongoing mechanisms and forums for regular consumer input regarding the long-term care system.*

Organizational Coordination and Accountability

Currently, no one organizational unit within DHS has responsibility for long-term care budgets, policies or programs. It is our observation that this contributes significantly to a failure to view long-term care as a system of services and supports through which consumers and their families will move as their needs and challenges change with time. Instead, we observed a number of good programs and services functioning more in a disconnected or uncoordinated manner—each in their own “program silo” which creates barriers for consumers attempting to access the most appropriate services to meet their needs.

Recommendations to Balance Arkansas's Long-Term Care System

- ★ *Establish one Administrative Unit, at least for a given population, responsible for all aspects of access, delivery, payment and quality assurance for both institutional and home and community-based services.*
- ★ *Establish a global budget for long-term care services.*
- ★ *Create a single point of entry and institute a single, standardized, automated assessment, service plan, authorization and data collection tool.*
- ★ *Develop data capability and report production to inform day-to-day program management and to provide information for decision makers' long range planning.*

Standardized and Effective Case Management

Clearly defined and highly accountable case management services should be a primary element in assuring that consumers gain access to appropriate and effective services. Effective case management services serve as a major accountability and management tool that reduces the incidence of inappropriate utilization of services.

- ★ *Institute a single, standardized, automated assessment, service plan and authorization tool.*
- ★ *Institute a robust case management service necessary to achieve positive participant outcomes and prevent unnecessary institutionalization.*
- ★ *Assure case management providers demonstrate neutrality and objectivity and are held accountable.*
- ★ *Case management reimbursement should be reviewed to ensure that it accounts for the full range of activities expected of case managers.*

Appropriate Array of Services to Meet Individuals' Needs

One of the most critical components of a balanced system of long-term care services is assuring a variety of service choices and options available to the population in need. Developing the public policy to direct and support the development and implementation of these services must be a priority for Arkansas.

- ★ *Review current rates and the process for setting rates for nursing home and HCBS.*
- *Change bed need rules to require county/market nursing home occupancy rates of at least 95% to approve new beds.*
- *Consider allowing nursing homes to bank beds.*
- *Expand in person transition services for nursing home residents wishing to return to the community.*
- *Revise the Nurse Practice Act to include delegation of certain nursing tasks in the range of community settings.*
- *Explicitly recognize the needs of special population groups, such as people with developmental disabilities, adults with physical disabilities, people with mental or cognitive disabilities, mentally fragile children and people with traumatic brain injuries (TBI).*
- *Pursue targeted and effective workforce recruitment and retention strategies.*
- *Expand funding and range of caregiver support programs.*
- *Expand availability of adult family homes.*
- *Investigate the feasibility of expanding adult day care and identify the barriers to, and opportunities for, expansion.*

The DHS report, **Choices In Living for Arkansans with Long-Term Care Needs**, recognized the need to analyze the current rates paid for a variety of home and community-based services in order to address inadequate reimbursement. With the recent passage of the Tobacco Tax increase, two of these programs, Personal Care and Home Delivered Meals, will receive an increase in the rates paid for these services, representing a significant step forward. However, the rates for many of the additional home and community-based services also need to be addressed.

Cost Containment

Containing the costs of services for an ever-expanding population is a major challenge for Arkansas. Monitoring and analyzing the relationship between reimbursement rates and the availability and quality of care, and developing systems and processes to assure that long-term care funds are spent in the most cost-effective manner for the most appropriate services to meet the consumer's needs is a critical component of balancing the state's long-term care services system.

- ★ *Develop data capability and report production to inform day-to-day program management and to provide information for decision makers' long range planning.*
- ★ *Establish a minimum occupancy of at least 85% for all nursing home cost centers to reduce payment for empty beds.*
- ★ *Develop tiered payment rates based on level of care for all settings.*
- *Rebase nursing home rates no more often than every three years.*
- *Ensure individuals have real choice of setting through efforts of the Choices in Living Resource Center and wider availability of lower cost service options.*
- *Establish rules requiring payment rates "settlement."*

Easy and Seamless Consumer Access to the Full Range of Long-Term Care Services

DHS has a Choices in Living Resource Center that provides a variety of information to people seeking long-term care services. However, too often, providers of services become the primary source of assistance in accessing the long-term care services and individuals must apply for specific programs, most with different criteria and processes for eligibility.

- *Enhance the Choices in Living Resource Center to add more pro-active intervention in critical pathways to institutions and a local community presence.*
- ★ *Institute a single, standardized, automated assessment, service plan and authorization tool.*
- ★ *Develop data capability and report production to inform day-to-day program management and to provide information for decision makers' long range planning.*
- *Establish nursing home pre-admission screening procedures.*

High Quality, Person-Centered and Consumer-Driven Services

Arkansas has made available a number of options for consumer-directed home care services, allowing consumers to choose services and providers of care. However, there is no systematic process for quality assurance for assessment, care planning and case management.

- *Enhance and expand a state Quality Assurance System.*
- *Provide training in core competencies for direct service workers and supervisors.*
- ★ *Develop data capability and report production to inform day-to-day program management and to provide information for decision makers' long range planning.*

Federal Stimulus Funding To Support Long-Term Care Reform

As recommended above, creating a standardized, automated assessment process would serve as the cornerstone for developing a seamless and more consumer friendly process by which all long-term care services could be accessed. This process and tool could accomplish the following:

- *Assure the quality, consistency and completeness of the assessment.*
- *Identify potential triggers for medical interventions to avoid unnecessary hospitalizations and harm to clients.*
- *Assure compliance with CMS protocols and regulations.*
- *Provide consistency in the application of policies and procedures.*

Recommendations to Balance Arkansas's Long-Term Care System

- *Provide diminished exposure to liability for the agency.*
- *Provide data for programmatic and budget decisions.*
- *Improve inter-rater reliability.*

At this time when money is available from federal stimulus funds it would be wise to develop a standardized client assessment tool, purchase the equipment, such as laptop computers needed to implement the tool in the field, and train staff to use the new assessment tool and process. Funds could also be used from the federal stimulus to create the report capability to use the data gathered from the standardized assessment to allow the state to make better informed policy decisions and better manage the long-term care budget.

The recommendations summarized above present a series of actions and initiatives that the Consultant Team believes can build upon the impressive innovations in long-term care services that Arkansas has accomplished to date. As with most such reports, along with the recommendations comes many more questions yet to be answered and issues yet to be addressed. Specifically, the report presents information on the costs or savings of some of the recommendations. This information will give the reader an estimate of the magnitude of costs or savings, not precise forecasts of costs or savings. We identified areas where Arkansas should invest additional funds to improve program performance. However, we believe the information presented will lead the reader to recognize that some of the recommendations for improvements to Arkansas's long-term care program can be accomplished by redirection of funds currently being spent in the program. The Consultant Team will continue to work with DHS staff to further refine cost or savings estimates.

Critical Elements for a Balanced Long-Term Care System

To achieve a more balanced long-term care system, the Arkansas Department of Human Services (DHS) needs to accomplish the following:

1. Establish a Common Philosophy and Shared Core Values Related to Balancing Long-Term Care
2. Centralize Organization for Coordination and Accountability for Long-Term Care Balancing
3. Standardize and Assure Accountability for Effective Case Management
4. Create an Easy and Seamless Consumer Access to the Full Range of Long-Term Care Services
5. Ensure Availability of an Appropriate Array of High Quality Services to Meet the Needs of Consumers
6. Create Policy and Structure for Cost Containment

Basis for Critical Elements for a Balanced Long-Term Care System

Research related to successful & unsuccessful states.

Expert opinion of both researchers and implementers with extensive relevant experience.

Background and Overview

As part of a Centers for Medicare and Medicaid Services (CMS) State Long-term Care Profile Grant, the Division of Aging and Adult Services (DAAS) convened outside experts in long-term care systems reform to make recommendations regarding actions to pursue in order to balance Arkansas's long-term care system. The experts included:

- ▶ **Charles Reed** who founded C.E. Reed and Associates, a long-term care consulting firm. Previously, he served as deputy secretary of Washington State's Department of Social and Health Services and assistant secretary of Washington's Aging and Adult Services Administration.
- ▶ **Penny Black**, a partner in C.E. Reed and Associates, a consulting firm specializing in long-term care issues and an expert in long-term care policy and program development with 25 years of high level experience in developing, implementing and managing long-term care systems.
- ▶ **Denise Gaither**, a partner in C.E. Reed and Associates, with 25 years of experience in state financing of long-term care and Medicaid rate setting for long-term care.
- ▶ **Carol O'Shaughnessy** served in the federal government as an analyst in long-term care legislation and policy for over 30 years and is a nationally recognized expert in Older Americans Act supportive service programs and activities.
- ▶ **Lisa Alecxih**, a Vice President with The Lewin Group for over two decades and a nationally recognized expert in long-term care financing and service delivery, has extensive research and technical assistance experience with systems change related to supportive services for older adults and individuals with disabilities.
- ▶ **Ray Scott** served as an in-state consultant and coordinator for our panel, bringing his 30 years of experience in health and human services in Arkansas as both a public official and private consultant, including serving as the former Director of the Department of Human Services (DHS) from 1981 to 1988 and more recently as a DHS Deputy Director from 2005 to 2007.

Most members of the expert panel had prior experience examining Arkansas's long-term care system and all attended a two-day site visit in January 2009. During the site visit, the panel met

with state officials across relevant divisions within DHS, consumer advocates and provider representatives. In addition, members worked closely with DAAS staff to gather additional information and ensure the accuracy of this report.

In our collective opinion, Arkansas continues to make strides in balancing and improving its long-term care system of services. Stakeholders, both inside and outside of government, seek to improve the array, quality and access of long-term care services. Many state government employees involved in planning, developing and operating the current system of long-term care services expressed commitment to improving and balancing the system.

In recent years, Arkansas successfully tapped various federal and foundation funding sources to move toward the goal of improving and balancing the long-term care system. Many stakeholders inside and outside of government indicated commitment to the concept of "Choice" and "Self-Direction" of care in the state-administered long-term care program. Arkansas's pioneering efforts in implementing one of the first Cash and Counseling programs in the United States serves as proof of this commitment. The state supports a wide array of home and community-based services available through the federal-state Medicaid 1915(c) waiver program for various population groups. These include home care services, respite care, attendant care, among many others. For individuals needing residential services, DHS recently added assisted living and adult family homes to the approved services in the state, including low income options as choices in the waivers.

Despite these accomplishments, Arkansas's long-term care system remains heavily vested in institutional care. In 2007, Arkansas allocated a much greater percentage of its Medicaid long-term care budget to institutions than most states (73 percent for all Medicaid populations in Arkansas versus 61 percent nationally). The proportion for institutional care differed by population with 79 percent of Medicaid spending for long-term care services among older adults and younger individuals with physical disabilities in nursing homes. In contrast, for individuals with developmental disabilities (DD), the proportion of Medicaid long-term care spending for institutional services appears more balanced at 58 percent.

Many potential consumers and their families still have great difficulty accessing services they want and need. These individuals either go without needed services or are placed in settings they may not want or that do not meet their needs. Individuals with developmental disabilities seeking Medicaid community-based services face considerable waiting lists. Many home and community providers say that the rates they receive to provide services to publicly funded consumers do not meet their cost of providing services, making it difficult for them to continue to provide such services. Adults seeking non-nursing home alternative residential care face many barriers. For example, even though the state has made adult family homes an option for consumers, no providers have been recruited and contracted for the provision of this service. In addition, assisted living providers find it difficult to engage consumers because of confusing eligibility and access issues. Adult day care providers face challenges in finding funds to start up new programs.

Between FY 1999-2008, Medicaid spending for nursing home care increased by 93% even though individuals served in nursing homes decreased by 9%. During the same period, expenditures for the ElderChoices waiver remained essentially flat.¹ Nursing Home residents in Arkansas have low disability scores which suggests that some of these individuals might be effectively served in other

¹ DHS Medicaid statistical report AFGM Report R-2242.

less restrictive settings at a lower cost if viable options to meet their needs were available in the state and promoted by state policy.

Arkansas currently administers a fragmented system of long-term care services which significantly impacts its ability to strategically plan, develop and operate a streamlined long-term care system that provides consumers with choice, access and quality they want and need. Because of this fragmentation, managers and decision makers do not have data and information to compare costs and effectiveness of policies and services for future program and budget development. Arkansas can improve its organizational structure to become more efficient in planning, developing, funding and operating its long-term care system. These improvements can provide consumers and their families with better options to meet their long-term care needs and save state resources in years to come as the population in need continues to grow.

A recent study "Common Consumer Perceptions About Arkansas' Long Term Care Rebalancing" (attached as an appendix) indicates that consumers agree that consumer-directed care, person-centered planning, self-advocacy and the empowerment of consumers found in the 1115 Medicaid Waiver Independent Choices have had a positive impact and should remain key elements of the state's long-term care system.

However, the study also states that there continue to be eligibility processes and payment structures that favor institutional care over consumer preferred home and community services. As a result many consumers feel home and community long-term care services are not widely available and are very difficult to access.

Exhibit 1 presents critical elements necessary for rebalancing a state's long-term care system and Arkansas's current status in terms of strengths and gaps. This chart provides a summary of the major recommendations to meet the critical elements in order to balance the long-term care system with those that we consider of highest priority in the near-term noted by a starred bullet (★). The remainder of the report provides important details regarding operational aspects of the recommendations. The organizational and infrastructure recommendations primarily, but not exclusively, focus on Medicaid and could be implemented across populations in need of long-term support services. The service recommendations focus primarily on frail elderly and younger individuals with physical disabilities. We encourage DHS to conduct a similar review of service strengths and gaps for other population groups, including individuals with developmental disabilities (DD), people with mental health or cognitive disabilities and substance abuse issues, medically fragile children and people with traumatic brain injuries (TBI) in order to make service recommendations for these populations.

The service recommendations focus primarily on frail elderly and younger individuals with physical disabilities. We encourage DHS to conduct a similar review of service strengths and gaps for other population groups.

Exhibit 1: Rebalancing Critical Elements, Arkansas’s Current Status, Recommendations to Balance the Long-term Care System

Rebalancing Critical Elements	Arkansas’s Current Status	Recommendations to Balance the Long-Term Care System
<p>Common Philosophy and Shared Core Values</p>	<p>Strengths – In September 2008, the Division of Aging and Adult Services published “Choices in Living for Arkansans with Long-term Care Needs” which included 12 priority recommendations and 13 additional recommendations to rebalance its LTC system and expand home care options. As a part of the State Profile Tool grant, Arkansas convened eight different stakeholder groups and met with over 120 consumers and advocates to gather information regarding consumer perceptions of the state’s long-term care system.</p> <p>Gaps -- “Choices in Living for Arkansans with Long-term Care Needs” reflects primarily an aging perspective and has yet to be publicly released. It also lacks a mission statement bought into by all of the divisions within DHS responsible for long-term care and does not address the needs of all populations seeking long-term care services.</p>	<ul style="list-style-type: none"> ★ <i>Continue to engage consumers, advocates, providers, state employees and legislators in establishing a Department of Human Services and statewide common philosophy and shared core values.</i> ★ <i>Establish ongoing mechanisms and forums for regular consumer input regarding the long-term care system.</i>
<p>Organizational Coordination and Accountability</p>	<p>Strengths – Responsibility for nearly all aspects of policy, programs, funding, regulation and oversight of long-term care services resides within the Department of Human Services. (Provider credentialing, Permits of Approval (POAs) for Nursing Homes, Residential Care Facilities, Assisted Living Facilities, Home Health and Hospice Agencies, Psychiatric Residential Care Facilities and Intermediate Care Facilities for the Mentally Retarded constitute the exceptions.)</p> <p>Gaps -- Various divisions within DHS hold responsibility for the policy, access, reimbursement and monitoring functions for institutional and home and community-based services, and the coordination appears minimal. Even within home and community-based services, no one division has responsibility or accountability for all aspects for a given population.</p>	<ul style="list-style-type: none"> ★ <i>Establish one Administrative Unit, at least for a given population, responsible for all aspects of access, delivery, payment and quality assurance for both institutional and home and community-based services.</i> ● <i>Establish a global budget for long-term care services.</i> ★ <i>Institute a single, standardized, automated assessment, service plan and authorization tool that builds upon information collected as part of the intake and eligibility process and classifies consumers according to acuity.</i> ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i>

Rebalancing Critical Elements	Arkansas’s Current Status	Recommendations to Balance the Long-Term Care System
<p>Standardized and Effective Case Management</p>	<p>Strengths – Arkansas has developed regulations for the provision of case management.</p> <p>Gaps – For HCBS, the same entity providing services is often also providing case management, resulting in a potential conflict of interest. Also access to services is confusing and fragmented and there is no case management of community residential and nursing facility patients. Current regulations do not address all of the commonly accepted elements of case management and lacks any system for assuring accountability.</p>	<ul style="list-style-type: none"> ★ <i>Institute a single, standardized, automated assessment, service plan and authorization tool that builds upon information collected as part of the intake and eligibility process and classifies consumers according to acuity.</i> ★ <i>Institute a robust case management service necessary to achieve positive participant outcomes and prevent unnecessary institutionalization.</i> <ul style="list-style-type: none"> ■ Identify and adopt standards that include a complete array of core functions. ■ Provide consistent training on the standards. ■ Provide in person short-term case management for nursing home entrants and appropriate individuals being discharged from a hospital. ■ Assure appropriate care plan authorizations for cost control. ■ Assure receipt of authorized services. ● Entities providing case management to participants in the community, community residential settings and nursing facilities must demonstrate neutrality and objectivity, and DHS needs mechanisms to ensure accountability. ● Case management reimbursement should be reviewed to ensure that it accounts for the full range of activities expected of case managers.

Rebalancing Critical Elements	Arkansas’s Current Status	Recommendations to Balance the Long-Term Care System
<p>Easy and Seamless Consumer Access to the Full Range of Long-Term Care Services</p>	<p>Strengths – The Choices in Living Resource Center provides information to individuals who have been newly admitted to nursing homes and have requested additional information regarding their options under Options Counseling, Act 516 of 2007. State employed and trained RNs conduct functional eligibility/nursing home level of care determinations for all waiver services.</p> <p>Gaps – Nursing homes conduct the functional eligibility/level of care assessment for their admissions. Providers become the primary source of assistance in navigating the long-term care system and make recommendations that may be based on a limited knowledge of available options and also may be self-serving. Individuals must apply for specific programs through DHS county offices where workers lack specialization and training to advise applicants regarding the best available publicly funded long-term care programs to meet their needs and circumstances.</p>	<ul style="list-style-type: none"> ● Enhance the Choices in Living Resource Center to add more pro-active intervention in critical pathways to institutions and a local community presence, including: <ul style="list-style-type: none"> ■ Standardize information and assistance and reconsider the role of AAAs relative to County Offices ■ Institute a standardized automated intake system that interfaces with the assessment tool for all organizations conducting intake ■ Provide in <u>person</u> options counseling <ul style="list-style-type: none"> ■ <i>Outreach to nursing home residents (both short and long stay patients)</i> ■ <i>Work closely with hospital discharge planners to gain access to hospital patients in need of long-term care</i> ★ <i>Institute a single, standardized, automated assessment, service plan and authorization tool that builds upon information collected as part of the intake and eligibility process and classifies consumers according to acuity.</i> ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i> ● Establish nursing home pre-admission screening procedures.

Rebalancing Critical Elements	Arkansas’s Current Status	Recommendations to Balance the Long-Term Care System
<p>Appropriate Array of High Quality Services to Meet Individuals’ Needs</p> <p><i>(Current status and recommendations for focus on frail elderly and younger individuals with physical disabilities)</i></p>	<p>Strengths – Arkansas pioneered self-directed services in the United States as a Cash and Counseling demonstration site and recently instituted assisted living and adult family homes as Medicaid options. DHS has also actively participated in many federal grant programs to expand home and community-based services and improve their delivery. Through its Medicaid waiver program, Arkansas has made available an array of home and community-based services to multiple populations. Arkansas appears to have an adequate supply of nursing home beds (66 beds per 1,000 persons age 65+ compared to 45 beds per 1,000 in the U.S. with an occupancy rate of 72% compared to 85% in the U.S.)</p> <p>Gaps – Medicaid home and community-based services payment rates may be insufficient and only periodically increase. Unlike many other states, Arkansas has not provided supplemental support for caregiver training and education outside of the federal matching requirement to receive Older Americans Act caregiver funds. There is no systematic process for quality assurance for assessment, care planning and case management.</p>	<ul style="list-style-type: none"> ★ <i>Review current rates and the process for setting rates for nursing home and HCBS</i> <ul style="list-style-type: none"> ■ Develop tiered level of care payment rates for all settings ■ Strive for parity between nursing home and HCBS rates and increases ● Change bed need rules to require county/market nursing home occupancy rates of at least 95% to approve new beds. ● Consider allowing nursing homes to bank beds. ● Expand in person transition services for nursing home residents wishing to return to the community. ● Revise the Nurse Practice Act to include delegation of certain nursing tasks in the range of community settings ● Explicitly recognize the needs of special population groups in Choices In Living for Arkansans with Long-Term Care Needs. These populations are people with developmental disabilities, adults with physical disabilities, people with mental or cognitive disabilities, mentally fragile children, and people with traumatic brain injuries (TBI). ● Pursue workforce recruitment and retention strategies, such as: <ul style="list-style-type: none"> ■ Realistic job previews ■ Career ladders ■ Supervisor training ● Expand funding and range of caregiver support programs. ● Expand availability of adult family homes. ● Investigate the feasibility of expanding adult day care and identify the barriers to expansion. ● Develop a core curriculum and standardized training for care providers across all settings.

Rebalancing Critical Elements	Arkansas’s Current Status	Recommendations to Balance the Long-Term Care System
		<ul style="list-style-type: none"> ● Enhance the Quality Assurance System, including: <ul style="list-style-type: none"> ■ Collecting participant feedback regarding satisfaction. ■ Determining participant outcomes related to costs. ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i>
<p>Cost Containment</p>	<p>Strengths – The nursing home payment system, while generous, is structured to promote quality nursing home care. Despite funding constraints, Arkansas has no waiting lists for home and community-based waiver services for older people.</p> <p>Gaps – Many people in need of long-term care services have great difficulty accessing services, especially home and community services. Arkansas has achieved cost containment primarily by limiting payment rates for home and community-based services and through declining Medicaid nursing facility use, which is not an active management strategy. Arkansas has constrained the number of people with developmental disabilities who may receive home and community-based waiver services, resulting in waiting lists for those in need.</p>	<ul style="list-style-type: none"> ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i> ★ <i>Establish a minimum occupancy of at least 85% for all nursing home cost centers to reduce payment for empty beds.</i> ★ <i>Develop tiered payment rates based on level of care for all settings.</i> ● Rebase nursing home rates no more often than every three years. ● Ensure individuals have real choice of setting through efforts of the Choices in Living Resource Center and wider availability of lower cost service options, such as adult family homes, assisted living and adult day care services. ● Establish rules requiring payment rates “settlement” such that if a nursing home does not spend Medicaid funds paid to it for patient care, the funds must be returned.

1.0

Common Philosophy and Shared Core Values

If stakeholders can agree on common values, they can return to the core values when operational details start to get in the way of moving forward.

States that have been most successful in balancing their long-term care systems developed a set of core values that drive the planning and development of the long-term care system, some stipulated in state legislation. An array of stakeholders, such as legislators, policy makers, providers, consumers, advocates and families, must arrive at a shared agreement and understanding regarding what they want “their” long-term care system to look like. While high level agreement regarding the important types of services can usually be reached fairly easily, service delivery and access to services - how to actually put the values in place in developing and operating the long-term care system -- can be more difficult issues. Of course, simply having a set of core values does not in itself improve or balance a state’s long-term care system, but it may be a necessary beginning. If stakeholders can agree on common values, they can return to the core values when operational details start to get in the way of moving forward.

The most successful states stress a consumer focus in their long-term care system that offers consumers and their families viable options for how they want to receive needed long-term care services. Examples of such values include:

- ▶ Persons with disabilities and their families are entitled to maximum feasible choice/participation in selecting care settings.
- ▶ Persons with disabilities have the right to expect “quality of life,” personal dignity, maximum feasible independence, health security and quality of care.
- ▶ Persons with disabilities have the right to choose and direct a care plan involving “managed risk” in exchange for the advantages of personal freedom.
- ▶ The array of public service options and individual participant choices may be bounded by reasonable considerations of cost effectiveness.

Several states have found that when they offer long-term care consumers and their families what they really want and need in a manner with viable access, the state can actually serve more people with available funds and perhaps even save money. Of course, to achieve this and assure an efficient cost-effective system, a number of factors need to be put in place to manage and control cost in the long-term care system. However, the most successful states started with an agreed-upon set of core values to drive the development and operation of their long-term care system.

In order to serve more people and/or save the state money, the core values statement should include a “reasonable cost” consideration in meeting consumers’ needs and preferences. In some cases, a consumer’s preferred setting may be too expensive to provide cost-effectively. Reasonable costs can often depend upon informal support systems and cognitive functioning. However, in states successful in balancing their long-term care systems, providing a wide array of accessible options from which consumers can choose has been very feasible and efficient.

2.0

Organizational Coordination and Accountability

If Arkansas wants a more balanced long-term care system, it becomes critical that one place in state government plans, develops, administers and is held accountable for the balanced system.

In Arkansas, no one place in state government holds the responsibility to plan, develop and operate the publicly funded long-term care system. The Governor and the legislature have no single place to hold accountable for improving and balancing the long-term care system. The current organization scatters the component parts of the long-term care system throughout state government. While the Department of Human Services (DHS) houses most of the components of the long-term care system, all of these components are dispersed throughout a number of different divisions within DHS. The Division of Medical Services (DMS) has responsibility for policy, regulation, quality assurance, rate setting and budget for all Medicaid funded long-term care services, including nursing home care and all Medicaid waivers which are the primary method for providing home and community-based alternatives to facility-based care. The Division of Aging & Adult Services (DAAS) administers all of the Older Americans Act funded programs and services provided through the network of Area Agencies on Aging. Importantly, DAAS has primary management and oversight responsibility for the Medicaid waivers for home and community-based long-term care services that were approved and funded through DMS. Staff responsible for nursing home policy have little incentive and no responsibility to try to introduce efficiencies in the nursing home program, policies and expenditures in order to fund program expansion in other long-term care services administered by other DHS divisions or state organizations.

Even for program managers with the best intentions of looking at the larger long-term care picture, the budget does not allow shifting of monies among the units. Further, staff in another separate DHS division, County Operations, determine financial eligibility for long-term care services. These staff have many other program responsibilities, lack in-depth knowledge of long-term care program requirements and have little incentive to expedite long-term care eligibility determinations, even though doing so might save the state money.

The current organizational structure described above means that funding, policy and program oversight, and assessment and eligibility determination are fragmented between three separate divisions within DHS. It should also be noted that the decision regarding the need for, location of and approval of long-term care facility construction also resides within the Health Services Permit Agency which is an additional state agency.

No single place in state government has overall authority or responsibility to assure that consumers and their families have access to needed services, or even know of available services. This often leads to confusion among consumers and their families in need of long-term care services, going without needed services to meet their individual needs and/or receiving care in more expensive and restrictive care settings. As a result, a greater proportion of Arkansans reside in nursing facilities and many of these nursing home residents have lighter care needs compared to other states.

For those participants who receive Medicaid or other state-funded services, no single place in state government holds ongoing responsibility to assure that they receive the most appropriate services as circumstances change so as to meet the participants’ needs and to protect state resources. Finally, no single place in state government holds responsibility to assure the availability of providers to meet consumer demand and that various types of providers receive fair payment based on the services they deliver.

The absence of a standardized assessment for functional eligibility for long-term care services makes it impossible to collect data needed to manage and control the increasing demand. Potential consumers can enter the long-term care system in a variety of ways, depending on where they live in the state and the types of providers available in their area. Other potential consumers in other parts of the state may not know how to access services or have very limited access to preferred services.

While the state uses a standard application process for financial eligibility, there seems to be great variation around the state in the administration of the assessment and the timeliness of the process. The workers who conduct financial assessments may also do other types of eligibility for public services and may only occasionally do long-term care financial eligibility. Any delays in long-term care financial assessments due to inaccuracies as a result of lack of familiarity with the process or system inefficiencies greatly impact a consumer's ability to access preferred services.

If Arkansas wants a more balanced long-term care system, it is critical that one place in state government plans, develops, administers and is held accountable for the balanced system. The states most successful in balancing their long-term care systems have one place in state government responsible for the entire effort, allowing them to be as strategic and efficient as necessary to plan and operate a balanced long-term care system. For example, some states that have tried to have a "global budget" for all long-term care services have found it very difficult, if not impossible, to have a "global budget" if more than one state agency retains responsibility for operating the long-term care system.

A flexible state budget provides a key tool in expanding preferred, less costly home and community services and managing state expenditures. The state budget structure should allow movement of funding among programs, allowing flexibility to provide the service that best meets the client's needs. Flexibility should also extend to provide short-term supports because these services may assist individuals to stay off of state-funded and Medicaid programs in the long term. Staff administering long-term care programs should have leeway to shift funding designated for nursing home payments to support other long-term care services when this results in more appropriate services for the client.

This "global budget" concept requires that the state long-term care agency have responsibility for managing all expenditures within the long-term care budget. Under a global budget, the money doesn't follow specific participants. Instead, the long-term care agency has flexibility to use institutional funding to expand home and community services.

In states using a global budget, the legislature may use detailed information about estimated caseloads and average costs for each service to establish an overall appropriation for the agency. Within the single appropriation, the agency has the discretion to fund needed services without specific approval by the legislature. The agency then provides periodic detailed reports on spending relative to the budget estimates. For example, Oregon monitors expenditures using a system that links billing and payments to the state's automated eligibility and assessment process. From this automated system, Oregon compiles data on the number of people currently receiving each service, the cost of authorized service plans and the service priority level. The state can then compare actual caseloads and expenditures to those projected in the budget and determine whether all priority levels have adequate funding. Thus, the state has frequent, accurate information about whether program changes may be needed to comply with budget limitations. As

discussed elsewhere in this report, consistent data regarding participant needs, characteristics and costs become critical to assuring policy makers of an effectively managed global budget.

In this approach, the state long-term care agency has the flexibility to determine needed expenditures (e.g., more case management resources, transitional funding for those leaving nursing home, higher payment rates for some providers) in order to make efficient placements in the most appropriate, economical setting possible. The agency also has an incentive to use funds as efficiently as possible in order to expand services.

In summary, this discussion is not about arranging boxes on the DHS organizational chart or about "fixing" long-term care policy and program concerns by moving them from one organizational unit to another. The point is, without addressing this issue, Arkansas will not achieve greater balance in its system of long-term care services and, more importantly, those in need of long-term care services will not have access to preferred services that in many cases will be more cost effective for the state.

Currently, no one organizational unit within DHS has responsibility for long-term care budgets, policies or programs. It is our observation that this contributes significantly to a failure to view long-term care as a system of services and supports through which consumers and their families will move as their needs and challenges change with time. Instead, we observed a number of good programs and services functioning more in a disconnected or uncoordinated manner—each in their own "program silo" which creates barriers for consumers attempting to access the most appropriate services to meet their needs.

Based on our knowledge of and work with organizational structures in other states and our review of the current structure in Arkansas, we make the following recommendations that we believe will create a structure to optimally serve consumers and their families seeking long-term care services. If implemented, we believe these recommendations will place Arkansas among the top tier of long-term care programs in the country and will better prepare and position the state to deal with the coming demographic challenges which will certainly increase the number of Arkansans seeking long-term care services.

Recommendations

Arkansas should consider combining the following state functions into one administrative organization in the Arkansas Department of Human Services. While state employees, or in some situations contractors, could provide these functions, they should still be held accountable to this single organizational unit. Some of these functions will require additional resources to ensure timely, appropriate service is delivered. Combining these functions under one administrative organization will facilitate decisions regarding how to most effectively deploy needed resources.

1. Planning, developing and operating the Arkansas long-term care publicly funded program.
2. Managing the "Global Budget" for all state administered long-term care funds. This would include administration of the Medicaid long-term care budget which includes funding for Nursing Facilities, Home and Community Services and all Waivers for long-term care services and Older Americans Act funds.
3. Determining functional and financial eligibility determination for all state administered long-term care services. Providing appropriate access to consumers and their families needing long-term care services.

4. Collecting and analyzing data to manage the long-term care system and report to the Governor and the legislature.
5. Managing all long-term care participants with public funding.
6. Assuring quality for all long-term care services.
7. Setting payment rates for all long-term care services.
8. Developing providers to meet participant demands.

Data and Report Capability

For program management and policy development, DHS and DAAS use data from the State of Arkansas Medicaid payment system and from national sources such as AARP, the U.S. Census, Thomson-Reuters, etc., as well as anecdotal information from participants. DAAS also uses these data to produce aggregated participant utilization and average spending per participant and spending across individual waiver and categorical grant programs – critical information in predicting and planning for the expansion of new service programs. Using data and information in this manner aided Arkansas in being innovative and developing a variety of new approaches to serve their long-term care population.

While these data provide output metrics for the long-term care system, they do not reveal which program policy and service offerings work best. Policy, budget and legislative decision makers do not have access to integrated data across all of the services provided related to acuity, costs, providers and service settings. Without these data, administrators cannot know which settings most effectively serve participants with the highest acuity needs, which providers need more training to deal with specific service requirements and which rates need adjusting. Additionally, managers have no effective tools for efficiently tracking productivity and quality of staff work or the appropriate allocation of staffing resources.

If Arkansas implemented an automated standardized functional assessment tool, ongoing monitoring and analysis could provide the necessary information for program adjustments as knowledge and experience expands. Monitoring the impacts of case management and service levels and models on participant outcomes and costs can provide information to impact decisions on service delivery methods and resource allocations.

Recommendations

1. To ensure consistent and accurate data collection, develop an automated functional assessment system that has the capacity to:
 - ▶ Identify and quantify costs, cost savings, cost avoidance and ongoing service delivery issues that should be addressed by decision makers.
 - ▶ Provide meaningful reports at the state, county, unit and individual case manager/nurse level for program development, staffing allocations and training provision and development.
2. To provide information to Program Management and Development staff consider creating the following reports:

- ▶ Assessment Totals—This report would provide data on the number of assessments completed.
- ▶ Assessment versus Payment Authorizations -- This report would indicate whether a payment has been authorized related to an assessment.
- ▶ Care Plan—This report would provide information on participant classifications, settings and rates/hours
- ▶ Participant Transfers—This report would provide information on the number of transfers occurring between offices.
- ▶ Clinical Scores—This report would list the various clinical scores (e.g., Mini-Mental Status Evaluation (MMSE)) for participants in different settings.
- ▶ Pilot Programs—This report would list participants who have been authorized under various pilot programs.
- ▶ Inactive Cases—This report would provide information on cases that have been entered into the system but have been inactivated and the reason inactivated.
- ▶ Intake—This report would provide intake totals by workers and the outcome of the intakes.
- ▶ Nursing Facility/Hospital Assessments—This report would list participants assessed in a Nursing Facility or a Hospital and would include information regarding participant discharge and the barriers to discharge.
- ▶ Nursing/Medical Referrals—This report would be a summary report that would capture the number of nursing/medical referrals triggered and answered yes for referral.
- ▶ Relative Providers—This report would provide information on relative care providers including the relationship of the relative.
- ▶ Service Delivery Overview—This report would provide data on the number of participants based on setting types, classifications and programs.
- ▶ Ticklers—This report would provide information to the case manager and supervisor on assessments due and/or overdue.
- ▶ Response Time Activity Report —This report would enable managers and supervisors to follow the flow of individual assessments from the beginning point of intake to transfer in order to monitor response time activity.

Most reports would be designed to produce data at the statewide, reporting unit, case manager and county levels.

An automated assessment and reporting system sets the foundation for a corresponding quality assurance system.

3. To assure that CMS protocols for quality improvement and quality assurance can be addressed, develop a data driven monitoring system that can be queried from any level in the long-term care system. The following reports can be considered for development:

- ▶ Provider Proficiency—This report would provide information on services provided.

- ▶ Case Management File Review—This report would provide information from assessments associated with dollar findings related to eligibility and CMS protocols.
- ▶ Supervisor Reviews by case manager -- This report would provide information on the number of reviews that were completed for all case managers.

All reports referenced here could be modeled on existing reports and systems in other states and tailored to meet the unique needs and requirements of the State of Arkansas.

3.0

Standardized and Effective Case Management

Typically, in a standardized case management system, case managers, assessors or options counselors assist participants in exercising their options in community-based care to prevent unnecessary institutionalization and decrease barriers that may prevent someone from remaining in their present place of residence or moving to a less restrictive environment.

In Arkansas, different staff and organizations conduct assessments and case management. The State of Arkansas employs registered nurses located throughout the state in county offices to conduct assessments to determine functional eligibility, complete reassessments and create care plans for the ElderChoices and the Alternatives for Adults with Physical Disabilities waiver. The nurses conducting the assessments do not provide any of the other elements of case management.

The state has developed general regulations for the provision of case management and it appears that most area agencies on aging (AAAs) provide varied aspects of case management to consumers. In addition to the eight AAAs, other organizations provide case management services, including the Department of Health and over two dozen other home and community-based providers. They often assist potential consumers with completing their applications for services and they also monitor the provision of various services authorized by the state. These same agencies provide personal care to the participants whose cases they monitor. This arrangement creates a potential conflict of interest for the AAAs. When interviewed, representative AAAs did not appear to provide case management services in the same manner from AAA to AAA.

As outlined in **Choices in Living for Arkansans with Long-Term Care Needs**, case management in Arkansas lacks standardization and consistent availability to those in need of this service. Although an array of services exists, access to these services can be confusing and fragmented for consumers. Information and Assistance lacks standardization and a formal or consistent connection to case management or assessment. Many times, consumers receive their first information about the greater long-term care system after placement in a nursing home. At this juncture, consumers receive a brochure outlining the options available to them. State officials report that many brochures are returned to the state without referrals for residents. Neither state staff nor targeted case management contractors routinely visit nursing facilities to discuss options for placement outside of the nursing facility with residents.

Many states have separate or a variety of agencies responsible for different elements of case management. These arrangements have usually resulted from the historical evolution of categorical programs, and they contribute to a lack of coordination and communication regarding specific participant needs. This appears to have been the case in Arkansas as well.

Typically, in a standardized case management system, case managers, assessors or options counselors assist participants in exercising their options in community-based care to prevent unnecessary institutionalization and decrease barriers that may prevent someone from remaining in their present place of residence or moving to a less restrictive environment. Case managers attempt to assist participants with complex or multiple problems and disabilities to receive needed services in a timely and appropriate fashion. A case manager maintains contact with participants to monitor changes in their condition or situation and to work with the individual to adjust and implement the plan of care through:

1. Assessment
2. Development of a detailed service plan
3. Periodic monitoring/verification of service provision

4. Periodic home visits or telephone contacts to monitor participant status and to facilitate appropriate implementation of the plan of care
5. Discharge/termination planning
6. Coordination with other services where appropriate

The case manager, nurse or options counselor should work with the participant to understand the potential outcomes of choice and assist the participant to:

1. Choose from an array of options for personal and health care services. However, service and service delivery options are generally limited by eligibility criteria, payment sources, functional ability and provider qualifications.
2. Understand (along with family members and service providers) that a comprehensive plan is developed within the narrowed choices and resources available and that meeting all needs is an expectation that may not be able to be achieved (this is often referred to as bounded or informed risk).

Current policies and regulations identified in the Division of Medical Services Provider Manual do not address all of the case management service elements necessary to achieve possible positive participant outcomes and prevent unnecessary institutionalization.

Recommendations

1. Develop standards for Information and Assistance at the AAA level.
2. Create an automated intake system that interfaces with the automated assessment tool that transmits demographic and screening information to the state nurses.
3. Determine a process for selecting qualified case management providers and whether the same provider will be responsible for community residential and nursing facility case management.
4. Revise rates to provide fair and reasonable reimbursement for the required elements of case management.
5. Develop or revise/expand existing standards for case management activities that include the following core functions:
 - a. Assessment—Face-to-face standardized and automated assessments for access to all long-term care services and programs that are performed in the participant's residence at least annually or as the participant's condition changes.
 - b. Planning—Develop an automated plan of care related to acuity and payment levels with each participant.
 - c. Termination Planning—If the reassessment determines that the participant is no longer eligible, discuss options available to the participant.
 - d. Supportive Functions:
 - 1) Participant Advocacy—Intervene with agencies or persons to help participants receive appropriate benefits or services.

- 2) Technical Assistance - Assist participants to obtain a needed service or accomplish a necessary task that due to physical or cognitive limitations, they cannot obtain independently, such as:
 - a) Completing a form
 - b) Researching a living situation
 - c) Assisting with moving arrangements
 - d) Arranging transportation
 - e) Other services related to the plan of care.
- 3) Referrals - Make and follow up on referrals to mental health and other services as identified in the assessment.
- 4) Family Support - Assist the family or others in the participant's informal support system to:
 - a) Make necessary changes in the home environment and lifestyle that participants have agreed to
 - b) Encourage changes in high risk behaviors or choices that may improve the stability of the plan of care
 - c) Plan a move to or from residential care, etc.
- 5) Crisis Intervention - Provide short-term crisis intervention in an emergency situation to resolve an immediate problem before a long-term plan is developed or the current plan is revised. Crisis intervention may include:
 - a) Exceptions to rules
 - b) Arranging for temporary placements in AFC, AL or NF
 - c) Authorization of other short-term services
- 6) Develop protocols for handling challenging cases.
- 7) Develop and implement Nursing Facility Case Management.
 - a) Assign specific case managers to specific nursing facilities to visit assigned facilities on a regular basis to assist Medicaid participants, Medicaid applicants or individuals who are likely to convert to Medicaid within 180 days of admission.
 - b) Nursing Facility Case Management should include:
 1. Informing the individual of discharge resources
 2. Identifying discharge potential in the automated assessment and discussing this potential with the individual and nursing facility staff
 3. Identifying barriers to discharge and developing plans to address the barriers
 4. Determining when ongoing contact and monitoring will occur

5. Developing and authorizing a service plan when the individual is ready to move
6. Develop a standardized Quality Assurance program for all aspects of case management to include assessment, care planning and ongoing case management activities. To achieve a full spectrum of quality and consistency in assessment and case management activities, the system should include:
 - a. Setting standardized procedures
 - b. Assessing compliance with existing regulation, policies and standards
 - c. Reviewing the overall quality of service files; focusing on the quality and accuracy of the assessment and care plan, and determining whether issues identified in the file regarding quality of care are responded to in a timely manner
 - d. Reviewing the level of care determination to assure that participants require the care and services for which they have been authorized
 - e. Assuring that participant services and payments for those services are appropriately authorized and paid
 - f. Reviewing the delivery of services to determine that participants receive services for which authorization and payment are made
 - g. Collecting participant feedback to determine satisfaction with services
 - h. Reviewing files to assure mandatory requirements are followed

4.0

Create Easy and Seamless Consumer Access to the Full Range of Long-Term Care Services

It is essential for consumers to have timely information on long-term care options and to have seamless access to services

A standardized assessment tool is a critical factor in managing and controlling access to the Arkansas long-term care system.

Enhanced and Standardized Information and Assistance

Consumers needing long-term care services face a daunting array of services and encounter many barriers to establishing eligibility for these services. In efforts to better assist consumers in making long-term care decisions and to eliminate administrative barriers, many states have developed single entry point systems (SEPs). SEPs refer to organizations that provide consumers readily accessible information about long-term support services through one administrative authority. SEPs may also provide referral, initial screening, nursing facility pre-admission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring and periodic reassessments. In 2003, 32 states and the District of Columbia had SEPs for various populations.¹ Since the time of that report, with funding from the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS), nearly all states have made progress in streamlining access to long-term care services through Aging and Disability Resource Centers (ADRCs). In some states, ADRCs operate statewide and some provide not only access to information, but also perform some of the functions mentioned above.

Arkansas established an Aging and Disability Resource Center (ADRC) in Little Rock -- the Choices in Living Resource Center -- to help individuals and families access long-term care services. The Resource Center provides assistance primarily via a toll-free telephone number. Nursing home residents receive booklets requiring them to either contact the centralized ADRC or request that nursing home staff make that contact for them if they prefer an option other than remaining in the nursing facility. The national philosophy behind the ADRC is to have information and assistance located in accessible, trusted locations, to provide personalized, one-to-one awareness, and to help people access services. However, unlike many other states, Arkansas has not established a single entry point system with staff that perform initial consumer screening and assessment, care planning, and service authorization, monitoring and reassessment. The absence of a SEP results in many barriers to easy and seamless consumer access to services.

For many Arkansas consumers seeking long-term care services, the County Operations staff serve as the first point of contact, not the Resource Center. County staff carry out a wide range of human services functions, and, often, they do not have sufficient training and knowledge (or the time necessary to spend on this activity), about the long-term care services system including the various waiver programs. This may result in families not receiving home and community-based services at all, having services delayed, or being referred to inappropriate or expensive institutional care when a lower cost community service may be sufficient to meet consumer needs. It is essential for consumers to have timely information on long-term care options and to have seamless access to services.

Recommendations

In order to create a seamless process to provide consumers choices about long-term care services, the state should invest in efforts to make the ADRC function available within the various regions of the state, as well as invest in training on long-term care services for staff likely to have the first point of contact with consumers seeking long-term care assistance throughout the state.

The state should develop plans to develop a SEP system for all consumers seeking long-term care services. (Also see section 3.0 of this report for related recommendations.)

1. For nursing home residents and other people residing in institutions seeking to relocate to community-based settings, the state should assure the availability of case management staff to assist them with assessment, care planning and service authorization for home and community-based services. In addition, the state should assure that county financial eligibility staff who often serve as the first point of contact with consumers have a basic understanding of how waiver programs work, understand the Arkansas policy toward long-term care rebalancing, share the value of providing options for maintaining independence and know to whom to refer an individual for assessment, further options counseling and care planning assistance.
2. Currently, area agency on aging staff conduct outreach and assistance primarily using limited Older Americans Act Title III funds. Arkansas officials should consider adequately funding area agencies on aging for information and assistance to help people in need of long-term care services. Arkansas may need to use other funding sources as it begins to standardize the information and assistance functions of area agencies. Intake should be automated and interface with the automated assessment tool used by either State nurses or designated case managers for entry into the long-term care system
3. Arkansas officials should establish a process where case managers or area agencies on aging staff work closely with hospital discharge planners to assure that all Medicare and Medicaid patients admitted to a hospital stay, and their families, have information about home and community-based care choices to inform them of how to apply for these services.
4. In conjunction with developing an automated assessment tool, an automated intake system should be developed and linked with the assessment process. The intake system should be able to link directly or export the demographic and present problem information into the assessment tool for use by the assessing case manager or nurse.

Automated Assessment Tool

The Arkansas Division of Aging and Adult Services currently does not use a standardized automated tool to assess individuals for the varied service options potentially available to eligible individuals. Such a tool should be able to receive information from the intake tool and pre-populate fields with information already obtained. Existing tools in Arkansas do not integrate eligibility, assessment findings, authorized hours, payment or the plan of care. As a result, payments not in accordance with Medicaid rules may be authorized. The lack of a standardized and automated approach to assessment and authorization, likely results in variation in the amount of services authorized between participants with similar clinical characteristics. In addition, some less needy consumers could have better access to limited services than those who may have greater need for these services. This makes it difficult to provide necessary access to services for some while at the same time authorizing a higher level of service at a greater than necessary cost to others.

An assessment system that draws on protocols for home and community residential care and supports translation of these into care plans for family members and providers provides cost saving

benefits. Protocols for care and referrals have prolonged independence and enhanced safety in home settings in other states.

A standardized assessment process can also mitigate the potential of the “woodwork” effect by controlling unnecessary access to services. This is especially true as a wider array of long-term care services are developed throughout the state to better meet the individual needs of consumers.

A standardized assessment tool is a critical factor in managing and controlling access to the Arkansas long-term care system. It is not possible to efficiently provide fair access to consumers in need of long-term care services while managing cost and increasing demand for long-term care services without using a standardized tool to assess need and generate data necessary to manage the system.

Recommendations

To ensure that assessments and service plans conform to Arkansas State policy and regulation, the new long-term care administrative unit should implement a standardized tool for use in authorizing all long-term care community and nursing home services provided by the state of Arkansas. This system should be an automated tool used to collect demographic data, assess functional needs and abilities, health and medical information, determine functional eligibility for services, develop a plan of care and authorize services for individuals requesting long-term care services. The automated tool must be designed to:

- ▶ Assure quality, consistency and completeness of assessments.
- ▶ Accurately identify the existence (or lack of) informal supports to avoid over or under-authorization of services.
- ▶ Assess for severity of need especially in the area of dementia and/or medication administration and as these issues relate to the degree of impairment, complexity of the problem or the amount of assistance needed.
- ▶ Identify potential triggers for medical interventions, especially related to skin breakdown, to avoid unnecessary hospitalizations and harm to participants.
- ▶ Provide consistency in the application of policies and procedures.
- ▶ Provide diminished exposure to liability for the agency.
- ▶ Improve inter-rater reliability. (This means that assessments on the same or similar participants done by different assessors will result in similar authorization levels.)
- ▶ Provide data for program, budget and rate-setting decisions.
- ▶ Build a foundation for outcome-based care planning and management.
- ▶ Assure compliance with CMS protocols and regulations.

Necessary Components for an Automated Assessment Tool:

- ▶ A clinically tested and widely accepted set of data elements that have proven to be reliable and valid in assessing and screening for medical, functional and psychosocial needs of participants
- ▶ Inclusion of additional proven, standardized screening tools to increase accuracy and reliability of clinical assessments

- ▶ A classification model for grouping participants of similar characteristics and needs into resource utilization groups
- ▶ Algorithms for resource utilization related to participant classification and payment systems. This means that the computer program determines the number of hours needed to provide care by applying an algorithm or formula to the answers given to the questions put into the machine.
- ▶ Automated production of care plans
- ▶ Capacity to generate data for the production of standardized management reports
- ▶ Flexibility to allow queries on participant classification groups related to expenditures
- ▶ Controls for restricting access to services for those not meeting the functional definition of eligibility

Arkansas can choose to adapt a tool in use by other state long-term care systems or create their own. Creating a new tool will be more costly and may take much more time to implement than would be desirable. Arkansas may also want to consider including a family caregiver assessment module. Adapting an existing intake and assessment system might cost up to \$5 million total funds (\$1.25 million Arkansas General Revenue). Most of this would be one-time expenditure; although laptop computers used by assessors would have to be replaced approximately every three years.

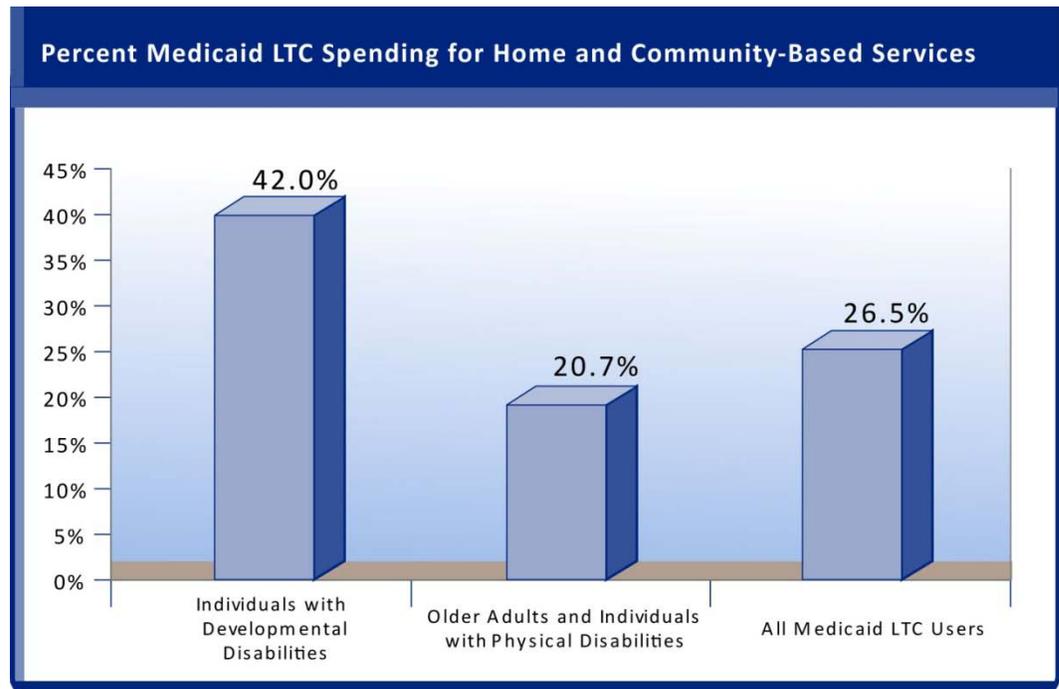
A more robust case management system and more rapid financial eligibility function will likely require additional staff. Depending on the workload expected of staff, staff necessary to accomplish these new duties could cost from \$3.5 - \$5.5 million (\$875,000 - \$1.375 million Arkansas General Revenue) per year.

5.0

Appropriate Array of High Quality Services to Meet Individuals’ Needs

While progress has been made in moving toward greater availability of home and community-based services as well as expansion of consumer choice, the state needs to take more aggressive actions.

In recent years, Arkansas has instituted new initiatives to expand home and community choices for long-term care consumers of all ages. While progress has been made in moving toward greater availability of home and community-based services as well as expansion of consumer choice, the state needs to take more aggressive actions. In FY2007, of the state’s total Medicaid long-term care expenditures, 73.5% was for institutional care, and 25.5% was for home and community-based services with the proportion of Medicaid long-term care spending in community-based settings for individuals with developmental disabilities approximately double the proportion for older adults and individuals with physical disabilities.



The following steps could take the State further in its efforts to balance the long-term care services system and to offer consumers more choice.

Review the Ability of Home & Community Rates to Encourage Sufficient Numbers of Quality Providers

States working to expand preferred home and community service options may encounter difficulty recruiting and retaining quality providers due to the payment rates they offer. Over the years, payment rates may have received inflation increases when budget money was available rather than having policy considerations drive the development of these payment rates. This appears to be the case in Arkansas’s home and community programs.

The **Choices in Living for Arkansans with Long-Term Care Needs** report recommends rate increases for personal care, targeted case management and selected waiver services. The report indicates that some of these rates have not been increased in almost 20 years. Most have not had rate increases since 2004. The report estimates that rate increases of about 15% for these

services would cost approximately \$19.3 million total funds (\$5.3 million Arkansas General Revenue).

As Arkansas considers how to target limited funding to long-term care services for elderly and disabled citizens, it should establish a stronger policy basis behind its home and community rates. Home and community rates should be linked to the needs of the participant – a participant with heavier care needs should receive a higher rate than a participant with lighter care needs. As discussed elsewhere in this report, Arkansas should use a consistent automated assessment to authorize services for all home and community participants receiving state funding

States such as Maine, North Carolina, Texas and Washington have developed standardized methods for measuring resident characteristics to determine the level of payment a provider will receive. Some of these states conducted time studies to identify the amount of time required for various participant conditions and characteristics. States have also used wage data reported in the state to set the level of wage costs to be reimbursed and nursing home cost data to approximate administrative, operating costs and capital costs that community residential facilities may experience. As demonstrated in the **Choices in Living for Arkansans with Long-Term Care Needs** report, home and community rates have a long way to go to reach the level of growth experienced in the last 10 years in nursing home rates. The Arkansas General Assembly recently passed and Governor Beebe signed into law an increase in the state Tobacco Tax to fund a series of health initiatives in the state. Among the actions outlined in proposing the tax was increased funding for home and community-based services targeted at increasing the rates for personal care services and home delivered meals.

Recommendations

1. In the short term, Arkansas should implement home and community payment rate increases funded through the recently enacted cigarette tax increase. The state should also consider redirecting funds from nursing home payment rate increases to fund home and community rate increases.
2. Arkansas should develop an automated assessment to provide a consistent basis for payment rates.
3. Arkansas should examine the time studies, and wage and cost calculations conducted in other states to determine if this work can be adapted to Arkansas or whether Arkansas needs to conduct its own studies of home and community residential costs.
4. The state should establish a state policy of striving towards parity between growth in home and community payment rates and growth in nursing home rates.
5. Policy makers should come to a common understanding that services provided in all settings are very similar or the same. While there is agreement that there are specific treatments/care that need to be provided to some participants most long-term care participants require the same types of services. This understanding will aid in promoting parity in rates and training.

Caregiver Support: Increasing Caregiver Support Services Would Increase Quality of Life for People with Disabilities and their Families and Deter Institutionalization

Arkansas's informal caregivers — family and friends — provide the majority of care to people needing long-term care assistance. According to a survey for the Rosalynn Carter Institute, almost one-fifth of adults age 18 and over in Arkansas were caregivers of people with a disability in 2000.² The aging of the Arkansas population will exacerbate demands on family caregivers who may have to rely increasingly on formal paid care to supplement their caregiving roles. In addition, caregivers are increasingly called upon to perform more challenging tasks as the range and intensity of medical and health care services needed by long-term care consumers grows. The number of people with Alzheimer's disease is expected to increase by 36% by 2025, and caring for these family members poses significant challenges for families. A key issue for Arkansas policy makers is to find ways to help families maintain informal caregiving efforts by expanding the capacity of the state's support for caregiver programs.

Arkansas primarily supports caregiver respite services under the ElderChoices Medicaid home and community-based services waiver and through Older Americans Act Title III grants. In SFY 2008, almost 3,900 participants received respite care services under ElderChoices; 97% of these participants received home care respite and the balance received short- or long-term facility respite. Older Americans Act Title III grants pay for a limited amount of caregiver training and education as well as a limited amount of respite care for those ineligible for ElderChoices. In FY2009, Arkansas received \$1.4 million in Title III funds. Unlike other states, Arkansas does not fund caregiver training and education beyond state matching funds for Title III funds.³

Recommendations

State officials should make every effort to assist caregivers who are on the front lines of long-term care. Arkansas should consider an investment of state funds to expand caregiver support beyond the state matching funds for federal programs. Arkansas should develop a system of outreach to those ineligible for private programs and apply a sliding fee schedule for respite services. Beyond the public programs, Arkansas should consider working with private industry groups to establish workplace caregiver programs and investigate the availability of private sector funds, including foundations, to bolster its efforts for caregiver support programs.

Arkansas officials should immediately implement the recommendations made in its **Choices in Living for Arkansans with Long-Term Care Needs** report, *Recommendations #17, 18 and 21*. These recommendations include integrating caregiver support information into the Choices in Living Resource Center, exploring grants for caregiver training and including caregiver support services into consumers' plans of care. Case management staff should assure that care plans include family caregiver assessment and training.

Adult Family Homes

Although none of the recommendations included in the **Choices in Living for Arkansans with Long-Term Care Needs** report address the service gap related to adult family homes, the recommendations listed above should not overlook this service development opportunity. Arkansas recently adopted a certification protocol for this program but to date does not have any providers available.

Arkansas recently decided that certification should be limited to no more than three adults. This decision may discourage potential providers from applying for certification and a contract because it may not prove to be financially viable. Policy makers may want to revisit this decision if after expanded recruitment efforts, participation does not increase.

Adult family homes are regular residential homes that are certified to care for up to three residents. The homes can provide rooms, meals, laundry, supervision, assistance with activities of daily living and personal care. Homes that are operated by nurses could provide nursing services.

Room and board, care and services can vary depending on provider qualifications and resident needs but because of the scale or size of adult family homes the staffing ratio to participant is much higher than in larger community residential settings and nursing facilities, so potentially adult family homes can either take higher acuity participants or retain participants longer as their acuity levels rise.

Adult family homes can encourage maximum residential independence and involvement, and, because of the scale of residential homes, they are able to tailor activities to resident preferences. In some states, adult family homes specialize in serving individuals with mental health issues, dementia or developmental disabilities. Additionally some states have experienced growth in homes specializing in particular ethnic populations.

The diversity of adult family homes can satisfy different residential preferences. The adult family home may be run by a family with children, a single person or a couple. The adult family home may also hire additional employees. Some may allow pets or multiple languages may be spoken.

Recommendations

6. Review current rate structure to determine adequacy of rates to attract providers to serve the acuity levels desired by DHS and DAAS. Current rates are related to acuity but the rates may not be sufficient especially at the higher end for high need participants.
7. Expand availability of the adult family home program to all participants eligible for long-term care services.
8. Expand existing training curriculum to include specialty training in the areas of mental health, dementia and developmental disabilities.
9. Develop an information and recruitment effort to encourage potential providers in providing this service.

Adult Day Care Services: Service Expansion Would Deter Institutionalization and Complement Informal Family Care

Arkansas supports adult day care services through the Medicaid ElderChoices home and community-based waiver program. In SFY 2008, the state paid \$1.3 million for Medicaid-supported adult day care programs. Currently, 39 adult day care programs are eligible to provide Medicaid services for eligible ElderChoice participants, serving about 294 consumers. Of the 7,950 ElderChoices waiver slots, about 4% of participants are served in adult day care.⁴ A 2002 national survey of state adult day care programs found that Arkansas was meeting only 34% of the need for adult day care.⁵

Arkansas supports two levels of adult day care programs, a "health" model, and a "social" model. Adult Day Health Care facilities are licensed by the Office of Long-Term Care (OLTC) to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to individuals who are functionally impaired and, due to the severity of their functional impairment, are not capable of fully independent living. These programs provide services that meet the health restoration and maintenance needs of participants that cannot be provided by the social model programs. The social model, Adult Day Care Facilities, are licensed by the OLTC to provide care and supervision to meet the needs of four or more functionally impaired adults for between two and 24 hours a day.

For many years, national and state policy makers have recognized the cost-effectiveness of adult day care in serving adults with physical, emotional or cognitive impairments. Adult day care services play a key role in preventing or delaying institutionalization. Moreover, these programs offer family caregivers the opportunity to continue working and/or to have respite from full-time caregiving responsibilities. Over the next few years, expansion of the adult day care programs will be necessary to meet the needs of Arkansas's growing elderly population. This is especially urgent, given projected increases in the number of people with Alzheimer's disease. Arkansas ranks third in the nation in the proportion of people age 65 and over with Alzheimer's disease (15%).⁶ While the state has developed a number of options for care at home, Arkansas consumers have limited choices of services that bridge the gap between home care and nursing homes, such as adult day care programs.

Once a day care program is established, Medicaid funding supports the ongoing expenses for adult day care for the Medicaid-eligible population. However, a key barrier to expansion of programs in Arkansas is the lack of start-up funds to pay for the necessary administrative and operational costs. Only two of the eight area agencies on aging have provided start-up funds for existing centers and it appears that there are no state funds used to help day care programs with administrative funds to begin operations. In the past, wide fluctuation in the number of centers has occurred; in 2007, about 30% of day care programs closed partly due to low rates but mainly due to lack of funding overall to pay for operational expenses.⁷ The fluctuating number of programs may have been somewhat resolved by a Medicaid rate increase in October 2008, but rates should be monitored to assure fiscal solvency of centers. Also the need for programs will grow with the aging of the Arkansas population.

Expanding adult day care programs would be a cost effective strategy in Arkansas. The Medicaid payment rate for the social model of adult day care is \$7.68/hour and for the health model is \$10.16/hour (effective October 1, 2008). These Medicaid rates are much lower than the daily Medicaid payment rate for nursing homes. Day care program expansion would reduce the reliance on nursing homes for the Medicaid population as well as people with low and moderate incomes who are at risk for institutionalization and spend-down to Medicaid. It would allow informal family caregivers to continue their caregiving roles without having to resort to 24-hour care in nursing homes.

Recommendations

10. The state should investigate the feasibility of expanding adult day care and identify barriers to such expansion. The state evaluation should determine how many programs under either or both the health care and the social models could be expanded, and which

model most effectively meets the Arkansas goal of promoting expanded choice for home and community-based services.

11. Identify start-up funds for adult day care expansion, perhaps using federal Medicaid stimulus funds, to serve both the Medicaid eligible population as well as those just above the Medicaid eligibility levels. Programs that serve low and moderate income people will potentially divert potential nursing home admissions and spend-down to Medicaid.
12. Review the current rate structure to assure that operating programs will be financially stable in the future, to reduce fluctuations in the number of programs, and to attract more providers.
13. Facilitate discussions with the nursing home industry to determine the feasibility of their diversification toward adult day health programs. Discuss with the nursing home industry the possibility of downsizing facility capacity in return for expansion of their capacity for adult day care, and use remaining facility capacity for short- or long-term respite.

Workforce Recruitment and Retention Strategies

Arkansas has pursued several workforce improvement initiatives since 2000:

- ▶ **Personal care attendant registry**—The Arkansas Department of Human Services operates a robust web-based registry to help individuals directing their own care to find a personal care attendant and also helps personal care attendants secure employment (<https://www.dswregistry.ar.gov/>). The registry was developed as part of Arkansas's 2004 CMS Direct Service Workforce Grant (http://www.directcareclearinghouse.org/dsw_ak.jsp).
- ▶ **Cash and Counseling**—As one of the original "Cash and Counseling" demonstration projects funded by the Robert Wood Johnson Foundation, Arkansas's IndependentChoices allows participants in this program to receive a cash allowance based on their need for personal assistance services. Using their cash benefit, participants choose who provides personal care services for them and how those services are provided. Consumers may hire a friend, relative or a professional direct service worker, which brings non-traditional workers into the field and helps overcome professional workforce shortages. The evaluation of Cash and Counseling found that participants in Arkansas experienced a significantly lesser degree of unmet need and higher satisfaction levels than with the traditional service model. A 2005 DHHS ASPE study found that workers in the Cash and Counseling Demonstration were at least as satisfied with their wages, benefits and working conditions as agency workers. http://www.directcareclearinghouse.org/s_state_det1.jsp?res_id=4&action=view
<http://www.independentchoices.com/>
<http://aspe.hhs.gov/daltcp/reports/earlyAR.htm>
<http://www.cashandcounseling.org/resources/20060120-102817/adultpcw.pdf>

- ▶ **Arkansas Medicaid State Plan Personal Care Services (PCS) benefit**—Arkansas Medicaid's PCS benefit has been identified as a promising practice because of features such as generous eligibility criteria for consumers, and a requirement that workers receive 40 hours of initial training and 12 hours of in-service training annually and structured work supervision by RNs.
http://www.pascenter.org/home_and_community/Arkansas_abstract.php
- ▶ **Training requirements for CNAs**—With 90 hours of required training, Arkansas is one of 27 states that requires more than the federal standard of 75 hours of training for Certified Nursing Assistants.
http://www.directcareclearinghouse.org/download/StateNA_Training_Requirements07.pdf
- ▶ **Community College Caregiver Training Initiative**—In July 2007, The Caregiving Project for Older Americans and the MetLife Foundation awarded 12 grants to community colleges across the country for innovative in-home caregiver training programs. Arkansas State University Mountain Home in Mountain Home, Arkansas received a grant to create the Geriatric Home Caregiver Project. This program allows participants to receive training at five levels: Elder Pal, Alzheimer's and Dementia Training, Personal Care Assistant, Home Care Assistant and Geriatric Caregiver.

Arkansas still faces several challenges in creating a balanced and stable long-term care workforce, as outlined below.

High nurse aide turnover—According to a survey by the American Healthcare Association (AHCA), in 2002 the statewide vacancy rate for Arkansas CNAs was 6.7% and the turnover rate was 114%. Nationally, turnover rates in facilities are 70% on average and 40-60% on average in home health settings. It is anticipated that the state's already high rates of direct-care worker vacancies and turnover will get worse as the population continues to age. It is expected that the "care gap" between those needing care and those available to provide care will continue to widen. Turnover is expensive for providers (and thus for state programs reimbursing providers) and has an adverse impact on quality of care.

http://www.directcareclearinghouse.org/s_state_det.jsp?action=view&res_id=4&x=15&y=4
http://www.ahca.org/research/rpt_vts2002_final.pdf

Limited training opportunities for workers in community-based settings—While Cash and Counseling has been a successful program and has helped to fill the care gap by bringing non-traditional workers into the field, it is important to note that a 2005 ASPE study found that a majority of workers were personally related to the consumers which led to greater emotional strain and less perceived respect. Directly hired workers were also less likely to have received training. Recommendations included more educational material, support groups and information for both workers and consumers.

Low wages -- Wages and benefits are the two factors that have been consistently identified in studies as factors associated with higher rates of turnover for DSWs across the developmental disability aging, physical disability and behavioral health sectors. Low wages translates into low family incomes, which can have an impact on state budgets through use of public programs. In Arkansas, 21.6% of direct care workers have some kind of public benefit (e.g. Medicaid, TANF, SSI, childcare assistance, WIC) compared with a 19.2% of workers at the national level.

	Arkansas	U.S.
Average wage for DSPs working for private providers	\$8.33	\$9.89
Average wage for state operated MR/DD institutions	\$12.46	\$15.58
Median hourly wage for CNAs	\$8.74	
Median hourly wage for Home Health Aides	\$8.13	
Median hourly wage for personal care attendants/home care aides	\$6.99	
Average hourly wage for direct care workers	\$8.33	\$9.85

http://www.directcareclearinghouse.org/s_state_det.jsp?res_id=4&action=view

<http://www.ancor.org/issues/medicaid/MedicaidSTFactSheets.html>

Recommendations

The following are our recommendations for steps Arkansas can take to strengthen and stabilize its long-term care workforce.

14. A rebalanced LTC system will require greater parity in wages, benefits and training for workers across facility and community-based settings. Currently wages, benefits and training opportunities offered to workers in home and community-based settings lag behind what is offered to facility-based workers. Arkansas should coordinate across state agencies and divisions to address workforce issues across different long-term care settings (e.g. nursing homes, ICF-MRs, and HCBS) and programs (e.g. Medicaid waivers, OAA) that serve people with intellectual and developmental disabilities, aging populations, people with physical disabilities and people with behavioral health services. Convene an advisory board with representatives from different agencies and programs, as well as community stakeholder groups, providers, workers and consumers to discuss options for developing a cohesive workforce agenda. This recommendation is consistent with the No. 1 recommendation from the **Choices in Living for Arkansans with Long-Term Care Needs** report.
15. Increase the wages of direct service workers across sectors. Identify strategies to increase direct service worker wages across sectors and settings, ensuring that this workforce earns family sustaining wages in every community throughout Arkansas. Wages should be commensurate with skills, experience and levels of responsibility. Identify and implement rate and other payment strategies that provide incentives for employers and provider organizations to invest in the workforce, improve retention, increase the competence of their workers and encourage delivery of high quality services and support. Consider including workforce standards (i.e. retention of DSWs, vacancy rates and DSW competence, family sustaining wages, adequate health-care coverage) in quality monitoring activities with states and providers.

16. Increase access to training, lifelong learning and career paths for direct service workers across sectors. Identify and implement strategies that increase access to affordable training, education and lifelong learning for direct service workers. These training and educational opportunities should lead to career paths and articulated credentials that connect with recognized skills and related incentives. Training should use evidence-based practices and be integrated into K-12 and post-secondary educational programs, as well as other career and workforce training options, such as credentialing, apprenticeship and employer-based training partnerships. Existing educational programs should complete regular self-assessments to assess the relevance and effectiveness of their current training and ensure they continue to deliver training that is based on contemporary competencies.
17. Ensure that direct service workers in each sector have competent and well-trained supervisors. The relationship workers have with their supervisors and the support they receive from supervisors are highly correlated with worker turnover and retention. States that have implemented competency-based supervisor training programs have seen significant reductions in worker turnover. Such a program should be accompanied by recommended standards on supervision that would include specification for how often and in what format supervision will be provided across settings. Training should build from existing identified supervisor training competencies within and across each sector.
18. Keep training and worker support central to all consumer-directed service programs. While consumer-directed programs rely, in part, on non-traditional workers, training and support remain critical for those providing services. Individuals and families should have access to high quality training on how to find, choose and keep their direct service workers, as well as to effectively support their worker.
19. Strengthen partnerships between health and human service agencies and the public workforce system (e.g. Workforce Investment Act programs and One-Stop Career Centers). The workforce initiatives undertaken by health and human services agencies and organizations are rarely coordinated with the workforce development system, which have valuable resources to bring to bear on these initiatives. Low wages and lack of career opportunities in the field often limit the development of publicly funded programs for this segment of the workforce. Yet workforce development systems should play a critical role in responding to the increased demand for direct service workers. Industry must work with the workforce system agencies to identify strategies to accurately measure the size and scope of the direct service workforce across service sectors. Once the economic impact of this workforce on communities has been calculated, it can help to inform and bring focus and resources to these business sectors.

Nurse Delegation

Arkansas currently allows for care to be self-directed by individuals deemed to be competent and desiring to direct their medically related and other forms of care. However, for populations who may be suffering from cognitive impairments or who simply do not feel comfortable directing their care, the only option that may be available is nursing home care.

Nurse delegation is a service option that provides training and nursing supervision for qualified caregivers to perform delegated nursing tasks. Consumers who receive nurse delegation services should be considered stable and predictable by the delegating nurse, lack informal support to

provide the delegated task and be unwilling or unable to self-direct their care. Community settings offer a more home-like environment than nursing homes, but very few can afford nurses on-site on a 24-hour basis.

Whether or not non-nurses can perform delegated nursing tasks has significant consequences for participants who seek care outside of nursing homes. Participants who may otherwise be able to live in community-based settings, will be forced to go to nursing homes if there is no way to provide this help in a safe way. Susan Reinhard (Rutgers, 2001) reported that almost all states have laws and/or regulations that permit nurses to delegate certain tasks; however, the diversity of delegation makes it difficult to make comparisons.

Oregon and Washington have implemented (since the mid-1980s in Oregon and the mid-1990s in Washington) broad programs in nurse delegation. They report that a large measure of safety has been introduced into community-based settings by involving nurses in the training and review of providers who may have been providing this level of care out of necessity prior to the introduction of delegation activities.

Currently, Washington has 150 delegating nurses participating in the program and 5,000 clients. State staff state that there have not been any reports of adverse outcomes since the implementation of the program in 1997. In fact more nursing (and safety) has been introduced into the community-based programs than was anticipated. States that have implemented nurse delegation have found that a large measure of safety has been introduced into community-based settings by involving a nurse in the training and review of providers who may have been providing this level of care out of necessity prior to the introduction of delegation activities.

Recommendations

20. Revise the Arkansas Nurse Practice Act to include the delegation of certain nursing tasks.
21. Identify those tasks that may not be delegated, such as sterile procedures, administration of medications by injection and acts that require nursing judgment.
22. Determine the settings where nurse delegation may occur, such as Adult Family Homes, in-home settings and Assisted Living facilities.
23. Determine the policies and procedures necessary for a safe and robust delegation program.
 - Identify the content and amount of training needed for providers, both caregivers and delegating nurses.
 - Develop the protocol of the supervising nurse, which may include the initial direction of the task, periodic inspection and the authority to require corrective action.
 - Develop the desired content of a care plan and the criteria by which the delegating nurse evaluates the effectiveness of the plan.

The Nursing Home Bed Supply

In 2006, there were 4.8 Arkansans in nursing facilities per 100 state residents age 65+. This compares to 4.0 nationally and makes Arkansas 16th in the nation in number of older state citizens in nursing homes. (AARP "Across the States Profiles of Long-Term Care and Independent Living, 2006").

According to data provided by state staff, Arkansas had almost 5,400 unoccupied beds reported on nursing homes' FY2008 cost reports. Approximately 25% of the state's licensed beds were unoccupied in FY2008. Most states include a minimum occupancy factor in their nursing home payment methodology to encourage nursing homes to close empty beds open. This recommended change to the Arkansas nursing home payment methodology is discussed more fully in Section 6 of this report.

Several states have made additional attempts to address the problem of vacant beds with bed buy-out projects, rate increases to encourage facilities to convert to single bed rooms, and options such as low cost loans or construction grants to encourage nursing homes to convert beds to other purposes.

One of the concerns of encouraging conversion of existing nursing home assets to other types of care is that the nursing home plant may not easily lend itself to requirements desirable for another type of care. For example, long hallways with nursing stations at the end, shared baths and a lack of kitchen facilities in nursing home rooms may not fit the assisted living model desired by consumers and state policy makers. Nebraska conducted a grant program in the late 1990s that required grant recipients to match grant funds with significant additional external financing. It also specified certain construction requirements to make converted nursing home assets conform to consumer expectations for assisted living. The state required that at least 40% of persons served in the new assisted living beds be Medicaid enrollees. While the program allowed conversion of some nursing home beds to other uses, Nebraska staff reports that this program operated during a period of relative financial wealth and that they would not be able to afford the grant program in today's budget climate.

State payment for bed buy-out programs ranged from \$10,000 - \$45,000 per bed closed. At least two states used a Quality Assurance Fee or Intergovernmental Transfer to finance their bed buyout programs (Indiana and North Dakota). CMS allowed Indiana's buyout program but would only approve matching funds for beds that had been occupied by Medicaid residents.

Arkansas is in a different situation than the several states that have tried buy-back or conversion programs in that all of those states had significantly higher nursing home occupancy levels than Arkansas. The investments made in those states to take a bed off line would potentially save the state from spending \$150 or more per day to serve a Medicaid resident. In Arkansas, it would be more likely that the state would be investing to take empty beds off line in order to reduce the upward pressure on the nursing home rate.

Arkansas can make changes in the nursing home payment methodology to encourage nursing homes to take beds off line and avoid including costs of empty beds in the nursing home per diem rates without spending \$10,000 or more per bed. These changes are discussed in Section 6 of this report. While it is unlikely that nursing home operators would choose to take all vacant beds off line if a buyout was offered, Arkansas operators might have a strong incentive to take a buyout since their vacant beds are not generating any direct revenue. With 5,400 vacant beds in the state, a comprehensive bed buyout program paying \$10,000 per bed could cost Arkansas up to \$54 million.

Nursing home providers argue that they have a right to a bed granted through the process called Permit of Approval in Arkansas or Certificate of Need in other states. They argue that the beds will be necessary some day as the aging population increases and it was costly for them to get the bed approval in the first place. Some states have chosen to allow nursing homes to "bank" or "layaway" unused beds that have been awarded to them by POA/CON. The beds are taken off the nursing

home's license and payment rates are calculated on the reduced number of beds. A nursing home has a certain time period such as five to eight years to bring the beds back on line before the bed is permanently removed from use by the state agency that authorizes beds.

The Arkansas Health Services Permit Agency authorizes Permits of Approval for nursing home beds. The permit agency has determined that the state will be over-bedded in 2013 by more than 3,100 nursing home beds. According to the January 2009 "Bed Need Book" issued by the permit agency, several counties have "approved beds" in process even though the counties are expected to be over-bedded in 2013. Beds are not approved in counties with less than 80% average occupancy in existing facilities. Beds are authorized in counties with greater than 90% occupancy even if the bed need formula does not indicate a future bed need.

The bed need book also forecasts need for assisted living, residential care facility beds and home health agencies. The agency forecasts a shortage of assisted living and residential care facility beds of almost 5,600 in 2013, based on a need ratio of 30 beds per 1,000 persons over 65. The agency forecasts an oversupply of home health agencies of 202 agencies by 2013. It is unclear how the availability of home and community services in a county influences decisions on whether to allow nursing home beds to be added in the county.

Actions on the part of a state agency such as tightening minimum occupancy standards or allowing bed banking can encourage nursing homes to take unused beds offline without large expenditure by the state. As discussed more fully in Section 6 of this report, an 85% minimum occupancy calculation in the nursing home rate methodology would strongly encourage nursing home providers to take up to 2,400 empty beds off line without any additional payment by the state. These policies allow nursing homes to take action to remove beds that are not generating direct revenue without additional expense on the part of the nursing home, without losing the rights to the bed and without a negative per diem rate impact.

Recommendations

24. Establish in rule a minimum occupancy percentage of at least 85% in all cost centers.
25. Work with the Health Services Permit Agency to a) establish bed banking ability for nursing home providers; b) change bed need rules so that the county occupancy level is at least 95% before any new beds are approved and that no approval is given if the bed need formula for a county does not indicate future need; and c) ensure that the growing availability of preferred home and community services is considered during the decision-making process on whether to allow nursing home beds to be added in a county.

Promotion of Policies to Enhance Services for Special Populations

Serving people with intellectual and developmental disabilities, adults with physical disabilities, children and adults with mental illness, medically fragile children and adults with traumatic brain injuries, represents special challenges for Arkansas policy makers. **Choices in Living for Arkansans with Long-Term Care Needs**, the Arkansas long-term care plan, recognizes certain weaknesses in serving these populations. However, the plan omits discussion of program issues affecting many of these populations. We encourage DHS to conduct a similar review of service strengths and gaps for individuals with developmental disabilities (DD) and mental health and substance abuse issues in order to make service recommendations for these populations.

People with developmental disabilities. Although the state has made great progress in serving people with intellectual and developmental disabilities in home and community-based settings through waiver programs, over 1,000 people are on waiting lists. In addition, applicants face a lengthy processing time for waiver applications. Some people served under the developmental disabilities waiver have dual diagnoses of developmental disabilities and mental illness. Yet, it appears that these people are not receiving mental health services, resulting in hospitalizations at the point of a mental health crisis and higher Medicaid costs.

Adults with physical disabilities. Reports from advocacy groups indicate that the types, range and amount of services under the Alternatives waiver for people age 18-64 need to be enhanced. For example, according to advocates, special equipment that is necessary to help people remain at home is not covered by the waiver. The average annual expenditure per Alternatives recipient is \$10,640 for attendant care, \$3,260 for agency attendant care and \$3,827 for environmental (exclusive of Medicaid state plan services).⁸ These expenditures are much less than the Medicaid nursing home annual reimbursement rate of about \$53,000.

People with mental or cognitive disabilities. Arkansas has one of the highest rates of mental illness in the nation.⁹ Almost 13% of the adult population suffered from serious psychological distress in 2004-05; over 8% had one or more depressive episodes during this period.¹⁰ About 16% of the Arkansas elderly population has a cognitive or mental disability.¹¹ Arkansas delivers mental health services through contracts with 15 community mental health centers (CMHCs). In 2006, 60% of funding for CMHCs came from Medicaid.

One of the top cost drivers for the Arkansas Medicaid program is in-patient mental health services for children. While the majority of adults with mental illness are served in the community, Arkansas predominantly serves children with mental illness in institutions. In 2007, the Medicaid program spent \$136 million on in-patient mental health services for children, the second highest rate in the nation. It is important to note the state's adoption of the System of Care model as the public policy of Arkansas regarding children's behavioral health care (Act 1593 of 2007). The act also created the Children's Behavioral Health Care Commission, which has led efforts to create a System of Care Plan to guide efforts towards reform of the institutional bias and achieve a more outcomes-based and balanced system.

Medically fragile children. Advocacy groups report that serving medically fragile children is a challenge due to an inadequate provider infrastructure and lack of specialized services. For example, some ventilator dependent children are not able to return home from hospitals due to lack of home-based equipment and backup caregivers to monitor children at home.

People with traumatic brain injuries (TBI). Challenges in providing services to people with TBI include length of time in recovery and lack of reimbursement for special care options. The Arkansas long-term care plan, **Choices in Living for Arkansans with Long-Term Care Needs**, recognizes the need to seek a home and community-based waiver for people with TBI.

Recommendations

Budget constraints may limit Arkansas's ability to deliver a full range of services to the groups identified above. However, the Arkansas planning document, **Choices in Living for Arkansans with Long-Term Care Needs**, should explicitly recognize the needs of these groups and continue to develop plans that would improve services. A high priority for Arkansas is to develop a single entry point for people to access services and a unified case management system, as

recommended above. Arkansas officials will need to determine how to phase in these activities and may not be able to accomplish both a system redesign and service enhancement for special populations simultaneously. Nevertheless, advocacy groups may continue to press for service improvements while the state considers actions for service redesign. Arkansas officials should use its Systems Change grant work to identify gaps in services for special populations and develop plans to fill these gaps. This will be an important step in providing balance to its long-term care system for all populations.

6.0

Cost Containment

Changes to the payment methodology that can be made to support policies of paying more for heavier care participants and encouraging more efficiency on the part of nursing homes without sacrificing support for quality of care.

Arkansas’s current methodology for paying nursing homes to serve Medicaid participants is structured to encourage quality of care. However, the payment system does not distinguish between nursing homes serving participants with higher needs and those serving participants with lower needs. Additionally, the payment system allows costs for empty beds to be reflected in the Medicaid payment rate. Changes to the payment methodology that can be made to support policies of paying more for heavier care participants and encouraging more efficiency on the part of nursing homes without sacrificing support for quality of care.

NH Rate Setting Methodology

Rate setting methodologies can support state long-term care policy. Incentives in the Medicaid nursing home rate can encourage or discourage specific nursing home behaviors, such as serving heavy care participants, investing in higher staffing levels or wages and benefits, ensuring that Medicaid funds are spent efficiently, developing new care models such as the “Green House” model, and so on. The **Choices in Living for Arkansans with Long-Term Care Needs** report includes two specific comments related to nursing home payment rates. It expresses a vision that nursing homes will continue to play an important role in serving people with high care needs. It also recommends: 1) a review of the nursing home reimbursement methodology to determine the cost, if any, of paying for vacant beds; and 2) that the state consider a case mix or tiered rate based on participant need.

Many of the policy directions behind Arkansas’s nursing home rate setting methodology support quality care. However, the state can take steps to encourage nursing homes to spend more efficiently, to serve heavier care participants and to reduce the number of empty beds for which the state pays without compromising quality of care.

The table below outlines the cost centers in Arkansas’s nursing home Medicaid payment methodology including costs included in each cost center and any payment limits.

Recommendations to Balance Arkansas’s Long-Term Care System

Cost Center	Costs Included	Payment Limits
Direct Care	Salary/fringe benefits nursing staff/aides; food; direct care supplies	105% of 90th percentile of all homes' costs
Indirect/Administrative and Operating	Salary/fringe benefits of non-direct staff such as dietary, housekeeping, laundry, maintenance, administrative; transportation & resident activities; other general administrative costs	Flat rate for all facilities originally set at 110% of median
Fair market rental	Payment approximates capital costs such as lease, mortgage principal/interest, depreciation. Also includes taxes	Value of assets established through negotiation with nursing home industry. Payment based on equity times U.S. Treasury Bond +1.5%; depreciation assumed at 2.5% of asset value. Cost center is subject to 80% occupancy assumption.
Quality assurance fee		5.5% add-on to other rate components

The current Arkansas nursing home payment methodology encourages nursing homes to spend in direct care. However, the reimbursement methodology does not distinguish whether costs are incurred for serving heavy care participants or light care participants. As a result, a nursing home that chose to serve light care participants could be reimbursed more than a facility serving heavier care participants.

Nursing homes are not expected to return funds to the state if they are not spent for costs related to their cost center. Nursing facilities can use the extra funds to invest in quality care or they can take the extra as profit.

There is little incentive in the current Arkansas reimbursement methodology for nursing homes to keep beds full. There is no minimum occupancy limit in any cost centers except the Fair Market Rental cost center (approximately 11% of the total rate). Many states use a minimum occupancy calculation to encourage nursing homes to take unused beds off line in order to avoid the state paying for costs associated with an empty bed. For these states, the Medicaid payment rate is calculated using the larger of the actual number of days of service provided (“patient days”) and an assumed number of patient days if the facility was 85% full. A simple example shows how the 85% occupancy assumption can change a nursing home’s per diem rate and thus impact decisions about how many beds to have open:

- ▶ Nursing home has 10 beds and \$50,000 in annual costs.
- ▶ If the facility has seven full beds, it has 2,555 patient days (10 beds * 365 days per year * 70% full beds). Without a minimum occupancy calculation, the nursing home’s per diem rate is $\$50,000/2,555 = \19.57 .

- ▶ With an 85% minimum occupancy limit, the nursing home's assumed patient days for purposes of calculating its rate are 3,103 (10 beds * 365 days/year * 85%). Its per diem rate is $\$50,000/3,103 = \16.11 .

Modeling of the impact of an 85% minimum occupancy requirement in all cost centers in the Arkansas nursing home Medicaid payment indicates that nursing homes would have a strong incentive to take up to 2,400 currently empty beds off line. More than half of all Arkansas nursing homes would have an incentive to reduce empty beds under a minimum occupancy requirement. Many would have an incentive to take large numbers of beds off line.

If facilities immediately reduced empty beds in response to the minimum occupancy requirement, there would be little immediate impact on the Medicaid payment rates. Using the simple example above, if the 10 bed facility closed two beds, its assumed patient days for calculating 85% minimum occupancy would be 2,482 (eight beds * 365 days per year * .85). The rate calculation uses the greater of actual patient days (2,555) or assumed patient days (2,482) so after closing two beds, the facility would receive a per diem rate of $\$50,000 \text{ cost} / 2,555 \text{ patient days} = \19.57 .

In the longer term, many nursing homes would reduce costs as a result of the bed reductions, particularly those taking large numbers of beds off line. The amount of cost reduction is difficult to quantify since there is no way to accurately predict the number of beds each nursing home would close and the associated cost reductions. Any cost reductions that did occur would be reflected in future, lower Medicaid payment rates.

A model of why an 85% occupancy requirement would impact the number of empty beds is shown in an appendix to this report.

Many states also use the policy on the frequency of "rebasings" payment rates to control growth in nursing home expenditures and rates. "Rebasing" is the recognition of a new set of costs on which payment rates are based. The longer it takes for a state to recognize actual costs in a nursing home's rate, the more likely the nursing home is to be efficient in its expenditures. Staff in Arkansas indicate that rebasing must occur at least every three years but that, in practice, there were only two years in the period between 2001 and 2008 in which the nursing home rates were not rebased. Program staff report that the nursing home Medicaid payment rate increased from approximately \$69 in 2001 to \$145 in 2008.

The practice of rebasing frequently has a negative impact on the Arkansas state budget. Program staff report that they expect the Medicaid per diem rate to increase by 4.5–5% from FY2009 to FY2010. If Arkansas chooses not to rebase nursing home rates in FY2010 and instead gives nursing home providers a generous inflationary increase of 3.5%, the Arkansas Medicaid long-term care program would spend approximately \$3.8 million total funds (\$525,000 Arkansas General Revenue) less on nursing home payment rates in FY2010.

Arkansas's nursing home reimbursement policy has been generous enough to strongly encourage quality of care. Changes to the policy recommended below are consistent with the state's policy to encourage quality of care in nursing homes but they also allow the state to focus on encouraging specific nursing home behaviors, such as serving heavy care participants, ensuring that Medicaid funds are spent efficiently and reducing expenditures on empty beds. The recommendations may also enable Arkansas to pursue the expansion of quality care services in preferred home and community services.

Recommendations

1. Establish in rule a minimum occupancy percentage of at least 85% in all cost centers.
2. Establish in rule the requirement that payment rates are "settled." If a nursing home does not spend the Medicaid funds paid to it for patient care, the funds must be returned. Arkansas may want to exempt some cost centers from this requirement in order to give efficient nursing homes an explicit opportunity for profit. However, funds paid for direct care should absolutely be required to be spent for direct care.
3. Develop tiered payment rates based on the level of care required by the participant.
4. Rebase rates no more often than every three years. An inflation factor can be added to payment rates in years in which there is no rebasing to reflect rising costs.

The Quality Assurance Fee

A relatively new "cost center" in the Arkansas nursing home rate methodology is the Quality Assurance Fee. The Quality Assurance Fee is based on the maximum currently allowed by the federal government. The state pays the Quality Assurance Fee (currently \$8.95 per day), for each Medicaid nursing home participant as a part of the total payment rate thereby earning matching funds from the federal Medicaid program. Nursing homes return the Quality Assurance portion of the payment to the state.

In Arkansas, the federal government matches approximately \$3 for every \$1 in state funds spent. As a result of the Quality Assurance Fee, the state effectively earns \$3 in federal funds without a long-term commitment of the \$1 state share. This strategy is far from unique in Arkansas. Termed a "provider tax" the Kaiser Commission on Medicaid and the Uninsured reports that in 2006 as many as 32 states used a similar "provider tax" strategy to enhance Medicaid payments from the federal government for nursing home services. Provider taxes are also used by states on home health, ICF/MR, hospital services, and in at least one state, home care services. Federal Medicaid rules allow the "provider tax" strategy although there have been attempts over the years to reduce states' abilities to use this strategy. States are not limited in how they can spend this additional revenue from the Medicaid programs.

Arkansas has chosen to use these funds to significantly increase nursing home payment rates since 2001. The Quality Assurance Fee may have somewhat masked the budget and public policy impact of the significant increases in the nursing home rate in the last 10 years. The use of this fee as the basis for nursing home rate increases appears to have created a distorted impression that this methodology is "budget neutral" for the state as evidenced by references to the nursing home industry "paying their own way." This fee mechanism is clearly a legal and federally approved way of generating additional state revenues that can be used as match to draw down additional federal funds. However, the decision to use these funds primarily to fund nursing home care ignores the public policy options and implications of also seeing these funds as an opportunity to fund additional home and community-based services. Medicaid expenditures for private nursing homes in Arkansas increased by 187% from FY1999 to FY2007, due largely to an increase in the average nursing home daily payment rates of 205%. At the same time, the number of people served in nursing homes dropped by 15%. It is unlikely that this increase is sustainable into the future.

A Appendix A: Rebalancing Recommendation Cross Walk

Critical LTC Elements	Recommendations to Balance the Long-Term Care System	Choices in Living for Arkansans with Long-Term Care Needs
Common Philosophy and Shared Core Values	<ul style="list-style-type: none"> ★ <i>Continue to engage consumers, advocates, providers, state employees and legislators in establishing a Department of Human Services and statewide common philosophy and shared core values.</i> ★ <i>Establish ongoing mechanisms and forums for regular consumer input regarding the long-term care system.</i> 	<p>7. Restructure the Governor’s Integrated Services Taskforce to advise DHS on the implementation of this plan.</p>
Organizational Coordination and Accountability	<ul style="list-style-type: none"> ★ <i>Establish one Administrative Unit, at least for a given population, responsible for all aspects of access, delivery, payment and quality assurance for both institutional and home and community-based services.</i> ● Establish a global budget for long-term care services. ★ <i>Institute a single, standardized, automated assessment, service plan and authorization tool that builds upon information collected as part of the intake and eligibility process and classifies consumers according to acuity.</i> ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i> 	<p>10. Review long-term care (LTC) Financing options (and organizational system design) to identify models that will enable the state to meet the future increase in demand for LTC services, including global budget, managed care and integrated service models, while improving care coordination and reducing the fragmentation of the LTC system.</p> <p>11. Improve the use of technology in the delivery of home and community based services (HCBS). As a part of this initiative, an Information Technology Plan, which will facilitate access to HCBS and support quality improvement and quality assurance activities, will be developed and funded. (Note: 90% federal funding is available for part or all of this recommendation.)</p> <p>25. Explore use of common functional assessment and care planning instruments in order to reduce the completion of duplicative assessments.</p> <p>12. Develop performance standards to measure the progress made in balancing the state’s LTC system.</p>

Critical LTC Elements	Recommendations to Balance the Long-Term Care System	Choices in Living for Arkansans with Long-Term Care Needs
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Standardized and Effective Case Management</p>	<ul style="list-style-type: none"> ★ <i>Institute a single, standardized, automated assessment, service plan and authorization tool that builds upon information collected as part of the intake and eligibility process and classifies consumers according to acuity.</i> ★ <i>Institute a robust case management service necessary to achieve positive participant outcomes and prevent unnecessary institutionalization.</i> <ul style="list-style-type: none"> ■ Identify and adopt standards that include a complete array of core functions. ■ Provide consistent training on the standards. ■ Provide in person short-term case management for nursing home entrants and appropriate individuals being discharged from a hospital. ■ Assure appropriate care plan authorizations for cost control. ■ Assure receipt of authorized services. ● Entities providing case management to participants in the community, community residential settings and nursing facilities must demonstrate neutrality and objectivity, and DHS needs mechanisms to ensure accountability. ● Case management reimbursement should be reviewed to ensure that it accounts for the full range of activities expected of case managers. 	<ol style="list-style-type: none"> 11. Improve the use of technology in the delivery of home and community based services (HCBS). As a part of this initiative, an Information Technology Plan, which will facilitate access to HCBS and support quality improvement and quality assurance activities, will be developed and funded. (Note: 90% federal funding is available for part or all of this recommendation.) 25. Explore use of common functional assessment and care planning instruments in order to reduce the completion of duplicative assessments. 16. Implement Administration on Aging nursing home diversion programs. 17. Improve access to LTC information and assistance. 18. Educate consumers and families regarding LTC financing options. 19. Review Medicaid LTC functional eligibility criteria and procedures.

Critical LTC Elements	Recommendations to Balance the Long-Term Care System	Choices in Living for Arkansans with Long-Term Care Needs
Easy and Seamless Consumer Access to the Full Range of Long-Term Care Services	<ul style="list-style-type: none"> ■ Enhance the Choices in Living Resource Center to add more pro-active intervention in critical pathways to institutions and a local community presence, including: <ul style="list-style-type: none"> ○ Standardize information and assistance and reconsider the role of AAAs relative to County Offices ○ Institute a standardized automated intake system that interfaces with the assessment tool for all organizations conducting intake ○ Provide <u>in person</u> options counseling <ul style="list-style-type: none"> ■ Outreach to nursing home residents (both short and long stay patients) ■ Work closely with hospital discharge planners to gain access to hospital patients in need of long-term care ★ <i>Institute a single, standardized, automated assessment, service plan and authorization tool that builds upon information collected as part of the intake and eligibility process and classifies consumers according to acuity.</i> ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i> ● Establish nursing home pre-admission screening procedures. 	<ol style="list-style-type: none"> 13. Create a work group to address the long-term care application process to ensure consumer choice and timely processing of LTC applications 4. Use a portion of the \$500,000 appropriated to Division of Medical Services for “fast track” to include transition services, case management and other costs for individuals in institutions wishing to return to the community. 5. Amend ElderChoices and Alternatives 1915 (c) Medicaid waivers to include transition services allowed under current federal regulations. 6. Create an internal workgroup within DHS to determine which Money Follows the Person Demonstration Services should be incorporated into Medicaid State Plan or waivers. 20. Improve Hospital Discharge Planning Process. 16. Implement Administration on Aging nursing home diversion programs. 17. Improve access to LTC information and assistance. 18. Educate consumers and families regarding LTC financing options. 19. Review Medicaid LTC functional eligibility criteria and procedures. 11. Improve the use of technology in the delivery of home and community based services (HCBS). As a part of this initiative, an Information Technology Plan, which will facilitate access to HCBS and support quality improvement and quality assurance activities, will be developed and funded. (Note: 90% federal funding is available for part or all of this recommendation.) 25. Explore use of common functional assessment and care planning instruments in order to reduce the completion of duplicative assessments. 12. Develop performance standards to measure the progress made in balancing the state’s LTC system.

Critical LTC Elements	Recommendations to Balance the Long-Term Care System	Choices in Living for Arkansans with Long-Term Care Needs
Appropriate Array of High Quality Services to Meet Individuals' Needs	<ul style="list-style-type: none"> ★ <i>Review current rates and the process for setting rates for nursing home and HCBS</i> <ul style="list-style-type: none"> ■ Develop tiered level of care payment rates for all settings ■ Strive for parity between nursing home and HCBS rates and increases ● Change bed need rules to require county/market nursing home occupancy rates of at least 95% to approve new beds. ● Consider allowing nursing homes to bank beds. ● Expand in person transition services for nursing home residents wishing to return to the community. ● Revise the Nurse Practice Act to include delegation of certain nursing tasks in the range of community settings ● Explicitly recognize the needs of special population groups in Choices In Living for Arkansans with Long-Term Care Needs. These populations are people with developmental disabilities, adults with physical disabilities, people with mental or cognitive disabilities, mentally fragile children, and people with traumatic brain injuries (TBI). ● Pursue workforce recruitment and retention strategies, such as: <ul style="list-style-type: none"> ■ Realistic job previews ■ Career ladders ■ Supervisor training ● Expand funding and range of caregiver support programs. ● Expand availability of adult family homes. ● Investigate the feasibility of expanding adult day care and identify the barriers to expansion. ● Develop a core curriculum and standardized training for care providers across all settings. 	<ol style="list-style-type: none"> 1. Increase reimbursement rates for Personal Care, Targeted Case Management and selected ElderChoices services. Incorporate pay for performance standards tied to reimbursement. 24. “Rightsizing” the NH industry/Addressing the Changing role of the NH industry. 8. Proceed with piloting SOURCE in four counties. 9. Develop a DHS strategic plan to meet the home and community based service needs of Arkansans with Traumatic Brain Injuries, including the feasibility of developing a Traumatic Brain Injury Medicaid waiver. 21. Enhance support services for informal caregivers 3. “Repurpose” unused or unoccupied nursing home beds by promoting non-traditional “Home-Style” facilities such as those found in the GreenHouse™ or similar small house models. Repurposing could assist with efforts to right-size the nursing home industry. 23. Support Quality Improvement/Assurance Initiatives

Critical LTC Elements	Recommendations to Balance the Long-Term Care System	Choices in Living for Arkansans with Long-Term Care Needs
	<ul style="list-style-type: none"> ● Enhance the Quality Assurance System, including: <ul style="list-style-type: none"> ■ Collecting participant feedback regarding satisfaction ■ Determining participant outcomes related to costs ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i> 	<p>12. Develop performance standards to measure the progress made in balancing the state’s LTC system.</p>
<p>Cost Containment</p>	<ul style="list-style-type: none"> ★ <i>Develop data capability and report production to inform day-to-day program management and to provide information for decision makers’ long range planning.</i> ★ <i>Establish a minimum occupancy of at least 85% for all nursing home cost centers to reduce payment for empty beds.</i> ★ <i>Develop tiered payment rates based on level of care for all settings.</i> ● Rebase nursing home rates no more often than every three years. ● Ensure individuals have real choice of setting through efforts of the Choices in Living Resource Center and wider availability of lower cost service options, such as adult family homes, assisted living and adult day care services. ● Establish rules requiring payment rates “settlement” such that if a nursing home does not spend Medicaid funds paid to it for patient care, the funds must be returned. 	<p>12. Develop performance standards to measure the progress made in balancing the state’s LTC system</p> <p>24. “Rightsizing” the NH industry/Addressing the Changing role of the NH industry.</p> <p>10. Review long-term care (LTC) Financing options (and organizational system design) to identify models that will enable the state to meet the future increase in demand for LTC services, including global budget, managed care and integrated service models, while improving care coordination and reducing the fragmentation of the LTC system.</p>

B Appendix B: Common Consumer Perceptions About Arkansas’ Long Term Care Rebalancing Issues

Background

In the administration of long term care services and supports an enormous volume of information is collected about expenditures, program regulatory compliance, and other operational issues. In well-managed systems, this information can be invaluable for informing important policy and program changes and development. However, some of the most valuable information that is often overlooked and sometimes disregarded are the opinions and perceptions of the consumers of services. Program administrators, provider associations and advocacy groups have ample opportunities and resources for communicating their views and concerns. Generally, actual consumers of services or their families do not have the means or access to communicate their opinions or concerns. To address this information gap, this CMS rebalancing project made a substantial effort to actively solicit input and information from a wide variety of consumers and their families currently receiving long term care services.

Process & Method

The following eight different consumer groups, sometimes with advocacy partners included, were identified as being representative of the consumer point of view:

Aging & Adults	CareLink Advisory Council; and Governor's Advisory Council on Aging
Developmental Disabilities:	Arkansas Chapter of People First
Mental Health:	Arkansas Mental Health Planning & Advisory Council
Nursing Home:	Arkansas Advocates for Nursing Home Residents
Physical Disability:	Choices In Living Conference Attendees
Special Needs Children:	Title V Parents Advisory Council
Traumatic Brain Injury:	Brain Injury Association of Arkansas

Leaders from each of these organizations were asked to convene a meeting of representatives from their membership to participate in a process designed to identify the Strengths, Weaknesses, Opportunities, and Threats (SWOT) in the long term care services system in Arkansas. Each session averaged approximately 3 hours devoted specifically to the SWOT process. The number of participants varied within each group but the total number of participants from all groups was over 120 individuals.

Each session was conducted by a consultant/facilitator who provided the background, purpose, and framework for the sessions and actively solicited input from participants.

This information was captured on chart paper and displayed for the purpose of allowing participants to rank the items in each of the SWOT categories. The results of this ranking process

are presented in the attached Table I, along with a brief description of each of the participating organizations.

Common Perceptions

The observations and perceptions provided through this process by each group of participants were very valuable for a better understanding of how they view the current long term care services and supports and what their concerns are for the future. However, of even greater value is the degree to which common themes and issues emerged among the groups through the process. This would suggest a high degree of validity regarding these common issues since they were identified independently within each group of participants.

The following summary highlights the common themes that were derived from the SWOT process and provides public policy and program administration officials with a clearer sense of consumers perceptions and concerns:

Strengths

(What is currently working well? What are the positive things going on?)

The primary strength identified by every group was the positive impact of the Medicaid waiver programs in creating more choices and options for home and community based services. In addition, the majority of the groups acknowledged that more choices and options would not be available to them in Arkansas were it not for these waiver programs.

A second major strength expressed by the groups using various terminology to make their points, was the increasing recognition of the importance of consumer directed care, person centered planning, self-advocacy and the empowerment of consumers.

A final common strength identified was the emergence of new models of care, levels of care, and alternative approaches to care. Examples given were the Eden and Greenhouse models for nursing home care; the Money Follows the Person program, and greater emphasis on independent and assisted living services for a wide range of disabilities and challenges.

Weaknesses

(What is not working well? What are the negative things going on?)

The common weaknesses identified by all participant groups were issues related to staffing, training, and compensation for direct care staff. The consensus was that this weakness plays a critical role in the incidence of high staff turnover, which negatively impacts the quality of care provided to consumers.

There is clearly a common perception among consumers that eligibility processes and payment structures favor institutional care over home and community based services. The standard expression heard repeatedly was that there is "no level playing field".

All of the groups complained that inflexibility of rules and regulations related to eligibility and reimbursement serves as a barrier and creates obstacles to services.

As noted in the Strengths section above, the choices and options available through waivers are an essential part of the LTC system. However, at same time, there was a broadly expressed concern regarding the public knowledge of and communication about these services. The feelings expressed indicated that there are so many programs, categories of eligibility, and separate processes and regulations for each of them that it makes navigating through this maze of services

very difficult for consumers. Specific reference was made to the different eligibility processes, regulations, and ways of accessing each of them. This was clearly expressed in terms of, "no universal or standard application across programs and little or no coordination between agencies and providers to provide answers or solve problems".

Opportunities

(What could improve future LTC services and supports?)

Of all the opportunities identified, issues related to the adequacy, flexibility, and more effective use of funding was a firm consensus among all groups. The sense was there are a number of programs working well but they are underfunded. Examples of specific opportunities provided by the participants were to make waiver services permanent, fully fund IDEA, eliminate waiver waiting lists, and implement more CMS options for home and community based services.

There was significant agreement among the groups regarding the need to improve the quality of services through better monitoring of providers and programs. Some suggestions were to more closely tie reimbursement to the quality of care provided; make quality a priority in our system; better use of technology in the monitoring and accountability processes; and better integrate long term care into the general "health care system".

Two other opportunities had strong agreement among the groups, both of which could have a positive impact on the quality of care. First, every group expressed similar sentiments regarding a larger role for consumers, their advocates, and their families in the development of long term care policies and in the provision of services pursuant to those policies. Several groups spoke of themselves using terms like "resources to be tapped", or the need for "better use of the skills and abilities of disabled people", or "family and consumer participation in developing plans of care". In addition, a number of the groups discussed the need for more job training and employment opportunities for people with disabilities.

Second, each group spoke clearly of the need to identify opportunities for workforce development initiatives designed to meet the increasing demand for direct care staff. Some examples presented were more career path programs, in-service training institutes, training for new service and care models being developed, and incentives for direct care staff to improve their education and training in long term care services.

Threats

(What threatens the future of LTC services and support?)

Given the time period during which these group SWOT sessions were conducted, it was not surprising that the one threat identified by every group was the current economic crisis. The potential impact of this crisis on federal and state budgets for programs and services was a primary concern. In addition, what impact the economic issues would have on the ability to address the constantly increasing cost of health care services was a concern.

Another threat identified by all groups was the growing shortage of direct care staff in the health and human services workforce and what impact this would have on the availability and quality of long term care services. A closely related threat that was identified was the changing demographics of our state where the demand for services will only increase over time putting more pressure on a dwindling workforce. Another aspect of these demographic changes identified as a threat was the "aging-out" of family caregivers who play a much larger role in the long term care services system than often acknowledged.

According to all groups, another threat to the future of long term care services and supports is concern about political will and influence. Specifically stated, the threat is public policy and political leadership not being knowledgeable about the importance of long term care issues in our state. In addition, the issue of how to inform and influence state leadership regarding the need for reform and system changes was expressed in various terms as a major threat to long term care in Arkansas.

Table 1: Consumer Groups Top Rankings of the Current Status of Long Term Care Issues in Arkansas

Arkansas Mental Health Planning & Advisory Council (AMHPAC)

The Arkansas Mental Health Planning and Advisory Council was established to monitor, review and evaluate the distribution and adequacy of mental health services in Arkansas. The Council is composed of advocates, providers, consumers, family members and representatives of state and private agencies. The members are responsible for the oversight of a multi-million dollar mental health block grant. AMHPAC promotes strong community-based systems of care for families with adults and children who have serious mental illnesses or emotional problems. The Council gathers data from the mental health delivery systems and solicits information from a wide array of program, services, and organizations regarding public mental health policy, regulations, planning, priorities and allocation of resources.

Group	Strengths	Weaknesses	Opportunities	Threats
<p>Mental Health: <i>AR MH Planning & Advisory Council</i></p> <p>Total Participants: 19</p>	<ol style="list-style-type: none"> 1. State is beginning person centered planning 2. Grants to provide options & choices recognition & treatment of co-occurring disorders 3. Real case management; focus on consumers; use of Medicaid waivers; residential care & assisted living resources 4. Recognize value of peer services; begin wrap-around services; system of care planning for adults 5. Better professional staffing 	<ol style="list-style-type: none"> 1. Lack of peer services; lack of rural area services; too much focus on institutional services rather than community integration 2. Lack of homeless services & support; schools not working with special needs and behavior issues; lack of adequate & flexible funds; services not culturally sensitive 3. Problem w/transitional services adolescent to adult; lack of follow up services/plans; lack of training & education for staff 4. Lack of professional staff for MR/MI persons; lack of child psychologist & other prof. staff; lack of workplace sensitivity for families w/special needs 5. Disconnect between plan of care and services provided; poor communication between parents, consumers, & treatment staff 	<ol style="list-style-type: none"> 1. Create crisis houses, drop-in centers & outreach teams; 2. Consumer phone line or website for medication management and other links 3. Training for peer specialist; more flexible funding 4. Statewide operational system of care; monitor waiver providers for accountability and family & consumer participation in plan-of-care process 5. More broad-based waivers for LTC balance; Positive Behavior Intervention Services in schools; training institute for professionals & consumers; create state “warm line”; create consumer directed Adult Assistance Network 	<ol style="list-style-type: none"> 1. No buy-in of decision leaders for reform of system (Recovery, Values Based changes) 2. Competing priorities between consumers & providers; overall lack of funding 3. Overemphasis on children’s behavior vs. their mental health & emotional needs 4. Outcomes not based on Recovery & Values 5. Legislature not informed on mental health issues; Stigma and lack of knowledge of complexity of mental illness, substance abuse, and mental retardation

Arkansas Advocates for Nursing Home Residents (AANHR)

Individuals concerned about the well being of nursing home residents founded the Arkansas Advocates for Nursing Home Residents in 1995. Their mission is to protect and improve the quality of care and life for residents in Arkansas nursing homes. They actively promote the formation of family councils and conduct research on current information from nursing home survey data and statistics. The organization serves as the primary resource for information and education of families with loved ones in nursing homes and offers access to counseling for families 24 hours a day. AANHR has worked actively in the legislative process advocating for minimum staffing ratios and other quality improvement initiatives on behalf of nursing home residents.

Group	Strengths	Weaknesses	Opportunities	Threats
<p>Nursing Homes:</p> <p><i>AR Advocates for Nursing Home Residents</i></p> <p>Total Participants: 17</p>	<ol style="list-style-type: none"> 1. Seeing new models of care emerge (self-directed, Eden, Greenhouse, etc) 2. Money follows the person efforts 3. Dental care available in some facilities 4. Good regulatory system 5. Efforts at culture change in the industry 	<ol style="list-style-type: none"> 1. Inadequate staffing (numbers & training) 2. Falsification of NH records 3. Lack of info about and knowledge of consumer choices 4. Leaving residents unattended; staff not trained to be respectful to residents; repeat violations & failure to comply with regulations 5. Too much employee turnover 	<ol style="list-style-type: none"> 1. Better training/education for staff 2. Available new care models; Do not reimburse for medical errors 3. Tie reimbursement to enforcing compliance with regulations 4. Revise Hospice regulation for conditions of participation w/LTC facilities 5. Use CMS options for more HCBS waivers; more resident directed care; Leg will be more aware of resident rights issues; enforce patient care contracts 	<ol style="list-style-type: none"> 1. Shortage of nurses & care staff 2. Provider greed 3. Lack of adequate funding 4. Tort reform 5. Demographic impact of boomers on the LTC system

Recommendations to Balance Arkansas’s Long-Term Care System

CareLink Advisory Council

CareLink is a private, non-profit Area Agency on Aging serving a six county area in central Arkansas. They provide a comprehensive array of direct services to seniors and their families and serve as the primary source for information and assistance in meeting the needs of seniors.

The Advisory Council serves to advise the agency and the Board of Directors. They review the annual budget and make recommendations regarding services needs in the community. The Council members serve as advocates for CareLink and work as volunteer representatives of the agency during legislative sessions and in meetings with agencies and organizations.

Group	Strengths	Weaknesses	Opportunities	Threats
Aging: CareLink Advisory Council Total Participants: 13	1. Variety of levels of care available 2. Awareness of LTC options & choices 3. Better understanding & awareness of new nursing home models (Eden/Greenhouse) 4. Consumers feel more empowered 5. Greater use of Meals on Wheels; More attentive medical providers; Role of Ombudsman	1. Training, pay, supervision of service staff (all services) 2. Worker shortages for most services 3. No level playing field among LTC services 4. Lack of preventive services; lack of use of community alternatives 5. Power of nursing home lobby	1. Ways to level LTC playing field; emphasize healthy lifestyles 2. Focus leadership on LTC as priority 3. Make Quality of Care a priority 4. Expand role of Faith community 5. More integration of LTC and “health care system”; Better career paths for caregivers; More cost effective services; More emphasis on Home/Community Based Services	1. Medical & direct care worker shortages 2. Opposition to universal health coverage 3. Bureaucratic inertia; Health system complexity will thwart change/create resistance 4. Declining economy 5. Changing demographics; Unintended consequences of health care when someone else pays

Recommendations to Balance Arkansas’s Long-Term Care System

Governor’s Advisory Council on Aging (GACA)

The Governor’s Advisory Council on Aging was established to assist the Governor and his administration in planning, establishing and implementing his plan of action for aging services. The Governor appoints members of GACA with a majority being at least 60 years of age. The Council provides guidance and expertise in the development of the State Plan by the Division of Aging & Adult Services and assists the Division in the implementation of the plan. The Council also serves as an advocate for the elderly in interactions with the Governor, state agencies, the Legislature, other organizations and the news media. GACA serves as a forum for addressing the public policy and services program issues related to the needs of older citizens of Arkansas.

Group	Strengths	Weaknesses	Opportunities	Threats
Governor’s Advisory Council on Aging Total Participants: 8	1. In-home services are available; Home delivered meals; Adult day care 2. Senior centers are good first step in LTC system 3. Communication/information about services & programs; Good hospice care; Personal care services; DAAS has outside sources for planning/development 4. Transportation for personal needs; AR better than other states 5. Senior centers are “one stop” centers	1. State rules/regs block access to services; lack of funding equals lack of services 2. Too many “categories of care” & red tape 3. Inadequate staff; lack of training; AAA funding formula not recognizing geography; Info not getting to who needs services 4. No workforce development; Lack of program/service coord. 5. Programs perceived as low income	1. Future “boomers” are resources to be tapped; Use technology to improve in-home services; Create new models for assisted living (Greenhouse) 2. Use senior talents as resources for service; More education & training focused on solving LTC problems 3. Create more preventive services & strategies 4. Combine agencies/programs for better use of resources; Better monitoring of programs; Reduce streamline paperwork 5. Improve quality monitoring of healthcare service providers	1. Inadequate workforce to meet need for services 2. Ineffective political leadership 3. Economic crisis threatens reform LTC and health systems 4. Education systems not preparing graduates for LTC challenges 5. Inability to envision our future

Recommendations to Balance Arkansas’s Long-Term Care System

Choices In Living Conference

This Conference was the first convened by the DHS Division of Aging & Adult Services (DAAS) for People with Disabilities (funded by a Quality Assurance, Quality Improvement Grant from CMS). The Conference was composed primarily of adults with physical disabilities who were participants in one of the DAAS Medicaid Waiver programs or were from nursing homes and waiting to transition to the community through the Money Follows the Person waiver.

Group	Strengths	Weaknesses	Opportunities	Threats
Physically Disabled: Choices In Living Conference Total Participants: 23	1. Home & community based services have expanded 2. More individual control over care 3. Money follows the person opportunities 4. Improved access for disabled; greater use of structured schedules 5. Independent living programs	1. Lack of therapies & dental care that promote independence 2. Too many regulations for certification 3. Lack of qualified DME vendors 4. Lack of employment education & training programs 5. Lack of affordable, accessible, integrated housing	1. Better use of available funding streams 2. Develop more waivers 3. Develop more employment 4. Utilize less institutional care 5. Better allocation of DME resources; better use of skills & abilities of disabled; show more respect & less pity	1. Economic crisis impact on funding, costs, etc 2. Waivers waiting lists too long; uninformed Medical Review Team 3. Lack of adequate funding 4. Excessive “red tape” 5. Loss of programs due to poor decision-making

Title V Parents Advisory Council

The Parent Advisory Council, Inc. (PAC) is a diverse group of parents and guardians of children with special health care needs (CSHCN). The PAC is committed to advocacy and educating other families, government agencies and healthcare professionals on issues that affect children with special health care needs. The mission of the PAC is to serve as a liaison between the families of children with special health care needs (CSHCN) and existing resources. The PAC will bring issues that impact the lives of these children and families, with appropriate recommendation, to representatives of service agencies within the state. The PAC will also have a teaching responsibility to the families they represent, service agencies and the professionals who serve the children.

Group	Strengths	Weaknesses	Opportunities	Threats
<p>Title V Children with Special Needs: Parents Advisory Council</p> <p>Total Participants: 18</p>	<ol style="list-style-type: none"> Variety of choices & waivers available Inclusion training & awareness of information Parent directed provider training(Families teaching faculty); options & choices are available-services & equipment; better awareness of special needs issues Advisory groups for parents involvement; no cost sharing for families (at this time); networking opportunities for families Optional Medicaid programs are available; providers more informed & responsive; better recreation therapy & opportunity; more educational opportunities for special needs individuals 	<ol style="list-style-type: none"> Waiver waiting lists Lack of access to specialty care (only ACH & DDC available); no transition services child to adult; no level playing field for program eligibility Waiting time for DME; poor assessment & instruction for using adaptive tech equipment; unclear guidelines for eligibility No universal/standard application across programs; lack of info & training for parents about rights to service; poor quality of caregivers; no coordination between agencies & providers to provide answers & solve problems Lack of trained and adequately paid staff; competition/infighting among disability groups; time from waiver approval to services; frequent policy or rules changes 	<ol style="list-style-type: none"> Make waiver services mandatory & no waiting lists Fully fund IDEA Money follows the person program; increase daily rate for waiver services Better transition services (child to adult) & job training Use parent & consumer input for to shape policy & programs; better use technology in services 	<ol style="list-style-type: none"> Shortage of health & human services staff; loss of funding for optional Medicaid services Healthcare costs; aging of family caregivers; age 21 limit for services Negative public attitude of funding for services; lack of employment opportunities; no assistance programs to pursue higher ed; inadequate advocacy for increased disabilities Estate planning for dependent care after death of parent Loss of/inadequate senior staff in programs

Recommendations to Balance Arkansas’s Long-Term Care System

Arkansas People First

People First is a self-advocacy organization whose mission is “working together for our rights as People First, speaking for ourselves as members of the community.” The organization’s activities include influencing systems change, educating people about disability issues, and supporting people to find alternative living options of their choice.

Group	Strengths	Weaknesses	Opportunities	Threats
Developmental Disability: Arkansas Chapter of People First Total Participants: 16	1. Funding for self-advocacy groups 2. Medicaid waivers for HCB services 3. The People First organization 4. Self advocates are pursuing state legislation 5. Good community based programs are providing good Group Home service	1. Low pay won't attract and retain direct care staff 2. HDC staffing inadequate for those remaining there 3. Lack of transportation; services don't honor individual rights 4. Poor planning by Medicaid for future needs; lack of flexible program eligibility; need more higher ed opportunities 5. Special Ed not responsive to individual needs; more funding needed	1. Provide incentives to retain direct care staff; provide more flexible transportation services 2. Identify ways to pay direct care staff more; develop long term plan for transportation; provide more training for independent living skills 3. Find more grant resources for programs & services; bring in instructors to teach care staff 4. Use self advocates like People First to raise profile of Dev. Dis; provide more job opportunities and revamp Sheltered Workshops provide better health & nutrition education; simplify, clarify & streamline Medicaid 5. Do Continuous Quality Improvement (CQI) for this rebalancing project	1. Future budget cuts to Medicare & Medicaid; 2. Poor attitude towards and communication about Dev. Dis; inheritance may cause loss of Medicaid eligibility 3. Changing demographics may overwhelm the system 4. The economy 5. Lack of a strong voice or lobby; firing of waiver care workers; lack of knowledge and expertise among self advocates regarding federal & state regulations.

Brain Injury Association of Arkansas

The Brain Injury Association of Arkansas is a state-chartered affiliate of the Brain Injury Association of America and is a non-profit advocacy and support organization for survivors of brain injury. The mission of the Arkansas affiliate is to be the voice of brain injury help, hope, and healing. Their goal is to be a primary point of contact for survivors and family members trying to learn about brain injuries and the recovery process that follows. The affiliate’s objective is to improve the support systems in Arkansas by working with a variety of other Arkansas organizations and resources. BIA-AR maintains a Registry of Brain Injury Survivors as a valuable resource in identifying and assisting survivors and their families. All Registry information is maintained by the Association in a strictly confidential manner and no individual information from the Registry is shared with anyone or any group.

Group	Strengths	Weaknesses	Opportunities	Threats
<p>Brain Injury Association of Arkansas</p> <p>Total Participants: 8</p>	<ol style="list-style-type: none"> 1. State Trauma System is a major improvement; most disability facilities work for improved services. 2. Good public info about programs & services; growing number of non-profits & advocates working on disabilities; good coordination across programs & agencies; UALR & other higher ed institutions offer survivor friendly atmosphere & accommodations 3. Good care for kids & elderly; good hospice services; 4. Medicaid waivers; state leadership “gets it” re: injuries & disabilities; Arkansas Children’s Hospital rehab is good 	<ol style="list-style-type: none"> 1. Lack of emphasis on prevention; no formal infrastructure for TBI; lack of funding for TBI services 2. Too much focus on facilities/not enough on individual needs; gaps in adult services/programs; lack of TBI case management; 3. Lack of PCP’s TBI knowledge ; lack of trained professionals; poor communication about services available; gaps in insurance; no system for transitional process or care; 4. Lack of TBI waiver; no system for early identification of TBI; too much red tape; discharge planners not well informed about TBI; lack of dental care; lack of adult day facilities for meeting other survivors; lack of info re: VA, TBI cases seeing private physicians; inadequate vocational services; TBI can be “hidden disability” 	<ol style="list-style-type: none"> 1. Provide better info to families & survivors about service options; public schools need better planning for transitions; 2. More TBI certified professionals; program focus on individual needs; training program for family caregivers & advocates; TBI Medicaid waiver; funding for research; more general funding & a TBI Trust Fund; 3. More emphasis on prevention; more formal infrastructure/coalition of non-profits & advocates; more resident training on TBI issues; 4. More HCBS; better insurance coverage; develop trauma network & state registry 	<ol style="list-style-type: none"> 1. Lack of public awareness re: TBI; 2. Societal stigma & reluctance to address TBI; use of inaccurate terms for brain injury; 3. Lack of diagnostic tools & procedures for early case finding; 4. Inadequate funds due to economy; silos & competition among advocates/non-profits; lack of programs to teach survivors about own needs & challenges; myths about TBI; lack of clearly defined constituency

Endnotes

- ¹ Robert Mollica and Jennifer Gillespie, Single Point Entry Systems: State Survey Results, Community Living Exchange Collaborative: A National Technical Assistance Program, Rutgers Center for State Health policy and the national Academy for State Health Policy, August 2003.
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- ³ Family Caregiver Alliance. *The State of the States in Family Caregiver Support. A 50-State Study*, November 2004.
http://www.caregiver.org/caregiver/jsp/content/pdfs/50_state_report_complete.pdf. See also National Conference of State Legislators. *Family Caregiver Support: State Facts at a Glance*.
<http://www.ncsl.org/programs/health/forum/caregiversupport.htm>
- ⁴ Personal communication with Arkansas officials, and ElderChoices Provider Participation Recipients Served and Expenditures YTD Feb 2009, HMGR340J and Active Provider Listing by Provider Types, March 13, 2009, HMVR351J0.
- ⁵ National Study of Adult Day Centers, Partners in Caregiving, Wake Forest University School of Medicine, National Study of Adult Day Services: Key Findings 2001-2002, at [\[http://www.rwjf.org/files/newsroom/adultdayPowerPt.ppt#318,\]](http://www.rwjf.org/files/newsroom/adultdayPowerPt.ppt#318) and http://www.rwjf.org/files/newsroom/interactives/adult_day_centers/adult_day.jsp (Arkansas).
- ⁶ AARP, *Across the States: Profiles of Long-Term Care and Independent Living*. 2009.
http://assets.aarp.org/rqcenter/il/d19105_2008_atc.pdf
- ⁷ Personal communication with officials with the Arkansas Adult Day Care Association.
- ⁸ Alternatives Expenditure and Utilization Analysis, Arkansas HMGR 622J Report, February 2008.
- ⁹ United States Department of Health and Human Services, SAMHSA, Office of Applied Statistics, and "Serious Mental Illness" based on data from the National Household Survey on Drug Abuse, 2001. Available from: <http://www.oas.samhsa.gov/NHSDA/2k1State/vol1/ch6.htm>.
- ¹⁰ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Arkansas: 2005 estimates of Serious Psychological Distress and Depression. Available from: <http://oas.samhsa.gov/2K5State/Arkansas/MH.htm>.
- ¹¹ AARP, *Across the States: Profiles of Long-Term Care and Independent Living*. 2009.
http://assets.aarp.org/rqcenter/il/d19105_2008_atc.pdf