



# Oregon

Theodore R. Kulongoski, Governor

Department of Human Services

Office of the Director

500 Summer St NE E-15

Salem, OR 97301-1097

503-947-5110

Fax: 503-378-2897

TTY: 503-947-5080

November 15, 2010

The Honorable Peter Courtney, Co-Chair  
The Honorable Dave Hunt, Co-Chair  
State Emergency Board  
900 Court St. NE  
H-178 State Capitol  
Salem, OR 97301-4048



RE: Seniors and People with Disabilities Report on Long Term Services and Supports Diversion and Transition Programs - Replacement

Dear Co-Chairpersons:

The Department of Human Services (DHS), Seniors and People with Disabilities (SPD) Division will present a report at the December 15, 2010 Emergency Board Subcommittee meeting. The attached corresponding report includes an overview of SPD programs –including ongoing federal grants that help seniors and individuals with disabilities transition to the most appropriate home or community based setting that meets their long term services and support needs.

The report covers several areas in these efforts and will discuss the renewed efforts of SPD's Diversion program, which helps individuals avoid unnecessary placements or lengthy stays in nursing facilities. In conjunction with the Diversion program, SPD is providing an account of On the Move's grant activities to date, including the grant's expenditures, federal match rates and requirements, and a timeline of grant milestones and future challenges. Finally, the report covers special pilots, including a grant that helps individuals transition back home or to the community after a hospital stay, and a new effort with Care Oregon on the coordination of dual eligible Medicare and Medicaid benefits.

The report responds to many questions asked by members of the Joint Emergency Board Subcommittee on Human Services meeting on September 22, 2010. Specifically, Senator Winters wanted to know more information about the

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The Honorable Peter Courtney, Co-Chair  
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On the Move program, Senator Bates wanted to know about re-admission rates of individuals transitioning from hospitals to home and community based settings, and Representative Kotek wanted to know more general information on transition programs. This report provides a comprehensive account of efforts both ongoing and newly underway.

If we can provide additional information, please contact James Toews at 503-945-5858.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jim Scherzinger', with a stylized flourish at the end.

Jim Scherzinger  
Deputy Director of Finance

Attachments

CC: Sheila Baker, Legislative Fiscal Office  
Linda Ames, Legislative Fiscal Office  
Blake Johnson, Department of Administrative Services

**A Report on:**

**Programs for Diversion and  
Transition**

**Department of Human Services  
Seniors and People with Disabilities**

**December 2010**

## Introduction

The Co-Chairs of the Ways and Means Committee of the 2009 Oregon Legislature directed the Department of Human Services (DHS), Seniors and People with Disabilities (SPD) Division to examine the future of long-term care, and present a report to the appropriate committees in 2010. This followed similar requests by the Governor and the Legislature between 2005 and 2009. SPD presented "A Report on Long-Term Care in Oregon" at the Senate Interim Human Services and Rural Health Policy and House Interim Human Services Committees on September 21 and September 22, 2010, respectively.

While reporting on several grants to the Joint Emergency Board on Human Services on September 22, 2010, the committee asked a series of questions related to DHS's efforts to help seniors and individuals with disabilities continue to live in their own homes and communities. Committee members wanted to know more about the programs, how they were funded and supported, and how effective they were in keeping seniors and individuals with disabilities from another hospitalization or a nursing facility stay.

What follows is a short report covering these ongoing and new programs or pilots, including the nursing facility diversion services, the Money Follows the Person demonstration grant, the Real Choices Grant demonstration in Lane County, new efforts funded by an Aging and Disability Resource Centers (ADRCs) grant, and a pilot in the planning stages with CareOregon.

As DHS's report to the interim committees in September stated, the reasons to undertake these efforts are compelling. The senior population will double over the next 20 years, to just under a million Oregonians by 2030. And most seniors and people with disabilities lack the financial resources to afford long term services and supports for more than a few weeks or months. The aging demographics, coupled with Medicaid spending, put Oregon on an unsustainable course if we simply continue with the long-term services and supports now in place. A state General Fund revenue shortfall of \$3.2 billion is expected for the 2011-2013 biennium, with \$2 billion biennial gaps predicted over the following decade.

## **Oregon's Long-Term Care System: Why Diversion and Transition Still Matter**

Most of Oregon's long-term care system is funded with Medicaid. Although used creatively by Oregon and other states to fund home and community-based services, it is important to understand how people end up in their care settings.

Traditionally, an individual's placement in the long-term care system, for those Medicaid eligible, occurs in two situations. The first situation is when the individual is starting services and when the local SPD or Area Agency on Aging (AAA) office opens a case. The second situation is when the individual's needs are not being met, and the individual must move to a more appropriate setting or their service plan must be changed in order to meet their needs.

Selection of a service setting is a two step process. First, local office staff make an assessment of an individual's needs. Staff provide an intensive, face-to-face assessment of the individual's abilities to complete activities of daily living, which include eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel and bladder management), and cognition/behavior. There is also an assessment of the individual's ability to perform instrumental activities of daily living (also known as "self-management tasks), which include housekeeping including laundry, shopping, transportation, medication management and meal preparation. An individual's access to natural supports (e.g., family members) is also considered.

Second, if an individual is determined service-eligible, local office staff engage in an interactive, choice counseling process with the individual. Once the individual expresses his or her preferences and desires, local office staff assist the individual to transition into a setting of his or her choice.

Unlike many states, in Oregon the emphasis has been on choice of home and community based services. Individuals prefer to receive their long term services and supports in the least restrictive setting possible, usually provided at a lower cost.

However, due to reasons listed in the September Long-Term Care Report, Medicaid nursing facility caseloads actually grew during the first twelve months of the 2007-2009 biennium, at a rate equivalent to a five percent annual increase. This trend presented the need to rethink the way in which programs assisted individuals in finding the long term services and supports that best met their needs while avoiding more restrictive forms of care.

## **Nursing Facility Transition Services**

In 2008, the department responded to increasing nursing facility caseloads by re-investing in its case management system and reinvigorating Oregon's history of helping people live in the most independent and least restrictive places possible. Dedicated transition teams (called "Nursing Facility Transition Services") were placed in every DHS district of the state, working with consumers and their families to help people remain or return to their homes and communities after a hospitalization or a rehabilitative stay in a nursing facility. Sixty five staff statewide had significant portions of their time devoted to the specialized work of diversion and transition activities, with 28 devoted full time to this work.

As of August 2010, this initiative has assisted over 3,000 individuals who chose to receive long-term services either by remaining in or returning to their own homes or other community-based settings. While the program does not track re-hospitalizations, data show that 2,827 individuals transitioned successfully to a home or community setting after 90 days, 275 were not successful because of a decline in health or because they moved back to a nursing facility, and 161 individuals were still pending in the 90 day period of transitioning to a home or community setting.

## **Money Follows the Person**

Oregon secured a new federal demonstration grant called "Money Follows the Person" (MFP), funded by the Centers on Medicare and Medicaid Services (CMS) in September 2007. As reported in September, MFP allows states to claim a 12-month higher federal match rate for persons transitioning from nursing facilities if they have lived there six months or more. The grant also allows the state to claim federal match for services that are not usually allowable, such as housing modifications. The grant was reauthorized through 2016 as part of federal health reform and the length of a nursing facility stay required for a person to be eligible was shortened to 90 days. To date, a total of 265 clients have been relocated from nursing facilities under the MFP grant.

As a requirement of the MFP grant, the department tracks individuals who re-enter institutions after they have moved back to a home or community based setting. To date, 20 individuals have left the program. Of these:

- Six were due to acute care hospitalization followed by long term rehabilitation;
- Four due to a request of participant or guardian;
- One due to deterioration in cognitive functioning;
- Seven due to deterioration in health;
- One due to lack of sufficient community resources; and
- One due to the loss of personal care giver.

As these data show, six individuals were hospitalized directly from the MFP program before re-entering a nursing facility.

The MFP program has different rates of federal match, depending on the goods or services covered by the grant. There are three general categories in MFP's service package:

- **Qualified Home and Community Based Services.** These are services that are already provided under Oregon's waiver, but receive the enhanced MFP demonstration match for one year. These services must be provided after the first year. Examples include specialized living services, personal care, and in home and adult foster home services.
- **Home and Community Based Demonstration Services.** These are services that are already provided under Oregon's waiver, but receive the enhanced match for one year and are not required to be provided after the first year. Examples include behavioral support services, crisis management services, and employment services.
- **Supplemental Demonstration Services.** These are services reimbursed at the regular Medicaid match rate during the year the individual is in the MFP program. These are services that Medicaid would not otherwise reimburse, such as housing cost subsidies, certain home modifications, assistive technology purchase, and moving expenses.

The source of state match is exclusively General Fund. However, SPD is exploring potential funding in partnership with housing grants. If these funds are secured, then they may be matched with Medicaid dollars to fund housing costs and modifications for participants in the MFP program.

Currently, the department is receiving an enhanced Medicaid match rate under the American Recovery and Reinvestment Act (ARRA). The enhanced regular match rate is 72 percent federal funds. For MFP Qualified and Demonstrated Services, this match rate is 86 percent federal funds. Federal match rates under the grant also

include Medicaid's 50 percent federal match for administrative activities and 100 percent federal match for staff who are full time working on the MFP program. While we do not currently have match rates after the expiration of ARRA funds in June 2011, the match rates before ARRA were 62 percent for regular Medicaid match, and 81 percent for MFP Qualified and Demonstrated Services.

As of September 30, 2010, the grant had a total of \$20,741,655 in expenditures, with \$15,119,991 of those expenditures in federal match. During the last completed quarter (July-September 2010), the total expenditures in the program totaled \$3,319,107, with \$2,577,714 in federal funds. These expenditures include:

- Qualified and Demonstrated Services: \$2,354,458
- Supplemental services: \$194,164
- Full time MFP staff: \$37,812
- Administrative billing for transition coordinators and other administrative staff: \$732,671

### **Aging and Disabilities Resource Centers (ADRCs) and Hospital Discharge Planning Models**

Seniors and People with Disabilities is partnering on a Centers for Medicare and Medicaid (CMS) grant with the Lane Council of Governments (LCOG), Lane Independent Living Alliance (LILA), Lane Individual Practice Association (LIPA), and PeaceHealth. The grant period is October 1, 2008 – September 30, 2011.

The grant supports the design and implementation of a person-centered hospital discharge planning model. The goal of the model is to transition targeted individuals (Medicaid eligible individuals 18 or older with chronic conditions and/or physical disabilities) from acute care to the least restrictive setting of their choice. These services are part of initiating an Aging and Disabilities Resource Connection (ADRC) program in Lane County.

The model is being piloted within the PeaceHealth system, and the pilot sites are heart and vascular units at Sacred Heart Medical Center RiverBend and the Med/Surg floor at the University District hospital.

One measure for this model is the rate of revisit to any PeaceHealth hospital as inpatient, observation patient, AmbSurg patient, or Emergency Department-only

patient.<sup>1</sup> The pilot took baseline measures of revisits to pilot sites from April 1, 2009 through September 30, 2009. The pilot will compare these baseline data with revisits to the same pilot sites from April 1, 2010 through September 30, 2010. Data were collected for Medicaid-eligible individuals as well as uninsured patients.

Here are the baseline data from April – September 2009 at the pilot sites:

Class	Disposition	Discharges	Discharge with one or more revisit within 30 days	Revisit rate
Medicaid	Home	247	71	29%
Medicaid	Home Health	26	10	38%
Uninsured	Home	234	37	16%
Uninsured	Home Health	6	2	33%

During the pilot, best practices to transition patients successfully include:

- Identifying the individual’s discharge goals on admission;
- Conducting high-risk screening on admission;
- Using hospital-based Medicaid case managers to coordinate post-hospital care needs;
- Post-hospital telephone follow up to assess stability of discharge plan; and
- Referring unstable situations to Aging and Disability Resource Connections Specialists for in-home assessment and interventions.

The pilot’s outcome measure will be based on the revisit data gathered from April through September 2010, comparing it with the 2009 data shown above. The goal is a ten percent reduction in the revisit rate for Medicaid-eligible patients.

While the Real Choices grant focuses on transition services for Medicaid-eligible individuals, the State Unit on Aging (SUA) is involved in three initiatives, partially funded through the ADRC grant by the Administration on Aging (AoA), that will expand transition services to a broader population. These initiatives are primarily targeting Medicare beneficiaries, regardless of income level, to assist them with

<sup>1</sup> Please note that “revisit” includes several services that a patient may receive at a hospital (e.g., Emergency Department services). It is a much broader than readmission to a hospital, and should not be regarded as the same term as re-hospitalization.

information, resources, and services to help them manage chronic conditions, direct their care, and to transition to their home or community after a hospitalization or nursing facility stay. The goal is to help individuals remain independent, and to lower the probability of readmission to a hospital or nursing facility in which they would likely spend down their resources and become Medicaid eligible.

The first initiative is the Oregon Transitional Care Collaborative. The Collaborative will support implementation of best practices to improve transitions of Medicare beneficiaries across care settings and reduce unnecessary hospital readmissions or nursing facility placements. Local Community Collaborative Teams, made up of hospitals, nursing facilities, home health agencies, physician offices, and AAAs will implement these best practices.

The Teams will come together with planners and guest faculty in a series of learning sessions to learn about emerging best practices for improving care transitions. Teams will also learn about and use an improvement model where they test or “try out” changes before implementing them throughout their settings. At the same time, each team will collect data routinely for measures to help monitor and demonstrate improvement. Community teams will collaborate or share their changes, experiences and data through the learning sessions, conference calls, and email.

The primary emphasis in this Collaborative is to test changes in cross-setting transitions with a targeted population of patients. Community teams will be asked to select a clinical condition that meet at least three of these four criteria:

- There are accepted clinical guidelines for managing the condition;
- There is evidence that good self-management has a positive impact on the condition;
- There is evidence that early re-integration of patients with their primary care providers can impact medical outcomes; and
- There are high financial costs associated with frequent or unplanned acute care episodes.

Some examples of clinical conditions that meet these criteria are congestive heart failure, diabetes with one or more complications, Chronic Obstructive Pulmonary Disease (COPD), and palliative or end-of-life care.

Each team is expected to develop a plan for sharing the work of convening partners, developing a work plan, and keeping partners engaged with the required tasks. Each team will create an Aim statement (a written, measurable, and time-sensitive description of the team accomplishments) with measurable goals for their target population. Then they will “test” and implement changes that they believe will help them reach their goals. To measure progress toward their goal, teams will routinely collect and monitor a small set of data monthly for their measures.

Participants will be recruited from counties where ADRCs are being developed and have the capacity to deliver a wide range of information and assistance to people living with chronic conditions and/or physical disabilities. Those counties include: Benton, Clatsop, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Yamhill, and Washington. To date, teams have signed a participation agreement in Lane, Clatsop, Marion, Polk and Yamhill Counties.

The second initiative is the training of staff in four AAAs<sup>2</sup> to function as “Hospital to Home” (H2H) transition coaches. These staff will use methods modeled after Eric Coleman’s Care Transitions Intervention. The methods include a home visit and follow-up phone calls over a 30 day period after an individual’s hospitalization or stay in a nursing facility. The home visit consists of reinforcing the individual’s understanding of the signs and symptoms they need to monitor and what to do if their condition worsens; checking discharge medications for discrepancies; reinforcing the need to schedule follow-up appointments with health care providers; and encouraging the person to use a Personal Health Record to communicate with their providers.

The third initiative is the “Critical Pathways Providers,” an initiative to strengthen referral mechanisms between hospitals, physician offices, and ADRC transition support and services. Criteria to support this objective include a local marketing plan with targeted outreach to Critical Pathways Providers (hospitals, physician offices) on transition services; a system to capture referrals from providers; agreements with providers to identify and refer individuals and caregivers who may need transition support and other services; and new work to link in transition support and services to the development of integrated health and medical homes in Oregon.

For the Transitional Care Collaborative and the H2H demonstration projects, outcome measures will include all-cause re-hospitalization rates in 30

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<sup>2</sup> Lane Council of Governments, Multnomah County Aging & Disability Services, Norwest Senior & Disability Services, and Oregon Cascades West Council of Governments.

days for the target populations. We will also encourage measures that capture the patient and/or care giver's assessment of discharge processes. For the Critical Pathway Provider work, local ADRC sites will be able to capture and track the number and type of referrals from hospitals, physician offices, and other providers, in an online client contact database. As all of these projects are in the early stages, any data will not be available for at least a year.

A chart displaying information of recent grants administered by the SUA, including the aforementioned Real Choices and ADRC grants, is attached to this report.

## **Care Coordination**

Oregon's robust long-term care system is highly valued by Oregonians and regarded as a model for the nation. Oregon has also been a leader in developing managed care systems for people eligible for Medicaid. The two parallel systems, medical and long-term care, operate independently of one another but serve much of the same population. Denial of important services for seniors and people with disabilities is often the result of one system believing it is the responsibility of the other to provide the service. Duplication of resources leads to consumer frustration and to inefficiencies. Additionally, the current parallel system sometimes results in the provision of a lower cost service without consideration of the higher costs that may be caused in the other system (for example, an alternating pressure mattress is denied causing the need for 24/7 staffing to turn a person.)

Changes in medical condition often precipitate costly charges in long-term care as well. Finding seamless ways to deliver coordinated acute and long-term care thus becomes a compelling agenda — with every indication that quality of life will be improved and costs better contained on both sides.

DHS is currently implementing pilot projects involving Medicaid managed care plans and SPD as the funder and coordinator of long-term care. The projects will adopt a joint care plan with a holistic view of the person's needs and a common, mutually agreed-upon set of service/care strategies.

The eventual aim is the development of a system-wide approach that holistically supports individuals who are Medicare, Medicaid, and long-term service eligible in a manner that promotes the health, well-being and choice of the individual while eliminating the fiscal and operating barriers between long-term services and the medical system.

Better communication, coordination and alignment of incentives between long-term service and traditional medical care will result in a set of services that helps keep people safe, independent and functioning at a higher level, while protecting individual choice, keeping people in the living situations of their choice, and in the long run, saving both long-term and health care funds.

The first pilot, a partnership between SPD and CareOregon is:

- Co-locating case workers from SPD and CareOregon, integrated with a medical home model to provide intense, integrated case management to a small group of individuals. There will be a common, single care plan and jointly administered resources with flexibility to bend current benefit limits.
- Serving pilot populations of seniors and people with disabilities who mainly are jointly eligible for Medicare and Medicaid and who are patients at a clinic that uses tenets of the “integrated health home.” While individuals in the pilot are currently eligible for nursing facility services, they have remained in the community, and live in their own homes, adult foster homes or community-based care. Participants demonstrate an increased risk of high utilization of medical services, as identified by an acuity scale.

The overall goals of this project are:

- To improve or maintain health, which includes both a person’s medical conditions and their ability to interact, function and appreciate life.
- To improve or maintain the satisfaction and well-being of clients.
- To stabilize costs or result in cost savings for the combined long-term and health care budgets. Traditionally increased coordination has resulted in increased Medicaid costs with more cost savings for Medicare, with an overall cost savings.

A rigorous evaluation is planned to assess any differences in health outcomes associated with better collaboration in medical and long-term care case management, and assess financial benefits, if any, associated with increased investments in case management/medical management. The department hopes to have data regarding rates of re-hospitalization among pilot participants in one to two years. Discussions have also begun with other plans to expand pilots across the state, with the eventual goal of blanketing the state with long-term services and health care coordination.

State Unit on Aging Grants

<u>Grant</u>	<u>Purpose</u>	<u>People Served</u>	<u>Local Government Partners</u>	<u>Stakeholder Partners</u>	<u>Grant Period</u>	<u>Grant Amount and Match</u>	<u>Department Full Time Equivalent (FTE)</u>	<u>What the Grant Pays for</u>	<u>Goals</u>
<u>Real Choices System Change</u>	To implement significant information and assistance programs for individuals discharged from hospital stays	At risk seniors and individuals with disabilities in the Lane County region of the state	Lane Coalition of Governments (LCOG)	PeaceHealth; Lane Independent Living Alliance; Lane Independent Physicians Association	September 2008-September 2011; Awarded September 9,2008	\$1,600,000; five percent match	1.0 FTE (Full-time equivalent) grant manager	Staff at 1.0 FTE; contracted services to direct service providers	Implement enhanced information and assistance services and long term services options counseling; serve as a model for statewide implementation of information and assistance services
<u>Evidence-Based Prevention Programs</u>	Continuation of existing grant – to promote health and independence of seniors through targeted self-management of chronic conditions, physical activity, and falls reduction. Focus on strengthening Living Well-Program	Seniors who are in the community, and who live in Multnomah, Columbia Gorge, Rogue Valley, and Warm Springs Region	Multnomah Aging and Disabilities Services (ADS); Mid-Columbia Council of Governments (MCCOG); Rogue Valley Council of Governments (RVCOG); Confederated Tribes of Warm Springs	Loaves & Fishes; NW Parish Nurse Ministries; Oregon Health Science University; Mid-Columbia Medical Center; Hood River Adult Education; Wasco-Sherman Health Department; Oregon State University Extension; Warm Springs Health and Wellness Center	August 2009-July 2010; One year extension of three year grant originally awarded September 28, 2006	\$200,000, 25 percent in-kind match	None	Instructor training; support materials, such as textbooks and other publications for program participants; regional marketing and promotional materials	Reach at-risk seniors with evidence-based programs; Maintain fidelity to design and research outcomes; Increase awareness and use of evidence-based health promotion programs for seniors; Sustain, replicate, and expand programs statewide

## State Unit on Aging Grants

<u>Grant</u>	<u>Purpose</u>	<u>People Served</u>	<u>Local Government Partners</u>	<u>Stakeholder Partners</u>	<u>Grant Period</u>	<u>Grant Amount and Match</u>	<u>Department Full Time Equivalent (FTE)</u>	<u>What the Grant Pays for</u>	<u>Goals</u>
<u>Aging and Disability Resource Centers</u>	To establish two new ADRCs to reach 30 percent of Oregonians, complete a five year strategic plan to establish ADRCs statewide, and support best practices to improve transitions of Medicare beneficiaries across care settings.	All Older Oregonians and their family members, as well as middle aged Oregonians planning for their future and younger adults with disabilities	Oregon Cascades West Council of Governments (OCWCOG); Northwest Senior and Disability Services (NWSDS)	Senior Health Insurance Benefits Assistance (SHIBA) program; Centers for Independent Living	September 2009-September 2012; Awarded September 29, 2009	\$738,168; Five percent in-kind match from local AAAs	1.0 FTE – limited duration grant coordinator	One limited duration grant coordinator; training; information technology needs; marketing expertise and materials; program evaluation and consultation; customer service surveys; contracts	Have ADRCs serve as a visible and trusted source of long term services information; provide personalized and consumer friendly assistance; coordinated and streamlined access to all publicly supported long term service options; help people plan ahead for their future long term service needs; with SHIBA, assist Medicare beneficiaries with drug coverage and prevention health benefits through Medicare

State Unit on Aging Grants

<u>Grant</u>	<u>Purpose</u>	<u>People Served</u>	<u>Local Government Partners</u>	<u>Stakeholder Partners</u>	<u>Grant Period</u>	<u>Grant Amount and Match</u>	<u>Department Full Time Equivalent (FTE)</u>	<u>What the Grant Pays for</u>	<u>Goals</u>
<u>Communities Putting Prevention to Work, Chronic Disease Self-Management Program</u>	To support two proven programs that help Medicare beneficiaries manage chronic conditions	Medicare beneficiaries in the following counties: Benton, Linn, Lincoln, Jackson, Josephine, Coos, Curry, Douglas	RVCOG and OCWCOG	Samaritan Health Systems; RSVP and Americorps	March 2010-March 2012; Awarded March 30, 2010	\$500,000; no match requirement	None	Training materials for participants; contracted services for continuation of programs; research and evaluation	Develop partnerships with public and private organizations to sustain programs; embed programs into Medicaid and ADRC programs; develop systems for regional coordination and marketing; effort to obtain insurance reimbursement for programs
<u>ADRC Options Counseling and Assistance Program</u>	To develop a minimum set of federal and state standards for options counseling and assistance	All older Oregonians and their family members, as well as middle aged Oregonians planning for their future and younger adults with disabilities	Lane County Council of Governments; OCWCOG; NWSDS	Portland State University; Local ADRCs and AAAs listed	September 2010-September 2012; Awarded September 27, 2010	\$500,000; no match requirement	None	Contracted services with Portland State University to develop standards; training for new or existing options counselors; gathering and analyzing service delivery and consumer outcome data; support for participation and travel in the federal-state collaboration for national standards	Develop and implement a minimum, comprehensive set of national standards for the Centers for Medicare and Medicaid Services and Administration on Aging; develop and implement state standards and core competencies to guide options counseling and assistance in Oregon

State Unit on Aging Grants

Grant	Purpose	People Served	Local Government Partners	Stakeholder Partners	Grant Period	Grant Amount and Match	Department Full Time Equivalent (FTE)	What the Grant Pays for	Goals
<p><u>ADRC Nursing Home Transition and Diversion Program</u></p>	<p>To implement the Long-Term Care Minimum Data Set (MDS) Section Q, which requires nursing facilities to ask their residents if they want to be referred to a local agency about home- and community-based care options</p>	<p>All residents (Medicaid and private pay) in Oregon nursing facilities</p>	<p>On the Move (OTM) staff in transfer AAAs; local staff for ADRCs; LCOG; OCWCOG; NWSDS</p>	<p>Local ADRCs; Oregon Health Care Association; Oregon Alliance for Senior Health Systems</p>	<p>September 2010-September 2012; Awarded August 30, 2010</p>	<p>\$400,000; no match requirement</p>	<p>No FTE at this time, but the department may propose hiring one limited duration staff to develop information systems if the department does not develop this capacity with contracted services</p>	<p>Develop an interface between the ADRC contact module and the department's case management system, Oregon ACCESS; develop an enhancement to the ADRC resource database for real-time provider information; training of ADRC staff on the changes to the new MDS Section Q</p>	<p>Train staff to use the new Section Q; interface Oregon ACCESS with the ADRC's contact modules; facilitate nursing facility residents transition to home and community based settings, if they so choose, once their preferences have been identified by the new Section Q</p>