Master Plan for Aging
Recommendation Form

Transitions from Institutions to the Community

Issue Statement:

Unmet need for institutional transitions to the community: According to the 2017 Long-Term Services and Supports Scorecard, almost 11 percent of California's 101,000 nursing home residents —or 11,000 --- are identified as having low-care needs. This means that these individuals could be cared for in the community as an alternative to institutionalization. But for many such individuals, the opportunities to transition either don't exist or these individuals and their families do not realize there are other alternatives. Nursing homes are often the only option due to lack of home- and community-based alternatives, affordable/accessible housing and awareness of alternatives. Surveys of nursing home residents reveal that a majority of residents do not want to remain in a nursing facility (NF), but thousands of Californians with disabilities are not because they need the level of care, but simply because they lack the appropriate services and resources necessary to transition. Individuals should have access to an array of services and supports that meet the needs and choices of each person, regardless of age or degree of disability, or stage of life to support living with dignity and independence.

Lack of timely access to HCBS assessments in nursing homes: When individuals desire to transition from institutional to community settings, it is critical that assessments to determine interest in and needs for return to the community be facilitated in a timely fashion. Yet, the complexity of the current system often causes delays in accessing needed services. For example, referrals to county LTSS services such as In-Home Supportive Services can often be complex and lengthy. An evaluation of Cal-MediConnect noted that counties are resistant to begin the IHSS assessment process before the beneficiary is back in the home setting—yet it is difficult to transition the individual without IHSS services already in place. The state has outlined guidance that requires IHSS assessments be performed while beneficiaries are in facilities, yet this has not alleviated the issue in its entirety.

MPA Framework Goal:

- **Goal 1:** Services and Supports: We will be able to live where we choose as we age and have the help we and our families need to do so.

Outcome: Older adults and people with disabilities who reside in institutional settings have access to the services and supports needed to transition from institutional settings to the community

Recommendation: Develop and implement a statewide strategy to ensure access to safe and timely transitions from institutions to the community.

Target Population and Numbers:

- Target population for Dignity Fund recommendation:
    1. Medi-Cal or near-Medi-Cal individuals who wish to transition from institutional settings to the community but for specified reasons are unable to transition; and
    2. Medi-Cal or near-Medi-Cal individuals who wish to remain in the community but are at-risk of institutionalization
- Target population for HCBS Transition Plans from NFs recommendation: Older adults and people with disabilities residing in nursing homes, counties, and Medi-Cal Managed Care plans.

Detailed Recommendation:

The new Department of Community Living, in partnership with the Department of Health Care Services, Social Services and Rehabilitation should develop an implementation plan and strategy for ensuring institutionalized individuals have access to opportunities for community transition. Elements of the plan should include, but not be limited to, the following:

- Establish the California Dignity Fund. The new Department of Community Living should establish a state-level California Dignity Fund that would serve as a "bridge" program to provide services to individuals moving from an institution to the community, as well as individuals residing in the community who are at-risk of institutionalization. The fund would address special circumstances that arise out of an eligible individual's need for certain goods or services, or other conditions on a non-recurring basis in order to transition individuals from institutional to community settings or to help individuals remain in the community and avoid institutionalization.

- Build upon the California Community Transitions program. The Department of Health Care Services should outline a plan and strategy for the California Community Transitions program now and into the future. Over the past 11 years, the California Community Transitions program has assisted over 3,500 Californians in transitioning from institutional living to their own home or other community setting. The Department of Health Care Services should outline its vision for this program and how to build on lessons learned so that individuals in institutions have the opportunity to return to the community, in accordance with needs and preferences.

- Conduct HCBS assessments and planning in nursing homes to support successful transition. The state should require transition planning within institutional settings, including identification of individuals desiring to return to the community, assessment for transition, and ready access to services in the community.

Evidence that supports the recommendation:

- Integrated Care Resource Center: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf
- 2017 Long-Term Services & Supports State Scorecard: http://www.longtermscorecard.org/databystate/state?state=CA
- The Impact of Cal MediConnect on Transitions from Institutional to Community-Based Settings: https://www.thescanfoundation.org/media/2019/08/the_impact_of_cal_mediconnect_on_transitions_from_institutional_to_community-based_settings_may_2017.pdf

Examples of local, state or national initiatives that can be used as an example of a best practice:

- San Francisco Dignity Fund: https://www.sfhsa.org/about/departments/department-aging-and-adult-services-daas/dignity-fund
- SSI/SSP Special Circumstances Program: This is no longer in operation and was eliminated through budget reductions in the mid-2000s, but this report explains how state provided these services: http://cdss.ca.gov/research/res/pdf/dapreports/SCP.pdf
- Re: CA Community Transitions, see also SB 214 (Dodd) http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB214
- Facilitating Community Transitions for Dually Eligible Beneficiaries: Recent report from Center for Health Care Strategies highlight two Cal MediConnect plans have helped individuals transition to the community through care coordination and addressing identified non-medical needs. https://www.chcs.org/resource/facilitating-community-transitions-for-dually-eligible-beneficiaries/?utm_source=CHCS+Email+Updates&utm_campaign=2b606ef1ca-PRIDE+Case+Studies+12%2F11%2F19&utm_medium=email&utm_term=0_bbced451bf-2b606ef1ca-152133329

Implementation:

- **State Agencies/Departments:** The new Department of Community Living would partner with the Departments of Health Care Services, Rehabilitation and Social Services in the development and implementation of a statewide strategy to ensure access to safe and timely transitions to the community.
- **State Legislature:** The Legislature would provide statutory authority, if necessary, to enable implementation of various components of the statewide strategy.
- **Local Government:** The state would partner with local governments to identify local barriers and solutions to support community transitions.

- **Federal Government:** The federal government would continue to support programs and innovations that create opportunities for states to prioritize and implement community transitions.
- **Private Sector**: The state would engage the partnership of private entities serving older adults and people with disabilities, including but not limited to institutional providers, to engage in developing and implementing community transition strategies.
- **Community-Based Organizations:** HCBS organizations would be engaged in developing and implementing community transition strategies with the state.
- **Philanthropy:** The philanthropic sector could support community transition programming and evaluation at state and local levels.

Person-Centered Metrics:

- Number of transitions to the community; and number of avoidable institutional placements (per data collected by the Dignity Fund)
- Percentage of HCBS assessments conducted in nursing facilities prior to transition to community
- Decrease in proportion of low-care need individuals residing in institutional settings
- Decreased institutional Medi-Cal LTSS expenditures and increased Medi-Cal HCBS expenditures

Evaluations:

- **Short-term (by 2020):** Development of statewide strategy to ensure timely transitions to the community; On-going reporting of person-centered metrics.
- **Mid-term (by 2025):** Development and implementation of Dignity Fund

Data Sources: see above

Potential Costs/Savings: Unknown

Prioritization: High priority

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