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# Redesigning Long-Term Care Systems Through Integrated Access & Services

## Final Report

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REDESIGNING LONG-TERM CARE SYSTEMS  
THROUGH INTEGRATED ACCESS AND SERVICES

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CONTENTS

INTRODUCTION: INTEGRATED ACCESS AND SERVICES ..... 1

INTEGRATED ACCESS TO SERVICES: SAN DIEGO, CALIFORNIA ..... 4

    1-I. AN OVERVIEW OF LONG-TERM CARE IN CALIFORNIA ..... 4

        A. Demographics ..... 4

        B. Long-Term Care Financing ..... 5

        C. Long-Term Care System and the Aging Network ..... 7

    1-II. INNOVATION OVERVIEW: AGING AND INDEPENDENCE SERVICES (AIS)..... 8

        A. AIS Call Center ..... 11

        B. AIS Services Offered ..... 12

        C. Outreach and Community Partnerships ..... 20

    1-III. KEYS TO SUCCESS ..... 25

INTEGRATED ACCESS TO SERVICES: MASSACHUSETTS ..... 29

    2-I. MASSACHUSETTS LONG-TERM CARE: AN OVERVIEW ..... 29

        A. Demographics ..... 29

        B. Long-Term Care Financing ..... 30

        C. Long-Term Care System and the Aging Network ..... 30

    2-II. INNOVATION OVERVIEW: AGING SERVICES ACCESS POINTS ..... 34

        A. An Overview ..... 34

        B. ASAP Services Offered ..... 36

        C. Outreach and Community Partnerships ..... 46

    2-III. KEYS TO SUCCESS ..... 48

INTEGRATED ACCESS AND SERVICES: OHIO’S PASSPORT PROGRAM ..... 51

    3-I. OHIO LONG-TERM CARE: AN OVERVIEW ..... 51

        A. Demographics ..... 51

        B. Long-Term Care Financing ..... 51

        C. Long-Term Care System and the Aging Network ..... 52

    3-II. INNOVATION OVERVIEW: THE PASSPORT PROGRAM ..... 60

        A. PASSPORT Screening and Assessment (PASS)..... 60

        B. PASSPORT Home- and Community-Based Services (PORT) ..... 62

        C. Outreach and Community Partnerships ..... 64

    3-III. KEYS TO SUCCESS ..... 66

INTEGRATED ACCESS AND SERVICES: MAINE ..... 70

    4-I. MAINE LONG-TERM CARE: AN OVERVIEW ..... 70

        A. Demographics ..... 70

        B. Long-Term Care Financing ..... 71

        C. Long-Term Care System and the Aging Network ..... 71

4-II. INNOVATION OVERVIEW: CENTRALIZED SERVICES .....	74
A.    An Overview .....	74
B.    Single Entry Point.....	78
C.    Home Care Coordination.....	800
D.    Reorganization/Community Partnerships.....	82
4-III. KEYS TO SUCCESS .....	83
REFERENCES .....	86

List of Tables, Exhibits and Figures

Figure 1-1    San Diego County Long-Term Care System .....	9
Exhibit 1-1    California Long-Term Care Spending 2002: Amount Spent per Individual Aged 65+ .....	11
Table 1-1    Types of Services Offered by San Diego AIS by Eligible Population.....	14
Table 1-2    Program Chart for Aging and Independence Services.....	15
Exhibit 2-1    Massachusetts Long-Term Care Spending 2002: Amount Spent per Individual Aged 65+ .....	31
Figure 2-1    Massachusetts Long-Term Care System.....	35
Table 2-1    Types of Services Offered by Massachusetts ASAPs by Eligible Population.....	37
Table 2-2    Program Chart for Massachusetts ASAPs.....	38
Table 2-3    Innovative Collaborations with Health Care Providers .....	47
Exhibit 3-1    Ohio Long-Term Care Spending 2002: Amount Spent per Individual Aged 65+ .....	53
Figure 3-1    Ohio Long-Term Care System.....	55
Table 3-1    Types of Services Offered by OHIO Area Agencies on Aging, by Eligible Population .....	56
Table 3-2    Program Chart for Ohio .....	57
Exhibit 4-1    Maine Long-Term Care Spending 2002: Amount Spent per Individual Aged 65+ .....	74
Figure 4-1    Maine Long-Term Care System.....	75
Table 4-1    Eligibility and Coverage Requirements for Maine’s Publicly-Funded HCBS Programs .....	77
Table 4-2    Types of Services Offered by Maine Long-Term Care System by Eligible Population.....	79

## INTRODUCTION: INTEGRATED ACCESS AND SERVICES

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The National Aging Services Network has played a key role in improving access to health and social support services needed by older Americans. In many places, the network provides a unified entry to information, services, and providers. By consolidating access to a range of services and funding sources, the network has strengthened the fabric that supports these individuals in the community. This integrated approach streamlines access to services while creating more choices and greater control for older Americans needing assistance as they age in the community. Options can be woven together from various program and funding streams to meet individual needs. Area Agencies on Aging (AAA) are often functioning as local resource centers that provide “one stop shopping” for people needing information on:

- The range of long-term care options available, including the types of community-based, institutional, and volunteer services they may need.
- The funding sources that may be available, including the Older Americans Act, Medicaid, the Social Service Block Grants, and state and local programs.
- The local providers and volunteer networks that can assist people who do not qualify for public programs but who need assistance to remain in the community.

The four models highlighted here integrate access to long-term care by providing information and assistance on services, funding, and providers; screening for service eligibility; case management across funding streams, and contracting with direct service providers. Each provides “one stop shopping” for people who need to:

- understand long-term care options, both institutional and community;
- be assessed for functional impairments and other limitations that may qualify them for public services;
- identify other related service needs, such as mental health counseling, nutrition assistance, or caregiver assistance to name a few;
- identify and navigate across a range of financing options that may be available; and
- receive on-going case management services to accommodate changing needs.

The four sites differ in the extent to which they rely on Medicaid home- and community-based waivers, state, and county funds to finance community-based options. While they also vary in terms of their resource levels, each builds on the information infrastructure that was created with Older Americans Act funds to support older adults in the community. Briefly, the four models are described below:

- ***San Diego's Call Center*** uses a business model or triage center model to channel callers from a county-wide toll free number to AAA case managers who know the various functional and financial eligibility criteria of available programs including Medicaid, State-funded home care, Older Americans Act and local private efforts. The call center is in the county-based Area Agency on Aging offices, staffed by trained social workers who are county employees and who manage access to services covered by federal, state, county and private funds. Clients are screened for a wide range of service needs in addition to the original reason for the call, thus identifying other problems that should be addressed to reduce the likelihood of institutionalization. Staff are trained to respond quickly and client telephone wait times are tracked (13 second average wait time) and shared among staff. AAA outreach workers also are in the community identifying local needs, developing partnerships to address those needs, and disseminating information about available LTC support services. Extensive community development with health promotion, social, and medical providers help centralize the Area Agency on Aging's role in providing information and promoting access to services in the community.
- ***Massachusetts' Aging Services Access Points (ASAPs)*** primarily use Area Agencies on Aging as single-entry access points to long-term care services (both institutional and community-based). Their nursing/social worker teams provide access to a range of services supported by the Older Americans Act, Medicaid state plan, Medicaid home- and community-based services waivers, and state home care funds. This centralized access in a locally recognized senior program allows one-stop shopping for older Americans who may not understand the existing system and/or may be unaware of all their options. ASAPs provide access to services for diverse populations with varying personal resources, cultural barriers, and health status.
- ***Ohio's PASSPORT Program*** is built largely around the local Area Agencies on Aging and the Medicaid home- and community-based services waiver program, with financing supplemented by local county tax levies. Sixty of Ohio's 88 counties have established these levies to support additional home care services not provided through other funding. Ohio relies extensively on the existing service network to identify populations needing services and coordinate options across providers, while using the infrastructure developed by the Area Agencies on Aging to identify and meet the needs of older Americans. The Area Agencies on Aging act as a coordinating mechanism to extend limited resources and develop state level advocacy.
- ***Maine's Home Care Programs*** illustrates a rural system that manages access to its institutional and community-based long-term care services by using a centralized access point, a uniform assessment instrument, and a decentralized local service system. Using one organization with staff out-stationed across the state, they conduct intake assessments for anyone seeking long-term care. Nursing home candidates are screened and funding authorized if appropriate; community-based options are identified to divert persons from nursing home care, and for those not qualifying for state or Medicaid covered services, referrals are made to local Area Agencies on Aging.

These four programs each use Area Agencies on Aging as entryways to senior and long-term care services.<sup>1</sup> The AAAs provide information and assistance, counseling about the various options, screening and case management for publicly-covered services, and contract with direct service providers to create a relatively seamless delivery system accessed through their offices. In some sites, the AAA also works with the younger people with disabilities.

These four sites differ in terms of the primary financing mechanisms and whether the effort was initiated at the state level and disseminated downward or at the local level and worked its way up to the state level. San Diego and Ohio's systems have strong county involvement, both financially and politically. They are also financially supported by state funding – either for broad-based adult protective services or through Medicaid waiver services. Massachusetts and Maine both rely on state-funded home care support in addition to Medicaid waiver funding although their models differ. Massachusetts, with its diverse communities, uses extensive local programming to create access in a way that meets the needs of the diverse local communities. Maine, on the other hand, uses centralized access to standardize options across the states, including creating options in rural communities as well as urban centers.

All four are unique and offer solutions to slightly different LTC population needs. Together, they provide a menu of ideas to help communities improve access to information and services, and increase community options for those needing help to age in place in their own homes and communities.

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<sup>1</sup> Maine uses a home care coordination agency which historically has been an Area Agency on Aging.

## **INTEGRATED ACCESS TO SERVICES: SAN DIEGO, CALIFORNIA**

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This case study highlights the role of the Aging Network in San Diego, California in promoting integrated access to senior services. The study focuses on the Aging and Independence Services (AIS) office in the County's Health and Human Services Agency, which acts as a central entry point for all public and many privately funded senior services. Using one county-wide toll-free phone number, they provide information and referral for options ranging from long-term care (LTC) assistance to recreational and employment services, individual insurance and service counseling, eligibility screening for public programs, LTC case management for public services, referrals to direct service providers, and identification of abused and neglected elders. In effect, AIS is a one-stop shopping point for a wide range of services for seniors and persons with disabilities.

Since many policies are set by State government, this case study begins with an overview of these policies to provide a context for understanding the San Diego County services. The second section presents a description of the AIS Call Center and how it provides a gateway into the aging and disability service system. Included is an overview of how it works, how clients use the system, and how other community partners are involved in its success. We conclude with information on the Call Center's keys to success—what other Area Agencies on Aging (AAAs) need to know to replicate this type of effort in their local area.

### **1-I. AN OVERVIEW OF LONG-TERM CARE IN CALIFORNIA**

#### ***A. Demographics***

California is one of the most populated states in the nation (an estimated 35 million people in 2002). Over 10 percent of its residents are aged 65 or older. While this is less than the national average of 12.4 percent of a state's population, the sheer number of elders constitutes a very large service group. This older population is ethnically diverse. Almost one-third (31.8 percent) of the 65+ population in California is Black/African American, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Kurdish, Arabic, Asian, Hispanic/Latino, or identify themselves as being of two or more races (U.S. Bureau of the Census, 2003). California is fourth in the nation in terms of having an ethnically diverse older population. As in other places, older

females outnumber older males. Women comprise 51 percent of the “60–64” year old residents and 60 percent of the “75 and older” group.

The majority of older people in California live in urban areas (92.9 percent in 2000) and are slightly wealthier than the rest of the nation’s elders. Only 8.6 percent of the older population was at or below the federal poverty level in 1999 compared to 10.9 percent nationally (Nawrocki and Gregory, 2000).

San Diego County is the size of Connecticut, encompassing 4,261 square miles, and having three distinct regions—each with different service barriers. The three regions are the shoreline and coastal plain, the interior uplands and mountains, and the deserts of the Salton Basin. Most of the county is rural. Only 631 square miles are in incorporated areas of the county, while 3,630 square miles are in unincorporated areas. Urbanization is concentrated in the western third of the county. There is an uneven distribution of the older population among the cities and towns in the county. Like the State, San Diego County’s elderly population is ethnically diverse and growing. The minority elderly population is expected to increase by 55.5 percent during the next decade, almost four times faster than the elderly white population in the county (AIS, 2004).

### ***B. Long-Term Care Financing***

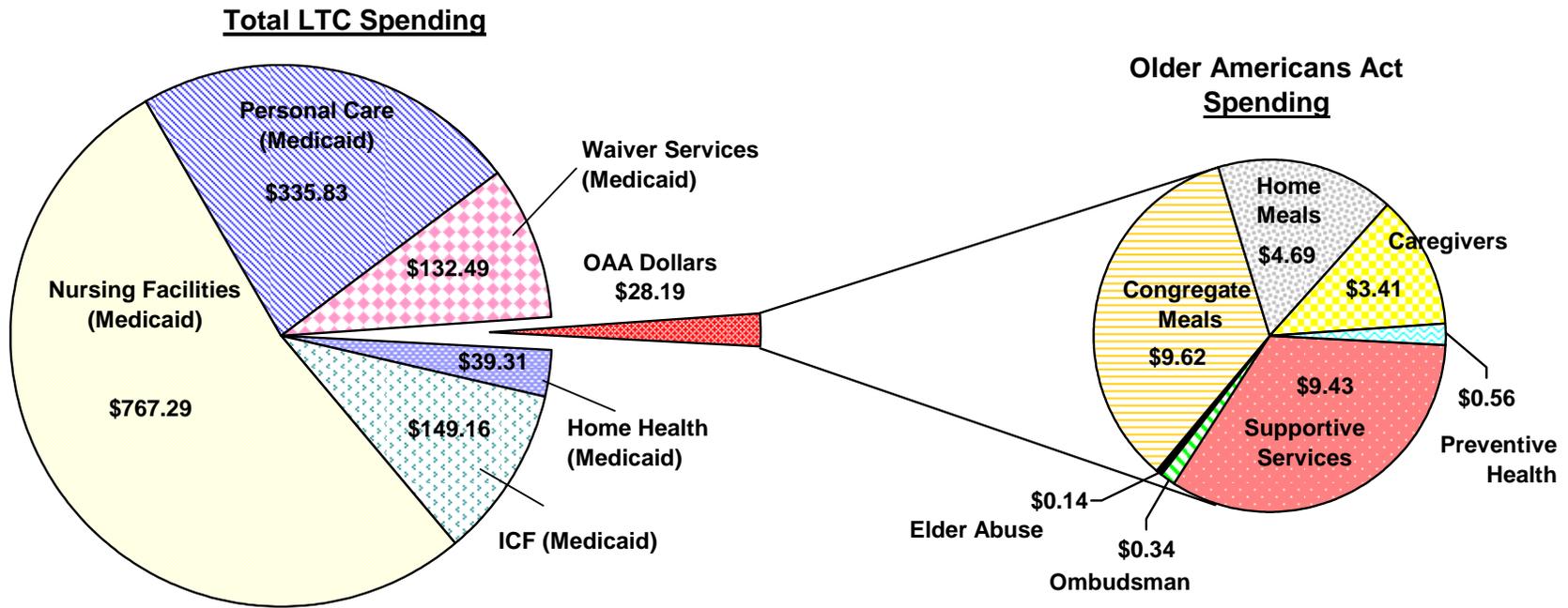
California has three primary funding sources for long-term care services: the State Medicaid program, State In-Home Supportive Services program, and County-based sources which play a large role in California’s system, although the level of contribution varies by county. Medicaid spending in California is relatively low per person, although the total amount is high because of the large number of qualifying residents. On average, California spent \$1,424 per person aged 65 years or older in 2002 compared to \$2,715 per senior in Ohio, \$2,890 per senior in Massachusetts, and \$2,354 per senior in Maine (*Exhibit 1-1*).<sup>2</sup>

Total Medicaid spending (excluding ICF) in 2002 was \$4.7 billion. Of this, 40 percent (\$1.9 billion) was for community-based services while the remaining was for nursing home services. Almost two-thirds of the Medicaid community-based spending is for personal care services (\$1.24 billion or 63 percent), almost 3 times the amount of waiver dollars (\$492 million)

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<sup>2</sup> These figures are based on 2002 Medicaid spending on nursing home, ICF, home health, personal care, and waiver services.

**Exhibit 1-1  
California Long-Term Care Spending 2002:  
Amount Spent per Individual Aged 65+**



NOTE: 2002 population estimates based on the 2000 Census were used to calculate per capita spending (see [http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002\\_files/sheet008.asp](http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002_files/sheet008.asp)). OAA spending is based on figures found at [http://www.aoa.gov/about/legbudg/current\\_budg/docs/FGS\\_FY\\_2002\\_Annual\\_Allocation.pdf](http://www.aoa.gov/about/legbudg/current_budg/docs/FGS_FY_2002_Annual_Allocation.pdf). State Medicaid spending is based on figures received from MEDSTAT.

in California. This is supplemented by the State's contribution to the personal care program or In-Home Supportive Services of about \$833 million. The County is another important player in the LTC budget.

### ***C. Long-Term Care System and the Aging Network***

California's LTC policies have been taking shape for more than 30 years. Early on, the State identified the need for community-based alternatives to institutionalization, better coordination at the state and local level, and the need for a single state agency to coordinate services and funding. To address these problems, the State passed a series of legislation to add new programs, consolidate the administration of existing programs and promote local initiatives.

During the 1970s, California focused on developing nursing home alternatives. The In-Home Supportive Services (IHSS) program was established to provide homemaker and personal care services to blind, aged, and disabled populations. This program uses State funds to cover both consumer-directed and agency services and is one of the oldest consumer-directed programs in the nation. In the 1980's, the Multi-Purpose Senior Service Program (MSSP) was established to provide community-based options for Medicaid-eligible elders (65+) who were at risk of institutionalization, and now provides case management services for this population as well. Independent Living Centers were also established to help people with disabilities advocate for the services and supports necessary to live in the community. Finally, Adult Day Care programs were established to provide:

- non-medical services to elders needing supervision;
- assistance with activities of daily living; or
- social interactions while giving their caregivers some respite time.

Also during the 1980s, California developed and expanded programs. They established a State-funded case management program (LINKAGES) for the frail and adults with disabilities (18+) who were at risk of nursing home placement but ineligible for other case management programs. California also consolidated all LTC services into the Department of Aging at this time.

During the 1990s, the State continued expanding LTC services. They broadened the funding for the IHSS program by adding Medicaid personal care funding to the State-funded services. They also developed Medicaid waiver programs to serve more people and established

and funded statewide standards for adult protective services (APS). These standards included expanding the definition of abuse and neglect to include self neglect, expanded the list of mandatory reporters, and added case management, client monitoring and reassessment, 24-hour response systems, and other services.

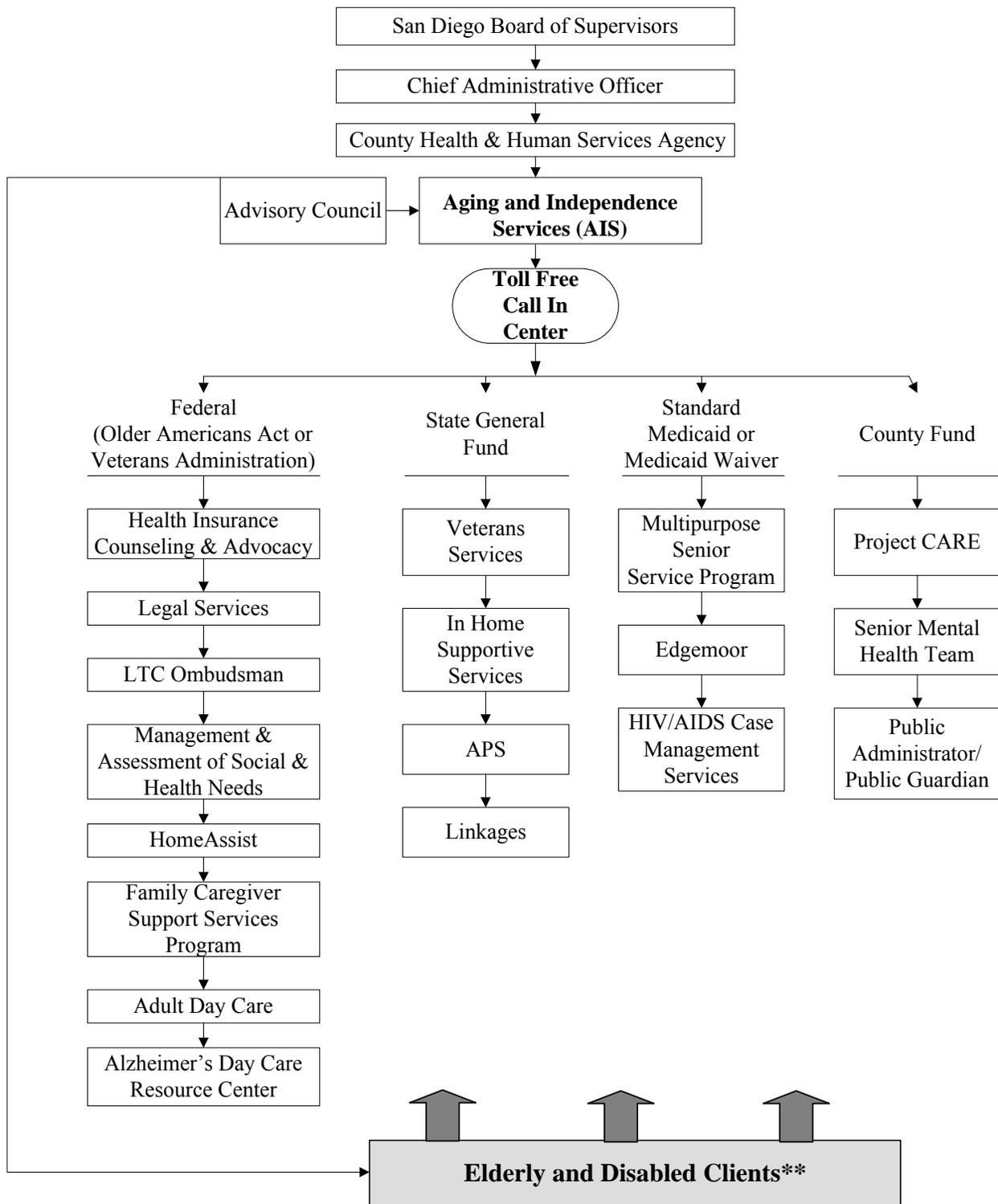
Another change that was launched in the 1990s is the “aging with dignity” initiative. This effort increased the number of qualified caregivers for seniors and disabled adults and included one-time startup funds for a variety of LTC-related innovation projects, including information systems development, transportation improvements, and alternatives to nursing home care. In addition, the initiative improved LTC facilities by increasing the numbers of inspections, mandating rapid response to complaint investigations, and strengthening enforcement activities and fiscal standards for nursing facilities. The legislation also raised skilled nursing facility payment rates.

While many of these policies were established at the State level, they were implemented by local governments. California is a state with strong county governments that often provide substantial support to public programs. In the early 1990s, the state began shifting more responsibility for aging services to county governments. Termed “realignment,” the State redirected sales tax revenues to county health, mental health, and social service programs. The purpose of this shift was to protect these services from state general fund reductions, as well as to provide greater local control. Additionally, the realignment increased the county share of non-federal IHSS costs from 3 percent to 35 percent (UCLA, 2003). This was true in both the state-funded and Medicaid components of the large, personal care program.

## **1-II. INNOVATION OVERVIEW: AGING AND INDEPENDENCE SERVICES (AIS)**

Aging and Independence Services (AIS) was originally established in 1974 as the Area Agency on Aging (AAA) for San Diego. It is part of the county’s Health and Human Services Agency, and administers over 40 federal, state, and county contracts with over 60 community organizations and service providers throughout the county (see *Figure 1-1*). As of 2003, AIS has 750 staff and an overall budget of \$250 million. They serve seniors, adults with disabilities, abused elderly and dependent adults, individuals with HIV, and others requiring home-based care to avoid institutionalization.

**Figure 1-1  
San Diego County Long-Term Care System**



NOTE: Programs are listed under the primary funding source but most also receive funding from more than one source.  
\*\*Clients access via home visits or telephone.

The AIS was created in 1997 as San Diego County consolidated its programs for the elderly and people with disabilities programs into one agency. These programs included the AAA, Public Administrator/Public Guardian, APS, IHSS, the County nursing facility (Edgemoor), Veterans Services and Mental Health Services. The purpose was to streamline service administration and improve service coordination and responsiveness to client needs.

AIS used state legislation (SB 2199) as the framework for consolidating LTC services. While the legislation was intended to improve identification, reporting, and investigation of elder abuse and neglect, it also mandated case management services and effectively provided a tool for identifying elders in the community who were in need of assistance. Passed in 1998, this legislation created a statewide Adult Protective Service program with minimum standards and adequate funding from the County Services Block Grant which, along with the state, funds APS, other information and referral services, residential assistance, and optional state services such as special services for adults and populations with disabilities. The legislation mandated the following:

- a 24-hour hotline to receive reports of elder or dependent adult abuse;
- establishing a system to respond immediately to any report of imminent danger to an elder or dependent adult;
- investigations of all reports of elder or dependent adult abuse;
- comprehensive case management services including an assessment, service plan development, and case monitoring; and
- provision of needed resources such as food, transportation, emergency shelter, and in-home services.

It also expanded the state's range of protections from physical abuse to include abduction, abandonment, isolation, financial abuse, and neglect by others or self. Mandated reporters were expanded to include all administrators or agency employees providing services to elders and dependent adults, including nutrition services, community-based support services, adult day care facilities, mental health or advocacy agencies, and agencies and persons providing health and social services to elders or dependent adults.

AIS built on this new APS infrastructure and the concurrent directives from the State to better integrate senior services by creating a system with one entry point to a range of aging and

disability services. AIS was able to establish one central location to access services ranging from the information and referral services supported by the Older Americans Act to the case identification and case management services of the APS to the case management and referral of other State and County-funded community services that allowed qualified seniors and people with disabilities to avoid institutionalization. This new organizational structure created a two-way street that provided information to the APS clients and other seniors seeking information on prevention, health, social support, recreational, and employment related options while increasing the AAA's ability to identify elders and assess their service needs. Since AIS manages IHSS, other Medicaid and County LTC programs, APS services, and Title III programs, they are able to serve elders of all income groups and better target the complete range of health, social, safety, and prevention needs of older Americans. By establishing one entry point to LTC staffed with trained caseworkers, the AIS can assess each caller's range of needs and identify appropriate services and resources needed to help seniors remain safely and independently in the community. The following section describes how this is accomplished.

#### ***A. AIS Call Center***

AIS uses a "no wrong door" approach to providing integrated access to a range of community-based LTC services. The gateway to these services is through the Call Center, which has a countywide toll-free telephone number. Callers may be traditional AAA clients seeking information about local services as well as providers, social workers, caregivers, law enforcement officials or others making referrals to AIS services.

The Call Center is modeled after private sector call centers used in banking and other businesses. Centralized intake workers answer all calls and channel referrals to the appropriate caseworker based on expected needs and eligibility for different programs. Response times are tracked with an electronic system that matches the caller with intake workers who are not on the phone with another client. Average monthly wait times are publicized in the AIS monthly newsletter which publicly recognizes reductions in client wait times. As of 2004, the average wait time to reach an intake worker was at or below 13 seconds.

The intake workers are professional social workers trained to assess callers for a range of needs that might prevent them from remaining safely in the community and to identify appropriate service programs to meet those needs. Many of the intake workers are Masters-level

social workers. All of them receive training on the different benefit and eligibility requirements of the available programs, including those financed by APS, Older Americans Act, Medicaid, state-funded home care, and private pay options. After identifying the needed service(s), the intake workers transfer the call to specific program case managers.

The Call Center staff positions are supported by integrated funding from the Older Americans Act, Medicaid state plan and waiver services, County dollars, and APS. This multiple funding stream allows AIS to not only improve its ability to identify and address a range of needs and share the cost of providing these services across several funding sources, but also to integrate the range of services offered to seniors and individuals with disabilities.

At the heart of the Call Center are two key resources:

- Trained social workers
- Electronic call management system

AIS used APS funds to purchase the call management system so they could better meet the needs of isolated elders. This system tracks incoming calls and posts them on an electronic board at the front of the Call Center identifying phone lines where the next caller is waiting. More importantly, AIS reorganized and trained their staff to be either expert generalists (intake workers) or expert specialists (program-specific caseworkers). All intake staff are trained to know the range of programs offered and different eligibility criteria. In addition, the program case managers are experts in their specific program areas. As a result, the intake staff have the ability to assess a range of client's needs and identify all potential services. The program specific case managers ensure that a comprehensive and coordinated service plan is developed across all relevant federal, state, and county-funded programs.

### ***B. AIS Services Offered***

AIS provides access to a continuum of services ranging from those used by relatively healthy seniors and individuals with disabilities (e.g., Older Americans Act-funded health promotion services) to those who have extensive health and social support needs such as homemaker and personal care services. Most services are for individuals 60 years or older, but exceptions are noted. Special populations such as Alzheimer's Disease/Dementia patients, individuals with HIV/AIDS, and Family Care Giver Support, do not have age or income requirements – individuals meet eligibility based on medical criteria.

**Table 1-1** shows the types of services that can be accessed through the AIS Call Center. Like other AAAs, AIS provides resource center services, such as general information, awareness and one-on-one assistance. It also provides access services, such as program eligibility screening for Medicaid-covered programs and case management for select populations. In addition, they manage a multitude of contracts with local providers to deliver direct services. Some of these services are available to those who are at least 60 years old while others have income-eligibility requirements. A few programs target special populations such as those with Alzheimer's disease, HIV or AIDS, or those needing family caregiver support services. Examples of the different types of services include the following:

- *Awareness and Information:* Older American Act-funded information services to help those 60 years and older identify services and local providers.
- *Assistance:* Health Insurance Counseling and Advocacy Program which assists people in understanding their insurance benefits, legal services, LTC Ombudsman.
- *Access:* Screening and assessment for Medicaid, state, and county income eligibility requirements.
- *Case Management: five programs targeting different populations*
  - Multipurpose Senior Services Program (MSSP): Medicaid waiver CM for seniors eligible for Medicaid and at risk of nursing home admission.
  - Management and Assessment of Social and Health Needs (MASH): Older Americans Act funded CM for frail and disabled people aged 60 and older who are at risk of nursing home placement and ineligible for other case management.
  - Two AIDS case management programs: Medicaid and Ryan White funding to serve any age with HIV symptoms or AIDS.
  - Linkages: State funding to provide case management to functionally impaired and disabled adults 18 years or older who are at risk of nursing home placement and ineligible for other case management programs.
- *Direct Service:* The largest component of this category is In-Home Supportive Services (IHSS): State, county and Medicaid-funded personal care and homemaker service program. It has both consumer-directed and agency services.

**Table 1-2** shows the types of services, eligibility requirements, and funding streams that are managed by the Call Center staff. These are organized by program under awareness and information, assistance, access, case management, and direct services. For example, the five case management programs each have different funding sources and provide supplemental services relative to each other. The goal is to cover all who need case management under at least one funding stream.

**Table 1-1  
Types of Services Offered by San Diego AIS by Eligible Population**

<u>Type of Service</u>	<u>INCOME LEVEL</u>			<u>SPECIAL POPULATION</u>		
	<u>Any 60+</u>	<u>Non- Medicaid Low</u>	<u>Medicaid</u>	<u>Alzheimer's Disease/ Dementia</u>	<u>HIV/AIDS</u>	<u>Family Caregivers</u>
<b>AWARENESS &amp; INFORMATON</b>						
Call Center	✓	✓	✓	✓		✓
Outreach	✓	✓	✓			
Alzheimer's Day Care Resource Center	✓	✓	✓	✓		
Older Adult Service and Information System (OASIS)	✓	✓	✓			
Family Caregiver Program I&A						✓
<b>ASSISTANCE</b>						
LTC Ombudsman Program	✓	✓	✓			
Health Insurance Counseling & Advocacy Program	✓	✓	✓			
Health Promotion/Education	✓	✓	✓			
Public Administrator/Public Guardian	✓	✓	✓			
Retired & Senior Volunteer Program	✓ (55+)	✓	✓			
Senior Employment	✓	✓	✓			
Legal Services	✓	✓	✓			
Family Caregiver Program (counseling, assistance)	✓	✓	✓			✓
<b>ACCESS: Screening/Assessment</b>						
Multipurpose Senior Service Program			✓			
Senior Mental Health Team	✓ (55+)	✓	✓			
<b>CASE MANAGEMENT</b>						
Multipurpose Senior Service Case Management			✓			
Management & Assessment of Social & Health Needs	✓	✓	✓			
Linkages	✓ *(18+)	✓	✓			
AIDS Medicaid Waiver			✓		✓	
Ryan White Care Act		✓			✓	
<b>DIRECT SERVICE</b>						
Personal Care/ADL Assistance Services* (IHHS)	✓ *	✓	✓		✓	
Chore/Homemaker* (IHHS)	✓ *	✓	✓		✓	
Adult Protective Services	✓ (65+)	✓	✓	✓	✓	✓
Adult Day Care	✓	✓	✓			
Senior Dining Centers	✓ *	✓	✓			
Home Delivered Meals	✓ *	✓	✓			
Monthly Surplus Food		✓				
Holiday delivery of hot meals, visits, and emergency supplies	✓ *	✓	✓			
Escort & Respite Care	✓ *	✓	✓			
Transportation	✓ *	✓	✓			
General Transportation Demonstration Project	✓	✓	✓			
Senior Companion		✓				
Project CARE						
Personal Emergency Response System	✓ *	✓	✓			
Home Repairs	✓ *	✓	✓			
Senior Volunteer Patrol Visits	✓	✓	✓			
Memory Impaired Identification & Safe Return	✓	✓	✓	✓		
Mail & Utility Monitoring	✓	✓	✓			
Magnetized Refrigerator Box for Emergency Information	✓	✓	✓			
Intergenerational Program	✓	✓	✓			
Foster Grandparent	✓	✓	✓			
Skilled Nursing Facility (Edgemoor)	✓ *	✓	✓			

\*Services available on a private pay basis for over income clients.

SOURCE: AIS services descriptions.

**Table 1-2  
Program Chart for Aging and Independence Services**

<b>Program</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Regions Served</b>	<b>Referral Process</b>	<b>Other AIS programs that serve same client population</b>	<b>Program Service Capacity</b>	<b>Funding</b>	<b>Available Service Funding per Client</b>
<b>AWARENESS and INFORMATION</b>								
Call Center	Provides a single point of entry for AIS Centralized Intake and Information and Assistance Program. Staff screen for various AIS programs, respond to request for information and resource referrals.	AIS Call Center welcomes all callers  AIS Program eligibility is determined by individual Case Management or Entitlement Programs	All	Call Center	N/A	Not defined	OAA, AIS Program contribution	N/A
<b>ASSISTANCE</b>								
Adult Protective Services (APS)	Investigations of neglect, physical abuse, mental suffering, abandonment, isolation, fiduciary abuse, or sexual abuse. Assessment and short-term crisis case management. Purchase of services available	Those older than 65 or 18 and older with disabilities who are harmed or threatened with harm	All	Call Center (24 hours)	No other program has the same legal power to investigate abuse  Clients may also be served by IHSS, Public Guardian, AWP/CMP/RW CA, MSSP, Linkages, MASH, Home Assist	No maximum cap	State General Fund, County Service Block Grant, County Contribution	Pooled amount  Utilized based on need
Senior Team	Information and referral, in-home assessment by psychiatric nurse and licensed mental health clinician. Crisis intervention, psychiatric evaluation, involuntary hospitalization if needed.	Those 55 or older who exhibit signs and symptoms of mental disorders or those exhibiting symptoms such as confusion and bizarre behavior with no previous diagnosis of mental disorders	All	Call Center	Only AIS program to provide psych. Evaluation and involuntary hospitalization. Clients may also be served by IHSS, AWP/CMP/RW CA, MSSP, Linkages, MASH, Home Assist, Public Guardian	300	State Funded (Mental Health Realignment Fund)	Pooled amount  Utilized based on need up to \$90,000 maximum.

**Table 1-2 (continued)**  
**Program Chart for Aging and Independence Services**

<b>Program</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Regions Served</b>	<b>Referral Process</b>	<b>Other AIS programs that serve same client population</b>	<b>Program Service Capacity</b>	<b>Funding</b>	<b>Available Service Funding per Client</b>
Public Administrator/ Public Guardian (PA/PG)	PA – Decedent estate management and investigation, legal representation, personal and real property management and sales, fiscal services, brokerage services, final arrangements and indigent burial, locate family.  PG-Conservatorship of person to make arrangements for health care, meals, clothing, personal care, housekeeping, transportation, and recreation. Conservatorship of estate to manage finances, locate and control assets, collect income, pay bills, invest money and protect assets.	PA – Mortuary, healthcare facilities, landlords, or citizens may report when someone dies and there are assets to protect and no family is known  PG – Any organization that knows of an individual unable to handle finances or is subject to undue influence can make referral.	All	PA/PG Office: 858-694-3500  Conservatorship referral form must be completed for all referrals  PG to have information calls directed to 1-800-510-2020	PA – No overlap with other AIS programs  PG – Clients may be served at the same time by Edgemoor, APS, IHSS, MSSP, AWP/CMP/RWCA, Linkages, MASH, Home Assist.	No maximum cap	Court ordered fees for County Counsel Services, County General Fund, Poded Estate, Targeted Case Management Medicaid Reimbursement	
<b>CASE MANAGEMENT</b>								
AIDS Waiver Program (AWP)	Multi-disciplinary assessment, care planning, and coordination, advocacy, education ongoing monitoring, referrals to service and purchased services, (Skilled nursing, attendant, homemaker, counseling, foster care supplement, minor adaptations, nutritional counseling, non-emergency medical transportation) based on client need.	All ages of individuals diagnosed with AIDS or HIV symptomatic Medicaid recipients, residents of San Diego County, under care of a physician, in a safe living arrangement, in need of assistance with activities of daily living, and willing and able to participate in a plan of care.	All	Call Center	Clients may be served at the same time by IHSS, PG, APS, Senior Team	270 (including CMP/RWCA)	Medicaid, State General Funds	Up to \$13,209 for purchase of service/ calendar/ year/client
AWP – Ryan White Care Act (RWCA)	Same as AWP with no purchase of services	Same as CMP	All	Internal transfer between programs	Same as AWP	Average monthly caseload of 30	Medicaid, State General Funds	No purchase of service

**Table 1-2 (continued)**  
**Program Chart for Aging and Independence Services**

<b>Program</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Regions Served</b>	<b>Referral Process</b>	<b>Other AIS programs that serve same client population</b>	<b>Program Service Capacity</b>	<b>Funding</b>	<b>Available Service Funding per Client</b>
Linkages	Comprehensive home visit assessment, care planning, service brokerage, monitoring and advocacy. Limited purchase of service once informal and referred services are ruled out.	Functionally impaired adults age 18 and over who are at risk of institutionalization and are not eligible for MSSP. Linkages cannot serve clients already receiving case management from Reg. Ctr., Dept. of Mental Health, or Dept. of Rehab.	City of San Diego, South Bay, North County (except for east rural districts)	Call Center	Clients may be served at the same time by PG, IHSS, APS, Ombudsman, Senior Team	200	State General Fund, AIS match through targeted case management, Handicapped fine money	\$33/client per month  Additionally, may use Home Assist if needed.
Multi-purpose Senior Services Program (MSSP)	Multidisciplinary assessment and care planning, service arrangement, limited purchase of service, advocacy, ongoing monitoring and follow-up for clients to remain safely in the home.	65 years or older, Medicaid eligible and at risk for institutionalization or skilled nursing facility placement	All	Call Center	Clients maybe served at the same time by PG, IHSS, APS, Ombudsman, Senior Team	687	Medicaid, State Funding	Approx. \$87/client/ month (higher with supervisor approval)
Management and Assessment of Social and Health Needs (MASH)	Comprehensive home visit assessment, care planning, service brokerage, monitoring and advocacy. Limited purchase of service once informal and referral services are ruled out.	Functionally impaired adults age 60 and older who are at risk of institutionalization and are not eligible for MSSP	All regions except east rural districts	Call Center	MASH case managers may arrange for Title III Home Assist services	75	OAA – Title III	Can only use Title III Home Assist funds as appropriate
<b>DIRECT SERVICE</b>								
Title III Home Assist	Home assessment for limited chore, meal preparation, medical appt. escort, personal care or respite services. Services authorized using vendor contracts. (H.A. is not a case management program)	Target population is functionally impaired adults age 60 and older who are not eligible for IHSS and cannot afford to pay for homemaker services	All Regions  (Difficult to find vendors to serve rural areas)	Call Center	Clients may be served the same time by any other AIS programs except IHSS	Approximately 230 clients	OAA	Funding for approximately 230 clients at a time
Edgemoor	Long-term 24-hour skilled nursing care, physical rehab, recreation, occupational, physical and speech therapies for those who meet District Part/Skilled Nursing Criteria  Senior nutrition center site	Need intense medical care at a higher level than regular Skilled Nursing Facility	All	Physician or discharge planner contacts Edgemoor admissions coordinator. Admissions team evaluates resident.	Clients maybe served at the same time by Public Guardian, Ombudsman (through patient advocate), Acute Hospitals/Skilled Nursing Facilities  Same client populations served as AWP/CMP/RWCA Linkages, MASH, IHSS	Approximately 175 currently admitted	Medicaid, Medicare, Private Pay	Services covered by clients' funding for health care (Usually Medi-Cal) Medicare, Private Pay

**Table 1-2 (continued)**  
**Program Chart for Aging and Independence Services**

<b>Program</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Regions Served</b>	<b>Referral Process</b>	<b>Other AIS programs that serve same client population</b>	<b>Program Service Capacity</b>	<b>Funding</b>	<b>Available Service Funding per Client</b>
In-Home Supportive Services (IHSS)	<p>Assessment of need and eligibility for domestic and personal care services, hours authorized as needed</p> <p>Domestic and personal care services maybe provided by an individual provider or a contract provider depending on client choice. This service enables individuals to remain safely in their home</p> <p>Payroll provided for 12,700 in-home care providers.</p>	<p>Services for low-income aged, blind and disabled persons.</p> <p>If income exceeds SSI benefit level, services may be provided on a share-of- cost basis. (SOC paid directly to provider)</p>	All	Health care or social service agencies, community organizations, or self-referrals may be made to the regional offices.	<p>Clients may be served at the same time by Public Guardian, APS, AWP/CMP/RWCA, MSSP, Linkages, MASH, Senior Team, Home Assist (money management only)</p> <p>Same client population also includes Edgemoor</p>	No maximum	Verify, Medicaid, State General Fund, AIS Contribution	<p>Varies, up to a maximum of 283 service hours/ month available to each client</p> <p>Service hours based on individual needs of each client</p>
Ombudsman	<p>Certified volunteers are in facilities as advocates to respond to and resolve complaints, witness certain legal documents, mediate, educate facilities, residents and staff regarding rights and elder abuse. Staff-investigate abuse allegations.</p>	<p>All residents in skilled nursing facilities and intermediate and residential care facilities for the elderly (board and care) and adult day health care.</p> <p>An abuse report or complaint regarding care or need for advocacy initiates service</p>	All	<p>Local phone #: 1-800-640 4661 or statewide crisis line: 1-800-231-4024</p> <p>Resident or family can talk with volunteer present at the facility or call number on poster in facility</p>	<p>Clients may be served at the same time by Public Guardian, MSSP, Edgemoor (contract Ombudsman), APS (no overlap)</p>	No maximum cap	OAA, State General Fund, Local Matched Funds	<p>No charge</p> <p>No purchase of service available for clients</p>

The Call Center also provides access to smaller unique programs developed by local leveraging of Older American Act funds. Many of these programs use public recognition to encourage community involvement and extend OAA resources. Some of these programs include supplemental nutritional, exercise, and volunteer programs. They are designed to support individuals who are able to live independently, prevent costly emergency situations, recognize when a client is in need of additional support, and facilitate the incorporation of new services into the care plan. One example is the Brown Bag program, a supplemental nutrition program which provides low-income seniors a monthly delivery of fresh and processed foods. Food is donated by a wide variety of sources including local farmers, warehouses, packaging companies and retail food chains. A second program, MoMeals, provides daily breakfast to homebound seniors and delivers between 1,000 and 2,500 meals on holidays when the congregate meal settings are closed. Local sponsors and donors pay for the meals. These programs supplement the nutrition programs sponsored by the Administration on Aging and other public funders.

AIS promotes many of these efforts as marketing opportunities for local businesses. For example, in exchange for their contributions to MoMeals, businesses receive ad and logo recognition as program supporters. Local celebrities, such as professional baseball players deliver the holiday meals. This generates media coverage and increases community awareness and support for both the participating businesses and AIS.

AIS also leverages its resources to expand access to nutrition and health promotion programs. One example is the AIS Wellness Program, particularly its “Feeling Fit” exercise class. Geared toward frail seniors, the goal of this fitness class is to help seniors improve flexibility, strength and balance, which in turn helps participants maintain and improve their ability to perform activities of daily living, and ultimately, maintain independence. These classes are offered at senior centers and are timed to end just before congregate meals are provided. This allows them to attract more attendees for both classes and meals. AIS has partnered with the local community college to provide certified and trained fitness instructors in 23 locations across the county. AIS fitness instructors are physical education or rehabilitation therapy students working to develop skills with senior populations. The instructors earn required practicum experience while seniors are lead by people with training in exercise and rehabilitation. The Feeling Fit program won an award from the American Society on Aging in 2003 for innovation and quality, and later that same year, they were recognized as one of the top

seven international projects by the International Council on Active Aging (ICAA), the world's largest association for the senior fitness and wellness industry.

AIS also targets mental health issues by reducing social isolation and preventing seniors from feeling disenfranchised from their communities. AIS, in conjunction with local community colleges and Head Start programs, sponsored development of a volunteer and employment center for seniors, LifeOptions. The target audience is “young seniors” or individuals nearing retirement. The goal is to help them improve their quality of life after retirement by discovering an area of interest and connecting them to volunteer opportunities. Individuals learn new skills at the community colleges and are then matched to nearby hospitals, daycare centers, schools, after school programs, and physical fitness programs to volunteer. Matches are made through a web-based program that offers information on different volunteer and employment options for local seniors. These opportunities can build on clients’ pre-retirement skills or newly learned skills which allow them to teach others in the community. Some are volunteer opportunities while other are paid positions. Computers and a counselor are available at the senior centers to facilitate the process.

### ***C. Outreach and Community Partnerships***

The Call Center owes much of its success to the community’s knowledge of the available resources. In order to educate the community, AIS uses a multifaceted outreach approach including the following:

#### ***1. Designated outreach and education staff in each region.***

Four outreach and education staff are stationed throughout the County. Where possible, these staff have ties to the various ethnic groups within each community. Outreach and education staff are responsible for informing the community about services, particularly APS, building regional networks, and providing administrative, communication, and outreach support to the networks. Staff meet with local businesses, providers, schools, and other community groups to identify local needs, educate them about AIS services, build community awareness regarding age-related issues, and invite them to participate in Project CARE (described below).

#### ***2. Project CARE.***

Project CARE (Community Action to Reach the Elderly) is a community partnership of more than 20 nonprofit organizations, public agencies, and businesses including law

enforcement, postal service, utility companies and other individuals in the neighborhood who develop a “safety net check-in system” for seniors or individuals with disabilities living independently. They offer six services to seniors including the following:

- Automated daily phone calls made at a prearranged time. If the call is not answered, agency staff or a volunteer will check on the individual.
- With help from AIS, the post office, utility, and refuse collection companies are trained by staff to recognize warning signs of an isolated individual in trouble. Signs may include mail not taken in, newspapers piling up, or garbage not set out for collection.
- Volunteers and local business assist in making minor home safety repairs for qualified individuals. Generally, the repairs are related to basic health and safety needs.
- Emergency information tools, such as the “Vial of Life” – a plastic box containing information on the individual’s medical history, medications, and health-related conditions. The Vial of Life is designed to provide emergency personnel information in a format that is easily recognized and located prominently on the refrigerator. AIS staff assist individuals with completing and updating the information every two months. The premise of this initiative is that by having all this information centralized, time and lives may be saved.
- Alzheimer’s Alert (“Safe Return”). This is a national bracelet identification system that helps authorities locate, identify, and safely return individuals with dementia who become lost.
- You Are Not Alone (YANA) is a personalized phone call or home visit by the senior volunteer patrol with oversight by local law enforcement.

### 3. *InfoVan.*

Using a grant from the California Department of Aging, AIS purchased a cargo van and retrofitted it to serve as a portable library of resource information, flyers, pamphlets, and videos. The InfoVan is designed to facilitate the work of the outreach and education staff by distributing information and linking individuals to services in settings where larger groups of people are meeting. The InfoVan is easily identifiable with the County symbol, AIS name, and toll free telephone number. The van is equipped with a sound system, a television, a VCR, a computer with Internet capacity, table and chairs, and a canopy.

### 4. *Elder abuse education campaign.*

The campaign includes four posters that include simple, easy to remember phrases describing elder abuse and AIS’s phone number. Each poster is a different color that represents a different type of abuse (yellow signifies silence about abuse, red signifies physical abuse, blue

signifies neglect, and green signifies financial abuse). The posters are widely disseminated across the county in Spanish and English versions on the sides of buses, in hospitals, outside of buildings, and other public places. AIS offers this campaign to other AAAs, free of charge. (See *Figure 1-2*).

5. *Monthly AIS publications.*

AIS publishes a monthly newsletter which is disseminated to more than 4,000 individuals through municipal offices, public officials, libraries, senior centers, service agencies, professional offices, and advocates and individuals interested in aging services. The bulletin reports on activities and events relevant to the senior community and Aging Network. It provides updates on the number of people being served, announces upcoming events and identifies community resources.

6. *Participation at community meetings.*

AIS staff and advisory board members actively participate in local community networks. San Diego has a large, active community of providers, businesses, nonprofit organizations, and others concerned with those who are older or have disabilities. AIS works closely with these groups and is represented at public hearings, meetings, and other activities to ensure AIS's goals are met. AIS' goals include:

- Leading in advocacy, information and safety.
- Fostering dignity and quality of life for seniors and persons with disabilities.
- Providing home- and community-based “systems of services” combined and integrated under one organization, serving the county seniors and persons with disabilities.
- Fostering physical activity and mental stimulation, broadening social interaction, and encouraging self-reliance.
- Responding to the needs and preferences of their customers and providing informed choices about LTC settings.
- Integrating social programs with physical and mental health services, since physical and psychological well being go hand-in-hand.
- Ensuring their clients affordable, efficient, high quality care.

By developing community buy-in of AIS goals, AIS effectively leverages private sector support in meeting their program goals.

Figure 1-2  
Elder Abuse Education Campaign Posters



7. *“Network of Care”*.

This is an Internet-based community resource for the elderly and individuals with disabilities as well as their caregivers and service providers. The “network of care” provides an extensive directory of services. Users can access information about diseases, situations, assistive devices and care giving. Clients can keep personal records, create an online meeting place for their providers and family, and communicate with elected officials. Access is protected through a password system. AIS received a grant from the California Department of Aging in conjunction with Alameda County Department of Aging and Adult Services to create the program.

8. *Community Partnerships*

In all these efforts, AIS recognized the importance of community partnerships as a tool to create additional access avenues, increase their awareness of local service needs, educate the public about issues pertaining to aging and disabilities, and create fundraising opportunities for programs. Recognizing that access to services is improved when more parties are aware of needs and services, AIS has developed extensive relationships between local providers, community organizations, and select municipal and state offices. In addition to the outreach efforts described above, AIS established many additional partnerships.

One example is the formal San Diego County Aging Network, a group of more than 500 organizations and individuals, that serve, represent, or are older Americans. This multi-agency collaborative meets twice yearly. Three regional action networks, (coalitions of more than 70 organizations), meet monthly to network, discuss local aging-related issues, exchange information, and advocate for special issues. AIS also sponsors an Aging Summit every other year as a way to keep partners and the network involved in identifying key issues and developing future agenda directions. A few of the partners are providers, educational institutions for both younger and older populations, newspapers, utility companies, mental and physical health providers, social organizations, police and fire departments, and the U.S. Postal Service.

Another community partner is The San Diego Union Tribune which publishes a weekly column on elder issues and an annual Eldercare Directory which they distribute across the County free of charge. The directory is also available on the Internet. In this win-win scenario, the newspaper increases readership as well as public awareness of the issues. They support the directory by charging providers to link from the online directory to their own websites.

Advertisements without web links are free. The community benefits because they have a useful tool to learn about and access services.

AIS also partners with Sharp Health Care, a major local health care system that sponsors three senior resource centers. These centers provide flu shots and other prevention and education programs to the public as well as a van to transport people to the centers. They are an active participant in AIS community planning efforts.

San Diego Gas & Electric (SDG&E), the local energy company, also partners with AIS on many levels. SDG&E participates in the Project CARE program by training meter readers to be aware of indications of problems for seniors living alone. The company also offers a 20 percent discount to seniors for replacement appliances. They support “Cool Zones,” a program that identifies and provides air-conditioned spaces for seniors and persons with disabilities during heat waves. The program also provides a limited number of fans to homebound seniors. In addition, SDG&E partners with AIS and other agencies to help disseminate information about these programs.

AIS also promotes access through their health promotion programs, which include very active community partnerships. They have an extensive Health Promotion Committee that includes 80–100 people who represent a wide range of agencies and consumers. The committee is divided into 10 workgroups that address health issues of older adults. Topics include:

- medication management;
- fitness;
- fall prevention;
- mental health and substance abuse; and
- spirituality.

The AIS health promotion staff coordinate the volunteers and community agencies that contribute time and materials to events, which in turn, increase the audiences reached by AIS. AIS outreach materials are distributed through these programs.

### **1-III. KEYS TO SUCCESS**

AIS created its integrated access point by rethinking how it organized senior service information and access. By pooling resources from several sources to fund staff positions, they literally integrated and centralized knowledge and authority in each senior staff person. They

reorganized staffing responsibilities to train information generalists (wide knowledge of programs, services, and eligibility requirements) and specialists (in-depth knowledge of specific programs). They also focused on building a “team” mentality so that staff in the different units saw themselves as part of the clients’ team. This required increased communication across the offices. To promote better communication, they developed an internal Aging and Independence newsletter which highlights different staff each month and distributes positive feedback to staff.

Briefly, AIS credits their success to the following:

- Having strong leadership, including a director who defined outcomes, had the ability to work in uncertainty, and to hire knowledgeable and engaged staff.
- Obtaining administrative and political support from the County Board of Supervisors.
- Investing in staff development—holding quarterly all-staff meetings, distributing monthly newsletters, providing the opportunity for “ride-alongs” in the community, promoting an environment for employee input and buy in, modifying work environment to be efficient and effective (co-locating staff and providing necessary tools—cell phones, computers, etc.).
- Promoting strong community support by cultivating relationships through committee participation, sponsoring trainings and offering AIS resources (vehicles, space, materials, etc.) to other community partners.

### **Investing in Staff Development**

Of particular importance are the staff development activities. AIS employs approximately 750 staff, many of whom are frontline or field staff. As an agency, AIS embraced the management philosophy developed by the Gallup Organization which promotes individual ownership of accomplishments, focuses on employee strengths, sets outcomes instead of steps, and fits jobs to the individual. Staff are actively valued and engaged in their work. In order to promote a supportive environment, quarterly staff meetings are held for the entire agency, bimonthly bulletins are circulated internally, and information fairs are held so staff can learn about other programs. Staff are required to shadow people from other departments in order to better understand the different services provided and individual jobs. The result of a greater degree of staff engagement is high staff morale, high quality outcomes, and low staff turnover. AIS feels the benefits of this philosophy far outweigh the costs involved in operationalizing the program.

### **Co-location of Programs**

Another important contributor to the agency's success was the co-location of several programs. By moving the IHSS program (the state and Medicaid-funded personal care benefit), the APS programs, and the traditional aging service programs into one space, AIS was able to maximize resources by allowing multiple program and funding sources to help finance administrative and other costs (such as rent). In addition, the close proximity of staff in these different programs improved the communication and consolidated the resources available to do their job. As a result, AIS had more resources to buy modern computers, cell phones, modular office furniture and other tools used to carry out their work which helped create a positive work environment.

### **Community Partnerships**

AIS also uses public recognition to raise private funding support. One example is the annual community luncheon which raises funds and awareness about homelessness and hunger. Each year, one senior is selected to tell their story. This puts a face to homelessness and personalizes the community's problems. Corporate/business leaders chair the event and individual businesses sponsor tables. This event is viewed as a "who's who" event in the community. AIS promotes this event as a marketing opportunity for area businesses. Depending on the size of the contribution, the sponsor can expect to receive ad and logo recognition on banners, promotional materials, and distribution of literature to volunteers. Secondly, AIS uses direct mailing to potential sponsors requesting a small donation for the cost of home delivered meals (\$2.50 per breakfast and \$5.00 per lunch) and sponsors an annual restaurant dinner to raise funds for the congregate meals. These efforts help defray the costs of community outreach and increase the resources available for integrated access to senior services.

### **Overcoming Barriers**

While all these efforts are important, a potential barrier to access for the County's large, senior minority populations would be the absence of culturally appropriate strategies to reach these communities. AIS incorporates numerous strategies to ensure minority clients are receiving culturally appropriate services, including the following:

- Locating senior centers and congregate nutrition sites in areas with high concentrations of minority populations.

- Contracting with minority service providers.
- Including provisions in service provider contracts that require targeting minority and low-income populations.
- Monitoring and reviewing service provider performance in serving minorities.
- Including minority related objectives in the local area plan.
- Collecting and disseminating demographic data on the County’s minority elderly.
- Hiring older, minority, and bilingual staff, and recruiting similar volunteers.
- Adequately representing targeted groups in their Advisory Council.
- Participating in and supporting the Council on Minority Aging.

### **Summary**

In general, AIS is using a multifaceted approach to improving access by involving the whole community in identifying elders and people with disabilities in the community who have needs; developing programs to address those needs, seeking county and private support to supplement federal and state funds; and creating a “no wrong door” approach to the whole range of services. Taken together these approaches reduce the risk of institutionalization. By using inclusive methods to develop buy-in from their staff and community networks, they expand support for their services. They meet the local needs by pooling multiple funding streams to sponsor program staff positions and developing private contributions from businesses, colleges, utilities, and newspapers to name a few. By approaching senior services as a holistic community issue, they have increased their ability to provide access while possibly reducing the need for services and giving healthier seniors and people with disabilities opportunities to give back to the community.

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### ***Additional Information:***

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## INTEGRATED ACCESS TO SERVICES: MASSACHUSETTS

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### 2-I. MASSACHUSETTS LONG-TERM CARE: AN OVERVIEW

Massachusetts has relatively generous state funding for long-term care (LTC), an extensive Aging Network, and a well developed, single entry point system. This single entry point system is provided by local Aging Services Access Points (ASAPs), administered on the state level by the Executive Office of Elder Affairs (Elder Affairs) and supported by integrated funding from the Older Americans Act (OAA), Medicaid, and a state-supported home care program. Integrated services work in Massachusetts because of the extensive Aging Network and ongoing work to develop and implement special programs at the state and local levels.

This case study highlights the role of the Aging Network in Massachusetts' LTC system. After providing some background information on Massachusetts' state policies, we present the innovation, Aging Service Access Points, which are single entry points that centralize local access to both Medicaid and non-Medicaid LTC services. This report includes a description of community partners and examples from several local programs. Finally, we discuss keys to success—features that would make these systems viable in other states—and remaining challenges.

#### A. *Demographics*

Massachusetts has a large elderly (65 years or older) population—about 13.5 percent of its 6 million state residents are elderly compared to 12.4 percent of the national population. While only 7.1 percent of the elderly are from minority communities (Black/African American, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Asian, Hispanic/Latino or two or more races) (U.S. Bureau of the Census, 2003), they represent a large number of ethnically diverse people and they are often concentrated in certain communities.

As in many states, a relatively large proportion of elderly individuals live in urban areas (92.8 percent). In 1999, 8.9 percent were at or below the poverty level, just below the national share of 10.9 percent of elderly in poverty (Nawrocki and Gregory, 2000).

### ***B. Long-Term Care Financing***

Long-term care in Massachusetts is generally supported through four sources: Medicaid state plan (70 percent), Medicaid home- and community-based waivers (22 percent), state general funds (6 percent) and Older Americans Act (1 percent). *Exhibit 2-1* presents these amounts on a per capita basis.

As in other states, Medicaid nursing home costs account for the largest share of long-term care expenditures - 57 percent or \$1.4 billion in 2002. Of the remaining community-based funds, the Medicaid waiver accounts for 51 percent of the spending (\$535 million) followed by Medicaid personal care (\$276 million or 26 percent of the community-based funding) and state-based home care funds providing another 15 percent (\$154 million). The remaining amounts are Medicaid home health (\$66 million) and Older Americans Act (\$26 million) monies (Burwell and Eiken, et al., 2003).

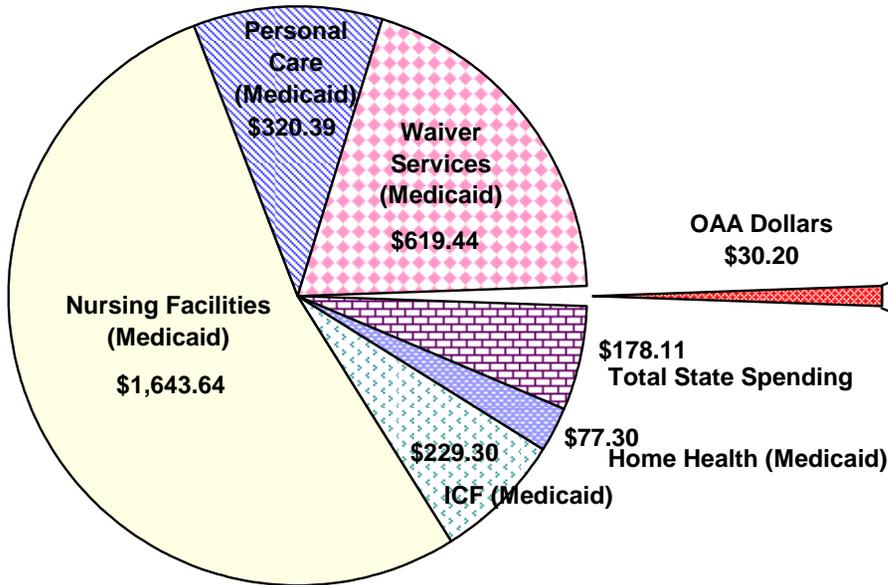
### ***C. Long-Term Care System and the Aging Network***

The Aging Services Access Points (ASAPs) were developed by Massachusetts to achieve various policy goals including improved access to long-term care services; integrated administration of senior programs (both funding streams and eligibility processes); development of a cost-effective, long-term care system; and, creation of viable alternatives to nursing facility care to control Medicaid expenditures. The local level integration reflects increasing integration at the state level between the Executive Office of Elder Affairs (OMA), the State Unit on Aging, and the Department of Medical Assistance (DMA), the State Medicaid Agency.

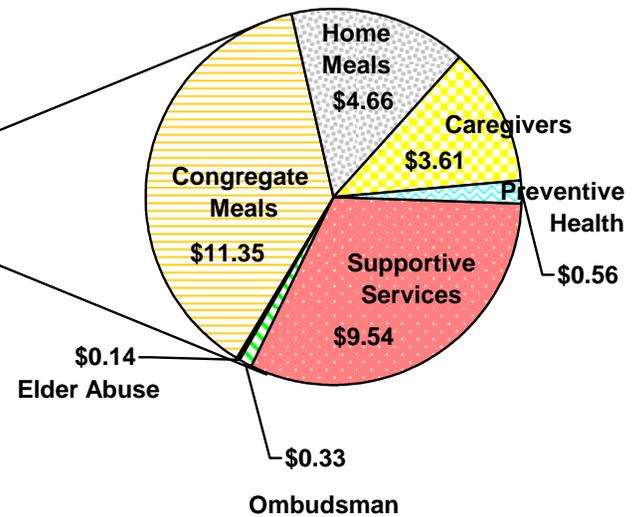
The Executive Office of Elder Affairs (EOEA) was established in 1971 as one of the first cabinet-level agencies in the country devoted to services for senior citizens. At that time, the state-funded home care program was established to provide home care services to low-income elders, including those with income or assets above the Medicaid eligibility criteria. With the advent of home and community-based waivers, Medicaid waiver funds have been used to expand the reach of these programs, reserving state dollars for those who are not waiver-eligible while increasing the range of services available under the waivers. Thus, Elder Affairs is responsible for developing, managing, and administering a comprehensive set of community-based programs, including services funded by the Medicaid state plan, Medicaid Home and Community-Based Waivers, state-funded home care services, and OAA-funded programs.

**Exhibit 2-1  
Massachusetts Long-Term Care Spending 2002:  
Amount Spent per Individual Aged 65+**

**Total LTC Spending**



**Older Americans Act Spending**



NOTE: 2002 population estimates based on the 2000 Census were used to calculate per capita spending (see [http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002\\_files/sheet008.asp](http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002_files/sheet008.asp)). OAA spending is based on figures found at [http://www.aoa.gov/about/legbudg/current\\_budg/docs/FGS\\_FY\\_2002\\_Annual\\_Allocation.pdf](http://www.aoa.gov/about/legbudg/current_budg/docs/FGS_FY_2002_Annual_Allocation.pdf). State Medicaid spending is based on figures received from MEDSTAT. State spending figures from the Massachusetts State Executive Office of Elder Affairs, 2/17/04.

Through interdepartmental agreements with the state Medicaid office, Elder Affairs administers various aspects of the Medicaid program, including preadmission screening for nursing facility care, home- and community-based waiver eligibility determination, and prior authorization of Medicaid home health, adult day health and other services. However, they do not control the Medicaid long-term care budget which remains with the state Medicaid offices. State reorganization in 2004 will shift all long-term care services and funding to Elder Affairs.

The ASAPs, which are primarily Area Agencies on Aging (AAA), are an integral part of the Massachusetts Aging Network along with Elder Affairs, the Massachusetts Home Care Association (representing the 27 ASAPs/Area Agencies in Aging), the AARP state office, Massachusetts Senior Action, the Massachusetts Association of Older Americans, the Massachusetts Association of Councils on Aging, the Massachusetts Assisted Living Facilities Association, the Alzheimer's Association, the Gerontology Institute at the University of Massachusetts in Boston and many provider organizations.

Of these organizations, The Massachusetts Home Care Association and the local Councils on Aging (COAs) are particularly important to the ASAPs on a day-to-day basis. The Massachusetts Home Care Association is a private, nonprofit corporation that was created in 1983 to represent the Home Care Corporations (now the ASAPs). It serves as a clearinghouse and as an advocate for and focal point on issues affecting seniors. Much of the Association's efforts target the state legislature where it has been consistently effective in moderating the impact of state budget cuts on the frail elderly.

Each municipality in Massachusetts has a local Council on Aging (COA), that receives modest direct funding from Elder Affairs (\$4.65 per elder annually). However, many COAs also receive funding from their cities or towns and from fundraising. In addition, ASAPs often contract with COAs to deliver OAA-funded services, such as congregate and home-delivered meals. The more generously funded COAs include senior centers and a wide range of outreach, information and referral services, recreational, and health promotion activities. As a result, the COAs and the ASAPs are often partners in providing complementary services to the senior population.

***Innovations in Home- and Community-Based Services.*** Massachusetts has a history of innovation in long-term care, starting with the state-funded home care program implemented in the 1970s, adding personal care services in the state-funded and Medicaid waiver programs, and

experimenting with capitated LTC systems in the 1980s. In 1990, Massachusetts shifted nursing facility preadmission screening from DMA to the local AAAs, and in 1997, restructured its home care delivery system into the current ASAP model. These ASAPs provide information and referral, counseling, case management and authorization for home- and community-based services, and preadmission screening for institutional care. Local ASAPs and Elder Affairs continue to look for new ways to address the needs of frail elders, implementing a variety of targeted programs and new delivery approaches to help elders remain in the community. Recent innovations include:

- Enhanced Community Options, which provide higher monthly home- and community-based service levels than the state home care program (up to \$812 in-home care services per month).
- Community Choices Demonstration, a “money follows the person” program targeting those at imminent risk of nursing home placement. CHOICES is funded on a cost reimbursement basis and allows whatever level of service is required to maintain clients in the community.
- Consumer-directed options including Medicaid Personal Care Attendant and the Take Charge program for non-Medicaid clients administered by some ASAPs.
- Clustered care approaches to delivering personal care and homemaker services, including a 24-hour supportive living services program in senior housing piloted by several ASAPs.

In 2004, Massachusetts will be implementing a new integrated model of delivering care to older people dually eligible for Medicare and Medicaid, and Medicaid-only seniors, through Senior Care Organizations (SCOs). A voluntary managed care program, the SCOs will cover the full range of acute and long-term care benefits for those who enroll. Unlike PACE plans that only enroll frail beneficiaries who meet the nursing home eligibility criteria, SCOs seek to enroll dually eligible beneficiaries including well elders. State oversight of the SCOs will also be transferred to Elder Affairs. ASAPs will provide case management services (called Geriatric Support Services Coordinators) for SCO enrollees, but rather than drawing on state home care or waiver funds, the ASAPs will be paid by the SCOs directly, and the home and community-based services provided will come out of the individual SCO’s capitation rates.

In this case study we describe the ASAPs and provide examples from site visits to two local ASAPs. We visited Somerville-Cambridge Elder Services (SCES), a large organization serving a predominantly low-income, ethnically and racially diverse urban population, and North

Shore Elder Services (NSES), the 7th smallest ASAP in Massachusetts, serving residents of five cities and towns including urban, suburban, and rural areas.

## **2-II. INNOVATION OVERVIEW: AGING SERVICES ACCESS POINTS**

### **A. *An Overview***

ASAPs serve as a single entry point for Medicaid waiver, state home care, and OAA funded services. Previously known as Home Care Corporations, Massachusetts issued new regulations and expectations to create the new ASAP structure in 1997. The goals of this new structure were to improve quality, increase standardization across regions, and enhance the ASAPs' abilities to authorize state long-term care services. Using the Massachusetts social work practice system as a model, the state developed Interdisciplinary Case Management Standards, required registered nurses at all ASAPs and in all quality improvement activities, established a basic standardized curriculum for training new case managers, and revised vendor contract monitoring. The state was looking to establish a competitive Request for Response (RFR) to designate the most qualified entity as the ASAP for a particular part of the state. However, because ASAPs are not allowed to provide direct services, it restricted many of the potentially interested providers and managed care plans from participating.

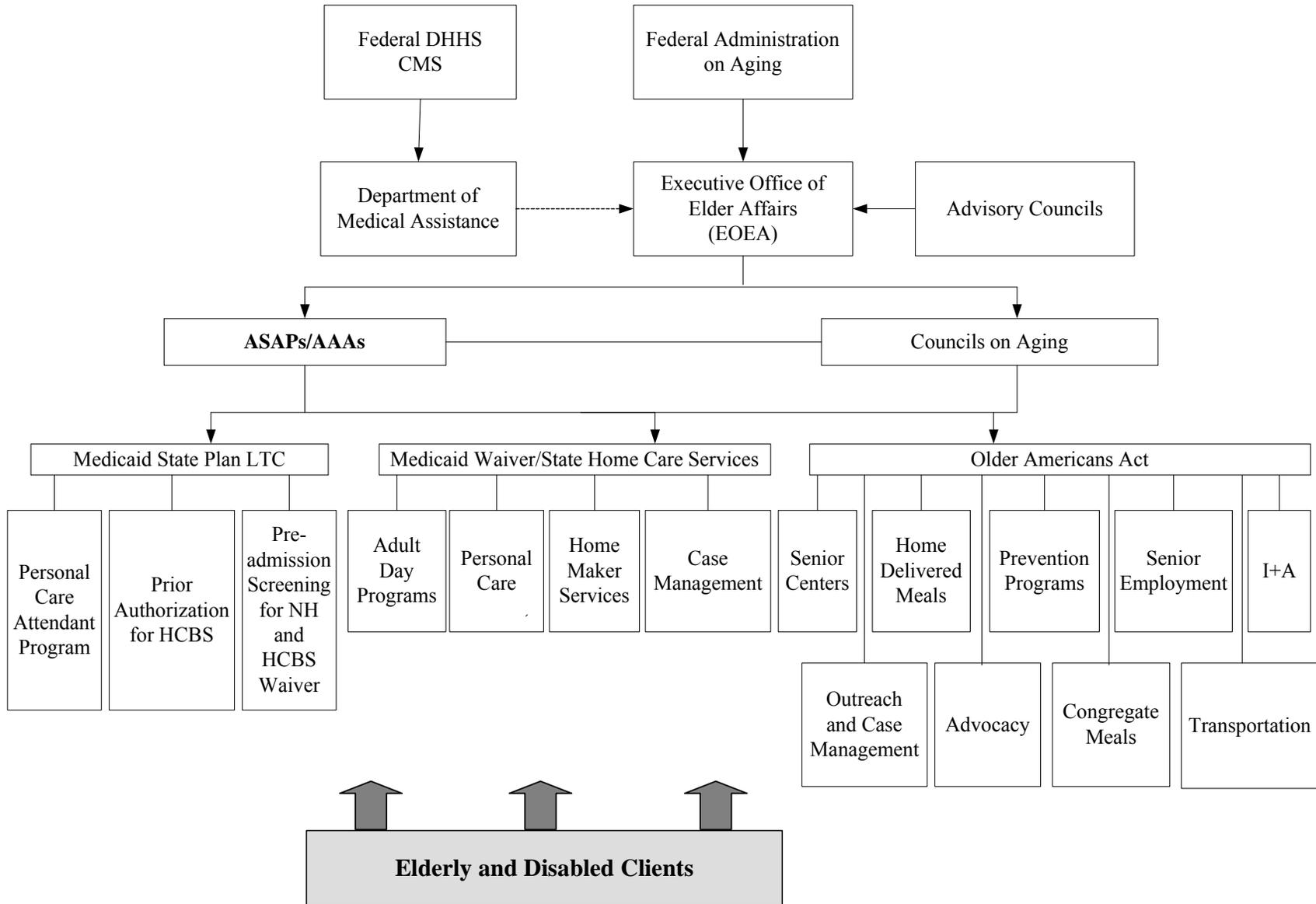
The 27 ASAPs are geographically dispersed and provide services for specific regions in the state. All AAAs serve as local ASAPs, as do a few other organizations.<sup>3</sup> Each is governed by an elected board of local elders and professionals. ASAPs offer a core set of programs and various supplemental programs depending on local initiatives and state pilot programs. The ASAPs also serve as Designated Protective Service Agencies.

*Figure 2-1* shows the ASAP's major funding streams and other organizations in the Massachusetts LTC system. ASAPs receive federal dollars from two sources, both of which are funneled to them through Elder Affairs. AoA funds are provided directly to Elder Affairs, which distributes them to the ASAPs and the COAs. They also receive Medicaid funds to carry out preadmission screening activities for nursing facility services and authorization activities for other state plan and waiver services. They also manage the state home care program. As

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<sup>3</sup> The 3 ASAPs that are not AAAs were grandfathered into these responsibilities.

**Figure 2-1  
Massachusetts Long-Term Care System**



community partners, the ASAPs and COAs work collaboratively on the local level to administer OAA-funded programs. Which OAA services are provided directly by the ASAPs and which are delivered through funds directed to the COAs varies across communities. For example, some ASAPs provide home delivered meals and transportation services through their own vendors while others funnel these funds to the local COA.

### ***B. ASAP Services Offered***

ASAPs provide centralized access to a range of services that enable seniors to remain in the community. **Table 2-1** lists the services they provide or authorize and the populations that are eligible for each type of service. Like other AAAs, ASAPs provide resource center services, such as information and awareness and one-on-one counseling assistance to seniors 60 years or older of all income groups. They also provide access services, such as eligibility screening for Medicaid-covered programs and case management for select populations. In addition, they manage a multitude of contracts with local providers to deliver direct services.

Some of these services are available to anyone who is at least 60 years old, whereas others have income eligibility requirements (see Table 2-2). For example, the state Home Care Program has income-related requirements and is available to those who do not meet the Medicaid eligibility but who need financial assistance to afford home care. Services may also be provided on a private pay basis for those whose income is too high to qualify for state assistance. The third group is the low-income or Medicaid-eligible population who has an additional set of services available to them. **Table 2-2** provides more information about the specific services and eligibility criteria for each program.

Functional eligibility for home care services is determined using a uniform assessment instrument first implemented in the early 1980s. This tool is used to group eligible seniors into priority levels based on functional impairment and level of informal supports, and is also used to develop the care plan and manage waiting lists when state funds are limited. Although HCBS waiver clients are never placed on waiting lists, waiting lists are ongoing realities for other ASAP clients when state funds fall short of the demand for services.

All ASAP home care clients are eligible for similar services regardless of their eligibility category (i.e., Medicaid waiver versus state home care) and many services are available on a sliding fee or at full cost to those at higher income levels. The basic state service level is based

**Table 2-1**  
**Types of Services Offered by Massachusetts ASAPs by Eligible Population**

<u>Type of Service</u>	<u>INCOME</u>			<u>SPECIAL POPULATIONS</u>	
	<u>All Income/ Aged 60+</u>	<u>Non-Medicaid Low</u>	<u>Medicaid</u>	<u>Alzheimer's<sup>a</sup></u>	<u>Family Caregivers</u>
<b>AWARENESS/INFORMATION</b>					
800-AGEINFO Web Database	✓	✓	✓	✓	✓
ASAP Aging Information Centers (I&A)	✓	✓	✓	✓	✓
Elders Count Outreach Program (SCES)	✓	✓	✓		
<b>ASSISTANCE</b>					
State Health Insurance Program	✓	✓	✓		
LTC Ombudsman Program	✓	✓	✓	✓	✓
Community Care Ombudsman Program	✓	✓	✓	✓	✓
Advocacy	✓	✓	✓		
Senior Community Service Employment Program		✓ (55+)	✓		
Volunteering	✓	✓	✓		
Legal Assistance		✓	✓		
Family Caregiver Support	✓ *(all ages)	✓	✓	✓ *	✓ *
Nutrition Consultation and Education	✓	✓	✓		
<b>ACCESS: SCREENING/ASSESSMENT</b>					
State Home Care Program		✓	✓		
NH Preadmission	✓	✓	✓	✓	
HCBS Medicaid Waiver			✓		
Medicaid State Plan Community Services			✓		
Home Health					
Adult Day Health Program					
DME					
Elder Care Advice Service (in-home visits)	✓	✓	✓	✓	
<b>CASE MANAGEMENT</b>	✓ *	✓	✓		
<b>DIRECT SERVICES</b>					
Care Consultation Service	✓ *#				
State Home Care	✓ *	✓	✓		
Personal Care Attendant Program (Consumer-Directed)			✓ (18+)		
Take Charge Program (Consumer-Directed)		✓			
Medicaid Waiver Group Adult Foster Care Program			✓ (22+)		
Personal Emergency Response System	✓ *	✓	✓		
Money Management		✓	✓		
Senior Companion Program ( <i>New Friends</i> at SCES)	✓	✓	✓		
Adult Day Health	✓ *	✓	✓		
Social Day Care	✓ *	✓	✓		
Homemaker, Personal Care, and Chore Services	✓ *	✓	✓		
Transportation and Escort Services	✓	✓	✓		
Adult Family Care	✓ *(18+)	✓	✓	✓	✓
Congregate and Home Delivered Meals	✓ *	✓	✓		
Home Repair and Modification	✓ *	✓	✓		
Caregiver Respite Program	✓ *	✓	✓	✓	✓
Adult Protective Services	✓	✓	✓		
Supportive Living Services Pilot Program	✓ *	✓	✓		

\*Services available on a private pay basis for over-income clients.

\*#Free initial visit, fee for service.

<sup>a</sup> Receive services through the same programs available to all elders. Checks in this column indicate programs or services specifically targeting elders with Alzheimer's.

**Table 2-2  
Program Chart for Massachusetts ASAPs**

<b>Programs</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Funding</b>
<b>Awareness/Information</b>			
800-AGEINFO Web Database	Free Web-based information database on aging resources and programs, searchable by area	Everyone seeking information on aging services	Combination of state and OAA funds
ASAP Aging Information Centers (I&A)	Free information and referral service open to the community; provides assistance, information, and resources on a wide variety of aging, disability and caregiving issues	Everyone seeking information on aging services in the ASAP catchment area	Combination of state and OAA funds
Elders Count Outreach Program (SCES)	Local door-to-door outreach program to inform residents of the ASAP's programs and services	Residents in the ASAP catchment area	Combination of city of Cambridge and SCES agency funds
<b>Assistance</b>			
Elder Care Advice Service	Service that provides information, advice, and education to older people, caregivers and families. Offers in-home, in-office and phone consultations	Residents in the ASAP catchment area	Combination of state and OAA funds
SHINE Program	Network of volunteer health benefits counselors who have been trained and certified to assist seniors, disabled Medicare beneficiaries and their families and caregivers	Residents in the ASAP catchment area aged 60+	Combination of state and OAA funds
LTC Ombudsman Program	Trained volunteers provide advocacy for nursing home and rest home residents to improve their quality of life and care. Program also provides information to seniors and their families about how to select a nursing facility	Nursing facility residents in the in the ASAP catchment area and those seeking NF information	Combination of state and OAA funds
Community Care Ombudsman Program	Trained volunteers provide advocacy for home- and community-based care recipients to improve their quality of life and care	HCBS recipients in the ASAP catchment area	Combination of state and OAA funds
Senior Community Service Employment Program	Federally sponsored program that offers part-time employment as a transitional bridge to the permanent work force. Provides training and limited benefits. Employment provided in the community or government services	Residents in the ASAP catchment area aged 55 and over with income less than 125% of poverty level.	Federal funds from the Department of Labor
Family Caregiver Support	Provides services to support caregivers by conducting support groups, educational activities and referrals to Respite program. Also performs outreach to caregivers in ethnic minority groups	Caregivers of adults aged 60+ or caregivers of persons with Alzheimer's disease or related memory disorders, grandparents aged 60+ taking care of children under 18 year old or developmentally disabled children	National Family Caregiver Program and state funds
Nutrition Consultation and Education	Free consultations by registered dietitians provided at senior centers or other community settings, in-home counseling sessions offered. Educational programs conducted at senior meal sites and senior centers, nutrition newsletter published	Residents in the ASAP catchment area aged 60+	OAA, state, and local funds

**Table 2 (continued)  
Program Chart for Massachusetts ASAPs**

<b>Programs</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Funding</b>
<b>Case Management and Care Coordination</b>			
Care Consultation Service	Program is available for families and caregivers to help them understand caregiving options	Residents of the ASAP catchment area of all ages (free initial visit and fee for other services)	OAA, National Family Caregiver Program funds, and private pay
Case Management	Provides free in-home assessment, care planning and ongoing monitoring of services. Can be provided as part of the Home Care, Medicaid, Respite or Elder-at-Risk Programs or as a stand-alone service	Residents in the ASAP catchment area aged 60+, based on need and varying income requirements.	Medicaid, state and OAA funds, private pay
<b>Direct Services</b>			
Community CHOICES	A demonstration program for frail elders that provides sufficient home-based services (up to \$1,200 monthly) to prevent or postpone nursing home placement. Program is based on the "money follows the person" model	Nursing home certifiable Medicaid enrollees at the eminent risk of NH placement	Medicaid and state funds
State Home Care Program	Program provides a combination of state-subsidized services to allow frail elders to remain in the community. There are various levels of service that range from the basic, that allows a person to get home delivered meals and some homemaking or personal care, to ECOP that provides a comprehensive package of HCBS to prevent NH placement	Residents in the ASAP catchment area who are disabled or aged 60+ with an annual income of less than \$20,351 (\$28,797 for couple), based on need in ADL/IADL limitations. Sliding copayments	State funds and private pay in the form of sliding scale copayments
Personal Care Attendant Program (Consumer Directed)	Consumer directed program where people can hire, train, supervise and schedule their own personal care workers. Skills trainer from ASAP provides technical assistance and ongoing support to consumers	Frail or blind individuals aged 18+ enrolled in Medicaid who have a need based on at least 2 ADL limitations, able and willing to direct their own care ( or have a surrogate)	Medicaid and state funds
Take Charge Program (Consumer Directed)	Consumer-directed program for non-Medicaid seniors where elders hire, train, supervise, and schedule their own workers to assist with personal care and homemaking	Residents in the ASAP catchment, aged 60+ who meet the need for services requirement and have income guidelines to meet state home care program requirements, able and willing to direct their own care	State funds
Group Adult Foster Care Program	Medicaid Assisted Living Program that provides comprehensive services to those in need of daily assistance to remain in their own homes	Medicaid enrollees or eligibles residing in subsidized housing with major ADL limitations and physician's approval for admission	Medicaid
Personal Emergency Response System	Provides equipment and monitoring to home bound or isolated elders by designating a person to be notified in case of emergency. Elders are given special equipment to contact and solicit help from a designated person during emergencies. This service can be offered through Group Adult Foster Care Program, Home Care program, or privately	Elders 60+ clinically eligible with physician's approval for admission	Medicaid, state, and private funds

**Table 2 (continued)**  
**Program Chart for Massachusetts ASAPs**

<b>Programs</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Funding</b>
Money Management	Program that matches trained and insured volunteers with elders who need help with money management and budgeting. This free service has two levels of assistance: Bill Payer Service and Representative Payee Service	Disabled or aged 60+ with an annual income of less than \$20,351 (\$28,797 for couple) and a cap of \$30,000 on liquid assets	OAA and state funds
Senior Companion Program	Volunteer visit program for home bound and isolated elders in the community	Residents in the ASAP catchment area	OAA
Adult Health Day Program	Program provides a comprehensive set of health and social services in the structured day setting for dependent adults. Skilled services, maintenance therapy, personal care, nutrition, and social activities are provided. Special dementia care programs. Can be offered through Home Care or Group Adult Foster Care programs	Adults 60+, clinically eligible. Medicaid enrollees need to be certified by ASAPs	Medicaid, state funds, and private pay
Social Day Care Program	Program provides a set of social interactions, activities, and meals in a structured day setting	Adults 60+	State funds and private pay
Home Maker Services	Homemaker Service provides light housekeeping, grocery shopping, and other home management services for functionally impaired and disabled adults. Can be offered through Home Care or Group Adult Foster Care programs or as a stand-alone service	Residents in the ASAP catchment, aged 60+ who meet the need for services requirement and have income guidelines to meet state home care program requirements, or Medicaid enrollees	Medicaid, OAA and state funds, and private pay
Chore Services, Home Repairs	Assistance with heavy household work and various chores, one-time home repairs	Residents in the ASAP catchment, aged 60+ who meet the need for services requirement and have income guidelines to meet state home care program requirements, or Medicaid enrollees	Medicaid, OAA and state funds, and private pay
Personal Care Homemaker	Limited ADL assistance provided under the direction of ASAP RN as a cost-effective alternative to home health aide services. Provided by vendor agency staff	Residents in the ASAP catchment, aged 60+ who meet the need for services requirement and need partial ADL assistance, and have income guidelines to meet state home care program requirements, or Medicaid enrollees	Medicaid, OAA and state funds, and private pay
Transportation and Escort Services	Transportation services include special lift-equipped vans, taxis, shuttle vans, buses, or a discount card for the MBTA. Depending on the program, transportation may be limited to medical appointments, or it may be for any purpose including shopping, visiting, etc. For Medicaid-eligible elders who have been certified by their physicians as unable to use public transportation, a taxi to doctor's appointments may be provided. ASAPs may also provide eligible elders transportation for lifesaving treatments such as dialysis, radiation, or chemotherapy	Residents in the ASAP catchment area aged 60+ who meet the need for services requirement and have income guidelines to meet state home care program requirements, or Medicaid enrollees	Medicaid, OAA and state funds, and private pay

**Table 2 (continued)**  
**Program Chart for Massachusetts ASAPs**

<b>Programs</b>	<b>Client Services Provided</b>	<b>Eligibility</b>	<b>Funding</b>
Adult Family Care	Foster care program for adults that provides supportive family environment for seniors to remain in the community. Provides personal care, homemaking, home delivered meals, transportation, adult day programs, grocery shopping, case management services (often provided by an RN)	Aged 18+ with the medical diagnosis, and at least one ADL limitation, with caregivers that are not related	Combination of Medicaid and private pay
Nutrition Services	This program offers nutrition services ranging from meals at congregate sites to home delivered meals. Meals-on-Wheels can be a part of the Home Care, Respite Care, or Group Adult Foster Care programs	Seniors aged 60+ residing in the ASAP's catchment area	State, OAA, and private pay (donation or fee) funds
Caregiver Respite Program	Program offers caregivers relief from caregiving and time to care for themselves and includes a comprehensive array of services from case management to emergency response systems	Those aged 60+ with need for assistance in ADLs/IADLs, with active caregivers who provide daily assistance. No income requirement	Combination of National Family Caregiver Program funds, state funds, and private pay in the form of sliding scale copayments
Adult Protective Services	Protective services investigates reports of elder abuse, neglect, and financial exploitation. Short-term crisis management provided. Caseworkers in conjunction with community agencies provide services designed to eliminate or alleviate abuse of elders that include health, mental health, legal, and social services	All elders aged 60+ who may suffer abuse or self neglect	OAA and state funds
Supportive Living Services Program (SCES)	Pilot program developed by Elder Affairs and the Dept. of Housing and Community Development to provide available staff and services 24 hours per day, 7 days a week. Services include help of a coordinator, structured social activities, monthly blood pressure screenings, congregate meals, escort to building activities, and 24-hour assistance from program staff (personal care, medication reminders, homemaking, grocery shopping, laundry, emergency response systems, transportation, and heavy chores)	A person has to meet Care Program requirements or pay privately	State funds or private pay

on payments of \$232 dollars per active client per month. Some clients may qualify for more generous service packages based on clinical criteria, such as the Enhanced Community Options Program (ECOP), which uses a monthly reimbursement allowance of \$812. Other service packages require Medicaid eligibility; for example, the CHOICES program (a money follows the person program for Medicaid beneficiaries at imminent risk of nursing home placement), the Medicaid Personal Care Attendant program, and the Group Adult Foster Care Program, which provides daily personal care assistance to residents in senior housing with daily personal care needs but who do not meet waiver eligibility criteria.

ASAPs integrate access to community services by:

- providing information and referral to the full range of health and social services available in their communities to all elders and their caregivers, regardless of income;
- determining clinical eligibility for home care, home and community-based waivers, institutional care, Medicaid home health, and durable medical equipment;
- determining financial eligibility for the state-funded home care program which serves low-income elders who do not qualify for Medicaid services (although ASAPs do not determine financial eligibility for Medicaid, they provide assistance with the application process);
- developing care plans, authorizing and monitoring services provided by vendor agencies for eligible clients; and
- coordinating services from three funding streams:
  - state-funded home care services (which predate Medicaid waivers),
  - AoA funded services, and
  - Medicaid services including both state plan and waiver services.

While the exact staffing arrangements for intake may differ across ASAPs, the basic client pathway is the same. Referrals are accepted at each local ASAP by telephone, fax, email or in some cases, online. Referrals may be initiated by the person seeking the services, a family member, hospital discharge planners, staff from other community agencies or providers, or result from inquiries to the statewide AgeInfo line. Potential clients enter the system by scheduling an initial, in-home assessment with their local ASAP. Professional case managers arrange a home visit to complete the assessment and eligibility determination process and initiate a service plan for those who appear to meet income and functional eligibility screens. Elder Care Advisors are available to provide in-home assessments, information, and counseling to those who do not appear to be income eligible for Medicaid or state-funded home care services. In addition, requests from providers for prior authorization of Medicaid state plan services including nursing

facility preadmission screening, home health, or adult day health automatically result in ASAP staff reviewing the potential eligibility for other ASAP services. The Long-Term Care Ombudsmen are also ASAP staff and provide information about community services to nursing home residents who request their help.

*Figure 2-2* is a flow chart describing how clients enter the system and where they receive information and assistance at Somerville-Cambridge Elder Services (SCES). While each ASAP may organize these services and functions differently, this chart depicts the range and complexity of case management, information dissemination and counseling, and other key ASAP activities. SCES's Aging Information Center (intake, information and counseling department) emphasizes ensuring a live response to every call and quickly directing calls to the appropriate staff person. In light of budget cuts, this has required substantial cross training and the involvement of supervisory and management staff.

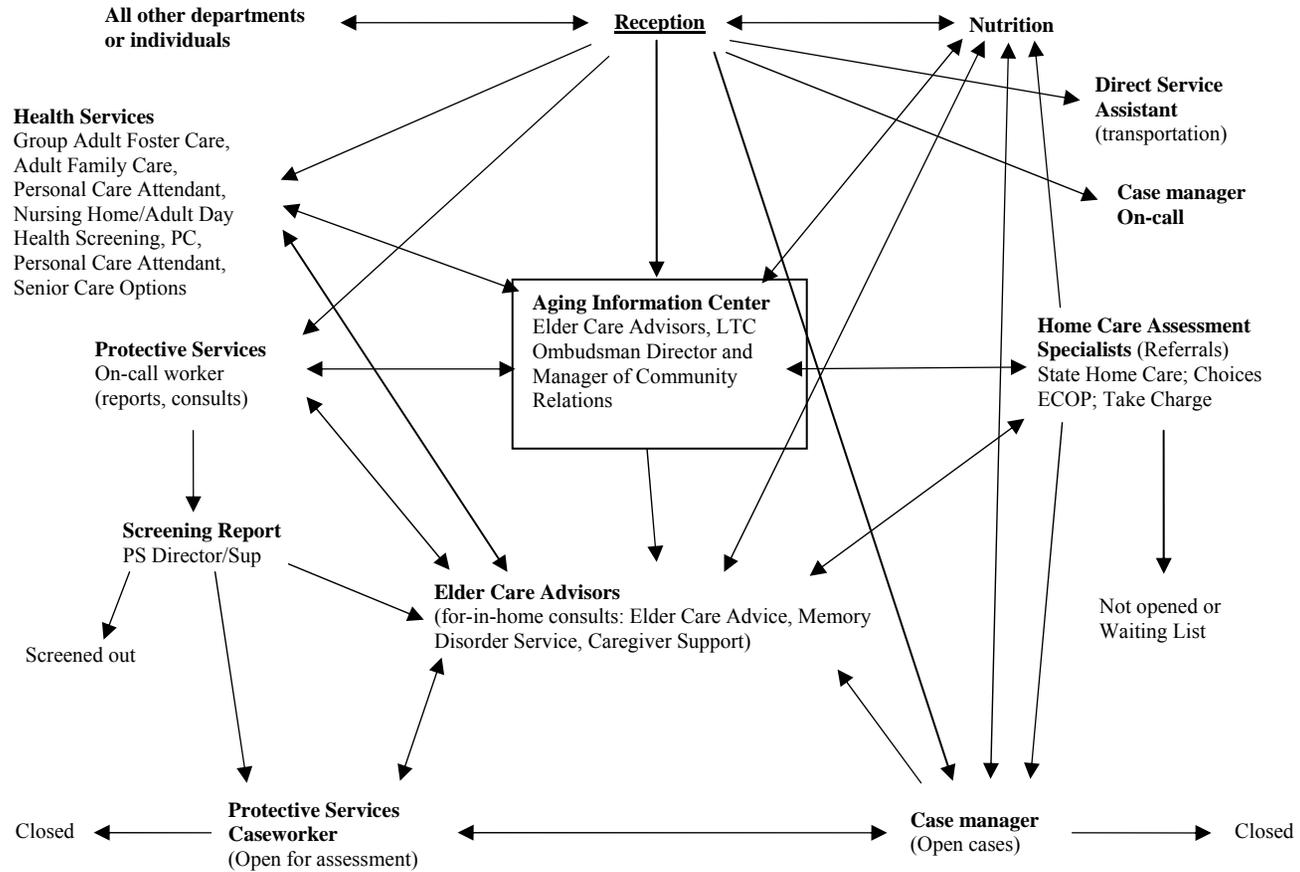
ASAPs use an interdisciplinary team model for staffing client cases. Nurses are part of the team, and their role has evolved as ASAPs were given additional responsibilities for long-term care service authorization and planning. They provide consultation to the case management staff on health and medical issues and evaluation and care planning for some types of personal care assistance, act as liaison to local hospitals, conduct nursing home preadmission screening and waiver eligibility determinations, and, most recently, grant prior approval for all Medicaid community long-term care services, such as certified home health and adult day health services.

This interdisciplinary staffing model has been key to the ASAPs' ability to integrate access to long-term care services. In particular, having the nurses cover multiple roles while giving the ASAPs responsibility for authorizing Medicaid state plan services (such as adult day health and home health), has created more informed service management. The same nurses who conduct preadmission screening and periodic review of nursing home authorizations also authorize other Medicaid state plan services, have a working knowledge of the home and community-based waiver system (because they also evaluate clients for waiver eligibility and personal care services), and participate in care planning meetings. Based on their knowledge of the community-based system, these nurses can be particularly effective in identifying individuals who might be diverted from nursing home placement or who can return to the community from a nursing home stay. Medicaid providers we interviewed also reported that local ASAP nurses

**Figure 2-2**

SOMERVILLE-CAMBRIDGE ELDER SERVICES

FLOW CHART



review prior approval requests on a timely basis and make valuable recommendations regarding service plans.

The multidisciplinary approach to service planning that was developed by individual ASAPs has become a statewide standard and includes intake, case management, nursing, and masters-level social work staff (i.e., case management supervisors or managers, protective services workers, and elder care advisors). They use service planning meetings as a key aspect to integrate access on an operational level, ensuring access to the most appropriate ASAP-authorized services and identifying other appropriate community resources. The goals are to ensure that the health and social services needs of their clients are addressed, starting at the outset, and that case managers have nursing consultation available to them as needed. Through these meetings, staff identify potential eligibility for Medicaid home and community-based waivers, personal care, and special home care programs, and brainstorm about options available to those who do not meet either the income or functional impairment levels required to qualify for ASAP services. Nursing staff specifically look for cases that may need ADL assistance or a skilled nursing referral to a home health agency. In addition, the involvement of supervisory and management staff in the development of initial service plans helps ensure creative service planning, identification of other agencies, and internal referrals to new programs, such as the Personal Care Attendant Program, as they come on line. This has become especially important as budget cuts have led to higher caseloads and as the cost of living in metropolitan areas has contributed to problems recruiting and retaining case managers for some ASAPs.

At North Shore Elder Services (NSES), similar interdisciplinary meetings are held as clients' needs change and case managers advocate for increased services for their neediest clients. Working to maximize the level and types of services available to each client, NSES's utilization review committee carefully monitors the agency's budget in relation to the \$232 per active client per month received from the state. NSES can respond realistically to any specific client need for additional services. As some proportion of clients do not use their allocated service dollars (for example, due to hospitalization) dollars can be reallocated across the agency's caseload to clients who need additional help but who do not qualify for one of the more intensive service packages such as ECOP or CHOICES. If the agency's budget is tight, such requests for additional services cannot be met.

### ***C. Outreach and Community Partnerships***

Clients learn about ASAP services by calling the highly publicized statewide *AgeInfo*-toll-free number, signing onto the Elder Affairs Web site, or calling their local ASAPs. In addition, many people are referred to the ASAP from a range of community partners and providers or learn about the services from other outreach activities developed at the local level. Local outreach activities include:

- a volunteer-staffed, door-to-door campaign to inform residents about the programs offered at local ASAPs, COAs, and other Aging Network service providers;
- nurse liaisons at local hospitals to take referrals, answer questions, and provide information to hospital staff; and
- special events, such as caregiver events, which publicize the availability of these support programs.

While Massachusetts's home care clients are largely lower income (<\$20,778 for an individual and \$29,402 per household) with specific functional impairments, higher income individuals are also served through the ASAP information and referral services. These may include a free, one-time assessment and consultation with an elder care advisor even if the client does not qualify for one of the public case management programs. In addition, some ASAPs have set up separate nonprofit organizations to provide care management and direct services to wealthier clients.

The ASAPs also have special services in place to reach their minority and ethnically diverse populations. ASAPs employ bilingual staff and contract with vendors whose staff speak the same languages as their clients (for example, Russian, Portuguese, various Chinese dialects, and Creole). In some areas, partnerships with the local COAs allow ASAP and COA staff to share the language skills of their respective staff and conduct outreach to various groups. Using a grant from AoA, Elder Services of Merrimack Valley hires bilingual staff to help SHINE volunteers provide health benefits counseling. ASAPs also hold contracts with translation services, which are used on an as needed basis.

ASAPs also have many types of community partnerships. They contract with a range of local providers including physicians, hospitals, visiting nurse association, adult day care centers, and senior centers to name a few. In addition, ASAPs also partner with congregate housing sites, PACE programs, and local COAs. Partnerships with local hospitals (see **Table 2-3**) have been facilitated by the presence of nurses at the ASAPs. One ASAP and a local hospital jointly

funded a nurse liaison position in the hospital to provide community information and referral services in the emergency room. In the North Shore area, the ASAP has collaborated in developing disease management programs for ASAP clients with congestive heart failure.

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**Table 2-3**  
**Innovative Collaborations with Health Care Providers**

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Individual ASAPs have gone beyond long-term care services to collaborate with local health providers on meeting the acute care needs of their clients. Here is a sampling of these activities.

**Housecalls.** A nationally recognized program, this medical home visiting program developed by The Cambridge Health Alliance includes interagency team meetings. SCES, the local visiting nurse association, and Geriatric Mental Health service staff meet weekly with the home visiting physicians to discuss their mutual clients' needs and develop integrated service plans.

**CHF Care Extenders.** For clients enrolled in a congestive heart failure (CHF) disease management program at a local hospital, NSES case managers conduct risk assessments as part of their routine quarterly visits. They provide important information and problem solving regarding challenges their mutual clients face in managing this chronic condition.

**Strength Training Program.** Funded jointly by NSES, the local visiting nurse association, and a local hospital, this program is held in elderly housing and focuses on improving balance, flexibility, and strength. The goals are to improve daily function and prevent functional decline.

**Telemedicine Project.** With grant funding from the state providing the equipment, individuals with chronic diseases can receive routine monitoring and patient education from nurse specialists at a local hospital. NSES staff help identify appropriate candidates and arrange for personal care workers to help clients "hook up" to the equipment. The program reduces transportation and escort needs and ensures more regular follow-up. Consoles are in individual homes and in offices of supportive living buildings.

**Geriatric Mental Health Services.** SCES works closely with The Cambridge Health Alliance's Geriatric Health Services program to coordinate care for close to 100 of SCES's clients who have mental health diagnoses. The two agencies share expertise and help each other maintain these clients with complex needs in the community.

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One of the more long-standing Aging Network partnerships is the Somerville/Cambridge Interagency Task Force on Elder Issues (SCIT) which ASAP co-founded. It brings together geriatric and mental health providers, private social service agencies, and the ASAP. Originally formed to address issues for at-risk elders, SCIT provides an ongoing forum for networking, education, and interagency collaboration. ASAPs often share clients and conduct joint care planning with various other providers, including geriatric mental health services.

In several communities, the state is piloting an innovative partnership among ASAPs, local housing authorities, and home care vendor agencies. The Supportive Living Services Program provides staff and services 24 hours per day, 7 days a week (including holidays) to residents in senior housing. The housing authority makes space available in the building for the on-site coordinator (an ASAP case manager), an ASAP nurse (as needed), and an office and break room for the home care workers. To participate, a housing site must also provide a congregate meal site in the building. The vendor agency provides coverage with a stable group of workers. ASAP clients in the building are eligible for an expanded set of services, whereas other residents can purchase services. The private pay structure is flexible and allows residents to buy only the time and services they need. This clustered care approach has proven to be cost-effective and is well received by building residents and the home care workers staffing the building.

In sum, the richness of the provider system in some parts of the state contributes to extensive community partnerships that help improve access to ASAP-authorized services, provide additional services to augment what is available through the ASAPs directly, foster the development of collaborative service models working across systems, and provide a base for effective advocacy on the state and local levels.

### **2-III. KEYS TO SUCCESS**

ASAPs were built around the AAA structure initiated in the 1970s to administer AoA programs and the state-funded home care program. This structure provided the foundation for the expanded ASAP model that came into being in 1997 and which integrates Medicaid waiver and state plan services into a single entry point system, streamlining the delivery system and avoiding duplication. In creating the current model, the State increased the responsibilities of the ASAPs and incorporated best practices from innovative ASAPs into state standards. The State created performance standards and quality improvement expectations that had not existed previously.

#### **Advocacy and Buy In**

Establishing the ASAP system required active state-level advocacy by the Department of Elder Affairs to move traditional Department of Medical Assistance (DMA) activities (e.g., preadmission screening) into the ASAPs and to develop the role of nurses in case management

teams. This process was facilitated by DMA's interest in controlling nursing facility expenditures and by their experience in a previous 2176 HCB Waiver demonstration in which Elder Affairs and Medicaid funds were integrated and delivered through an interdisciplinary case management model. Elder Affairs was also interested in determining the lowest cost options for providing in-home services, such as substituting personal care services for more costly home health aide services. Thus, both state agencies had an interest in making changes in the way long-term care services were administered and in developing cost-effective alternatives to institutional care. Other factors include:

- establishment and maintenance of relationships with community partners that enrich referrals to and from ASAPs and help identify new opportunities for collaboration;
- a receptive and forward-thinking State Unit on Aging that fosters innovation and incorporates best practices into new statewide programs or regulations;
- support from the state legislature and a strong trade association that actively advocates for funding community-based services; and
- regional collaboration among some ASAPs to share ideas, develop and provide shared training for case managers, and identify opportunities to contract collectively for administrative services.
- state funding for home care services that supplement waiver services and are available to low-income elders who are not Medicaid eligible;
- increased responsibility of ASAP nurses for conducting nursing home preadmission screening and working with case managers to develop community-based care plans;
- time-limited nursing home approvals which lead to frequent review by the ASAP nurses for potential return to community-based care; and
- dedication and innovation at the local level that has led to many best practice models.

### **Local Efforts**

Many of the collaborative efforts with health care providers and other community members grew out of the dedication and creative ideas of ASAP staff and others in the community. Having extensive Aging Networks allowed them to develop and implement these creative ideas. Many of the State's initiatives were developed at the local level.

This report was written at a time of flux at Elder Affairs—major changes are planned at the state level. Responsibility for all long-term care expenditures are shifting from DMA to Elder Affairs. This has the potential to strengthen the state's ability to divert individuals from nursing facility care, for example, by implementing demonstration programs that allow money to

follow the person. However, concerns exist about the potential of state-level restructuring to weaken the voice of Elder Affairs within state government. Integration of Medicaid and Elder Affairs within a larger human services department, combined with pressing concerns about the Medicaid budget and a focus on special Medicaid programs like PACE and SCOs, could undermine the effectiveness of Elder Affairs and reduce the visibility and influence of the Aging Network in serving non-Medicaid, low-income elders. Conversely, it may lead to increased integrated planning for the populations they serve.

Operationally, the ASAPs' plan to switch from their current uniform assessment tool to the MDS-HC assessment tool for community assessments, and, budget permitting, to modernize their data collection systems. Elder Affairs is also wrestling with an important policy issue regarding the need for medication management services to further divert frail elders from institutionalization. The state has assembled a Blue Ribbon Commission to explore options, such as the provisions in the Older Americans Act, for addressing this problem.

In sum, State leadership, local agency innovation, and Elder Affairs' receptivity to new ideas lead to the ASAP's success. While many challenges remain, individual ASAPs and consortia of ASAPs continue to experiment with new approaches and it is likely that further improvements will be made.

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## INTEGRATED ACCESS AND SERVICES: OHIO'S PASSPORT PROGRAM

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This case study highlights Aging Network services in Ohio. Ohio extends its limited resources by building on the Medicaid waiver program to create integrated access for anyone seeking long-term care institutional or community-based services. While Ohio's nursing home admission recommendations are only binding for Medicaid populations, Ohio's centralized involvement of the Area Agencies on Aging (AAA) helps educate all individuals about alternatives to nursing homes. Second, Ohio's Aging Network, including the consumers, has effectively developed an additional funding source to increase the number of community-based options. This funding is from county-based property tax levies and plays an important role in providing resources that create access for senior services.

The first section of this report describes Ohio's long-term care (LTC) system, and is followed by a focus on the state "PASSPORT" system, the innovation that is the foundation for integrating access to senior services. We conclude with information on the PASSPORT systems' keys to success - what other AAAs need to know to replicate this type of effort in their local area.

### **3-I. OHIO LONG-TERM CARE: AN OVERVIEW**

#### ***A. Demographics***

Ohio has a relatively large population (11.4 million residents), 13.5 percent of whom are at least 65 years old. Ohio ranks 7th nationally in terms of the size of its elderly population. About 10 percent of the 65+ population are Black/African American, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Asian, or Hispanic/Latino or are two or more races/ethnicities (U.S. Bureau of the Census, 2003). Like much of the nation, almost 80 percent of Ohio's elderly live in urban areas. In 1999, 9.1 percent of the older population was at or below the federal poverty level, placing Ohio below the national average of 10.9 percent (Nawrocki and Gregory, 2000)

#### ***B. Long-Term Care Financing***

In 2001, the Governor issued a call for action to shift long-term care resources from institutional to community-based settings (*Ohio Access for People with Disabilities*). As a result,

Ohio's community-based programs such as their Medicaid Home- and Community-Based Waiver (HCBW) and Medicaid Home Care programs have been growing rapidly. Waiver funding increased from 9 percent to 14 percent of Ohio's Medicaid LTC budget between 1997 and 2002. Total Medicaid home care spending, which includes both state plan home care and Home- and Community-Based Waiver expenditures, increased about 250 percent during that period, rising from \$263.9 million to \$677 million (Burwell and Eiken, et al., 2003). In contrast, the growth in average spending on nursing homes declined between 1997 and 2001, moving from a 5 percent increase down to a 3 percent increase by 2001. This was echoed by declining occupancy rates in the state's nursing homes.

In 2003, nursing facility expenditures accounted for 60 percent of the LTC dollars or 77 percent if ICF spending is excluded. Medicaid waiver funds accounted for 14 percent. On a per capita basis, Ohio spent approximately \$1,652 per person on nursing facility care and \$384 per person under the community-based waiver (*Exhibit 3-1*).

Ohio also supplements its Medicaid spending with state funds through several programs. The Residential State Supplement (RSS) program provides a cash allowance to Medicaid-eligible aged, blind, or disabled individuals to assist in paying for accommodations, supervision and personal care in approved residential settings. The amount of supplement received by the individual is dependent on the living arrangement and the amount of SSI received by the individual. In addition, Ohio has two small state funds that match Older American Act funding – the Senior Community Services Program (funded at \$11 million) and the Alzheimer's Respite Program (funded at \$4.5 million).

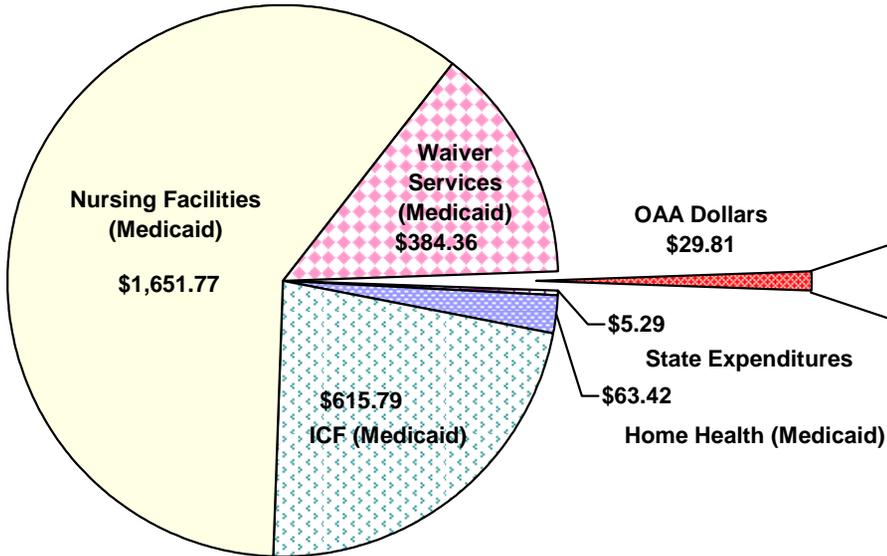
Most notably, Ohio law allows counties to generate local support for senior services through voter passage of county property tax levies. Of the 88 counties in the state, 60 counties used this mechanism (58 senior levies and 2 combined levies) to raise over \$87 million for senior services in 2003, making this a significant supplement to the 245 million dollars in the Medicaid PASSPORT program and the 42 million dollars in Older Americans Act funding. This money is used to serve elders who do not qualify for Medicaid or state covered home care options.

### ***C. Long-Term Care System and the Aging Network***

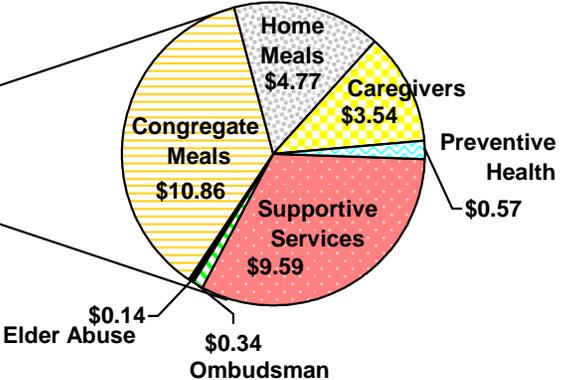
Funding for home- and community-based LTC services for older populations in Ohio is largely consolidated under the Ohio Department of Aging (ODA), although much of it is through

**Exhibit 3-1  
Ohio Long-Term Care Spending 2002:  
Amount Spent per Individual Aged 65+**

**Total LTC Spending**



**Older Americans Act Spending**



53

NOTE: 2002 population estimates based on the 2000 Census were used to calculate per capita spending (see [http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002\\_files/sheet008.asp](http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002_files/sheet008.asp)). OAA spending is based on figures found at [http://www.aoa.gov/about/legbudg/current\\_budg/docs/FGS\\_FY\\_2002\\_Annual\\_Allocation.pdf](http://www.aoa.gov/about/legbudg/current_budg/docs/FGS_FY_2002_Annual_Allocation.pdf). State Medicaid spending is based on figures received from MEDSTAT. State spending figures abstracted from interviews with the State Unit on Aging.  
\*There was no Medicaid personal care spending in Ohio in 2002.

an interagency agreement with the Ohio Department of Jobs and Family Services, which oversees the Medicaid program.<sup>4</sup> The ODA began as a division within a larger department, became a commission in 1973, and became a full-fledged department of state government in 1984. As the State Unit on Aging, ODA contracts with individual Area Agencies on Aging to deliver LTC services.

Ohio's Aging Network includes the ODA, 12 Area Agencies on Aging, the Ohio Advisory Council, county and local agencies, senior centers, senior service provider agencies, and several university academic departments.<sup>5</sup> The 12 Area Agencies on Aging have dual roles, serving as the 12 planning and service areas for Older American's Act-funded services as well as administering the PASSPORT program, Ohio's Home- and Community-Based Waiver program, and serving as PASSPORT Administrative Agencies (PAA). In one planning and service area,<sup>6</sup> a faith-based organization, Catholic Social Services of Miami Valley, serves as a PAA.

Of the 12 Area Agencies on Aging (AAA), 10 are non-profit corporations, one is a city government unit (Columbus), and one is the Appalachia Redevelopment Authority serving the most rural, southeastern part of the state. As in other states, Ohio's AAAs provide information, one-on-one assistance, eligibility screening, access, case management and contract with providers for direct services. On average, each AAA contracts with 80 to 100 providers, including both for-profit and non-profit agencies.<sup>7</sup>

Ohio's Aging Network has a large consumer advocacy group. The Aging Network has been responsible for helping to establish some of the smaller state-funded senior programs and for protecting other funding when it is threatened. For example, in 2003 the Aging Network successfully conducted an advocacy campaign to restore \$7.8 million to the PASSPORT program that had been lost during 2001-2002 state budget cuts. They were also successful in

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<sup>4</sup> Persons with mental retardation or developmental disabilities still have to go to county Mental Retardation and Developmental Disabilities (MR/DD) offices to access programs for the disabled. Those with physical disabilities access Ohio's Medicaid waiver programs through four agencies under contract with ODJFS.

<sup>5</sup> Scripps Gerontology Center at Miami University has a long relationship with ODA to evaluate PASSPORT and other aspects of the OH LTC system; the original evaluation was mandated by General Assembly to examine its cost-effectiveness.

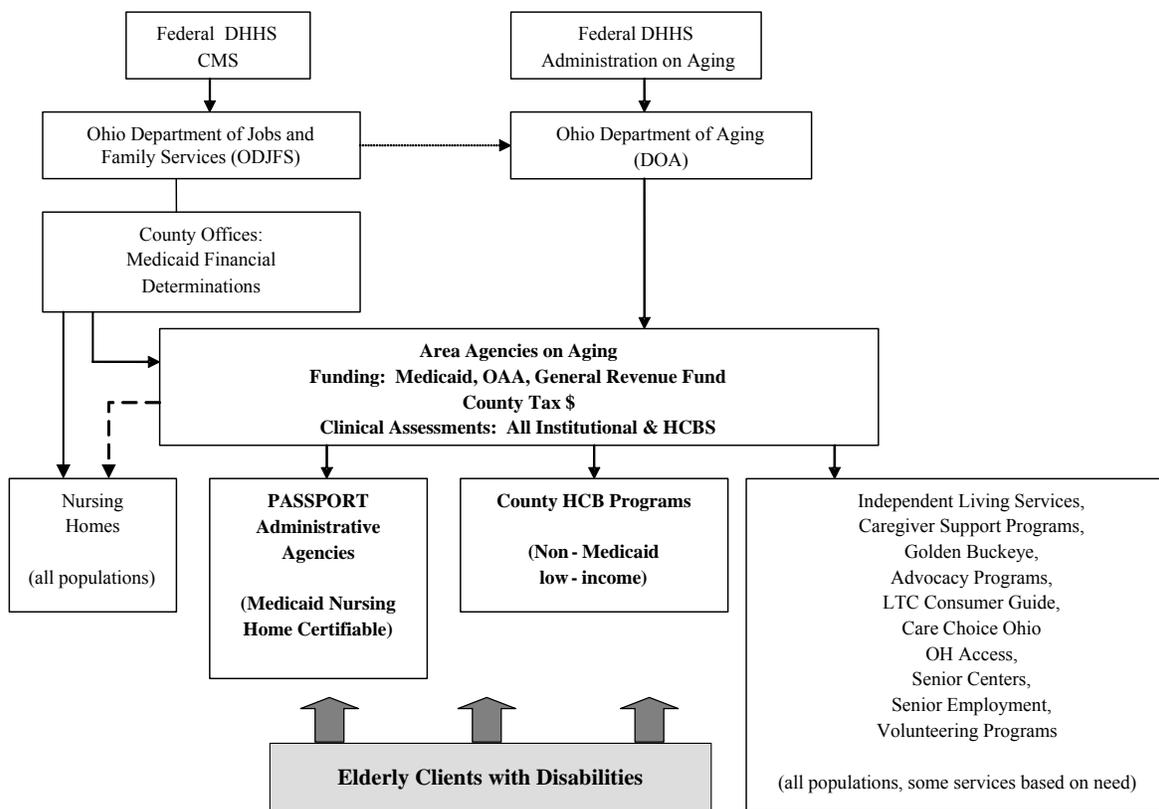
<sup>6</sup> This area includes rural Champaign, Drake, Logan, Miami, Preble, and Shelby counties.

<sup>7</sup> Workforce shortages in Ohio present a challenge in finding an adequate number of providers, so the state has undertaken a number of steps to address this issue, such as conducting a summit and creating a task force.

convincing the General Assembly to add an additional \$23 million in state General Revenue Funds to prevent waiting lists from developing in PASSPORT. They accomplished this by establishing toll-free telephone call-in lines to state legislators' offices and encouraging local constituents to use them. As a result, PASSPORT has funding in the current fiscal year for almost 30,000 participants. In the next fiscal year, the number grows to more than 32,000.

*Figure 3-1* shows the organization of the Ohio LTC system and the flow of funding to individual programs.

**Figure 3-1  
Ohio Long-Term Care System**



\*Disabled populations are served through ODMR/DD or ODJFS.

The AAAs provide access to a whole range of services including the PASSPORT program and other community-based services (*Table 3-1*). These services range from information and assistance to access/screening, case management and direct services. Many of the direct services target lower income populations but are available on a private pay basis and may be accessed through the AAA. The eligibility and funding sources vary in the AAA programs (*Table 3-2*).

**Table 3-1**  
**Types of Services Offered by OHIO Area Agencies on Aging, by Eligible Population**

Type of Service	Income			Special Population		
	Any 60+	Non-Medicaid Low Income	Medicaid	Alzheimer patients	Rural Elders	Family Caregivers
<b>AWARENESS/INFORMATION</b>						
AOA Title III Information and Referral Service	✓	✓	✓			
LTC Consumer Guide (online resource)	✓	✓	✓			
Housing Options and Advocacy	✓	✓	✓			
Family Caregiver Support I&A	✓	✓	✓	✓		✓
Golden Buckeye Internet Resource System	✓	✓	✓			
<b>ASSISTANCE</b>						
Caregiver Support Programs (counseling, support groups, training)	✓	✓	✓	✓		✓
Golden Buckeye Discount Card Program	✓	✓	✓			
LTC Ombudsman Program	✓	✓	✓			
Senior Community Service Employment Program		✓ (55+)	✓		✓	
Senior Volunteer Programs	✓	✓	✓			
AOA Title III Outreach and Education Programs	✓	✓	✓			
Energy and Disaster Assistance Programs		✓	✓			
Senior Farmer's Market Nutrition Program		✓	✓			
Legal Services Program		✓	✓			
OH Senior Health Insurance Counseling	✓	✓	✓			
<b>ACCESS: SCREENING/ASSESSMENT</b>						
PASS (Pre-Admission Screening System)	✓	✓	✓			
CARE CHOICE OH	✓ all ages	✓	✓			
<b>CASE MANAGEMENT</b>						
	✓ *	✓	✓			
<b>DIRECT SERVICES</b>						
Senior Centers	✓	✓	✓			
County HCBW Programs/Options/ESP		✓				
PASSPORT Home Care			✓			
Residential State Supplement Program			✓			
Homemaker/Chore Services	✓ *	✓	✓			
Adult Day Health Program	✓ *	✓	✓			
Personal Care	✓ *	✓	✓			
Transportation and Escort Services	✓ *	✓	✓			
Congregate and Home-Delivered Meals	✓ *	✓	✓			
Home Maintenance, Repair, and Modification	✓ *	✓	✓			
Personal Emergency Response System	✓ *	✓	✓			
Family Caregiver Respite Program	✓ *	✓	✓	✓		✓
Kinship Care	✓	✓	✓			✓

\*Services available on a private-pay basis for over-income clients.

**Table 3-2  
Program Chart for Ohio**

<b>Program</b>	<b>Services Provided</b>	<b>Eligibility</b>	<b>Funding</b>
<b>AWARENESS AND INFORMATION</b>			
AOA Title III Information and Referral Service	Information and referral: all LTC issues and services	Everyone	Federal (OAA) & state
LTC Consumer Guide	Web-based information and referral system that includes all LTC resources: nursing homes, homecare, and assisted living information; facility specific quality and customer satisfaction data for nursing homes.	Everyone	Federal (OAA) & state
Housing Options and Advocacy	Information and referral on housing issues	Everyone	State
Family Caregiver Support I&A	Information and referral program for family caregivers	Active caregivers providing help to frail elders	Federal (OAA) & state
Golden Buckeye Internet Resource System	Aging information portal run by the OH Department on Aging	Everyone	Federal (OAA) & state
<b>ASSISTANCE</b>			
Family Caregiver Support Programs	Counseling, support groups, and training for caregivers	Active caregivers providing help to frail elders	Federal (OAA) & state
Golden Buckeye Discount Card Program	Discounts on prescription drugs, goods, and services	Individuals age 60+ and 18+ with total permanent disabilities	State & donations from local business
LTC Ombudsman Program	Planning, referrals, assistance, conflict resolution, and complaint investigation assistance. Ohio's ombudsman program has responsibility for complaints about community services as well as institutional services.	Everyone	Federal (OAA) & state
Senior Community Service Employment Program	Job training and matching service	Low-income individuals age 55+	Federal (DOL) & state
Senior Volunteer Programs	RSVP, foster grandparents, senior companion	Volunteers age 55+	Federal (CNS) & state
AOA Title III Outreach and Education Programs	Outreach and education program on nutrition and health promotion; wellness and disease prevention	Individuals age 60+	Federal (OAA) & state
Energy and Disaster Assistance Program	Emergency assistance, home winterization, and payment assistance for heating bills	Low-income individuals age 60+	Federal and state (OH Department of Development)
Senior Farmer's Market Nutrition Program	Coupons to redeem for free locally grown fruits and vegetables from May to October – available in participating counties	Low-income individuals age 60+ who meet income guidelines	Federal (USDA)
Legal Services Program	Legal assistance and representation	Low-income individuals age 60+	Federal and state
OH Senior Health Insurance Information Program	Provides answers to questions about health insurance and offers counseling	Individuals age 60+	Federal (OAA and Medicare)

**Table 3-2 (continued)  
Program Chart for Ohio**

<b>Program</b>	<b>Services Provided</b>	<b>Eligibility</b>	<b>Funding</b>
<b>ACCESS</b>			
Preadmission review	Screening for anyone seeking LTC services in any setting, regardless of income	All individuals seeking long-term-care services	Federal (Medicaid waiver) & state
Care Choice Ohio	In-person LTC counseling and planning service, offering in-home assistance	All individuals seeking information on LTC and help in planning	Federal & state
<b>CASE MANAGEMENT</b>			
Care Management and Care Coordination	Case management and care coordination; can be received through PASSPORT Home Care program or as a stand-alone service. Some AAAs care coordinate federal and state funding and services for those not eligible for PASSPORT.	Individuals age 60+ and based on need	Federal (OAA), state, and county
(PASSPORT Home Care)	Access to Home Care Services	Individuals who are Medicaid-eligible and age 60+, based on need	Federal (Medicaid waiver) & state
<b>DIRECT SERVICES</b>			
Senior Centers	Socialization, skill enhancement, exercise, education, and nutrition	Individuals age 60+	Federal, state and local, private pay and private donations
Options, ESP, Other County Programs	Home care services – Larger programs include a case management component.	Non-Medicaid-eligible low-income seniors age 60+, based on need	County funds
PASSPORT Home Care	Medicaid waiver program providing independent living services such as personal care, homemaker and chores, adult day program, personal emergency response, transportation, home-delivered meals, and other assistance	Medicaid enrollees with nursing-home-level needs	Federal and state (Medicaid waiver )
Residential State Supplemental Program	A cash supplement added to individual’s monthly income to pay for room, board and services in approved living arrangements such as adult care facilities and residential care facilities.	Residents who meet financial eligibility requirements	State
Home Maker /Chore Services	Home maker services can be accessed though PASSPORT, County programs,, OAA- funded, or paid for privately	Individuals age 60+, based on need	Federal (OAA), state, local, client donations, and private pay
Adult Day Health Program	Adult Day can be accessed though PASSPORT, county programs, OAA-funded, or paid for privately	Individuals age 60+, based on need	Federal (OAA), state, local, client donations, and private pay
Personal Care	Personal care can be accessed though PASSPORT, county programs, OAA-funded, or paid for privately	Individuals age 60+, based on need	Federal (OAA), state, local, client donations, and private pay
Transportation and Escort Services	Transportation and escort services can be accessed though PASSPORT (must be transportation to meet medical needs) county programs, OAA-funded, or paid for privately	Individuals age 60+, based on need	Federal (OAA), state, local, client donations, and private pay

**Table 3-2 (continued)  
Program Chart for Ohio**

<b>Program</b>	<b>Services Provided</b>	<b>Eligibility</b>	<b>Funding</b>
Congregate and Home-Delivered Meals	Home-delivered meals can be accessed through PASSPORT, county programs, OAA-funded, or paid for privately; congregate meals available at meal sites	Home-delivered meals for individuals age 60+, based on need; congregate meals for all individuals age 60+	Federal (OAA), state, local, and client donations
Home Maintenance, Repair and Modification	Help with minor repairs and home modification for accessibility	Low-income individuals age 60+	Federal (OAA), state
Personal Emergency Response System	Provides equipment and monitoring to home-bound or isolated elders by designating a person to be notified in case of emergency. Elders are given special equipment to get in touch with and solicit help from a designated person during emergencies. Can be accessed through PASSPORT or county programs, or paid for privately	Individuals age 60+, based on need	Federal and state (Medicaid), local, and private pay
Family Caregiver Respite Program	Program provides respite services to caregivers of frail elders, including those with Alzheimer's disease	Caregivers of frail elders, based on need	Federal (OAA) and state (special Alzheimer's Disease Respite fund); private pay
Kinship Care	Program provides support to seniors who take care of their grandchildren	Primary caregivers age 60+ who provide care for grandchildren	Federal and state
Adult Protective Services	Through Department of Jobs and Family Services, reports of elder abuse including physical, sexual, emotional, or financial abuse or neglect are investigated. Crisis intervention and referral services.	Individuals age 60+ in danger of abuse, exploitation, and self-neglect	Federal and state

### **3-II. INNOVATION OVERVIEW: THE PASSPORT PROGRAM**

PASSPORT is an acronym for Preadmission Screening System Providing Options and Resources Today. Ohio's PASSPORT program provides the framework for the state's community-based LTC system for elders. While it is funded through a Medicaid Home- and Community-Based Waiver program, the program was established to:

- develop a stronger community-based system in Ohio;
- offer more opportunities for people with functional limitations to remain in the community;
- provide an alternative to facility-based LTC;
- prevent inappropriate nursing home placements;
- slow down the overall growth of the nursing home industry;
- provide people seeking LTC with more information and choices; and
- establish Area Agencies on Aging as single entry points for all LTC needs regardless of the source and amount of a person's income.

These efforts were accomplished by combining an HCBS waiver mechanism for Medicaid-eligible with county-supported home care and Older Americans Act support services, and delivering them through local Area Agencies on Aging.

The PASSPORT program is comprised of two components. *PASS* is a universal screening component for all Ohio residents seeking LTC services, regardless of payer. Clients are screened for nursing home needs, presumptive Medicaid income eligibility, and functional status. *PORT* is a package of community-based services for Medicaid-eligible individuals who meet nursing home level-of-care criteria. The cost of PASSPORT waiver services cannot exceed 60 percent of the cost of nursing home care.

In 2002, the Area Agencies on Aging screened 55,722 people by phone. Of these, 30,206 people were assessed by either a registered nurse or a licensed social worker, and 7,315 of the assessed individuals were enrolled in the PASSPORT waiver program (Ohio Association of AAAs).

#### **A. *PASSPORT Screening and Assessment (PASS)***

Ohio residents access PASSPORT screening and assessment by calling a statewide, toll-free phone number. Calls are routed to the Area Agency on Aging that is local to the caller's

area code.<sup>8</sup> Some AAAs also have staff permanently stationed at local hospitals to provide seniors with information about community-based options. Clients are also referred to the AAA by county offices, hospitals, and other local providers.<sup>9</sup>

**Eligibility Screening.** The AAA conducts pre-admission screening for everyone seeking nursing facility admission in Ohio, regardless of their income.<sup>10</sup> Initial screening is by phone or conducted through a “paper” review. Criteria have been established to determine who receives a phone screen and who receives a “paper” review. The screener collects preliminary information on the caller’s health, functional, and financial status. Those who are screened through a paper review submit required documents for screening. People who appear to be eligible for nursing home or community-based services are referred for an assessment.

**Assessments.** In-home assessments are conducted by an Area Agency on Aging utilizing licensed social workers or registered nurses. They assess whether someone qualifies for nursing home level-of-care or community-based services and discuss all the service options available to the individual. Individuals who qualify for a nursing home level-of-care determination are offered the option of seeking enrollment into the PASSPORT waiver program. The individual may also choose nursing facility placement. If the individual does not qualify for a nursing home level-of-care, the individual is informed about other community services that might meet his or her needs. If the outcome of the assessment is that the individual does not meet the criteria for nursing home placement, then Medicaid funded admission to the nursing facility is denied. For privately paying individuals, the assessment outcome is not binding and they may enter the nursing home.

The assessor also determines whether the client appears to meet Medicaid financial eligibility criteria. While the final financial determination is made by a separate county Medicaid office, AAA staff determine during the assessment whether the client meets *presumptive eligibility* standards and authorizes payment for services in the PASSPORT program.

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<sup>8</sup> The ODA is currently developing a new “No Wrong Door” website scheduled to be implemented in mid-2005. This website will describe the widely available services available through the AAAs.

<sup>9</sup> MR/DD and other disabled clients may be referred to AAAs for screening, but they receive assessment, level of care determinations, case management and direct services from the ODMR/DD, ODMH, and ODJFS.

<sup>10</sup> This assessment is federally mandated for those seeking Medicaid nursing home placement.

If the county subsequently determines a person is not financially eligible for PASSPORT, the person is promptly disenrolled and provided with referrals to other county-based or private pay services. In this case, ODA adsorbs the cost of the services already delivered by using its state-only funds. According to ODA, Area Agency on Aging staff are very well versed in the financial eligibility rules, so these costs have never been a serious liability for ODA.

Presumptive eligibility is an important component of the PASSPORT program. It is an intentional effort by the state to decrease institutional bias in the Medicaid program. ODA wanted HCB Waiver enrollment rules to be comparable to nursing home rules which require enrollment of those determined to be presumptively eligible. It also allows the PASSPORT services to begin immediately, without delays associated with processing the enrollment paperwork.

For both the preadmission review services and the PASSPORT program, the Area Agencies on Aging are required to use an integrated software system custom-designed for PASSPORT. The assessment instruments are embedded in this software system. The range of data collected includes health status, functional ability, social, financial, and environmental situations, informal support systems, demographic, insurance information, hospitalization/institutional history, behavioral and mental health assessment information, as well as descriptions of formal supports already in place.

#### ***B. PASSPORT Home- and Community-Based Services (PORT)***

***PORT Eligibility.*** While anyone seeking nursing home admission or other LTC services is eligible for the initial intake assessment (PASS portion), one must be at least 60 years old and meet the Medicaid eligibility for nursing home care to qualify for PORT home care services. Medicaid eligibility requires an income of less than 300 percent of Supplemental Security Income (SSI) (about \$1,600 per month for an individual) and assets of no more than \$1,500. In addition, applicants must meet the strict standard of care needs such as requiring hands-on assistance to dress, bathe, toilet, prepare meals, etc. According to state rules, care plan costs may not exceed 60 percent of the cost of nursing home care. Additional waiver conditions include:

- Reside in a non-institutional setting;
- Service needs cannot be met by other available community resources;
- Not receiving Medicare/Medicaid hospice care;

- Health and safety can be adequately assured at home; and
- Physician approves and client agrees to the service plan.

*Services.* Area Agencies on Aging are under contract with ODA to act as PASSPORT Administrative Agencies (PAAs)<sup>11</sup>, or regional managers for the PASSPORT program. They procure and monitor all PASSPORT home care services including:

- Adult Day Services
- Personal care/independent living assistance
- Homemaker and chore services
- Home-delivered meals
- Nutrition consultation
- Personal emergency response system
- Social work/counseling
- Minor home modifications
- Adaptive and assistive devices/durable medical equipment and supplies
- Transportation.

In addition, PASSPORT home care clients are eligible for the complete range of Medicaid services, such as nursing, physical or occupational therapy, and prescription drug coverage. Personal Care is the most widely used PASSPORT service. In 2000, the PASSPORT service use rates were as follows (Murdoch et al., 2003):

- 89 percent of PASSPORT clients received personal care.
- 65 percent received emergency response system.
- 51 percent received home-delivered meals.
- 42 percent received medical equipment.
- 18 percent received homemaker services.
- 12 percent received transportation services.
- 8 percent received adult day services.
- 3 percent received chore services.
- 3 percent received home modification.

Currently there is no waiting list to deliver services to frail seniors in the PASSPORT program. However, there have been waiting lists in the past. Clients can also be put on a

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<sup>11</sup> As noted above, a thirteenth PASSPORT administrative agency is Catholic Social Services of Miami Valley – one of the original PASSPORT sites created before Ohio decided to utilize AAAs for this function.

waiting list to receive OAA services that may not be immediately available. In addition, some counties may simply not have enough levy dollars to finance county-based services. In these areas clients have to wait for OAA services.

***Client Monitoring and Reassessment.*** PASSPORT services are monitored on an ongoing basis. While Ohio does not have a unified, statewide system for tracking LTC services across funding streams, they do have an electronic monitoring system. Electronic screens mimic care management tool pages including the care manager's assessment, notes, care tools, bills, and invoices. Clients are also surveyed annually for client satisfaction. In addition, the PAAs are responsible for collecting and investigating complaints from PASSPORT consumers, usually through their case managers.

***Provider Payments.*** Area Agencies on Aging are also responsible for paying PASSPORT providers directly. The AAA then bills Medicaid electronically through ODA. ODA pays all claims before submitting them to the Medicaid Management Information System (MMIS) for federal reimbursement.

### ***C. Outreach and Community Partnerships***

Outreach activities and community partnerships are local efforts. This section illustrates Western Reserve Area Agency on Aging's outreach efforts and highlights particular features that are characteristic for the region serving Cleveland and the five surrounding counties. This agency provides a good example of how local agencies are meeting the mandates of the Older Americans Act to ensure access for all residents, including multicultural populations.

The Western Reserve area is characterized by:

- a large proportion of ethnically diverse elderly population residing in urban areas, a strong network of well-established senior centers, and
- extensive partnerships between the Western Reserve Area Agencies on Aging (WRAAA) and local community organizations.

The WRAAA contracts with a full range of providers, both for-profit and non-profit, to deliver services for seniors. In this local area, there are 130 service providers for the PASSPORT program, some of whom also provide OAA Title III services.

***Serving Minority Elders.*** The WRAAA serves a 5-county region, most of it urban, with some small pockets of rural areas. As it covers a large minority population (35 percent of the

state's minority population is in this service area), the WRAAA focuses on providing culturally appropriate services. One of its major successes lies in its ability to effectively reach African-American, Hispanic, Chinese, and Russian/Jewish elderly residents.

WRAAA takes a multi-faceted approach. First, all materials are published in Chinese, Spanish, and Russian, in addition to English. Second, the agency maintains strong ties with ethnic providers. WRAAA contracts with one Russian adult day care and one Russian home care agency, as well as with one Chinese senior center. It also collaborates with Jewish service agencies to serve the Russian/Jewish population and contracts with two agencies that serve predominantly Hispanic populations, one of which is faith-based (Catholic). To reach the African-American seniors, the agency partners with 12 providers that target this population. The WRAAA has been particularly successful in reaching the African-American community. While 8 percent of the elders in Ohio are African-American, the group represents 25 percent of the PASSPORT clients and half the WRAAA clients.

The key to WRAAA's successful outreach is that it contracts with service providers who are already working with the communities. The providers are trusted by the respective ethnic/racial communities, and they employ bilingual staff who can work with clients in their own language. Establishing these relationships allows the Area Agency on Aging to do less-aggressive and less-expensive outreach to reach these populations. Once these providers join the AAA network, the minority participation rates in the respective communities increase dramatically.

***Community Partnerships.*** The Western Reserve service area has a long history of Community partnerships. The Red Feather program, a program in operation for many years that is a precursor of the United Way, originated in the Cleveland area and the WRAAA has long been associated with the program.

Another important partner of the WRAAA is the Council of Older Persons which was established under the auspices of the Red Feather program. This Council represents about 20 local organizations that include health care providers such as home health agencies, nursing facilities, hospices, educational institutions, and architects interested in designing appropriate housing for aging in place.

The WRAAA also has forged partnerships with local community service planning entities, such as the Federation for Community Planning, which supports many local social

services. The WRAAA also solicits support from local businesses for social services and housing in the area.

Another important WRAAA community partner is the Consortium Against Adult Abuse. This consortium includes about 80 local organizations that are active in supporting adult protective services. In addition to lobbying for the enactment and funding of adult protective services in the area, it is involved in advocacy, planning, research, and training to prevent abuse, exploitation, and neglect of the elderly. The Consortium Against Adult Abuse organizes an annual conference to educate the surrounding community about these issues.

### **3-III. KEYS TO SUCCESS**

Several factors have led the success of Ohio's PASSPORT program. These include statewide name recognition, strong leadership, consolidated access to services, active consumer involvement, and outreach activities. One of the most important keys to the PASSPORT program's success has been the wide recognition of the program's name and services. This recognition was developed through extensive leadership support, consumer involvement, and good marketing and outreach strategies. Having this recognition was key in facilitating Ohio's restructuring of its LTC system. The program delivered on its promise to provide care at home at no more than 60 percent of nursing facility costs. While the 60 percent figure is the legal cost cap, the actual results are more startling. The cost of the average PASSPORT client is less than one-fourth the cost of caring for a nursing home resident (ODA, 2003).

#### **Leadership and Support**

One of the key factors in changing the state's long-term care policy and developing more community-based options was having consistent state-level leadership committed to reforming the system. Before restructuring, Ohio's LTC system had a strong bias toward nursing homes. The nursing home occupancy rates were above the national average, and the nursing home lobby was and remains very powerful. Beginning in 1986, Ohio has had a succession of Governors of both parties with a vision to create a strong community-based system. The current Ohio efforts to develop strategies to improve access for Ohioans with disabilities of any age are one example. The Department of Aging is one of the key cabinet-level agencies charged with continuing to develop a more balanced LTC delivery system.

### **Cost-Effectiveness**

The PASSPORT program has continued to have state-level support because of its success in serving nursing home-eligible seniors at no more than the 60 percent of nursing home costs. While the average Medicaid annual reimbursement for nursing home care was \$55,200 per person, the average annual cost for the PASSPORT program, including the cost of all the screens, assessments, and services for those who qualify for home care, was \$12,333 per person in 2002. This is about 20 percent of the average annual Medicaid nursing home care reimbursement. (ODA Annual Report, 2002). As a result, the program also has legislative support.

### **Consolidated Access**

Designating the AAAs to be the PASSPORT Administrative Agencies was also a key factor in creating a single point of entry for access to all LTC resources. Making the AAAs responsible for access to both community and institutional services allows them to educate potential nursing home residents about community-based options. Using trained and competent personnel to conduct the screening and assessment components ensures that people are directed to the most appropriate care and allows the state to better target scarce resources. If institutionalization is deemed inappropriate, agency staff are also knowledgeable about the range of community resources and, depending on the client's frailty and financial circumstances, can refer people to Medicaid waiver services, county-supported programs, OAA community-based services, and private pay services.

### **Consumer Involvement**

Another strength in restructuring Ohio's LTC system has been the active involvement and support of the Ohio Aging Network in general. The Ohio Aging Network has played an important role in advocating for county taxes to cover services for seniors. These efforts led to the establishment of county funding for home care programs such as Options and ESP. Another example of their advocacy was the establishment of a toll-free phone line to the state legislative offices when the PASSPORT funding was threatened. This gave local constituents direct access to their legislators to express their support for state spending on home and community-based services. As a result, PASSPORT funding was the number one issue for calls to General

Assembly members in 2002. This led to the restoration of funding that had been lost during 2002 budget cuts.<sup>12</sup> The PASSPORT program enjoys substantial bipartisan support in the General Assembly, as well as among constituents. The FY 2004-05 budget, signed by the governor, provided enough funding for the program to enroll all potential applicants seeking services.

### **Outreach Activities**

Another key factor has been the use of an easily recognizable program name in local outreach activities. The Area Agencies on Aging have been committed to promoting the advancement of the PASSPORT program and have conducted vigorous advocacy campaigns on its behalf. Together with the ODA, they plan their marketing activities around the program's easily recognizable name.

In summary, the keys to success for Ohio's PASSPORT program are:

- Strong state and local leadership to support program development;
- Ability to serve nursing-home-eligible seniors in their own homes at no more than 60 percent of nursing home costs;
- Single entry point at which appropriate screening and assessment tools ensure that people are directed to the appropriate level of care; and
- Aging Network involvement in lobbying for the program to prevent budget cuts and a strong marketing campaign to promote program name recognition.

### **Future Directions**

While Ohio is very proud of its integration efforts, it believes that additional steps remain. In its strategic plan for the years 2004-2007, ODA identified eight strategic goals that build on extending the system it has in place. These goals include promoting choice and quality long-term care services and supports for consumers; increasing service utilization by unserved and underserved populations; further development of the National Family Caregiver Support Program; and addressing the health care workforce shortages issues that Ohio faces. Other goals include improving the Aging Network program efficiency, integration, coordination and evaluation capacity and enhancing services for active seniors and baby boomers. Further increasing the representation of seniors' interests in the legislative and policy-making process is

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<sup>12</sup> This mid-year budget correction bill allowed the PASSPORT program to eliminate waiting lists once again and to add 2,900 new slots.

also recognized as an important target. Thus, while Ohio has used the Medicaid waiver program to create an integrated access point for seniors seeking LTC information and services, it is still seeking at ways to build on this system and continue to expand community-based options.

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## INTEGRATED ACCESS AND SERVICES: MAINE

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This case study describes Maine's long-term care (LTC) system which provides an excellent example of a system designed to serve a large, rural state while providing integrated access to a range of institutional and community-based services. Maine manages its LTC system by:

- centralizing access for most long-term care in one agency;
- using a standardized, uniform assessment instrument for determining access to both institutional and community-based services; and
- applying a decentralized service model that uses local nurse assessors dispersed throughout the state.

Consolidating access to all LTC through one entry point is intended to educate consumers about LTC options, standardize LTC service determinations (both institutional and community-based), decrease the rate of institutionalization, and reduce long-term care costs.

This case study presents an overview of the state's LTC policies, a description of the integrated service system, how it works, and the local restructuring that resulted from it. The final section presents information on their keys to success - what information states and AAAs would need to know to duplicate this effort in another state.

### **4-I. MAINE LONG-TERM CARE: AN OVERVIEW**

#### ***A. Demographics.***

Maine has a relatively large number of elderly residents. Despite having a small total population (only 1.3 million people resided in Maine in 2002), a large share of those residents are age 65 or older (14.4 percent compared to 12.4 percent, nationally). The majority of older people are white with only 1.2 percent of the 65 and older population Black/African American, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Asian, Hispanic/Latino or two or more races (U.S. Bureau of the Census, 2003). Maine is ranked last in the nation in terms of ethnic diversity among the elderly.

Unlike other states, many older people reside in rural areas with less than half of the older population living in urban centers (44.2 percent) in 2000. In 1999, 10.8 percent of seniors were

at or below the federal poverty level, which is nearly the same as the national average of 10.9 percent of elderly in poverty (Nawrocki and Gregory, 2000).

### ***B. Long-Term Care Financing***

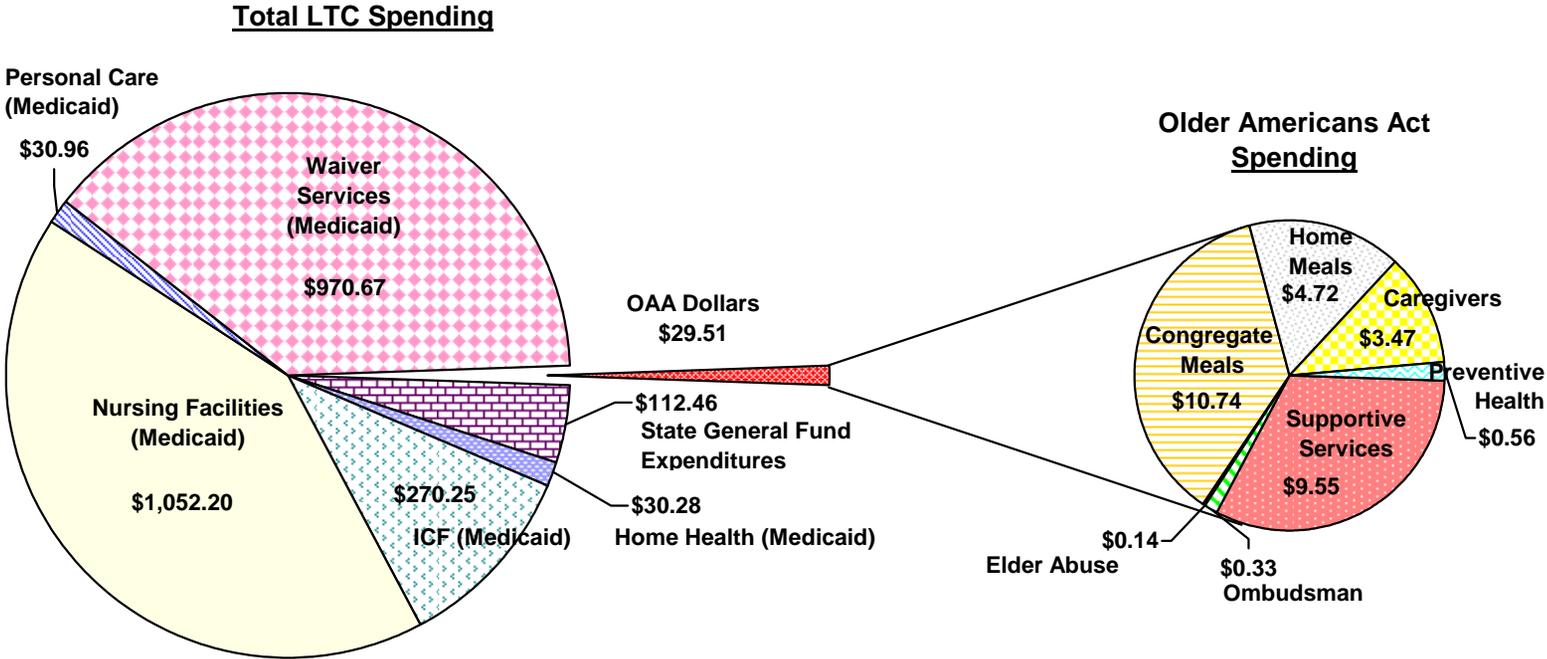
LTC in Maine is generally supported through three funding sources: Medicaid state plan, Medicaid home- and community-based service waivers, and state general revenue programs. Medicaid nursing home costs account for less than half the state's LTC spending (\$201 million in 2002). The Elder and Adults with Disabilities Medicaid waiver accounted for a large share of community-based LTC expenditures (\$18.2 million), followed by the state-funded Home Care program (\$12.8 million) and the Medicaid state plan services for nursing and personal care (\$11.4 million) (see *Exhibit 4-1*). Consumer-directed personal care options accounted for 36 percent of the Medicaid personal care and HCB Waiver funds and almost 25 percent of the state funded home care program in 2002. The Older Americans Act contributed another \$5.5 million for senior services.

Over the last few years, Maine's reliance on nursing home services relative to community-based LTC has been declining. In the Medicaid program, which accounts for a large share of the state's LTC funding, nursing home payments dropped from 84 percent of total long-term care costs to 60 percent between 1995 and 2002. This is due to both a decline in nursing home expenditures (2.5 percent) and more than a doubling of spending on personal care (204 percent) and waiver expenditures (225 percent) (Burwell and Eiken, et al., 2003).

### ***C. Long-Term Care System and the Aging Network***

Maine's LTC system went through many changes during the early 1990s. In 1993, the state experienced a serious revenue downturn which required them to review the growing nursing home expenditures and to consider alternatives. Seeing an opportunity to simultaneously improve the system by responding to senior and disabled adults' interests in HCBS alternatives, standardizing service options across the state, and saving money, the Legislature passed a series of policy reforms that expanded home- and community-based services by providing individuals and families more affordable, appropriate choices.

**Exhibit 4-1  
Maine Long-Term Care Spending 2002:  
Amount Spent per Individual Aged 65+**



72

NOTE: 2002 population estimates based on the 2000 Census were used to calculate per capita spending (see [http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002\\_files/sheet008.asp](http://www.aoa.gov/prof/Statistics/2002Pop/Stterr2002_files/sheet008.asp)). OAA spending is based on figures found at [http://www.aoa.gov/about/legbudg/current\\_budg/docs/FGS\\_FY\\_2002\\_Annual\\_Allocation.pdf](http://www.aoa.gov/about/legbudg/current_budg/docs/FGS_FY_2002_Annual_Allocation.pdf). State Medicaid spending is based on figures received from MEDSTAT. State spending figures abstracted from the State of Maine Long-Term Care Status Report, Department of Human Services, December 2002.  
\*General fund programs include state spending on home based care, adult day services, congregate housing, assisted living, alzheimer's respite care and homemaker.

The policy changes initially created barriers to LTC since they made it more difficult to qualify for nursing home admissions before HCBS alternatives were fully in place. By the end of a five-year period, however, increases in community-based options had successfully shifted more LTC users from institutions to the community. Policy changes that reduced the reliance on institutional care included:

- Raising the Medicaid nursing home eligibility standards to include only those most in need of intensive levels of care. While this made it more difficult for people to access nursing home services, it had the intended effect of reducing nursing home admission for the less impaired population;
- Restricting changes in nursing home capacity. While this was intended to limit future state Medicaid costs for nursing home use, it also reduced the number of beds available which encouraged more people to find community-based services;
- Placing stricter controls on individual asset transfers. This policy reduced the number of people who could qualify for Medicaid nursing home coverage, resulting in a need for more community-based services.
- Requiring universal pre-admission screening for all institutional and community-based long-term care services. By providing assessments for all LTC clients, more people were educated about their community-based options and selected them instead of nursing home placement.

Policies that increased community-based options included:

- Expanding access to Medicaid Waivers and state plan services as well as state funded home care, consumer-directed personal care, adult day care, respite and assisted living programs. This provided more funding and more slots for clients choosing community-based services;
- Developing residential alternatives to nursing homes, including programs specializing in Alzheimer's care. This provided more appropriate options that allowed people to remain safely in the community without generating the expensive and unnecessary medical costs associated with nursing home care.

In addition to these policy changes, several other movements were occurring in the early 1990s which contributed to the growth of Maine's home- and community-based options:

- An independent governor who supported home- and community-based care services was elected;
- A new group of legislators were elected who supported policy changes;
- The DHS Commissioner worked with the Legislature to change the system;
- The nursing home association underwent changes in leadership.

While these changes provided a framework for shifting consumers into community-based options, it also reduced the opportunity for nursing home admission. The state needed to ensure

that clients had equal access to all services across the state. This raised the importance of having standardized service determinations across the state. In response, the state reorganized their LTC authorization process.

Prior to 1995, LTC clients seeking public assistance for home care were assessed and received case management from the state's five Area Agencies on Aging, or local home care providers. During the early 1990s, Bureau of Elder and Adult Services (BEAS) found access to home- and community-based services was neither equitable nor standardized across the state. Disparities existed because of the differing authorization patterns of the AAAs and other providers, and the variation in the availability of direct care staff in particular regions. In response, Maine reorganized its LTC system in 1995 to centralize home care service coordination in one agency. This was intended to increase consistency of assessor training and application of the rules.

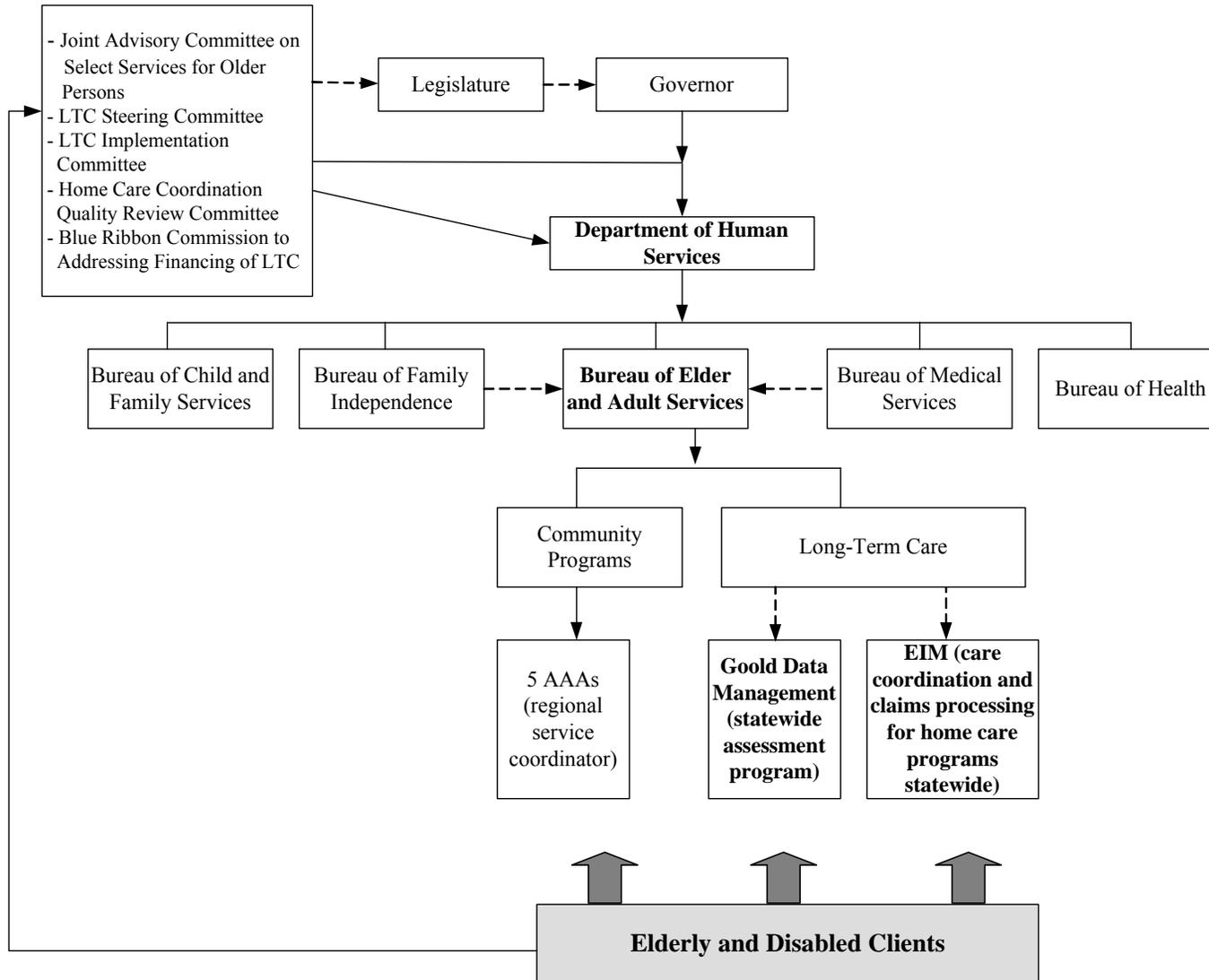
#### **4-II. INNOVATION OVERVIEW: CENTRALIZED SERVICES**

##### ***A. An Overview***

The Bureau of Elder and Adult Services (BEAS) within the Department of Human Services (DHS) is responsible for the planning, policy development, coordination and evaluation of Maine's aging and long-term care services. BEAS, as the State Unit on Aging, establishes the overall planning, policy objectives and priorities for all functions and activities for Maine's older persons. It includes a unit for community programs which manages Older Americans Act services and a unit on long-term care programs, which oversees the Medicaid and state-funded home care programs. Both units report to the Director of the BEAS. In addition to managing access to public LTC benefits, BEAS is responsible for determining nursing home medical eligibility (regardless of payer) and for developing and licensing assisted housing options.

BEAS has an interagency agreement with the Bureau of Medical Services (BMS) to authorize Medicaid state plan and waiver services for their clients. BMS, which is also in DHS, oversees the medical components of the state's Medicaid program. The Bureau of Family Independence (BFI) determines financial eligibility for Medicaid. *Figure 4-1* shows the organization of Maine's long-term care system. As can be seen, BEAS oversees the Area Agencies on Aging, all LTC assessment, and the care coordination for public home care programs.

**Figure 4-1  
Maine Long-Term Care System**



BEAS administers the publicly funded LTC programs, including the Medicaid Maine Care programs and the state funded home-based care program. Eligibility for the community-based services is based on the clients' individual financial resources and functional impairment levels. **Table 4-1** shows the services, funding, coverage levels, and variations in financial and clinical eligibility criteria for the major components of the publicly funded home care programs in 2002. The programs for adults have four levels of coverage which also have varying impairment criteria. Together, they create a system of coverage for community-based services.

MaineCare, the Medicaid state plan benefit provided up to \$800 a month in 2002 for private duty nursing and personal care for Level I recipients if they need limited assistance or support in 2 of 7 activities of daily living (ADL) or daily cuing in 4 ADLs. The monthly allowance increases with impairment levels. Medicaid waivers for Elderly and Adult Services provide expanded levels of coverage, case management services, and additional community-support services to individuals with higher incomes (up to 224 percent of the federal poverty level). The state-funded home-based care program provides services to people who do not meet Medicaid income qualifying criteria but who have functional impairments. Like the state plan services, the monthly coverage level for the state-funded program increases with impairment levels. Services available through these programs include personal care (both agency-based and consumer-directed options), care coordination, adult day services, emergency response, homemaker, mental health, transportation, Alzheimer's respite care, congregate housing, and assisted living.

All applicants for long-term care services (both institutional and community-based) are assessed by Goold Data Management Systems. As part of the 1995 reorganization effort, BEAS consolidated access to these services by issuing a pair of competitively bid contracts to:

- 1) centralize all LTC client assessments state-wide and authorize all institutional and publicly funded community-based services, and
- 2) coordinate or case manage all publicly funded home care services. These contracts were awarded to two independent agencies.

The first one, Goold Data Management Systems, is responsible for screening all long-term care clients for nursing home- and community-based services, regardless of payer source. They also determine coverage levels for clients receiving community-based services. Goold serves as the mandatory single entry point for all state and Medicaid funded home care programs serving elders and adult with disabilities. The second contract was awarded to Elder

Independence of Maine (EIM). EIM is a subsidiary of one of the Area Agencies on Aging and provides statewide home care coordination services. Those not meeting the income criteria of the Medicaid or state-funded home care services are referred to the AAAs for services funded by the Older Americans Act. Together, each of these programs builds on the others to create a more comprehensive community-based system.

**Table 4-1  
Eligibility and Coverage Requirements for Maine’s Publicly Funded HCBS Programs**

	<b>Maine Care Private Duty Nursing/Personal Care</b>	<b>Maine Care Elderly And Adult Services</b>	<b>State Home Based Care</b>
<b>Funding Source</b>	Medicaid State Plan	Medicaid Waiver	State General Fund
<b>Income</b>	Medicaid: up to 100% FPL	Medicaid & up to 224% of FPL	No income limit: Cost sharing based on income & assets greater than \$15,000
<b>Services</b>	RN/LPN or HHA, CNA, PCA	Case Management RN, HHA, CNA, PT, OT, ST, PCA, Homemaker, ADH, ERS, MH, Transportation, Respite	Case Management, RN, HHA, CNA, PT, OT, ST, PCA, Homemaker, ADH, ERS, MH, Transportation, Alzheimer’s Respite, congregate housing, and assisted living
<b>2002 Funding Levels</b>	\$6.9 M	\$18.2 M	\$12.8 M
<b>Level I</b>			
<b>Functional Impairment</b>	Limited assistance and support in 2/7 ADLs or daily cuing in 4 ADLs	NF eligible	Requires assistance with at least one ADL from the following bed mobility, transfer, locomotion, eating, toilet use, dressing, or bathing & support in 2 IADLs
<b>Monthly Cap</b>	\$800/mo	100% NF (\$4341)	\$1,000/month
<b>Level II</b>			
<b>Functional Impairment</b>	Level I Plus monthly nursing needs		Medically eligible for Level II Private Duty Nursing
<b>Monthly Cap</b>	\$1,060/mo		\$1,250/month
<b>Level III</b>			
<b>Functional Impairment</b>	Monthly nursing, limited assistance and physical support in 2 of bed mobility, transfer, location, eating or toileting		Require assistance from at least 2 ADLs from the following: bed mobility, transfer, locomotion, eating, or toilet use and support in 3 IADLs from the following: main meal prep, routine housework, grocery shopping, laundry
<b>Monthly Cap</b>	\$1,800/m		\$1,800/month
<b>Level V</b>			
<b>Functional Impairment</b>	Ventilator dependent or 24-hour care in 3 areas of SN		Level IV-no V in HBC Medically eligible for NF level of care
<b>Monthly Cap</b>	\$20,682/mo		\$3,472/month or 80% NF

NOTE: Level IV in Private Duty Nursing /Personal Care Services is for children, therefore, not included. All three public programs offer consumer-directed PCA options. Medicaid also covers adult day health, adult family care homes, residential care facilities, and nursing facilities. Monthly cap amounts are for 2003.

SOURCE: “Long-term Care Community Programs Description.” Bureau of Elder and Adult Services, January 22, 2003

**Table 4-2** summarizes all the services accessed through Goold, EIM and the AAAs. These services are organized into the following categories: awareness and information, assistance, access, case management and direct services. Awareness and Information is defined as public education and information on long-term support options and is primarily offered through the local AAAs. Assistance is defined as counseling on employment, long-term care, health insurance, program referral, or crisis intervention services; these services are provided through the local AAAs. Access includes the screening and assessment services provided by Goold. Case management is for the public programs. Table 4-2 also lists some of the direct services available through this system.

### ***B. Single Entry Point***

The assessment agency, Goold, serves as the mandatory single entry point for state and Medicaid funded home care programs serving elders and adult with disabilities.<sup>13</sup> Referrals come from multiple sources including nursing homes, home health agencies, state agencies, hospitals, family members, community agencies, residential care facilities, consumers, physicians, advocacy agencies, adult day programs, case managers and the consumer-directed program.

After receiving the initial call, staff speak with the client or their designee and obtain enough financial and clinical information to determine if a formal assessment for LTC services is warranted. If it is, assessments are conducted by a network of 40 nurses across the state employed by Goold. They use a uniform pre-admission assessment screen for all clients, including those seeking institutional and community-based care. All nursing home entrants must be assessed to determine if they meet nursing home level-of-care regardless of payer. The goals of this centralized, uniform assessment are to:

- Provide timely and objective functional eligibility decisions;
- Educate consumers and families about community-based options, and
- Support a fair allocation of resources based on need.

Goold assessors are community-based and travel to the client's home to conduct the assessment. They use laptop computers to complete the assessment form which includes many

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<sup>13</sup> Clients seeking consumer-directed services are referred to the state Independent Living Center (under Contract with the Department of Labor) to determine their capacities to self-direct services and for care coordination.

**Table 4-2  
Types of Services Offered by Maine Long-Term Care System by Eligible Population**

<u>Type of Service</u>	INCOME LEVEL			SPECIAL POPULATION	
	<u>Any 60+</u>	<u>Non-Medicaid/ Low Income</u>	<u>Medicaid</u>	<u>Alzheimer's Disease/ Dementia</u>	<u>Family Caregivers</u>
<b>AWARENESS &amp; INFORMATION</b>					
Information & Assistance	✓	✓	✓	✓	✓
Family Caregivers Support Program I&A				✓	✓
<b>ASSISTANCE</b>					
Health Insurance Counseling	✓	✓	✓		
Health Promotion/Disease Prevention/Education	✓	✓	✓		
Public Administrator/Public Guardian	✓	✓	✓		
Adult Services Guardianship/Conservatorship	✓	✓	✓		
Retired/Senior Volunteer Programs	✓	✓	✓		
Family Caregiver's Support Program Counseling	✓	✓	✓		✓
Legal Services	✓	✓	✓		
Senior Employment		✓ (55+)	✓		
Maine Medicare Education Partnership (MMEP)	✓	✓	✓		
LTC Ombudsman Program	✓	✓	✓		
<b>ACCESS</b>					
MaineCare services (regular + waiver)	✓	✓	✓		
Home Based Care (state)	✓	✓	✓		
NH admissions					
<b>CASE MANAGEMENT</b>					
Care Coordination/Care Management		✓	✓		
<b>DIRECT SERVICES</b>					
MaineCare Private Duty Nursing/Personal Care Services			✓		
Consumer-Directed Attendant Services		✓	✓		
Personal Care Services	✓ *	✓	✓		
Adult Day Care	✓ *	✓	✓		
Homemaker	✓ *	✓	✓		
Transportation	✓ *	✓	✓		
Foster Grandparent	✓	✓	✓		
Senior Companion	✓	✓	✓		
Assisted Living/Adult Family Homes		✓	✓		
Home Delivered Meals	✓ *	✓	✓		
Alzheimer's Respite Program				✓	
Money Minders Program		✓	✓		
Home Repairs	✓ *	✓	✓		
Senior Centers/Recreational Activities	✓	✓	✓		

\*Services available on a private pay basis for over income clients.

data elements that crosswalk to the nursing home Minimum Data Set. Service eligibility levels are based on measures of cognitive, behavioral and physical functions. Additional items are assessed to collect information that enhances the assessor's ability to recommend a community-based option.

Each completed assessment is valid for 30 days during which time a consumer can decide to initiate services at any point. After 30 days, the assessment's validity lapses unless a program option has been chosen by the consumer. No presumptive financial eligibility for Medicaid is granted; services cannot begin until after the Bureau of Family Independence determines financial eligibility for Medicaid coverage.

Goold assessors must respond to all referrals within a limited time period. Hospital referrals must be addressed within 24 hours of discharge. For non-emergency, in-home assessments, Goold is expected to respond to referrals within 5 calendar days. If Goold does not respond within these required time periods, the state can lower the reimbursement for the assessment.

After completing the clinical assessment and assessing the client's financial resources, Goold authorizes services. Goold explains options to the consumer and family. Once the consumer chooses a home care option, Goold assessors refer the consumers to the appropriate home care coordination agency (HCCA) and share the assessment outcome with the provider of choice. In many cases, the HCCA is Elder Independence of Maine (EIM).<sup>14</sup>

### ***C. Home Care Coordination***

EIM is a separate division of one of the five AAAs in the state. Their primary function is to provide care coordination and case management to all LTC consumers participating in one of the three publicly-funded community-based long-term care programs; additionally, EIM manages provider contracts, authorizes provider payments and collects co-payment from clients.

EIM receives a monthly per capita payment from BEAS to:

- Arrange services;
- Coordinate and monitor the consumer's Plan of Care;
- Collect consumer co-payments;

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<sup>14</sup> Other HCCAs include home health agencies for home health and state funded homemaker services, and the state Independent Living Center for consumer-directed services.

- Administer contracts with service providers;
- Pay provider claims;
- Audit provider agencies;
- Administer/participate in quality improvement activities; and
- Provide resource information for consumers and care givers.

EIM has two branch offices, Auburn and Bangor, which serve the whole state. Their staff are grouped to work in teams and matched to consumers based on the county where the consumers live. While much of the work conducted by EIM staff is completed over the phone, staff travel to a clients' home when needed or required. Like Goold, EIM care coordination staff work from two regional offices which allows them to know the community they serve, its resources, and better identify client needs.

EIM employs about 38 care coordinators who serve as telephone case managers for all program participants. They regularly call consumers to check on their status. The frequency of these calls varies by client program levels. In addition, care monitors visit Medicaid clients who are waiver or Home Based Care level IV recipients at least every four months. Consumers of the self-directed option receive home visits every six months. This allows the EIM staff to assess environmental needs and provide general follow-up recommendations. They work with the consumer to discuss service options and implement a care plan as well as refer to other community resources and to ensure continued medical and financial eligibility in the program. Care coordinators also work with local providers and make the necessary referrals for other community services.

As an outcome of their care coordination services, EIM refers consumers to the following services as needed: residential care facilities; home health services, homemaker services, personal care services and adult protective services. They also refer to AAAs for family caregiving assistance, Meals on Wheels, Alzheimer's respite services or adult day services.<sup>15</sup>

Similar to other states across the country, some areas of Maine lack sufficient direct care providers to meet consumer needs. EIM maintains an "unstaffed" client list for all programs, including the Medicaid waivers, Medicaid state plan and state home care services. This allows them to ensure consumers receive services as soon as a provider has available staff. Clients can receive partial services until full services are available. In order to review quality of the care

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<sup>15</sup> The Care Coordinators are mandated reporters.

coordinating services and monitor consumer needs, EIM conducts weekly case conferences internally and holds meetings with those providing services as needed.

EIM also manages an electronic information system that serves multiple functions. It documents consumer contacts, generates internal and state-required reports to monitor clients, authorizes services, and bills and pays providers. EIM also calculates client co-payments based on a cost sharing formula and bills them using this system. The system maintains an up-to-date and current list of the participating providers and their related network information. Again, these services are managed on a statewide basis through EIM's information system. This consistent provision of information across the state, regardless of local resources, assures consistent access to services for all consumers.

#### ***D. Reorganization/Community Partnerships.***

As mentioned above, the five AAAs in the state previously performed some of the functions Goold and EIM are currently providing. The state's move to a competitively bid single contracting system had an effect on each of the AAAs and their staffing since it reduced their base revenues and eliminated certain jobs. While all 5 AAAs provide core Title III services funded by the Administration on Aging, each had to rethink their revenue sources and missions. During the site visit, RTI staff spoke with three of the five AAAs in the state. Each developed different niche services that reflected the goal of addressing local unmet needs and diversifying their funding base. Many of these were based on partnerships with local community members.

*Home Care Coordination Agency.* SeniorsPlus in the Lewiston area successfully bid on the state contract to be the home care coordination agency (EIM). They utilized former AAA case management staff and have since added additional staff in a separate unit to provide home care coordination statewide.

*Assisted Living Services.* Eastern Agency on Aging in Bangor responded to the loss of case management responsibilities by developing a partnership with a local real estate developer to establish an assisted living facility for low-income elders. Together they modified a former department store for both commercial use and to develop suitable apartment space for elderly low-income residents. The developer was responsible for the rehabilitation and rental of the property while the AAA developed a 24-hour personal care service system for residents of this building. Their expertise allowed them to develop a program that met regulatory standards while

implementing clustered service approaches. Started in 1996, this partnership has resulted in the development of 3 facilities and a total of 89 assisted living apartments. This clustered housing approach provides 24 hour assisted living services.

*Entrepreneurialism.* Senior Spectrum, the AAA located in Augusta, has responded by establishing region-wide personal care services and developing entrepreneurial efforts to leverage private resources at their senior centers. Senior Spectrum's personal care agency serves clients across the region and employs 160 temporary staff to work with these clients. Over half (55 percent) of their clients are referred by EIM. The other 45 percent are private-pay clients.

Senior spectrum also offers a day care program at senior centers. To staff it, they have partnered with a local community college to bring students into the day care center as teachers. As a result of this partnership, college training programs now require a practicum at the senior center as part of their curriculum for certain health service fields. Teaching at the senior center gives the students valuable work experience with seniors that supplements their classroom learning. At the same time, the centers maintain highly trained staff without additional expenditures.

In addition, one of the senior centers has established a small catering business to supplement its income. They use their available space to hold catered events for local private business functions. These events are catered by the same staff as those who work in the AAA-sponsored congregate- and home-delivered meal programs preparing meals. The senior center also works with the community to promote the catering service to local businesses and residents for meetings, luncheons, retirement functions, or family celebrations. The additional funds are used to supplement the state and federal dollars that support the senior center programming.

Senior Spectrum also uses volunteers to support the work of the paid staff and provide additional attention to the clients at their senior centers. Some volunteers work directly with clients at the centers and many are former caregivers whose family members have passed away. Classes are frequently led by senior volunteers who were formally employed in that particular area.

#### **4-III. KEYS TO SUCCESS**

Maine's current system of contracting with one AAA to coordinate home care services statewide and using one contractor to perform pre-admission assessments grew out of the state's

efforts to standardize and increase service options while extending LTC resources. The state used data on program expenditures to convince legislators and other policymakers that the number of people served could be expanded without increasing, and in fact decreasing, state costs. By providing more home care and assisted living support in place of nursing homes, Maine has been able to serve more people with only modest increases in total long-term care spending.

### **Standardized Access**

Because of the geographic size of the state and the rural nature of the population, the Bureau of Elderly and Adult Services needed to design a system that provided standardized access but also incorporated expert knowledge about local long-term care providers. Having a single entry point with local assessors allowed them to meet these goals. Using local assessors also helped control travel costs and allowed more people to be served.

Maine uses one tool to determine nursing home and home care eligibility for all populations. Staff are trained to use it and it is consistently applied to all individuals seeking LTC. This approach has several advantages, including fairly uniform level of need determinations across the state with similar populations being admitted to nursing homes or referred elsewhere for community-based services

In addition, using laptops in the field adds to the system's efficiency and makes it possible to collect data that is useful in program planning. While the computers have associated purchase costs, they reduce the staff time needed for data entry. Assessments are completed during the interviews and the consumer is informed of the outcome and their options before the assessor leaves. The assessment data is submitted electronically shortly afterwards. This reduces the need to return to the office to submit paperwork. It also allows faster submission to state offices, which in turn, can process applications and allow services to begin faster.

### **Strong Communication**

There was a common belief shared among Goold, EIM and BEAS staff in the importance and value of strong communications. Because staff are dispersed across the state and all authorizations and care plans are controlled by these 3 agencies, frequent and regular communications were cited as key to this model's success.

While the communication lines between the state regulators, service authorization, and home care coordination teams are strong, one area that was less well developed was their communication with the AAAs. This system is strongly directed towards those needing clinical or personal care assistance and less involved with social, prevention, and health promotion activities. Clients are, however, referred to other AAAs for these services.

### **Data Analysis**

Finally, Maine has a long history of using program data to analyze cost and monitor systems. The data gathered during client assessments is used to identify characteristics of long-term care clients and answer questions the legislature may have about the impact of proposed program changes. Additional analysis of this data is conducted by the Muskie School of Public Service at the request of the Department. Such analyses supplement program information on state Medicaid costs, utilization, provider certification, and other information useful for policy-making. State administrators, Legislators, and advocates all use the information to recommend policy changes. As a result, Maine's policies are based on current program information, which in turn, reduces uncertainty in policy debates and increases support for their program.

Maine's system has been useful for standardizing decisions about LTC use. It has reduced some of the statewide variability in service use and has increased consumer awareness of community-based options. The restructuring did, however, have an impact on the Aging Network. As a result, many providers developed new niches and addressed new areas of senior needs in their communities.

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