



Minnesota

Federal Vision for Successful Diversion and Transition

To be a "visible" source of individualized counseling and help with accessing long term services and supports (LTSS), the No Wrong Door (NWD) System must proactively engage in public education to promote broad public awareness of the resources that are available from the NWD System. A NWD System must also have formal linkages (e.g., Formal Agreements and Protocols, etc.) with the key referral sources in a given community to ensure the staff in these entities know about the functions of the NWD System and have up-to-date information and tools for quickly identifying and referring individuals to the NWD System. Among other key sources of referral, the NWD System must have formal linkages with nursing homes and other institutions. The NWD System should be seen as a major resource for health care systems and providers; it will have the capacity to serve as a "front door" to the LTSS System that can quickly link their clientele to a full range of community services and supports. Health care settings are major pathways that represent critical junctures where decisions are made -usually in a time of crisis - that often determines whether a person is permanently institutionalized or transitioned back to the community. The NWD System should be seen as a resource to discharge planners across the state to help facilitate the transition of residents back to the community, thus making nursing homes a key referral source to the NWD System.

For more information about the NWD model, visit <http://www.acl.gov/Programs/CDAP/OIP/ADRC/Index.aspx>.

This brief highlights Minnesota's promising practice to develop and implement an evidenced based nursing home diversion and transition program.

Minnesota's Successful NWD Promising Practice

As a result of federal and state interests to reduce costs and increase available community living options, backed up by findings from a nursing home admissions study conducted by the University of Minnesota and Indiana University for the Minnesota Department of Human Services, the Minnesota state legislature passed a statute in 2009 creating the Return to Community initiative. This nursing home transition and diversion initiative targets residents interested in returning to or staying in the community. The initiative also built upon the federal Aging and Disability Resources Center (ADRC) initiative, designating the ADRCs as implementers of Return to Community. Minnesota has demonstrated successful nursing home transitions and diversions due to:

- ▶ Minnesota's state leadership commitment to increase community living opportunities and decrease costs which led to the development of Return to Community. The program is funded by the state.
- ▶ A foundational program element which is the IT system Minnesota uses for the Return to Community initiative. In addition to publicly-accessible real-time data collection and report capability, secure web-based chats for communication across the state are available to staff.
- ▶ The program's rigorous protocol/structure was designed and based on evidence-based research.is attributed to its evaluation.

Acronyms

- ADRC = Aging and Disability Resource Center
- LTSS = Long Term Services and Supports
- MDS = Minimum Data Set
- NH = Nursing Home
- NWD = No Wrong Door

Resources

Click the links below for key resources on Minnesota's Promising Practice;

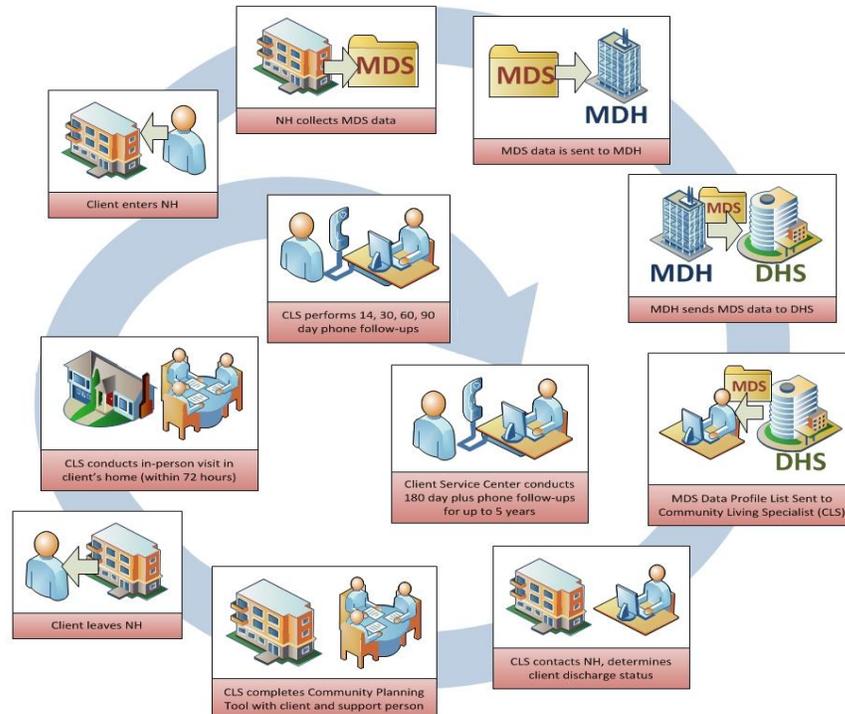
- ▶ [Minnesota Board on Aging Return to Community Initiative website](#)
- ▶ [Targeting Criteria and Quality Indicators for Promoting Resident Transitions from Nursing Home to Community: a Report to Minnesota Department of Human Services](#)
- ▶ [Minnesota 2009 Statute specific to Minnesota's Board on Aging](#)

Return to Community focuses on individuals who are pre-dual, private-pay and have been admitted into the nursing home within the past 90 days (thus not overlapping with residents who are targeted for Money Follows the Person at 90 days). The targeting window for this model was based on research from the University of Minnesota and Indiana University finding that a cohort of low-need nursing home residents should have transitioned home, but for some reason or another continued to stay in the nursing home. The study found that targeting low-needs residents at 90 days would result in successful transitions; however the program has now initiated contact with residents at 60 days, finding even higher success rates with this population.

The implementation for Return to Community included several important steps:

- ▶ Business process modeling which led to development of the Step-by-Step model or work flow as described in Exhibit 1 below
- ▶ Development of a Community Living Support Plan protocol and tools which are based on evidence-based elements. (Development of a highly transparent communications strategy focused on stakeholder engagement which includes road shows, booklets, brochures, webinars, and dashboards.
- ▶ Development of a data exchange process to implement the sharing of profiles and information. The exchange uses a HIPAA compliant web-based management tool and statewide secure communications architecture/ infrastructure with secure web-chats for communications.
- ▶ Development of an evaluation and continuous quality improvement strategy which includes regular conference calls, site visits, specialized training, data collection reports, dashboards and data tracking at the state-level.

Exhibit 1: Return to Community Step-by-Step model



In addition to tracking individuals transitioned through the Return to the Community program, staff also track those naturally occurring discharges for follow-up as well. Thus, all individuals leaving the nursing home receive follow-up calls.

The Return to Community staff, called Community Living Specialists, are primarily nurses or social workers. Minnesota has found that the most successful Community Living Specialists are nurses or social workers with nursing home experience. Those with medical training are also especially good fits. Regardless, as part of the State Health Insurance Assistance Program SHIP, all staff receive training on Medicare benefits and have a thorough understanding of benefits for paying for long term care and conducting long term care options counseling.

Partnerships

Involvement from key stakeholders throughout the planning process was critical. For example, the business process model was created with a wide variety of stakeholders including nursing home administrators and staff at the table. Stakeholders engaged in the planning process included: Departments of Health and Human Services nursing home policy and nursing home compliance staff; nursing home discharge planners and social workers; nursing home administrators/managers; ADRC members including Centers for Independent Living who had direct experience; and the State Unit of Aging. Representatives from the nursing homes were hesitant initially, but through discussions, provided essential input to design a program to complement rather than replace the existing discharge planning process. Nursing home stakeholders shared that the risk for readmission is greatest after an individual returns home. For example, if home care or meals are not provided as needed, then the individual may end up being readmitted. The Return to Community staff developed a follow-up process with input from nursing home stakeholders that was based on a Kansas study which followed individuals over the course of five years after they returned to community life.

Resources and Infrastructure Requirements

State leadership commitment to increased community living opportunities was a key driver for this initiative. State legislation was enacted in 2009 which created the Return to Community program and provided state funds for program staff positions. The comprehensive web-based management tool and secure communications infrastructure are the crux of the program. In addition, Minnesota has received a grant from the Agency for Healthcare Research and Quality (AHRQ) specifically for the evaluation component.

Identifying No Wrong Door Promising Practices

No Wrong Door (NWD) Promising Practices highlight successful state programs providing a model from which NWD Systems can gather strategies and innovations that can augment their own work. While Promising Practices are unique to each program, they do offer replicable components for diverse settings and share many common characteristics, including the capacity to reach the population of focus, address the aspirations of individuals, drive quality and impact methodology and measurement.