



## **The Implementation of Kentucky Transitions:**

A Money Follows the Person Demonstration Grant Program

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## EXECUTIVE SUMMARY

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Kentucky Transitions is a Kentucky Medicaid program that is funded primarily by a grant from the Centers for Medicare and Medicaid Services. The purpose of this program is to transition individuals residing in long-term care facilities back into the community, where they will continue to receive health, social, and other benefits but do so in an approved residential setting. Individuals living in the community may experience higher quality of life and the increased ability to choose how and when they receive services, while Medicaid reaps the projected financial benefit of providing less-expensive community alternatives for care.

Though Kentucky Transitions operates within Kentucky Medicaid, several organizations contribute to the operation and oversight of the program. Coordinating services from multiple organizations has proven to be difficult and the program has been struggling to sort out the administrative procedures for hiring staff and sharing sensitive case information. This implementation analysis proposes to compare program goals with program achievements and to analyze the current process by which Kentucky Transitions receives and processes records and referrals.

Federally-set benchmarks were used in this analysis as performance indicators for Kentucky Transitions. The comparison for program goals versus actual achievement was made by reviewing program records and reports that were submitted to the Centers for Medicare and Medicaid Services by staff. Documents and records regarding patient referrals and marketing materials were analyzed and information regarding the source of referrals by type was extracted. Staff members from Kentucky Transitions, the University of Kentucky, and Kentucky Housing Corporation were interviewed for opinions regarding challenges and barriers faced by the program.

Kentucky Transitions did not achieve goals regarding the expected number of patient transitions or transportation allotments for the first two years of the grant period. Program goals were achieved, however, for target expenditures for Home and Community Based Services. Whether or not the goal for patient participation in self-directing their services was achieved is ambiguous due to discrepancies in program records and reports. Data collected regarding referrals indicates that the primary sources of reliable referrals come from facility ombudsmen and social workers.

I recommend that Kentucky Transitions clarify the responsibilities of staff and partners and that the web based system of record keeping be made available to staff members as soon as possible. I also recommend that the concept of self-direction be more clearly defined and that marketing efforts be focused upon social workers and facility ombudsmen. The final recommendation is that benchmarks be modified so that program-specific goals about Home and Community Based Services expenditures could be adopted to alleviate uncertainty about the effect of Kentucky Transitions on overall Medicaid expenditures.

## **INTRODUCTION**

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Implementation studies of public programs are important because all programs must be implemented before they are able to provide the services for which they are intended. Studying this process can assist policy makers when gauging the feasibility of a proposed program and determining whether or not implementation is performed efficiently and effectively. This study is intended to inform program officials and staff about the progress of Kentucky Transitions, which is a program that transitions individuals residing in long-term care facilities back into the community by coordinating care with community providers.

### **Problem Statement**

Federal benchmarks and guidelines set by the Centers for Medicare and Medicaid Services must be met for Kentucky Transitions to maintain funding. Though the program is currently in the third year of the five year grant period, implementation of many of the services purported to be offered has only recently begun. The purpose of this implementation analysis is to evaluate the progress of the program's implementation and to offer recommendations for achieving program goals. This paper will address two research questions. First, how has Kentucky Transitions been implemented? And second, how is the Kentucky Transitions' system of promoting, gathering, and processing referrals operated? To investigate the answers to these questions, a review of the literature of implementation analyses is conducted,

performance indicators are identified, and then the progress of the program is measured by using the identified performance indicators.

## **Background**

The Deficit Reduction Act of 2005 called for sweeping changes of current long-term health care options provided by Medicaid, with the intention of making long-term care options more consumer-driven and less expensive (Centers for Medicare and Medicaid Services web site, 2009). As part of this act, grant funding was made available for state Medicaid programs to assist with the long-term care transformation. A key strategy for rebalancing funds included the enactment of the Money Follows the Person Rebalancing Demonstration Grant, which was awarded to Kentucky and twenty nine other states along with the District of Columbia. The purpose of this rebalancing grant is to allow Medicaid patients residing in long-term care facilities (such as nursing facilities and intermediate care facilities) to participate in community-based alternatives for care. By allowing Medicaid patients to choose to live in the community, patients may experience higher quality of life and experience greater control over their care.

Kentucky was awarded a five-year \$49.8 million Money Follows the Person Grant in May of 2007 and Kentucky state government allocated an additional \$10.8 million in funds, which brings the total five-year budget up to \$60 million. This funding supports the Kentucky Transitions program, which is operating within Kentucky's Department of Medicaid Services in the Division of Long-Term Care and Community Alternatives. The primary objective of Kentucky Transitions is to offer community-based options for care

to Kentucky’s more than 31,500 institutionalized Medicaid patients (Wenzlos, Lipson, 2009).

### Organizational Structure of Kentucky Transitions

The Kentucky Transitions program operates within the Department of Medicaid Services but maintains partnerships and close ties with other organizations. The location of Kentucky Transitions within the hierarchy of Kentucky Medicaid is outlined in Figure 1.

The University of Kentucky is responsible for oversight of most of the hiring

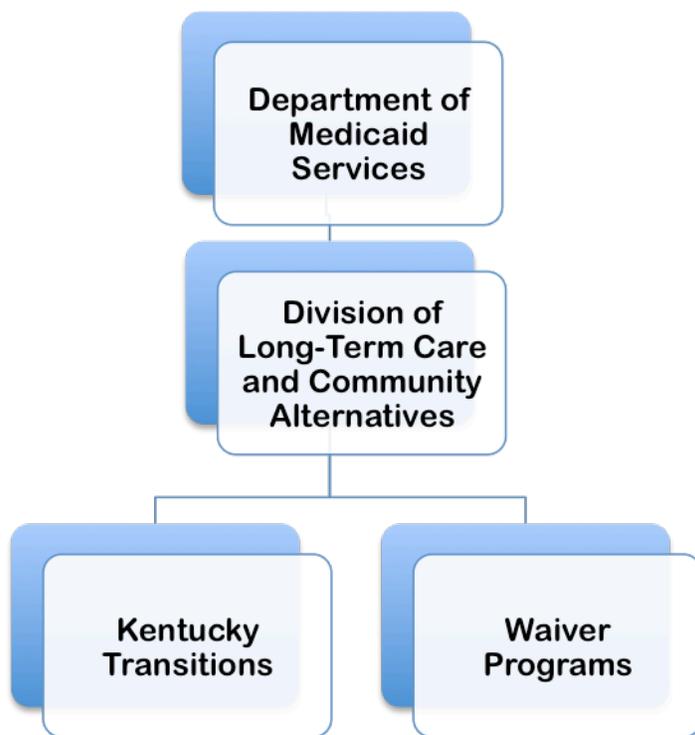


Figure 1: Organization Hierarchy within Medicaid

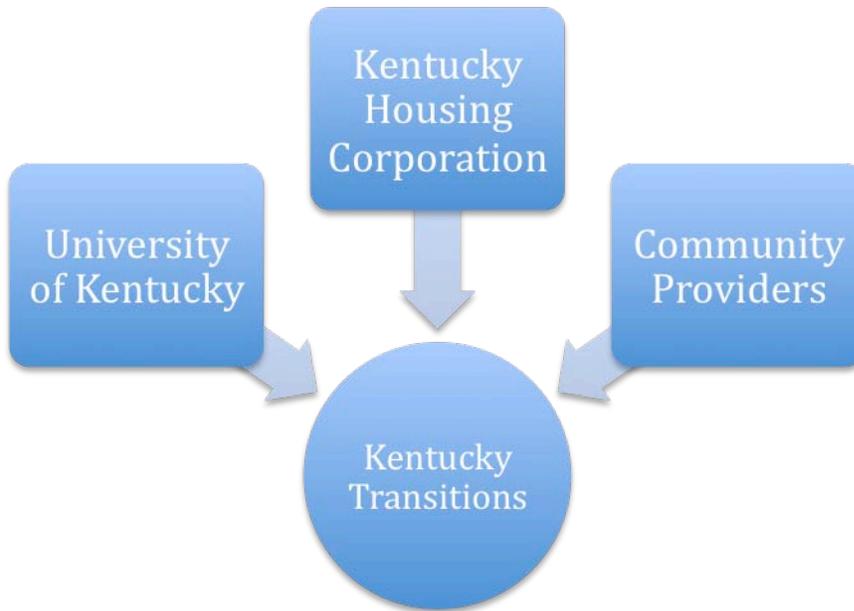
process and also manages data collection and reporting for the program. Other partnering organizations, such as the Kentucky Housing Corporation, provide assistance for patients seeking specific services that are not directly related to healthcare. Partnerships

with Kentucky Transitions are reflected in Figure 2. Kentucky Transitions handles individual patient’s cases through “transition teams” comprised of a nurse, social worker, housing coordinator, and other needs specialists. The program currently relies

on outside referrals to recruit participants and Medicaid patients may self-refer.

Kentucky Transitions is currently in the process of organizing regional transition teams

Figure 2: Kentucky Transitions and Partners



that assess  
program  
participants within  
their respective  
areas of the state.

Once a  
referred patient  
has met eligibility

criterion<sup>1</sup> the transition team completes assessments of client health, housing needs, the availability of family/guardian assistance, and other personal care needs (Money Follows the Person operational protocol, 2009). The team then constructs a package of benefits that is customized to the client, though the cost of the services must fall within federally-specified budget restrictions. If the client gives consent, then the client can transition back into the community by utilizing the benefits and public services available.

The demonstration period is 365 days, during which the client is monitored by the transition team closely. A quality of life survey is administered by the team before the transition and then again after both one and two years of community living. The

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<sup>1</sup> Eligibility Criteria include: individual has been a Medicaid participant for at least six months, participant has lived in institutional care for at least one month, participant is deemed capable of living outside of a facility with medical and/or personal assistance, and the estimated cost of care for the individual must satisfy a budget neutrality requirement.

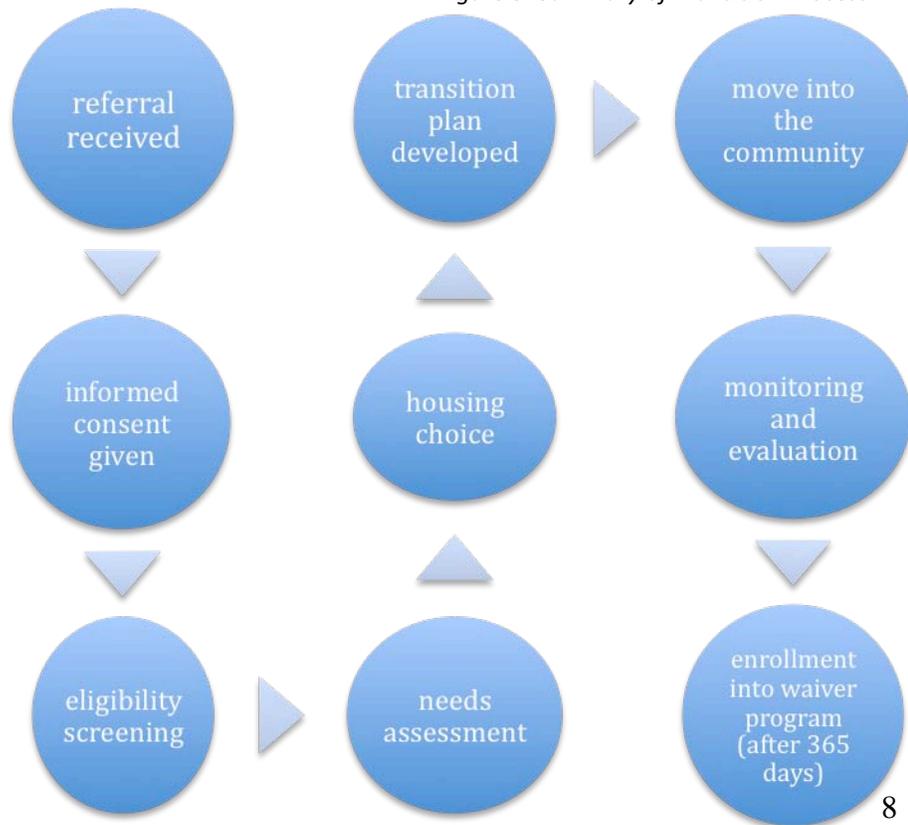
results of this survey will be used by Mathematica Policy Research Company, which was hired by the Centers for Medicare and Medicaid Services to evaluate all Money Follows the Person grant programs, to evaluate whether or not quality of life of program participants improves after moving back into a community setting.

**Available Services**

Kentucky Transitions serves individuals who have acquired brain injuries, mental retardation or developmental disabilities, the elderly, and individuals with physically disabilities. The transition team screens the patient for eligibility for one of several available waiver services. Once the patient is found to meet eligibility requirements, the patient then receives waiver support to transition back into the community where a variety of community-based services for care are utilized. Necessities for the client to live in the

community that are not covered by existing services, such as home modifications, are evaluated and resolved by sub-contractors

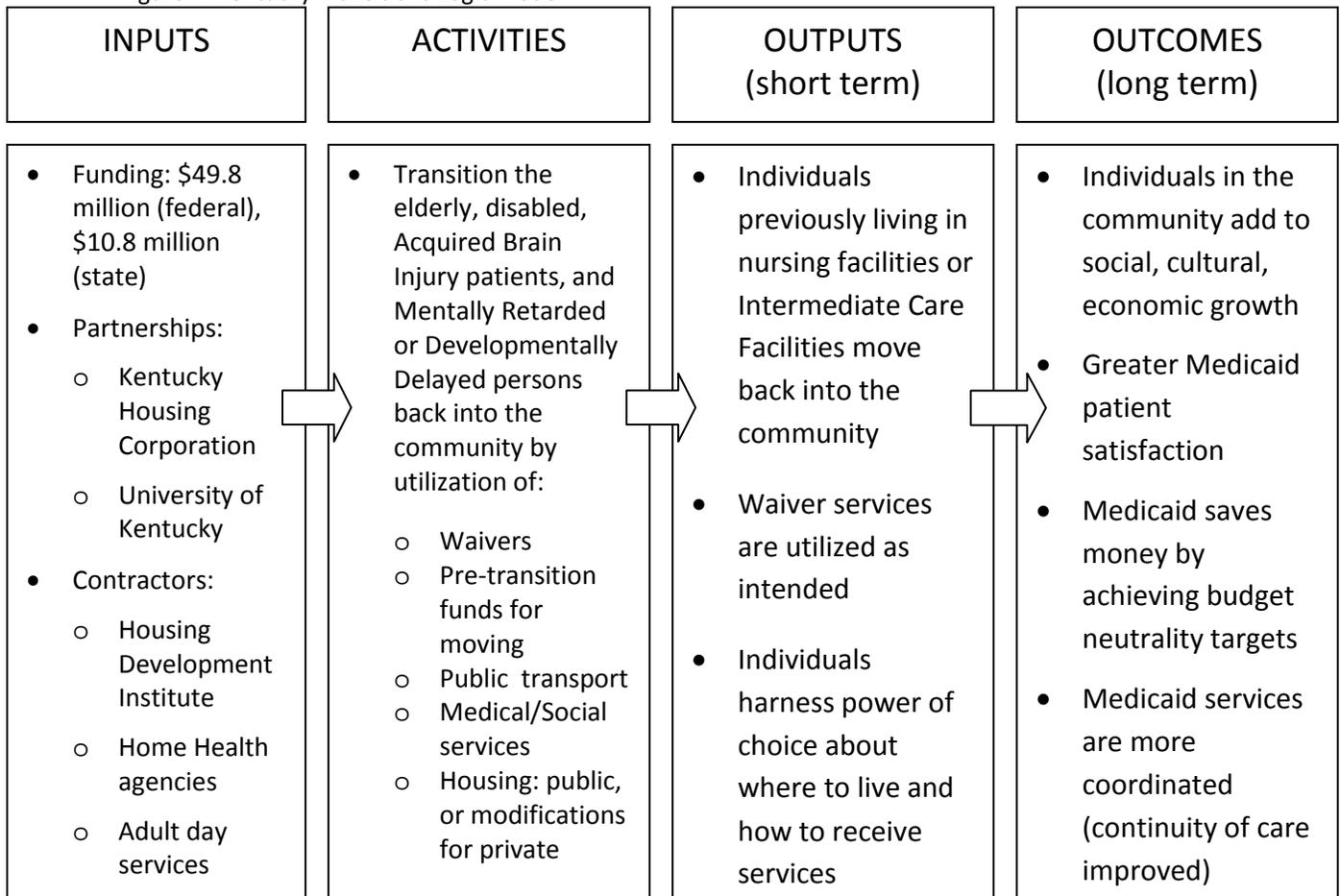
*Figure 3: Summary of Transition Process*



that bid for the job. Kentucky Transitions pays sub-contractors through Medicaid reimbursement within pre-set spending limits per client. A summary of the transition process can be seen in Figure 3. Kentucky Transitions covers services such as home health, respite, and personal care. Transportation options for clients include guardian/family assistance, public transport, medical transport, and other community transportation services. Transportation services for clients in rural areas can be limited. Transportation for the transition date can be arranged by the transitions team and one-time moving expenses for the transition are covered for up to \$2000 per client.

Services are covered by Kentucky Transitions for 365 days and then the program participant can choose to enroll in a traditional Kentucky Medicaid waiver program to continue receiving services in the community. Kentucky Transitions differs from existing Medicaid waiver programs in two key respects: first, Kentucky Transitions can provide funding for moving expenses and transportation services; and second, Kentucky Transitions coordinates multiple services into one benefits package for the program participant, which makes it easier for the participant to get the services they need without having to be enrolled into multiple benefits programs (e.g. housing assistance and medical services). Figure 4 depicts a logic model of Kentucky Transitions that outlines inputs, outputs, and outcomes.

Figure 4: Kentucky Transitions Logic Model



### Review of the Literature

Implementation analyses, or formative evaluations, are evaluations of a program that occur while the program is still being implemented (Fink, 2005). The purpose for performing this type of analysis is to provide reports about the progress of a program, while the program is still operating, that can assist policy makers by providing recommendations that are feasible (O’Toole, 1986). Though implementation analyses are useful for reporting program progress, it is less likely than other types of program evaluation to yield information about the overall effectiveness of the program.

Several studies recommend that both similarities and discrepancies between the original policy making structure and the actual management of service delivery be explored when performing implementation analyses (Robichau & Lynn, 2009), and Forbes, et al. (2007) have found that the organizational structure as well as the administrative strategies utilized by a public program have a significant effect on outcomes of health-care policies. Evidence from the successes and failures of earlier policies intended to redirect individuals from institutions to community care support the notion that the interplay between the policy and the actual management of the program affect the outcomes of the program (Castellani, 1992).

An implementation analysis of a program with a similar mission to Kentucky Transitions (a Canadian community-driven public health initiative) was conducted by first mapping out the structure and processes of the program, constructing a logic model, and then providing recommendations to facilitate better coordination among the participating organizations (Smith, 2000). The author provides a comprehensive overview of the program and concludes that a “shared vision” among the organizations partnering with the program is vital for successful implementation.

An implementation analysis of all Money Follows the Person programs, including Kentucky Transitions, is to be performed by Mathematica Policy Research in 2011. Mathematica proposes to evaluate program implementation by using the target benchmarks of each program as performance indicators (Brown, et al., 2005), though this evaluation will occur after the grant period and proposes to focus on program outcomes rather than the process of implementation. This paper also utilizes

benchmarks as performance indicators; however, the process of implementation is the primary focus.

## **METHODS**

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### **Section I: Implementation Analysis**

The primary research question, “How has Kentucky Transitions been implemented?”, will be answered by comparing the Federally-set benchmarks and goals to actual program achievements and progress. Progress will be determined by analyzing program records and documents to identify barriers to coordination amongst organization and challenges to providing services to the target populations. In this implementation analysis, federally-set benchmarks will serve as performance indicators for the program. Mathematica Policy Research, the company hired by the Centers for Medicare and Medicaid Services to evaluate all Money Follows the Person grant programs, also proposes to use each respective state’s benchmarks as performance indicators, though their analysis will focus on program outcomes (Brown, et al, 2008). A description of each of the five benchmarks as well as the performance of Kentucky Transitions can be found in the RESULTS section.

### **Section II: Analysis of the Referrals Process**

Kentucky Transitions relies on outside referrals for the recruitment of program participants. The process for gathering and promoting referrals has not been defined within the organization’s operational protocol, though a system of processing referrals

has been enacted. The secondary research question, “How is the Kentucky Transitions’ system of promoting, gathering, and processing referrals operated?” will be answered by analyzing program records and reports as well as conducting staff interviews. The type of information to be gathered includes the number and source of referrals, the number and type of promotional materials, and the methods of gathering referrals. This information will be reported in the RESULTS section.

## **RESULTS**

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### **Section I: Implementation Analysis**

Section 1 focuses on the overall progress of Kentucky Transitions by comparing goals to actual performance. Performance, in this instance, is measured by using the five benchmark goals set by the Centers for Medicare and Medicaid Services as standards of progress of the program.

#### **Benchmark #1: Number of Transitioned Individuals**

The first benchmark outlines the number of individuals that should be transitioned from long-term inpatient care to a community in Kentucky, where they will receive comparable services but live in an approved residential setting. The transition goal for each target population group is outlined in Table 1. Kentucky Transitions is expected to be continued and sustained by the state of Kentucky after the demonstration grant period of five years, which suggests that transition goals should then at least be expected to remain similar in later years to previous years. It is unclear

then why transition goals have been set lower for year 5, the last year in the grant period. Kentucky is expected to transition 546 individuals into the community by the end of the grant period.

Table 1: Transition Goals by Target Population

<b>Target Population</b>	<i>Year 1 (2007)</i>	<i>Year 2 (2008)</i>	<i>Year 3 (2009)</i>	<i>Year 4 (2010)</i>	<i>Year 5 (2011)</i>	<b>Total</b>
<i>Elderly</i>	0	11	78	78	48	<b>215</b>
<i>Physically Disabled</i>	0	1	33	34	22	<b>90</b>
<i>Individuals with MR/DD*</i>	0	8	72	72	45	<b>197</b>
<i>Individuals with ABI**</i>	0	2	17	17	8	<b>44</b>
<b>Total</b>	<b>0</b>	<b>22</b>	<b>200</b>	<b>201</b>	<b>123</b>	<b>546</b>

\*MR/DD: Mental Retardation and/or Developmentally Disabled

\*\*ABI: Acquired Brain Injuries

For Year 1 of the grant period (2007), no transitions were expected to occur.

Table 2 below indicates that the goal number of individuals to be transitioned from long-term inpatient care to the community was not met for most categories of the target population in 2008, which is the second year of the grant period. The number of physically disabled persons who were transitioned into the community exceeded the target substantially, though only 23% of the expected number of total transitions was achieved. For the current year, three transitions have occurred as of March. Not enough time has passed in the current year to make predictions about whether or not transitions goals will be achieved.

Table 2: Transitions in 2008 by Target Population

<b>Population</b>	<b>Year 2 (2008) Target</b>	<b>Year 2 (2008) Actual</b>	<b>Met Goal?</b>	<b>% of Target Achievement</b>

<i>Elderly</i>	11	1	No	9%
<i>Physically Disabled</i>	1	4	Yes	400%
<i>Individuals with MR/DD</i>	8	0	No	0%
<i>Individuals with ABI</i>	2	0	No	0%
<b>Total</b>	22	5	No	<b>23%</b>

This goal was not achieved most likely due to inadequate staffing of the program. The staff included only one nurse and zero social workers until December of 2008. Without a full transition team, assessing participant needs and coordinating services was extremely challenging. Sharing information about participants with other organizations presented another problem. Different specialists assess participant needs at different times so constant communication between the organizations' handling the participants case is necessary so that all staff working with the participant has the same information. These challenges will be addressed more fully in the DISCUSSION section.

**Benchmark #2: Increased Expenditures on Community Services**

The second benchmark requires that expenditures on community alternatives to facility care by target population should increase for each year of the grant period. Expenditures on community alternatives to care are made by both Kentucky Transitions and by other Kentucky Medicaid waiver programs. The expenditure targets are outlined in Table 3.

Table 3: Home and Community Based Services Expenditures by Target Population

TARGET POPULATION	Baseline*	YEAR 2 (2008)	YEAR 3 (2009)	YEAR 4 (2010)	YEAR 5 (2011)	TOTAL
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<i>Individuals who are elderly and/or physically disabled</i>	\$ 94.0	\$104.2	\$115.0	\$123.4	\$131.0	\$473.6
<i>Individuals with MR/DD</i>	\$177.9	\$196.8	\$224.5	\$244.2	\$260.6	\$926.1
<i>Individuals with ABI</i>	---	\$0.1	\$ 1.6	\$ 2.4	\$ 2.7	\$ 6.8
<b>TOTAL</b>	<b>\$271.9</b>	<b>\$301.1</b>	<b>\$341.1</b>	<b>\$370.0</b>	<b>\$394.3</b>	<b>\$1,406.6</b>

\*Kentucky State Fiscal Year 2006 expenditures

Because this benchmark measures the expenditures of all Medicaid programs that spend money on community services, this benchmark serves as a better performance indicator for Kentucky Medicaid waiver programs as a whole than it does for Kentucky Transitions. Expenditure goals that are specific to Kentucky Transitions may be a better indicator of performance. Nonetheless, the target expenditures on community services by Kentucky Medicaid were achieved for the year 2008, with an 11% increase in expenditures compared to the baseline year 2007. If Kentucky Medicaid continues to increase spending on Home and Community Based Services, then the 2009 target will likely be achieved as well. This information is provided in Table 4.

Table 4: Expenditures on Home and Community Based Waiver Services by Kentucky Medicaid

<b>Year</b>	<b>Target Expenditures</b>	<b>Actual Expenditures</b>	<b>% Change</b>	<b>% Achievement</b>
2007	\$271.9	\$287.4	---	>100%
2008	\$301.1	\$301.8	11%	>100%
2009	\$341.1	---	---	---
2010	\$370.0	---	---	---
2011	\$394.3	---	---	---

**Benchmark #3: Increased Proportion of Expenditures on Community Services**

Benchmark #3 requires that there should be a percentage increase in community services expenditures versus institutional long-term care expenditures for each state fiscal year of the grant period. This means that more funds should be directed into community alternatives while diverting away from long-term facilities. This benchmark also considers community services expenditures for all Kentucky Medicaid waiver programs rather than isolating expenditure targets for Kentucky Transitions. A program-specific expenditure target may be a more appropriate indicator of program performance. The specific expected increase community services spending can be seen in Table 5.

Table 5: Percent Increase in Home and Community Based Services Expenditures by Target Population

Target Population	Institutional Baseline* (in Millions)	Home and Community Based Services Baseline* (in Millions)	HCBS as % of Baseline	2009	2010	2011	2012
<i>Nursing Facility</i>	\$781.4	\$94.0	12.0%	13.3%	14.7%	15.8%	16.8%
<i>Intermediate Care Facility (Mental Retardation)</i>	\$119.4	\$177.9	149.0%	64.9%	188.1%	204.5%	218.3%
<i>Acquired Brain Injury</i>	\$7.4	---	0.0%	1.4%	21.8%	32.3%	36.4%
<b>TOTAL</b>	\$908.2	\$271.9	29.9%	33.2%	37.6%	40.7%	43.4%

\*Baseline is state fiscal year 2006 expenditures

The required percentage increase community services expenditures versus institutional long-term care expenditures for the second year of the grant period (2008) was nearly achieved. Though this goal was missed, the proportion of community services out of total long-term care expenditures was nearly 99% of the target

proportion. Projected expenditures for 2009 are not currently available. See Table 6 below.

Table 6: Percentage of Expenditures on Home and Community Based Services by Kentucky Medicaid

Year	Target %	Actual %	Met Goal?	% Achievement
2007	29.9% (baseline)	---	---	---
2008	33.2%	32.9%	No	99%
2009	37.6%	---	---	---
2010	40.7%	---	---	---
2011	43.4%	---	---	---

#### Benchmark #4: More Patients Self-Direct Services

The fourth benchmark requires that participation in self-directed services by Kentucky Medicaid waiver participants increase by 10% each year. This means that Kentucky Transitions participants (as well as any Medicaid participant that receives services from a waiver program) should be given the opportunity to choose how their services will be delivered and by whom. Again, a program-specific goal for Kentucky Transitions may serve as a better performance indicator. See Table 7 for an outline of the goal numbers of participation in self-direction.

Table 7: Target Numbers of Patients Choosing to Self-Direct in Medicaid Waiver Programs

Number of Self-Directing Participants	Baseline*	Year 2 (2008)	Year 3 (2009)	Year 4 (2010)	Year 5 (2011)
	550	+55	+61	+67	+73
<b>Total Self-Directing</b>	550	605	666	733	806

\*Number of individuals who were self-directing services in Kentucky Medicaid waivers in 2006

Reports submitted to the Centers for Medicare and Medicaid Services indicate that the target for year 2008 was achieved, though no Kentucky Transitions participants chose to self-direct services in 2008. It is likely that a reporting error has occurred but

the source was unable to be identified. However, it is possible that more Medicaid patients that are not enrolled in Kentucky Transitions have been choosing to self-direct services. Table 8 contains details about self-direction goals.

Table 8: Kentucky Medicaid Recipients who Choose to Self-Direct Services

Year	Self-Directed Participants: Target	Self-Directed Participants: Actual	Met Goal?	% Achievement
2007	550 (baseline)	550	---	---
2008	605	605	Yes	100%
2009	666	---	---	---
2010	733	---	---	---
2011	806	---	---	---

The concept of self-direction has been loosely defined by Kentucky Transitions and the Centers for Medicare and Medicaid Services grants some flexibility in categorizing what exactly constitutes self-direction of services. Staff members of Kentucky Transitions report that self-direction is explained to participants as the option of choosing their own providers and/or budgeting for services themselves. The ambiguity surrounding what actually qualifies as self-direction may be acting as a deterrent for participants, who have been reported by staff to show some confusion and concern as to how much responsibility of their care they would actually have.

**Benchmark #5: Increase Transportation Allotments**

The final benchmark requires that the availability of transportation services to participants should increase. The proposed method of increasing transportation services is to provide a transportation allotment for eligible Kentucky Transitions participants. Medicaid waiver programs have not previously offered this benefit. The second requirement of this benchmark is to show an increase in the positive response rate for

Quality of Life survey questions relating to transportation. Quality of Life surveys are administered to all Kentucky Transitions participants once before they transition back into the community and again after about one year of living in the community. Because positive response rates cannot be measured until at least one year after the first participants' transition, this measure is not in effect until the year 2009, which is year 3 in the grant period. See Table 9 for the expected numbers of transportation allotments to be provided by Kentucky Transitions.

Table 9: Target Numbers of Participants Receiving Transportation Allotments in Kentucky Transitions

<b>TARGET POPULATION</b>	<b>Baseline*</b>	<b>Year 2 (2008)</b>	<b>Year 3 (2009)</b>	<b>Year 4 (2010)</b>	<b>Year 5 (2011)</b>
Individuals who are elderly and/or physically disabled, with MR/DD, or with ABI who receive a transportation allotment	0	22	108	110	72
Increase in positive response rate for each question related to transportation in the Quality of Life survey	-	Baseline	10% increase from baseline	20% increase from year 3	20% increase from year 4

\*Baseline is state fiscal year 2006. No transportation services were offered.

No participants in Kentucky Transitions received allotments for transportation in 2008. Though five participants were transitioned into the community in 2008, each participant had access to the transportation assistance of guardians or public transportation. Transportation targets are detailed in Table 10 below. Data from the Quality of Life Surveys will not be available until late 2009.

Table 10: Kentucky Transitions Participants Receiving Transportation Allotments

<b>Year</b>	<b>Participants Receiving Transportation Allotments: Target</b>	<b>Participants Receiving Transportation Allotments: Actual</b>	<b>Met Goal?</b>	<b>% Achievement</b>
2007	0 (baseline)	0	---	---
2008	22	0	No	0%
2009	108	---	---	---
2010	110	---	---	---
2011	72	---	---	---

## Section II: Analysis of the Referrals Process

Section II focuses upon the referrals process of Kentucky Transitions. A total of 57 referrals have been made to Kentucky Transitions as of March 2009. These referrals have come primarily from Facility Ombudsmen, family members, and social workers.

Table 11 below summarizes the number of referrals by source as well as the percentage of referrals by source that were eligible for program participation.

Table 11: Referral Source by Type to Kentucky Transitions

<b>Referral Source</b>	<b>Marketing Material Distributed</b>	<b>Number of Referrals</b>	<b>% Eligible</b>	<b>% Willing to Participate*</b>	<b>% Transitioned</b>
<i>Family Member</i>	Form letter	17	41%	31%	13%
<i>Advocate or Organization</i>	Form letter, brochures	5	60%	60%	20%
<i>Facility Ombudsman</i>	Form letter, brochures	15	67%	53%	20%
<i>Social Worker</i>	None	17	65%	53%	12%
<i>Other (e.g. friend, attorney)</i>	None	3	33%	33%	0%
<i>Nurse</i>	Continuing education sessions (PowerPoint presentations and information packets), brochures, form letter	0	0%	0%	0%
<b>Total</b>	---	<b>57</b>	---	---	---

\*Patients willing to participate that also meet eligibility criterion.

The information presented in Table 11 indicates that professionals (social workers, ombudsmen) refer participants that are more likely to meet eligibility requirements. This is a logical occurrence because professionals are better able to assess the level of care that an individual needs. Advocates appear to be effective referral sources for individuals who are willing to participate in the program, though fewer of these referred individuals have met eligibility criterion when compared to referrals from social workers and ombudsmen. No individuals have self-referred as of yet and six individuals who were eligible for program participation decided not to participate. Three of the six individuals that declined to participate cited “safety concerns” as their primary reason for remaining in a long-term care facility. There have been no referrals for persons in Intermediate Care Facilities (individuals who are Mentally Retarded and/or Developmentally Disabled) as of March 2009, though every other target population has been represented in referrals.

The percent of referred individuals who were actually transitioned appears to be fairly small and this is due in part to the large proportion of referred individuals who are still in the process of being assessed. Out of 57 total referrals, 23 of these individuals (or about 40%) are still undergoing eligibility screening and needs assessment. This delay in the transition process is primarily due to an inadequate amount of staffing, which has kept the process slow and complicated without the necessary staff to screen, assess, and coordinate services.

Kentucky Transition's staff does not recruit participants, though promotional and educational materials have been distributed as per grant requirements. Mass mailings that briefly described Kentucky Transitions, eligibility, and contact information were sent to Medicaid patients and providers in late 2008. A brochure has been produced and distributed to nurses during continuing education seminars and Kentucky Transitions' contact information is readily available on Kentucky Medicaid's web site. Within the past two months, Kentucky Transitions has hired a Marketing and Outreach Director who is responsible for developing and overseeing a marketing budget. The Director has since put together informational packets to be distributed to facility ombudsmen and other interested parties. Social workers have not yet been targeted for the distribution of marketing materials, though within the last few weeks information packets have been distributed through social worker organizations.

The absence of referrals from nurses despite providing this group with several types of information about the program is not surprising. Nurses, who may be more likely to be in the employment of a long-term care facility, do not have the same incentives to refer individuals as do ombudsmen or social workers. Ombudsmen and social workers are charged with providing individuals with the best options for their overall quality of life, whereas it is possible that nurses may be primarily concerned with the immediate medical needs of the individual. Within facilities, medical care is readily accessible and care is comprehensive. An individual receiving care in the community, however, may need the services of more than one provider and continuity of care is more difficult when multiple providers are involved.

## **DISCUSSION**

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### **Challenges to Implementation and Recommendations**

As can be seen in the RESULTS section, many of Kentucky Transition’s benchmark goals have not been achieved and the program remains in the implementation phase despite being in the third year since enactment. The slow progress of implementation can be attributed to several challenges that staff members face as well as the inherent complex task of coordinating multiple services across multiple organizations. Hasnain-Wynia, et al, (2001) note that “evidence from demonstration projects...and partnerships indicate that they frequently fail to achieve measureable results,” though Kentucky Transitions has managed to transition eight individuals since a full state transition team has been hired and trained. According to staff, one of the most challenging aspects of coordinating efforts across multiple organizations has been making sure that each involved party has all of the updated information about each patient (each team member conducts an independent assessment of patient needs) while maintaining patient privacy (for example, housing coordinators are not permitted to access patient health information).

To address challenges associated with sharing information between organizations, Kentucky Transitions is in the process of developing a web-based records system that would allow staff members and affiliated organizations to access up to date participant information and case progress. It is recommended that all staff members

and affiliated organization staff undergo training for the use and necessity of maintaining records electronically via this system as soon as possible. The system is still being tested, though it is expected to be active within the next two months. If records are updated vigilantly, then this web system can alleviate many of the challenges that staff members face by ensuring that every staff member has access to the same information about the case and its progress. This system may serve as a model for other states' Money Follows the Person programs, as no other state has reported handling program records in this way (Lipson, et al., 2005). There is still a potential for problems associated with granting staff access to sensitive participant information, though this can be resolved by creating different levels of access to the system.

Exacerbating these challenges is the inherent complexity of each individual case. Every patient faces unique obstacles to transitioning back into the community and no two patients require the same mix and level of services. Also, the rural location of many patients makes it difficult to locate adequate housing, transportation, and community providers that are willing to contract with Medicaid waiver services that are to be delivered outside of a long-term care facility.

Now in the third year of the grant period, Kentucky Transitions still has vacancies for several key staff positions including policy specialist and grant reporting specialist. Until December 2008, the program lacked any social workers and had only one nurse. These staffing inadequacies made the transition process slow and complicated as staff were required to assess needs of the individual that often lay outside of their specialties. A full state transition team consisting of at least one nurse, one social

worker, a housing coordinator, and other needs specialists has only existed as of December of 2008. Staff members explain that coordinating a transition with a missing team member is extremely difficult due to the complex needs of each individual patient. Regional transition teams have yet to be hired and so state transition team members spend a great deal of time traveling throughout the state to assess each individual's needs in person. The hiring process for transition staff members has been slow for two reasons. First, the Kentucky state government hiring freeze prevented new government employees from being hired when the grant was first obtained. To overcome this, the University of Kentucky contracted with Medicaid to perform hiring and screening. This action created further problems because the complicated administrative and legal tasks involved with coordinating hiring through these two large entities created delays that were unexpected and frustrating to staff. Policy makers should take note that the hiring freeze, which was intended to save Kentucky money, may have actually led to increased administrative costs in this instance. When contemplating future hiring freezes, policy makers may want to consider exempting programs such as Kentucky Transitions that primarily operate with federal funding.

In addition to the slow administrative process of hiring staff, Kentucky Transitions has yet to adopt a formal staff training manual. The program currently operates using the Centers for Medicare and Medicaid Services approved version of Kentucky's operational protocol; however, this protocol serves as a general guide that outlines objectives, goals, and services and does not include specific direction for day-to-day operation. For example, when a participant is undergoing needs assessment, in

what order do specialists assess? Should housing specialists wait to locate housing until after medical needs have been determined? These questions would be best addressed in a manual or guide for staff. A staff training manual was in fact started in 2008 but little progress has been made. Now that more nurses and social workers have been hired, it is imperative that program staff and partnering organizations understand the specific responsibilities of each team member and these expectations should be outlined in a manual. Clarified responsibilities and expectations can create a process that is standardized so there is less time spent determining who does what and when. A reference manual can also provide direction for handling problems that may arise in the transition process and how to categorize patients that are dually eligible for transition categories (for example, individuals that are both physically disabled and elderly could be assigned to categories based upon either of these characteristics), both of which are absent in the operational protocol.

In regards to “self-direction”, it is recommended that the concept be more formally defined and simplified by Kentucky Transitions. The Centers for Medicare and Medicaid Services grant some flexibility in determining what constitutes self-direction by participants and Kentucky Transitions has not settled on specific qualifying criteria. Staff members note that it has been difficult to encourage patients to choose to self-direct their services because the unclear nature of the concept as well as the complicated nature of the task, both of which are unappealing to patients and their guardians. For example, the operational protocol of Kentucky Transitions suggests that one type of self-direction may include the patient overseeing the hiring and paying of

providers, which appears to be an overwhelming concept for many patients that have not lived outside of a facility and managed finances on their own for several months or years. One possible strategy of encouraging patients to self-direct some of their services could be to explain to patients in rural areas that their transportation allotment could be used to pay caregivers like neighbors and friends to provide transportation to medical appointments or social activities. This could potentially help alleviate the transportation shortage in rural areas as well as encourage partial self-direction of some services. Program participants may feel that paying caregivers for transportation is more manageable than for hiring providers and budgeting for multiple services.

It is recommended that Kentucky Transitions submit revisions to the Centers for Medicare and Medicaid Services of benchmarks to include some program-specific expenditure goals for community services. The current benchmarks #2 and #3 outline target spending levels for community services statewide, though Kentucky Transitions is not the only Medicaid program that spends on community services. It would be more useful for program evaluators to be able to compare the expenditures of Kentucky Transitions to expenditures of traditional Kentucky Medicaid waiver programs, rather than having to estimate the effect of Kentucky Transitions on total community services spending from data that is aggregated and difficult to sort. Also, a program-specific goal for participation in self-direction would be a stronger indicator of performance than the current goal, which refers to participation in self-direction among all Medicaid programs (i.e. Kentucky Transitions and traditional waiver programs). Again, this aggregate

information makes it difficult to determine how well Kentucky Transitions is promoting participation in self-direction.

In regards to the marketing and outreach of the program, data collected about referral sources indicate that social workers refer a significant percentage of program participants. Social workers have only recently been targeted as a group to which to provide promotional materials and it is recommended that similar materials and education sessions be provided to social workers that are currently being provided to nurses. Offering informational sessions during social work continuing education seminars may be a good place to start promoting Kentucky Transitions, while other groups that provide referrals like facility ombudsmen and family members of institutionalized patients should continue to receive information about the program. Facility ombudsmen, in particular, appear to be the most effective group for referring eligible participants. Sending promotional materials and providing education about the program to the approximately 170 Kentucky facility ombudsmen is a more realistic marketing strategy for promoting Kentucky Transitions than for staff members to attempt to visit Kentucky's more than 250 long-term care facilities themselves to distribute similar materials. Table 12 outlines a summary of recommendations.

*Table 12: Summary of Recommendations*

<i>Summary of Recommendations</i>	<i>Purpose</i>
Clarify Responsibilities of staff and partners, compile reference manual	Provide reference for staff
Train staff to use the web system immediately, record updating should be vigilant to ensure everyone has the same information	Maintain uniform records
Self-direction should be defined, simplified, and encouraged (especially in regards to transportation)	Clarify what constitutes self-direction
Provide materials to social workers, continue to send information to ombudsmen	Distribute promotional materials effectively
Revise benchmarks to include program-specific expenditure targets	Align goals with mission

## **Limitations of the Study**

This study has many limitations. Because the program is still in the process of implementation, measuring program outcomes would be premature. The shortage of available quantitative data limits the data collection to qualitative observations and summary statistics. It is difficult to pinpoint the significance of the evaluation results if the use of applicable statistical tools is limited. I hope that the results of this study can be used by the staff of Kentucky Transitions to gain insight into their progress and to target marketing to groups that will make productive referrals.

During the last years of the grant period, program progress should continue to be measured using federal benchmarks as indicators of performance. In addition to benchmark goals, Medicaid claims data should be utilized to measure whether or not the program has the intended effect of lowering overall expenditures on institutional care or is more cost-effective for individual patients than institutional care. Cost-effectiveness analysis of the program should take into account the less tangible benefits of transitioning patients, such as whether or not there is improvement in quality of life for patients when living in the community (Rogers, et al, 2009). In addition to cost-effectiveness analysis, the results from the Quality of Life surveys that are administered to transitioned patients could be a key component to determining “gaps” of need (Nolin, et al, 2006).

## **Conclusion**

The Kentucky Transitions program faces many challenges and barriers to transitioning patients from institutional care back into the community. By continually

monitoring progress, the program can identify areas for improvement. Though the implementation process has been slow, Kentucky Transitions has been able to meet some of their goals for the first and second year of the grant period. Patients are being transitioned more frequently now that all members of a state transition team have been in place.

## REFERENCES

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Brown, R., Irvin, C., Lipson, D., Simon, S., & Wenzlow, A. (2008). Research Design Report for the Evaluation of the Money Follows the Person (MFP) Grant Program. *Mathematica Policy Research, Inc.* Retrieved January, 2009, from Mathematica Policy Research Web Site: [http://www.mathematica-mpr.com/publications/PDFs/MFP\\_designrpt.pdf](http://www.mathematica-mpr.com/publications/PDFs/MFP_designrpt.pdf)

Castellani, P.J. (1992). Closing Institutions in New York State: Implementation and Management Lessons. *Journal of Policy Analysis and Management*, 11(4), 593-611.

Fink, A. (2005). *Evaluation Fundamentals: Insights into the Outcomes, Effectiveness, and Quality of Health Programs*. Thousand Oaks, California: Sage Publications, Inc.

Forbes, M.K., Hill, C.J., & Lynn, L.E. (2007). The Logic of Governance in Health-Care Delivery: An Analysis of the Empirical Literature. *Public Management Review*, 9(4), 453-477.

Hasnain-Wynia, R., Margolin, F.S., & Bazzoli, G.J. (2001). Models for Community Health Partnerships. *Health Forum Journal*, 44(3), 29-33.

Lipson, D., Gruman, C., Schimmel, J., Colby, M., Denny-Brown, N., Peterson, S., & Williams, S.R. (2007). Money Follows the Person Demonstration Grants: Summary of State MFP Program Applications. *Mathematica Policy Research, Inc. Report to the Centers for Medicare and Medicaid Services*. Retrieved January, 2009, from Centers for Medicare and Medicaid Services Web Site: <http://www.cms.hhs.gov/DeficitReductionAct/downloads/StateMFPGrantSummaries-All.pdf>

*Money Follows the Person Grant (Kentucky Transitions)*. (2008). Retrieved January, 2009, from Kentucky Cabinet of Health and Family Services Web Site: <http://chfs.ky.gov/dms/MFP.htm>

Money Follows the Person Grants and Rebalancing Efforts. (2009). Money Follows the Person and the Deficit Reduction Act. Retrieved February, 2009, from the Centers for Medicare and Medicaid Services Web Site: [http://www.cms.hhs.gov/DeficitReductionAct/20\\_MFP.asp](http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp)

Nolin, J., Wilburn, S.T., Wilburn, K.T., & Weaver, D. (2006). Health and Social Service Needs of Older Adults: Implementing a Community-Based Needs Assessment. *Evaluation and Program Planning*, 29, 217-226.

O'Toole, L. (1986). Policy Recommendations for Multi-Actor Implementation: An Assessment of the Field. *Journal of Public Policy*, 6(2), 250-267.

Robichau, R.W., & Lynn, L.E. (2009). The Implementation of Public Policy: Still the Missing Link. *The Policy Studies Journal*, 37(1), 21-36.

Rogers, P.J., Stevens, K., & Boymal, J. (2009). Qualitative Cost-Benefit Evaluation of Complex, Emergent Programs. *Evaluation and Program Planning*, 32, 83-90.

Smith, N. (2000). The Implementation and Evaluation of a Healthy Communities Process in Central Alberta: Some Implications for Public Health Practice. *Journal of Public Health Management and Practice*, 6(2), 11-21.

Wenzlow, A.T., & Lipson, D.J. (2009). Transitioning Medicaid Enrollees from Institutions to the Community: Number of People Eligible and Number of Transitions Targeted Under MFP. *Mathematica Policy Research, Inc. Report to the Centers for Medicare and Medicaid Services*. Retrieved January, 2009, from Centers for Medicare and Medicaid Services Web Site: [http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFPPReportsFromTheFieldNum1\\_508.pdf](http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFPPReportsFromTheFieldNum1_508.pdf)

