Administration on Aging
Affordable Care Act Training
Transitions and Long-Term Care:
A Look at MDS 3.0 Section Q and Money Follows the Person
January 30, 2012
3:00 - 4:30 pm Eastern

Coordinator: Welcome and thank you for standing by. At this time, all participants will be in a listen only mode until the question and answer session of today's conference. At that time, to ask a question over the phone please press star 1 on your touchtone phone and record your name at the prompt.

This call is being recorded. If you have any objections you may disconnect at this time. I would now like to introduce Ms. Marisa Scala-Foley. Ma'am, you may begin.

Marisa Scala-Foley: Thank you, Victor. Good afternoon everyone. Good morning those of you who are - I guess we're not quite - maybe good morning to those of you who are in Alaska or Hawaii and since we haven't talked with you all since early December, happy 2012.

My name is Marisa Scala-Foley. I work in the Office of Policy Analysis and Development at the Administration on Aging. We thank you for joining us for this month's webinar, our latest in a series of webinars focused on opportunities for the aging and disability networks, both state and local

agencies within the Patient Protection and Affordable Care Act, also known as the Affordable Care Act or the ACA. This webinar series is designed to provide the networks with the tools that you need to develop care transition work or to participate in other ACA related efforts, such as accountable care organizations, health homes and so forth that may be coming up in your area.

If you were with us on any of our 2011 webinars, because of its importance within the ACA you'll know that most of our series thus far has focused on the topic of care transitions. Clients are patients going from one care setting to anther -- from hospital to home, from hospital to skill nursing facility, from nursing facility to home and more.

Today we begin what we plan to be a multipart look throughout 2012 as a tope of care transitions and long-term supports and services. Specifically today, we'll be talking about transitions from nursing facilities back into the community. Through the Minimum Data Set 3.0 Section Q and the Money Follows the Person Program. You'll hear an overview of these programs from our presenters today. As well as how they - these programs have impacted the aging and disability network. And finally, we'll close with a view from the field. How these programs have been implemented in the state of North Carolina.

Before I introduce our speakers, we have a few housekeeping announcements. First of all, if you have not yet done so, please use the link that was included in the email confirmation you received from WebEx to get onto WebEx so that you can not only follow along with our slides as we go through them, but also ask your questions when you have them the chat function within WebEx.

If you don't have access to the email via the link that we emailed you, you can also go to www.webex.com. Click on the attend the meeting button at the top

of the page and then enter the meeting number, which is 663905636. Again, that's 663905636 and you can fill in your information. If you are asked for a password, it is AoAwebinar and that is all one word.

If for some reason you have any problems with getting in to WebEx, we do ask that you please call WebEx technical support at 1-866-569-3239. Again, that's 1-866-569-3239.

As Victor mentioned, all participants are in listen only mode right now. However, we do welcome your question throughout the course of this webinar. There are two ways that you can ask your questions.

First, through the web using the chat function in WebEx and you can enter your questions, we'll sort through them and answer them as best we can when we take breaks for questions after each set of presenters go.

In addition, after our presenters wrap up, we will offer you a chance to ask your questions through the audio line. When that time comes, Victor will give you instruction as to how to queue up to ask your questions. And if you think of any questions after the webinar or have any questions you'd like us to follow up on, you can email those to us at affordablecareact@AoA.hhs.gov. Again, that's affordablecareact@AoA.hhs.gov.

And as Victor mentioned, we are recording this webinar. We will post the recording, the slides and a transcript during the - from this webinar on the AOA website as soon as possible. Hopefully, likely by early next week.

Okay, so now enough of the housekeeping announcements. We are thrilled to have with us today a wonderful panel of speakers to talk about this very important topic of transitions and long-term care. So first up will be MaryBeth

Ribar, who is with the Centers for Medicare and Medicaid Services specifically with the Center for Medicaid CHIP and Survey and Certification. MaryBeth is a registered nurse with a B.S. degree in nursing and an M.S. degree in adult education with 16 years of clinical experience in intensive care, medical, surgical, home health and long term care nursing as well as positions directing staff development, quality assurance and infection control in nursing home.

She is currently in the CMCS Division of Community Systems Transformation and is working as the technical director and the CMS project officer for the Money Follows the Person National Evaluation Contract as well as an MSP subject matter expert for improving nursing home transitions, elderly population transitions, home and community based services quality of care outcome and the nursing home Minimum Data Set 3.0 Section Q, Return to Community. So with that, I will turn things over to you MaryBeth

MaryBeth Ribar: Yes. Thank you, Marisa. Good afternoon everybody. We have a fair number of slides here, but I will be skipping through some very quickly. I want to make a couple of important points and the relevance to you as community care providers and working on care transitions and, you know, leave plenty of time for the other presentations and questions and answers. So, we're going to just get started.

The basic think to remember about the Minimum Data Set -- many of you probably already know this. But this is the nursing facility resident assessment instrument so it is conducted as an assessment tool when all residents admitted to Medicare, Medicaid certified nursing facilities or skilled nursing facilities regardless of pay or source.

So the person you have all, you know, any kind of issue on Medicare, Medicaid, private pay combo, whatever. It's done on admissions, it's also done in critical points in time to either with significant change and quarterly as subset of elements are done at that point.

The MDS 3.0 was implemented on October 1 of 2011. In fact, that was 2010, that's a typo. And it was really the first major change that happened with MDS for, oh, a good 10 years or so. And the focus of the whole change in the instrument was to make it more person centered, talk directly to the resident and family.

And for this Section Q part, it really starts to connect people to get information to make choices about care -- you know, their care whether they want to be in an institution or in the community.

The other thing to remember about the MDS course, it's a basis for person centered care planning. Information is used then to do care planning for the resident.

Once it got implemented - on this slide, just gives you a sense of all the dialogue we did with states and the other stakeholders. So if (unintelligible) a person grantees, there are colleagues in the AAA and that ADRCs just to see how it was going and what were the things that were working well and weren't working well to identify residents who wanted to talk to someone to learn about the possibility of moving to the community.

And the referrals that were given to these local contact agencies, which were the community agencies that do information and referral and options counseling and transition work like that ADRCs and AAAs.

On the next slide, just some results of what happened when we went out and talked to folks and we had a lot of meetings - ongoing meetings and found from both the nursing facility side and the community side there were things that really needed to be improved.

So, what you see here is that we did some things to make the Section Q questions more effective. So residents are asked the question, they're given an opportunity to say what they think and want and ask to get more information.

But also to accommodate the situation where you have a resident who's been admitted and they may have -- they don't want to be asked this question all the time. They've been through all this. They've been living in the community, they've exhausted all their resources, their family can't provide care and really, they do want to be in the nursing facility at this point because they, you know, for whatever reason and they don't want us to keep asking them the question every quarterly.

The feasibility question -- that really left a lot of decision making up to the facility. They could actually kind of decide whether someone should be referred or not. So we changed that again to make it more person center.

So as a result of the first year, year and a half of implementation and getting input from all the levels of stakeholders and consumers, we made some changes and that's what you'll see on Slide 5. The feasibility of discharge item was dropped because, you know, it really left too much into the decision making of the facility staff who may or may not know what's available in the community and what a person's options for care and support and services are.

In addition, you know, as I said before, if a person doesn't want us to keep asking them the question they can say I don't want you to ask it for me. Come

back in a year but don't keep asking me every couple months. And then, of course, we clarified some language to make it more clear, you know, for use for both the nurses that serve as staff assessors as wells as the referral system.

The intent of the changes, really - but for MDS 3.0 and with these changes that get implemented in April 2012, it that just to move more and more toward a more person centered approach. You know, talking to the residents, directly. It puts them at the center of the decision making. It gives the resident a voice and a choice. And really the question itself just asks the resident directly, do you want to talk to someone about the possibility of returning to the community.

So, if they're asking the resident if they want to get information, if they want to talk to someone, it doesn't say that this can happen or not or that it has to happen or not. It's all dependent on that person's needs and preferences and choices, as well as the availability of community supports and services.

Moving on to the next slide. So, we did get some changes into the Section Q items. We've tested those in six states and then we're incorporating those changes into the April 2012 update.

Slide 8, really no changes in the question one. And we do have to go over the specifics of the questions. There is about six or so questions in Section Q of the Minimum Data Set.

The next slide, Number 9, again really no change. It's just that residents overall expectations when they're admitted. Because there actually is on admission, you know, why are you here. Do you think you're going to stay or not? Are you here for rehab? Do you want to go home? Do you think you're

going to go home? That kind of thing. So that's what this section, I mean, question three is about.

So moving to Number 10, here's where we did make some significant changes. This one question - well, there's two here. One is, is there an active discharge plan in place for the resident to return to the community?

And there's some manual directions that go along with the instrument to say, you know, depending on what the answer is to this question, you need to find why or why not there is a discharge plan in place or not for this resident and follow up on that. And if there is no active discharge plan in place then the person is asked the question, do you want to talk to someone. Another major change for this (unintelligible) question is this B, was the determination made by the resident and care planning team that the discharge to community is feasible.

That was eliminated, as I said before, because it really left too much decision making on part of the staff when they may not have the information to make that decision. And again, to put the decision making and choices in the resident and their family's court.

Moving on to page Number 11, this is part of the follow up that we added up with the four - we added a question that if there is no - you can see here, there wasn't one on the current version. But in the April 2012 version it's really asking the question, is there documentation in the resident's record stating that only to ask this question on comprehensive assessment. And then some, you know, directions around that depending on the answer.

The 500 question Return to Community on page 12, this is where we kind of get at the crux of the matter. The whole point of the changes in this section

and is to ask the resident do you want to get information, do you want to talk to someone. And prior to this, this was not the case.

Before the 3.0 version in October 2010, it was a kind of the nurse assessor or whoever did this kind of made their own judgment - well, this person's too sick, they need too many supports, they're too frail. They can't return to the community, so we're not even going to think about that. So again, this puts the decision making and the - did the person get information about choices and what's available and not available and the possibility to the resident and their family.

On Slide 13, this is where we got a the issue for residents who don't want to be asked this questions every time. We did hear form nursing facilities and families and residents, you know, especially families, with their loved one who had severe dementia. And asking this question very much upset the resident.

And then to keep asking it every, you know, three months just was not, you know, a good thing to do. It did not really help the resident or the family or, you know, do anything that was in a positive way. So this really give kind of that out for the resident or their family when it's a situation where they really don't want you to keep asking them the question that they can opt not to have it done on all the assessments. It would be asked again on annual assessments, but it doesn't have to be asked quarterly.

And then, of course, you can see that if it's a zero, you document in the resident's chart. And then also they indicate the source of the information.

Again, in Slide 14, just showing you what's in the current version that went live on October 2010 versus the April 2012 version. There change here is now

you have to document the reasons in the resident's chart why or why a referral has or has not been made.

And then we also direct the staff to Section Q, the care areas assessment, which really gives the staff some places to go and things to explore on, you know, what - where is this person, what are there supports and needs and services and what are their preferences and if a referral is not going to be made. Then what can we do here at the nursing facility, get the ball rolling or work with this resident or whatever the situation is.

Okay, I know I'm talking really fast so we'll have plenty of time for questions. Slide 15 really shows you the expected impact of the changes that are going live in April. And we learned this in the pilot testing that with dropping this feasibility of discharge item that many more residents were asked that question - do you want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community and many more did say yes. Another expected impact, we believe that there will be more referrals as a result of the changes that go into effect in April of this year.

The other thing is that on Slide 16, for residents and families who don't want to be asked this question quarterly will be less upset. It'll cause less anxiety and stress on the resident. And it should reduce the number of residents for whom the question is not appropriate or ineffective referrals we're calling it. And it works better than the feasibility of discharge question.

So, you know, of course, as with everything when you first put it in, you know, the referrals to the local contact agencies. In some cases, everyone was getting referred, even if they were there for two weeks and going out for rehab and they didn't need any supports and services, you know, arranged for, to not

having any referrals from some nursing facilities. So we've done a lot of education and outreach and training and through Money Follows the Person, as well as our colleagues at AoA.

And, you know, trying to educate people on what exactly the question is about, how to ask it, who to refer and make those referral effective for the local contact agency than to go work with the resident in the nursing facility.

So, some of the challenges that are still, you know, ahead of us and part of what, you know, this implementation is that there needs to be ongoing outreach and education to nursing facilities and nursing homes constantly. Change over in staff. Change over in resident population. Differences in the infrastructure of community supports and services that are always, you know, evolving to have more available to residents so that the nursing homes, nursing facilities and skilled nursing facilities know, you know, act on the yes I want to talk to someone question and who to make referrals to.

The challenge for all of you on the phone and as, you know, Money Follows the Person grantees, as well as AAAs, ADRCs, centers for independent living, is they have this work. You know, so any nursing home knows who to call, who to make the referral to. That referral's acted upon and the resident gets a chance to talk to some and is always referred to someone for whatever they need. Whether it be options counseling, whether it be transition planning, whether it be for looking at community resources for - that are volunteer or that can be paid for.

So, the challenges at the local level, as you guys know, making this effective referral and transition planning service process work along with your stakeholders.

There is - on Slide 18, there is a new opportunity that we've been working on and that is our partners at the Veterans Administration. In fact, this was at a, I believe, ADRC conference that AoA held that, you know, came up that, you know, we have veterans in nursing homes. And not just the stated veteran homes, in regular nursing homes. And how do they get access to these transition planning and services and supports and opportunities and learning about what's in the community.

So we've been working closely with AOA and the veterans to develop -- and we will be providing information and resources for each agency and their stakeholders so the veterans have an understanding of Money Follows the Person, as well as with AAAs and ADRCs do, we have an understanding of what they do and how we can work together.

One of the nuances of the veterans is that depending on the veteran's length of service and their disability level, they may or may not have full benefits and they may, in fact, be able to benefit for some of the Medicaid and other state services to kind of wrap around their VA benefit. The veterans program is operated at the state and local level. The fund streams vary per state. So it can get pretty complicated.

So our goal is to provide information to all of us -- both at the federal, state and local so we can start to work for veterans in a person centered approach. You know, so that appropriate referrals happen, the right people talk to each other and work with that veteran if he wants information, and also to get him back to the community or her back to the community if that's what their wishes are with the appropriate supports and services.

Let's see what we have. So that's really it. I know I spoke very quickly, but you will have the slides and Don's going to -- you see on that last one - 19 and 20 -- some resources.

And the key for all of us is that, you know, communication and partnering at the local level is where all this work is happening and needs to happen, because that's where it's going to impact the resident to both get the information they need to make choices and decisions as well as the assistance for transition planning. And, you know, for all the stakeholders to work together. For the nursing facility staff as well as the local contact agencies - the AAA and ARDCs, you know, to work together for that resident.

So I know I talk fast. Like I said, again, I just - I'm going to stop now and I - are you going to introduce John or should I, Marisa?

Marisa Scala-Foley: I will introduce John. And thank you so much.

MaryBeth Ribar: Yes, thank you everybody for your attention.

Marisa Scala-Foley: All right. So, next to talk about the Money Follows the Person rebalancing demonstration, we have John Sorenson.

John is a one time radio on air personality, but he has been an advocate all his life.

First for himself and later as a leader of a statewide self-advocate disability rights group in Maryland. Through his involvement in disability rights, he also became involved in national disability policy issues as well. Not at the Centers for Medicare and Medicaid Services, he works as a project officer on the Money Follows the Person demonstration and that helps to create a new

Minimum Data Set 3.0 Section Q that you've just heard about from MaryBeth. John has been part of the team that created the new question support materials and trainings on Section Q implementation.

So John, I will turn things over to you.

John Sorenson: Thanks very much. Can everybody hear me okay?

Marisa Scala-Foley: Yes, we can hear you just fine.

John Sorenson: Okay. Next, start slides. Okay. I'm going to discuss briefly today about Money Follows the Person program. It's been in place at CMS for five years, recently extended another five years. I'll give more details on that in a moment. But first, this slide gives you some of the current rebalancing options that CMS is offering to the public to the Medicaid programs across the country. First is the person centered hospital discharge planning and this program has - is active through September of this year as you see.

Next, of course, is the Affordable Care Act, Section 2703, which created health homes for individuals with chronic conditions. This permits states to be able to offer services for individuals with multiple chronic conditions or serious mental illnesses in their homes and was effective January of last year. It also provided a coordinated person centered care, primary acute behavioral long-term care, social services to encompass the needs of the entire person. And states receive enhanced federal FMAP or the medical assistance percentage of 90% available for (unintelligible) services for the first two years of implementation in the state.

Another of the rebalancing options currently available is the community first choice option, also known as CFC and it is a 1915(k), which is new for CMS -

the K option. And with - and it is of course the state plan option. The goal of the community first choice option is to provide person centered home and community based attendance services and supports as an optional service under the state plan. And this programs became effective October 1, 2011.

However, as many states are aware, the final regs on this are not yet published. And so, states are free to begin a program that they've created and submit their plans to CMS. But those programs may have to change depending on what the final regs are. Some states have begun to implement a CFC option, but final regs are expect soon. However, are not available yet. And the CFC offers a financial incentive of a 6% increased FMAP to states that choose the CFC option. Next, please.

Okay, finally we get to Money Follows the Person. Section 2403 of the Affordable Care Act extended Money Follows the Person for an additional five years and will now allow transitions through -- well funding will be available, I should say, to grantee through the year 2020. Although, the last bit of funding will be distributed in the year 2016. Grantees have an additional four years to spend any unused funding. So, awards made in 2016 may be utilized through 2020.

The Money Follows the Person programs supports transitions of individuals from institutions to community based care and add the resources to balance long-term care in the state. MFP offers an enhanced federal FMAP for community services for the first year an individual is in the community or actually for a total of 365 days.

Now, sometimes that year, of course, is interrupted by brief re-institutionalization and once an individual is able to return to the community, they can again pick up where they left off in their year of service in the MFP

program. If they're in an institution for a longer period of time, they are permitted to rejoin the MFP program and can get an additional year of support if they've been institutionalized for more than 90 days.

Currently we have 43 states and the District of Columbia participating in MFP. There was recently a second solicitation that added an additional 12 states late last year. And here's the map of currently participating states. Now you see we have a big slice down - I guess that's the Mountain Time Zone and then Alabama. We do have plans to put out another solicitation and hopefully bring in those remaining - I believe it's those seven states including Alaska and America Samoa. Next, please.

Thank you. The goals of MFP are to transition individuals to the community, as I said, institutional long-term care settings and to use support states to rebalance their long-term care systems by elimination barriers to home and community based services and transitioning from intuitional settings. And by eliminating barriers, what we mean is there are features of the MFP program, including the enhanced FMAP which can be up to 90% per state and a supplemental service category that allows states to support certain things that will make a transition possible that aren't typically funded by Medicaid.

A state can receive its standard FMAP reimbursement for supplemental services and state is expected to use its savings over an individual's institutional cost over that one year that they participate in the program to reinvest in the state on the community base services and increase access to and availability of those services. Another goal of MFP is, of course, to assure quality procedures. Next, please.

MFP has a very specific quality management system built into the program in addition to the standard waiver of quality requirements. There are three

additional requirements in MFP that states must insure and those are risk assessment and mitigation processes, which are reviewed by CMS and must be approved prior to an MFP program implementation. A 24 hour emergency backup system or an individual that has been transitioned is required, as well as an incident report management system. And, of course, these processes vary by state, but they are all required for MFP bonding. Next, please.

Categories of service, I mentioned briefly earlier under MFP they are qualified to have a community based services and those are typically qualified under waiver of service packages, services that beneficiaries receive. There are also demonstration services which are services the state doesn't currently offer under waivers or they plan but can't offer under MFP or program participants and the state can receive the enhanced FMAP rate that is available to that state for demonstration services.

And then finally, as the supplemental services category, which is one time or limited duration of services to support an individual's successful transition to the community not typically supported by Medicaid, but a state can receive its regular FMAP for these services under the MFP program. Next.

Now this may be a little bit hard to see on some of your computers. I know I have a very tiny computer for my job here at home. But, this is a pie chart showing the distribution last year of MFP transitions and then you'll note there's a 7 1/2% wedge there that we later found enough and labeled and that will be our other category.

Those are folks that have been unidentified because of missing documentation identifiers such as names or Social Security numbers have not been available, but you'll see the hottest proportion of transitions under MFP have been persons with disabilities under the age of 65 and then the next highest

category are older adults. With persons with developmental disabilities being next and then probably most of the 1.85 would be dual eligible individuals.

Next slide, I'm sorry. You can that there were approximately 16,000 individuals have been transitioned under MFP since its inception in 2008. Thank you. Medicaid and the Affordable Care Act Section 2403, Money Follows the Person. ADRC, MFP has done - I'm sorry, let me back up a little. MFP, CMS has partnered with AOA recently under a couple of initiatives including increasing work of the Ombudsman program and helping to develop aging and disability resource centers, which are of course supported by the agency on aging.

Recently, through this partnership AOA and CMS under MFP offered supplemental funding to our MFP grantees in 25 states, up to $400,000.00 to grow their ADRC network to support transitions and to help better utilize and implement MDS 3.0 Section Q. States eligible for the 2012 ADRC would get this originally is 2010.

As you see on the slide, there were 25 states and then this year, eligible states will be these 12 that are - 12 or so that are listed here. MFP states will submit their regular budget in early 2012 and will include this money once approved to receive it and that should happen by April of this year.

As I've said briefly earlier, CMS is planning a third solicitation for the Money Follows the Person program in the hopes of bringing in those remaining seven states. And this is expected to come out some time probably mid to late February or early March, and awards by summer time. Next, please.

Oh, okay. That does it for me. Thank you very much.

Marisa Scala-Foley: Okay, thank you so much, John. Our final presenter in this first sort of group of presenters is Becky Kurtz. Since July 2010, Becky has been the Director of the Office of Long Term Care Ombudsman program within AoA. In this capacity, she promotes effective ombudsman services for our nation's long-term care facility residents and advocates for resident interests at the nation level.

Prior to coming to AoA, she was Georgia's State Long Term Care Ombudsman for 16 years and during that time, she served various leadership roles in the National Association of State Long Term Care Ombudsman programs, including serving as its president from 2004 to 2006. So with that, I will turn things over to you Becky.

Becky Kurtz: Thanks Marisa, and hello to everyone on the call.

I want to -- actually go back one slide, Marisa, for just a second. I just wanted to say sort of the purpose of what I'm talking about is an overview of where the work of the aging network intersects with the CMS initiatives that MaryBeth and John have just described.

So I really want to give you sort of a sense of what's happening among the state, what's been happening over the last five years of the history of MFP, as well as the one year plus history of MDS 3.0. And then talk a little bit about some opportunities and resources for further aging network involvement in supporting nursing home residents who which to transition to community alternatives.

So, the policy objective of these transition programs that we've just been talking about are very consistent with the objectives that are laid out for the aging networks and the Older Americans Act which, of course, created

governs and provides core funding for the aging network. Among the objectives in the Older Americans Act is freedom, independence and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community based services and programs provided for their benefit and protection against abuse, neglect and exploitation.

Of course, I should say the their is older Americans. But you can see that's a really close fit with the kind of objectives that are going on in the nursing home transition programs. Next slide.

The aging network, of course, as folks on this call know well, consists of the state agencies on aging, area agencies on aging, service providers and the tribe. So I want to talk about five areas where the role of the aging network in supporting nursing home transitions work has really emerged. I see those in five areas - providing consumers with assistance with transition, increased demand for this long-term services and supports that are provided by the aging network, state and local policy development implementation. Fourth, ombudsman resident advocacy and fifth, follow up after transition activities.

So I want to go through each of those five areas and give you some examples.

In the first area, providing information or actually it's more than information, it's also assistance with transition more broadly from nursing home to home and community based services. First of all, there's the very basic, but very important, role that the aging network has provided for many, many years, which is that information and referral piece. Providing information that help consumers get access to long term supports and services in the community.

But, when MDS 3.0 Section Q came in October 2010, it came with a requirement, the question that MaryBeth covered - Section Q says that if you want - if you the resident in a nursing facility want information about what's available in the community for you that then you need to be referred to a local contact agency. But that local contact agency was never - it was never determined for states who that would be.

And so some states found themselves scrambling to find out who will that be in our state. Other states had a ready answer for that. Some states had ADRCs ready to go. Some states have a AAA network ready to fill that role or a combine of AAAs and SIL centers for independent living. Or maybe there were Money Follows the Person transition agencies that were already in place ready to fill that role.

So states took a different approaches to filling this local contact agency role. But in many states, it involved some or all of the aging network. So the local contact agencies or the LCAs today have been met in 12 states by the ADRCs only. So that 12 states, statewide ADRC are not performing that role - the Aging and Disability Resource Centers. But in 39 states, ADRCs play at least one of those - one of the roles. It might be a combination of entities that provide that service. So, the aging network has definitely stepped up to the plate in terms of participating in this requirement or in these needs - (unintelligible) need.

So just a word about the role of ADRCs with the goal of it being a single coordinated system of information and access for all persons seeking long term support and can minimize confusion, enhance individual choice and support in form decision making, it was a clear opportunity for ADRCs to fill those ACA roles - very lots of synergy there. And just to remind you that most ADRCs, not all, but most do include area agency on aging involvement - 71%.

And there are 383 ADRC programs in 51 states and territories, which cover 60% of the population. So, it's not universal, but it's definitely an area where we've seen tremendous growth in the aging network.

So the role of ADRCs with respect to CMS's initiatives and how AOA has been envisioning their work together with CMS on ADRCs is looking to catalyze broader systems change, to promote participant direction, to build stronger partnerships across a fragmented system for long term supports and services, to intervene during care transitions and certain this is one of those transition times, to assist with institutional transitions as we mentioned and to implement a new initiative, including MDS 3.0 Section Q.

The synergy, as I mentioned, between the development of the ADRCs and the need for the local contacts agencies as part of MDS 3.0 Section Q, really can't be overstated. And I think both CMS and AOA saw this as a real opportunity for partnership and many states saw this opportunity and continued to see this opportunity. So at the same time, you've got the MDS 3.0 going on and its need for the LCAs and you've got ADRC development going on.

You also have simultaneously this Money Follows the Person program demonstration project which has not only been going on for a few years, but has been now extended and reinvigorated during the Affordable Care Act. And that has presented some opportunities for resources and John did a nice job of explaining what some of those opportunities have been. Some targeted at ADRCs, some targeted at ombudsman programs and some more broad for state systems, which certainly can include the aging network.

And so the MSP funding has been available to help support aging network involvement in the success of Section Q implementation. The next slide.

So the second area where we've seen aging network involvement, whether they want it or not, is that aging networks have seen increased demands for the long term supports and services that the network provide. As people move out of nursing homes and into other settings, they definitely require more of the services that are provided through the aging network. Certainly, those can be the Older Americans Act funded home and community based services, including nutrition, supports and social services and caregiver services that are available in every state and territory.

But also, the aging network has such an important role to play in many states in Medicaid, home and community-based service waiver programs. Thirty-two states providing those services through the Aging Network.

So that's another demand for services that hits the Aging Network when people are transitioned into those Medicaid waiver programs.

In addition, 24 states through the Aging Network state fund additional home and community-based services. And in some states the Aging Network is actually providing the MFP -- the Money Follows the Person -- transition services. Ohio and Georgia being a couple examples of that.

Next.

So the third area where we've seen Aging Network involvement has been at the state and local level policy, development and implementation of these initiatives.

So we've seen state units on aging, state long-term care ombudsman, and others in the Aging Network engaging with their state Medicaid agencies and others to help design and implement MFP and Section Q initiatives.

So some examples we've seen have been in actually developing the Money Follows the Person protocols for that state and the evaluation processes for the state to get a sense of how well MFP is doing.

We've seen the Aging Network involved in designing the Local Contact Agency processes. As I mentioned before, the Aging Network often was the best fit in the state to provide that information service. And we'll be hearing more from North Carolina about their process. But they've developed a toolkit that's real helpful in that regard.

Excuse me. We've also seen the Aging Network play a very critical role in educating consumers and also nursing home staff about how to implement Section Q, and what it's all about and why am I being asked this question if I'm a consumer or a family member trying to understand why are they asking my family member this question about returning to the community. Giving some context for it and helping people understand the value and the importance of asking that question, and then what their opportunities are for getting more information. And Nebraska had some good examples related to that.

So some states have been doing this already, as I mentioned. Some are in the midst of doing these activities. And some still have some outstanding opportunities to step up to the plate. And certainly those seven states that have not had Money Follows the Person funds yet have some great opportunities coming if those states want to take advantage of the Money Follows the Person demonstration projects.

But whether or not you -- as a state Aging Network -- are engaged in helping, design and implement MFP and or the Section Q processes and systems in your state or your local area, you're undoubtedly seeing the impact of these initiatives on your services and demand for your services.

The fourth area I wanted to speak about was ombudsman residency advocacy sense. Of course the Ombudsman Program is present in facilities on a regular basis and working with residents anyway. It makes sense that they would be very involved in transitioning and helping residents who wish to transition to home and community-based services.

As MaryBeth pointed out, the implementation of Section Q happened in October 2010. And soon after that there was a letter from CMS and AoA that went out to the Aging Network -- as well as to Medicaid agencies at the state level -- saying that ombudsmen are an important stakeholder that should be included in the development and implementation of all MFP programs.

They're a critical resource to provide information to the state Medicaid agency on how the Section Q referral and follow-up process is functioning and to handle consumer complaints should they arrive. Any state that currently has an MFP demonstration grant program can request supplemental administrative funds to work directly with the state ombudsmen. And certainly we've seen some states take advantage of that opportunity.

Next slide.

To continue that ombudsman helps. By being involved, ombudsmen help keep the process focused on the consumer's priorities. And they have been involved in a number of activities related to nursing home transitions, including

conducting outreach to residents -- Oklahoma and Nebraska being a couple of states that have done good work in that area -- educating residents and families about the Section Q process and home and community-based service options, making referrals to the LCAs supporting residents through the process of transition planning and resolving consumer complaints related to the Section Q process.

Since the inception of Section Q we've been looking at some ombudsman data. And in FY'10 we saw a 41% increase in ombudsman complaints in the area of nursing home residents seeking requests for less restrictive placements. We're expecting to get our FY'11 data in very soon. In fact, data is due this week. And when we see that data come in we're expecting that we'll see an even greater increase in demand because that will reflect the year that Section Q was actually implemented.

Lastly I wanted to talk about follow-up after transition. The Aging Network does a number of things related to individuals when they've transitioned out of a nursing home and into home and community-based services.

In addition to the case management and the actual provision of home and community-based services, some states are participating in Money Follows the Person quality of life surveys. Michigan is one program where the Ombudsman Program participates in that.

Of course there's always access to Adult Protective Services and Elder Abuse Prevention Services and legal services when those needs arise. And ombudsman has followed up providing complaint resolution in a number of situations.

So for example, if the individual is in assisted living or board and care, then the ombudsman is visiting those locations anyway with an exception. Money Follows the Person only provides services to people in congregate settings of four beds or less. But Section Q referrals can be to any home and community-based service setting. So ombudsmen have often followed up in those settings.

In addition, in 12 states ombudsmen do complaint resolution services in in-home settings. So they could certainly be available for complaint resolution in those settings.

And then in a couple of states - at least Georgia and Delaware, so the states have expanded ombudsman services to provide in-home services to MFP consumers.

So for the next slide I'm going to talk a little bit about some lessons learned. One lesson that we've learned is that if AAA has developed the capacity to do ADRC work or care transitions work or the (VDHCBS) work, they will have developed much of the same capacity and can leverage that capacity to serve as the Local Contact Agency under MDS 3.0 Section Q or for MFP transition work. It requires many of the same core functions.

And by partnering with MFP, the Aging Network has access to the resources that are needed to help individual residents and state systems succeed in transitions work.

Next slide.

Marisa Scala-Foley: Becky, I need you to wrap this up in a couple of minutes.

Becky Kurtz: Yes. Over the past year AOA has worked with the National Ombudsman Reporting -- excuse me -- National Ombudsman Resource Center -- which is at Consumer Voice -- to ask ombudsmen across the nation about their experiences with Section Q. And they've shared these with CMS as well.

So just to end on what are we seeing after the first year of implementation.

Challenges we've seen have been insufficient community resources to accommodate the transition -- including housing -- lack of timeliness of the process, challenges in discussing community options with residents with dementia or diminished capacity, family and guardian disagreements, and the emotional stress and anxiety residents experience from being asked the question. And you heard MaryBeth talk about some of the changes that are being made in response to some of those challenges.

Some of the successes that we've heard. Most importantly, residents who wish to are being returned to the community. There's improved collaboration and communication between nursing home staff and other agencies. Nursing homes have improved their communication with residents. And residents have a better understanding of their rights and options.

So to conclude, through initiatives such as MDS 3.0 Section Q and MFP, CMS, AOA, nursing homes and the Aging Network are indeed helping increasing numbers of nursing home residents experience freedom, independence and the free exercise of individual initiatives in planning and managing their own lives and full participation in the planning and operation of community-based services and programs provided for their benefit.

Thanks so much for this opportunity.

Marisa Scala-Foley: All right. Thank you to all of our first set of presenters, MaryBeth, John and Becky.

We're going to take a couple of minutes to answer a few of the questions that have come in through chat so that we can have time for our presenters from North Carolina to talk about how these things are working in their state.

The first question came in from Jennifer, who asks -- hold on a minute, scrolled out -- "Who has the responsibility of monitoring or oversight whether or not the MDS 3.0 Section Q is actually being implemented?"

MaryBeth Ribar: Oh man. This is MaryBeth. We've gotten that question over and over again. So let me tell the group where we are with things right now.

We cannot pursue - we were told that it is not possible to pursue having it part of the long-term care survey process to look at how this is being implemented. That because of what's happening with that, you know, they're doing a computerized as well as the old one, they've got multiple critical issues, we just cannot pursue that.

So here's what we have in place right now. Via the Money Follows the Person Grant Program and the ADRC Grant Program, the grantees have to report every six months on their implementation status.

And we've put into their Web report -- which is looked at by our national evaluators and calculated and analyzed and provided to CMS -- responses to certain key questions. And they include things such as how many referrals have you received as a result of the MDS Section Q?

And from the referrals you received, how many - there's follow-up questions. How many have resulted in effective transition to the community?

In addition, at least from Money Follows the Person we are doing some in-depth analysis on both the level of care needs of individuals in the nursing facilities as baseline and the individuals who are being moved out under MFP.

So those are like what we have in place right now. We also are going to be doing some data collection via our own data systems to look at how many people are saying yes they want to talk to someone. And of those people who say yes, how many people were referred to a Local Contact Agency?

So we're doing a lot of information gathering at this point in time to kind of get both a baseline and trending moving forward. After the April 2012 version gets implemented and we get this trending information -- which will take about another year or so just to see kind of what is happening -- we are also, you know, getting (unintelligible) information for a variety of stakeholders on how this is going and, you know, the implications of not having a formalized approach to check on the implementation status. So that's where we are right now.

Marisa Scala-Foley: Okay. I think we'll take one more question right now so we can give others a chance to present. We got a question in from Evelyn who asks, "If someone has received funds from Money Follows the Person twice and both times after returning home that person had to be readmitted to a nursing facility. Are there any - and they think they may want to try again a third time if they qualify for MFP. Is there any limit to how many times a person can be sort of readmitted and transferred out again?"

John Sorenson: MaryBeth, do you want me to get this one or do you want to do it?

MaryBeth Ribar: Yes. Go ahead, John. Go ahead and do it and I'll, you know, chime in if there's anything else.

John Sorenson: Okay. At this time we've not established a maximum number of times that an individual can participate in the program. However, it sounds, you know, in a situation like that it sounds as though there hasn't really been very good care planning going on prior to or post-discharge for an individual.

If they're coming out under MFP, you know, the idea is that we offer this extended range of services -- particularly at the time of discharge -- and so if there's something going on that's causing an individual to be re-institutionalized repeatedly, then there must be something going on with the care planning.

But as I said, no, we don't have a maximum number of times an individual can participate. And if someone is institutionalized for more than 90 days they are eligible to basically re-up in the program and begin a brand new 365 days.

Marisa Scala-Foley: Okay. I think with that, in the interest of making sure we have enough time for Trish and Lorrie to present, I think we're going to stop with the questions for right now. Hopefully we should have about 10 or so minutes at the end where we can clear up some of the other questions that have come in through chat and also take questions through the audio lines.

So with that, I think we're going to turn to our final presentation. North Carolina's no holds presentation about Money Follows the Person, ADRCs, Local Contact Agencies and getting people home.

And to do that presentation we have Trish Farnham, who has been the Project Director of North Carolina's Money Follows the Person Demonstration Project since January of 2010 and has been supporting people to live in their own homes and communities for nearly 20 years as a Direct Support Worker, a Job Coach, an Executive Director of a supported living organization, and an Advisor on Developmental Disability Services to the state of New Mexico.

Joining her is Lorrie Roth, who is the North Carolina Community Living Coordinator providing leadership for North Carolina's Local Contact Agency network whose mission is the facilitation of institutionalized individuals' transitions to community living.

Before that she was employed as the Piedmont Triad - the Resource Coordinator for two years developing and implementing the network of community providers that comprise a regional community resource connection for aging and disabilities, their ADRC.

So with that, I will turn things over to Trish.

Trish Farnham: Thank you, Marisa. Can you hear me?

Marisa Scala-Foley: Yes, we can hear you.

Trish Farnham: I just want to make sure I took myself off mute.

Thanks so much for this opportunity. We're really excited to present on what our experience has been in North Carolina. We were very honored to be asked. We want to make sure everybody's very clear that we are still in our learning phase ourselves.

So while we have certainly learned some lessons and I think implemented some things that are maybe some promising practices, we certainly have a lot of learning to do ourselves. And I appreciate the opportunity to kind of learn collectively with other people.

Importantly, as the Money Follows the Person Project Director, I think it's really important for people to hear directly how strong and how important we feel the collaboration is with our ADRC network. And so, we're really honored to be kind of co-presenting this with a colleague from our sister agency, the Division of Aging and Adult Services. And that's Lorrie Roth, who actually serves as the state's LCA Coordinator. And that's housed within our ADRC network.

So we have a saying kind of within our own projects that MFP is a public initiative but it's a community effort. And really the ADRC's role in our MDS Section Q work and also just our transition work in general I think really honors that spirit.

So I'm going to start before handing it over to Lorrie. We're going to tag team a little bit. And I'm just going give some very basic background about where we are in North Carolina's Money Follows the Person program.

We are still a fairly young program. We started supporting people to transition under MFP in North Carolina in 2009. Currently we support three primary groups of folks, although we're really excited to (maybe) expand this. But that's individuals with intellectual and developmental disabilities, individuals with physical disabilities, and older adults.

Historically I think it's fair to say that North Carolina's state-level transition infrastructure has been more coordinated for individuals with IDD than for

individuals within the physical disability and aging community. There's a lot more local activity for those transitions.

And I think it's fair to say that our ADRC network and MDS 3.0 really helped move that kind of state-level coordination further along. And so we're very appreciative of the opportunities that both of those initiatives have created.

And I'm going to hand it over to Lorrie to get some background about our ADRC network.

Lorrie Roth: Okay. Thank you, Trish. And I'm hoping everybody can hear me.

Marisa Scala-Foley: We can hear you, Lorrie.

Lorrie Roth: Okay. Again like Trish, I want to make sure that I have it off of mute.

Trish has asked me to give a brief overview of how the ADRCs were sort of setup in North Carolina. And at the very beginning I want to give some props to all of the people who spoke before me because they set this up very well for us.

The ADRCs in North Carolina are the LCA, they were designated by our Division of Medical Assistance. And so we are one of those states where they are the organization that was designated to provide those services.

Our ADRCs -- as mentioned earlier -- are actually called Community Resource Connections because North Carolina felt that that was a little bit more descriptive since we were taking the No Wrong Door approach that it's more of a network rather than a center, which the Aging and Disability Resource Center kind of made you think of bricks and mortar.

And North Carolina has really taken the path that it's more this network of providers, the aging providers, the Centers for Independent Living, all of those community-based providers who come together to provide these services to the individuals that need them.

Originally we had two pilot projects that started back in 2004 and 2005. And then in 2008 we - North Carolina got some more money and we were able to start expanding the ADRC project, and that's when we started calling it a Community Resource Connection.

And we had six additional areas that developed any kind of ADRC you could think. We had some single county ADRCs, we had some multi-counties. And we also had a regional ADRC that was being developed in those next couple years. And actually currently we're up to 14 separate CRCs and we still don't cover the entirety of North Carolina.

There are 100 counties in North Carolina. And we have - there are a number of areas that are very urban. Lot of you folks will know of Charlotte and Raleigh and Greensboro, those areas where it's a very urban area. But we also have the counties that are out in the mountains and down at the beach and everywhere in between that are more rural. And so it really - you have to be very flexible when you're putting this network together because it functions very differently depending on what type of an area you're covering.

And what we found is in a lot of the areas the local networks were already very well formed and they had lots of connections that were already there and had been there for a long time, and we just build upon those.

Again, I mentioned earlier the typical anchoring partners are the same folks - the usual suspects -- as I call them -- that were mentioned before. The AAA, the Councils on Aging, the Centers for Independent Living, our Vocational Rehab Independent Living programs, the Department of Social Services. And in the Department of Social Services, a lot of times it's our Aging and Adult Service Division as well as our Medicaid units.

Our goal is for our ADRCs to be statewide by the end of 2012. And MFP is helping us to be able to do that.

And why I say that is because we were using some of our MFP funds to feed money to develop the Local Contact Agency organizations which then are going to blossom into the ADRCs in regions where they don't already exist.

And the last thing on this slide that I want to address before allowing Trish to talk a little bit more about how this emerged was one of our long-range goals is figuring out our transition teams.

And that sort of is where do the LCA functions end and where do the transition team functions begin and how do our partners at the nursing home fit in and the ombudsmen and all of those folks that, again, we mentioned earlier by some of the other presenters, they're all present in North Carolina. And so it's just trying to figure out how those teams work. And in different areas, who takes the lead and when.

And so Trish, I'll turn it over to you for the next slide, which is titled How the Structure Emerged.

Trish Farnham: Just to give people a little bit of history about how our partnership came to being. When MDS Section Q was first kind of coming down the pike, North

Carolina's Medicaid Agency -- the Division of Medical Assistance -- had not yet identified a Local Contact Agency.

And so we all started at the state level kind of coming together with our Community Resource Connections, State Director, MFP and an MDS 3.0 Steering Committee, which included folks from our Oversight (unintelligible), our ombudsman network, nursing facility representatives, community services representatives kind of coming together to say what made the most sense for us in North Carolina for this function.

And it became very clear that the Local Contact Agency function is really a logical extension of the CRC's options counseling role. And so we started working with the Community Resource Connection's networks and those local directors to really think through what would be the protocols for this LCA function, how could it best work, really getting feedback, making some missteps frankly in our assumptions, and then working together to correct those, and really kind of developing the protocols for how the LCA service and function would be implemented in our state.

We use MFP administrative funding and continue to use MFP administrative funding in addition to what we call the (opportunities) grant funding, which is the AOA CMS grant funding available, became available in 2010. That was mentioned earlier.

And through those resources not only did we create a reimbursement structure for the LCA function, but we also used it to fund things about outreach. I couldn't agree with MaryBeth's point more about the importance of educating and reeducating and introducing these concepts over and over and over again to nursing facilities and to community partners.

And so we did a statewide roadshow to go and talk to folks at the regional level about all of the stuff that we were talking about and what we were trying to accomplish with it.

Lorrie?

Lorrie Roth: Okay. And the way that the LCA currently is structured is we are using the MFP funds to expand into other areas where we don't have CRC implementation. And the Division of Aging and Adult Services, we're using the existing structure that they use through the AAA. And that allows us to get the funds out very quickly.

And that's especially important in the areas where -- as I mentioned -- we don't have current CRCs working, and get partners identified that can provide the LCA options counseling to the referrals that we are getting.

And so where we had CRCs or ADRCs they identified an LCA. And it may be - it's exactly the way they described it. It may be one entity for that CRC, it may be multiple entities. Where we have CRCs that are over multiple counties, it may be a different entity for each different county.

I have one county that has their Division of Social Service folks each cover their county, but then they have a Center for Independent Living that covers multiple counties, so they're covering more than one county for them. And it depends on the type of referral we get which one of those agencies that referral gets fed to.

And as I mentioned, in the areas where there are no CRCs, we are having the - the AAAs are the ones that are using the funds to - they're using them to identify organizations that will function that way and to help them put all of

the processes in the place that they need to. And so we're referring to that as feed money because the goal is that the LCAs will then grow into the CRC, they'll just be the very first bud coming out onto that branch.

And the next slide I'm not going to go through. But I just wanted to - earlier it was mentioned that we have a toolkit that we had developed. And in that toolkit one of the first pages is actually this flowchart. And it just sort of goes through step-by-step what happens from the time that a facility calls our call center.

We do have a statewide call center, so there's one phone number that's provided to all of the nursing homes. And when they have a referral from an individual who's interested in getting information, they call that one call center. And from that call center then the referrals are directed out to whatever LCA they need to go to that covers that region or that county or that territory that the nursing home is located in.

And like I said, they're just different steps to follow along that timeline about how we want that referral to be handled through the very last step, which says that they document their activities and submit the appropriate paperwork.

We also in that toolkit provide them with some standard forms that they can use to communicate with the nursing home, forms that they can use to communicate when there is a desire for MFP applications to be completed and submitted.

We give them some questions that they can ask to collect information that they will need from the individual so that they can provide the appropriate options counseling that they will need to do when they actually meet with them.

Let me go to the next - lessons learned, what works.

One of the things that Trish mentioned is the roadshows. The thing that really works is that we have a good working relationship between the Division of Medical Assistance who is charged with implementing the MDS 3.0, and the Division of Aging and Adult Service who is overseeing the Local Contact Agencies, and the Division of Health Facility Regulation who is charged with going out and overseeing the nursing homes that are asking the MDS questions.

And the three of us all came together and did what we refer to as our roadshows. We did five of them across the state. We had between 433 to up to 500 individuals who attended these roadshows. And they ranged from social workers at skilled nursing facilities to ombudsman, CRC partners, folks from voc rehab, folks from the Centers of Independent Living, in some cases any of the other home and community-based services that might be a part of a transition were invited to come to these roadshows to learn more about how this whole process worked and where they might fit into that.

And I do want to put a shout out to the Ombudsman Program because they were very instrumental in helping us put these on. They helped us to identify locations and all that sort of thing. So the Ombudsman Program in North Carolina was very involved with the roadshows we did to promote the information that we needed to get out about it.

And another thing that works well about the structure that we have in place is that we do have a lot of local knowledge. We have a lot of good relationships that already exist and we just have built on that. We've overlain a structure

that already was there as opposed to developing a whole new one. We used that and that was a big strength.

Also it allowed us -- like I said -- to get word out about MFP because a lot of folks did not know about that.

And the one thing I want to say about funding is we used up funding and we based it on the number of skilled nursing facility beds across the state and also the square mileage area that those beds, you know, drew from.

Again, when you have a large state and part of being rural, you have to be very conscious of being able to supply the appropriate amount of funding for those rural areas because they may not have as many beds but they may have a lot more driving that the need to do to get out to those folks.

And I think that's pretty much all that I wanted to really say about some of the lessons that we learned. And I guess the biggest lesson is the collaboration is the biggest key to bring all of the stakeholders together to develop your protocols and also to implement and then to do the outreach. It's very important that you have all of your folks at the table.

And I think Trish is going to talk a little bit about some of the challenges that we've encountered.

Marisa Scala-Foley: We've got two more minutes.

Trish Farnham: Yes. And I'm going to keep this pretty short.

We've already highlighted either directly or indirectly several of these challenges, so I won't spend any time on them. But I do want to highlight the last two on there because I think this is noteworthy.

I think one of the challenges we've experienced as project is that there is still a relatively weak correlation between the LCA visits and the MFP applications that those visits produce.

As an example, in 2011 less than 5% of our MFP total application volume was a result of an LCA visit. I think that there's a real chance that some of the changes that are going to go in effect in April 2012 through the MDS 3.0 will probably address that. I bet there's going to be a stronger correlation this year than there was last year.

And the other thing is the communication challenges. I think for us as a state there were so many partners involved that sometimes we had a case of kind of who's on first. And I think -- just like Lorrie said -- the key solution to that challenge is the ongoing communication with collaborators and partners within the state agencies, and very importantly with your partners at the local level. And constantly asking for feedback and constantly tweaking and reworking your systems to make them more responsive for people.

And I think I'm actually going to stop there, Marisa, unless people have questions.

Marisa Scala-Foley: We do have questions. But before we turn to those, I'm going to just take a couple of minutes to talk a little bit about -- as we always do on these webinars we have created for you all -- a couple of slides looking at different resources related to the topic, the topics at hand.

We have a slide on resources on the MDS 3.0, one on MFP, and another one just on general resources on the Affordable Care Act, including a link to the page where all of our webinar recordings, transcripts and slides are stored.

As lots of you have asked and I've answered, we will make the slides recording and transcript from this webinar available on the AOA Web site likely within the next week. If you need the slides sooner than that, please do contact us via email at AffordableCareAct@AoA.hhs.gov.

And we hope you would join - before we move to questions, we hope you will join us next month when we will shift our focus a little bit to talking a little bit about prevention.

In honor of American Heart Month we'll continue our webinar series. We'll look at the HHS' Million Hearts campaign as well as an AOA-funded Chronic Disease Self-Management Program in Florida that works with people with cardiovascular disease. Please check your email in early February for registration information.

So with that, (Victor) - we have about five minutes left for questions. Victor, if you could give people instructions as to how they can queue up through the audio line. While we're waiting for people to queue up, then we'll take a couple of questions from chat.

We probably won't be able to answer all the questions that have come in through chat. If any of these are burning questions you can also feel free to email us at AffordableCareAct@AoA.hhs.gov and we'll make sure your questions get answered.

So Victor, if you could give people instruction.

Coordinator: We will now begin the question-and-answer session. To ask a question, please press star 1 on your touchtone phone and record your name at the prompt. Your name is required to introduce your question. To withdraw your question press star 2.

One moment please for incoming questions.

Marisa Scala-Foley: Okay. While we're waiting for people to queue up, I'll take a couple of the questions from chat.

The first one came from Michael. And I believe this question is for John or MaryBeth. I think when you were talking briefly about health homes, you mentioned the term serious mental health illnesses. He wanted to get a little bit of clarification about what is considered to be a serious mental illness.

John Sorenson: MaryBeth, I'm going to throw this one to you.

MaryBeth Ribar: Yes, I know that answer I think. But anyway, it's those things that are more severe. In other words, bipolar depression, schizophrenia, severe depression, things that require ongoing medical and behavioral support, as well as support in the community so that person can cope and live and be -- lack of a better word -- successful.

So it's the major mental in the (unintelligible) -- I always do that wrong -- is major mental illness classification.

Marisa Scala-Foley: Okay, thank you MaryBeth.

John Sorenson: DSM...

Marisa Scala-Foley: Oh sorry. Go ahead, John.

John Sorenson: No, I said I think it's the DSM 3 she's talking about.

MaryBeth Ribar: Yes, thank you John. I had a total blank.

Marisa Scala-Foley: Okay, we got another question from Kathy, which I believe is meant for Trish and Lorrie. And she asks if in your work as a Local Contact Agency if you're finding resistance from nursing homes.

Trish Farnham: I'm actually going to defer to Lorrie on that one.

Lorrie Roth: Okay Trish. And yes. I mean I know that's a quick answer. But there are some nursing homes that make referrals very easily and understand it - and have a good understanding of it. And there are other ones that we've not seen any referrals from at all.

Or when we do interact with them they're concerned about some of the same things. I think -- and I don't want to say the wrong thing -- whether it was MaryBeth talked about at the very beginning about them being concerned about building folks' hopes up and then they're not able to actually transition.

So we are working with them so that they understand that we're not guaranteeing a transition, we just want to come in and talk with those folks about possible options if there are any.

So we do see some hesitancy.

Marisa Scala-Foley: All right. Victor, have we gotten any questions come in through the audio lone?

Coordinator: There are no questions at this time, ma'am.

Marisa Scala-Foley: Okay, then we'll take a couple more through chat and we'll check one more time and then we'll close things out.

We got a question in from Shelly -- and this may be for any of you actually -- who asks if there's any state-specific data available on how many referrals have been made to Local Contact Agencies.

MaryBeth Ribar: Oh there are. This is MaryBeth. There definitely are. I said that very half literally, I guess. But I know that Michigan and I know this one state that's been tracking this. Even before Money Follows the Person they've been tracking transitions and different things.

I know there's other states. But you know where we probably could find that is through new additions is the Technical Assistance Contractor for the Money Follows the Person Program. And we could ask them if they have any information about that from the state.

John Sorenson: MaryBeth, I'm going to jump in for a second. This is John. I do know that some MFP grantees track this data but not all, and we don't have a requirement that it be tracked. I think this likely not - this is an educated guess on my part, but I think that our TA provider -- as MaryBeth stated -- new additions might be able to find data for you for a specific state, but I don't believe it's part of their work to keep that information for each state.

So if it were requested by an individual or a program they'd likely be able to get that information for you.

MaryBeth Ribar: Yes, and one of the things that -- thanks John -- I talked about CMS is pursuing and we're hoping to in the next three months or so we'll be doing data runs on - and it will be state - at state level. How many people said yes? And of those people who said yes, how many people were referred?

Now of course there's a lot of caveats and variables around that and what it doesn't tell us, but we're going to just start to look at it just to kind of get trends on, you know, what's happening and give us information to the states, you know, the Medicaid agencies.

Lorrie Roth: And this is Lorrie. And I'm going to say a yay. In North Carolina we happen to know how many MDS referrals were made simply because we have a central call center.

And so because every nursing home that makes an MDS referral has to call that call center, we can track what nursing homes they came from and how many there are. But that doesn't answer the question on the other end, how many transitions has that resulted in.

That's another more manually tracked result. And I'm not as confident in giving out that kind of data. But in North Carolina, I can tell you exactly how many referrals have been made as a result of MDS.

I can't tell you how many - and the reason I say yay is you were saying you're going to do a run of how many people said yes. And I'll be interested in comparing that to how many calls were actually made in North Carolina. That'll be an interesting kind of piece of information to know.

Marisa Scala-Foley: All right. And unfortunately with that we are out of time.

I do want to say thank you to our speakers very much for wonderful presentations. And thank you to our audience for asking such stimulating questions.

We do know that there were several of you via chat and possibly on the audio line who were not able to ask your questions. If you would like to email those in to us you are welcome to do so at AffordableCareAct@AoA.hhs.gov. And we'll work with our speakers to make sure your questions get answered.

Also if you have suggestions for future webinar topics, AffordableCareAct@AoA.hhs.gov is the place to send those suggestions. Because we want these webinars to be as useful to you as possible, so we would be more than happy to hear what you think we should be addressing in future webinars.

We thank you all for joining us. And we look forward to having you with us on future webinars. Thank you.

Coordinator: Thank you for your participation in today's conference. You may now disconnect.

END