

Transitions and Long-Term Care: The Minimum Data Set 3.0 Section Q and Money Follows the Person

Agenda

- Housekeeping/Introductions
 - An overview of the Minimum Data Set (MDS) 3.0 Section Q
 - An overview of the Money Follows the Person (MFP) program
 - How these programs affect the aging network
 - A View from the Field – A look at MDS 3.0 Section Q and MFP Implementation in North Carolina
 - Resources/Next training
 - Questions/Comments
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Presenters

- Trish Farnham, Division of Medical Assistance, North Carolina Department of Health and Human Services
- Becky Kurtz, Office of Long-Term Care Ombudsman Programs, Administration on Aging (AoA)
- MaryBeth Ribar, Center for Medicaid, CHIP, and Survey and Certification (CMCS), Centers for Medicare & Medicaid Services (CMS)
- Lorrie Roth, Division of Aging and Adult Services, North Carolina Department of Health and Human Services
- John Sorensen, Center for Medicaid, CHIP, and Survey and Certification, CMS

Identifying Individuals for Transition from Nursing Homes & Changes to the Minimum Data Set

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Minimum Data Set (MDS) 3.0

- Nursing Facility Resident Assess Instrument
 - Used for all nursing facility residents
 - Primarily used for rate setting & quality assurance
- Version 3.0 implemented on October 1, 2010
- CMS used the opportunity to improve the functionality of Section Q –Participation in Assessment and Goal Setting
 - More person-centered -- interview resident/family
 - Action Steps – Connection to Local Contact Agency (LCA)

Need for Change Identified

- CMS conducted an open dialogue as part of the Section Q implementation process
 - Open Forum teleconferences
 - Monthly State Medicaid Agency teleconferences
 - Discussion sessions at conferences
 - Posting Questions & Answers on CMS website
 - Posting Pilot Test Results
 - Posting Local Contact Agencies & State coordinator Points of Contact
- Ongoing input from Improving Transitions Work Group (States and other Stakeholders)

Results of the Dialogue

- Many program operation issues were resolved
- Suggestions for improving the functioning of Section Q were made
 - Skip patterns may preclude resident choice
 - Feasibility of discharge question may exclude potential candidates for transitioning
 - Need to better accommodate residents with cognitive impairments, dementia, mental illness
 - Some residents need to explore more options
 - Some residents/families were upset by being asked about returning to the community

Changes

- Feasibility of discharge item was dropped
- Individuals can opt-out of being asked if they want to speak to someone about returning to the community
- Some clarifying language changes were made

Intent of Changes

- Adopt a more person-centered approach
- Place resident/family at center of decision-making
- Give individual residents a voice and a choice while being sensitive to those who may be upset by the assessment process
- Be more targeted about who gets queried

Results of the Process

- Suggested changes were incorporated into new draft Section Q and discussed with Improving Transitions Work Group
- Proposed language changes were pilot tested in six states (9 facilities) in February 2011
- Results are being incorporated in MDS revisions to be implemented in April 2012

Changes to Section Q: Side-by-Side Comparisons

| Current Version | April 2012 Version |
|---|--|
| <p>Q0100A. Resident participated in assessment</p> <p>0. No 1. Yes</p> | <p>Same</p> |
| <p>Q0100B. Family or significant other participated in assessment</p> <p>0. No 1. Yes 2. No family or significant other</p> | <p>Same Same In <i>User's Manual</i>: "Resident has no family or significant other"</p> |
| <p>Q0100C. Guardian or legally authorized representative participated in assessment</p> <p>0. No 1. Yes 2. No guardian or legally authorized representative</p> | <p>Same In <i>User's Manual</i>: "Resident has no guardian or legally authorized representative"</p> |

Changes to Section Q (continued)

| Current Version (on admission) | April 2012 Version |
|---|---|
| <p>Q0300. Resident's Overall Expectation</p> <p>A. Select one for resident's overall goal established during assessment process</p> <ol style="list-style-type: none"> 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain | <p>Same</p> |
| <p>Q0300B. Indicate information source for Q0300A</p> <ol style="list-style-type: none"> 1. Resident 2. If not resident, then family or significant other 3. If not resident, family or significant other, then guardian or legally authorized representative 9. None of the above | <p>Same</p> <p>Same</p> <p>Same</p> <p>9. Unknown or uncertain</p> |

Changes to Section Q (continued)

| Q0400 Discharge Plan | |
|--|---|
| Current Version | April 2012 Version |
| <p>A. Is there an active discharge plan in place for the resident to return to the community?</p> <p>0. No 1. Yes -> Skip to Q0600, Referral</p> | <p>A. Is active discharge planning already occurring for the resident to return to the community?</p> <p>Same Same</p> |
| <p>B. What determination was made by the resident and the care planning team that discharge to community is feasible?</p> <p>0. Determination not made 1. Discharge to community is feasible – Skip to Q0600 2. Discharge to community is not feasible – Skip to next active section</p> | <p>Item eliminated</p> |

Changes to Section Q (continued)

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B (complete only when A0310 = 02, 06, 99)

| Current Version | April 2012 Version |
|------------------------|---|
| Does not exist | A. Is there documentation in the resident's clinical record stating only to ask this question on comprehensive assessments? 0. No 1. Yes, Unless is comprehensive assessment, (in User's Manual) -> Skip to Q0600, Referral 8. Information not available |

Changes to Section Q (continued)

| Q0500. Return to Community | |
|--|---|
| Current Version | April 2012 Version |
| <p>B. Ask the resident, (or family or significant other if resident is unable to respond): “Do you want to talk to someone about the possibility of returning to the community?”</p> <p>0. No 1. Yes 2. Unknown or uncertain</p> | <p>B. Ask the resident, (or family or significant other if resident is unable to understand or respond): “Do you want to talk to someone about the possibility of returning to the community?”</p> <p>Same Same 9. Unknown or uncertain</p> |

Changes to Section Q (continued)

| Q0550. Resident's Preference to Avoid Being Asked Question Q0500B again | |
|---|---|
| Current Version | April 2012 Version |
| A. Does not exist | <p>A. Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on <u>all</u> assessments? (rather than only on comprehensive assessments)</p> <p>0. No – then document in resident's chart (<i>clinical record</i>) and only ask again on the next comprehensive assessment.</p> <p>1. Yes</p> <p>8. Information not available</p> |
| B. Does not exist | <p>B. Indicate information source for Q0550A</p> <p>1. Resident</p> <p>2. If not resident, then family or significant other</p> <p>3. If not resident, family or significant other, then guardian or legally authorized representative</p> <p>8. No information source available</p> |

Changes to Section Q (continued)

| Q0600. Referral | |
|--|---|
| Current Version | April 2012 Version |
| <p>Has a referral been made to the Local Contact Agency?</p> <p>0. No - determination has been made by the resident and the care planning team that contact not required.</p> <p>1. No – referral not made</p> <p>2. Yes</p> | <p>Has a referral been made to the Local Contact Agency? (Document reasons in resident's chart)</p> <p>0. No - referral not needed</p> <p>1. No – referral is or may be needed (For more information See Section Q Care Area Assessment- #20)</p> <p>2. Yes – referral made</p> |

Expected Impacts

- Based on pilot test results; big caveats
 - By eliminating the Determination of Feasibility of Discharge item, many more residents were asked the question, “Do you want to talk with someone about the possibility of leaving this facility and returning to live and receive services in the community?”
 - And many more said Yes
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Expected Impacts (continued)

- By giving residents/families an opt-out provision (for those who cannot or do not want to move out), on subsequent quarterly assessments about talking to someone about returning to the community, they likely will be less upset
 - Should reduce the number of residents for whom the question is not appropriate
 - Works better than the feasibility-of-discharge question in targeting who should be asked the return to community question
 - More clarity about referrals
 - But key is communication at the local level
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Challenges

- Ongoing outreach and education to nursing homes (NH)
- NH making effective referrals, knowing who to contact
- NH and LCA making connections to work together for resident in person-centered approach
- Implementation of an effective referral and transition-planning process at local level, i.e., LCA, Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRC), MFP, and other stakeholders

New Opportunities

- AoA, CMS, and Veterans Affairs (VA) working together to provide information and resources for each Agency and their Stakeholders
 - State VA programs and funding streams vary
 - Goal is to work for Veterans in a person-centered approach for appropriate referrals and to meet transition planning needs
 - Veterans in NHs and State Veterans Homes depending on length of service and level of VA benefits can be eligible for wrap-around Medicaid and other services
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For more information:

For more information:

- Send questions to:

www.MDSforMedicaid@cms.hhs.gov



Money Follows the Person Rebalancing Demonstration

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Development and Implementation Team

Division of Community Systems Transformation

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Current CMS Rebalancing Options

- **Person-Centered Hospital Discharge Planning** – Active through September 2012 – assists States with the development and implementation of enhanced hospital discharge models and with increasing capacity of single entry points (including ADRCs). Participating States: AK, CA, HI, ID, KS, MD, MO, NC, OR, and SC.
- **Affordable Care Act (ACA): Section 2703: Health Homes for Individuals with Chronic Conditions**
 - States are able to offer health home services for individuals with multiple chronic conditions or serious mental illness effective January 1, 2011
 - Coordinated, person-centered care
 - Primary, acute, behavioral, long term care, social services = whole person
 - Enhanced Federal Medical Assistance Percentage, or FMAP (90%) is available for the health home services (first 8 quarters)

Current CMS Rebalancing Options

- **ACA: Community First Choice (CFC) - 1915(k) State Plan Option**
 - Goal - To provide “person-centered” home and community-based attendant services and supports as an optional service under the State Plan
 - Effective October 1, 2011
 - Financial Incentive - 6% increased FMAP

Section 2403: Money Follows the Person

- Now extends through 2019-transitions individuals from institutions to community based care and adds resources to balance long-term care (LTC)
 - Enhanced Federal match for community services for first year following transition from facility
 - 43 States and the District of Columbia now participating in the demonstration
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Goals of MFP

- Transition individuals to the community From Institutional Long-Term Care Settings
- Rebalance the long-term care system by:
 - Eliminating barriers to home and community-based services (HCBS) and transitioning from institutional settings
 - Increasing availability of and access to HCBS
- Assure HCBS quality procedures

MFP Quality Management System

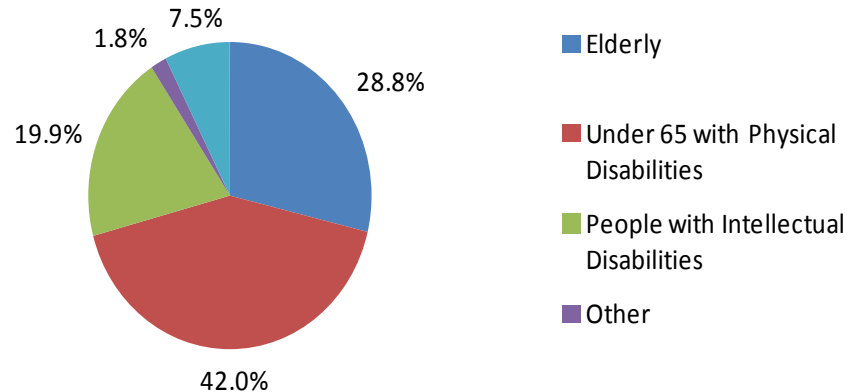
- In addition to waiver quality requirements, States must ensure the following:
 - Risk assessment and mitigation process
 - A 24 hour emergency back-up system
 - Incident report management system

Categories of Services

- **Qualified HCBS:** Services that beneficiaries typically would receive
- **Demonstration Services:** Optional services that States can choose to cover
- **Supplemental Services:** One-time or limited-duration services

MFP Transitions by Population

Distribution of Total MFP Transitions As of September 2011



Source: Mathematica analysis of quarterly MFP Program Participation Data files submitted through December 9, 2011.

Note: This graph depicts the distribution of the total number of MFP transitions that have occurred since program start through the end of September 2011. Virginia is excluded from this analysis because of missing data. In addition, transitions in Arkansas, California, the District of Columbia, Maryland, Michigan, New York, and Wisconsin are underreported because of lags in state data submissions.

Medicaid ACA: Section 2403: Money Follows the Person

- ADRC/MFP Supplemental funding opportunity: in 2010, (25 States) up to \$400,000 for MFP and ADRC was provided for MFP Grantees to work together to expand ADRCs, build processes & partnership & utilize MDS 3.0 Section Q
 - States eligible for the 2012 ADRC Supplemental Funding Opportunity: CO, FL, GA, HI, ID, IL, ME, MA, MS, MN, NV, NJ, NM, OH, RI, SC, TN, VT, WV
 - MFP States will submit with budget in early 2012, approved by April of 2012
 - CMS is planning a MFP solicitation for the remaining 7 States to become participating MFP Grantees, hope to release sometime in February and award in late Spring, early Summer
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MDS 3.0 Section Q, MFP and the Aging Network

Becky Kurtz

Director, Office of the Long-Term Care
Ombudsman Program
Administration on Aging

Among the objectives of the Older Americans Act (OAA):

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.

Section 101(10) of the Older Americans Act.

The Aging Network

- Established by the Older Americans Act, today the Aging Network consists of:
 - 56 State agencies on aging,
 - 629 area agencies on aging,
 - nearly 20,000 service providers, and
 - 244 Tribal organizations, and 2 Native Hawaiian organizations representing 400 Tribes

Roles of Aging Network in Supporting Nursing Home Transitions Work

- Providing consumers with assistance with transition from nursing home to HCBS
- Increased demand for long-term services and supports (LTSS)
- State and local-level policy development and implementation
- Ombudsman resident advocacy
- Follow up after transition

Providing Information about Home and Community-Based Services

- Information and Referral: Providing information to access LTSS -- an important role of the Aging Network for many years
- LCAs: Part of MDS 3.0 Section Q
 - States have met need in a variety of ways:
 - ADRC serve as sole LCA (12 states)
 - ADRC designated as at least one of several LCAs (39 states)

Role of ADRCs

- A single, coordinated system of information and access for all persons seeking long-term support to minimize confusion, enhance individual choice, and support informed decision-making
 - Most include an Area Agency on Aging (71%)
 - 383 local ADRC programs in 51 states and territories, covering 60% of population

Role of ADRCs (cont'd)

- CMS and AoA envision ADRCs to:
 - Catalyze broader systems change
 - Promote participant-direction
 - Build stronger partnerships across fragmented LTSS system
 - Intervene during care transitions from hospitals and other acute care settings
 - Assist with institutional transitions
 - Implement new initiatives (e.g., Veteran-Directed Home and Community Based Services, MDS 3.0 Section Q)
 - Synergy between development of ADRCs and need for LCAs as part of MDS 3.0 Section Q implementation
 - CMS/AoA announced grant opportunities in 2010 and 2011 using MFP funds to support ADRC and other Aging Network involvement in Section Q implementation
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Increased Demands for LTSS

- As people move out of nursing homes and into other settings, they require more of the services provided through the Aging Network:
 - OAA Home and Community Based Services (HCBS) – e.g., nutrition, social services, caregiver services (all states/territories)
 - One or more Medicaid HCBS waiver programs are provided through Aging Network (32 states*)
 - State funded HCBS through Aging Network (24 states*)
 - In some states, the Aging Network is providing the transition services for MFP (e.g., OH, GA)

*Source: NASUAD, “State of the States Survey 2011”

State and Local Level Policy

Development and Implementation

- State units on aging, State long-term care ombudsmen and others in Aging Network have been engaging with state Medicaid agencies and others in design and implementation of:
 - MFP
 - Section Q initiatives.
 - Examples:
 - Developing MFP protocols, evaluation processes
 - Designing LCA processes (e.g., “NC MDS 3.0 Section Q Referral Response Toolkit” developed by NC Community Resource Connections for Aging and Disabilities)
 - Educating consumers and nursing home staff re: Section Q (e.g., Nebraska Long-Term Care Ombudsman Program)
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Ombudsman Resident Advocacy

November 2010 Letter from Cindy Mann (CMS) and Kathy Greenlee (AoA):

“The Office of the State LTC Ombudsman [LTCO] is a stakeholder that should be included in the development and implementation of all MFP programs. They are 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 arise. Any State that currently has an MFP Demonstration Grant program can request supplemental administrative funds to work directly with the State LTC Ombudsman.”

http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/docs/AoA_CMS_Section_Q_memo.pdf

Ombudsman Resident Advocacy (continued)

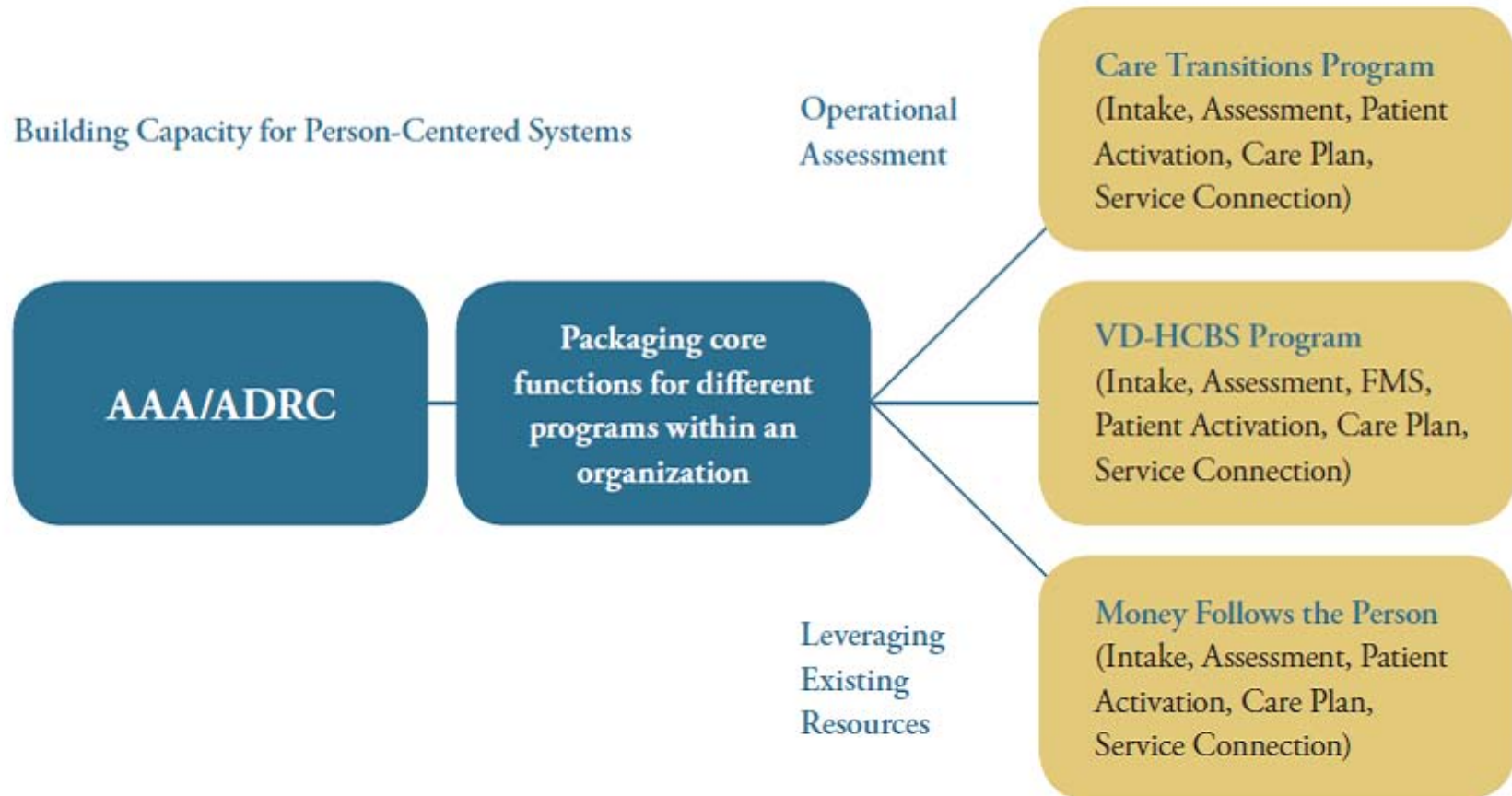
- Helps keep process focused on the consumer's priorities
- Examples of LTCO activities re: nursing home transitions:
 - conducting outreach to residents;
 - educating residents/families about the Section Q process and HCBS options;
 - making referrals to LCAs;
 - supporting residents through the transition planning process; and
 - resolving consumer complaints related to the Section Q process.
- 41% increase in LTCO complaints from nursing home residents related to “request for less restrictive placement” in FY 10 (compared to FY 08)

Follow-up After Transition

- Examples of Aging Network roles related to follow-up with resident after transition:
 - Case management/provision of HCBS
 - MFP quality of life surveys
 - Access to adult protective services (APS)*, elder abuse prevention services, and legal services when the needs arise
 - Individuals need protection from abuse, neglect, exploitation in all settings
 - Ombudsman follow-up/complaint resolution
 - Available in assisted living/board and care
 - NOTE: MFP limited to congregate settings of 4 beds or less
 - 12 states expand LTCO complaint resolution services to individuals receiving in-home services (state law)
 - Some states have expanded LTCO service to in-home MFP consumers (e.g., GA, DE)

*APS is housed within the Aging Network in 27 states

Integrating Functions Across Core Programs



Section Q Challenges:

1st Year of Implementation

- Insufficient community resources to accommodate transition
- Lack of timeliness of the process
- Challenges in discussing community options with residents with dementia or diminished capacity
- Family/guardian disagreements with resident preferences
- Emotional stress and anxiety residents may experience if they believe they can transfer to the community but they have not yet been given community options.

Source: National Ombudsman Resource Center 2010-2011 questionnaires to LTC Ombudsmen <http://www.ltcombudsman.org>

Section Q Successes

- Residents who wish to are returning to the community
- Improved collaboration and communication between the nursing home staff and other agencies
- Nursing homes have improved their communication with residents especially during care plans and explaining community options
- Residents have a better understanding of their rights and community options

Source: National Ombudsman Resource Center 2010-2011 questionnaires to LTC Ombudsmen <http://www.ltcombudsman.org>

Conclusion

- 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 our nation's nursing home residents experience:
 - Freedom, independence, and the free exercise of individual initiative 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.

NC's "No Frills" Presentation about MFP, ADRCs, LCAs and Getting People Home

Trish Farnham, NC MFP Project Director, Division
of Medical Assistance (DMA)

Lorrie Roth, LCA Coordinator, Division of Aging
and Adult Services (DAAS)

With Diane Upshaw, MFP Administrative
Coordinator, DMA

Brief Overview of NC MFP

- Began supporting people to transition in 2009.
 - Supports three primary groups: individuals with intellectual disabilities (I/DD); individuals with physical disabilities and older adults.
 - Historically, NC's state-level transition infrastructure has been more coordinated for individuals with I/DD than for individuals within physical disability and aging communities, which were more local.
 - ADRC network and MDS 3.0 key pieces in strengthening statewide network that also plays to the strengths of local efforts.
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Brief Overview of ADRC Set-Up in North Carolina

- ADRC= NC Community Resources Connections (CRCs)
- No wrong door
- Options Counseling
- Intent to cover all 100 counties by end of 2012
 - NC is big state, with both rural and urban areas.
 - Many local areas are already well-networked.
- Typical “anchoring” partners: AAAs, Independent Living, Dept. of Social Services
- Goal: statewide IT network.
- Long-term goal: Figuring out “transition teams”

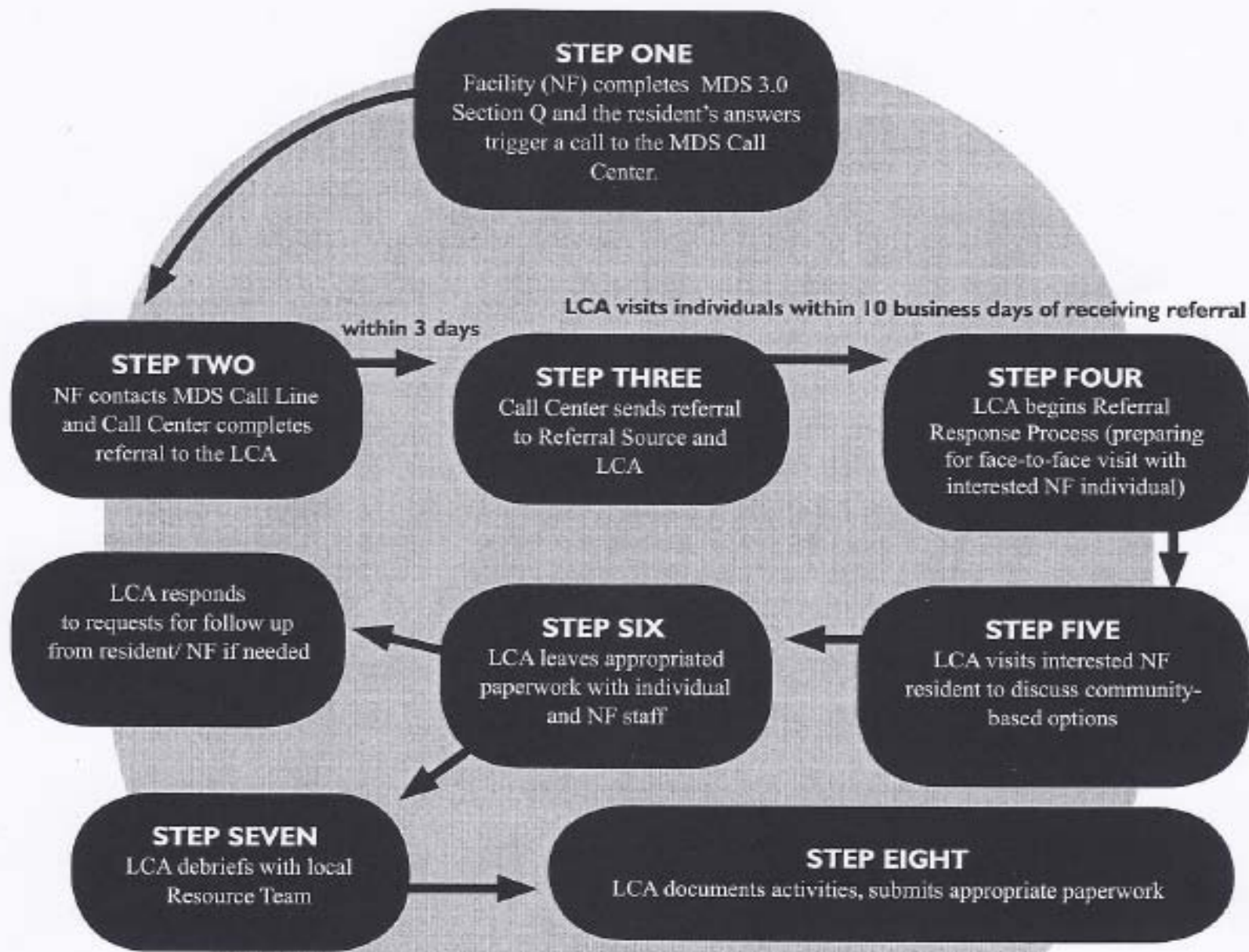
How NC's LCA Structure Emerged

- NC's Medicaid Agency (DMA) had not yet identified LCA entity.
- Joint conversations between CRC State Director, MFP, MDS Steering Committee
- LCA function is logical extension of CRCs' options counseling role.
 - Fleshed out role and developed protocols in conjunction with local CRC representatives
- Used MFP administrative funding and Opportunity C grant funding to support LCA function and provide outreach
 - "MDS Roadshows"

LCA Current Structure

- DMA/MFP funds/DAAS manages
 - Including Opportunity C funds
- Each CRC identifies LCA
 - May be one or more entities
- In areas where no CRC, LCA funds flow through AAAs
 - Intended to be “seed money” for new CRC/LCAs.

LCA Referral & Response Flowchart of LCA Activities



Lessons Learned: What Works

- What works about structure
 - Local knowledge – existing relationships
 - Opportunity to get word out about MFP
 - Funding
 - Collaboration between state agencies in getting the word out.
 - MFP Roadshows/Division of Health Service Regulation

Lessons Learned: Challenges

- Everything was new!
 - MDS 3.0, LCA, MFP, CRCs. Often introducing multiple functions/ initiatives, not just LCA.
 - CRCs not statewide yet.
 - Had to create Plan B for uncovered areas
 - But this has also served as great “seed” for future CRC development.
 - Initial confusion about MDS referral process.
 - Initially, high volume of calls to Call Center. Created “volume anxiety” among LCAs initially.
 - Weak correlation between LCA visit and MFP applications.
 - In 2011, less than 5% of MFP’s total application volume was a result of an LCA visit.
 - Communication Challenges
 - Multiple state players: sometimes we experienced “Who’s on first?” challenges
 - Lack of integrated statewide database
 - But lack of automation created stronger “human” systems regarding information collection and feedback loops.
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Emerging Opportunities

- Partnership has created much stronger ties around transition work between sister agencies.
- LCA function/resources now serve as “seed money” for CRC expansion.
- Exploring how to best integrate LCA into transition planning process.
 - Sometimes same agency is serving role of LCA and transition coordination.
 - We worked so hard to clearly define roles and prevent “function creep” that we inadvertently limited people’s potential engagement.

Why It Matters: A Quick Story

Resources: MDS 3.0 Section Q

- http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage (CMS resources on MDS 3.0)
- http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage (CMS training on MDS 3.0)
- <http://www.ltombudsman.org/issues/MDS-3.0> (National Long-Term Care Ombudsman Resource Center resources on MDS 3.0)

Resources: MFP

- <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html> (MFP web site)
- <http://www.cms.gov/SMDL/SMD/list.asp#TopOfPage> (State Medicaid Director letters)
- <http://mfp-tac.com/> (MFP technical Assistance web site)

Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page – where webinar recordings, transcripts and slides are stored)
- <http://www.healthcare.gov> (Department of Health and Human Services' health care reform web site)
- <http://www.thomas.gov/> (Affordable Care Act text and related information)

Next Training

- *Million Hearts*
 - Tuesday, February 28, 2:00-3:30 pm Eastern
 - Watch your email in early February for registration information

Questions/Comments/Stories/ Suggestions for Future Webinar Topics?

Send them to:

AffordableCareAct@aoa.hhs.gov