

Targeted Approaches to Assisting People to Transition From Nursing Homes to the Community

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Today's Topics

- **New Nursing Facility Level of Care**
- **Automating Minnesota's New Comprehensive Assessment**
- **New Return to the Community Initiative**

Handouts

- Power point for today

How are these initiatives related?

- Person –centered
- Streamlined care transition partnerships
- Fewer low-need individuals will live long-term in nursing homes
- The critical loop will be closed between assessment and care planning.
- Public long-term dollars will be well-targeted to support persons with higher needs, in the most integrated settings possible.

Nursing Facility Level of Care Legislation

- Current NF LOC criteria are low compared to other states
- Legislation strengthens NF LOC criteria to redirect people with lower care needs to other supports

Nursing Facility Level of Care Legislation

- For Medicaid payment for NF care, certain community-based long-term care waivers (EW, CADI, TBI-NF), or state-funded Alternative Care, a person must need at least one of the following:
 - Assistance with 4 or more Activities of Daily Living
 - Assistance with an unscheduled ADL such as using the toilet, transferring or positioning
 - Significant difficulty with memory, using information, daily decision making or behavioral needs, or
 - Risk of institutionalization
 - Qualifying NF stay of at least 90 days or
 - Living alone + fall-related fracture, risk of maltreatment or neglect/self-neglect, or sensory impairment that substantially interferes with ability to maintain community residence

Nursing Facility Level of Care Legislation

- Effective January 1, 2011
- To qualify for MA payment, a person must meet NF LOC criteria at both:
 - Admission/entry into program
 - 90 days after admission/entry into program
- Admissions/entries on or after October 1, 2010 affected if criteria not met at 90 days

Nursing Facility Level of Care Legislation

Information specific to nursing facilities:

- Eligibility will be determined based on Pre-Admission Screen
- Qualifying residents will be reevaluated on subsequent Minimum Data Set assessment no more than 90 days before MA eligibility date
 - Criteria will be crosswalked between tools
- NF staff will need to be aware of and begin timely discharge planning for residents not likely to qualify at 90 days

New Comprehensive Assessment

- Formulated in the early part of the decade and realized this last legislative session.
- Across several populations, divisions and programs.

Home and Community Based Services

- Five Waiver Programs
 - Elderly Waiver
 - Community Alternatives for Disabled Individuals CADI
 - Traumatic Brain Injury (TBI)
 - Community Alternative Care (CAC)
 - Mental Retardation/Related Conditions (MR/RC)
- PCA Services, private duty nursing services, home health agency services

RFP April 2004

- Streamline and Integrate Processes of Assessing all Individuals with Disabilities and All Minnesotans
 - Common Assessment Protocol
 - Data Collection Tool
 - Recommendations

Goals

- Greater Consistency
- Improve reliability and equity of service provision
- Support improvements to the quality and efficiency of supports

Based on the Input and Research

- Created a Comprehensive Person-centered Assessment to:
 - Determine Overarching Life Goals
 - Assess Desire for Consumer Direction
 - Focus Service Planning and Provision on Personal Strengths

Assessment Tree

- Modular approach
- Prompts for information relevant to a particular individuals
- High level trigger question determine modules or subset of questions within modules that need to be completed

Pilot Tested

- June 4 – July 27, 2008
- Counties
 - Clay, Ottertail, Koochiching, Carlton, Chisago, Hennepin, Dakota, Scott, Carver, Swift, Wilkin
- Health Plan
 - United Health Care, Fairview Partners, Health East, Medica

Where are we now

- 2009 Legislation funded the web-based development for Minnesota Compass
- Currently working internally to update the content of the modules
- Determine the technology platform to use

Other legislation that impact Minnesota COMPASS

- Assessments must be completed by certified assessors
 - Discussions are underway to develop certified assessor training including competencies and curriculum
 - Certification of assessors will begin in 2010 with all assessor certification complete by December 31, 2010

Timelines

- The Minnesota COMPASS is schedule to be implemented by January 1, 2011

Return to the Community Legislation

Targeting Criteria developed in study:

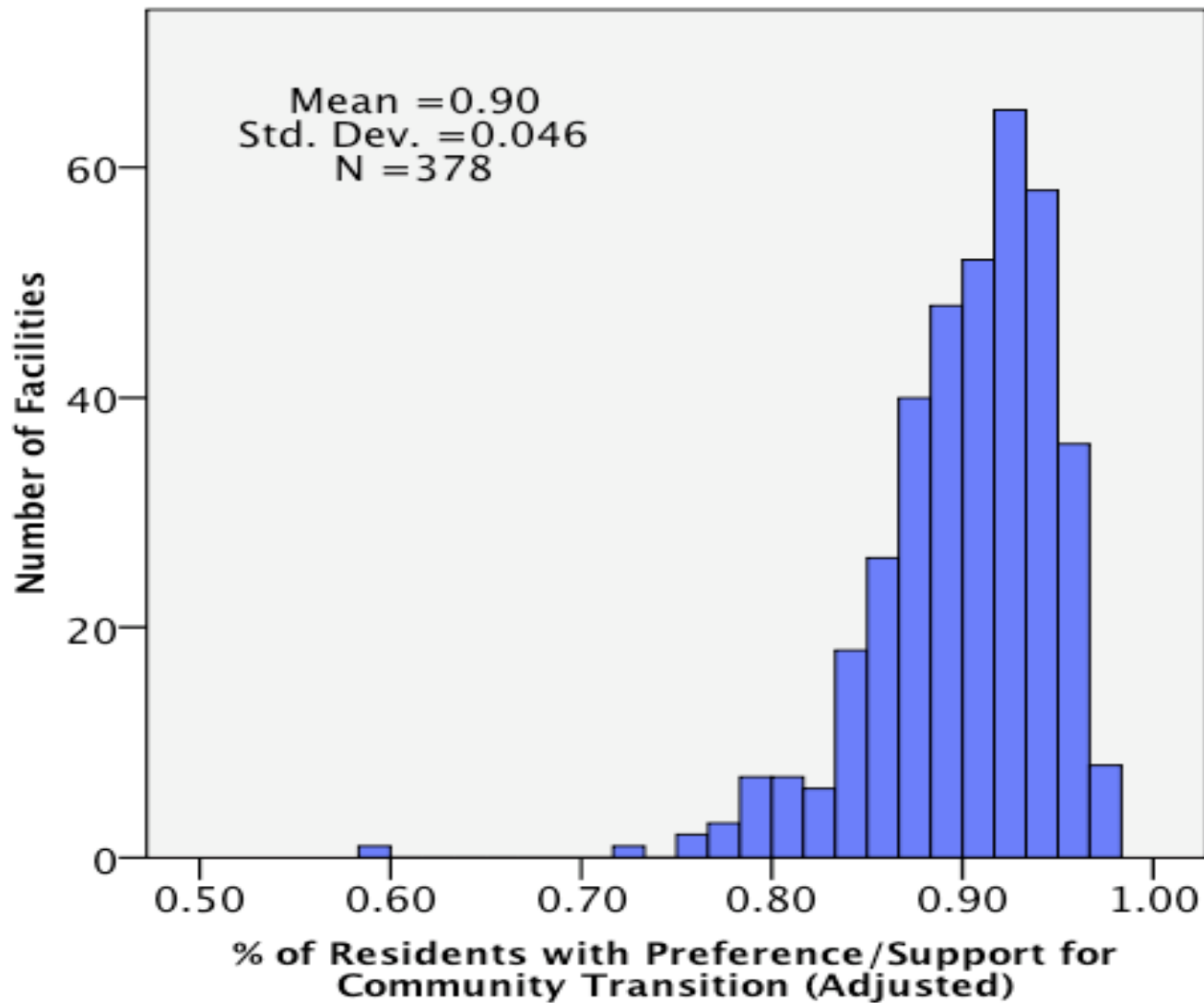
- Residents who are early in their nursing facility stays and still have community ties
- Prefer to return to the community and/or have a support person for community care
- Fit a community discharge profile -- health, functional, or personal characteristics indicating high probability of community discharge

Return to the Community Legislation

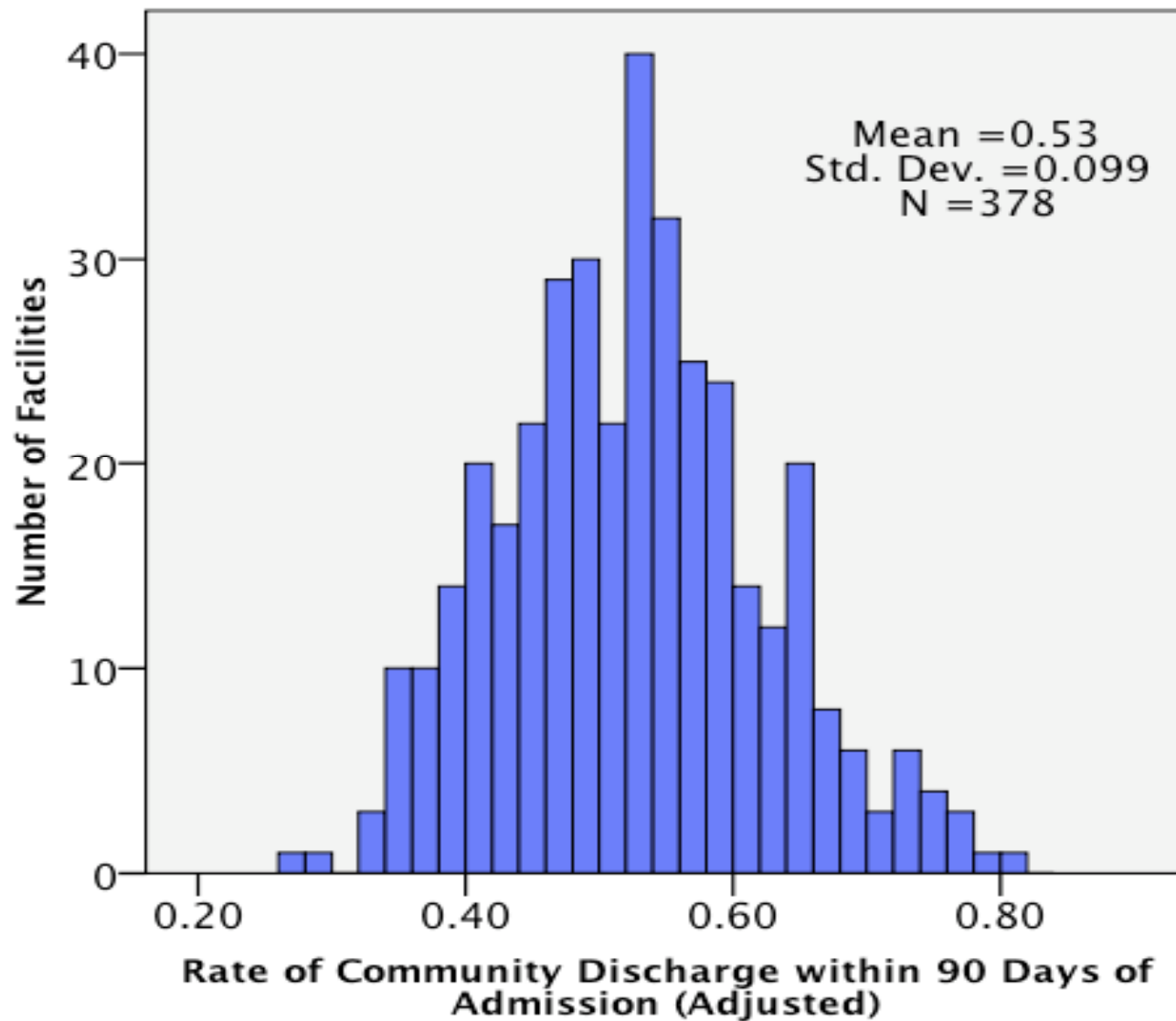
Preferences make a difference:

- Majority of nursing facility admissions prefer to return to the community and have a support person
- Preferences and support are strongly associated with length of stay and discharge status

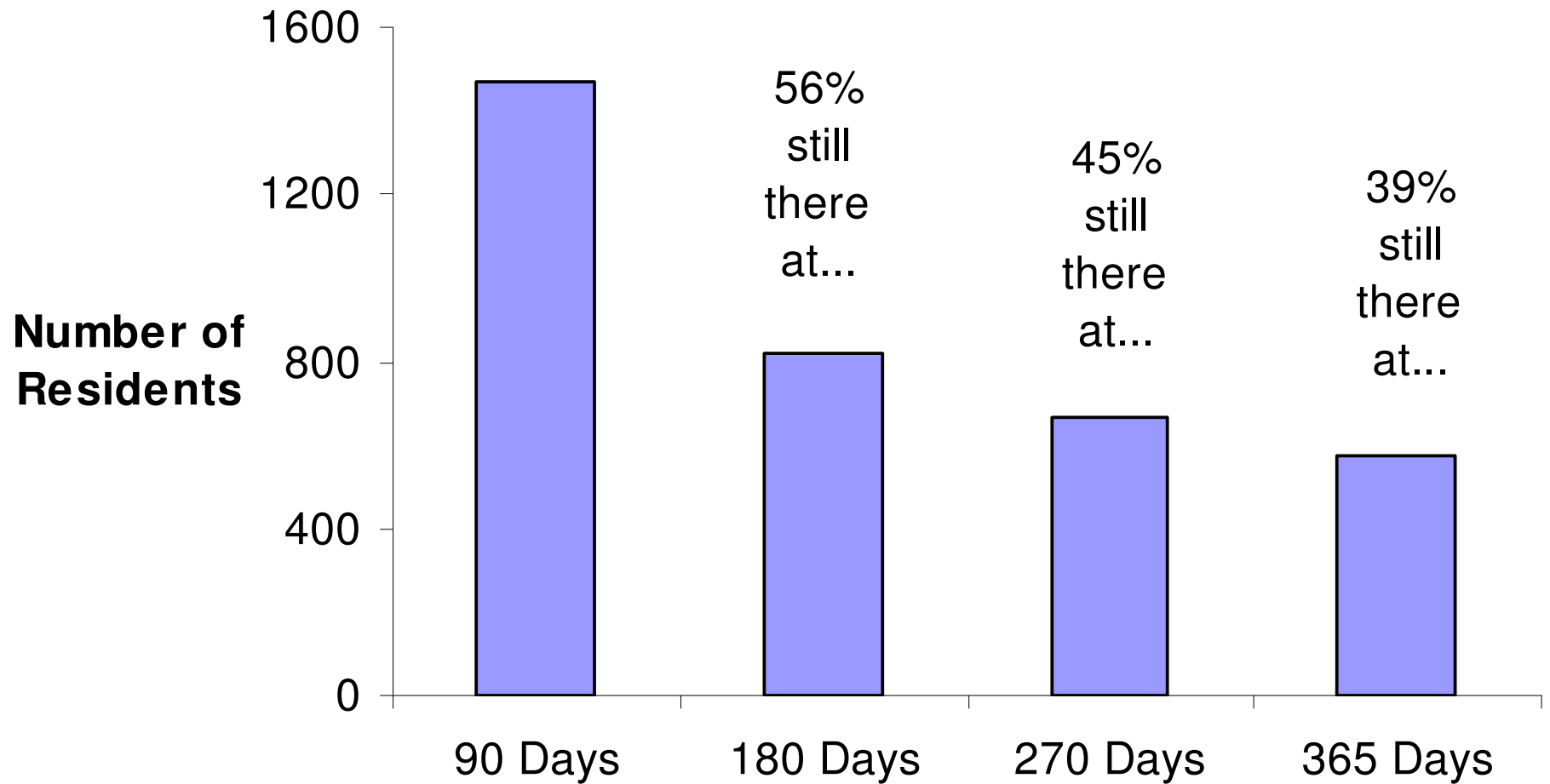
Facilities by Resident Preference or Support for Community Transition at Admission (Adjusted)



Facilities by Community Discharge Rate within 90 Days of Admission (Adjusted)



What Happened to Residents in the Study Who Met Target Criteria?



Community Transitions Initiative Overview

- Effort to change mindset that NFs are best long-term residence for people who could live successfully in community
- Facilitate successful NF → community transitions
 - Respect people's preferences for living and care-giving arrangements
 - Use public resources efficiently
 - Promote good health and quality of life
- Targeted to residents
 - Early in their nursing facility stays (90 days after admission)
 - Good candidates for transition – desire and resources to return to the community
 - Otherwise would become long stay residents

Community Transitions Initiative Targeting Protocol

- DHS will produce real-time “Watch List” from Minimum Data Set resident assessments
 - 90 days after admission
 - Meeting targeting criteria above
 - Still in facility
- Will be shared with appropriate community partners via secure web-based portal (in development)

Community Transitions Initiative

- Partnership between public agencies and nursing facilities
 - Currently also establishing partnerships with hospitals and other health care providers
- Focus on residents and families
 - Begin discharge planning at NF admission
 - Equip individuals with self-care skills
 - Support family caregivers
 - Line up community resources

Community Transitions Initiative

- Senior LinkAge Line® Long-term Care Options Counselors will provide intensive support activities for facility discharge statewide:
 - Assessment
 - Care planning
 - Service coordination
 - Placement
 - Follow-up with clients in the community
 - Facilitated by SLL communication/tracking technology
- Will target private pay residents to avoid duplication of services
 - Will include steps to connect managed-care enrollees and those under 65 to appropriate parties if needed

MDS 3.0: Section Q Discharge Potential

(Per Draft – 3.0 Implementation 10/1/2010)

- Residents will be asked on a quarterly basis “Do you want to talk to someone about the possibility of returning to the community?”
- If “Yes”, staff are directed to develop a comprehensive person-centered discharge care plan based on the individual’s needs and preferences with associated time frames.
- The NF is required to make a referral to the designated Medicaid agency (or its agent) within 10 business days. (Senior Linkage Line options counselors).
- SLL Options Counselors will triage people into County based relocation service coordination depending on age.
- The NF and local contact agency collaborate and coordinate to develop and implement a comprehensive and complete discharge plan.

Centers for Medicare and Medicaid Services Section Q discharge potential presentation.

Questions?

