

# RETURN TO COMMUNITY INITIATIVE

## Presenters:

**Krista Boston, Director Consumer Assistance Programs – Minnesota Board on Aging (MBA)**

**Valerie Cooke, Supervisor – DHS Nursing Home Rates and Policy Division**

**Darci Buttke – Return to Community - MBA**



## Today's Presentation

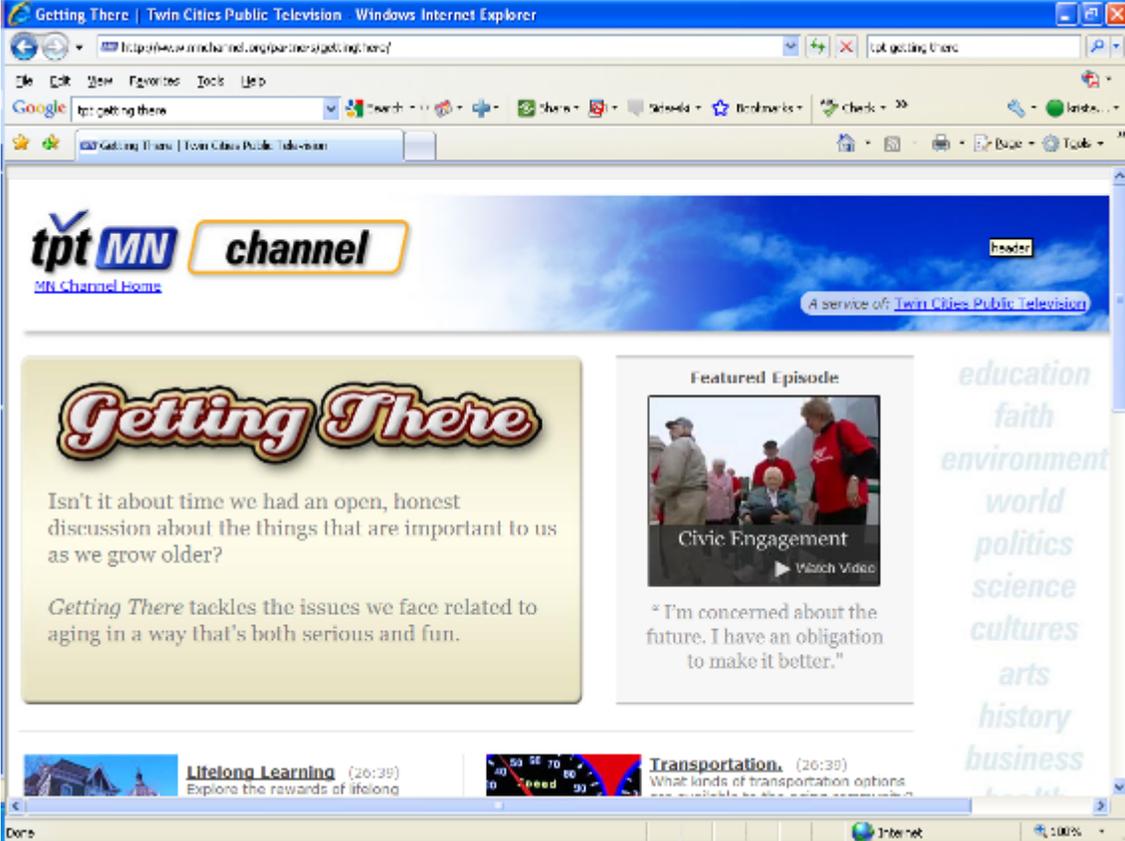
- Learn about the MinnesotaHelp Network™ and how to become a member.
- Understand the purpose for the Return to Community Initiative
- Understand how the effort will be implemented
- Learn about the partnerships with the Nursing Homes to make this effort successful
- Meet your MinnesotaHelp Network™ Community Living Specialist



## Kelsey Visits Grandpa in a Nursing Home

“Getting There” is a co production  
of:

The Minnesota Board on Aging and  
Twin Cities Public Television



Getting There | Twin Cities Public Television | Windows Internet Explorer

http://www.mnchannel.org/partners/gettingthere/

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### Getting There

Isn't it about time we had an open, honest discussion about the things that are important to us as we grow older?

*Getting There* tackles the issues we face related to aging in a way that's both serious and fun.

**Featured Episode**

Civic Engagement

Watch Video

"I'm concerned about the future. I have an obligation to make it better."

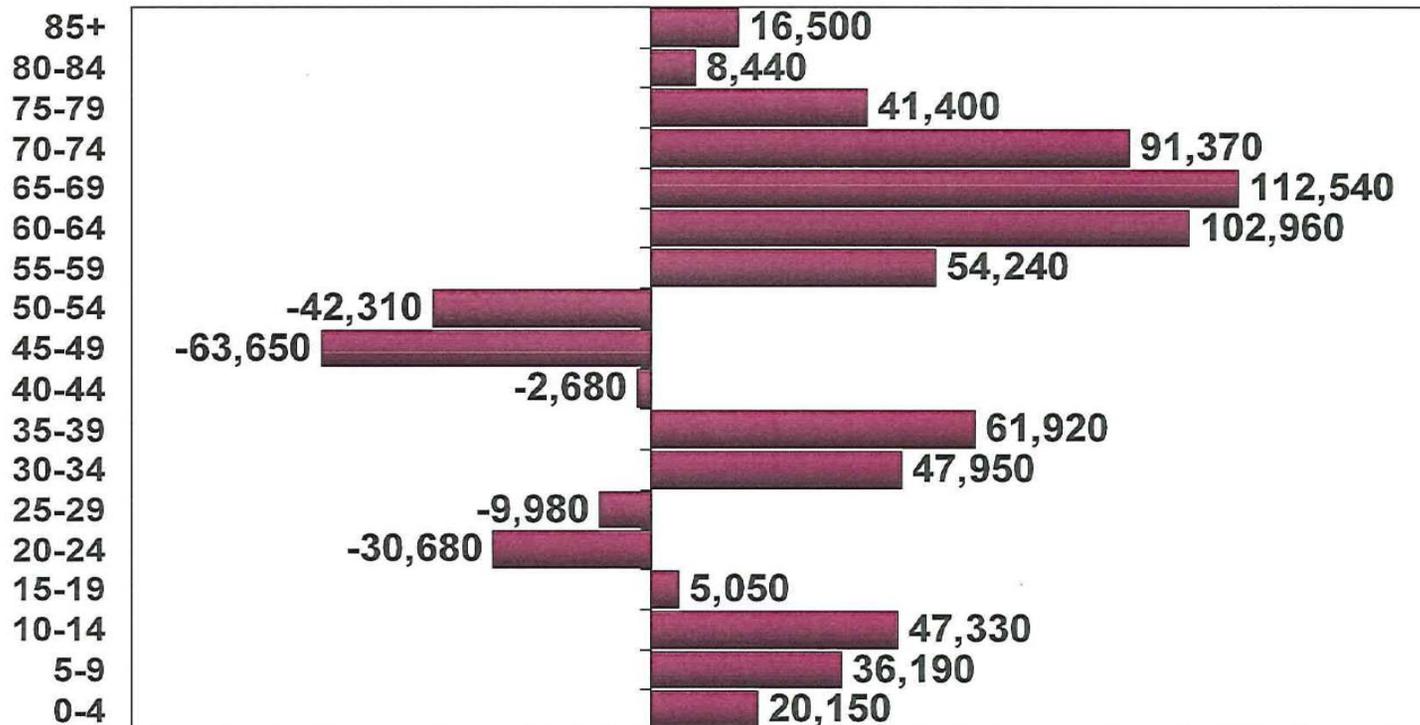
**Lifelong Learning** (26:39)  
Explore the rewards of lifelong

**Transportation** (26:39)  
What kinds of transportation options

education  
faith  
environment  
world  
politics  
science  
cultures  
arts  
history  
business



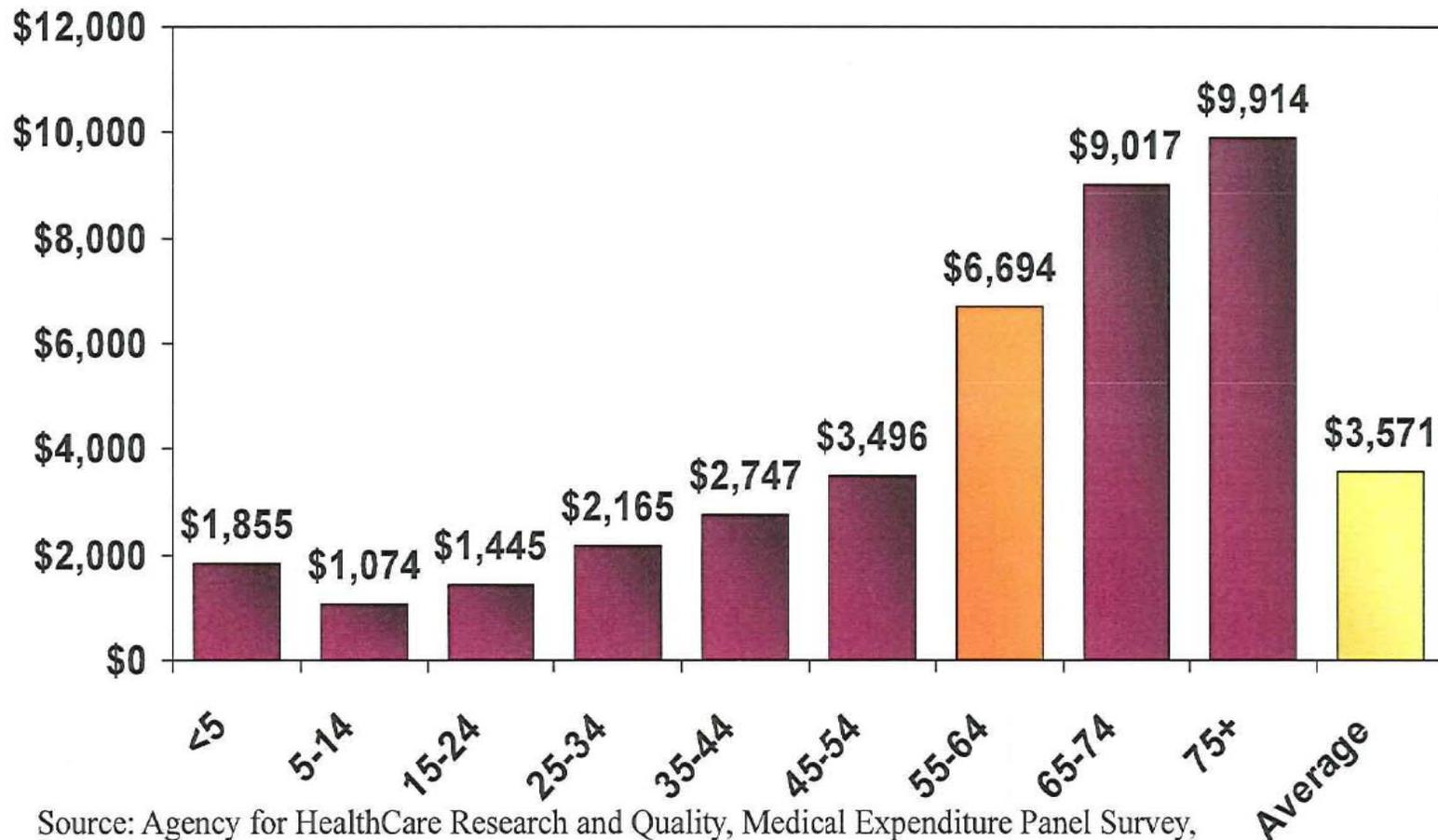
# From 2010 to 2020, Minnesota Will See Large Increases Age 50s and 60s



Source: Minnesota State Demographic Center, rev 2007  
Numbers are rounded

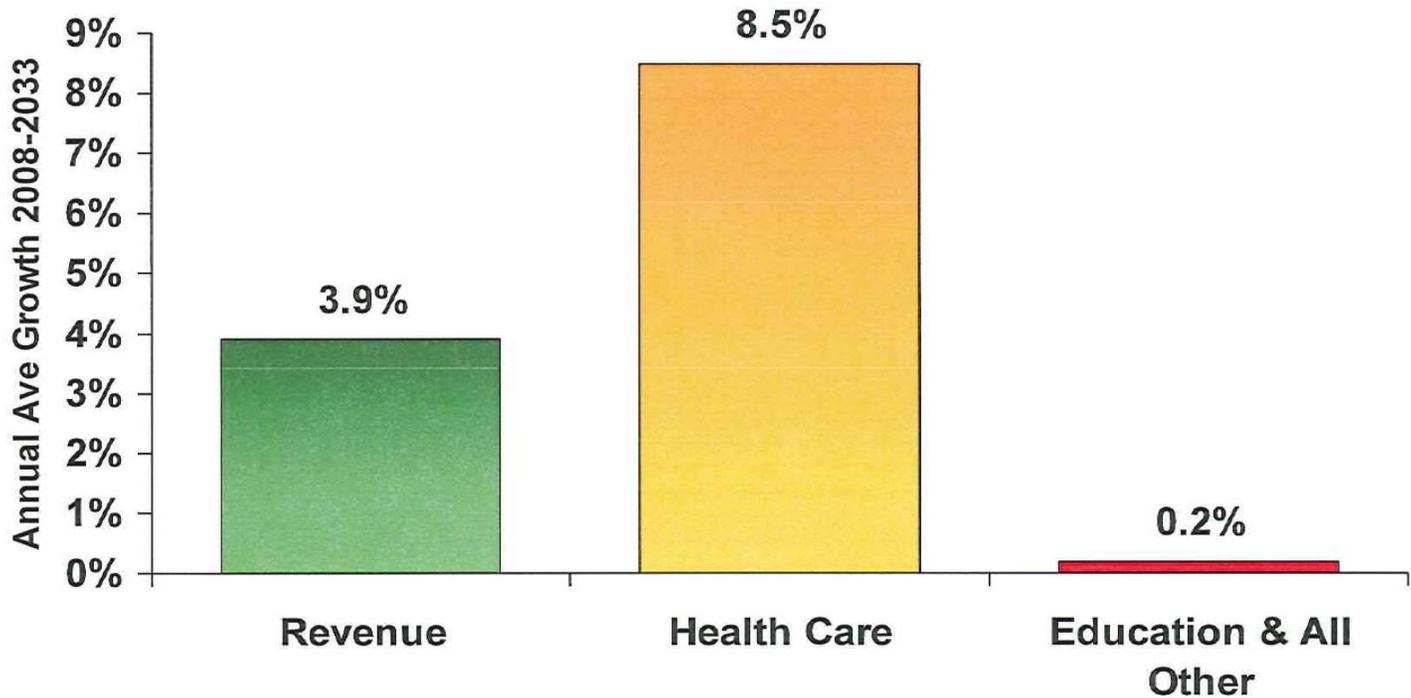
# Health Care Spending Jumps After 55

## U.S. Health Care Spending By Age, 2004



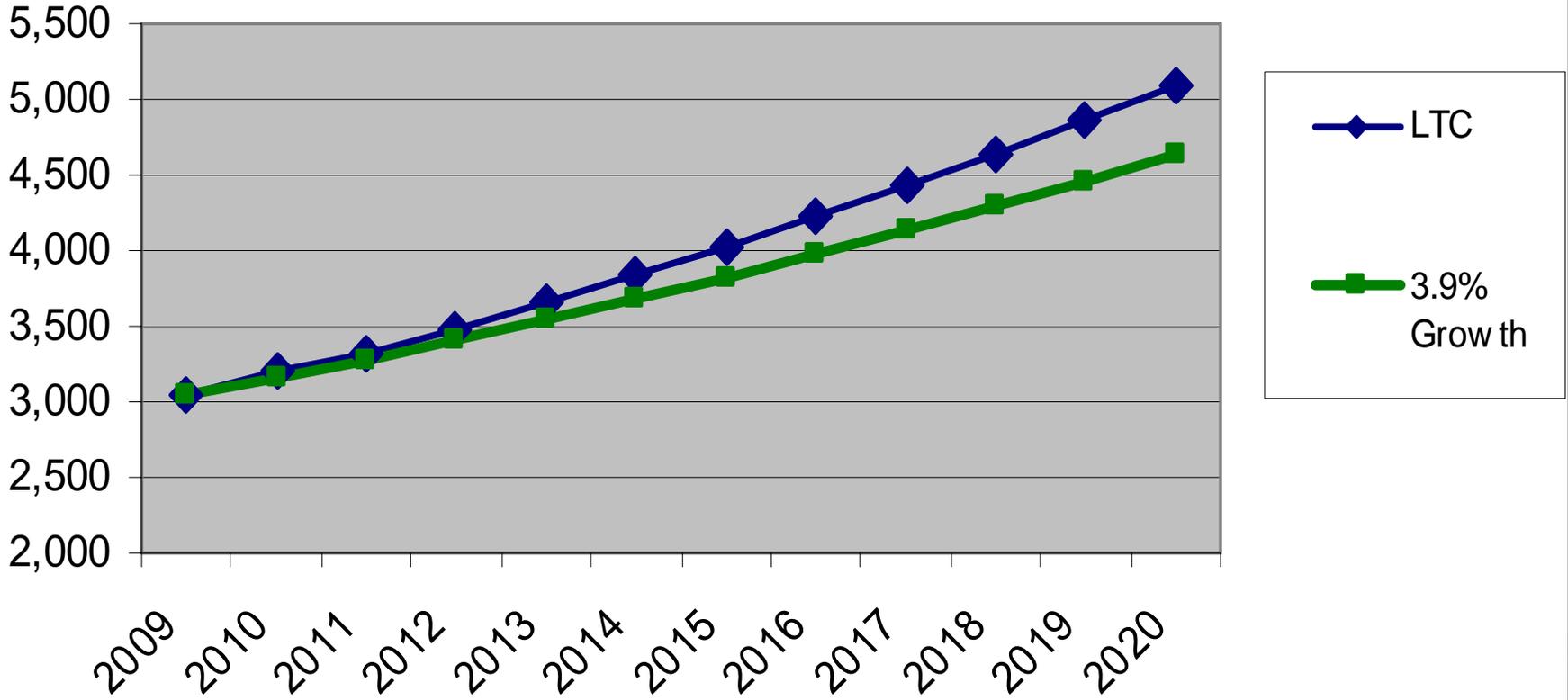
Source: Agency for HealthCare Research and Quality, Medical Expenditure Panel Survey, data for per capita spending by age group in the Midwest. Excludes spending for long-term care institutions.

## If State Health Care Costs Continue Their Current Trend, State Spending On Other Services Can't Grow



General Fund Spending Outlook, presentation to the Budget Trends Commission, August 2008, Dybdal, Reitan and Broat

## Total Medicaid Spending Elderly and Disabled In Millions of Dollars



## Business Drivers

- **Increased Pressure on State Budget**
  - Health and Human Services makes up 28% of state budget
  - The fastest growing portion goes to low income seniors in long-term care and children and adults with disabilities
- **Caregivers will have to be increasingly tapped to care for aging relatives (current estimates range from 75%to 90%)**
- **There is a slow uptake on long-term care insurance even with LTC Partnership incentives**
- **Coordination of programs doesn't always happen (silos)**
- **A new Level of Care Criteria is coming so fewer people will be eligible**



## Federal Business Drivers

- **There are similar messages coming out of federal government**
  - We need to Reduce Fiscal Pressure on Medicaid and Medicare
  - Increasing need to explain and manage health insurance options
  - CMS is placing a bigger emphasis on diversion and community living
  - New MDS 3.0 is coming in October 2010 – New Section Q – Return to Community - facilities will have new responsibilities in this area
  - CMS is starting new efforts focused on improving care transitions between hospitals, NHs and community





## Our Bigger Challenges

- Information for consumers is often not accessible and too high of a literacy level
- People who need help, don't self identify
- There are many “sources” of information and assistance but not all are neutral
- Generation Xr's and Millenials have high demands for technology and we are not prepared as they move into the role of caregiver





## Network Component 1: Telephone assistance



# Network Component 2: In Person and Face to Face Assistance

## Warroad Care Center



## Care Ventures



## Whitney Senior Center



## Waseca Clinic



## Network Component 3: Print, At Outreach Sites



## Network Component 4 - The Internet

- Service of the MN Board on Aging on behalf of the State of Minnesota
- 1999 legislative mandate for a long-term care database that grew into a larger initiative
- Online at [www.minnesotahelp.info](http://www.minnesotahelp.info) since 2003
- It is the web-based means of finding provider information about health and human services endorsed by the state of Minnesota
- The Web access point for Aging and Disability Resource Centers – a national CMS and AOA initiative
- The primary data infrastructure of the network (this is the way we ensure people find the “right service at the right time.”) so we need you to keep your information in the web site up to date



## What's in MinnesotaHelp.info?

- Nearly 30,000 services (plus)
- More than 11,000 providers
- More than 18,000 sites
- Over 123,000 unique visitors in FY2009
- In FY2009, there was a 111% increase in the number of visitors visiting more than once







## Resulted in Change to Statute 256.975 subd.7-

- ***11) using risk management and support planning protocols, provide long-term care options counseling to current residents of nursing homes deemed appropriate for discharge by the commissioner. In order to meet this requirement, the commissioner shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:***
  - ***(i) long-term care consultation services under section [256B.0911](#);***
  - ***(ii) designated care coordinators of contracted entities under section [256B.035](#) for persons who are enrolled in a managed care plan; or***
  - ***(iii) the long-term care consultation team for those who are appropriate for relocation service coordination due to high-risk factors or psychological or physical disability.***



## Targeting Criteria Developed in Study

- Prefer to return to the community and/or have a support person for community care

Residents early in nursing home stays and still have community ties

- Fit a community discharge profile -- health, functional, or personal characteristics indicating high probability of community discharge



## Preferences Make a Difference

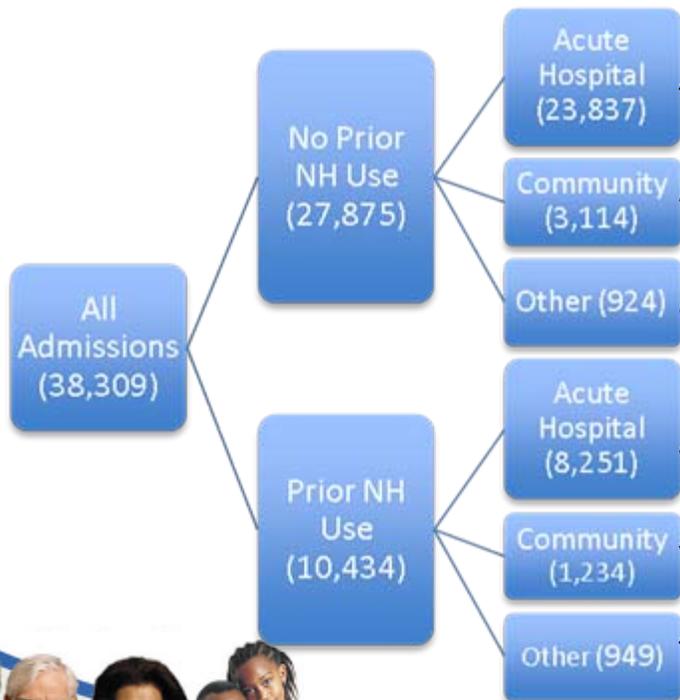
- Majority of nursing facility admissions prefer to return to the community and have a support person
- Preferences and support are strongly associated with length of stay and discharge status



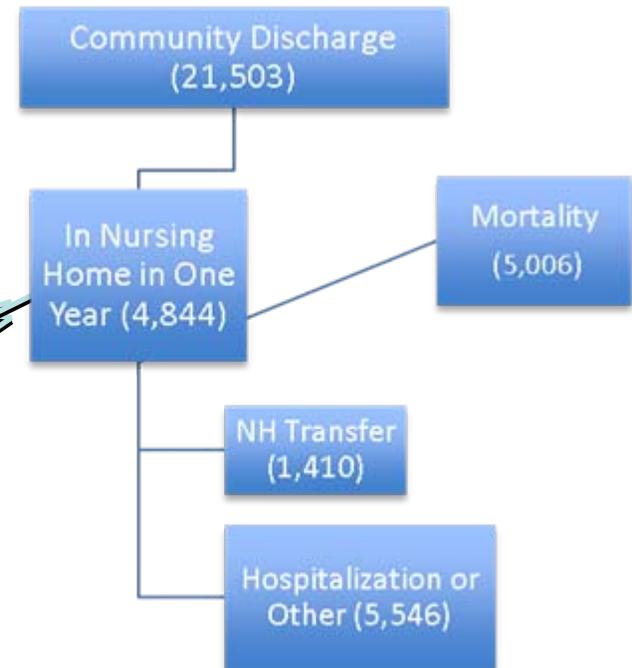


## Annual Minnesota Nursing Home Admissions (38,309) July 1, 2007 through June 30, 2008

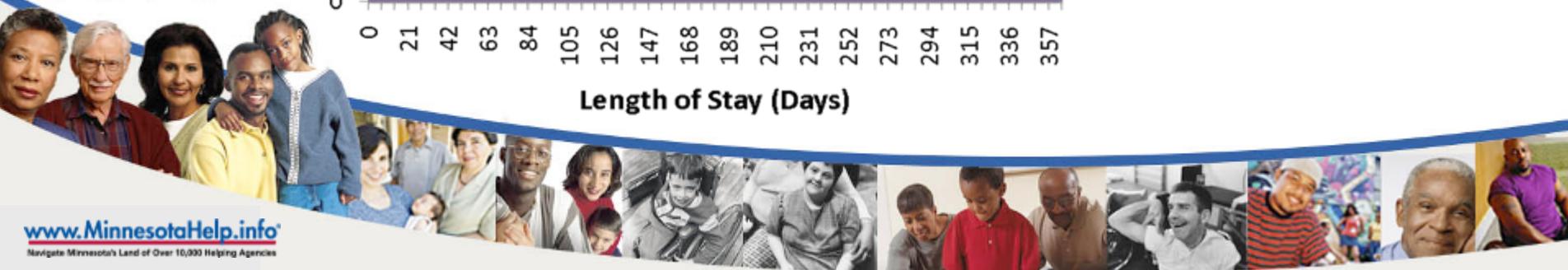
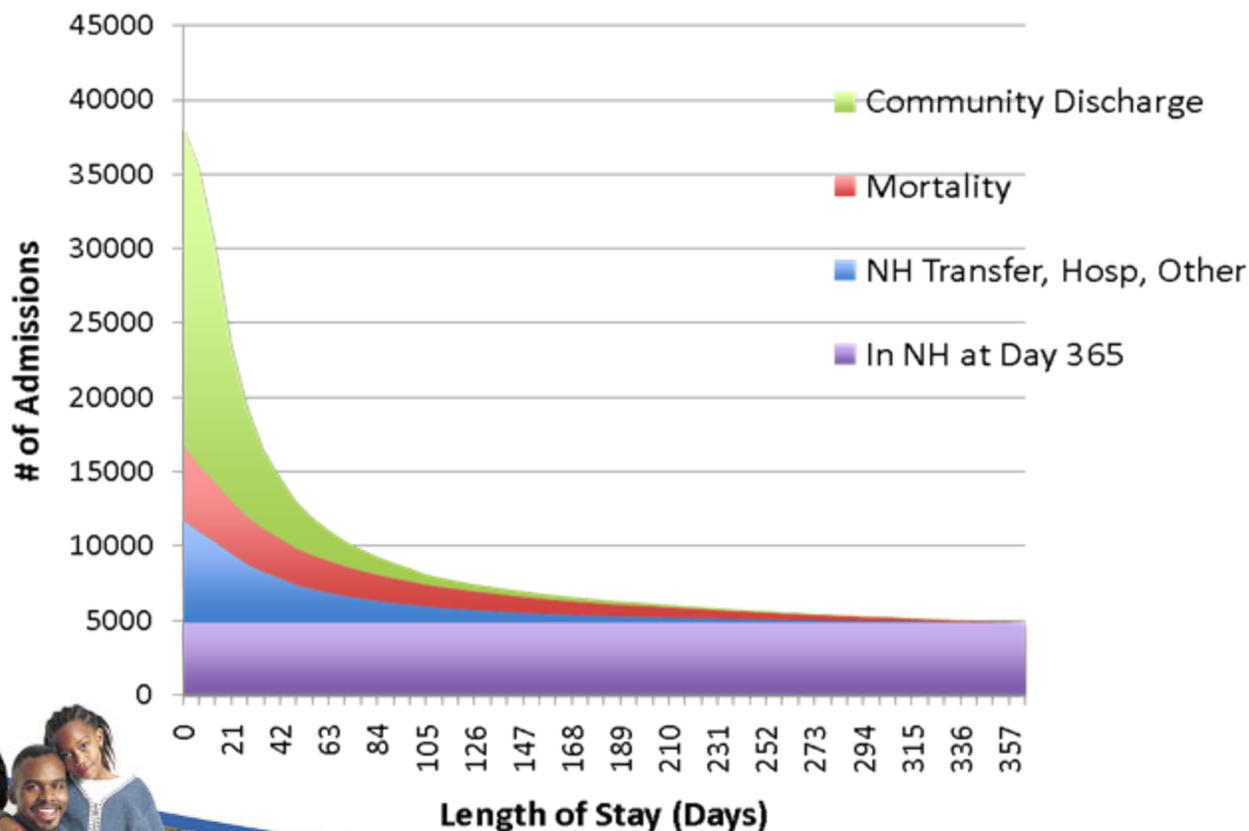
### Admitted from where?



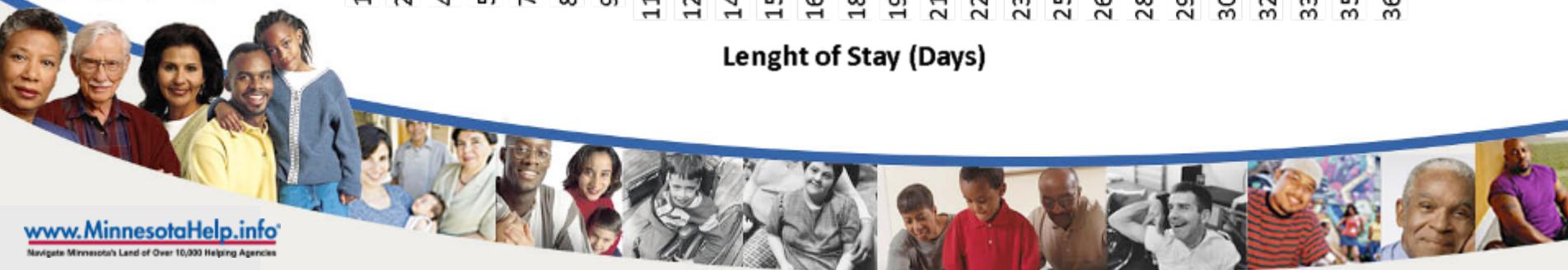
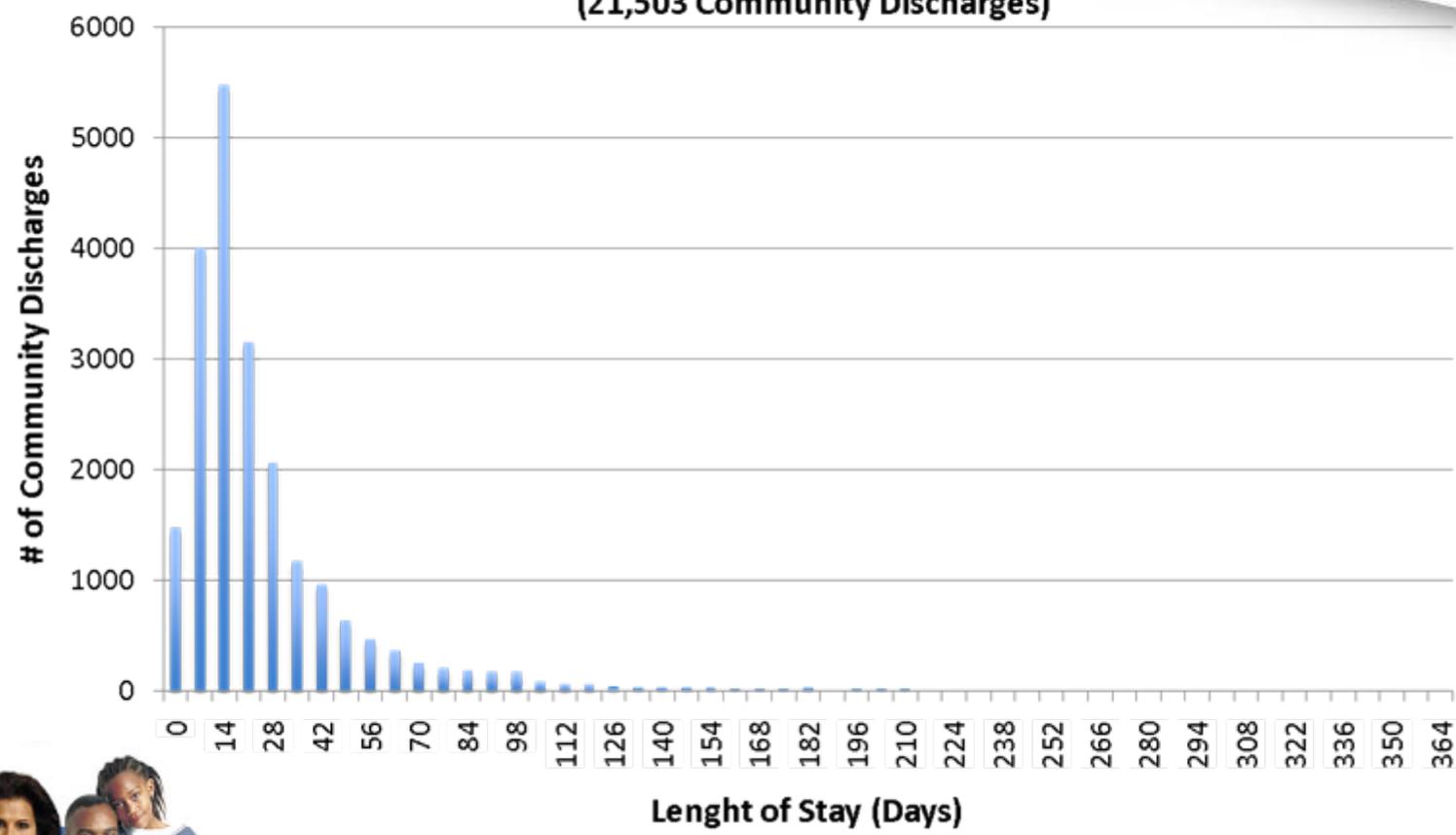
### Where are they after 1 year?



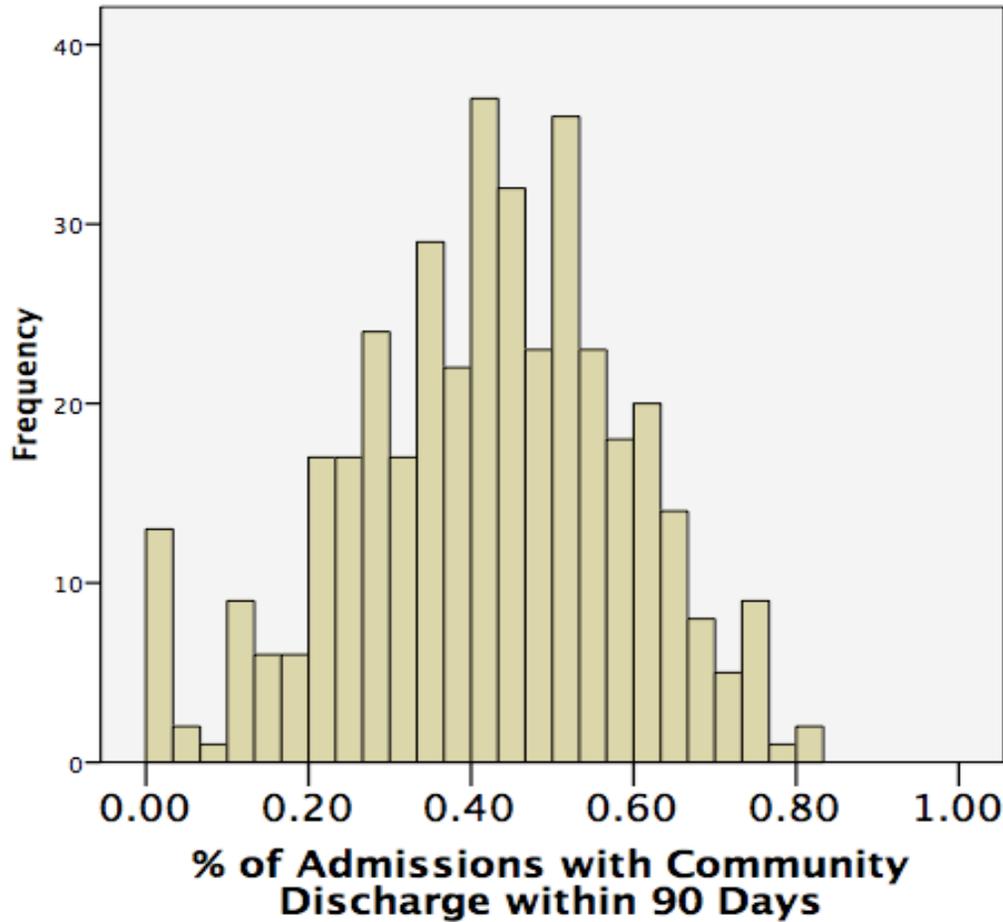
## LOS and Discharge Status for Annual MN Nursing Home Admissions (N=38,309)



**Community Discharge by Length of Stay for  
Annual MN Nursing Home Admissions  
(21,503 Community Discharges)**



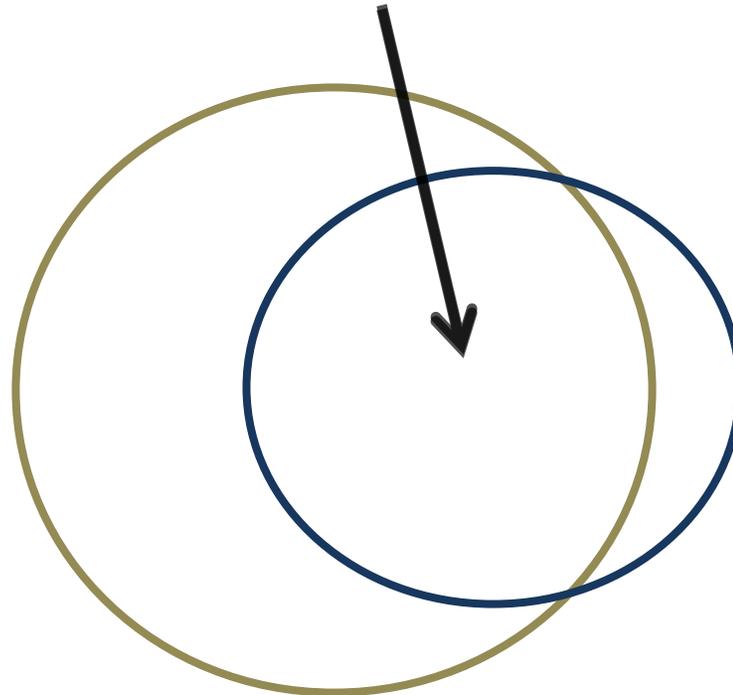
## Minnesota Nursing Facilities



# Residents Still in Nursing Home at 90 Days (8,765 Residents)

**Targeted: 22% Prefer/Support & Fit Profile  
(2115 Residents)**

**45%  
Prefer/Support  
Return to  
Community  
(3785 Residents)**



**25% Fit  
Discharge  
Profile (2941  
Residents)**

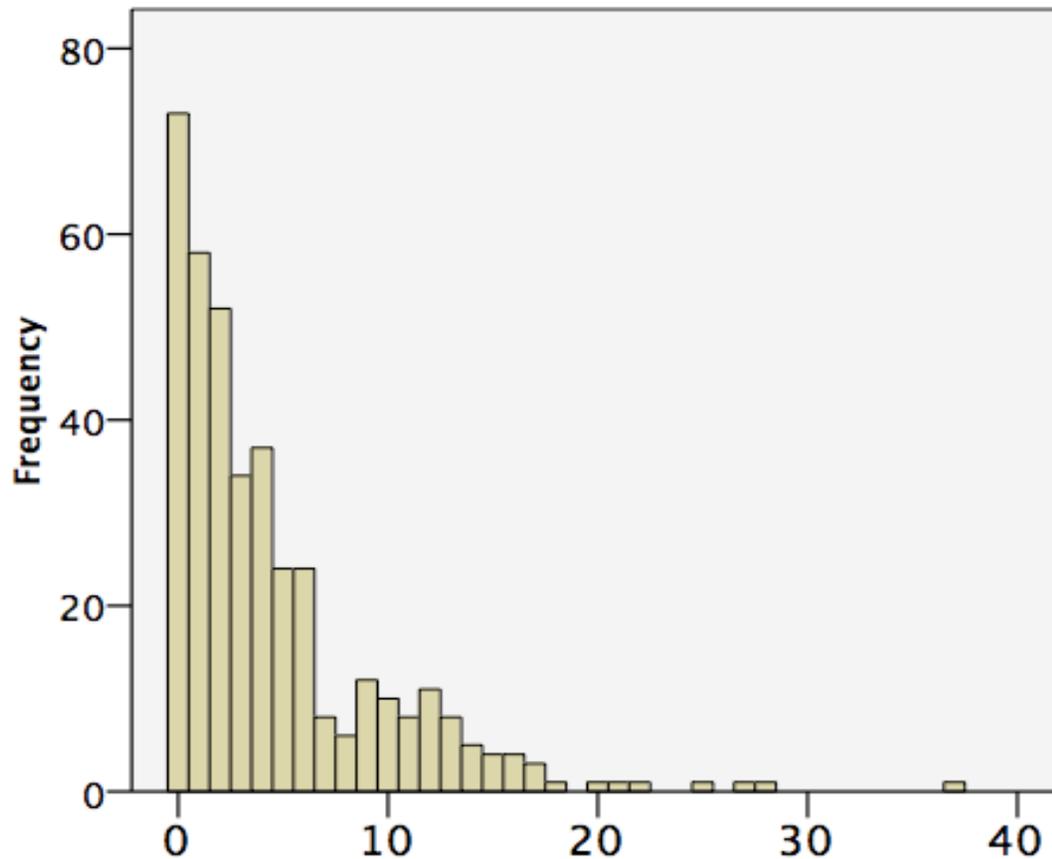


## In review of nursing home admissions over a 12 month period.....

- How many residents are likely to fit the discharge profile in my nursing home?
- As few as “none” or possibly up to 37 residents
- In the average nursing home, 4 residents will fit the profile



## Minnesota Nursing Facilities



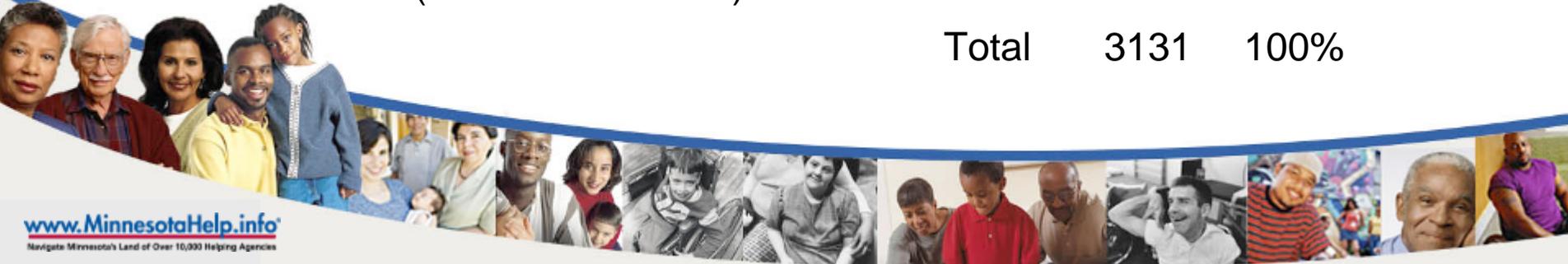
Mean = 4.51  
Std. Dev. = 5.15  
N = 389

**Number of Residents at 90 Days who Meet Return to Community Targeting Criteria**



## Residents Fitting the Profile at 60 days. Where are they? (Based on data from 2007-2008)

<u>Area Agency on Aging (AAA)</u>	Number	Percent
Duluth Region (Arrowhead)	289	9%
St. Cloud Region (Central)	374	12%
Fergus Falls Region (Land of the Dancing Sky)	190	6%
Warren Region (Land of the Dancing Sky)	74	2%
7 County Metro Region (Metropolitan)	1391	44%
Mankato Southwest Region (MN River)	408	13%
Rochester (Southeastern MN)	405	13%
<b>Total</b>	<b>3131</b>	<b>100%</b>



# Age Distribution

(Based on data from 2007-2008)

<u>Age Category</u>	Number	Percent
Under 18	2	0%
18-55	240	8%
55-65	310	10%
65-80	911	29%
80-90	1232	39%
90+	434	14%
Under 65	514	16%
Over 65	2615	84%



## First Time Admission?

New Admit and No NH Use < 2 Year	Under 65		Over 65	
	Number	Percent	Number	Percent
	379	74%	1827	70%



## Admitted to NF from where?

<u>Admit Source</u>	Under 65		Over 65	
	Number	Percent	Number	Percent
Priv residence No HH	13	3%	63	2%
Priv res with HH	5	1%	15	1%
Asst Living/ B&C	5	1%	15	1%
NH Transfer	0	0%	14	1%
Acute Hospital	484	94%	2486	95%
Psych/DD Hosp	1	0%	3	0%
Rehab Facility	5	1%	11	0%
Other	1	0%	8	0%



## Pay Source and Other Demographics

<u>Pay Source (MDS)</u>	Under 65		Over 65	
	Number	Percent	Number	Percent
Medicare	285	55%	2340	89%
Medicaid	148	29%	117	4%
Other	81	16%	158	6%
Probable Veteran	5	1%	11	0%
Female	275	54%	1870	72%
Unmarried	395	77%	1791	68%
Lived Alone	228	44%	1368	52%



## Race/Ethnicity

	Under 65		Over 65	
AmerIndian/Alaskan	12	2%	10	0%
Asian/Pacific Islander	1	0%	8	0%
Black (not Hispanic)	50	10%	23	1%
Hispanic	7	1%	9	0%
White (not Hispanic)	426	86%	2503	98%



## Preference and Support

	Under 65		Over 65	
Preference and Support for Discharge	438	85%	2280	87%
Prefer Community Discharge	512	100%	2594	99%
Support for Community Discharge	440	86%	2301	88%



## Cognitive Status

	<b>Under 65</b>		<b>Over 65</b>	
Intact	301	59%	1251	48%
Borderline Intact	109	21%	544	21%
Mild Impairment	64	12%	533	20%
Moderate Imp	38	7%	272	10%
Mod-Severe Imp	2	0%	13	0%
Severe Imp	0	0%	2	0%



## ADL Dependency Category (0-28)

	Under 65		Over 65	
Low (0-6)	169	33%	286	11%
Mod (7-12)	76	15%	379	14%
Mod-Severe (13-16)	78	15%	481	18%
Severe (17-22)	182	35%	1433	55%
Very Severe (23-26)	9	2%	36	1%



## Admission RUG group

<u>RUG Group</u>	<b>Under 65</b>		<b>Over 65</b>	
Extensive Services/Rehab	445	87%	2470	94%
Special Care/Clinically Complex	50	10%	91	3%
Impaired Cognition/Behavior	4	1%	6	0%
Impaired Phys Function	15	3%	48	2%



## Return to Community Goals

- Effort to change mindset that NHs are best long-term residence for people who could live successfully in community
- Facilitate successful NH stay → community transition
  - Respect people's preferences for living and care-giving arrangements
  - Use public resources efficiently
  - Promote good health and quality of life



## Meet your Community Living Specialist:

- **MinnesotaHelp Network™ Community Living Specialists will provide intensive support activities but they do not replace a Discharge Planner:**
  - Long-term Care Options Counseling
  - Evaluation over time
  - Support Planning in collaboration with discharge planning team
  - Service Coordination
  - Follow-up in the community for 5 years
  - Documentation in secure web based portal
- **These specialists will target private pay residents to avoid duplication of services**
  - Steps to connect Managed-Care and Medicaid enrollees to appropriate parties



## What is Long-term Care Options Counseling?

An interactive process where consumers, family members and/or significant others are supported in their decisions in order to make appropriate long-term care choices in the context of needs, preferences, values, and individual circumstances. It may be provided over the phone, online chat or in person such as in the Return to Community initiative.

Long-term Care Options Counselors help people look at all of the options in terms of their health and wellness as they age. Specifically their expertise includes an understanding of:

- The benefits provided by private options and how they intersect with public options (such as Medicare or Medicaid)
- Public systems and assistance with applications
- Other insurance benefits like Long-term Care Insurance and other financing options
- Housing options and the appropriate time to consider a move
- Caregiver supports
- Understanding home and community service options



## How did we develop the service protocol?

- We retreated in October with key stakeholders including representatives of the Nursing Home industry
- They assisted us in realizing the challenges and gaps that they have;
- As well as the strengths they bring to how people plan to return home
- We designed an approach that would compliment but not duplicate efforts that are out there



## So how will this work?

- First – it will have to be a close working partnership with Nursing home staff
- Some people may need a Long-term Care Consultation from the county
- We will need to pay attention to and manage risk for consumers, but they may want to take on some risk
- Everyone going into an NH will get a brochure about their options in returning to the community (rollout July 1)
- Use of Senior LinkAge Line® number for Options Counseling



## But won't this duplicate what is already happening?

- Counties primarily do relocation service coordination for under 65 – they can bill for it
- Medicaid Managed Care and MSHO Care Coordinators serve the dual eligible who are enrolled in Medicare and Medicaid
- Discharge planners and social workers in provider facilities or agencies can generally serve those who they have funding stream for
- They have a difficult time serving private pay people without a way to bill
  - **Community follow up is difficult but very necessary**
  - **Services brokering can be challenging when the person is back in the community**
  - **Providers do not have a call center infrastructure to handle some of the basic information and assistance that people may need**



## What about caregivers?

- Caregiver reengagement and support will be a priority
- There may be people who are un-befriended that need help strengthening their personal networks
- Cost calculators will be used as well as long-term care options counseling
- Benefit reviews will be conducted
- There may be need for application assistance



## Step By Step with Nursing Homes

- Community Living Specialist receives a name from the MDS profile list
  - Determines status – managed care or public program enrollee
- Contacts nursing home designee (NHSW or NHDP)
- Current resident discharge status determined
  - No discharge date and resident is private pay
  - Consumer says yes, they want a meeting
- Meeting arranged with resident and support person, if available
- Resident interview completed at nursing home
  - Release of Information obtained
    - Chart review
    - Staff interaction
    - Support person involved
- Collaboration/Partnership between NH, resident, Community Living Specialist, support person

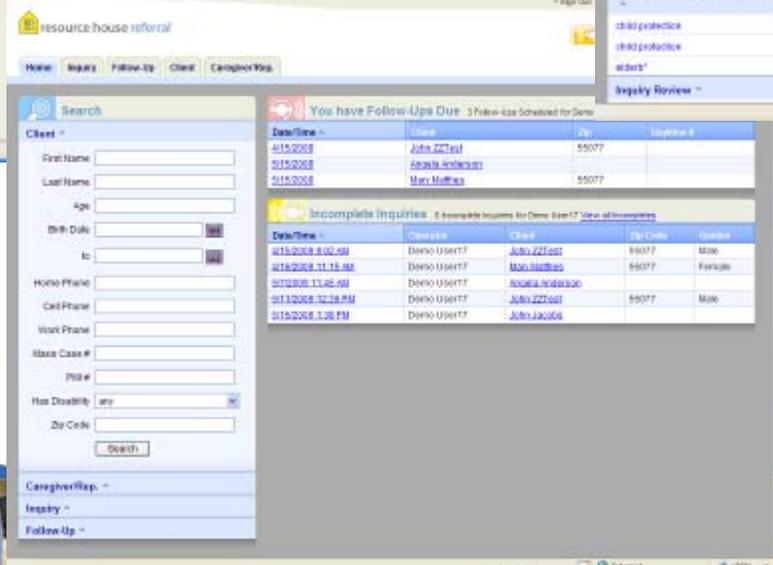
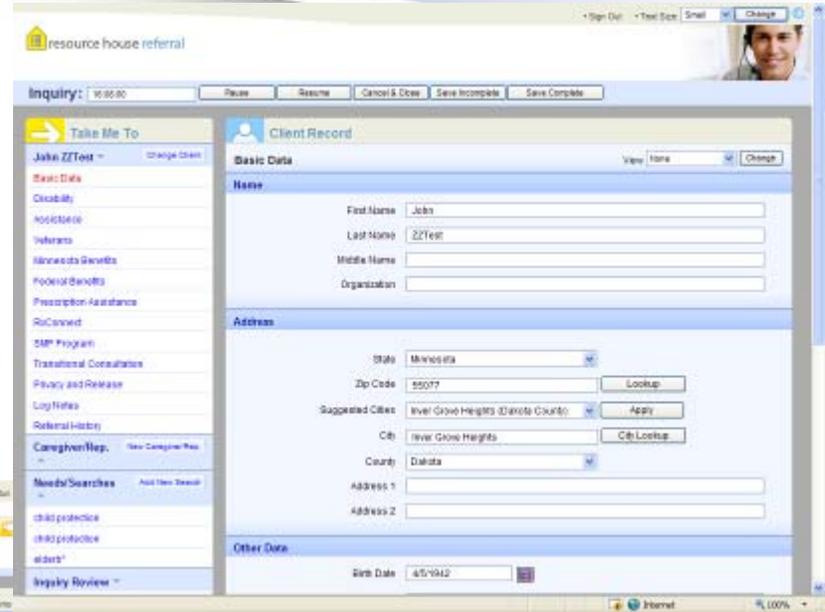
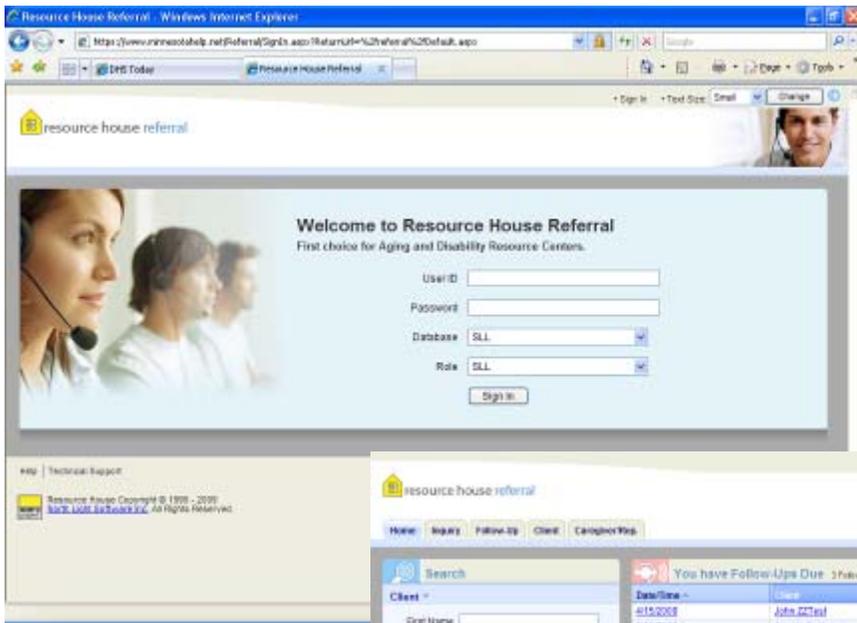


## Follow Up Protocol

- Initial follow up
  - In home visit within 3 days after NH discharge
- Continued follow up by Community Living Specialist
  - 14 days after NH discharge
- Phone based follow up continues
  - 30 days
  - 60 days
  - Quarterly for 5 years
- Person can decline further contact at any time



# Robust Client Tracking System



## Return to Community Communication Plan

- Brochure (in development and distributed to nursing homes July 1)
- Letter to Nursing Home Administrators
- Informational Resource Guide (in development)
  - Every person who receives assistance from Community Living Specialist will receive guide
- Minnesota Road Shows March 2010
- AASD Videoconference March 18
- MSSA Presentation March 25
- Care Providers Webinar April 20
- DHS Bulletin



## Well...we needed to do this anyway-MDS 3.0

- New MDS 3.0 implemented October 1, 2010
- Questions added to Section Q
- Nursing home mandated to make referral to local designated agency
- Person centered approach discharge planning must be conducted
- MDS training begins in April 2010



## **MDS 3.0: Section Q Discharge Potential (Per Draft – 3.0 Implementation 10/1/2010)**

- Residents asked on a quarterly basis “Do you want to talk to someone about the possibility of returning to the community?”
- If “Yes”, staff will develop a comprehensive person-centered discharge care plan based on the individual’s needs and preferences
- NH is required to make a referral to designated local agency within 10 business days. (In MN, this is Senior LinkAge Line®)
- The NH and local contact agency collaborate and coordinate to develop and implement a comprehensive discharge plan



## Level of Care

- In 2009, the MN Legislature passed legislation that changes nursing facility level of care (NF LOC) criteria for public payment of long-term care
- The change affects Medical Assistance payment for the most independent people receiving:
  - Nursing facility services
  - Long-term care services in the community such as Elderly Waiver (EW), Alternative Care (AC), Community Alternatives for Disabled Individuals (CADI) and Traumatic Brain Injury (TBI)
- Established Essential Community Supports, an alternative for those 65 or older whose eligibility is affected



## Why was the NF LOC criteria modified?

- Provide more consistent access to services
- Address Minnesota's aging demographics and manage growth in public spending for long term care
- Support service sustainability
- Improve the ability of lead agencies to assess individuals, monitor programs, evaluate outcomes and assess the impact of public spending
  - A new assessment tool (MN COMPASS) is being developed to support these goals.



## What are the new NF LOC criteria?

- For Medicaid payment for LTC services, a person must need at least one of the following:
  - Daily clinical monitoring
  - 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



## When will this change be implemented?

- The criteria are effective January 1, 2011
  - If Federal stimulus funding is extended for 6 months, implementation would be delayed until July 1, 2011
- New applicants to the HCBS programs will be assessed using the new criteria starting January 1, 2011
- Current participants in these programs will be assessed using the new criteria at their next reassessment that occurs on or after January 1, 2011



## The timeline for the implementation for nursing home services is as follows:

- MA payment for nursing home services will be unaffected for residents admitted before Oct. 1, 2010 and remaining for at least 90 days
- Privately-paying nursing home residents admitted on or after Oct. 1, 2010 who become financially eligible for MA over the course of their stay must meet NF LOC criteria at their most recent assessment prior to MA eligibility in order to qualify for MA payment for nursing home services
- Starting Jan. 1, 2011, individuals who are on MA prior to nursing home admission must meet criteria upon admission and at their first quarterly assessment in order to qualify for MA payment for nursing home services



## How are the Return to Community and New NF LOC Initiatives related?

- NF staff will need to be aware of and begin timely discharge planning for residents not likely to qualify at their first quarterly assessment
- LOC target group will be in the profile list sent to area agencies so Community Living Specialists can assist with relocation back to the community
- State will gain experience with this population prior to the effective date of the new LOC criteria (many of the residents that would not meet the new LOC criteria, will likely be in the Return to Community targeting profile)

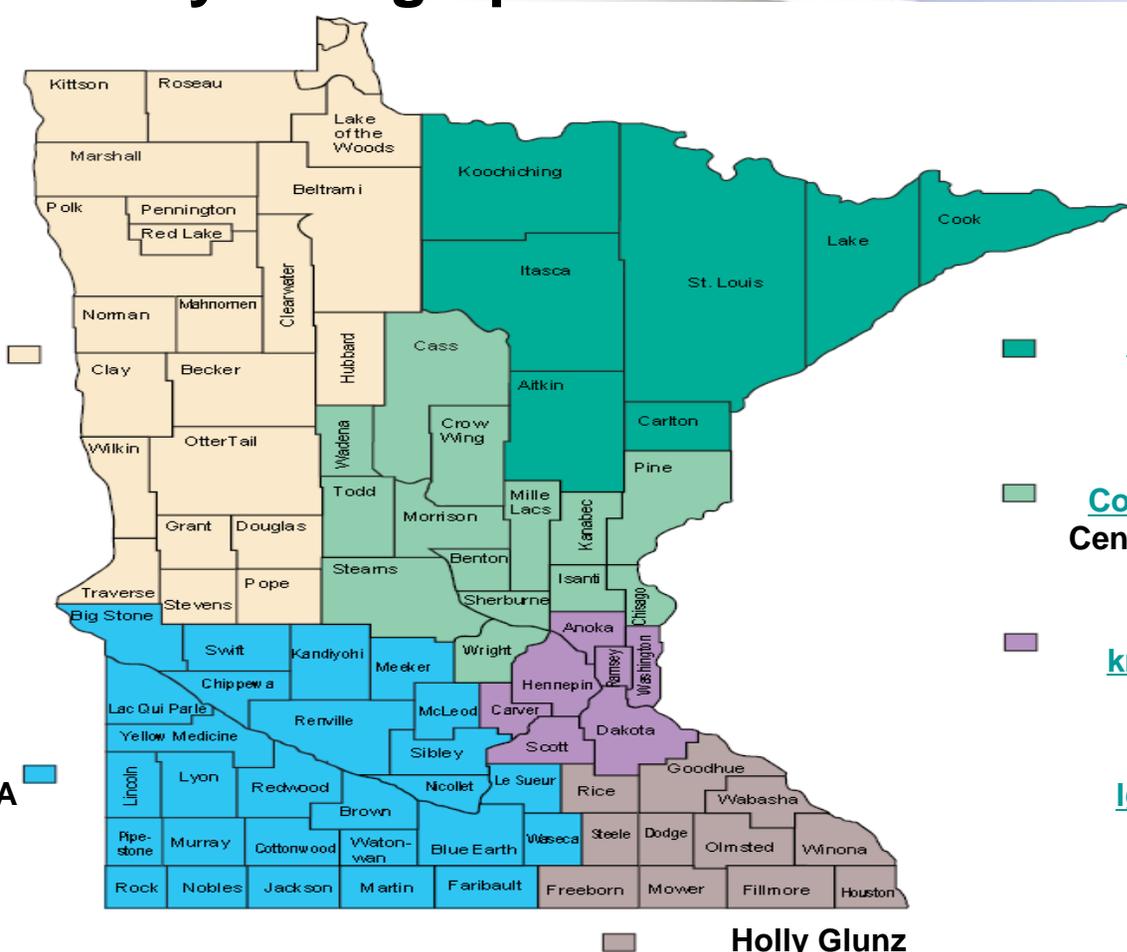


# Nursing Home Perspective

Chere Rikimoto  
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# Find a Community Living Specialist Near You....



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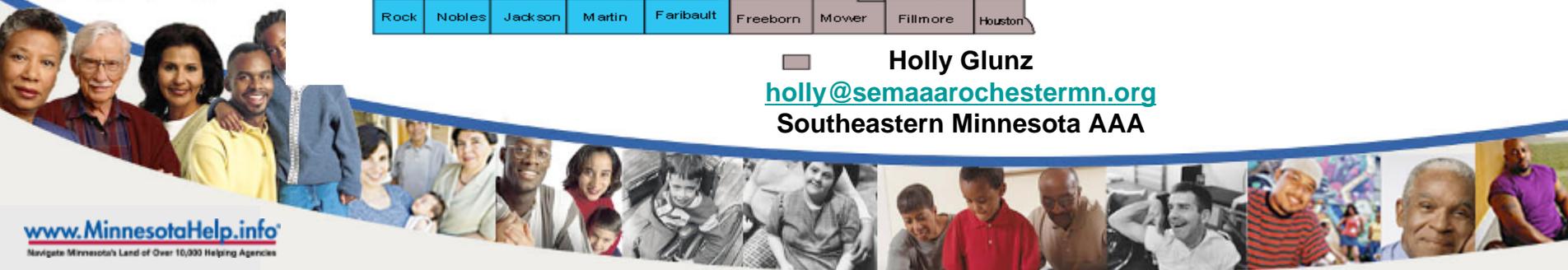
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