Minnesota Department of Human Services

Bulletin

NUMBER

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DATE

April 21, 2014

OF INTEREST TO

County Directors

Social Services Supervisors and Staff

County Public Health Supervisors and Staff

Tribal Health Directors

Health Plans

EW and AC Case Managers

Nursing Facility Owners

Nursing Facility Administrators

Nursing Facility Trade Associations

Long-Term Care Consultation Contacts

Area Agencies on Aging

ACTION/DUE DATE

Please read information

EXPIRATION DATE

April 21, 2016

Assistance for private pay nursing facility consumers who want to return to the community

TOPIC

Updates to 2009 legislation targeted to assist nursing facility consumers who express a desire to transition back to the community using home and community-based services.

PURPOSE

Summarize the policy and implementation requirements related to the statewide initiative that helps people return to the community from a nursing facility. Describe the roles of the Senior LinkAge Line®, nursing facilities and lead agencies. This bulletin replaces DHS bulletin #12-25-07.

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TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

I. Background

The 2009 Minnesota Legislature amended Minnesota Statutes, section 256.975, subd. 7 requiring the Minnesota Board on Aging and its designated Area Agencies on Aging, which operate the Senior LinkAge Line®, to provide Long Term Care Options Counseling to current nursing facility residents. Senior LinkAge Line® Community Living Specialists provide in-person assistance for consumers not on Medical Assistance and have expressed a desire to return to the community from the nursing facility.

This initiative, a service of the Senior LinkAge Line®, is based on research done by the University of Minnesota Center on Aging and Indiana University Center for Aging Research. The report to the Minnesota Department of Human Services, *Targeting Criteria and Quality Indicators for Promoting Consumer Transitions from Nursing Home to Community* reviewed Minnesota nursing facility admissions for a period of one year. The researchers found that over 80% of people admitted were successfully discharged back to the community within 90 days. If considering only those people most likely to successfully discharge – that is, people who prefer to return and/or have a supportive caregiver, and also have particular characteristics that make successful discharge more likely – over 90% have left the nursing facility within 90 days. Each of these characteristics (listed below) has a certain ability to predict discharge. A person may have a combination of these characteristics, which the researchers used to develop a "Discharge Probability Score" that can identify people who are comparatively more likely to be discharged successfully.

- Married
- Younger
- Female
- Live Alone Prior to Admission
- Medicare
- Hip Fracture
- Better Cognitive Performance Scale (CPS) Score
- Better Activities of Daily Living Long-Form Scale Score
- Continent Bowel and Bladder most of the time
- Resource Utilization Group (RUG) Extensive Services
- RUG Rehabilitation
- No Mental Health Diagnosis
- No Alzheimer's or Dementia Diagnosis
- No Diabetes
- No Cancer
- No End-Stage Renal Disease
- No Depression
- No Behavioral Problems

The initiative focuses on the other 10% of people- that is, those people who were admitted with the desire and capacity for a successful discharge but who, for unknown reasons, remains in the nursing facility. This report can be found on the Minnesota Department of Human Services website.

When Senior LinkAge Line® Community Living Specialists provide in-person assistance, this assistance includes assessment, support planning, service coordination, placement and ongoing follow-up in the community. This intervention is based on a person-centered approach and engagement of nursing facility staff as key partners to an effective transition. The initiative is primarily focused on serving private pay nursing facility consumers aged 60 and older. Individuals who are participating in a public health care program will be connected to other organizations and agencies responsible for serving these populations, such as care coordinators and case managers and tribes.

Senior LinkAge Line® in-person assistance for those who want to return to a community setting from a nursing facility is provided through the MinnesotaHelp Network™ Aging and Disability Resource Centers (ADRCs). The goal of the MinnesotaHelp Network™ is to identify highly visible and trusted community access sites for consumers of any age, income or disability to get information on the full range of long-term support options. The MinnesotaHelp Network™ creates a person-centered, community-based environment that promotes independence, easy access to information to assist consumers with long-term support options and provides resources and services that support the range of needs for families and caregivers. Consumers will be connected to the other Linkage Lines (Disability and Veterans) when necessary.

II. Implementation Model for the Initiative

Initially, the statute required the Minnesota Board on Aging (MBA) and the Minnesota Department of Human Services (DHS) to focus the initiative based on specific nursing facility consumer information compiled from the Minimum Data Set (MDS) nursing facility admission assessments. The MDS information was extracted 60 days from admission for consumers in Minnesota nursing facilities, that:

- Meet the targeting profile described previously;
- Are currently a resident and
- Have indicated the desire to return to the community on MDS Section Q

Since March 2014, MDS information is extracted after 45 days of the consumer being in the nursing facility rather than 60 days.

The MDS information is provided to designated Senior LinkAge Line® specialists known as Community Living Specialists. The Specialists contact the nursing facility-designated social worker or discharge planner to assist with the discharge planning process. The Community Living Specialists focus on assisting nursing facility consumers who request assistance to return to the community and are not on Medical Assistance. The service is intended to support current discharge planning efforts already occurring in nursing facilities and should not be viewed as a replacement to those services.

Since April 1, 2014, the Community Living Specialist will contact the nursing facility to determine if the consumer is currently residing in the facility. If so, the Specialist will notify the discharge planner/social worker they will be visiting the consumer to explain the in-person assistance that is available through the Senior LinkAge Line® as well as ongoing follow-up once discharged. Please see below for an overview of the full process. This in-person visit is expected by the Centers for Medicare & Medicaid Services (CMS) and is outlined in the CMS MDS Section Q RAI Manual Version 3.0.

A. Process for Assisting Consumers

The process for providing assistance to a consumer who expresses the desire to return to the community includes the following steps:

1. The Community Living Specialist securely receives the potential discharge candidate names from DHS or as a referral from a nursing facility.

2. A contact is made to the designated nursing facility social worker or discharge planning staff to confirm whether the consumer identified has already been discharged or is still in the facility.

3. If the consumer has not been discharged, the Community Living Specialist will schedule an appointment to meet with the consumer to explain the assistance that can be provided through the Senior LinkAge Line® and discuss community based options that may be available. The meeting will include anyone the consumer requests.

4. At the initial meeting the Community Living Specialist will obtain a written release of information from the consumer that will cover the scope of interaction the Senior LinkAge Line® will have with the consumer including follow-up services.

5. The Community Living Specialist will work with the consumer to understand their preferences and develop an individualized Community Living Support Plan intended to identify needs and supports required to help the consumer return to the community. The plan will be reviewed with the consumer and modified, if needed, to meet the consumer's preferences and needs.

6. The Community Living Specialist along with the nursing facility discharge planner will ensure appropriate services are arranged at the time of discharge.

7. Within 72 hours of nursing facility discharge, the Community Living Specialist will provide a face to face visit at the consumer's home to ensure services arrived as scheduled based upon the Community Living Support Plan. The consumer will receive additional follow-up at 14 days, 30 days, 60 days, and 90 days after nursing facility discharge and then on an ongoing quarterly basis for up to 5 years. The purpose of the check-in is to see if changes to the support plan are needed and also for initiative evaluation. The check-in is critical to help the consumer maintain

successful community living. The consumer can opt out of the follow-up at any point in the process.

In addition to the process outlined above, each consumer receives a brochure, titled, “Start planning now to return and remain at home successfully” upon admission to the nursing facility. The brochure informs nursing facility consumers about Long Term Care Options Counseling and how they may access this service through the Senior LinkAge Line® by calling 1-800-333-2433.

B. MDS (Minimum Data Set) 3.0 Changes

On October 1, 2010, MDS 3.0 was distributed to nursing facilities throughout the United States. MDS assessments are completed with all nursing facility consumers across the nation. This assessment is completed, at a minimum, upon admission, quarterly and annually. Additional assessments are completed with nursing facility consumers who are utilizing their Medicare benefits or who have had significant changes in their functional or health status. MDS assessments are completed with nursing facility consumers to determine their Resource Utilization Group (RUG) rate. This rate is used by states as well as the federal Centers for Medicare & Medicaid Services (CMS) to determine the level of care the consumer requires from the nursing facility. This also is the daily rate the facility will be paid either through Medical Assistance, private resources or Medicare.

In October 2010 and again in April 2012 significant changes were made to the MDS including changes to Section Q. This section is known as the “Discharge Potential” section. It is completed with consumers to determine what their discharge goals are once they have been admitted to the nursing facility. Most consumers have a goal to return to the community setting where they resided prior to admission. Consumers are now asked additional questions that includes finding out if they would like to speak to someone about returning to a community setting. If the consumer says yes, the nursing facility then indicates if they made a referral to the “local contact agency”. If a referral is made, it must be done within 10 days of MDS Section Q being completed.

The “local contact agency” as defined by CMS is the following: Each state has community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

In Minnesota, the local contact agency is the Senior LinkAge Line® (1-800-333-2433). MDS Section Q referrals to the Senior LinkAge Line® do not guarantee that the consumer will, in fact, discharge from the nursing facility but simply provides an opportunity for the consumer to learn more about their options.

When an MDS Section Q referral is made to the Senior LinkAge Line®, phone based options counseling will be provided to consumers who are not on Medical Assistance as

well as in-person assistance if the consumer requests. However, according to the CMS RAI Manual for MDS Section Q 3.0, an expectation is present that each consumer referred will receive in-person assistance. Consumers who are referred to the Senior LinkAge Line® through MDS Section Q and are open to Medical Assistance will be referred to their county case worker or managed care coordinator to discuss options for returning to a community setting.

Minnesota was able to easily implement the Section Q referral protocol due to two strategies that had been successfully implemented prior to the MDS Section Q change: 1) the initiative which began in 2010 and requires the Senior LinkAge Line® to provide statewide in person assistance to private pay nursing facility consumers who want to return to a community setting and 2) requirement that all Senior LinkAge Line® specialists have expertise in providing Long Term Care Options Counseling.

To assist nursing facilities with a convenient way of making MDS Section Q referrals to the Senior LinkAge Line®, the Minnesota Board on Aging developed a secure online referral site. Please see section D for more information on using the online referral site.

C. Direct Referrals from Nursing Facilities

Partnerships and relationships have developed since the launch of in-person assistance through the Senior LinkAge Line® and nursing facilities have been making direct referrals to the Senior LinkAge Line®, even if MDS Section Q did not trigger a referral. Often the referral is due to the fact that nursing facilities feel the consumer may need additional follow-up in the community after the discharge or because the nursing facility would like assistance developing a comprehensive discharge plan. The Senior LinkAge Line® can provide this additional assistance.

As mentioned above and to assist nursing facilities with a convenient way of referrals to the Senior LinkAge Line®, the Minnesota Board on Aging developed a secure online referral site. Please see section D for more information on using the online referral site.

D. Senior LinkAge Line® Online Referral Site

In the past, when nursing facilities felt a consumer may benefit from in-person assistance provided by the Senior LinkAge Line®, the nursing facility would contact the Senior LinkAge Line® or the Community Living Specialist directly to make the referral.

To allow for ease of communication and ensure all necessary information is collected when referrals are made, the Minnesota Board on Aging created a secure online referral site that allows nursing facilities to make referrals directly to the Senior LinkAge Line®.

There are three options available for types of referrals. Referrals related to MDS Section Q, Moving Home Minnesota (Money Follows the Person), or direct referrals for assistance from a Community Living Specialist can be made by choosing the third option available.

It is requested that nursing facilities use this online referral site for appropriate tracking and collection of information.

E. Assistance for Consumers in the Community

Beginning January 1, 2014, with a hard launch on March 1, 2014, the initiative was expanded to include assistance to consumers who are residing in the community, but seek additional assistance to remain in their home long-term. The current follow-up protocol developed through the initiative allows the Senior LinkAge Line® a way to assist these consumers, even though they are not residing in or discharging from a nursing facility.

While all consumers who would benefit from Senior LinkAge Line® assistance may receive it, the target group for consumers residing in the community are those who are thinking about moving to a registered housing with services setting (assisted living), but have not yet moved. These consumers are identified through another initiative of the Senior LinkAge Line® known as Long Term Care Consultation Expansion which began in October 2011. More information about this service can be found in DHS bulletin #12-25-08.

Prior to moving to a registered housing with services setting, consumers contact the Senior LinkAge Line® to be offered Long Term Care Options Counseling. Options counseling consists of providing information to the consumer about housing options and community resources. Senior LinkAge Line® provides follow-up ten days later determine if the consumer has decided to move or remain at home after receiving options counseling. If the consumer states they will remain at home or are undecided, they will be offered in-person assistance by a Senior LinkAge Line® Community Living Specialist. The assistance is identical to the assistance provided to consumers who discharge from a nursing facility, which includes follow-up in the community for up to 5 years.

III. Financing the Initiative

The 2009 and 2013 Minnesota Legislature appropriated funds for this initiative. The funds, provided to the Minnesota Board on Aging, will be provided to the Area Agencies on Aging for staffing through the Senior LinkAge Line®. The initiative is also being supported through the Aging and Disability Resource Center (ADRC) federal grant funds provided to the Minnesota Board on Aging. Additional Community Living Specialists have been hired at each of the six Area Agencies on Aging which cover all 87 counties in Minnesota. Additional information about each of the six Area Agencies on Aging providing the service as well as the counties served by each Area Agency on Aging can be found on the Minnesota Board on Aging website.

IV. Referrals to Lead Agencies

The initiative is focused on serving private pay individuals, those who are not on a public health care program. If a Community Living Specialist is asked to assist a nursing facility

consumer who is enrolled in Medical Assistance, the consumer *will be connected to the local lead agency for assistance*. If the consumer is enrolled in a Medical Assistance managed care plan, the Community Living Specialist will connect the consumer with their managed care coordinator. For non-managed care Medical Assistance participants, the Community Living Specialist will connect with a county lead agency for Relocation Service Coordination. If the consumer is under age sixty-five, open to Medical Assistance and requesting transition assistance, the consumer may be connected to the local Center for Independent Living (CIL).

Contact information for county agencies and managed care plans can be found in the resource section of this bulletin (Section VI).

A. MnCHOICES Requests [also known as Long Term Care Consultation (LTCC)]

Consumers who meet the targeted profile mentioned earlier in this bulletin and are under age sixty-five should have had a face-to-face MnCHOICES visit completed within forty days after nursing facility admission as required under Minnesota Statutes, section 256B.9011, subd. 4d. Community Living Specialists or other designated Senior LinkAge Line® Specialists will verify a referral has been made to the lead agency on behalf of the consumer to have the MnCHOICES completed. For consumers who are on Medical Assistance or a managed care plan, designated Senior LinkAge Line® Specialists will verify the nursing home has made a referral for relocation services or has contacted the consumer's county case worker/managed care coordinator. The reason is to ensure the consumer's goals have been shared with the lead agency and are being responded to if the consumer wants to discharge from the facility.

B. Follow-Up

Consumers who discharge from the nursing facility with assistance from the nursing facility discharge planning team, county case worker, or managed care coordinator, will be contacted in the community by the Senior LinkAge Line® within 14 days from discharge. Ongoing follow-up will occur every 90 days for up to 5 years. The consumers will be asked to participate in the evaluation that is occurring regarding this service. The consumer is welcome to decline this service at any point in the evaluation process. The evaluation will include collecting information about caregiver supports, activities of daily living and instrumental activities of daily living, hospital and emergency room utilization patterns, as well as home and community based service usage.

Release forms will be provided to protect the consumers' rights and privacy. The consumer will be connected with community resources or their managed care coordinator/county case worker, if necessary, for additional follow-up.

It is the responsibility of the nursing facility discharge planner to provide contact information for nursing facility consumers who appear on the profile list and discharged without the

assistance of the Community Living Specialist. Nursing facilities should be aware they are in compliance and not violating the federal Health Insurance Portability and Accountability Act (HIPAA) when providing this contact information to the Senior LinkAge Line® as follow-up in the community is part of the statutory language for the initiative.

V. Communication

A Senior LinkAge Line® brochure titled, "Start planning now to return and remain at home successfully" was developed and provided to each Minnesota nursing facility in July 2010 and again on March 14, 2014. Each consumer who admits to a Minnesota nursing facility should receive this brochure in order to understand that options counseling is available from the Senior LinkAge Line®. Additional brochures are available at no cost through the statewide Senior LinkAge Line® by calling 1-800-333-2433.

In addition, for each nursing facility consumer assisted by a Senior LinkAge Line® Community Living Specialist through this initiative, the "Returning Home: Making a Successful Move to your Home and Community" booklet will be provided. The booklet is a planning tool to help the consumer prepare for discharge.

On March 14, 2014, a joint letter from the Minnesota Department of Human Services and the Minnesota Board on Aging outlining the changes to the initiative was sent to each Minnesota nursing facility administrator and social services director.

VI. Related Bulletins and Other Resources

Bulletins issued in the last two years are available on the Minnesota Department of Human Services' website. Click on bulletins.

The Minnesota Department of Human Services website contains more information on this initiative.

The statute governing the initiative is available on the Office of the Revisor of Statutes website.

The online referral site for Senior LinkAge Line® referrals is available on the Minnesota Board on Aging website.

Contact information for each Area Agency on Aging is located on the Minnesota Board on Aging website.

Additional information about MDS 3.0 changes, including the protocol for Section Q referrals to the local contact agency can be found on the Centers for Medicare and Medicaid website.

A listing of the statewide LTCC Administrative Contacts for all counties can be found on the Minnesota Department of Human Services website.

A listing of the statewide Minnesota Senior Health Options (MSHO) Care Coordinators for all managed care plans can be found on the Minnesota Department of Human Services website.

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-2500 (voice) or toll free at (800) 882-6262 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.