Nursing Facilities: Creating a Pipeline to the Community

HCBS CONFERENCE
Home & Community-Based Services

2023 Home and Community-Based Services Conference

Introductions

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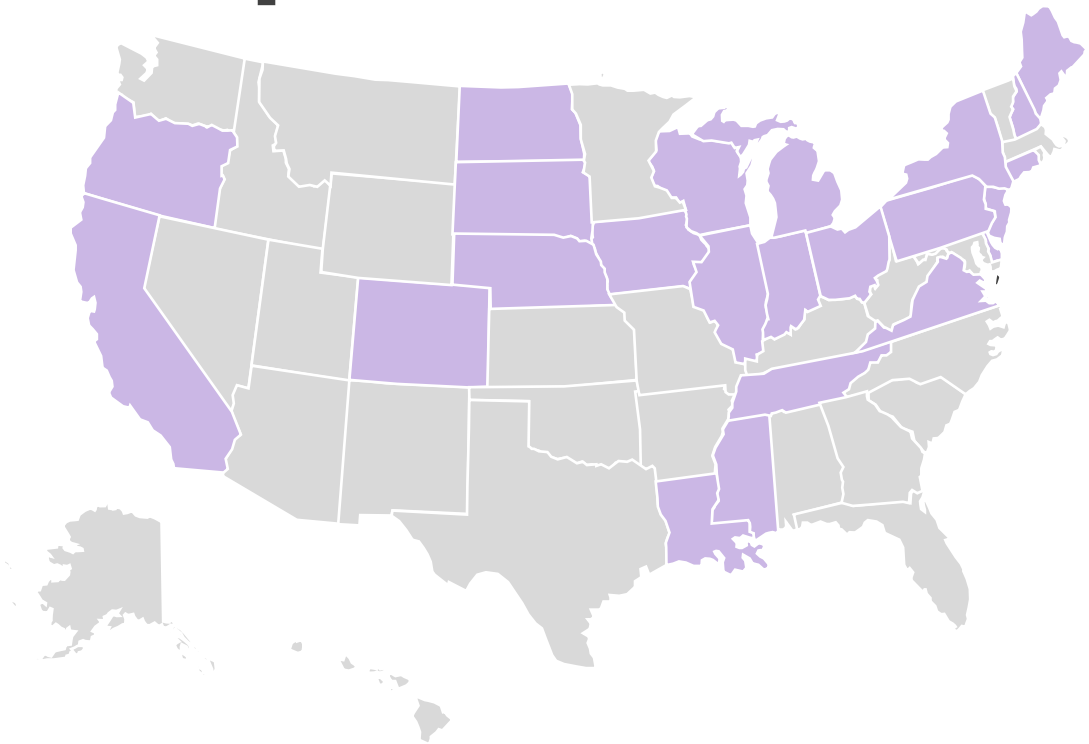
Maximus LTSS Assessment Experience

21 years'
of clinical review & functional assessment experience

22 states
served with statewide clinical programs

8K clinicians
in our clinical network

2M assessments
completed annually



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Long-Term Service and Support Option Counseling (LTSSOC) and Home and Community Based Services (HCBS) in North Dakota

Nancy Nikolas Maier
Director ND Department of Health and Human Services Adult and Aging Services Section

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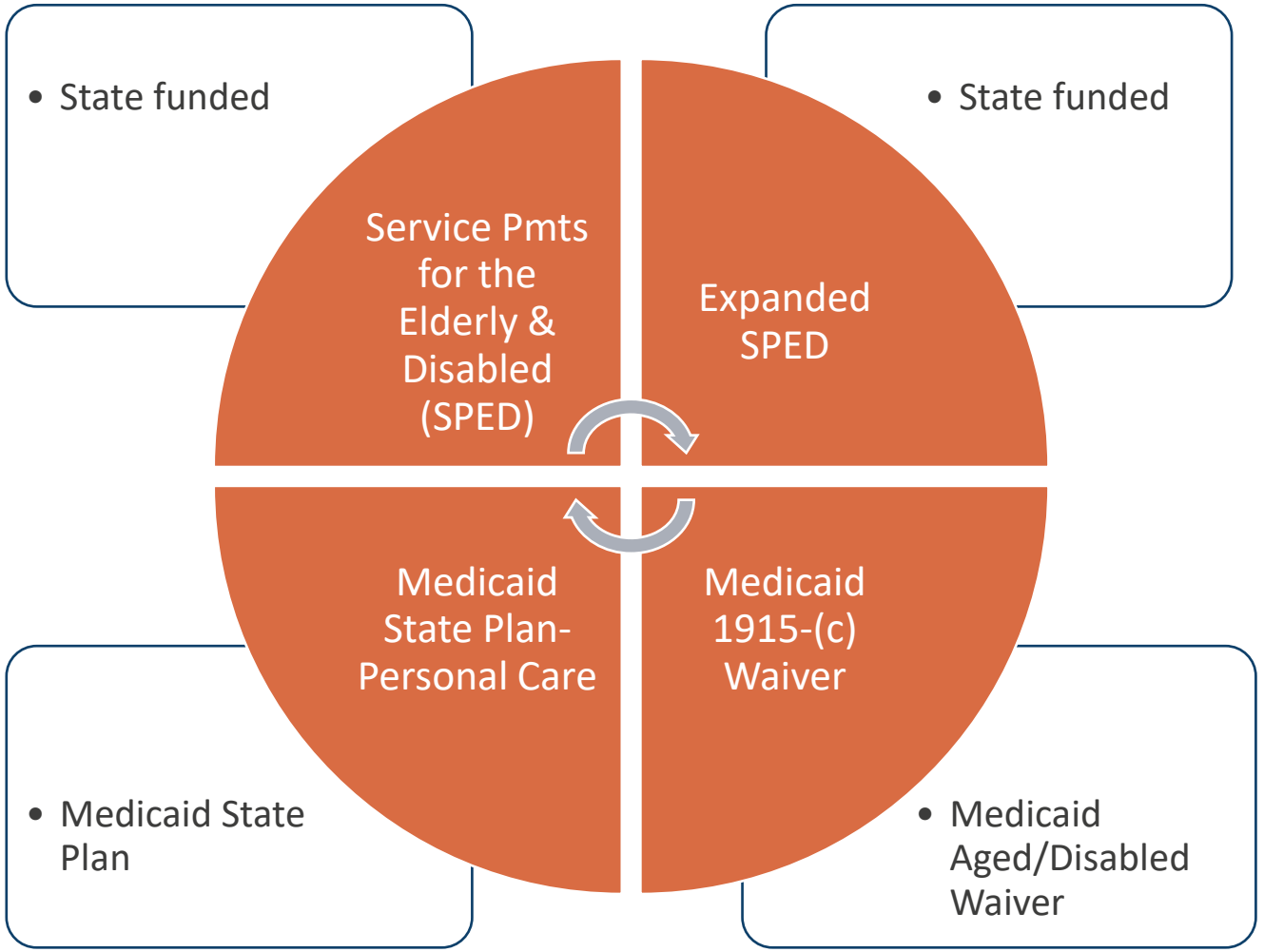
North Dakota Adult & Aging Services
Home and Community Based Services

- Primarily serves older adults and individuals with physical disabilities
- Recipients must be both functionally and financially eligible
- May have client cost share based on income
- Federal and state funds
- Services focus on individual choice and maintaining independence in the most integrated setting



North Dakota HCBS Service Array
Types of *Support Services* available

- Adult Day Care
- Adult Foster Care
- Adult Residential
- Case Management
- Chore Service
- Community Support
- Community Transition
- Companionship
- Emergency Response System
- Environmental Modification
- Extended Personal Care & Nurse Education
- Family Home Care
- Family Personal Care
- Home Delivered Meals
- Homemaker
- Non-medical Transportation
- Residential Habilitation
- Respite
- Specialized Equipment
- Supervision
- Supported Employment
- Transitional Living

North Dakota Long-Term Care Services & Supports (LTSS) Identified Concerns

- Historically reliant on institutional care for older adults and adults with physical disability
  - Nursing facilities in many rural and urban cities across the state
  - Unnecessary segregation of individuals in nursing facilities
  - Adults in skilled nursing facilities who would rather be in their community
  - Lack of awareness about existing transition services and available tools

PEOPLE OVER 65 IN CERTIFIED NURSING FACILITIES

Sources: Henry J Kaiser Foundation, US Census Bureau (2016)

History of North Dakota Department of Justice Settlement Agreement

- In 2015, the Governor's office received a letter from the DOJ regarding a complaint that the state was not serving individuals in the most integrated setting, as required under the ADA
- Investigation findings supported that individuals weren't aware/informed of available community resources OR when they did seek assistance for community resources, they were difficult to obtain
- A settlement agreement was offered and agreed to, as North Dakota was already undergoing several changes with their Home and Community-Based Services (HCBS) programs
- Final agreement signed in December 2020, laying out what was required by North Dakota to demonstrate meeting benchmarks under the ADA regulation for most integrated settings over the next 8 years

Legislative investments in HCBS

HCBS Informed Choice Referrals - Rulemaking

- The Department of Human Services shall adopt rules, on or before Jan. 1, 2021, establishing a process and requirements to involve public and private entities in identifying individuals who are at serious risk of accessing Medicaid-funded long-term care in a nursing facility and inform them about home and community-based services options
- Beginning December 2022, all Medicaid eligible individuals who reside in a nursing facility must have an annual nursing facility level of care screening to determine continued functional eligibility

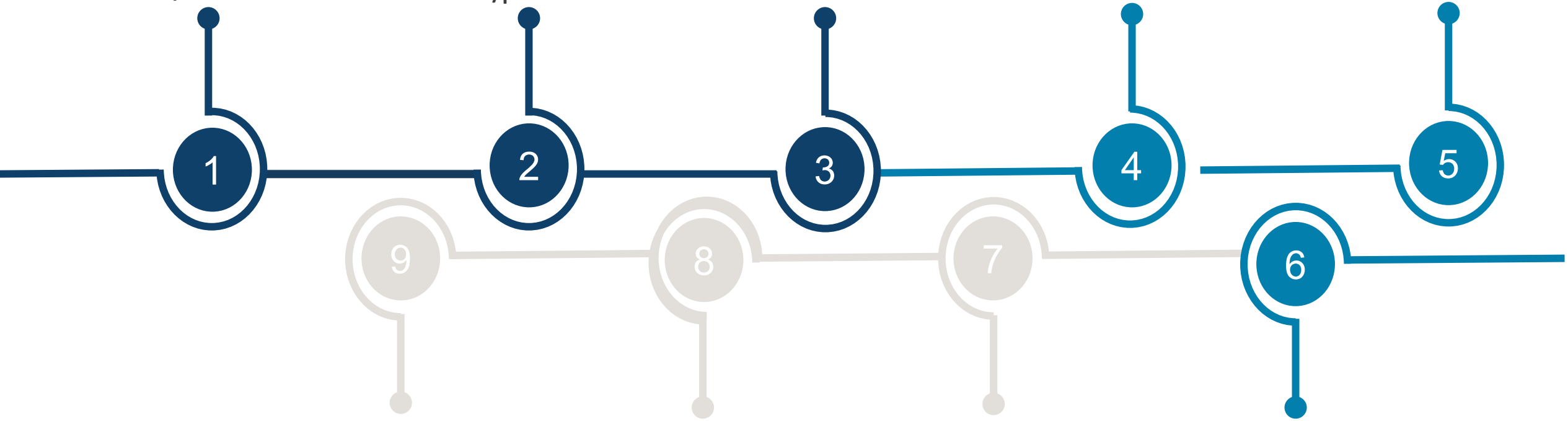
Long-Term Services and Supports Options Counseling

Ensures Medicaid eligible individuals know their LTSS options

Provides essential information for improving access and delivery of long-term services and supports

Addresses identified barriers through person-centered planning

Timeline of Activities



July 2020: Collaboration between DHS and Maximus to align on incorporation of existing NF LOC process and develop workflow

August 2020: DHS administrative code development; refinement of workflow for triage approach of high/low needs/preferences

September 2020: Applied historical data to finalize triage approach; proposed LOC tool updates

October 2020: Tested proposed LOC tool questions with sample of PASRR population and edited based on feedback; IT system adjustments

December 2020: Conducted provider training on LOC tool updates; developed daily report mechanism

January 1, 2021: Go-live of new LOC tool updates with daily report of triaged population and subsequent HCBS case manager follow up

February 2022: Annual LOC requirement into effect, requiring time-limited approval

June 2022: All individuals getting a NF LOC (admission or annual) receive subsequent HCBS case manager follow up

December 2022: Annual LOCs required for those individuals with historical non-time-limited approvals; Maximus sends notifications of all expiring approvals

Questions on the NF Level of Care Screening

Answered by facility staff

1. Why is nursing home admission/continued admission being considered for this individual's care over other settings?
2. What other less restrictive options were considered?
3. What is their greatest need right now?
4a. Is there potential for this individual to live outside of a nursing facility within the next 6 months with community supports in place?
    - Yes/No

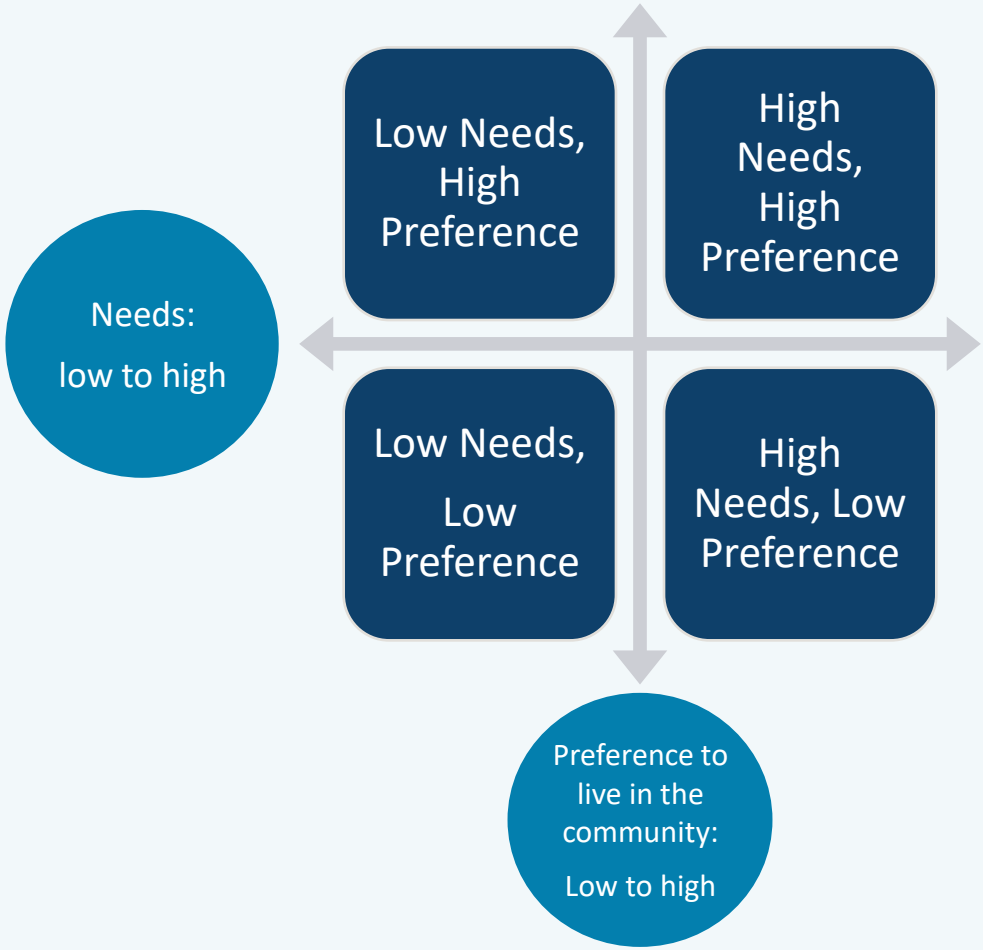
4b. If yes to question 4a, what would the individual need for that to happen (e.g., housing, support with ADLs, medical support, etc.)?

Facility staff ask Medicaid member

1. Would you be interested in getting information about the possibility of receiving different kinds of supports that may assist you to be able to live outside of a nursing facility?
2. Do you believe a nursing facility is the best place for you to receive care right now?
3. Does your family/natural support group agree with you receiving nursing facility care?
    - No/Yes

- 4. What are your long-term goals for where you would like to receive care?
- 5. What is getting in the way of you reaching that goal?

Needs and Preference Matrix



Long-Term Services and Supports Options Counseling (LTSS OC)

The department provides information on the options that may be available for long term services and supports in an integrated setting to Medicaid eligible individuals

Daily Referrals

- Started January 2021; only included visiting individuals who expressed interest or had lower-level needs as described on the “new” level of care form
- June 2022 started seeing all individuals over age 21, who were referred for a long-term stay in a nursing facility
- Maximus created a report with the name and location of individuals screened at nursing facility level of care the day before
    - 10 LTSS OC staff check the list daily and make face-to-face visits within 14 days of referral
    - 679 individuals agreed to the LTSS OC visit in 2021
    - 1,170 LTSS OC visits completed in 2022

Skilled Nursing Facility Presentations

- Started 2020 and are done annually
- Invite all residents, family, and facility staff
- Provides follow-up contact opportunity for residents
    - 443 individuals (resident, family, staff) attended in-person presentations in 2021
    - 952 individuals (resident, family, staff) attended in-person presentations in 2022

Annual Person-Centered Care Planning with SNF Residents paid for by Medicaid

- Started June 14, 2022
- Complete a Person-Centered Plan of Care and Risk Assessment & Health and Safety Plan
- Focuses on Medicaid members who have lived in the facility long-term
- Annual nursing facility level of care functional eligibility determination for Medicaid members

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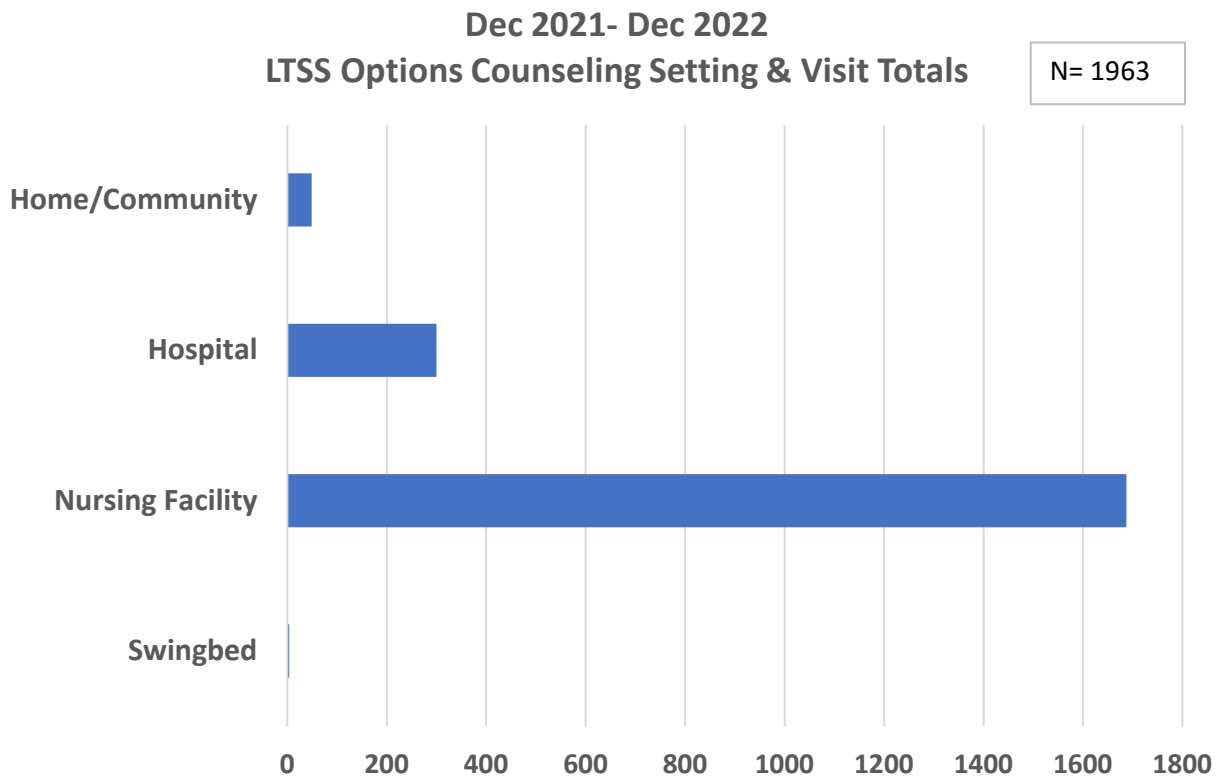
Who are we reaching?

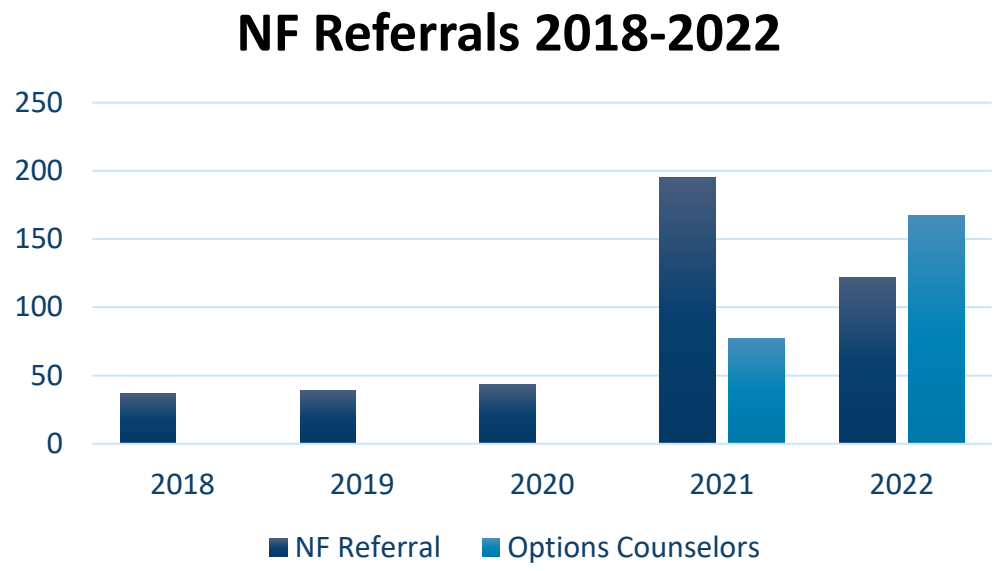
- Medicaid eligible individuals, 21 and older, who are referred for a long-term stay (90 + days) in a nursing facility
  - 95% of visits are done in person
  - 5% Virtual/Telephone



Outcomes – Increase in referrals to Money Follows the Person (MFP)

Increase in MFP referrals coming directly from the nursing facility staff

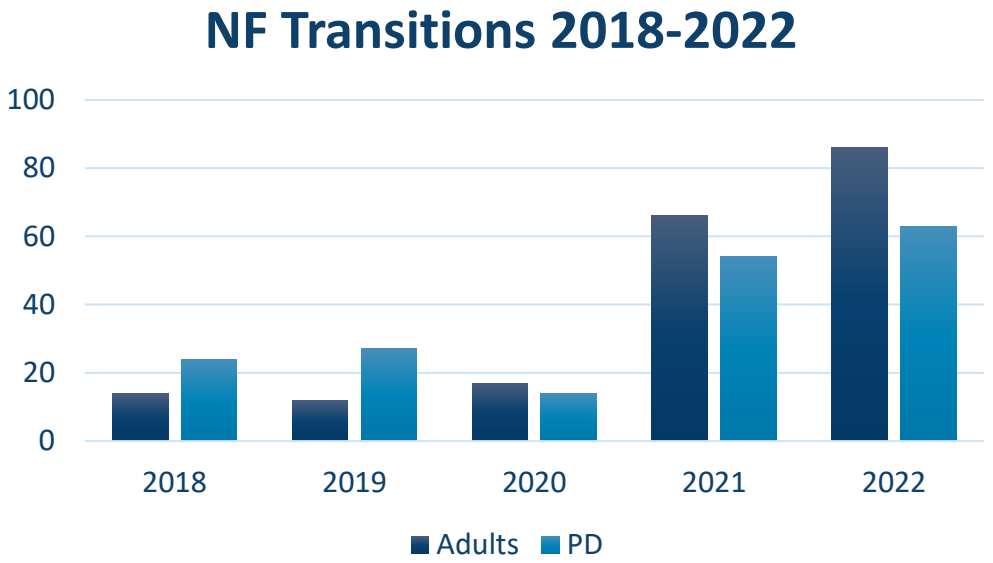
Year	NF Referral	Options Counselors	Total Referrals
2018	37	N/A	37
2019	39	N/A	39
2020	43	0	43
2021	195	77	272
2022	122	167	289



Outcomes - Increase in MFP transitions

- Increase in overall transition numbers
- Increase in number of transitions involving older adults

Year	Older Adults	Physical Disability	Total
2018	14	24	38
2019	12	27	39
2020	17	14	31
2021	66	54	120
2022	86	63	149



Outcomes – Individual and facility feedback

- Initially there was some resistance from family, guardians and facility staff
  - Created brochures and FAQs to answer common questions about confidentiality, visitation rights and access to Medicaid information
  - Held virtual provider training to explain process
- LTSS Options Counseling has now become normal and expected. Negative feedback has decreased
- Increased awareness about LTSS options available to Medicaid recipients
- Residents and families are expressing that they are happy that someone is visiting the residents to see how they are doing and that they better understand their care options
- Private pay residents are also asking about their LTSS options

for Family Members

if an individual can't safely live in the mmunity?

People with long-term support needs can and do live in the community with the right supports. A team will help the individual plan and line up needed services and support.

We are unable to provide all the needed care. How can our loved one move back to the community?

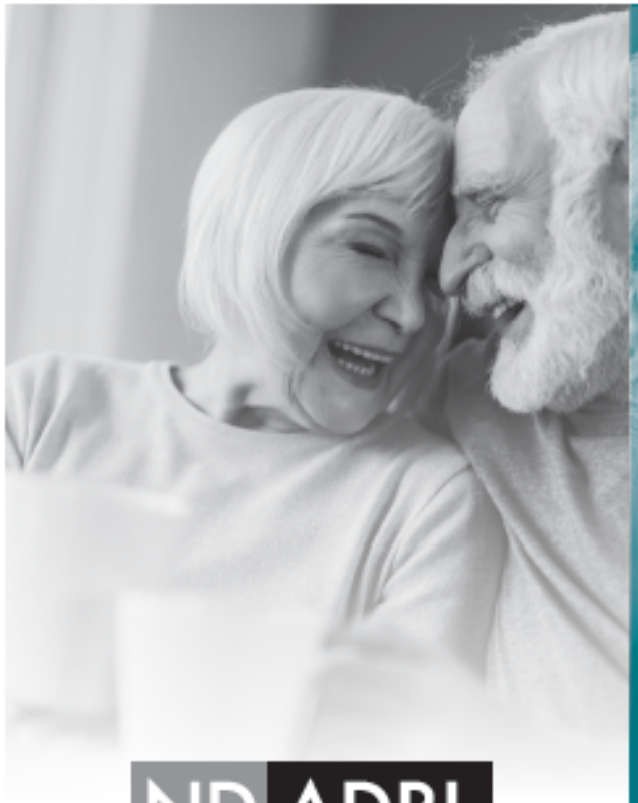
- Individuals should not have to rely on family members. A team will help line up supports that can be provided by others – including up to 24-hour support program services, transportation, medical appointment coordination and more – if your loved one qualifies.
- If desired, qualified family members can also be paid to provide care and support services.

Where would our loved one live?

- A housing coordinator can work with individuals to find accessible housing options in the area/region.
- Environmental modification services and equipment can help make a home accessible.

appens if our loved one chooses cility care?

s a person qualifies for nursing the choice is theirs.



ND ADRL

AGING & DISABILITY RESOURCE LINK

Contact Us

1.855.462.5465

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Long-Term Services and Support Options Counseling for Medicaid Members

Know Your Care Options.

Visit With Us Toda

ou are a Medicaid ember and are referred or a long-term stay in a nursing home or already live in a nursing home, you can expect a visit from a Long-Term Services and Support Options Counselor.

The counselor will talk to you about long-term care and support options, including services at home and in the community.

WHY? North Dakota is now required to share this information annually with Medicaid members who are considering moving to a nursing home or who already live in a nursing home.

DID YOU KNOW? Medicaid members must qualify to live in a nursing home.

- You must qualify (physically, functionally and financially) for Medicaid to pay for your long-term care in a nursing home.
- no longer qualify, a team will help for the transition to a home care needs are met.

About the Visits:

- Counselors are there to provide information about care options.
- You can choose what's right for you:
  - In-home and community-based care and support services
  - PACE senior care services
  - Nursing home care
- IMPORTANT: If you participate in Medicaid, you must continue to qualify for nursing home care to remain living in a nursing home.

Want to live in the community and get care at home?

- With good planning, you may be able to receive the right supports to live in the community safely, long term.
- Services are available to help you plan for and move from a nursing home back to the community if you want to, and your needs can be met.
- The goal is safe and healthy transitions if you want to move out.

To find services and support, contact the Aging & Disability Resource L

- **Phone: 855.462.5465, option 1**
  711 (TTY)
- **Email: carechoice@nd.gov**

Apply on our website:

- **https:// carechoice.nd**

Long-Term Services and Supports Options Counseling

TAKEAWAYS...

Barriers that are identified are being addressed with the individuals through person-centered planning.

Data tracking has shown trends and possible gaps from a systems level.

Feedback and building of relationships with stakeholders, TPM's and LTSSOC have been essential through this process.

Contact Information

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Illinois PASRR and SMHRF Assessment Redesign

Illinois and Maximus: Partners in Transformation

IL PASRR and SMHRF Redesign: A Collaborative Approach

Department of Healthcare and Family Services (HFS)	• Provide Maximus contract oversight and day-to-day decision-making
Department of Mental Health (DMH)	• Provide oversight of Olmstead Compliance • Manages contracts for Front Door Diversion Providers (FDDPs) and the Comprehensive Class Member Transition Program
Illinois Department of Developmental Disabilities (DDD)	• Provide oversight of Independent Service Coordination (ISC) Agencies, who complete Level II evaluations for the IDD population in Illinois
Department of Aging (DoA)	• Complete Choices Counseling + conduct LTSS (LOC) assessments through the Care Coordination Units (CCU) for people in the community ages 60+
Department of Rehabilitative Services (DRS)	• Complete Choices Counseling + conduct LTSS (LOC) assessments for those in the community age 59 and under

Timeline of Redesign

DECEMBER 2021:
IMPLEMENTATION MEETINGS BEGAN

MARCH 2022:
PASRR GO-LIVE

APRIL 2022:
SMHRF ASSESSMENT GO-LIVE

Illinois Consent Decrees

- Both lawsuits alleged violations of the ADA and Olmstead Supreme Court Decision
- Both Consent Decrees seek to provide Class Members with services in the least restrictive and most integrated setting possible

Williams Consent Decree

- Entered in 2010, specific to Specialized Mental Health Rehabilitation Facilities (SMHRFs)
- All persons with serious mental illness (SMI) have the right to choose to live in community-based settings
- No individual with SMI who is determined to be able to live in a community-based setting shell be admitted to a SMHRF before first being offered community-based services
- The State has an obligation to expand the community-based service system to support Class Members' needs

Colbert Consent Decree

- Entered in 2011, specific to Nursing Facilities (NFs)
- Parties agreed that State defendants':
  - Inform Class Members regarding their eligibility for community-based services
  - Provide, as appropriate, Class Members with housing, services and supports in a community-based setting

Class Member Definitions

Williams Class Member	Colbert Class Member
Illinois resident (state-wide)	Cook County resident
18 years of age or older	18 years of age or older
Has SMI	Has a disability
Institutionalized in a SMHRF setting	Reside in a Cook County NF
Able to live in the community with specialized supports and services	Able to live in the community with appropriate supports and services
Medicaid eligible	Medicaid eligible
~4,000 Williams Class Members	~20,000 Colbert Class Members

Why Redesign, Why Now?

Improve Effectiveness of Tools and Forms

- Opportunity to **disentangle** PASRR and SMRHF assessment tools and processes to align with CMS screening initiatives
- Improved inter-rater reliability with a **consistent clinical approach** and **adherence to federal regulations and state administrative code**

Consistent Single Point of Entry

- Regardless of referral source or location, all referrals have the same process that is all electronic, **reducing administrative burden**
- Reduced confusion around who has **responsibility** for each step in the process
- **Rapid availability** of determinations, assessment results, and service recommendations

Enhanced Data Collection, Tracking, and Reporting

- Statewide data tracking process that allows for reporting on **how many people are diverted** as a result of prescreening and assessment processes
- A robust system for data capture that allows the State to identify service needs and gaps to support the **building of a community services system**
- Ability to incorporate, track, and enforce **time-limited outcomes**

Bringing intentionality and focusing on individual choice and access to the right supports

Prior to Redesign: Approval Gave 'Access' to All Facility Types

- Same prescreening tool and LOC tool completed
- If approved for ‘long term care’, approved for both NF and SMHRF admission

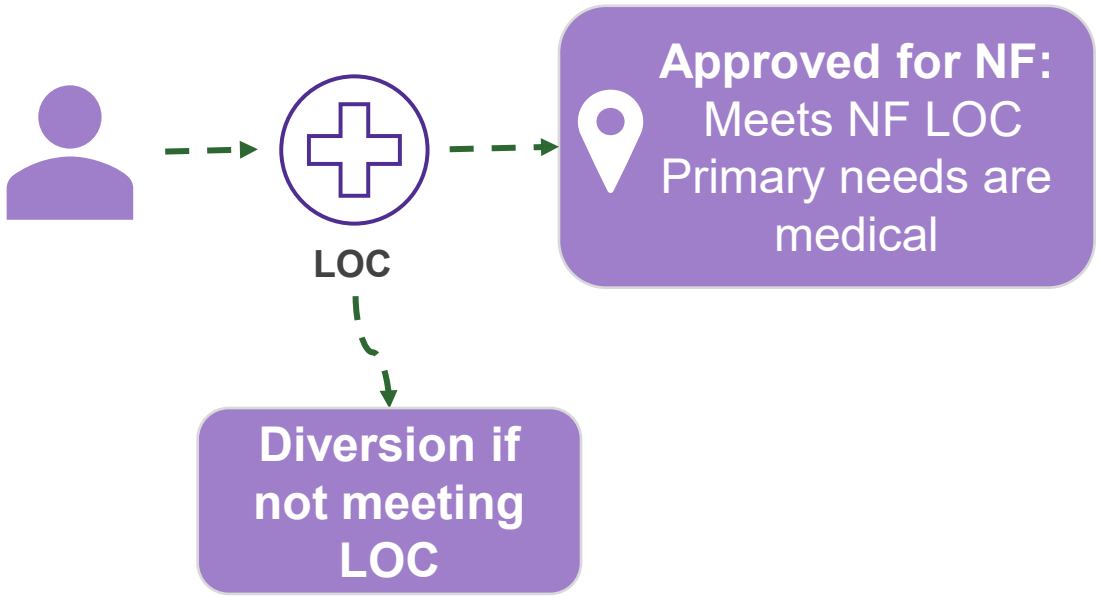
NF:
Meets NF level of care; primary needs are medical

SMHRF:
Many medical needs exclusionary; primary needs are mental health

In the past, one approval could give access to all facility types, regardless of criteria/eligibility for the location

Present: NF Redesign

PASRR-specific Level I and Level II tools containing CMS-recommended components



Consistent Time-Limited Approvals

Reduces risk of long-term admission based on clinical needs that should resolve on a short-term basis

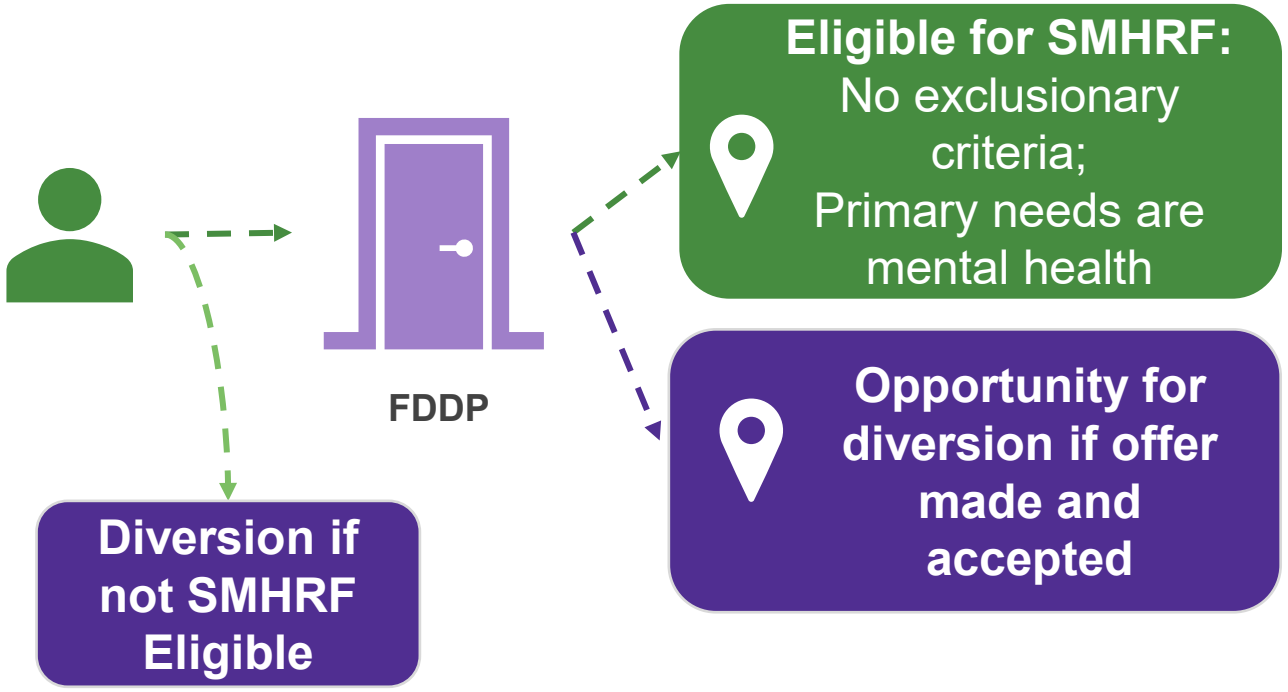
Follow-up Visit

Identifies barriers to discharge and connects NF residents to community resources

Additional opportunities for diversion post-admission through the Comprehensive Class Member Transition Program

Present: SMHRF Redesign

SMHRF-specific assessment meeting state admin code requirements



Time-Limited Approvals

Reduces risk of long-term admission based on clinical needs that should resolve on a short-term basis

Rapid Reintegration

0 – 59 days of Admission

Additional opportunities for diversion post-admission through the Comprehensive Class Member Transition Program

AssessmentPro

- Secure, intuitive, cloud-based application, available 24/7/365
- One point of entry for PASRR screens and SMHRF referrals
- Clinical alerts that indicate if person is not eligible for SMHRF admission if exclusionary present is entered in the referral
- NFs and SMHRFs can track census
- Streamlines work with automatic queuing to external stakeholders—no waiting or lost paperwork
- Determinations immediately available to admitting facility upon entering the person in census

AssessmentPro is the **first** CMS-certified PASRR application.

Redesign Successes

PASRR

- 30+ PASRR focused trainings and information sessions provided for stakeholders and associations
- Increased state compliance with PASRR, Olmstead, and ADA
- Defensible, consistent decisions and consistent use of time-limited determinations
- Electronic referrals and queues for stakeholders completing LOC assessments and PASRR Level II evaluations for the state ID authority
- Access to significant data to improve tracking, oversight, and reporting capabilities

SMHRF

- 15+ SMHRF focused trainings and information sessions provided for stakeholders and associations
- Development of criteria for a standardized assessment process and consistent application of clinical and exclusionary criteria
- Electronic referrals and queues for diversion agencies
- Time-limited eligibility determinations
- Access to significant data to improve tracking, oversight, and reporting capabilities

Questions?

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Thank you!

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