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Long-term Care Consultation Expansion and Return to Community Update

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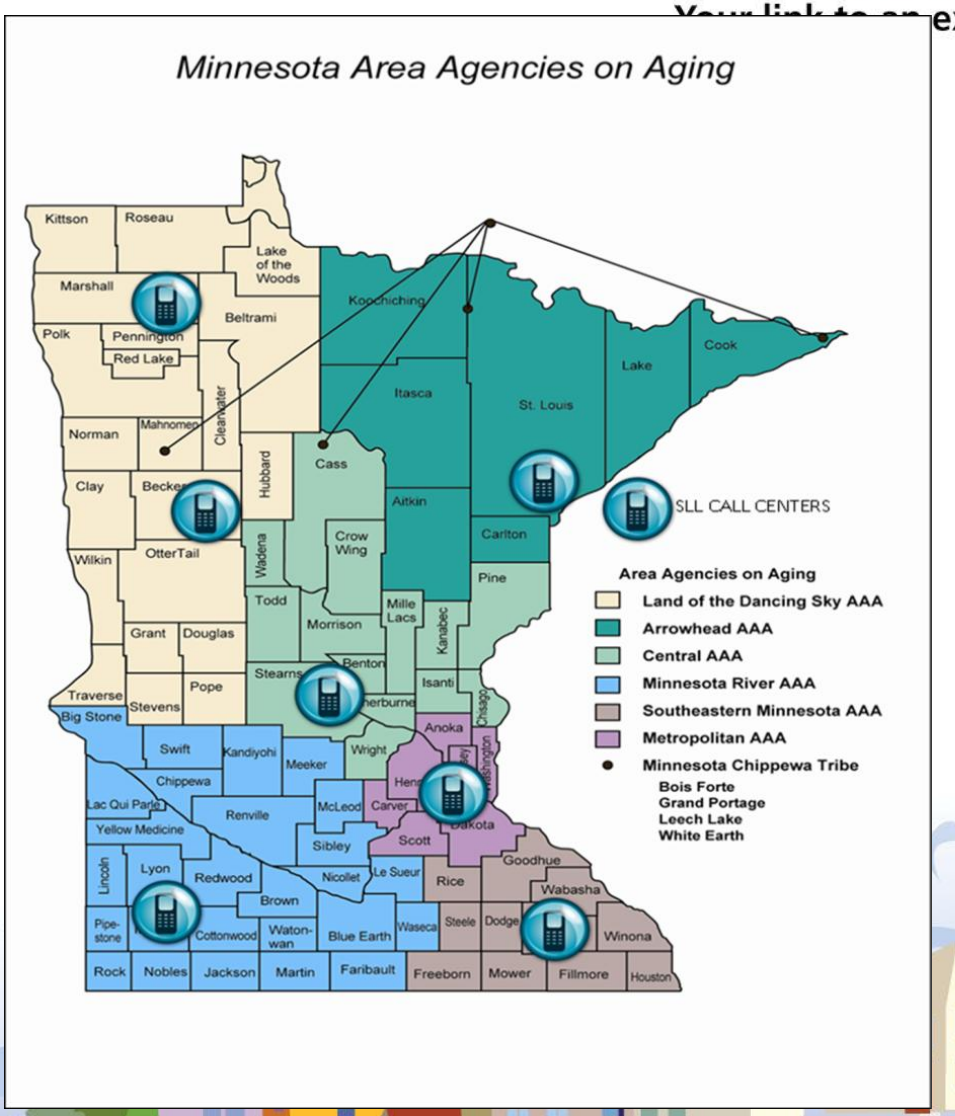
About your hosts today: Area Agencies on Aging/ Senior LinkAge Line®



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Overview of Today

- The 2011 Special Session passed Long Term Care Consultation Expansion, this reform initiative will be covered
- In 2009 road shows occurred about the Return to Community reform initiative, data will be presented and a progress report will be given
- Please hold your questions until the two allotted Q & A sessions

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Why did this pass?

- Legislature had to make a decision about the budget
  - The options available
    - A. balance the budget through cuts
    - B. increase sources of revenues
    - C. borrowing or delayed payments
      - The legislature chose A and C and this was one of proposals adopted to achieve the savings
- Some members of legislature have expressed concerned about assisted living, spend down into EW and increasing costs to the state budget overall.
- Regardless – this initiative has the potential to have a ***positive*** impact because information supporting choices is *always* good for Minnesota citizens.

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So What Is It?

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- The 2007 the Legislature amended Minnesota Statutes, Section 256B.0911 governing Long Term Care Consultation Services to include a new service called transitional consultation service for people entering assisted living.

- In the 2011 special session, the Legislature amended the same statutes to require all registered housing with services to give the information with some exceptions.

- Consumers are required to call and get a verification code. Providers are required to put a verification code in their file.

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Consulting with Stakeholders

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Business Process Modeling with Stakeholders

- On August 10th stakeholders gathered to provide input for the Long Term Care Consultation Expansion reform

- Stakeholders included-Reps from Aging Services of MN, Care Providers, Counties, Health Plans, Advocacy Organizations, Ombudsman Office, Area Agency on Aging and Senior LinkAge Line®

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During the Business Process Modeling the following was accomplished…

- Review our as-is process
- Develop the to-be process based on the as-is
- Conceptualize protocols that will need to be developed
- Identify system changes to customer relationship management/data tracking tools used by the Senior LinkAge Line® and county LTCC
- Flush out any operational barriers that may be present

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What they don't like:

- Timing of Delivery of Information
  - Process will affect consumers who need immediate access
  - It delays the opportunity for seniors to move to their new home
  - Could delay a move that is necessary
  - Info about options should be marketed when people are younger- where you're 88 and looking at HWS- it's too late
  - Process of getting certificate will be more work and time consumingI
  - Contact with SLL and education occurs late… after decision has been, with some effort, has been arrived at

- Forced Choice/Information
  - Force of screening to seniors-discrimination
  - Should not be mandatory
  - Disregards seniors lifelong lessons and assumes they cannot make decisions
  - Ageism
  - How will you explain to someone who has the financial resources why the state determines their LTC choices
  - Required for all regardless of payment of financial status
  - Applying to everyone even private pay- isn't that a bit overacting
  - ts ageist to assume seniors can't make good decisions without gov't help

- Will Spur Competition
  - Will create even greater competition among HWS to have a "wow factor" in an already competitive market
- SLL
  - Can't assume that SLL will know all options and choices that exist in the greater community

What they don't like:

- Need more information
  - Don't know yet how it will be implemented, realized this is intended to do that
  - Refusals
  - Quick? Slow? Need documentation?
  - How often do they go through counseling? Every time housing option considered?
  - What do housing people need to document?
  - How quickly will response come? Hours? Sometimes necessary
- Legislative Process
  - The process- zero collaboration-until laws are passed
  - Offering the service is generally good, I just think it's at the wrong point in the decision making process to get the cost savings desired
- Process Intensive
  - Process seems a bit complicated… excess paperwork
  - Will likely slow the process of information collecting assessments and move-in to housing and seniors, AL, MC, etc
  - Dates not accommodate for people with disabilities
  - No exception for emergency situations (can't stay out at hospital and can't go home)
- Provider concerns
  - Not a proposal where we had input
  - Threatening to providers
  - DHS/MBA goal is to reduce spending on Medicaid and somehow that relates to providing consumer information
  - Potential negative impact on assisted living business

What people like:

- Information is good
  - An important service to inform consumers about services, housing and all options
  - Getting info to people to help people make choices
  - I love it! People need to understand options in an objective non-pressured way
  - Consumers have yet another opportunity to learn about home and community based services
  - I like it because seniors will be required to consider and make informed decisions
- Choice
  - Consumers Have Choice/Making sure people have the tools to make meaningful choices
  - I like that SLL is a neutral party in the mix
  - People who can't afford high cost service will be able to make cost effective decisionsl
  - like that seniors have choice and can make educated decisions
  - Consumer knowledge
  - Making sure people have the tools to make meaningful choices
  - Empowers individuals to make good decisions
  - Education for seniors and families
  - It will help some seniors make better choices (if they were not aware before talking with SLL
- Affects All people regardless of payor source
  - Persons and families regardless of income will be informed through multiple options of choices for long-term care
  - Available for seniors who may need help

What people like:

- System Improvements
  - It could help the communication between providers and counties that can always be improved upon
  - Keep people in home that can be
  - Track refused people by their code to see if down the road they end up on a waiver
  - Will save money for the state of MN
  - Policy supports/promotes education and independent choices, consumers centered
  - Seniors will learn to make better use of community services
  - This is a great opportunity for lead agencies and linkage line to work together.
  - If we all do this right, we can work as partners with the providers

- Comparisons
  - Ability for seniors and their families have the chance to really have compare information on options
  - Offering different options to all people, consumer directed, who may not have access like MA people spending down in home using FSE)
  - Offering consumers choices and the information to make necessary decisions can only be a positive thing

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Here is what we learned…The Indifferent

- How will emergency placement into AL's from ER be handled?
- Will it make a difference?
- Will this impact seniors entering adult foster care?
- This bill has been passed by the powers that be. So now it has to be dealt with by all parties. Like it or not!
- How will this impact county case management? Is it duplicative?
- From a county view- mechanically this is a wash

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More about the current model:

- Its a combination of telephone-based and in-person assistance with SLL doing telephone based assistance and County LTCC doing the face to face (initial face to face not reassessments).
- Reflects partnerships between the 87 county Long-Term Care Consultation (LTCC) units, and the six Area Agencies on Aging (AAAs)
- Distributes LTCC funding between both agencies to support this service
- The model depends on the positive working relationships between the AAAs and county LTCC units.

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Current Service Requirements under state law

- Information has to be made available to prospective Housing with Services residents.
- Consumer may choose to call or not.
- When the call comes in, the SLL must provide Transitional Housing with Services Consultation must be provided within five working days of the request of the prospective resident.
- A face-to-face LTCC visit may be requested by the client or caregiver, without regard to resource level, as a result of participating in the Transition to Housing with Services Consultation (this is determined through the Rapid Screen – screening for risks – see next 2 slides).
- The AAAs have implemented a follow-up strategy, the follow-up occurs 10 days after initial call to the SLL.

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General Information

Reason For Move

- ☐ Family Encouraged
- ☐ Socialization
- ☐ Death of Spouse
- ☐ Word of Mouth
- ☐ Need for Services
- ☐ Housing Inadequate
- ☐ Client Refused
- ☐ Other

When Moving [ ]

Assisted Living ☐

Rapid Screen

- ☐ Walking
- ☐ Going to the Bathroom
- ☐ Dressing
- ☐ Injurious fall or 3 or more falls (last 6 months)
- ☐ Considered Housing Move (to Nursing Home or Assisted Living)
- ☐ Memory - Very Concerned
- ☐ Getting Out of Bed/Chair
- ☐ Bathing
- ☐ Eating
- ☐ Caregiver Not Available
- ☐ Stressed Caregiver
- ☐ Live Alone
- ☐ Memory - Somewhat Concerned

Rapid Screen Result [ ] Recalculate

Preferred Residence [ ]

In Home Supports ☐

LTCC Referred [ ]

LTCC Referral Date [ ]

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Follow Up - please schedule a follow-up within 2 weeks of contact

Received LTCC

Reason Not Received

Appeal Filed

Date Appeal Filed

Decision Made

Decision Factors

- ☐ Family Pressure
- ☐ Too Many Modifications
- ☐ Socialization
- ☐ Need Help Arranging Svcs

Enough Information

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Data Results From 2008 rollout – 2011

- Senior LinkAge Line® received calls from some consumers based on literature handed out by the HWS and referrals by others.

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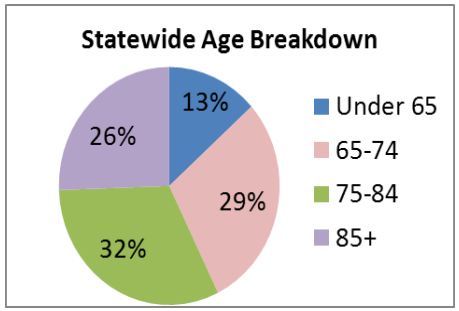
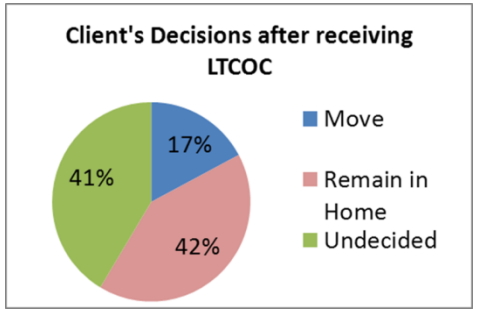
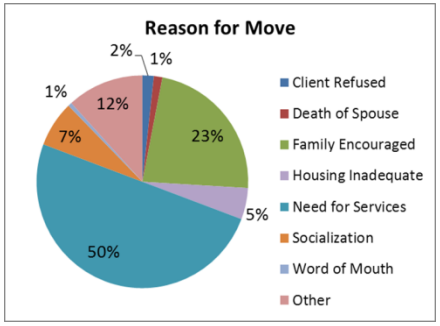
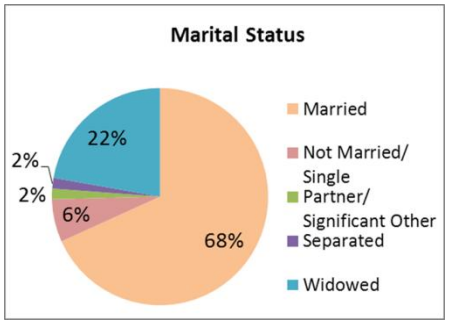
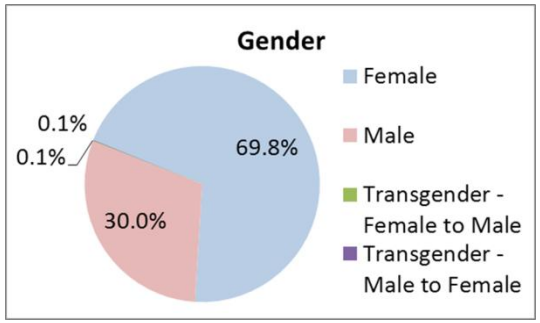
SLL Data Results…10/1/08 to 7/31/11

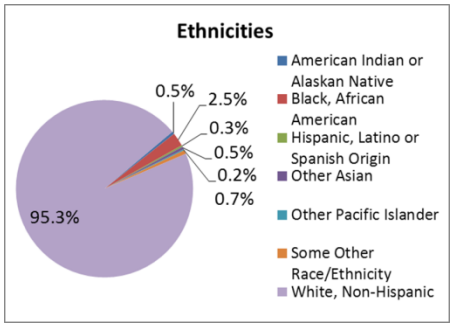












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Long-term Care Consultation Results…10/1/08 to 7/31/11

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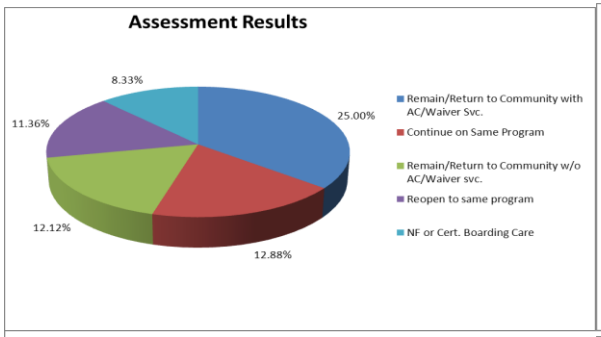

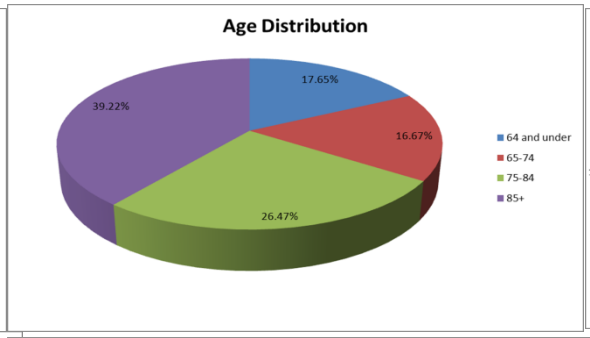

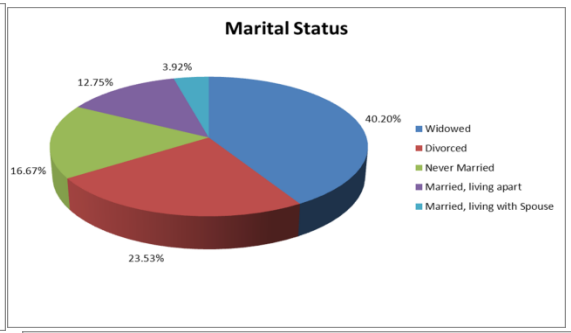

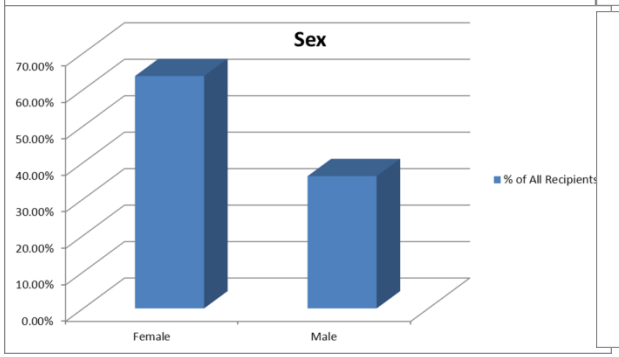

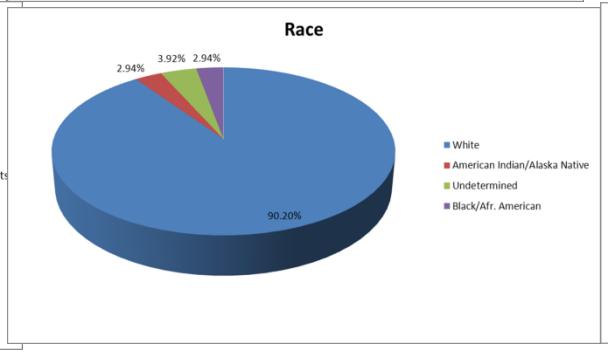

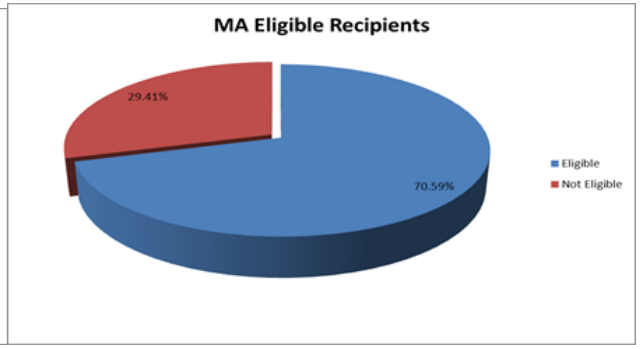

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Background on the Changes to LTCC Expansion

- The data results you have just reviewed were also of interest to the legislative chairs who requested them updates.
- During the 2009 and 2010 sessions Senators and Representatives requested a revised proposal from DHS to implement this service as a requirement for consumers.
- DHS presented these proposals – there was testimony in committees
- These were called “mandatory transitional consultation. The proposals had a variety of level of interest by the committees.
- A revised proposal was requested during the 2011 special session and was adopted as LTCC Expansion.

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Statutory Changes

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 3c, was amended:

Subd. 3c. Transition to Consultation for housing with services. (a) Housing with services establishments offering or providing assisted living under chapter 144G shall inform all prospective residents of the availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident.

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Amendments Cause Changes to the Service but There Are Few

- Information has to be made available to prospective Housing with Services residents.
- *Consumer must get a "verification code" from SLL showing that they called.*
- When the call comes in, the SLL must provide Transitional Housing with Services Consultation must be provided within five working days of the request of the prospective resident.
- A face-to-face LTCC visit may be requested by the client or caregiver, without regard to resource level, as a result of participating in the Transition to Housing with Services Consultation (this is determined through the Rapid Screen – screening for risks).
- *The Senior LinkAge Line® will do additional follow up*.

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Continues a positive working relationship between LTCC and SLL by creating a "point of entry to long-term care"

- Continuing and even furthering the combination of telephone-based and in-person assistance with SLL doing telephone based assistance and County LTCC doing the face to face.
- Provides an opportunity for the 87 county Long-Term Care Consultation (LTCC) units, and the six Area Agencies on Aging (AAAs) to continue to and strengthen the partnership by building on each organization's strengths.
- Continues to distributes LTCC funding between both agencies to support this service. New funding will go to SLL contact centers and to LTCC county units.
- The model continues to depend on the positive working relationships between the AAAs and county LTCC units.

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HWS Establishments will:

- Inform all prospective residents of the availability of and contact information for consultation services under this subdivision;
  - Except for individuals seeking lease-only arrangements in subsidized housing settings, receive a copy of the verification of counseling prior to executing a lease or service contract with the prospective resident, and prior to executing a service contract with individuals who have previously entered into lease-only arrangements; and
  - Retain a copy of the verification of counseling as part of the resident's file.

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Senior LinkAge Line® will:

- Take the calls
- Perform the rapid screen – identify the risks for the caller
- For high risk callers – refer them to LTCC at county for more in depth assessment
- For low and medium risk callers – identify ways to age well and live well.
- All callers will be offered an age in place packet.
- Verification of counseling through a random numeric code will be generated and provided to the prospective resident by Senior LinkAge Line® upon completion of the telephone-based counseling.

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Who is Exempt from the Process:

- The following people will not have to go through this process:
  - Signed a lease or contract prior to October 1, 2011.
  - Had a long-term care consultation (PAS) for eligibility determination purposes prior to October 1, 2011
  - Went into a NF facility longer than 40 days and received a face-to-face assessment as a result of referral by NF staff
  - Did not call for counseling but the Senior LinkAge Line ® referred them to the county AND they sought and received a face to face assessment.
  - Lease only arrangements with a subsidized housing (HUD being consulted)

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Why does the idea of a point of entry to LTCC make so much sense?

- The Senior LinkAge Line ® and counties have successfully collaborated over the years in serving seniors.
- This proposal offers an opportunity to move toward more collaborative models of assisting seniors by establishing a point of entry to long-term care options counseling and long-term care consultation.
- There are new models in operation now that have tested these approaches.

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County/AAA Partnership-Chisago County Pilot

- In 2009, Chisago County and Central Minnesota Council on Aging established a collaborative contact center model in which:
  - Phone based pre admission screening was shifted to the St. Cloud Senior LinkAge Line®
  - Callers are screened for risk and as needed, sent to the county for face to face Long-term Care Consultation

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The Senior LinkAge Line® Strengths

- Highly focused on private pay
- Consumers/families looking at financing options –
- Long-term care insurance, reverse mortgages, annuities, LTC Partnership
- Caregivers who need support to avoid burnout
- Medicare open enrollment-reviewing Part D options
- Consumer needs in-person assistance for applications
- Consumer transitioning from skilled nursing facilities to the community
- Specialized concerns/hot topics = e.g. Hospital observation status issues

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The County LTCC Strengths

- Experts in public eligibility processes
- Have the indepth expertise to perform needed face to face assessments around complex medical concerns and frailty
- Can identify the need for addressing safety concerns and also preventative strategies for aging and living well in the home
- Assists and supports relocations (familiar with various health care systems and available transitional supports)
- Connected with vulnerable adult systems
- Connected to the county mental health authority
- Connected to other social services which may impact across families

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Expansion Model and Process Developed with stakeholders

- Covering the business process model

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Long Term Care Consultation Expansion
Questions & Answers

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5 Minute Standing Break and In Person Questions

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What is the Return To Community Initiative?

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- Passed in 2009 and based on research conducted by the U of MN School of Public Health & the Indiana University Center for Aging Research
  - http://www.dhs.state.mn.us/main/dhs16_148973

- Utilizes the MinnesotaHelp Network™ which includes the LinkAge Lines (Senior, Disability and Veterans), the web site MinnesotaHelp.info®, and in-person assistance through staff and volunteers.

- The MinnesotaHelp Network™ is Minnesota's federally designated Aging and Disability Resource Centers (ADRCs). There are ADRCs in every state.

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Targeting Criteria Developed by Researchers

- In working with the Centers on Aging at the U of M and Indiana University – researchers determined that a group of people were more likely to return home, but weren't doing so.

- They created a profile:
  - 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

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Community Discharge Profile

- Greater than 50% probability of community discharge
  - Each resident has unique combination of discharge characteristics

- Characteristics predicting discharge that are included in model:

Female	No Mental Health/Alzheimer's/Dementia Dx
Married or Lived Alone	No Serious Behavioral Problems
Younger	No Diabetes
Medicare Admission	No End Stage Disease or Cancer
Hip Fracture	Lower Cognitive Impairment
RUG Extensive	Lower ADL Dependence
RUG Rehabilitation	No Serious Incontinence

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Findings of Follow-up Study by University of MN/Indiana U

- **Characteristics of nursing homes with a higher community discharge rate (adjusted for resident differences)**
  - Higher percentage of Medicare residents and lower percentage Medicaid
  - More nursing hours per resident day
  - Higher facility occupancy rate
  - Higher percentage of residents preferring or having support for community discharge
  - Located in areas with more use of home and community-based services

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Follow-Up Protocol for Those Assisted by Community Living Specialist

- Initial follow-up
  - In-home visit within 3 days after nursing home discharge
- Continued follow-up by Community Living Specialist
  - 14 days, 30 days and 60 days after nursing home discharge
- Phone based follow-up continues by Senior LinkAge Line®
  - Quarterly for up to 5 years

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Why is this service important?

- It focuses on private pay individuals
  - Upstream planning is unique
- Intensive follow-up services are available for people assisted out of the nursing home
  - Also available for those we don't specifically assist
- Trend data will be available for years to come

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Program Evaluation

- All consumers - private or public pay - discharged from the nursing home will be contacted every 90 days for up to 5 years

- Unique collaboration between University researchers and the MN Department of Human Services

- Goals:
  - Better understanding of participant experiences
    - CLS, nursing home staff, community care agencies, residents, families
  - Refining targeting criteria based upon knowledge of programs successes and challenges
  - Discover factors that influence successful transitions

- Cost savings for state of MN
  - Delay spend down to Medical Assistance
  - Access to home and community-based services

Characteristic	Non Transitioned N=1,756	Transitioned N=1,120
Female	64%	63%
>80 yrs old	59%	43%
Mild or no Cognitive Impairment	80%	89%
Behavior problems	11%	6%
ADL limitations	53%	57%
Incontinent	20%	16%
Admitted from Hospital	90%	90%
Unmarried	70%	68%
Lived alone prior to entry	45%	49%

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Individual Resident Characteristics: Predictive of Transition?

- Compared to the transitioned, non-transitioned residents are:
  - Slightly older
  - Slightly less cognitively impaired
  - Slightly more behavioral
- Overall, very little difference
  - Individual factors not likely to predict much variance in ability to transition
- Are their differences identified in the nursing home reported barriers to transition?

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Barriers to Transition: What Can We Learn?

- 56% noted a decline in heath status
  - Unexpected given use of targeting criteria and previous research on health status in early NH admission
  - Need for closer examination of MDS data; what are the clinical factors impeding discharge?

- 46% reported “personal choice”
  - Vague, need further information
  - What influences the choice to stay in a population that wanted to leave upon admission?

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Barriers to Transition: What Can We Learn?

- 17% noted a family refusal
  - Need qualitative data, what influences the family decision making process?
- Nursing homes are key information source
  - Is there motivation not to discharge? Need more information
- Refine program to identify and address resident and family apprehensions early in the assessment process; create a “discharge culture”

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THANK YOU
for being with us today!

You will find the powerpoint online at www.mnaging.org .

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