Minimum Data Set 3.0 Section Q

Local Contact Agency

October/November 2010

Ohio Department of Job and Family Services

Agenda

- Welcome and Introductions
- MDS 3.0 Overview
- MDS 3.0 Ohio Implementation Plan
- Roles and Responsibilities of the State Medicaid Agency
- Roles and Responsibilities of the Nursing Facility
- Roles and Responsibilities of the Community Living Specialist (the term for LCA)
- Community Living Specialist Key Points
  - Provider Agreement
  - Interaction with the HOME Choice Intake and Care Coordination Unit
  - Face to Face Meeting with the Resident
  - Using Connect Me Ohio
  - Completing necessary paperwork

Minimum Data Set 3.0 Overview

- Omnibus Reconciliation Act of 1987 required a comprehensive assessment tool for planning and delivering care to nursing facility residents.
- The Minimum Data Set was developed in 1995.
- Required by all long term care facilities certified to provide care to Medicare and/or Medicaid residents throughout the U.S.

Minimum Data Set 3.0 Overview

- Frequency of MDS completion:
  - Admission - completed by the 14th day of the stay
  - Annually – completed within 366 days of the comprehensive assessment
  - Quarterly – every 92 days
  - Significant Change – completed by the end of the 14th day following a determination that a significant change has occurred

Minimum Data Set 3.0 Overview

- Why is it all so important?
  - Legislation such as the Americans with Disabilities Act in 1990 and the Olmstead Decision in 1999
  - Multiple CMS demonstrations to balance the long term services and supports system
  - Broadening the definition of "discharge planning" in nursing facilities
  - Expanding the range of home and community based options
- Individuals have a right to receive care in the least restrictive and most integrated setting.

Minimum Data Set 3.0 Overview

- Progress is being made......
  - In 2003, 67 percent of Medicaid expenditures were for institutional LTC – according to national data.
  - In 2008, the number dropped to 57.3 percent.
  - Nursing facility use has declined among older adults in 2/3 of States, however utilization did increase for ages 31 to 64 in all but two states.

Minimum Data Set 3.0 Overview

- Nationally, there is a substantial increase in persons with psychiatric disorders at admission. For ages 31 to 64, there is more likely to be a stay in a psychiatric facility prior to admission.
- The revised Section Q is a critical step toward continued progress providing more choice and options to meet care needs based on preferences and within a least restrictive setting.

Minimum Data Set 3.0 Overview

•MDS version 3.0 includes an expanded Section Q. Section Q is designed to collect information regarding a resident's potential return to community living.

Discharge potential item asked the assessor if the resident expressed a preference to return to community living	Return to Community referral item asks the resident if s/he is interested in speaking with someone about the possibility of returning to the community
Assessor findings recorded in database with no follow-up required	If the resident responds "yes", the facility must initiate care planning and refer the individual to a local contact agency
Determined if the resident has a support person who is positive toward discharge	A more extensive series of questions for assessment and investigation for care planning are asked
Asked only upon admission and annually	Asked at admission, annually, quarterly, and on significant change assessment

Minimum Data Set 3.0 Overview

- Section Q requires discharge planning collaboration
  - Meaningfully engages residents
  - Directly asks the resident if s/he wants information about community living options
  - Promotes linkage and information exchange between nursing facilities, local agencies, and community based providers

Minimum Data Set 3.0 Overview

- Section Q broadens the traditional definition of discharge planning by the nursing facility including a care plan that is individualized and person centered.
- The care plan must include preferences and needs, connections with community providers, continued contact with the nursing facility during discharge, medication education, prevention and disease management, who to call in an emergency.
- Discharge planning now includes assistance with locating housing, employment as well as social engagement opportunities.

Minimum Data Set 3.0 Overview

- Relationship between MDS 3.0 and PASRR
  - PASRR ensures that individuals with serious mental illness and/or developmental disabilities are not placed in nursing facilities inappropriately
  - Nursing facilities may not admit a person until a PASRR determination by the State MH and/or DD authorities is made. Nursing facilities may also not retain persons determined inappropriate for placement by the State MH and/or DD authorities. Failure to meet PASRR requirements does result in Medicaid payment recoupment and deficiencies.
  - PASRR is a powerful tool for diversion and transition and helps States comply with the Olmstead decision.
  - PASRR is linked to the MDS 3.0 significant change in status process.

Questions?

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Nursing Facilities complete Section Q	Same
Nursing Facilities contact a Local Contact Agency – LCA starting October 1	Modified Approach – ODJFS serves as a clearinghouse for Section Q – Nursing Facilities do not directly contact LCAs. ODJFS received approval to phase-in contact
LCAs respond to referrals by providing information to residents in community based services and supports	Same
Nursing facility follow-up with LCA required if no response following referral to LCA	Modified Approach – ODJFS will reconcile LCA referrals to LCA activity. The nursing facility retains responsibility to develop a person-centered plan in accordance with CFR 483.20(1)(3)

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 1

- The nursing facility completes MDS 3.0, in accordance with CMS training, at admission, quarterly, annually, and for significant changes in status, and asks the individual if s/he is "interested in speaking with someone about the possibility of returning to the community". Answer "yes" to 0600.
- If yes, the nursing facility initiates care planning. The nursing facility pre-populates the CMS brochure #11477 as shown in attachment #7 (and located at http://go.usa.gov/xTe). The nursing facility then provides a copy of this brochure to the resident.

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 2

- The ODJFS HOME Choice Intake and Care Coordination Unit (HCICCU) will use MDS data received in the ordinary course of business as the Nursing Facility submission of Section Q information.
- The HCICCU will pull a weekly MDS report starting the week of November 1, 2010.
- ODJFS will work to develop a feedback loop to Nursing Facilities.....at this time, ODJFS does not have a reliable set of e-mail addresses to nursing facility social workers/discharge planners. If you want to be in the feedback loop, please sign the "nursing facility contact sheet".

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 2 Continued....

- The HCICCU will review the weekly report and will first break out the data into the following three categories:
  - Residents with less than a 90 day stay will not be referred to the CLS.
  - Residents with greater than 90 days, Medicaid, will be referred to the CLS for a *face to face* visit.
  - Residents with greater than 90 days, non-Medicaid, will be referred to the CLS for information and referral via *phone as a minimal standard.*
- The HCICCU will then notify the appropriate Community Living Specialist (CLS).

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 3

- For residents receiving Medicaid benefits, the CLS will contact the resident (and guardian as applicable) *by phone* within three days of HCICCU notification to:
- Begin research using the Connect Me Ohio website.
- The CLS shall schedule a face to face meeting with the resident, his/her family/guardian (when applicable) and the nursing facility discharge planner (when requested by the person) to identify resources to facilitate the resident's discharge goals and preferences (Medicaid and non-Medicaid). This face to face meeting should occur within 7 working days of initial phone contact unless the resident requests otherwise.
- The CLS will gather necessary resources in preparation for the face to face meeting.

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 3 Continued....

- For residents who are non-Medicaid, the CLS will contact the resident *by phone* within three days of HCICCU notification and begin research using the Connect Me Ohio website.
- The CLS will identify the resident's discharge goals, previous efforts within the community, and any informal support systems.
- The CLS will identify resources to facilitate the resident's discharge goals and preferences (Medicaid and non-Medicaid).
- The CLS will provide, *via mail*, a list and source for applications to necessary programs, phone numbers needed to assure continuity of care, and any steps needed to locate and secure housing and accommodations.
- The CLS provider may choose to meet face to face with non-Medicaid residents. Information by phone is a minimum standard.

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 4

- For residents receiving Medicaid benefits, the CLS will lead the face to face meeting with the resident.
- The CLS will share the results of his/her research through Connect Me Ohio (and other website sources). The CLS will establish next steps through the completion of a **Community Living Plan (as populated by the Connect Me Ohio website)** which includes, but is not limited to, a list and source for applications to necessary programs, phone numbers needed to assure continuity of care, and any steps needed to locate and secure housing and accommodations.
- The CLS will assist the resident in making initial contacts with potential resources during and/or following the face to face meeting as needed.
- If the resident requires transition coordination and meets HOME Choice eligibility requirements, the CLS will assist the resident in completing the application.

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 5

- For residents receiving Medicaid benefits, the CLS will send the resident, *via mail*, within 5 working days of the face to face meeting, a copy of the written Community Living Plan and Addendum. The CLS shall also provide the person with a copy of the HOME Choice Relocation Workbook.

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 6

- For residents receiving Medicaid benefits, and within 5 working days of the face to face meeting, the CLS shall submit the **Community Living Plan Addendum** to the ODJFS HCICCU prior to release of payment by the fiscal intermediary.
- For residents who are non-Medicaid, the CLS will submit the **CLS Tracking Sheet** at least monthly.

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Step 7

- For residents receiving Medicaid benefits, the HCICCU will data enter the information contained on the **Community Living Plan Addendum** and will provide approval to the fiscal intermediary to provide payment to the CLS.

Step 8

- The HCICCU will reconcile all weekly submissions to CLS providers, prevent duplication when possible, and will monitor compliance with provider agreements.

Minimum Data Set 3.0 Section Q Ohio Implementation Plan

Elderly

- Phased in beginning November 1, 2010

Physical Disability, TBI, DD

- Phased in by January 1, 2011

Mental Health

- Phased in by March 1, 2011

Questions?

Roles and Responsibilities of the State Medicaid Agency

State Contact (the policy developer, operations manager, facilitator, and monitor)

- Manage the MDS data for dissemination to Community Living Specialists.
- Track the disposition and timeliness of Community Living Specialist services.
- Follow-up with CLS providers on referrals accepted to assure timeliness and completion of CLS services.
- Assure compliance with the CLS provider agreement.
- Process applications for the HOME Choice Transition Program.
- Monitor for health and welfare upon return to community living.
- Interface with State PASRR MH and DD authorities.

Roles and Responsibilities of the Nursing Facility

The Lead Care Planner on the Discharge team

- Discharge Planning responsibility under CFR 483.20(1)(3).
- Completes the Care Area Assessment Tool titled "Return to Community Living".
- Conducts follow-up assessments and care planning to support individuals in achieving the highest level of functioning until the resident is discharged from the facility. This includes collaboration in a thorough assessment of needs and care planning to support the choice to return to community.
- Develops a comprehensive person-centered care plan for each resident.
- Nursing facilities may be able to use the HOME Choice Transition Program as a tool in developing the person centered plan – please see the fact sheet and visit http://jfs.ohio.gov/OHP/consumers/homechoice.stm for information and application materials.

Roles and Responsibilities of the Community Living Specialists

- Community Living Specialists = Local Contact Agency

The Initial Information and Referral Source

- Provide information, within timelines established by the ODJFS HCICCU as outlined in the provider agreement, about choices of services and supports in the community that are appropriate to meet the individual's needs.
- Collaborate with the nursing facility to organize the transition to community living if possible.

Roles and Responsibilities of the Transition Coordinator

Transition Assistance for Medicaid Residents – a Member of the Discharge Team

- Assist with the completion of the HOME Choice participant workbook that helps the participant formulate a transition plan, if needed.
- Participate in team meetings as scheduled by the case manager.
- Participate in discharge planning from the institutional setting.
- Arrange, secure or provide transportation for the participant for the purpose of visiting community resources, e.g., to potential housing units or the social security office, or to purchase goods and services, etc.
- Provide Housing navigation that assists the participant in securing appropriate housing when moving from an institutional setting to a qualified residence.
- Assist the resident in connecting to benefits.

Questions?

Community Living Specialist Key Points

Community Living Specialists must first be one of the following:

- PASSPORT Administrative Agencies
- Centers for Independent Living
- Brain Injury Association of Ohio
- County Boards of DD or Councils of Government
- ODMH designated Mental Health agencies and Peer Centers
- ODJFS approved non-profit agencies

Community Living Specialist Key Points

- Complete a HOME Choice Demonstration Time-Limited Provider Agreement and sign the MDS Data Use Agreement Addendum
- Once ODJFS receives the provider agreement, ODJFS will send the MDS data use agreement to the Centers for Medicare and Medicaid Services for signature and will not release names to the potential CLS until the data use agreement is returned.

Community Living Specialist Key Points

- The CLS provider is required to indicate the number of Medicaid AND non-Medicaid resident referrals that can be accepted per week.
- The CLS provider is required to establish a minimum of 20 percent non-Medicaid per week.
- Information regarding available CLS providers per county will be located on the HOME Choice website at http://jfs.ohio.gov/OHP/consumers/homechoice.stm.

Community Living Specialist Key Points

- For consistency and continuity of care, each CLS is required to use, at a minimum, the Connect Me Ohio website – See Users Manual within the Ohio Community Living Guide.
- CLS providers shall assist residents in completion and submission of a HOME Choice Application for ALL residents meeting HOME Choice Transition Program Participant Requirements. The requirements are as follows:
  - The resident has, or will have, at least 90 days within the nursing facility (or a continuous stay of 90 days in a combination of hospital/ICFMR facilities/nursing facilities).
  - The resident has Medicaid Claims while in the inpatient facility.
  - The resident is likely to move to a qualified residence as defined by HOME Choice.

  Visit http://jfs.ohio.gov/OHP/consumers/homechoice.stm for information and application materials.

Community Living Specialist Key Points

- CLS providers are required to obtain a signature from the resident on the **Community Living Plan Addendum.** Payment will not be released without a signature and completion of all data fields contained in the addendum.
- The HCICCU will notify the fiscal intermediary to release payment following receipt of an accurate and signed addendum.
- CLS providers meeting all requirements outlined within the provider agreement shall receive $150 per Medicaid resident receiving CLS services.

Community Living Specialist Key Points

- Payment will not be released for CLS activities to Medicaid residents if the tracking sheet for non-Medicaid residents is not submitted as required per the CLS provider agreement.

The Community Continuum

Building an Ohio Community Living Guide

What's in it now?

- Section A: Talking to an Individual about Community Living
- Section B: Ohio Continuum of Long Term Services and Supports – *COMING SOON*
- Section C: Connect Me Ohio – Resource Connection
- Section D: Housing Primer
- Section E: Finding Employment
- Section F: Help with SSI/SSDI
- Section G: Helpful Resources

Why do we need it? To inform "navigators" at the local level of ALL services and supports available across settings and needs as well as provide a foundation of tools to assist in coordination.

Want to Join a Small Workgroup to revise/expand?
If yes, sign up today.

Questions?

After training, feel free to contact us with questions via:
*e-mail at mfp@jfs.ohio.gov
*or call 1-888-221-1560