NEW YORK STATE | Department of Health

Return to the Community

Money Follows the Person & The Open Doors Program

January 10, 2022

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What is Money Follows the Person?

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What is MFP?

Federal Demonstration

- Authorized and established by federal statute
- 33 Participating states
- New York has participated in MFP since the beginning of the demonstration in 2007
- National evaluation of MFP by Mathematica Policy Research through 2016

Rebalancing Initiative

- Rebalance the Long-Term Care system from institution to community
- Earn enhanced federal match on HCBS for each MFP participant
- Current projects include person-centered planning training, access to assistive technology and DME (TRAID)

Open Doors

- Assists participants to transition from Nursing Homes and Intermediate Care Facilities to the community
- Provides peer support
- Provides Education and Outreach to all nursing homes in NY State
- Local Contact Agency for MDS Section Q referrals

MFP Qualified Transitions

- ✓ 18 years of age or older
- ✓ Medicaid Benefits for one day of institutional services
- ✓ Lived in a nursing home, hospital, or intermediate care facility for at least 60 days
- ✓ Needs that can be met in the community
- ✓ Move to a qualified setting, including house, apartment, or small group home of 4 or less individuals
- ✓ Have a physical or developmental disability, traumatic brain injury, or is elderly (including those elderly with mental health needs)
- ✓ Enrollment in a constituent program (MLTC, MMC, NHTD, TBI or OPWDD waiver or Health Home

Why is MFP Important?

Decrease Institutional Services

↓

Decreased Costs

Increase HCBS Services

↓

Improved Quality Of Life

Role of the Olmstead Decision

Olmstead v. L.C. (1999)

> "Unjustified isolation" of persons with disabilities is a form of discrimination in violation of Title II of the Americans with Disabilities Act (ADA)

In its 1999 Olmstead v. L.C. decision, the U.S. Supreme Court ruled that States, in accordance with the Americans with Disabilities Act (ADA), have an obligation to provide services to individuals with disabilities in the **most integrated setting appropriate to their needs** (MISCC).

State Level Collaboration and Partnerships

- Office for People with Developmental Disabilities
- Division of Nursing Homes and ICF/IID
- Bureau of Managed Long-Term Care
- Health Homes/ Coordinated Care Organizations
- Justice Center
- Division of Veterans' Affairs
- Office of Community Transitions/PASRR
- Homes and Community Renewal/MRT Supportive Housing
- State Office for the Aging/NY Connects

Medicaid Managed Care and Managed Long-Term Care

A natural, mutually-beneficial, cross-referral relationship

- Medicaid Managed Care and Managed Long-Term Care approved for MFP as qualified constituent programs since 2015
- MMC, MLTC, and MFP: A Value-Added Alliance
  - MFP adds value by expediting transition to home and community-based services
  - Transition Specialists provide a bridge from the facility to the community
  - Managed Care increases access to more robust home and community-based services for MFP participants

MONEY FOLLOWS THE PERSON

NEW YORK ASSOCIATION ON INDEPENDENT LIVING

OpenDoors

Transition Assistance, Peer Support, Outreach and Education

A project of NYS Money Follows the Person

New York Association on Independent Living (NYAIL)

- NYAIL administers MFP on behalf of NYS Department of Health
- Statewide, not-for-profit membership association of Independent Living Centers
- ILCs are unique disability-led, cross-disability, locally administered not-for-profit organizations, providing advocacy and supports to assist people with disabilities of all ages to live independently and fully integrated in their communities
- ILCs have been transitioning and diverting people from institutions for many years

Open Doors Video

https://vimeo.com/228253296

Infrastructure

- **Transition Centers**
  - 9 Regional Lead Independent Living Centers and 15 Auxiliaries
  - Regional Transition Coordinator/Liaison in the 9 Regions
  - Over 60 Transition Specialists statewide
- **Peer Support**
  - Over 30 peers available at ILCs across the State
  - Approximate the demographic characteristics of the MFP participants
  - Live independently in the community
- **Nursing Home Outreach and Education**
  - 8 Dedicated staff regionally based
  - Education on MFP, MDS Section Q and Local Contact Agency referral

Transition Center Activities

- **Open Doors:** Provides assistance to participants to transition from Long-Term Care facilities to the community, peer support for participants to support these transitions, and outreach to transition partners
  - **Transition Assistance:** Identifies potential participants in nursing homes and intermediate care facilities and facilitates successful transitions to one's community of choice
  - **Peer Support:** Provides outreach and peer support to individuals and families interested in transitioning to community living
  - **Education & Outreach:** Provides information about the Local Contact Agency (LCA) and Section Q of the Minimum Data Set (MDS)

New Capacity Building Initiatives

- **Good Neighbor program**
  - Provide informal support/companionship
  - Volunteers receive monthly stipend
- **Open Doors Phones**
  - Increased communication between participant and Transition Specialists
  - Increased independence/participation in transition planning
- **Person Centered Planning Coaching**
  - Individualized skill building to support *person centered participation* in care planning

Open Doors Eligibility

- Currently in a nursing home
- Interested in returning to the community

Referral Sources

- Section Q of the Minimum Data Set (MDS)
- Nursing Home Social Workers and Discharge Planners
- Self
- Family/Advocate
- PASRR
- Regional Resource Development Centers (RRDCs)
- MLTC Care Managers
- Health Homes
- CFEEC
- OPWDD
- Veteran’s Benefit Advisors

Transition Specialist Role

- Provide objective information about services available in the community
- Link and refer nursing home resident to home and community-based services like MLTC
- Work with Discharge Planners, Service Coordinators, and Care Managers to develop a transition plan that meets the resident's needs and links individuals to the programs in the community that will meet their needs

- Community Preparedness Education for Day One in the community
- Referral to peers who share experiences of living independently in the community
- Resolve barriers to transition, e.g., housing, enrollment assistance
- Administer Quality of Life survey

Open Doors and Nursing Homes

Open Doors – an asset to Discharge Planners and Care Coordinators

- Transition Specialists work together with Discharge Planners to develop a discharge plan that meets the resident's needs
- Transition Specialists educate individuals about available community resources
- Transition Specialists are familiar with local community-based supports that are not medical in nature

Housing and Open Doors

- Transition Specialists can assist with
  - Housing location
  - Connection to Olmstead Housing Subsidy
  - Connection to sources for security deposits and essential household items
  - Connection with MLTC Housing Allowance

Open Doors Referral Form

NEW YORK ASSOCIATION ON INDEPENDENT LIVING

155 WASHINGTON AVE | SUITE 208
ALBANY, NY 12210
518.465.4650 PHONE | 518.465.4625 FAX
INFO@ILNY.ORG | WWW.ILNY.ORG

OPEN DOORS TRANSITION CENTER REFERRAL FORM

☐ Section Q Referral ☐ PASRR Referral ☐ Other Referral

Date: _____

Resident Name: _____

Medicaid # (if available): _____

Resident Phone or best method of contact: _____

Family/Advocate name and contact information: _____
(please indicate if guardian) _____

Facility Contact Information: _____
(name/position)

_____
(Facility name)

_____
(Street, City, State, Zip)

_____
(phone/email)

Date of Birth: _____ County: _____

Room Number: _____

Primary Language: _____

Comments: _____

_____

Please attach a **FACE SHEET** and any other relevant information.
For list of Regional emails and fax numbers to send referrals to go to www.ilny.org
Or send to: Open Doors Transition Center
Fax: 518-465-4625
Email: secq@ilny.org
Phone: 518-465-4650
If you would confirmation of receipt of a referral, please email secq@ilny.org

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Preadmission Screening and Resident Review (PASRR)

- Federal requirement for any individual that has or may have a Serious Mental Illness (SMI) or an Intellectual or Developmental Disability (I/DD) seeking nursing home admission, or who already resides in a nursing home and has a significant change in condition.
- Nursing Home is responsible for implementing the recommendations in the Level II PASRR evaluation report and referring to Open Doors when the evaluation results determine that the individual's needs can be met in the community

PASRR Recommendation

IS NURSING FACILITY AN APPROPRIATE OPTION FOR YOU TO CHOOSE?

PASRR Grouping

You fall into the category of having a diagnosis that the PASRR program was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is:

[redacted]

Least Restrictive Treatment Setting Determination

Your needs can be met in a community setting (for example, home or a residential setting)

Least Restrictive Treatment Setting Determination Explanation

- Based on information provided in this Level II assessment, medical records, and your Patient Review Instrument (PRI), your needs could be met in the community.
- You do not have any acute medical or functional needs that would need 24/7 nursing facility care.
- You have completed your rehabilitation services and are now independent with daily tasks.
- Your need for medication management [redacted] can be received in a supported community setting.
- A referral to Open Doors through the New York Association on Independent Living is strongly recommended in order to support transition planning. A referral may be submitted by accessing the referral form at https://ilny.ur/programs/mfp/transition-center, emailing secq@ilny.org, or calling 1-844-545-7108

Open Doors Referral

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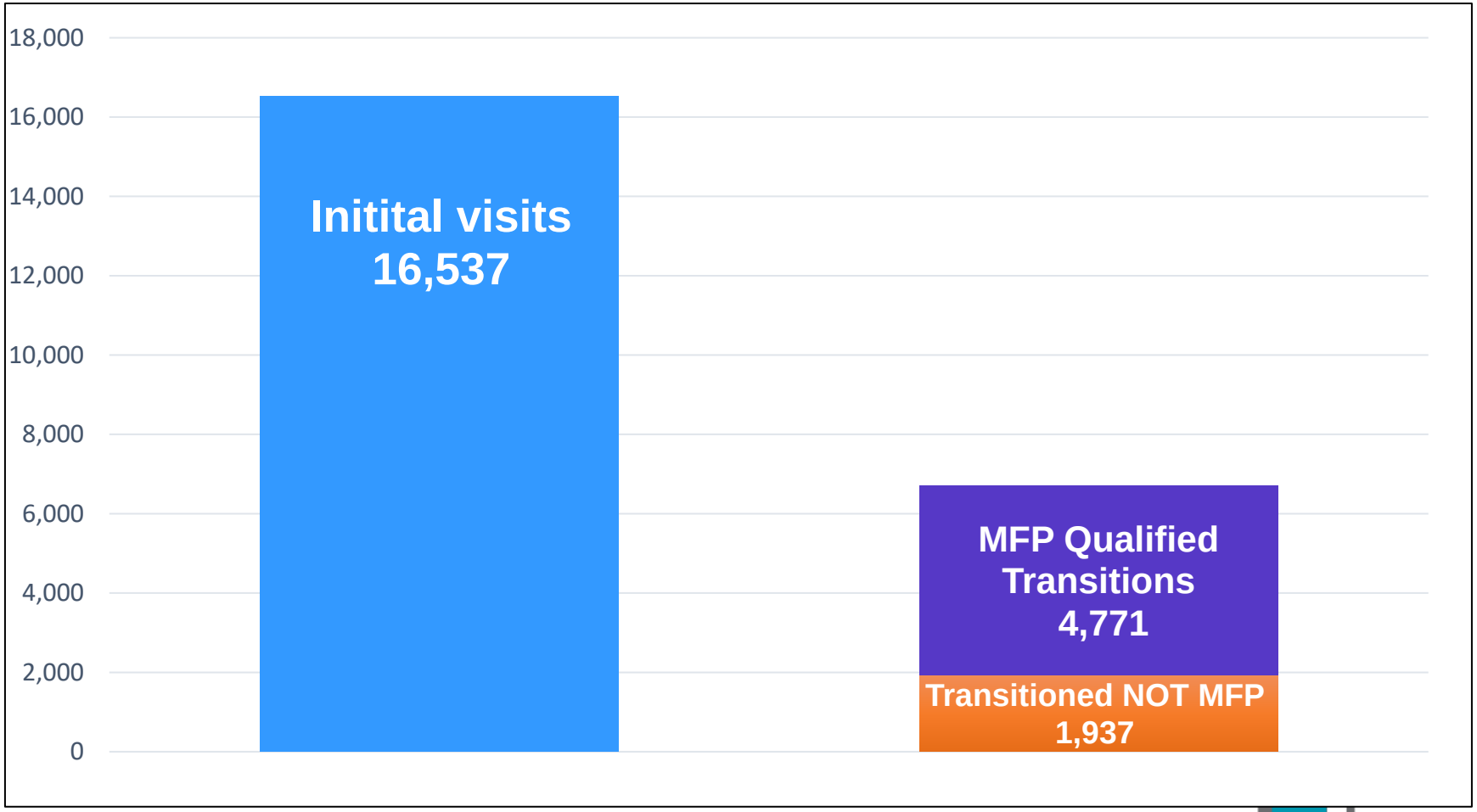
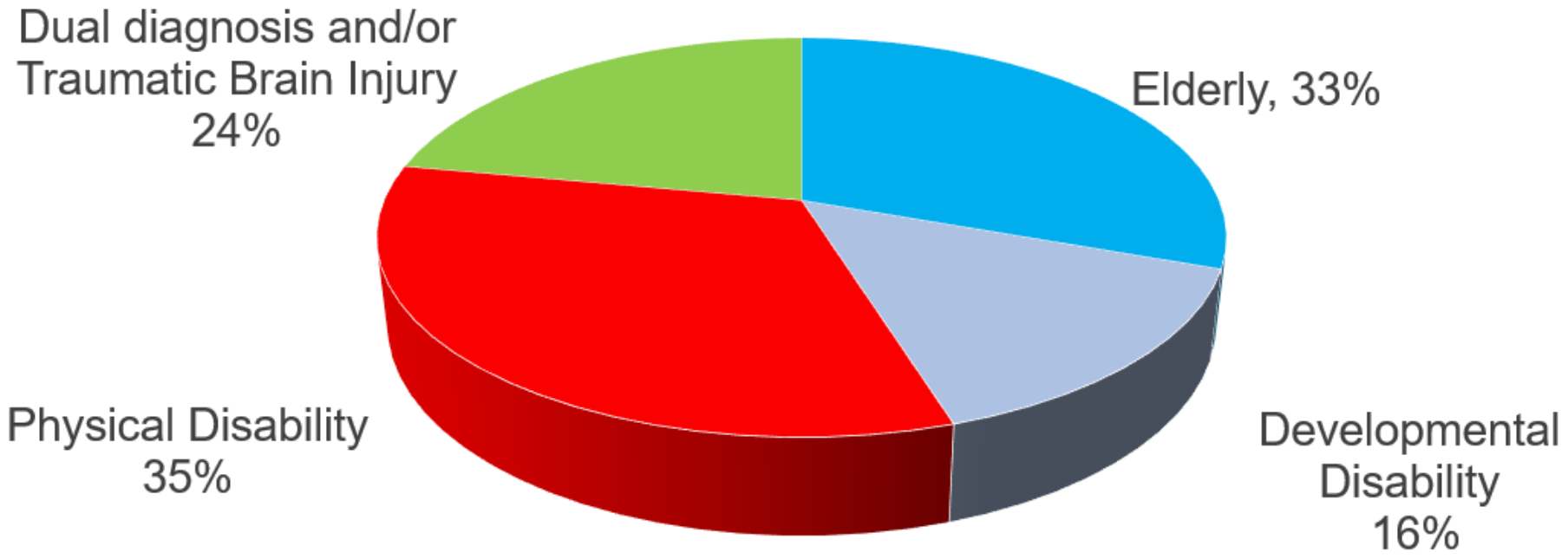
NY State MFP Program

Initial Transition Specialist Visits and Transitions 2008-September 2021



Cumulative NY State MFP Qualified Participants by Target Population 2008 – Jun 2021



Peer Role

- Characteristics of peers approximate the MFP participants (age, physical and/or developmental disability, veteran status)
- Provide outreach to families and individuals living in long-term care facilities
- Provide one-on-one peer support to individuals and families interested in transitioning to community living
- Share experiences of living with a disability or long-term health care needs in the community with participants
- Promote successful transitions through community integration

Open Doors Peer Visits 2015 –2021

Initial Visits	Ongoing visits	Post Transition Visits*
2130	**3268**	**128**

*Post transition visits implemented 2020

Education & Outreach

- Dedicated Outreach and Education staff throughout NYS
- Educates nursing home staff about MDS Section Q and LCA referral
- Educates community based & service provider agencies about Open Doors (ex: Licensed Home Care Service Health Agencies)
- Provides outreach and education to every nursing home in NY State on a 2-year cycle, or more if needed/requested
- Referrals have increased as a result
- Most successful transitions result from referrals from nursing home staff

Open Doors Education and Outreach 2018 – September 2021

	2018	2019	2020	2021	TOTAL
NURSING HOME EDUC & OUTREACH	416	266	160	285	**1127**
OTHER COMMUNITY EDUC & OUTREACH*	1	48	38	24	**111**
TOTAL	**417**	**314**	**198**	**309**	**1238**

* Includes community-based organizations, Health Homes and MLTC plans

MDS Section Q - Identification of Nursing Home Residents Wishing to Transition

- Section Q of Minimum Data Set (MDS) is used to identify individuals who wish to explore their options for returning to their community of choice, to live and receive services

  Q0500: "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

- Nursing Facilities are required to refer all individuals who answer 'Yes' to Q0500 to the Local Contact Agency (LCA)

Section Q "Cheat Sheet"

9. Unknown or uncertain

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?

1. No
2. Yes → Skip to Q0600, Referral

Answer YES **ONLY** if:
- LCA (Open Doors) already involved
- Discharge date is < **3 months** and referral to LCA cannot improve plan

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

02, 06, 99 = Quarterly Assessment types

Enter Code ☐

Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?

1. No
2. Yes → Skip to Q0600, Referral

- Only applies to Quarterly Assessments
- **Q0500 MUST be asked on ALL annual or change-of-status**

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**

1. No
2. Yes
9. Unknown or uncertain

MUST ASK THIS Question unless resident has ACTIVE discharge plan!! **DON'T judge** whether resident can be discharged to community.
If YES, MUST REFER TO LCA (Open Doors). LCA will provide information and explore possibility of alternate settings so resident can make informed choice.

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Federal Guidance – MDS Section Q

The US Department of Health and Human Services' (DHHS) Office for Civil Rights (OCR) 2016 guidance:

- Clarified Section Q definition of ***active*** discharge
- Increased awareness of mandates to refer individuals answering "Yes" to Q0500
- Addressed misconceptions and pre-conceived notions
- Educated nursing home staff about availability of HCBS
- Enhanced collaboration between nursing home staff and Open Doors
- Reinforced person-centered approach

MLTC-MFP Policy and Guidance

2016 Guidance for MCOs

- Describes MFP- Open Doors
- Outlines CMS mandate to refer to Local Contact Agency anyone who identifies interest in returning to the community
- Provides referral process

2016 MLTC Policy 1604

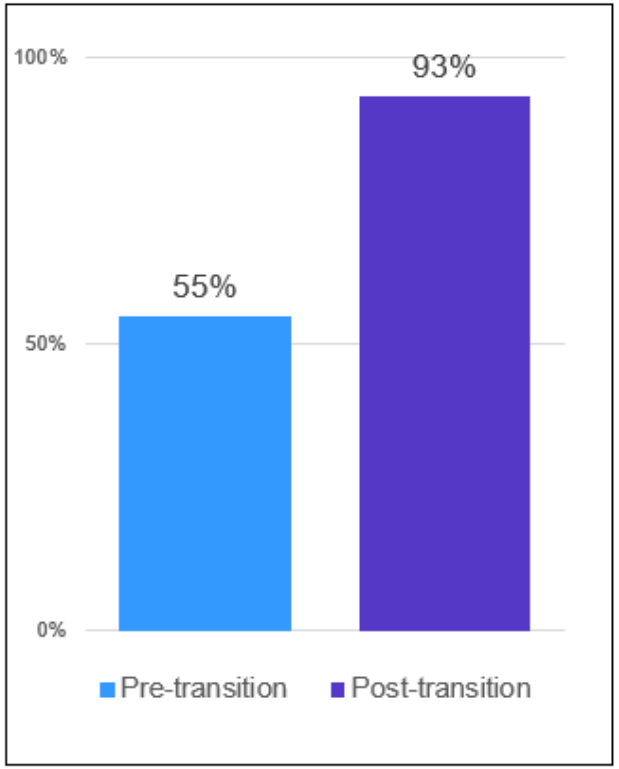
- Describes MFP- Open Doors
- Outlines requirements for MLTC plans to include an MFP attestation in Enrollment agreement and a description of MFP in plan handbook

State and Federal Policy Work Together

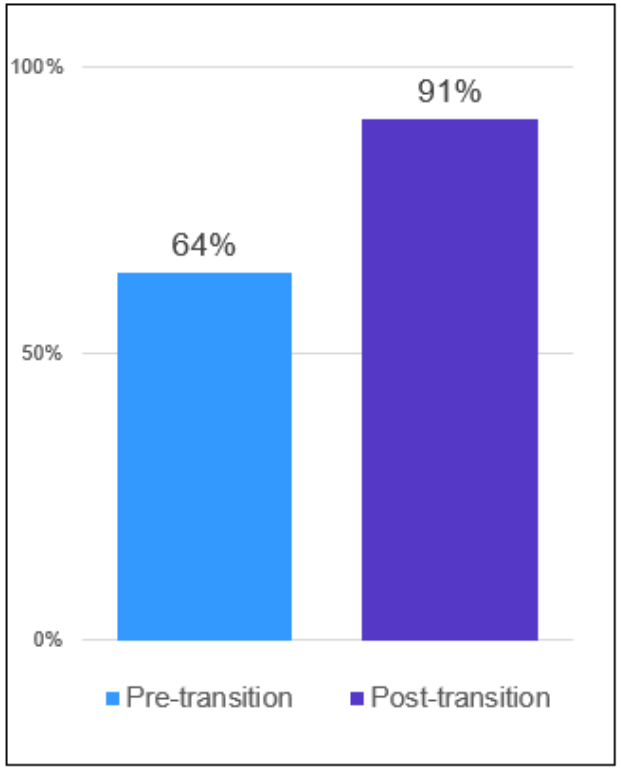
- Encourage development of strong working relationships with the Local Contact Agency – NYAIL and the Independent Living Centers throughout NYS
- Clarify proper administration of MDS Section Q so all SNF residents have access to Open Doors
- MFP/Open Doors utilize home and community based services to safely and successfully transition people out of SNF

Quality of Life 2019 Survey*

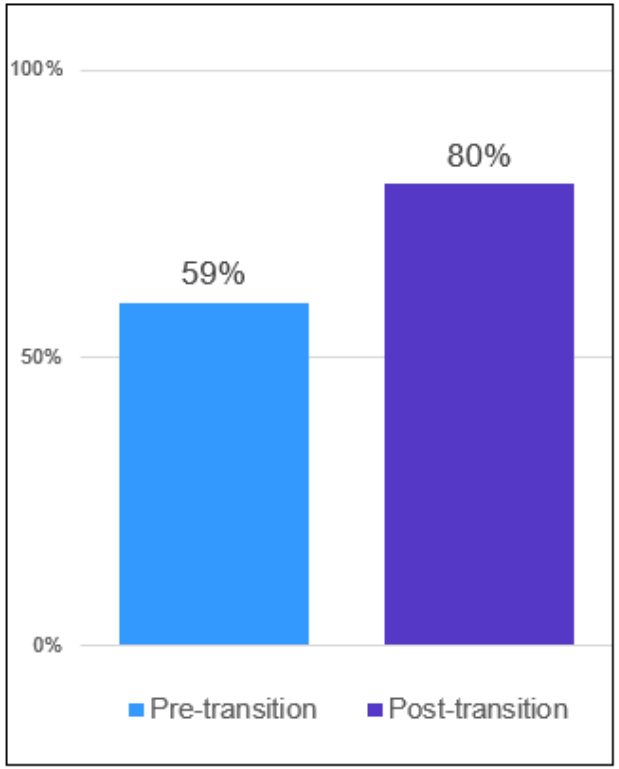
Do you like where you live?



Are you able to take a bath or shower when you need one?



During the last week, have you been happy with the way you live your life?



*Excerpts from 2019 Quality of Life Survey

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Contact Regional Lead:
Transition Center (ilny.us)

Open Doors Referral form

Refer to *Open Doors*

Call 1-844-545-7108
Email: secq@ilny.org
Fax: 518-465-4625

Open Doors Transition Centers

Resources

For more information about MFP, visit the DOH web page at:

- NY State Dept of Health MFP Program

For more info about Open Doors and NYAIL

www.ilny.org

View the following free Public Health Live webcasts on Open Doors, MDS Section Q and Person-Centered Planning:

- The Money Follows the Person Program: Facilitating Return to Community-based Settings
- Discussing Return to Community Living: Best Practices for MDS Section Q
- Person-Centered Healthcare in Planning and Practice

Informational Links

- HHS Guidance on MDS Section Q
  - 2016 HHS Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting
- MLTC/FIDA Individual Consumer Advocacy Network (ICAN)
  - http://icannys.org/aboutican/what-we-do/
- Managed Care Complaints and Appeals Information
  - https://www.health.ny.gov/health_care/managed_care/complaints/
- Complaints about Nursing Home Care
  - https://www.health.ny.gov/facilities/nursing/complaints.htm

State Requirements – Informational Links

- Dear Administrator Letters
  - NH DAL 16-10: MDS Version 3.0, Section Q
  - NH DAL 18-05: Nursing Home Discharge Requirements
  - NH-19-16: Residents' Rights

- Revised NY State regulations direct nursing homes to inform residents of community transition programs and the LCA
  - Title 10 NYCRR:
    - 415.2 (Definitions)
    - 415.3 (Resident's Rights) – MFP/Open Doors LCA info in a public space at wheelchair height

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For more info: NYS Money Follows the Person (MFP)