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Using In-reach Strategies to Identify Potential Home and Community Based Service Applicants in Nursing Homes

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Q. We are monitoring implementation of an ADA settlement agreement which requires the expansion of home and community-based waiver services for persons with brain injury in nursing facilities. Because of restrictive enrollment procedures, limited outreach mechanisms, and a general lack of understanding of waivers, the annual utilization of these services is less than the amount of new waiver capacity mandated by the settlement agreement. What advocacy strategies should we consider to bolster interest in available community service options?

A. Staff from the state agency that administers the home and community-based services (HCBS) waiver program should create an intensive in-reach program that regularly visits all nursing facility residents who might be eligible for, or interested in, community transition. Waiver care coordinators and oversight staff can provide face-to-face counseling on service options, facilitate the submission of waiver applications for interested individuals, and provide support as they navigate the eligibility determination process. Initial Medicaid screening of nursing facility residents by nursing staff, as well as periodic MDS assessments of resident diagnoses and preferences can also be used to identify and refer potential applicants to in-reach counseling.

I. Introduction

The creation or expansion of home and community-based waivers is a common form of relief in settlement agreements brought on behalf of institutionalized persons. In addition to building community service capacity, these agreements should include intensive in-reach and education strategies so that individuals with disabilities can make informed decisions about their service options. This is particularly important for people who have experienced prolonged institutionalization in nursing facilities or other segregated settings. These individuals are often isolated from the larger community, have limited access to information about less restrictive service options, and may present with

multiple, complex needs. While notices about community options, provider fairs, and facility trainings are elements of the standard outreach program, they are not sufficient for reaching these institutionalized populations, especially individuals with more significant cognitive disabilities. Instead, facility-based in-reach programs should provide face-to-face interactions with someone knowledgeable about community options, trained in effective communication strategies, experienced in planning for community transitions, and committed to the benefits of community living.

For these reasons, State agency staff can and should play a critical role in conducting this type in-reach programs, facilitating waiver applications, and providing the kind of personalized information necessary to assist individuals and families in overcoming barriers to community transition. Involving State agency staff in these activities also creates a direct line of accountability for achieving settlement agreement standards, including utilization of waiver capacity. When combined with a system for the identification and referral of individuals in facilities, this face-to-face in-reach can dramatically increase the number of people who consider, apply for, and ultimately enroll in waiver services. If in-reach provisions are not part of an existing settlement, and waiver utilization is an area of concern, advocates should consider these strategies as part of ongoing efforts to implement, and achieve compliance with, that agreement.[1]

II. Providing face-to face interactions between individuals in nursing facilities and staff experienced in supporting community service transitions is one strategy to effectively communicate HCBS waiver options.

During the era of Money Follows the Person, many States used transition entities – often private contractors or other community-based nonprofits – to communicate information about waiver services to individuals in qualified settings. However, these entities generally worked outside of the waiver system, with little direct knowledge of waiver programs or providers' capacity to serve individuals with significant needs. Many did not have experience guiding individuals and families in transition planning from institutional to community service delivery.

State agency staff, including agency service coordinators, are likely to be more effective than transition entities in providing in-reach to individuals who are institutionalized. At a minimum, they should play an important and complementary role to these entities,

[1] The 2013 Settlement Agreement in *Hutchinson v. Patrick* (now *Hutchinson v. Baker*) required Massachusetts to engage in specific education and outreach, with the option to use either state agency staff or designated transition entities. Additional outreach strategies, including the creation of peer to peer counseling, were triggered by under-utilization of the waiver programs. As class counsel, CPR advocated for state agency waiver staff to conduct in-reach to class members, a change which was implemented when Massachusetts' MFP Demonstration ended. In order to sustain ongoing outreach obligations under the Agreement, State agency staff and service coordinators assumed this responsibility in 2017, resulting in a significant increase in the rate of waiver applications and successful enrollments. More information about the *Hutchinson* Settlement Agreement and its implementation is available at: https://centerforpublicrep.org/court_case/hutchinson-v-patrick/.

becoming directly involved with in-reach and transition planning at the earliest opportunity.

In Massachusetts, waiver service coordinators and state oversight staff were already in nursing facilities on a regular basis, assisting individuals and families in active transition planning. While in these settings, it was efficient for them to meet with other interested individuals, and provide information about the range of waiver services and the process for application. Most importantly, these staff could share their personal experiences supporting and planning for individuals' community transitions. Because of their regular presence, individuals and families could request additional follow-up meetings as they considered their service options. Specific facility assignments ensured that in-reach counseling was available statewide, and allowed State agency staff to build relationships with nursing facility residents.

To be effective, this face-to-face in-reach must be paired with multi-media resources, designed to accommodate individuals' cognitive and communication needs. Videos are a particularly compelling way to illustrate community service settings, and to feature the stories of individuals who have made the transition from nursing facility to waiver services.[2] Most importantly, pairing in-reach meetings with opportunities for community exploration and peer to peer counseling is critical to informed decision-making for individuals and families who may have reservations about community living, or difficulty conceptualizing how a waiver setting would meet their family member's needs.[3]

Finally, advocates should insist on data documenting the number of facility visits, the number of individuals seen, the extent to which consumer videos are used/viewed, the frequency of peer-to-peer counseling or community exploration visits, and the number of applications submitted. This information allows the P&A, and relevant state agency staff, to assess the efficacy of enhanced in-reach efforts and to measure their impact on waiver utilization.

III. Ensuring that nursing facility residents are screened upon admission, and periodically referred to in-reach counseling using active resident assessments, allows for the identification of individuals interested in learning about community options, as well as those who may have barriers to discharge.

When individuals are institutionalized in state or privately-operated nursing facilities, there are often existing screening and assessment procedures which can be used to identify and refer residents to the in-reach process. All States are required to have a Pre-Admission Screening and Resident Review (PASRR) program that screens and

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[2] Examples of peer-focused outreach videos developed in *Hutchinson v. Baker* can be viewed at https://onedrive.live.com/?authkey=%21AP7N9BSOEpXpEo4&id=95CCBD3C1894520B%211178&cid=95CCBD3C1894520B.

[3] *See* Q&A on Designing an Informed Choice Process in Olmstead Litigation, August 2017, CPR, available at https://www.tascnow.com/tasc/images/Documents/Publications/Q_A/2017/QA_-_Designing_an_Informed_Choice_Process_in_Olmstead_Litigation_CPR_FINAL.pdf

evaluates individuals with mental illness, intellectual disability, or related conditions. *See* 42 U.S.C. 1396r(e)(7) and 42 C.F.R. § 483.100 *et seq.*[4] In addition, for individuals with other disabilities or conditions not covered by PASRR, most States employ a process for reviewing individuals' Medicaid eligibility before or shortly after nursing facility admission. In Massachusetts, Clinical Assessment and Eligibility (CAE) nurses determine a person's clinical eligibility to enter a skilled nursing facility with Medicaid (MassHealth) as the principal payer of record, or when Medicaid is needed to pay for a longer term stay. As part of implementation in *Hutchinson v. Baker*, CAE nurses were directed to include within their existing screening tool a question that identified individuals willing to receive information on community service options.[5] When initial data showed a small percentage of individuals answering 'yes,' the State agreed to refer all screened individuals for in-reach counseling, as a way to assist individuals who may have specific reservations or perceived obstacles to community living. Well over 100 individuals per month are now identified and referred for in-reach counseling through this process.

In additional to screening, all nursing facilities are obligated to conduct active resident assessments as part of State and federal reporting obligations under the Minimum Data Set (MDS).[6] These assessments capture information about a resident's primary diagnoses, allowing for the targeting of individuals with Acquired Brain Injuries (ABI).[7] The MDS also requires that nursing facility staff pose a set of questions related to individuals'/guardians' discharge planning and interest in community alternatives, including: "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" [8] These responses are reported to the Center for Medicaid and Medicare Services (CMS), where State data is aggregated and published.

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[4] For a more detailed description of the potential of PASRR programs to promote and effectuate transitions, *see* CPR Fact Sheets and Q&As, including Strategies for Enforcing the Nursing Home Reform Amendments and PASARR Regulations for Persons with Developmental and Psychiatric Disabilities (May 2010).

[5] CAE nurses were trained to pose the following question, with a default in favor of in-reach: "Is the consumer (or guardian if applicable) willing to receive information about options to support the consumer's future discharge planning and return to the community? *(Consumers do not need to express a preference for community living, or an immediate interest in discharge, in order to be appropriate for referral. Unless he/she is opposed to receiving more information about community service options record the response to this question as 'yes'.)"*

[6] The Minimum Data Set (MDS) is a federally-mandated clinical assessment of all residents in Medicare and Medicaid certified nursing facilities. MDS assessments must be completed for all nursing facility residents upon admission, at periodic intervals, and at discharge. MDS information is transmitted electronically by nursing facilities to the national MDS database at CMS. More information about the MDS and its public reporting can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/index.html.

[7] A copy of the MDS Resident Assessment and Care Screening form for nursing facilities can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Archive-Draft-of-the-MDS-30-Nursing-Home-Comprehensive-NC-Version-1140.pdf.

[8] *See* MDS 3.0 at Section Q0500

CPR worked with Massachusetts officials to collect Section Q responses from individuals with ABI, and to identify those who had expressed interest in learning more about community living. These individuals and their guardians were then referred to waiver service coordinators in their respective facilities for face-to-face in-reach counseling.

As the federal MDS data collection tool has evolved over time, Section Q questions have increased in frequency and broadened to assess not just current preference, but an individual's interest in speaking with someone about the possibility of community living.[9] While it is an important source of referral information, MDS assessments are typically performed by nursing facility staff with little time or incentive to discuss community alternatives with residents, and who may have no training on what community services exist. In addition, residents and family member may choose to opt out of these questions, except for comprehensive assessments, reducing the frequency with which they are asked. Therefore, advocates should keep in mind that Section Q data has limitations, and may significantly underestimate the number of individuals who, with the benefit of more specialized in-reach counseling, would choose waiver services.[10]

IV. Conclusion

By advocating for responsible state agency staff to: (1) conduct face-to-face site visits; (2) create accessible, multi-media information on HCBS services options; and (3) develop comprehensive referral mechanisms, advocates can identify potential waiver beneficiaries, provide meaningful information about service options, and facilitate the application and transition planning process for waiver beneficiaries. Negotiating for the collection and dissemination of quarterly in-reach and referral data will allow advocates to monitor the impact and effectiveness of these strategies in increasing waiver applications and enrollment.

[9] *See*, e.g., presentation on differences between MDS Section Q 2.0 and 3.0 at https://ltcombudsman.org/uploads/files/support/MDS-3.0-Section-Q-Presentation.pdf.

[10] This difference in referral rate is illustrated by a snapshot of outreach referral data in *Hutchinson*. In the quarter ending June 30, 2018, 136 in-reach referrals came from CAE nurses, 130 from direct facility outreach, and 16 from Section Q responses. Generally speaking, new Section Q referrals for individuals with ABI have ranged from 15-30 per month.