My Place Louisiana

Overview of the Program

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CMS's overview of MFP Video

- https://www.youtube.com/watch?v=PEoxR3UkuNs

Freedom of Choice

"Mankind is at its best when it is most free. This will be clear if we grasp the principle of liberty. We must recall that the basic principle of liberty is freedom of choice, which saying many have on their lips but few in their minds."

- *Dante Alighieri*

Intro To My Place Louisiana

- The *Money Follows the Person (MFP) Rebalancing Demonstration* is a **Centers for Medicare and Medicaid Services** (CMS) demonstration designed to assist states in delivering Medicaid services in new ways. The Demonstration is designed to help people transition from an institution into community-based settings, such as a home or an apartment. In Louisiana the Money Follows the Person Rebalancing Demonstration is known as *My Place Louisiana*.

My Place Louisiana

Quality of Life Surveys

- Gives participants a voice about services
- CMS uses data to improve/create programs

Transition Coordinator

MFP Housing Coordinator

- Technical assistance for Support Coordinators
- Develops resources/ access to housing

Supplemental Funding

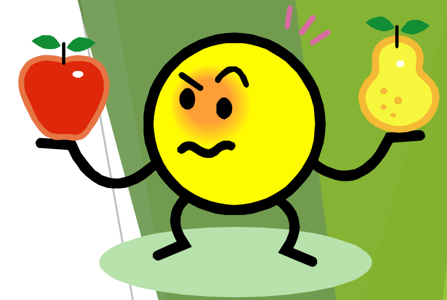
- Removes barriers to transition
- Helps maintain independent living

Collaboration

- OCDD
  - Children with developmental disabilities (birth to 18 years of age, residing in a nursing facility)
  - People of any age with developmental disabilities living in an ICF/DD
- OAAS
  - Elders (age 65 and older)
  - Adults with physical disabilities(21 years are older…disability must have occurred after 21st birthday)

Who is Eligible?

- Anyone currently residing in a nursing facility for 90 days or longer who continues to meet NF LOC, and who meets both the financial eligibility and program criteria requirements for a qualified Home and Community Based Service under the demonstration, can participate in the Demonstration.



Services

- Waivers:
  - Community Choice Waiver (Formerly known as EDA)
  - Adult Day Health Care Waiver
  - Program of All-Inclusive Care for the Elderly (PACE)

    (available in Regions 1,2 and 4) or

  New Orleans, Baton Rouge, and Lafayette areas

My Place Incentives

- **Opportunity to voice opinion on quality of care provided in institutional verses HCBS to improve current service and create and implement new services.**
- **My Place Louisiana Participants are eligible to receive additional funding/services provided through supplemental budget requests. Participants may receive these funds prior to and up to 365 days after HCBS begin.**
  - Funds to obtain documents needed for housing (ID, BC, SSC)
  - Funds for environmental modifications not covered through waiver/Medicaid
  - Emergency rental assistance
  - Assistance with security rental and/or utility deposits
  - Funds for legal services needed for transition
  - Funds for consultation (s) with community based physicians

MFP Goals

- Achieve Transition
- Achieve Timely Transition
- Effective Risk Mitigation
- Successful Development of Community and Natural Supports
- Successful Community Integration
- Make Effective Linkages and Build and Attain Supports for Transition Needs

Referral Processes into My Place

Roles of My Place Transition Coordinators and Waiver Support Coordinators

Referral Process for MFP

- Referrals come from several sources Including:
  - Ombudsman (from Governor's Office of Elderly Affairs)
  - Self Referral
  - MDS Section Q
  - Support Coordination Referrals from Registry mail out waiver offers
  - Hand delivery of registry offers

MDS Section

- The MDS (Minimum Data Set) is part of the federally-mandated process for assessing individuals receiving care in nursing facilities . The MDS provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and supports.

- The MDS is administered to all NH residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition.

- Beginning October 1, 2010, all Medicare and Medicaid certified NH were required to switch to the MDS 3.0. Emphasis is on an individual's participation in assessment and goal setting. The MDS 3.0 Section Q allows individuals to express interest in learning more about possibilities for living outside of the NH.

MDS Section Q Continued

- Nursing facilities are required to notify designated Local Contact Agencies (LCAs) when a resident expresses a desire to learn more about options for living in the community. Including when a resident answers "yes" to Section Q questions. These referrals are then divided by those that financial qualify for waiver services and those that do not. Those that qualify are referred on to My Place Louisiana.
- There is one LCA in each region. The LCAs are responsible for keeping data on nursing facility referrals that do not qualify for My Place La, and providing information/education to individuals who have indicated the desire to speak with someone about home and community based living options.

Flow of Referrals

Referral Received:

*Ombudsman

*Self Referral

*MDS Section Q

*Waiver registry

Intake and referral manager inputs data into spreadsheet to began tracking transition

Once Financial Eligibility is confirmed, MFP intake coordinator sends a request for a waiver offer to SRI.

SRI sends waiver offer to intake coordinator , and coordinator sends waiver offers to Transition Coordinators.

Transition Coordinator hand delivers waiver offer and completes initial packet with potential MFP participant.

Completed waiver packets are returned to intake coordinator and intake coordinator sends Freedom of Choice and Informed Consent form to SRI. SRI then makes referral to chosen Support Coordination Agency

Support Coordination Agency assigns a Support Coordinator to MFP participant and Support Coordinator meets with participant to complete MDS-HC and develop Plan of Care.

Transition Coordinator continues to follow the participant and assist the Support Coordinator as needed to ensure participant can transition as expeditiously as possible.

Person Centered Thinking

Person centered thinking and planning is a process for continual listening and learning, focusing on what is important to someone now and in the future, and acting upon this in alliance with their family and friends. It is the foundation of transition planning and care planning.

Person Centered Planning

Person centered planning is a way of assisting people to work out what they want, the support they require and helping them get it.

Transition Coordinator Role

- Coordination with Intake Specialist regarding Medicaid eligibility and receipt of CCW waiver offer from SRI.
- Hand Delivery of Waiver Offer and My Place Louisiana information.
- Obtain pertinent documents from NF records while in facility (face sheet, H&P, legal documents, list or diagnosis and medications)
- Return signed CCW documents and MPL informed consent to Intake Specialist so forms can be forwarded to SRI to establish Support Coordination (SC) services. (for waiver offers sent by Intake Specialist)

Transition Coordinator Role

- Monitor Data Collection spreadsheet for accuracy and documentation of progress in transitions. Notify Donna of any needed changes to spreadsheet.
- Communicate with SC, participants, and Regional Offices to ensure transitions are occurring in a timely manner
- Participate on conference calls or meetings with SC agencies, regional office, and OAAS staff at regular as requested.
- Completion of Home Visits and Transition Assessment with in 7 days post transition
- Home visit at 30, 90, and 180 days post transition
- A final phone follow up at 365 days post transition

Transition Coordinator Role

- On-going training and support for SC agencies on community resources.
- Problem solving for special circumstance transitions/technical support for SC
- Coordination with MFP Housing Specialist (Yvette) to transfer documents pertinent to obtaining housing (referrals, identification documents, ROIs, etc)
- Communication with key Nursing Facility staff (Social Service Designee, DON, Administrator, etc.) as needed.

Transition Coordinator Role

- Communication, support and training for Office of State Ombudsman staff
- Communicate with concerned family members and others involved in the transition
- Resource Development
- Identification and communication of changes/revisions needed in current policies related to transitions
- Approval and requisitioning of funds for pre and post-move activities

Support Coordinator Role

- With in 3 days of linkage SC will contact individual to schedule face to face meeting
- Within 10 days of linkage SC will conduct a face to face meeting and complete a MDS-HC
- Meets with NF staff, staff, family, and friends as warranted, to ensure individual's needs can be met
- If health and welfare can not be reasonably assured the SC will complete a narrative to give to the OAAS RO office
- When efforts to secure housing have been exhausted SC completes a narrative to give to OAAS RO office and they decide on inactive status

Support Coordinator Role

- Ensures timely communication and problem solving through meetings with Regional office and Transition Coordinators at regular intervals
- If it appears individual can transition POC is submitted to OAAS RO within 45 days of the linkage
- SC has the option to invite Transition Coordinator to POC meeting
- SC will conduct a monthly meeting with individual at NF to ensure transition efforts are ongoing and barriers are addressed

Support Coordinator Role

- Visit individual prior to transition to ensure:
  - D/C date
  - All needs will be met through coordination of supports and completed environmental modifications