

Bureau of Elderly and Adult Services
MED FOCUS GROUP FORUM
January 29, 2010
1:30-3:30pm (Brown Auditorium)

Meeting Notes*

*These notes are an informal summary of the discussion that took place at the MED Focus Group Forum held on January 29, 2010. They are provided by the Bureau of Elderly and Adult Services (BEAS) for general informational purposes only and should not be construed as an official record of the meeting or reflective of policy, practice or a course of action to be taken by BEAS.

BEAS Attendees: Kathleen Otte Kathy Minaert Karen Carleton
Susan Rydberg Sally Varney Mary Maggioncalda
Diane Langley Wendi Aultman Kerri Coons

Attendees: Russ Armstrong, SCOA Kathy Boylan, Moore Center, Manchester
Donna Guillemette, NH Adult Day Assn. Amy Newbury, ServiceLink Belknap County
Kristy Hayden, SLRC, Strafford County Peg Lins, Crotched Mountain Community Care
Walter Perry, Residential Care Homes Madeline Clark, Residential Care Homes
Ruth Hall, Adult Legal Assistance & SCOA Ted Purdy, Sullivan County
Ann Berthiaume, Elliot Hospital Betsy Miller, NH Assn. of Counties
Susan Young, Dir., HomeCare Assn. of NH John Poirier, NHHCA
Doug McNutt, AARP Dan Klein, NHHCA
Barbara Ryan, Heritage Case Management John Carmichael, Regency Nursing Home
Erin Hall, Brain Assn. Mickie Grimes, DFA
Kelly Clark, AARP

I. Welcome and Introductions

Kathleen welcomed attendees and thanked everyone who participated in the last meeting.

II. Open Forum/Review of January 13th Meeting

- A. Currently working to centralize the DFA/BEAS portions of the eligibility process.
 1. The idea is to have one application that is completed only one time.
- B. Kathleen provided the 36-month look back, statistics, running LTC caseload. This information was requested at the last meeting.
- C. The questions were asked, how does it relate to community partners? How many pending? How many waiting for redetermination? Kathleen asked Karen Carleton to provide a quick overview.
 1. Karen Carleton (KC): Five nurses (at State Office) are doing assessments. To date, 90 people are waiting to have an initial assessment completed. Redeterminations are being scheduled. There are only 30 community partners trained to do redeterminations, to date. We do not have a good volume of provides to do redeterminations. Looking at how many redeterminations we have in a year to determine how we might disburse them more evenly throughout the year. Currently there are 82 Nursing Facilities trained to conduct the MED. 20 hospitals (to be) trained. 30 community providers trained. The next training will be a Web-based training on February 17th. Looking at having someone help out in areas Karen cannot get to.
 2. Kathleen asked Karen to report back at the next meeting on how many nurses, overall, have been trained.
 3. Russ asked what the difference between the initial process and the redetermination process. KC replied that a reassessment is required after 365 days. We strive to conduct the redeterminations with 30 days. Some providers have offered to do them for us. However, if it isn't done within 30 days, services will not lapse. Services are still maintained. This determination process is not linked to financial determination. It is totally separate.

4. Karen C. coordinates the redeterminations, contacts Case Managers. Karen C. does it here at State Office. Case Managers go out and do the redeterminations
5. Kathleen asked if anyone had any comments or suggestions at this point and reiterated that is the purpose of these forums.

III. 2-Page Application

- A. The group was asked to review and submit comments regarding the 2-page application (used for initial determinations only). The comments received were distributed to the group. This application is completed by hospitals, SLRCs, DFA, individuals. It is completed in writing, not electronically.
- B. The Application was referred section by section:
 1. Referral Source: Not used for any statistics. Karen commented that as a nurse, it's nice to know where the referral came from. It's important on the consumer level to document the referral source. Sometimes a Power of Attorney (POA) or Guardian will make the referral and we would want to know that. Wendi Aultman commented that when they applications arrive by fax or mail, it helps to know who sent it. It can help the councilor.
 2. MID (Medicaid Identification Number): Only DFA knows this number. State Office goes by DOB or ID #.
 3. Do we need to know if it was from a hospital or transfer facility? It was asked if the Change of Status form takes the place of this information. KC said that it could. It is helpful for State Office to know if it's for admittance to a nursing facility or for a home assessment.
 4. It was stated that the "New Applicant" section is too far down on the form. A Discharge Date would be helpful. (The former application included it).
 5. Assessment Trigger: Nursing Home or Homecare? (Office use only box could go away).
 1. Ted P.: Is the assumption that the financial part has been made prior to? No. But the medical and financial application has to be merged before someone can be approved. Ted then asked what info do we need to have as a basis, not to duplicate information? KO: At some point the systems have to merge. Currently, our computers do not communicate. It would be astronomical to achieve this. So we are working on one application that would hopefully not be much more than 2 pages.
 6. Do we need developmental retardation, mental illness on this application? Yes, PASAR (Pre admission tool for those disabilities) has to review those people for Nursing Level of Care. This is a queue for them to do so.
 1. It could be moved from the initial app., however, it has to be identified somewhere. It is not a demographic piece. It could be part of the Assessment. That would be a more appropriate place.
 2. Wendi A.: There are instructions that go with the application that lend to some definitions. There are several items on this form that are not input into the Options System. However, some of the information is used when determining assessment. It's important to know their primarily language.
 7. Mailing Address needed? Secondary Address? Marital Status? This information will be picked up by DFA. Communication? Under demographic section. Is it helpful to our nurses? KC: Make an actual demographic application...and move most everything else to the Assessment most of this information is covered again in the Assessment.
 8. Usual place of residence: The unusual circumstances for residence definitely should stay on this form so we know how to go about doing the Assessment. Kerri C: It's also required for federal reporting. It is entered into a system that can pull the info for federal reports.
 9. Medicaid Status? How does someone know his or her Medicaid status?
 1. Wendi A.: the box is important because if they don't have Medicaid checked, we check if they do in fact have Medicaid.
 10. Physician: KC: it's good to know the "Primary Physician". Perhaps change it to say "Primary Physician". If someone does not have a physician; it is hard to get services.
 11. Dentist/Eye Doctor? Not important.
 12. Responsibility/legal guardian/self/POA: It is included above on the form. Support documentation is requested however it is rarely provided.
 1. Suggestion was made to move the Guardian info to the top of the form. State Office only uses it as a reference.
 2. Don't really need to know about advanced directives.
 3. Question was asked who is first person to see the application? KO: it depends; it arrives at State Office, via SLRC or Community Provider. John P.: Not sold that we need supporting document for legal

guardian and POA. What is it used for, initial determination? Karen C. stated that we do get supporting documentation. We need that info because that's the person that's going to be making the health decisions. More the guardian, not so much POAs.

4. Kristy H.: Prior to this, an application would be submitted and the client wouldn't even. You call the client, and they don't even know about this application. Hopefully they are aware of what's being applied for.
 13. Organ Donation: Not needed.
 14. Autopsy Request: Not needed .
 15. DNR Info: Not needed on app.
 16. Emergency Contact/Legal Guardian contact info. YES. The lines need to be longer. Susan Young suggested this be on the Assessment. Person getting this info may not even meet the client. Karen C. said that when we can't reach the client, we can call the emergency contact. That said, it would be helpful to ask for an alternate or other contact if client is not reachable (under demographics). Legal Guardian and other/alternate contact (in demographic section).
 17. Signatures are highly important. This tells us the client understands what they are applying for and agreeing to participate in (Assessment, etc.). Peg Lins suggested moving signatures to the top so they fully understand from the start what they are applying for/agreeing to. Another suggestion was to add verbiage on the form, under the document title, outline what it is and the process, and to keep signatures at bottom, to be uniform with most other forms.
 18. For Office Use Only: The Long Term Care Support Councilor uses this section. When they mail out the app, they document the date when they get them back. If the return time is longer than one hoped, this could tell them how long it took to get it back. Helps with timeframe tracking.
- C. Mickie Grimes volunteered to draft a prototype of the application to bring back to the next meeting. Thank you Mickie.
- D. The next meeting is on Fri., February 12th. We will do like we did today, come together for a brief period of time to review the process of these meetings, then break out into two meetings at 2:00 pm. Kathleen thanked Marsha for taking notes at these meetings. The notes are emailed to the group and are posted on the Web site under "Outreach". These meetings may continue into April.

IV. Break-out Meetings

Kathleen introduced the discussion leaders of the two breakout meetings. Diane Langley and Karen Carleton will lead the "Assessment" discussion. Kerri Coons and Susan Rydberg will lead the "Process" discussion. The discussion leaders will report out on each meeting.

Submitted by:

Marsha M. Lamarre

BEAS Administrative Assistant I

MED Focus Group – January 29, 2010
Assessment Break-Out Discussion
Discussion Leaders: Diane Langley and Karen Carleton

Attendees: Ted Purdy, Peg Lins, Ruth Hall, Margaret Clark, Kathy Boylan, Donna Guillemette and John Carmichael

Karen Carleton began the discussion by asking the group what they like and dislike about the Medical Eligibility Determination (MED) Assessment?

Ted suggested reviewing the legal requirement of the statute as he felt it would help when reviewing the form, knowing what components are needed. Karen read the **Eligibility criteria from RSA 151-E:3** as follows:

- I. A person is medicaid eligible for nursing facility services if the person is:
 - (a) Clinically eligible for nursing facility care because the person requires 24-hour care for one or more of the following purposes, as determined by registered nurses appropriately trained to use an assessment tool and employed by the department, or a designee acting on behalf of the department:
 - (1) Medical monitoring and nursing care when the skills of a licensed medical professional are needed to provide safe and effective services;
 - (2) Restorative nursing or rehabilitative care with patient-specific goals;
 - (3) Medication administration by oral, topical, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions requiring medical or nursing intervention; or
 - (4) Assistance with 2 or more activities of daily living involving eating, toileting, transferring, bathing, dressing, and continence; and
 - (b) Financially eligible as either:
 - (1) Categorically needy, as calculated pursuant to rules adopted by the department under RSA 541-A; or
 - (2) Medically needy, as calculated pursuant to rules adopted by the department under RSA 541-A.

Diane Langley informed the group the eligibility criteria defined in RSA:151E-3 is embedded in an algorithm within the assessment instrument. The current process utilizes the data collected by nurses employed by nursing facilities, home health agencies, adult medical day facilities, case management agencies and residential care facilities statewide to collect the data required by the MED. That data is sent into State Office where nurses employed by the State of NH determine eligibility.

Diane suggests from a process perspective the group review each line of the MED assessment instrument. BEAS will try to incorporate as many of the suggested recommendations as possible. However the group needs to understand there will be some recommendations that cannot be accommodated. Ruth Hall asked if the algorithm varies from state to state. Diane responded, “Yes, but in general states use criteria that is very similar to determine level of care (LOC). The eligibility criteria determine LOC for nursing homes. Once the individual is determined to be medically eligible for NF LOC it is incumbent upon that applicant to choose where he or she would prefer to receive services; i.e. in a NF or in the community as a CFI clients. Choice is critical in LOC determinations.

1st section: The group began with a discussion regarding colostomies? Nurse’s aid can do those things, but they cannot assess. If you have colostomy, you have a skin condition that needs to be assessed. Members of the focused group suggested this area could be moved to treatments and dressings

The discussion moved to feeding tubes? The group doesn’t think it needs to say “new or unstable”...just that they have a feeding tube and the date it was inserted. This page is not for new conditions, just for current conditions.

Members of the focused group suggested reconsideration organizing a further separation between acute and chronic conditions, i.e. recommending current, not on-going chronic conditions on the front page followed by acute and chronic conditions in the second section. (suggested by Peg Lins).

John Carmichael stated he liked the content of the instrument and the way it is set up currently with separate sections for acute and chronic. He has completed several assessments and does not see a need to change the instrument, a sentiment echoed by several other members.

Ted Purdy offered it would be easier for his nurses if the instrument was ordered or designed in a manner consistent with the Minimum Data Sets (DMS) used by NF. Diane responded that it is the Departments goal to work with CMS to gain approval to have all of the assessments completed by NFs using the MDS as opposed to the MED. The state office staff at that point could simply pull the elements necessary to determine eligibility from the MDS and input the data.

Ruth Hall asked if the MED is a working tool right now? Diane stated it was and it assessed level of function as opposed to diagnosis based on specific medical eligibility criteria (RSA 151-E). In the event medical eligibility is denied, the applicant has the right to file an appeal. During the appeals process medical/surgical information is provided from providers for consideration and it may influence the outcome of the decision.

Kathy Boylan asked the question, "Why are we reviewing the MED? Is it too cumbersome, does it take too long, is it duplicative, is it not working?" Karen C. stated that it could be duplicative as Nursing Homes use the MDS tool. Kathy also asked, "What are we trying to fix in this process?" Diane responded there are those who consider the instrument too long and duplicative. The instrument was put in place as a result of recommendations from CMS that the previous process was subjective, lacked adequate information and objectivity. Dr. Steve Bartels, a geropsychiatrist from Dartmouth Medical School and BEAS Medical Consultant consulted around the last revisions of the instrument. His criticism was of the instrument was it needed to be expanded to include questions that would help to uncover other co-existing conditions. As a result the following nationally accepted mini assessments were included in the instrument: the Patient Health Questionnaire a depression screening; the Mini Mental status exam; the CAGE a substance abuse screening and the Mini Cog a cognition screening. However there are those who continue to advocate for a return to the use of the previous process and the old 276 A and B forms. An initial assessment where services needs are identified requires a one-hour period of time. From that assessment a Case Manager is able to develop a comprehensive service plan. However there continues to be pushback about the amount of time an assessment takes. Beyond an actual assessment there is the time required to document the service plan. Skill clinicians incorporate that time into the assessment process. In response to the continued criticism the Bureau is committed to revisiting the instrument once again from a clinical perspective. If the focused group determines the instrument is currently meeting the assessment needs, the Bureau will provide that information to the Legislature stating the instrument works and was reviewed by a group of providers skilled and experienced in its use. If the group recommends change, that too will be report as detailed, specific recommendations from providers skilled and experienced in using the instrument. BEAS is the only division within the Departments clinical program areas where the assessment and the development of specific service/treatment plans was not done at a local, community level by provider's familiar with the applicant.

Madeline C express concerns about functionality and what happens if relevant, necessary assistance is removed. Madeline gave an example. Diane stressed the importance of assessing level of function accurately; i.e. those services that are in place enable the individual to remain at a level where they are able to function. If services were removed they would not be able to function both would result in a determination of medical eligibility.

Madeline thinks it's a good tool as long as adequate space is available to make comments. Most folks use this as a written tool vs. an electronic tool.

The issue of acute and chronic was revisited. It was decided to integrate it or better identify each section. The majority were in favor of combining the two sections. John and Madeline are opposed to combining the sections. John Carmichael commented, "*After doing it so many times, it becomes scarily logical. You get good results from this.*"

Kathy Boylan asked for an example of something that might be questioned. John C. used blood pressure as an example. A client goes to Easter Seals for one shower a week. Most of us would like to have more than 1 shower a week. She also has hypertension. If not paid attention to, it goes array. It was suggested to use the notes section in the back...or explain under "identify needs". Under diagnosis is where you would state the Blood Pressure issue.

Lots of people ask, “What does uncontrolled seizure disorder mean?” It’s not something we see a lot of because most people are controlled on medication. However, in an acute facility, everyone makes notes in that box. It’s very subjective. This needs more clarification as to what’s being done; to assist everyone that completes the MED. It’s unsure if it should go under section 1 or 2.

Whole first page is for needs that are short-term, skilled person to monitor, people going into a facility for that reason. If you’re transferring someone from a hospital to adult home care, you can still use skilled nurses for components of this assessment; Medicaid just may not cover it. It might be Medicare, or other Insurance.

It was suggested to include a statement on Page 1 of the MED that reads: “First Page for Skilled Nursing ONLY. For Home Care and Residential Care, skip this page. The group thought this was a great idea.

Closing Remarks

Diane reminded the group that the next meeting is Fri., February 12th.

Homework Assignment - please review the full assessment and send any comments/suggestion to Diane Langley @ dlanglely@dhhs.state.nh.us .

Submitted by:

Marsha Lamarre, BEAS Administrative Assistant I.

January 29, 2010

RE: MED Process Discussion Notes
Discussion led by Kerri Coons and Susan Rydberg
2:30 p.m.

I. To begin the process discussion, please identify current barriers to the MED process:

- The process is too long
- There is no transparency to this process.
- Communication related to expectations - timeliness of communication is a concern
 - a) Keeping client informed
 - b) Overly Complicated. Certainly not seamless.
- Customer Service not optimum for client
 - a) Providers call and ask the 'client' questions.
- Roles are not clarified. Presents a concern when Hospitals are asked to do a re-determination when they are not familiar with the client or their home environment.
- Conflict of Interest as to who is doing initials/re-determinations is a concern.
- Communication does not get back to ServiceLink Resource Center following an MED. There may be additional resources that could be suggested to assist the client and/or family.
- More follow-up with the person is required. "Shepherding is required in many instances".

II. Define the Current Process

- Discussion Leaders will provide a flow chart of current process.
- The process begins when application has entered into Options for MED application.
- Question: What is the volume for new applications?
- Answer: There are 148 pending for HCBC and 106 pending for Nursing Facility for the month of January 2010.
- Question: Real or Rumor: Is it faster at a District Office vs. a Nurse/Community Provider/SLRC?
 - a) Presumptive Eligibility reviewed. LBA audit recommendations Reviewed.

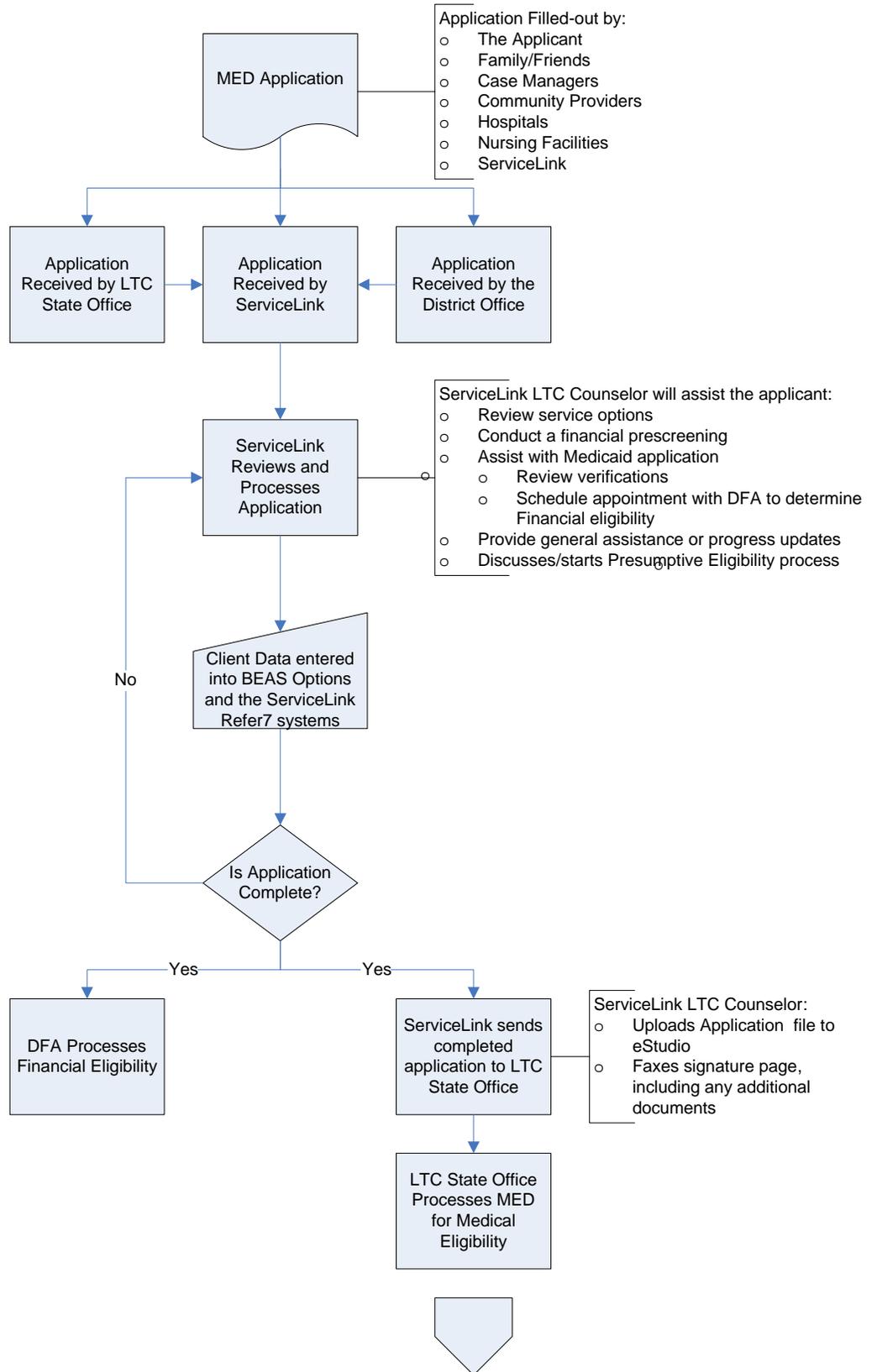
III. Process Discussion Wrap-up 3:25 p.m.

- a) Focus group requests a process flowchart with bullets under each contact point.
- b) Issue List will be started for next discussion.

CFI MED Application Process for New Clients

Process Problems:

- Clients are confused between financial and MED applications
- ServiceLink doesn't always receive a copy of the MED application if sent to SO or DO
- Confusion over where to send applications for CFI vs NF
- Process can be lengthy - difficult for clients to timely obtain all required verifications
- ServiceLink has to check with DFA for Medicaid eligibility
- Presumptive Eligibility process is not well known and the provision to pay back claims is often misinterpreted



Long Term Care Medical Eligibility Determination (MED) Focus Group
 MED Process Workgroup
 Issues List

Issue #	Pri	Issue	Owner	Due Date	Status	Action Items / Resolution	Discussion/History
1		Where to send MED apps - confusion over where to send CFI vs. NF apps					1/29/10 - Meeting - Issue identified
2		Role Clarification - what provider should do which MED assessments?					1/29/10 - Meeting - Issue identified. A Hospital is sometimes assigned the MED when the client has only been there for a short hospital stay. They can't evaluate the client for being at home, especially for redes.
3		MED Status - need a more effective way to communicate where a client is in the process					1/29/10 - Meeting - Issue identified
4		ServiceLink Counseling - SL needs to be aware of all initial CFI applicants for counseling					1/29/10 - Meeting - Issue identified
5		Expedited Process - Is there a method to expedite a MED?					1/29/10 - Meeting - Issue identified