

MFP Sustainability Action Planning – February 13, 2015

What key steps need to be taken to sustain

1. Transition Competencies?
2. Housing Access?
3. Family Caregivers?
4. Community Life?
5. Collaboration?
6. Behavioral/Medical Supports?

What is already known and underway (provided by Trish before group work)

1. Transition-Related Competencies

- a. Keep in mind for Medicaid Reform
- b. Launching Community Transitions Institute – Summer 2015 (2-day conference kick-off in May)
- c. Setting up Curriculum with NC State/UNC Chapel Hill (e.g., dignity of risk, medical supports, employment supports)
- d. Sharpening/honing skills
- e. Forming Learning Communities
- f. 3-day person-centered practices
- g. Pilot – if it works, will sustain

2. Housing Access

- a. Section 8 housing slots, 811 housing grant – hard to use/access
- b. Sometimes it's not that housing is unavailable – sometimes barriers are related to awareness, rules, and logistical issues.
- c. MFP has priority access to Key housing slots
- d. Housing taskforce working with NC HFA on these issues

3. Family Caregivers Supported

- a. Initiatives developed through MFP Rebalancing Funds in collaboration with the Lifespan Respite Grant State Advisory Team and staff. Three pilots currently underway (i.e., Family Caregiver-to-Caregiver Peer Support mini-grants) and new project proposal under development.

4. People Participate in Community Life
 - a. Need to think through employment
 - b. Need team of folks that work with Transitions Coordinator & Care Coordinator to make sure participant is integrated in community.
 - c. Helping person build community with particular support needs
5. Agencies Collaborate to Support Individuals
 - a. Few formal structures for inter-organizational collaboration during and after transition
6. Access to Behavioral/Medical Supports
 - a. CCNC potential to be part of transitions process
 - b. Encouraging Transition Coordinators to link with MCOs/LMEs for support (e.g., substance abuse)

Sustainability Action Table Created through Group Process on February 13, 2015:

Topic:	2015	2016	2017	2018	2019	2020
Transition-Related Competencies	<p>Establish list of resources currently present for support in each county.</p> <p>Support & utilize CILs. CILs have a federal mandate to do transitions work</p>	<p>Focus on Transition Coordinator retention - reduce turnover and provide training.</p> <p>Training for staff on disabilities so that aging and disability populations have equal access.</p> <p>Continuing Education Module Development</p>	<p>Get Transitions Institute off the ground and have reliable data about its impact</p>	<p>Educate SNF, resident about options, opportunities, encourage, build POSITIVE environment to enable/motivate resident through ongoing PC training.</p> <p>Social worker/ Discharge Planner education - mandatory training</p>	<p>Continuation of efforts</p>	<p>Competency to Transition exists throughout community</p>

Housing Access	(Do whatever is necessary to hit that housing benchmark – Period.) Identify & recruit Subject Matter Experts	Improve databases Priority for Section 8, etc.	Address lack of appropriate housing, especially in rural areas Education for housing arena	Continue efforts	Continue efforts	Housing available for 100% of transitions
Family Caregivers Supported	Mode of Communication	Expand/Extending Information	Training	Support Groups	Respite	Individual Caregiver Plan
People Participate in Community Life	Educate each community & collect information from each community	Bridge the gap of resources available in the communities Build a financial base	Develop our brand to raise visibility and awareness Build & share a user friendly database	Continue efforts	Continue efforts	Personalized, self-directed access to services
Agencies Collaborate to Support Individuals	Identify team with tools – assess. org. chart	Cross training - in-person Technology (email, database, contacts up-to-date)	Measurements (# transitioned, length of time, environment of choice & less restrictive)	Participatory re-evaluation	Continue efforts	Consumer – Optimal independence & self-determination Agencies - Efficiency
Access to Behavioral & Medical Supports	Research unmet needs	Assessment for services & results Identify quality providers	Training for TCs & providers Ongoing evaluation	Continue efforts	Continue efforts	Expanded quality provider network

Individual ideas for each priority area, generated by those attending the February 13th MFP Roundtable:

Transition-Related Competencies – all ideas represented on the Sustainability Action Table

Housing Access

- Examine what grants (funds) support infrastructure and the community's voice in regards to development and growth in different areas
- If a person is on a public housing wait list, they cannot be discharged from SNF to ALF (thinking about Olmstead Decision)
- Legislative buy-in to have housing as part of discharge planning. Not just send people to assisted living
- Need to incorporate residential providers; info/database on vacancies matched to individuals; who is willing to work with & throughout MFP/transition process
- Reaching out to more/all housing options to offer Target housing or incentives to renting to participants
- Policy change to enable housing application process to accommodate a person who is in a facility
- Home ownership
- Database of accessible housing
- Develop more housing specialists who can assist the transition team in identifying and overcoming barriers to housing (not just lack of housing).
- Housing for ex-offenders
- Maintenance of housing lists by county/city
- Landlords with Targeted or Key units to learn about SNF residents - talk or have regional Ombudsman/TCs/CILs train on SNF to Community Living (i.e., "How Tos")
- Combine rent and utility costs (like HUD) for Section 8 housing.

Family Caregivers Supported

- Career Coaching to allow for employment that allows more flexibility in schedule
- Educate families about different resources through PSA, meetings, education. Also, conduct assessments to examine the needs of families and individual, whether they are accessible online or a facility.
- Encourage use of Family Caregiving Learning Modules (Lifespan Respite?)
- Bring guardians/family ideas – community connection
- Respite – relieve caregivers
- Support Groups
- Having a Family Advocate to support and educate and link families

- Hands-on training for caregivers that want to take participant home
- Professional Personal Care training for non-professionals (ex: moving from bed to chair without personal injury)
- For full-time caregiver, have “Caregiver Day Out” with volunteers staying with client/participant
- Marketing of Family Caregiver Specialist provider in county
- Build relationships with AAA Family Caregivers who can provide consults about services
- Continue work on No Wrong Doors grant to support stronger options counseling and information availability
- Link resident & their family to caregiver specialists who can link to education, support groups, etc.
- Access to adult day, respite care, PACE
- Provide specific information on Social Security benefits – SS/SSI/SSDI

People Participate in Community Life

- Telephone reassurance to call daily for needs
- Local churches have outreach/senior ministries. Encourage individuals to link with these groups
- Access to county 1st contacts
- Develop informal “care teams” to facilitate involvement in community life
- Hold or create a support group that should meet at least once a month to discuss and familiarize people in the community of the different conditions and much needed supports to provide and lay the groundwork for understanding what is needed.
- Identification of groups around interests/talents of the client for engagement (e.g., LGBT community tapped for volunteerism to a transgender hospice patient abandoned by family)
- Call system (call center) for someone with disabilities – referral specialist will send email to agency regarding information on call
- Employment
- Involve faith community with transition work (e.g., transportation)
- Link our 60+ individuals with senior services, transportation to Senior Center to take part in services and programs that are FREE at senior center
- Connect people with Centers for Independent Living
- Contact the employment office or relative agency to get data regarding employment available. Also, ask public what jobs would be feasible or of interest.
- Define the role of the entity the Transition Coordinator will hand over the resident to. (e.g., Life Coach, Community Specialist) who will help resident engage in community.
- Pull in police, medical, churches, commissioners – community leaders as part of process of integration into community
- LCAs, TCs, link with local Ombudsman to have VR representatives go to speak at Resident Council meetings.

Agencies Collaborate to Support Individuals

- Training on physical and mental disabilities

- Outreach
- Formal organization structure shared between MCO and aging agencies – meeting with MCO & aging agencies
- Agency cross training to expand partnerships
- Encourage widespread access to internet for residents of SNFs (encourages self-motivation & resourcefulness)
- Staff trainings to foster professional development to work towards rapport with other agencies – professionalism – conduct
- Support for/connection between Transition Coordinators
- When training Transition Coordinators, connect them with different players (so many different pieces)
- Linkage to college (interns/depts.); linkage to senior centers; have church/organization sponsor a participant; adult daycare; funding for peer support through LME/MCO
- Websites focused on agency services to support at-home caregivers & participants
- Develop professional networks like CRC
- Encourage SNFs to use email. Phone tag is a huge waste of time.

Access to Behavioral/Medical Supports

- Organize data about MFP participants related to behavioral and medical needs
- Uniform assessment for services
- List of knowledgeable agencies that can and are willing to support medical and behavioral needs.
- Training in communities
- Increase availability of technology to support access to physician/nursing information and guidance
- Collaborate with all of the MCOs and with all Mediation (?)/Psych amenities/facilities to get ideas on how to better support those in need
- PSAs on TV for accessing support for med/behavioral services
- More providers that provide specialized consultative services for behavior support plan development
- Can directly refer to MCO and receive care coordination
- Facilitate communication between TCs and MCOs
- Training for agencies on how to support individuals with medical & behavioral (issues) by agencies that currently are (providing these services).

Next Steps (following Roundtable):

1. Written notes – Group table (transcribed from post-it notes on wall) & individual remarks
2. May need MCO and other organizations to test out (i.e., behavioral/med topic)
3. Some things relevant to Medicaid Reform - *group encouraged to follow this
 - a. Advocate with members of the General Assembly
 - b. Need to have unified agenda - (Disability Rights, MCOs, AARP, CILs, AAAs) – “NC Community Living” agenda