

**NC MFP Roundtable Meeting
Friday, August 8th, 2014
CarePartners Health Services
286 Overlook Road
Asheville, NC 28803
AGENDA**



9:30: Arrive, Sign-In, light breakfast snacks

10:00-noonish

Welcome!

Why This Matters: Real People, Real Impact

MFP Update and Discussion

- Transitions Report
- Director's Report/Staffing Update
- MFP Rebalancing Fund Report
- Outreach Update
- Operational Protocol Revisions
 - Sub CAP Service Area Limits
 - Disenrollment/Due Process
 - MCO Guidance
 - Follow Along
- Efforts around Substance Addiction
- Other systems updates
 - Medicaid Reform

**WANNA CHECK ON THE
STATUS OF AN MFP
APPLICATION?**

1-855-761-9030 or email
Natarsa.patillo@dhhs.nc.gov

LUNCH

1ish-2:45ish: MFP Transition Coordination: The Next 5 Years

- **Update from the Future: Western Carolina Collaboration**
- **Transition and Coordination Capacity Institute & Thoughts on Scope and Structure**
- **Restructuring Transition Coordination**
 - Performance Measures
 - Transition Coordination Organizations

**2:45-3:00p
Closing**

Save the Dates

MFP Year in Review Roundtable: Friday, November 14, 2014

NC MFP Roundtable Meeting Notes

Friday, August 8th, 2014
CarePartners Health Services
286 Overlook Road
Asheville, NC 28803



Meeting Participants:

- Al Frye, Sandhills Center
- Ashley McGill, NC DVR-IL
- Barbara Many, NC DVR-IL
- Barbara Woodbury, Sunny's Home Care
- Carol Melimans, Land of Sky Regional Council
- Christian Horton, NC DVR-IL
- Diane Upshaw, DHHS MFP
- Donna Case, Council on Aging, Inc.
- Donna Tooill, Disability Rights & Resources
- Erin Strain, DHHS
- George Wood
- Ginger Parker, Smokey Mountain Center-LME/MCO
- Jen Branham, Smokey Mountain Center-LME/MCO
- Julia Gibson, Land of Sky Regional Council (CIL)
- Lakeisha LaPorte, DHHS MFP
- Linda Kendall Fields, MFP/DAAS/LOS
- Lisa Ashe, NC ILRP
- Lori Massey, NC Independent Living Program
- Lorrie Roth, DHHS-DAAS
- Lydia Cosgrove, Disability Rights & Resources
- Lyn Kim, Southwestern Commission Area Agency on Aging
- Michelle Kluttz, NC START West
- Sarajane Melton, Southwestern commission Region AAA
- Sheila Brown, Kerr Tar AAA
- Sonny Woodbury, Sunny's Home Care
- Tosha Breland, Disability Rights & Resources (CIL)
- Tracie Ford, Sandhills Center
- Trish Farnham, DHHS MFP
- Vivian Leon, DSOHF

Welcome

Several people were new to these meetings – Trish gave a short history on the MFP Roundtable. She set the tone for the meeting – a structured and relaxed day.

Pleased to be in Asheville today, mindful of the work being done in the west and other specific areas of the state.

Trish introduced Linda Kendall Fields, who lives in this area and is the Outreach Facilitator for MFP. The MFP icebreaker question accompanying introductions

was: “What music would you listen to if you were going out in Asheville this evening?”

Lakeisha LaPorte, new Program Assistant for MFP was introduced to the group – a kind, warm, competent member of the staff. Lakeisha is originally from New York and moved to Raleigh to help out with her grandmother, who transitioned out of a skilled nursing facility under MFP.

Diane Upshaw shared housekeeping items, which Lakeisha will do in future meetings.

Why This Matters: Real People, Real Impact

People shared the following experiences in supporting people to transition:

- Barbara Many, new MFP Transitions Coordinator with the area DVR-IL shared a success story about a woman who transitioned to an existing home with a supportive sister. She is very happy.
- Tosha shared news of success in getting a person home – overcoming obstacles and importance of collaboration. The MFP participant, a woman in a facility in Brevard has CNA coverage – CNA lives down the street – it’s working out so much better than they thought.
- Hannah noted how important her role as a Transitions Coordinator was with a client, who ultimately passed away, but benefited greatly from MFP and going home.
- JacLee’s story, highlighted on DMA-MFP website, was shared again.
- Jen Branham of Smoky Mountain Center updated the group on Oshin, who was highlighted on the DMA website as a “MFP Success Story. Oshin encountered a complicated situation including the whole family. The MFP Transition Coordinator followed up, stuck with the situation, which ultimately resolved.
- Julia Gibson commented that she was glad to know about transitions She has had many years of experience as a nursing home administrator and is now an Ombudsman in the Asheville area.

MFP Update and Discussion – please see meeting handouts for information

- Transitions Report
 - Review of the graph
 - Highlighted pre-transition training
 - Clarification around graph on page 4 – “other” category includes “no reason, “family/health reasons that don’t fit in other categories.

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- Physical Disability/Aging transitions
Benchmarks off the target
- Director's Report/Staffing Update
 - See the Director's report handout
 - Vivian Leon shared information about individuals living in neuro-medical/developmental centers. In working with families, learned they would like to support people with IDD to live in their own home. Her Division is researching service definitions and found a good model in Tennessee. Talking about people's lives, not just systems issues – there is hope!
- MFP Rebalancing Fund Report
 - Diane Upshaw reviewed the handout
 - In surveying the MFP community, new awareness has arisen over the need for a "Community Network" following transition. The following comments were collected from Roundtable participants on a flipchart during the meeting:

Community Network of Friends and Family: What does this mean? What does it look like?

- Faith community wrapped around the person
- Support teams – churches and other
- Working with the individual to create support teams
- Difficult to ask for help
- Ask person to identify other help
- Tap into other resources, e.g., DSS "Family Finder"
- Senior Programs, e.g., Senior Companion program (trend to work with individuals rather than in group settings)
- Council on Aging volunteer to assist
- Can Google "support teams in faith communities network"
- Need hired staff to coordinate – i.e., volunteer programs are not "free."
- Without friends and family, person can be isolated
- May not have the support system in new place or because person was in institution.
- Sometimes promises are made by family and may go by the way-side when reality hits.
- Sometimes the resources have already been exhausted.
- Family may need more information, education, and support.

Community Network Pilot Ideas

- Support Groups – identifying gaps
- Create MFP Roundtables for consumers and families – provide supports/housing information and resources for participants
- Peer-to-Peer Support Programs – engage/pay former MFP clients to be peers
- Create "Welcome Wagon" – partner with Boy/Girl Scouts, rotary groups, etc.

- Link up with apartment complexes
- Get better idea of what person enjoys/identifies with (e.g., “Wolfpack”)
- Support groups that cater to rural areas - target these areas
- Sororities/Fraternities sponsoring people – college students needing service hours; “pay it forward” services (e.g., 1st in Families).
- NC BAM, Baby Boomer retirees; 4H
- Sheriff programs that check in on people – identify all of these
- Step down facilities – importance of learning/reintegrating
- Senior Centers/PACE/adult day care environment help with culture shock and offer opportunity to form friendships.
- Agency called “Love, Inc.” in Charlotte provides volunteers (another set of eyes and ears on a situation)

LUNCH – During the break, the MFP Roundtable learned more about PACE and the developing model at CarePartners from Director, Dave Beijer

MFP Update and Discussion Resumed – please see meeting handouts for information

- Operational Protocol Revisions – Trish reviewed handouts – available for public comment through September 15th.
 - Operational Protocol link: <http://www.ncdhhs.gov/dma/mpproposed/index.htm>
 - Sub CAP Service Area Limits – need to have more infrastructure in place
 - Disenrollment/Due Process
 - MCO Guidance
 - Follow Along
- Efforts around Substance Addiction – thinking through; creating more structured response
- Outreach Update – Meeting on the 4th Friday of the month. Three major efforts 1) Tumblr blog; 2) Newsletter; 3) Roundtable takeaway
- Other systems updates
 - Medicaid Reform – Trish gave an update – see handouts of PowerPoints. Other states doing well with transitions under managed care models. Setting up work groups:
 - Quality
 - Understanding options – options counseling key
 - Budgets

- Timeline – Pulling information together by the time General Assembly comes back in November (later changed to January 2015). Will take direction from there.
- Workgroups will continue after November – applied for “No Wrong Door Grant” – can fund a planning process with these funds.
- Options counseling built into infrastructures – probably in 2 to 3 years
- This next year, state will be working with NC FAST to build the capacity originally aimed at NC CareLink

MFP Transition Coordination: The Next 5 Years

- **Update from the Future: Western NC Collaboration highlighted**
 - Trish introduced the subject – some background on use of MCOs/VR-IL/CAP-DA
 - Three lessons throughout transition
 - Important to set up structures/processes to encourage collaboration – recognizing whole person’s needs
 - Focusing on quality transitions as opposed to quantity – working to develop performance measures for transitions outcomes
 - People all over the map regarding skills as transitions coordinators – building capacities of transitions coordinators
- **Transition and Coordination Capacity Institute & Thoughts on Scope and Structure**
 - Current transitions – what’s going well
 - Pre-transitions process/plan has gone well – i.e., things you have to work on re: IDD population
 - Planning tool is good but we need more background information about what happened in the past. * Will be important in substance abuse issue.
 - MFP is a learning community – tweaking system/structures to encourage collaboration – streamlined process - e.g., revised MFP application; now have full time staff devoted to applications.
 - Need flexibility in use of transitions funds
- **Restructuring Transition Coordination**
 - Performance Measures
 - Transition Coordination Organizations
- Example: The Land of Sky (Asheville area) CRC assisted in strengthening aging and disability relationships – having the face is important. Out of the initiative, an ongoing transitions team meets once a month and members “know how to pick up the phone” in between times.
- Need to clarify the status of application forms with state office sometimes
- **We (i.e., MFP) have learned that there is not always a clear correlation between agency based on age and disability.

- State person needs to “own” the referral until information has been passed to another agency
- At present, under 65, transition goes to Erin; Over 65, it goes to CAP-DA agencies – not always available.
- CILs can often be faster because VR-IL is part of state system.
- Can we open the door to VR-IL Counselors doing transitions?
- Idealism vs. pragmatism – statewide agreements vs. regional agreements of the willing.
- MFP will be tracking which CAP-DAs are active in transitions work. Look at areas where CAP is and develop strategy for where there are gaps.
- Want to create a “Transition Coordination Institute.” – see concept paper provided in handouts– please think about this:
 - Does this resonate with Transitions Coordinators? Yes – there used to be CAP/Thomas S. training (reflections on this). Strengths-based assessment
 - On list, add person-centered thinking
 - Training on criminal records; working through those issues
 - Class on budgeting; independent living skills
 - Transitions Institute – who will be the trainers? Both “experts” and experienced Transition Coordinators
 - Pilot: statewide or regional?
 - Interest in keeping communication going out here in the west – now a regular line item on IL agenda

Closing – The meeting was adjourned; Tours of the developing PACE site were made available after the meeting

Save the Date

MFP Year in Review Roundtable: Friday, November 14, 2014 in Raleigh

MFP – NC Transitions

August 8, 2014 Update

Transitions Information:

Total Transitions:*	438**
Total Aging and Physical Disability Transitioned:	277
Total Development Disability Transitioned:	159
Number of participants enrolled who have not transitioned:	279
Number of participants who have returned to facility: (Cumulative number of individuals who returned to the facility during MFP participation year divided by total number of transitions)	44 (10.04% of total transitions) (This data is from self-report only. No DRIVE information was available for this periods report.)
Number of active participants who have passed away since transitioning home: (Cumulative number of individuals who died during MFP participation year divided by total number of transitions)	37 (8.45% of total transitions) (This data is from self-report only. No DRIVE information was available for this periods report.)

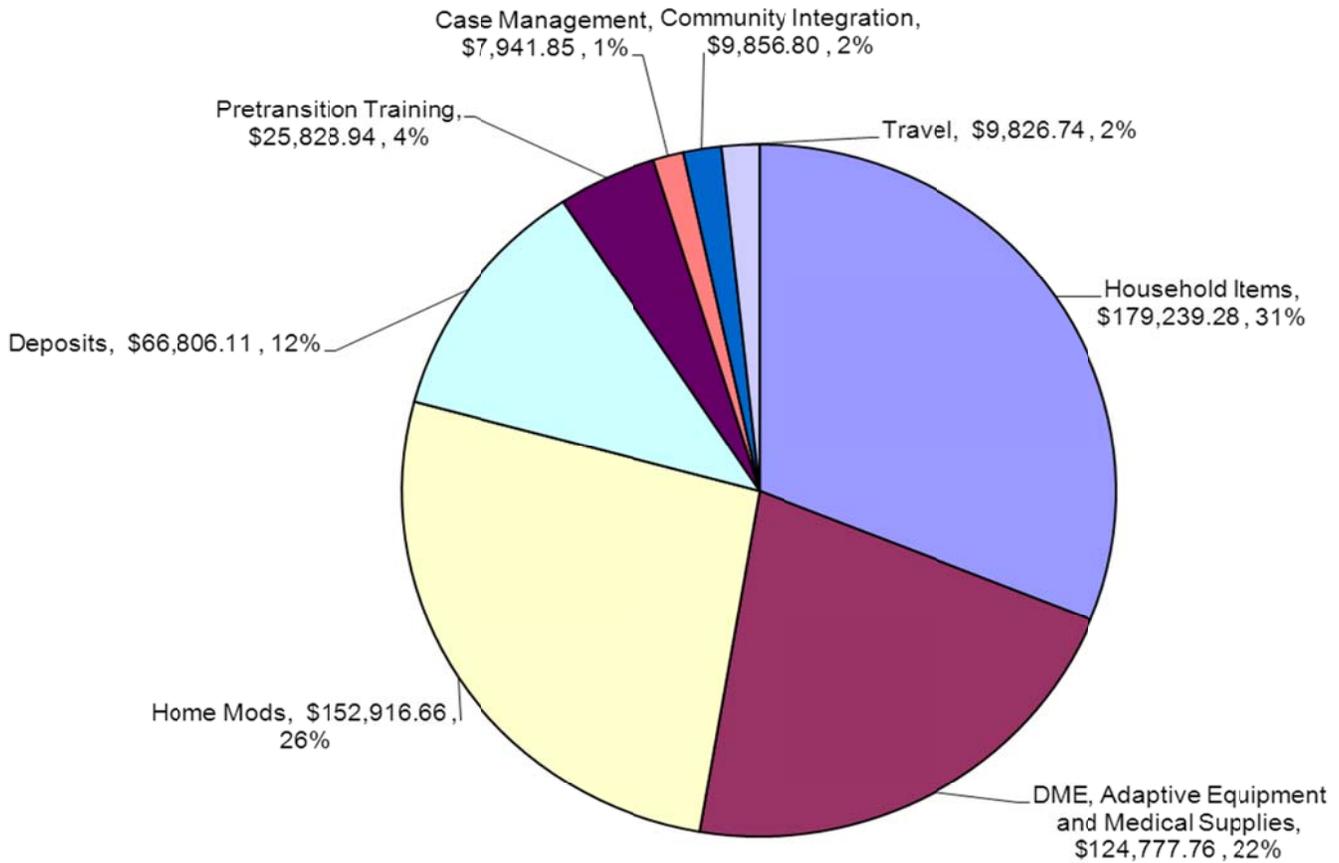
Additional Information about our Benchmarks:

NC MFP Projected Revised Benchmarks				
	Aging and Physical Disability		Intellectual/Developmental Disability	
YEAR	Projection	Notes	Projection	Notes
CY 2014	105		30	
CY 2015	125		30	
CY 2016	150		30	
Benchmark Commitment 2014 - 2016			470	
Revised Benchmark Commitment 2017-2019*			To be determined with thoughtful, collaborative decision making.	
2019=last year of MFP slot allocation				

NC MFP Housing Benchmark - Percentage of MFP participants who do not have identified housing at the time of application and desire to live in their own homes (not family's homes) who have housing identified within 6 months of MFP application approval date.			
YEAR	Benchmark Goal	Year	Actual Progress
2012	20%	2012	5%
2013	25%	2013	4%
2014	20%	2014	5.7%

*The transition totals reflect number of transitions, not number of specific people
 **Transition information is collected by Transition Coordinator/Case Manager reporting and verified through semiannual DRIVE analysis.

Transition Year Stability Funds Spending Chart

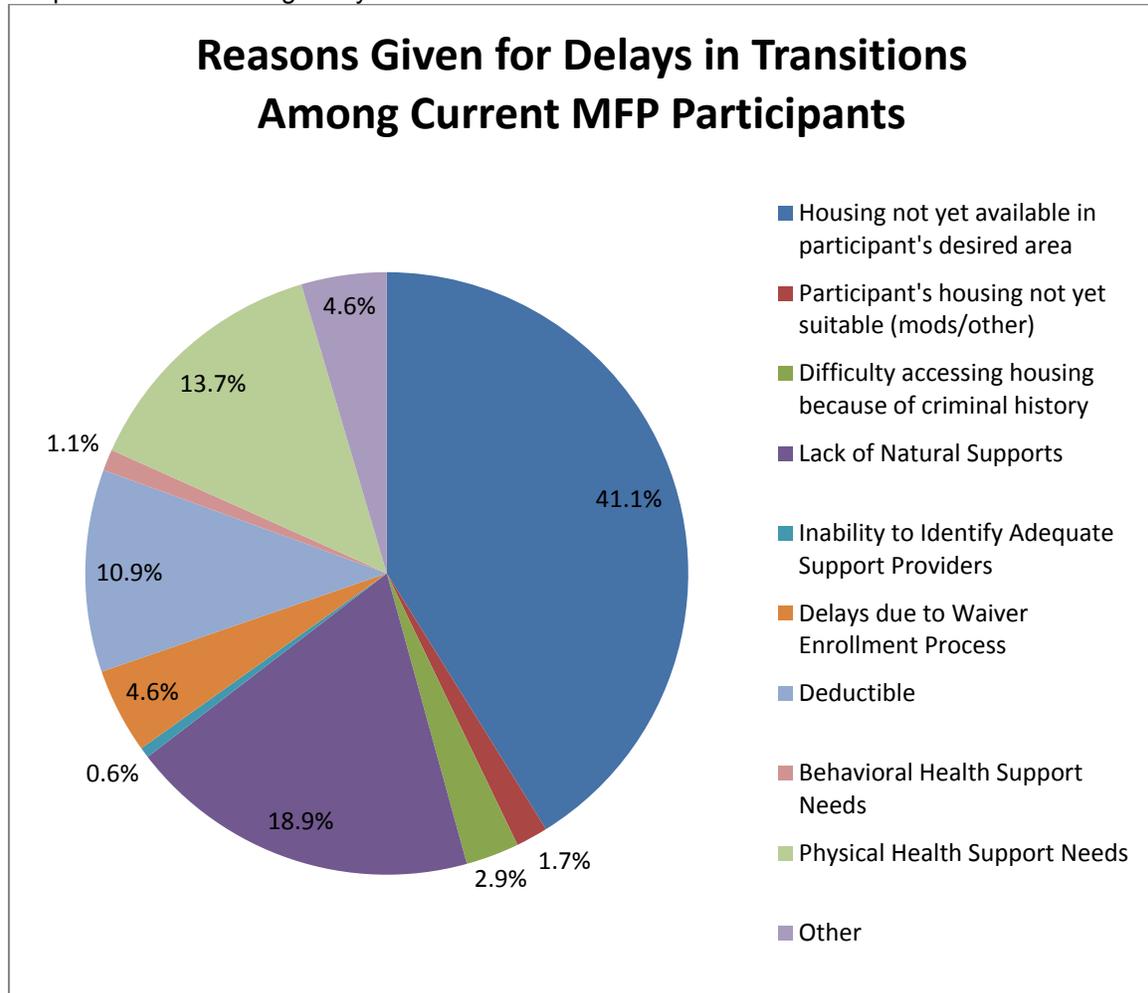


- 318 participants have used TYSR Funds.
- \$602,911.44 has been accessed.
- \$1,895.95 average used per person.

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August 8, 2014 Update

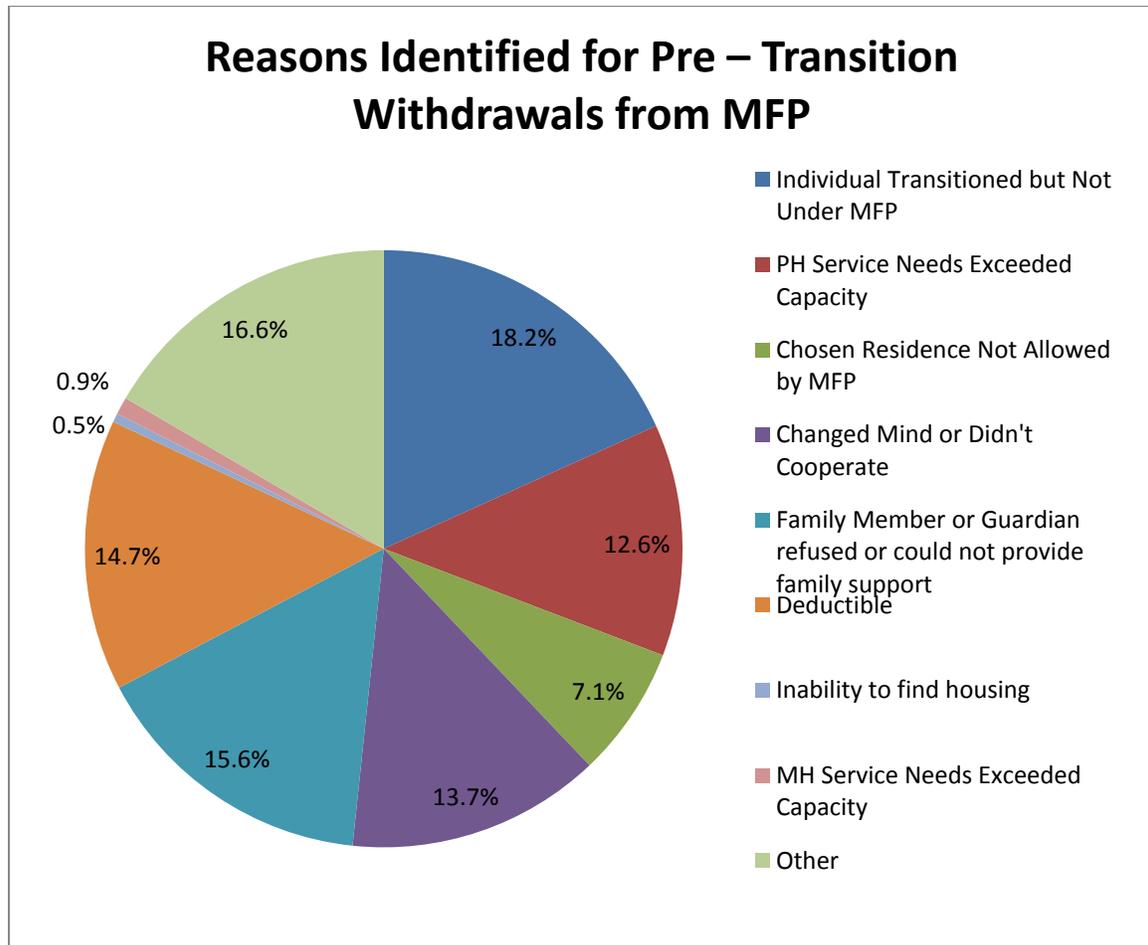
*Represents data through May 2014



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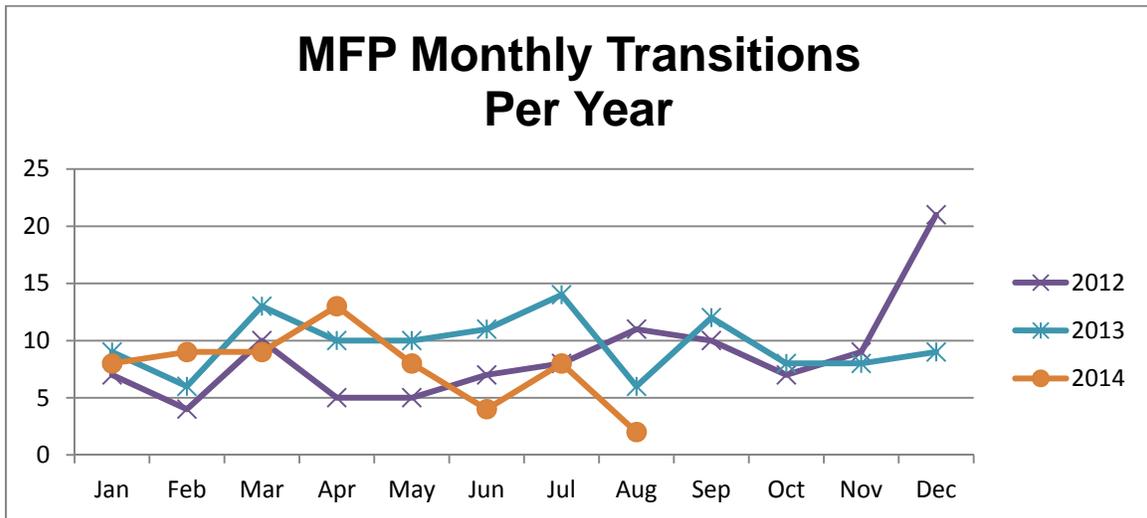
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 This document was last updated at 11:17:18 AM on 8/11/2014

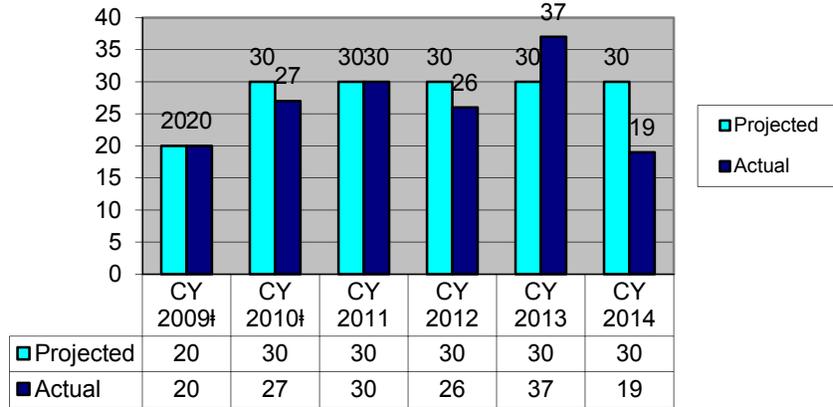
Total Transitions to date: 439
Total for 2014: 61

Transitions totals by year	I – DD	Older Adults	Physical Disabled	PACE	Sub - CAP
2009 = 29	20	6	3	--	--
2010 = 39	27	7	5	--	--
2011 = 89	30	31	27	2	--
2012 = 104	26	42	36	--	2
2013 = 116	37	56	23	1	7
2014 = 61	19	14	28	1	3

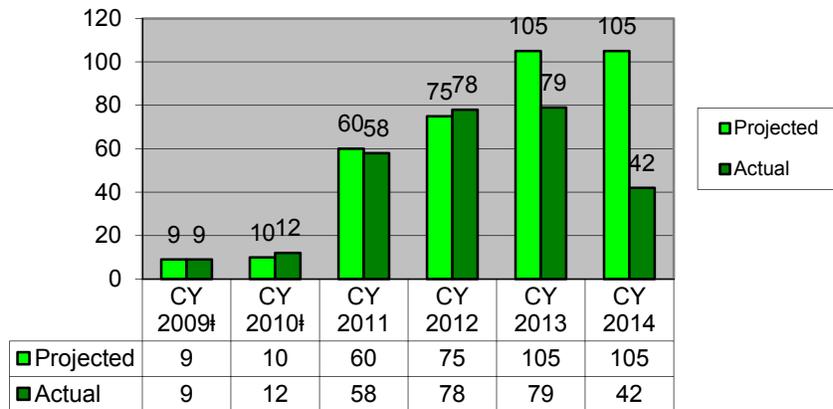


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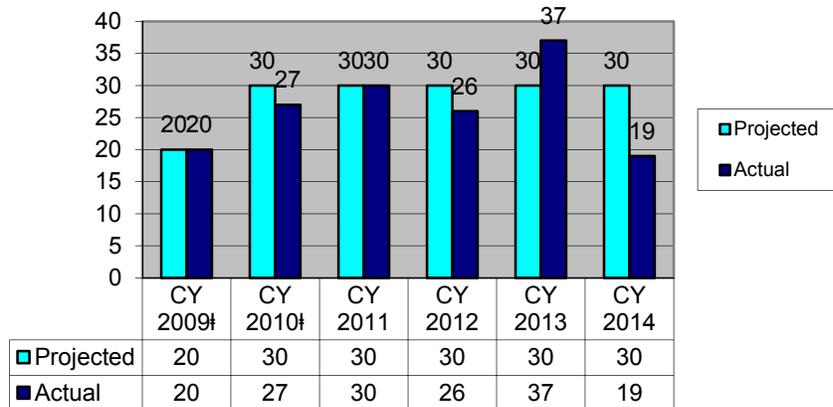
MFP I-DD Goals vs Actuals



MFP Aging and PD Goal vs Actual



MFP I-DD Goals vs Actuals



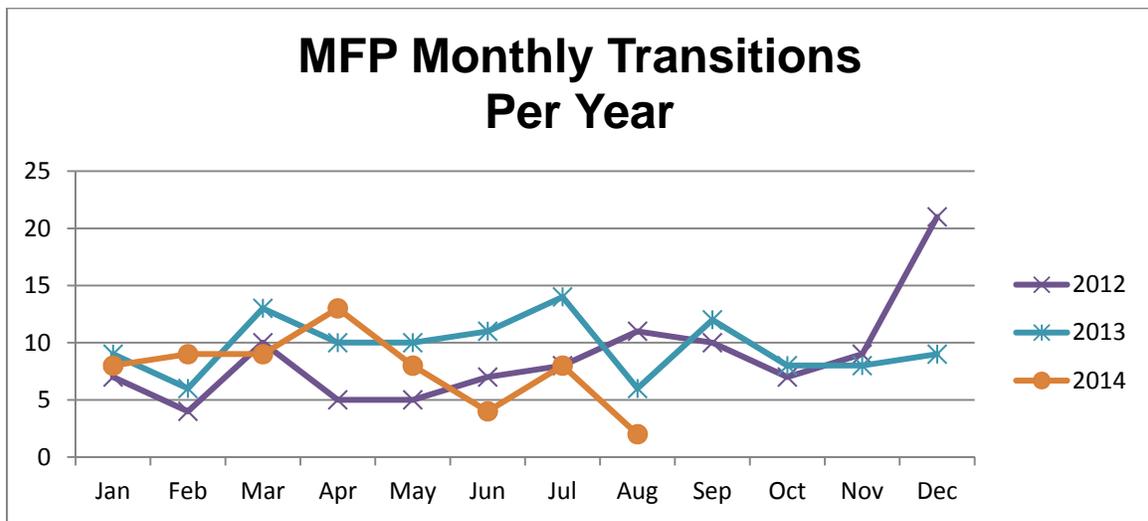
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MFP – NC Transitions

At a glance - as of August 8, 2013

Total Transitions to date: 439
Total for 2014: 61

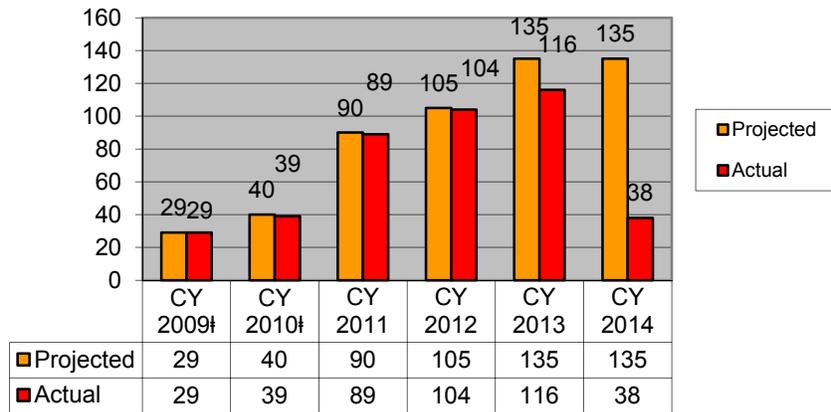
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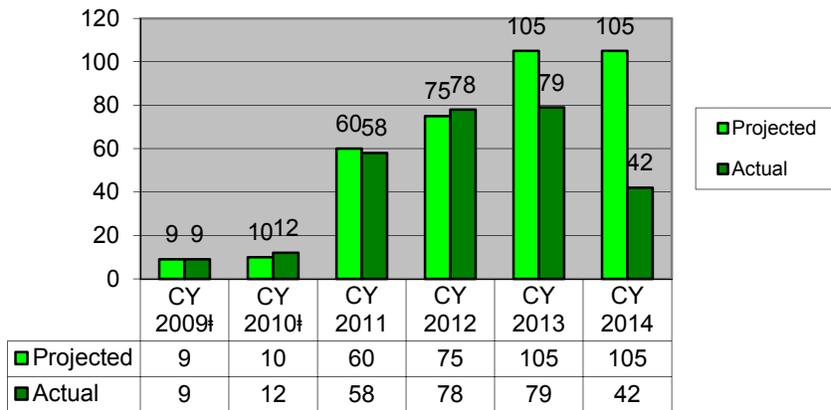
MFP – NC Transitions

At a glance - as of August 8, 2013

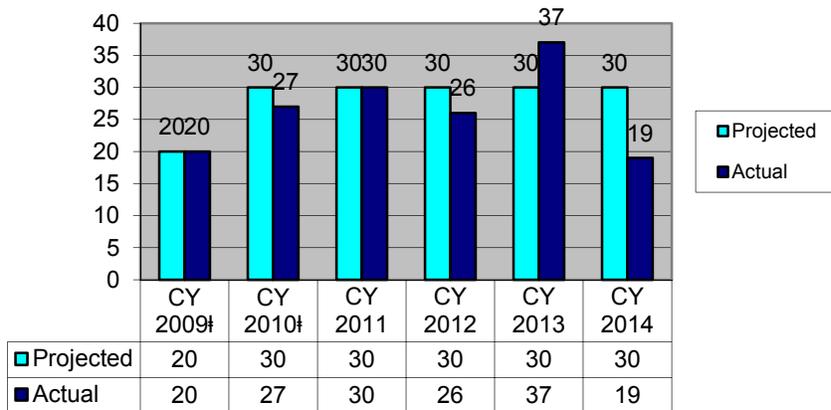
MFP Yearly Goals vs Actuals



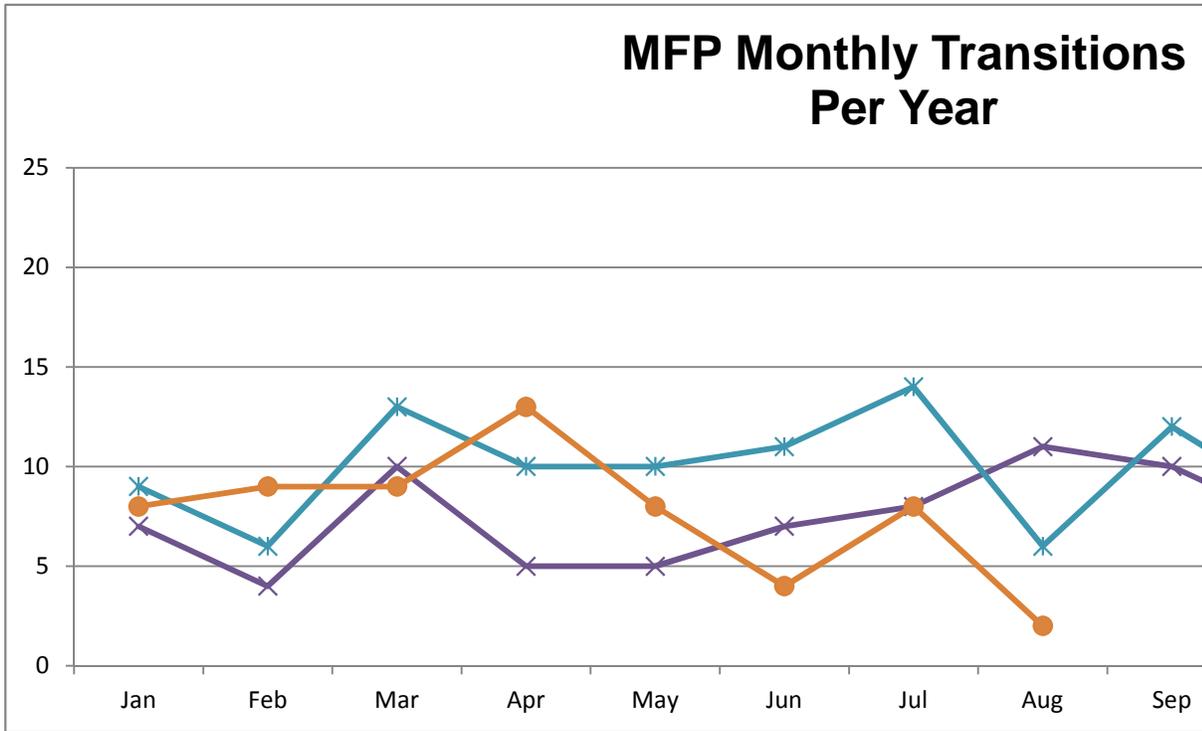
MFP Aging and PD Goal vs Actual

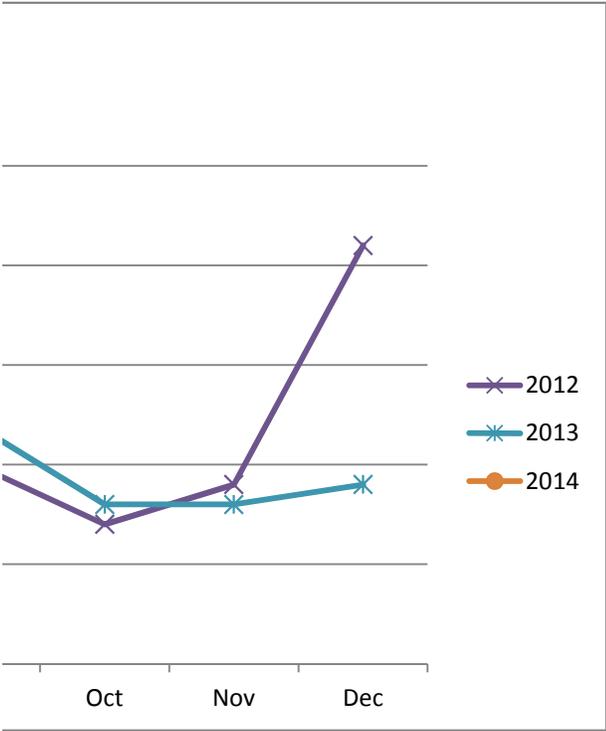


MFP I-DD Goals vs Actuals



	2009	2010	2011	2012	2013	2014
Jan	3	1	5	7	9	8
Feb	1	1	7	4	6	9
Mar	1	2	5	10	13	9
Apr	0	9	12	5	10	13
May	3	2	7	5	10	8
Jun	4	1	6	7	11	4
Jul	1	2	8	8	14	8
Aug	6	3	7	11	6	2
Sep	3	4	13	10	12	0
Oct	2	2	11	7	8	0
Nov	2	7	5	9	8	0
Dec	3	5	3	21	9	0
	29	39	89	104	116	61





Director's Report: The Super Summarized Bulleted Version

For August 8, 2014 Roundtable

Since We Last Met.....

Staffing Updates:

- Lakeisha: Program Assistant
 - Supporting transition tracking and transition coordinators
 - Outreach support
 - Admin support
- Natarsa: FULL TIME applications coordinator
- Laura: MFP data coordination and Medicaid Reform support
- Diane, CB and Trish: Business as usual. ☺

CSC Update:

- Soon to be in testing phase
- Likely going "live" January, 2015

PERS:

- Will be funding 12 months of Personal Emergency Response Services for Sub-CAP participants

Supported Living Demonstration Definition

- Piloting supported living service definition in partnership with IDD partners
- Greenlight from CMS to fund
- Supported living definition being designed by Innovations workgroup.

Beginning to shift to performance-based contracting

- Working to incorporate National Core Indicator-based questions into quality of transition practice

Revised Follow Along Guidelines

- New guidelines going into effect for "high engagement" transitions

Due Process

- See handout
- To go into effect late August

Sustainability Planning

- Will be partnering with stakeholders to develop sustainability plan, per CMS' recent guidance

Medicaid Reform:

- SWOTS
- No Wrong Door Grant
- Update

**Summary of Proposed Revisions to MFP Operational Protocol
Version 1.4
Physicians Advisory Group
June, 2014**

Applicable Section of the Operational Protocol	Proposed Revision
Benchmarks	<ul style="list-style-type: none"> • Update <u>Transition Benchmarks</u> • Update <u>Projected Expenditures</u> • Revise outreach and recidivism benchmarks • Add Housing Benchmarks
Participant Recruitment and Enrollment	<ul style="list-style-type: none"> • Revise to include Psychiatric Residential Treatment Facilities under <u>Qualified Institutional Settings</u>
Benefits and Services	<ul style="list-style-type: none"> • Delete/revise dated references to CAP MR/DD; CAP DA waiver renewal; under <i>Service Delivery Systems</i>
Benefits and Services	<ul style="list-style-type: none"> • Update <u>Service Package</u> section: CAP DA/CAP CHOICE/Innovations waiver
Benefits and Services	<ul style="list-style-type: none"> • Revise PACE coverage area limitation language under <i>Program of All Inclusive Care for the Elderly (PACE)</i>
Benefits and Services	<ul style="list-style-type: none"> • Reformat and Update table under <i>Home and Community Based Demonstration Services</i> section.
Benefits and Services	<ul style="list-style-type: none"> • Remove dated language under <i>Home and Community Based Supplemental Services</i> related to Transition Coordination and remove references to former Demonstration Services under <u>Service Definitions</u>
Benefits and Services	<ul style="list-style-type: none"> • Delete reference to CAP MR-DD under <i>Pre Transition Case Management</i> • Add Reference Follow Along Attachment T under <i>Transition Coordination Services</i>
Benefits and	<ul style="list-style-type: none"> • Addition of section <u>MFP Activity within DHHS Behavioral Health Managed</u>

Services	<u>Care Organizations (MCOs)</u> and reference to Attachment S
Benefits and Services	Add clarifying language in section <u>Transition Services to Qualified Individuals Who Do Not Require Waiver Services</u> re: individuals who are transitioning without waiver services only under specified organizations.
Benefits and Services	Add section <u>Transition Services to High Engagement Participants</u>
Benefits and Services	Deletion of dated language under <u>Waiver Amendments</u>
Benefits and Services	Revision to <u>Wait List</u> section to reflect current Innovations practice.
Benefits and Services	Addition of <u>Follow Along Practices</u> section.
Benefits and Services	Adding <u>Denial or Termination from the Project</u> section
Attachments	Addition of Attachment R, <i>MFP Projected Expenditures</i> ; Attachment S, <i>North Carolina Money Follows the Person (MFP) in an MCO Landscape</i> ; Attachment T, <i>Supporting People to Thrive: MFP Follow Along Practices</i>



N.C. Department of Health
and Human Services

MFP and Due Process



What IS Due Process?

- The Fourteenth Amendment and 42 U.S.C. § 1396a(a)(3) confer individual federal rights to ***due process and a fair hearing***, and these rights are enforceable under § 1983.
- These rights apply to adverse decisions made within entitlement programs, including Medicaid.



Principles of Due Process

- *Timely and adequate notice*
- *Detailed reasons for a proposed denial, reduction or termination of services, and*
- *Effective opportunity to defend*

- *Goldberg, 397 U.S. at 269, 90 S.Ct. 1011.*



North Carolina's Experience

- DTM v McCartney Settlement Agreement
 - Improper/untimely notices
 - Failure to send notices of adverse decision to beneficiaries
 - Failure to consider beneficiary's current needs during Appeals proceedings
 - Failure to continue services during Appeal process
 - Lengthy delays in deciding Appeals of decisions
 - Misinformation/discouragement of Appeal requests.



Due Process in North Carolina

- Timely decision on requests for products, treatment or service and written notices to the beneficiary
- Notices must 'detail the reasons or an adverse decision or proposed termination'
- Recipients entitled to fair hearing on adverse decisions
- No 'discouragement' of beneficiary requests for appeal
- No offering of 'substitutions for requested services
- Services continued without interruption during a mediation or Formal Appeal

Some Refresher Points about MFP's Structure

- Federal, Congressionally mandated requirements.
- MFP applicant= someone who has APPLIED for MFP but has not yet been approved.
- MFP participant=someone who has been APPROVED for MFP and has not withdrawn.
- Federal requirement: MFP participation ends 365 days AFTER transition.

So What is Covered for MFP?

- If MFP has to deny an application;
- If person's participation ends **BEFORE** the transition occurs;
- If person's participation ends at some point during the 365 days **AFTER** transition;
- When MFP status ends 365 **AFTER** transition.

What does denying or ending MFP participation mean?

- Not considered MFP participant
- Not eligible for MFP demonstration services
- May or may not be impacted by waiver eligibility (depends on situation, will explain).
- May or may not impact a person's ability to transition out of a facility.

Denial of Application

- An MFP applicant will be denied enrollment into NC MFP if the NC MFP staff determine the applicant is ineligible for the program.
- NC MFP's eligibility requirements are outlined in applicable federal law and further clarified by the NC MFP project.

An MFP application will be denied if an application does not meet the following criteria:

- Currently resides in a *qualified facility*;
- Has resided in the qualified facility for at least 90 consecutive days, excluding days reimbursed under Medicare Part A;
 - NOTE: If we receive an application that is prematurely submitted but is ANTICIPATED to meet criteria, we do not typically deny but rather hold the application until the proper date.
- Receives Medicaid benefits from this facility for at least one day prior to transition; and
- Continues to meet federal and state program level of care requirements.

So What Happens if Application Denied?

- Informal resolution (clarification, update information, etc.)
- Phone call to individual/representative who submitted application.
- Mailed letter to participant/legal representative.
- Appeal rights apply

MFP Participant Disenrolled
from the Program **prior** to
transitioning for the following
reasons:

Reasons MFP Participation May End Prior to Transition

- MFP participant does not meet the criteria for the applicable HCBS program outlined above.
 - Appeal rights for Innovations, CAP DA/CHOICE and PACE are managed according to the guidelines of the specific program.
- Unable or unwilling to move into a “qualified residence” that is both authorized under federal law and supported by the applicable NC waiver program.
- Failure to honor transition-related commitments as outlined in the NC MFP Informed Consent document.

Reasons MFP Participation may end AFTER transition

- Per federal statute, a person's MFP participation ends after 365 days. This has no impact on waiver services a person is currently receiving and remains eligible to receive.
- MFP participation may also end prior to 365 days for the following reasons:

MFP Participation May End During 365 Days Post Transition

1. Beneficiary's circumstances no longer meet criteria of applicable HCBS program;
2. Beneficiary is reinstitutionalized for more than 30 days;
3. Beneficiary transitions to a residence that does not meet MFP federal criteria or does not meet applicable home and community-based program criteria;
4. Beneficiary no longer receives Medicaid;
5. Beneficiary refuses to comply with agreements as outlined in the Informed Consent, Plan of Care or Risk Mitigation agreements; or
6. Beneficiary no longer meets relevant level of care criteria.

So What Happens if Participation is Terminated before 365 Days End?

- Informed Consent to reflect these termination categories;
- Informal discussion/troubleshooting;
- Participant disenrolled through trackable letter sent by the Project;
- If reason is related to NC specific conditions...

Termination due to changes not outlined in federal requirements.

- Beneficiary refuses to comply with agreements as outlined in the Informed Consent, Plan of Care or Risk Mitigation agreements;
- Beneficiary's circumstances no longer meet criteria of applicable HCBS program;
 - i.e. Participant is disenrolled from CAP/Innovations/PACE services

Due Process Steps—How Services are Impacted

- Informal discussion/troubleshooting
- Will follow applicable waiver protocols
- Will provide 30 days notice of service termination or up to 365th day of MFP participation—whichever comes first.
- Will send trackable letter
- If participant appeals, services continue through appeals process
- Mediation first.
- If disenrolled from waiver program, will synch MFP disenrollment with waiver disenrollment procedures

Wrap Up Thoughts

- Anticipated to be rare occurrence.
- Will always seek informal, “win/win” resolution to issues first.
- Policy anticipated to be finalized by August 31, 2014
- Questions and thoughts?



Shaping our Future
**A Medicaid Long-Term Services and
Supports Strategic Planning Process**
Long-Term Care Strategic Planning Group

May 22, 2014



Welcome

Dr. Robin Cummings



Medicaid Reform: An Overview

Mardy Peal



Aims of Medicaid Reform

BETTER VALUE FOR NC TAXPAYERS

- **Strengthen Medicaid fiscally**
 - Flatten cost growth trend
 - Make budget more predictable
- **Improve beneficiaries' health outcomes**
 - Address population-wide needs
 - Consider whole person in coordinating care
 - Reward quality explicitly



Multi-faceted reform tailored to NC

PHYSICAL

Accountable care organizations (ACOs)

MH, I/DD, SA

LME-MCOs ... consolidated, upgraded

LONG-TERM
CARE

Stronger case management, and beyond



What are ACOs?

Accountable care organizations are networks of health care providers who

- (1) deliver coordinated care across multiple settings
- (2) agree to be held accountable for
 - a) improving quality of care and
 - b) slowing the rate of spending growth.

Medicare, private payers, and some state Medicaid programs have started using ACOs

NC has 18 ACOs today, 12 accepted into Medicare



Providers aligned, with incentives

Today	After ACO
Providers fragmented	Providers linked in organized systems of care
Beneficiary may choose a PCP	Beneficiary selects a PCP, is assigned to ACO to which PCP belongs
Fee-for-service payment – rewards volume & intensity	Rewards for efficiency and quality
CCNC coordinates primary care	CCNC helps State and/or ACOs manage utilization and quality



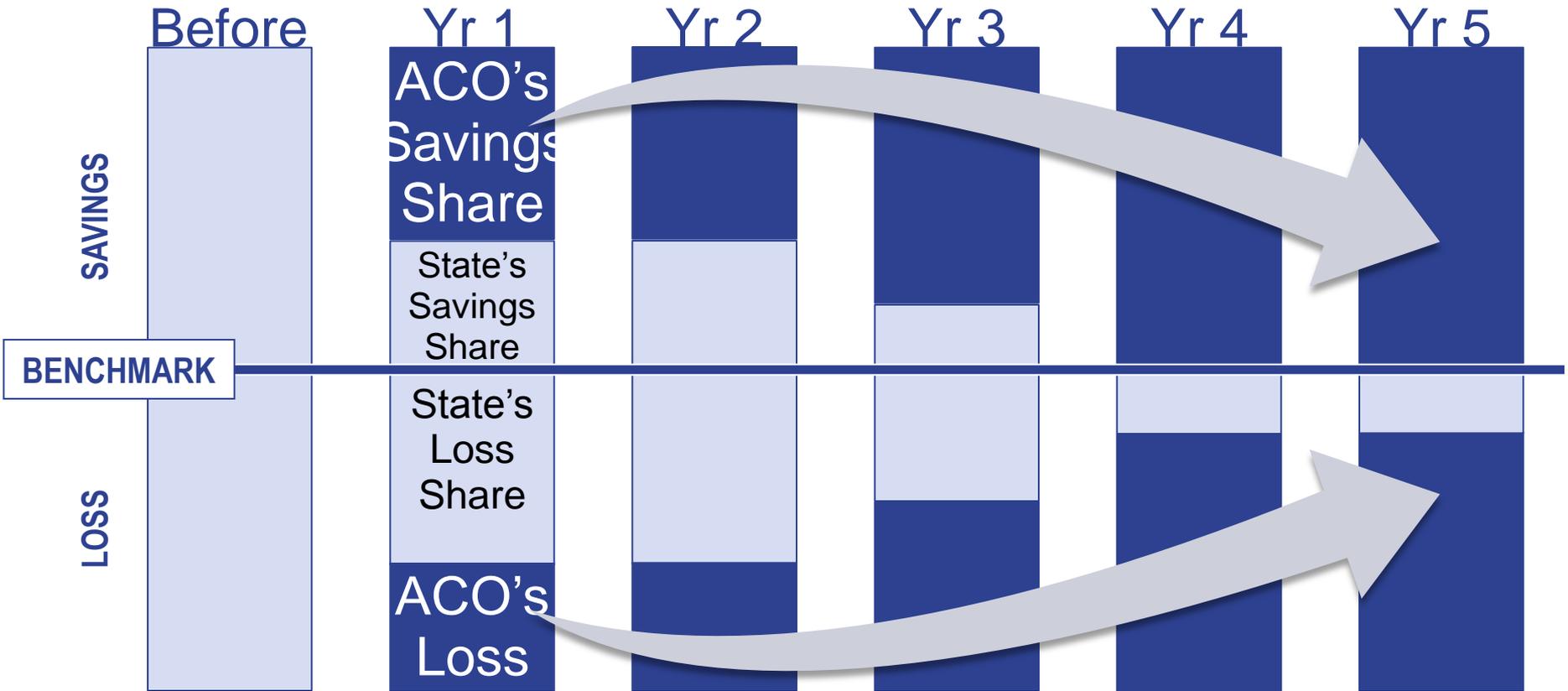
Plan for ACOs in NC Medicaid

- Target start date for ACOs: July 2015
 - ACOs to apply for contracts early 2015
 - Participation voluntary initially
- ACOs expected to meet yearly benchmarks
 - **Access:** More beneficiaries linked to ACOs each year
 - **Cost:** Growth trend reduced materially
 - **Quality:** Quality measures steadily improve

DHHS will take corrective action if annual benchmarks not met



ACOs take rising share of risk



ACO gets lower reward or pays higher penalty if quality isn't best



Quality is factored into rewards

Medicare Shared Savings Program Quality Measures Are a Starting Point

Domain	Examples
Patient/Caregiver Experience	<ul style="list-style-type: none">• Patient rating of provider• Timely appointments, information• Access to specialists
Preventive Health	<ul style="list-style-type: none">• Influenza immunization• Screening for clinical depression
At-Risk Population	<ul style="list-style-type: none">• Diabetes: Hemoglobin A1c control• Hypertension control• Coronary artery disease: lipid control
Care Coordination/ Patient Safety/ EHR	<ul style="list-style-type: none">• Hospital readmissions• % of PCPs who qualify for EHR incentive payments



Is there a more potent alternative?

Full-risk managed care was considered

- Potentially, more budget predictability and savings

Conclusion: managed care not now viable

- Unacceptable to NC health care providers
- Supplemental payments threatened w/o 1115 waiver
- Savings lessened by insurer industry tax under ACA



LME-MCO improvements

- **Contracting**
 - Enhanced process and outcome measures
 - Penalties and incentives for performance
- **Oversight**
 - More sophisticated monitoring
 - Technical assistance
- **Service array**
 - Solutions for I/DD waiting list
 - Re-evaluate LME-MCO benefit package



Who's Here?

Trish Farnham



How This Group Came Together

- Building off Medicaid services managed by DMA's Facility, Home & Community Services Section
- Department's recognition of the need for thoughtful strategic analysis of individual Medicaid LTSS programs and LTSS services.
- Desire to keep groups inclusive and productive
- Acknowledging that in Reform, services often considered "LTSS" are actually more rehabilitative or intermittent in nature and potentially interface with Reform elements differently than traditional LTSS services
- Invitees developed from identified stakeholder groups.



Post-Acute/ Intermittent	Long-Term Care ★	Capitated Programs
<ul style="list-style-type: none">• Home Health• Hospice• Post Acute Rehab• HIT	<ul style="list-style-type: none">• Nursing Facility Services (custodial)• Community Alternatives Program• Personal Care Services• Private Duty Nursing	<p>PACE</p>



Setting the Stage for the LTSS Strategic Planning Process: Objectives and Parameters

Sabrena Lea



We are Seeking Strategies and Solutions that....

- **Address the overarching goals of Medicaid Reform**
- **Recognize the General Sentiments in NC about LTSS**
- **Incorporate the Essential Aims of LTSS Reform**



The General Sentiments of NC's LTSS Stakeholders

Build and support a system that promotes consumer choice.

Recognize that a continuum of care exists and there are a variety of legitimate settings in which to receive services.

Recognize the key role family caregivers and other natural supports play in supporting a person's long-term needs.

Develop systemic parity and flexibility in supporting choice among service options, recognizing that public funding streams and public policy have historically restricted these choices.



The LTSS “Essential Aims”

Information about Options

- Clear, responsive, user-friendly points of access to the system.
- Beneficiaries are informed about all available LTSS options

Whole Person Supports

- Unified assessment
- Improved integration of primary care and behavioral care into LTSS
- System ensures continuity through transitions in setting and services

System Capacity

- Elevated case management, options counseling, transition planning and care integration competencies
- IT platforms effectively meet the short-range and long-term needs of the reformed LTSS system.



Building the Foundation of Our Work: Milestones in the History of NC LTSS

Trish Farnham



Recognizing our History.....

At your table, we invite you to work as a group and identify,

EITHER

- Three positive milestones in our state's LTSS history that should inform our strategic direction.

OR

- Reflect on past public/private LTSS initiatives that were both collaborative and productive. What were they? Why did they work?

 If time permits, feel free to talk about both. 😊



Building the Foundation of our Work: Incorporating Baseline Data

Bob Atlas

Approximate Medicaid LTSS Enrollment (SFYE 2013)

Service	Approximate Enrollment	Notes
CAP DA	11,000	
CAP CHOICE	1,400	
PCS	44,000	
PDN	500	
CAP Children	1,500	
PACE	700	
SNF	40,000	includes all days
Home Health	29,000	
Hospice	5,000	
HIT	2,200	
APPROXIMATE TOTAL	135,000+	



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Description	SFY2013 Actual	% of Total
Skilled Nursing Facilities		
Total Skilled Nursing Facility	\$1,188,684,090.35	54.72%
Personal Care Services		
Total Personal Care Services	\$440,521,563.76	20.28%
HIV Case Management		
Total HIV Case Management	\$1,373,214.09	0.06%
Community Alternative Program Disabled Adults (CAP DA)	\$242,823,980.18	11.18%
Community Alternative Program Children (CAP C)	\$74,117,475.86	3.41%
Private Duty Nursing	\$72,791,068.28	3.35%
PACE	\$19,256,485.73	0.89%
Home Infusion Therapy	\$8,585,016.63	0.40%
Home Health	\$55,179,270.62	2.54%
Hospice	\$68,969,215.64	3.17%
Total LTSS Expenditures	\$2,172,301,381.14	100.00%

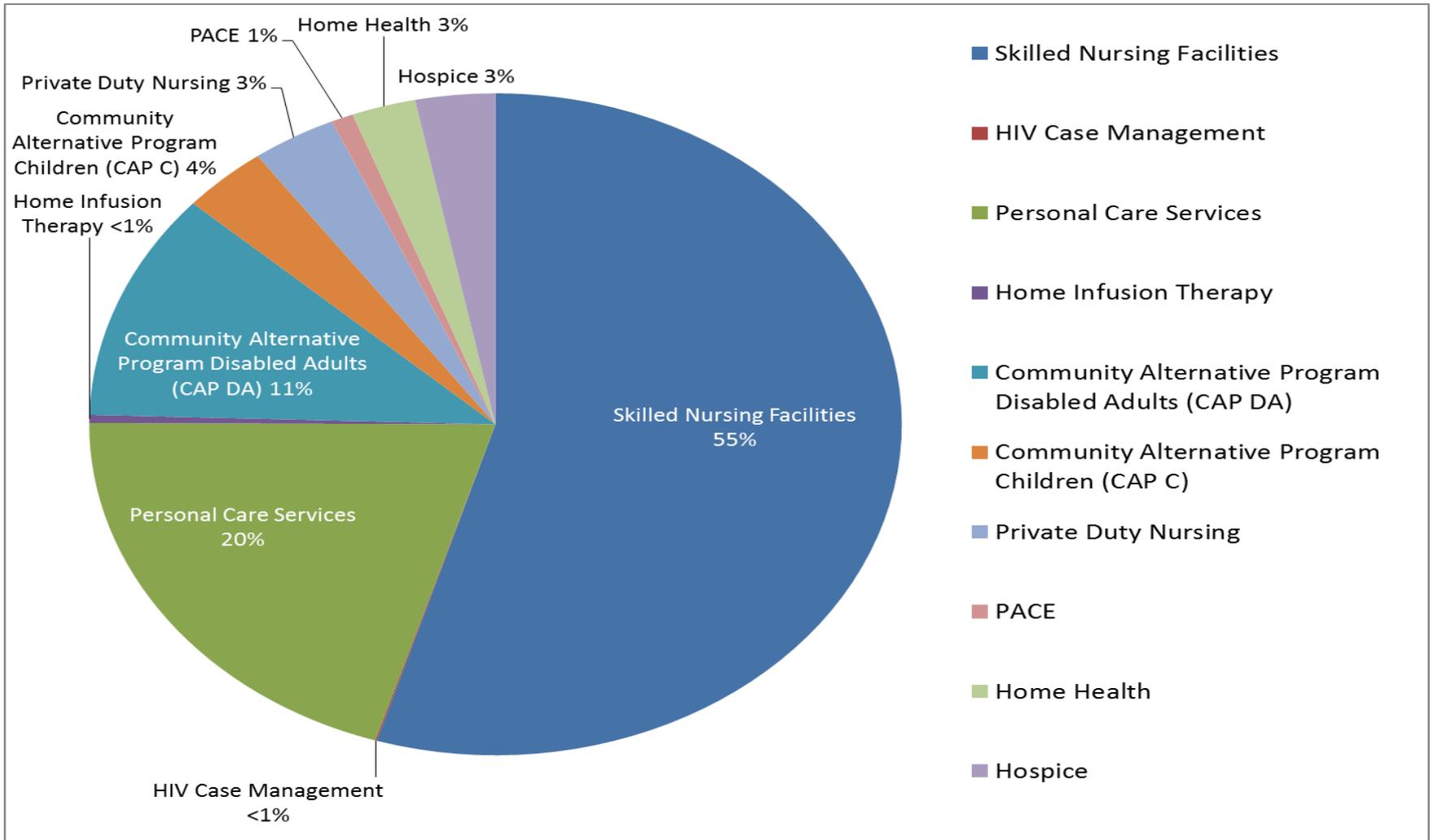
Notes:

1. Data source is June 30, 2013's BD701 - all funds
2. Effective SFY2014/15, SNF and ICF expenditures to be recorded in same account
3. Effective SFY2014/15, PCS budgeted only in account 536144
4. Includes all costs



N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES

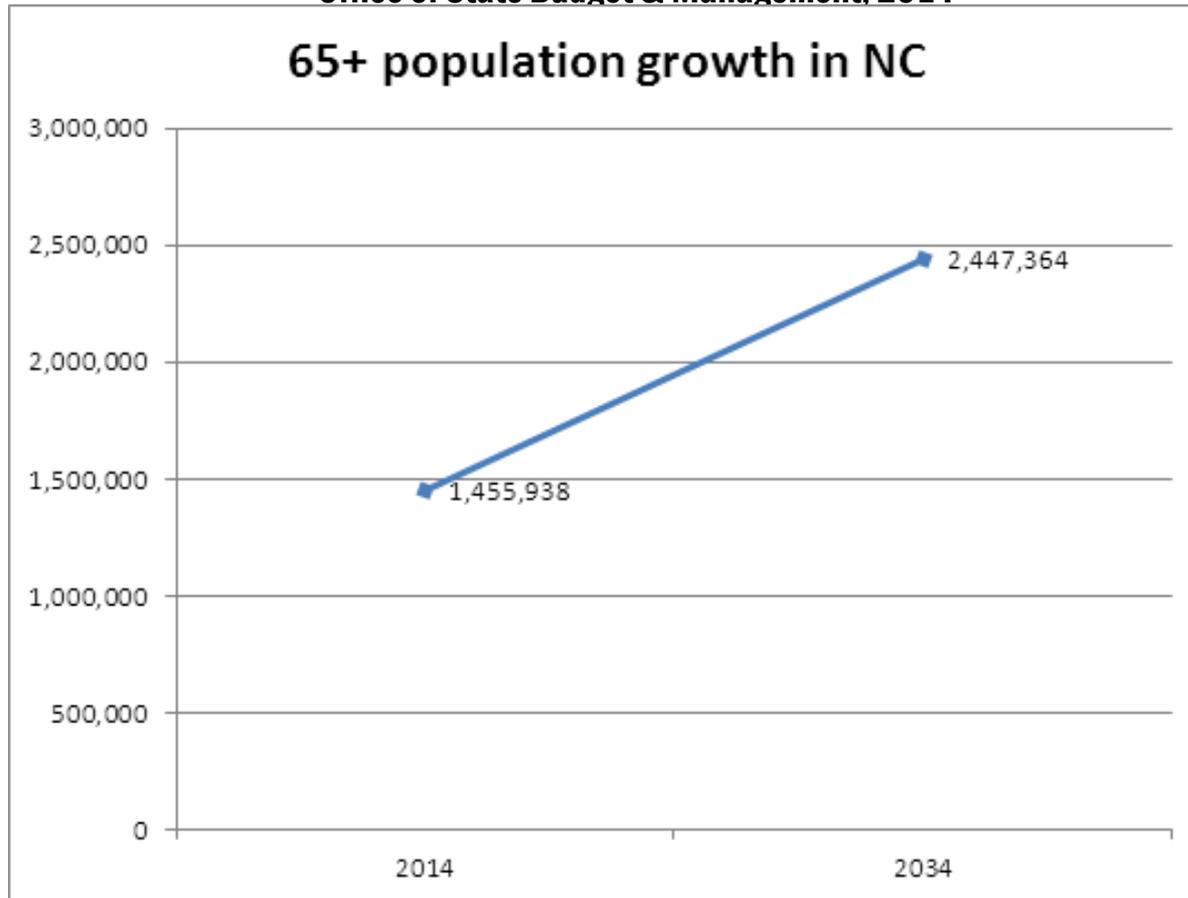
Medicaid LTSS SFY 2013 Expense Data By Percentage





NC's Anticipated Growth of 65+

Office of State Budget & Management, 2014





Overview of Anticipated Planning Process

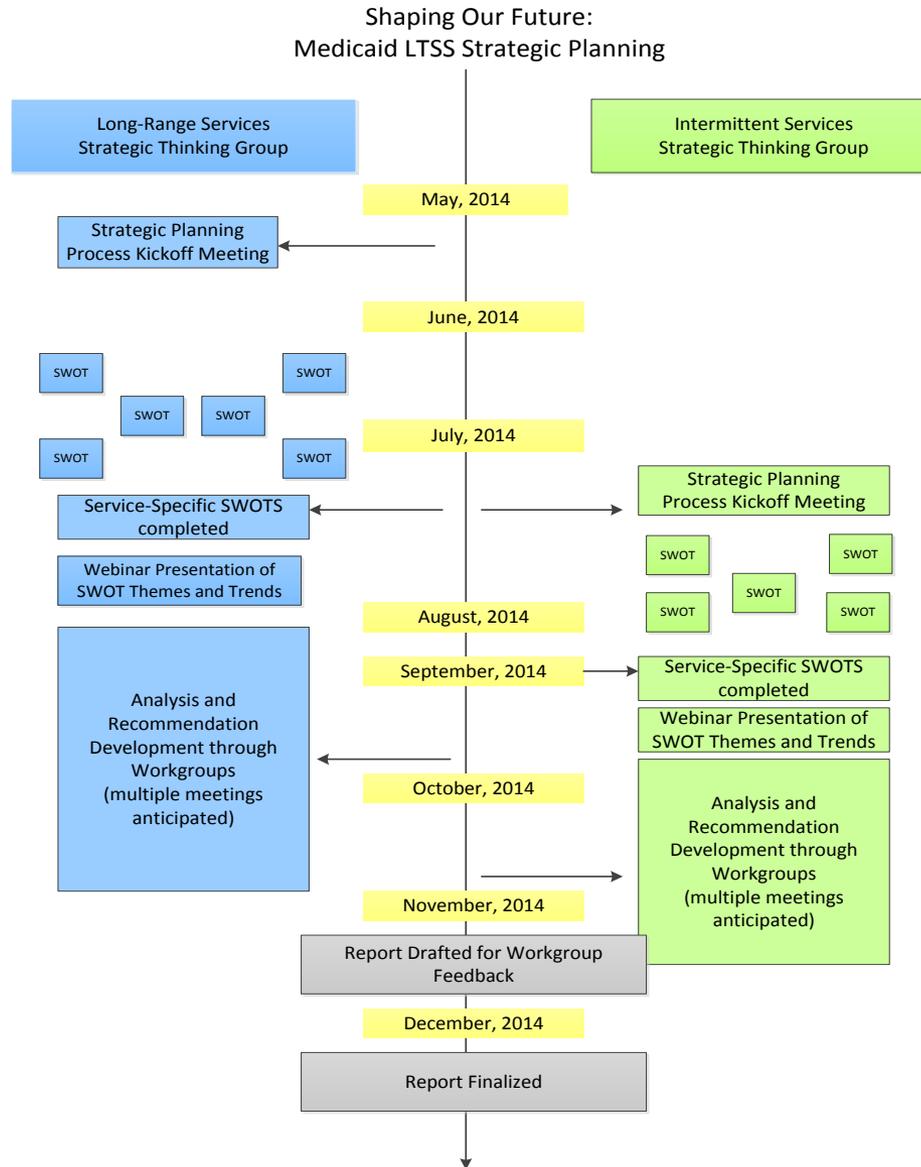
Trish Farnham



What We Have Committed to Do:

- Planning for how current programs could better meet the goals of Medicaid Reform.
- Building a service-delivery system that solidifies the mechanism for accomplishing the LTSS “essential aims.”
- By December 31, 2014:
 - Detailed work plan
 - Proposed budget
 - Recommendations related to rate, licensing and admin changes
 - Projected timeframes.

Overview of Proposed Process is on Page that Looks Like This:





Next Step: Program-Specific SWOT Analysis

- **LTC SWOTs**
 - Strengths, Weaknesses, Opportunities, Threats
 - Integrating the 4+1 questions of person-centered planning
 - Similar to PACE strategic planning process
 - See handout for dates
 - Anticipate groups to be <40
 - RSVP guidance to come!
- LTC SWOT themes to be presented by webinar in mid July.



Organizing Our Work: Preliminary Workgroup Design

Information about Options

- Will focus on points of access and options counseling
- Co-chaired by Mardy Peal and Heather Burkhardt

Whole Person Supports

- Will focus on practices that better integrate physical and behavioral systems into LTSS
- Co-chaired by Bob Atlas and Trish Farnham

Unified, Holistic Assessment

- Will examine methods for developing unified assessment tool
- Co-chaired by Sabrena Lea and (invited) Pam Silberman

All groups will incorporate workforce and IT capacity considerations.



Commitments

- **Workgroups will be under rigorous timelines and will require work between meetings.**
 - We appreciate those who are willing to work.
- **Groups will be meeting regularly, potentially every other week.**
 - We appreciate those who can commit to remaining involved.
- **Groups will be diverse, representing varied perspectives and insight.**
 - We appreciate those who value this diversity.



Our Communication

- You all have now formed a listserve! Information will be shared through this group.
- Information will be posted on Medicaid Reform Website.
- Workgroup meetings will begin late July/early August.
 - Initial announcement will go to listserve by June 1st.
 - After initial meeting, each workgroup will manage communication with members.



N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES

“To go fast, go alone. To go far, go together.”

-- attributed to “African Proverb”



Close and Thank You

Sabrena Lea



N.C. Department of Health
and Human Services

Shaping Our Future: A Synthesis of Long Range Services

SWOT Sessions

A Medicaid Reform Initiative

What Brought Us Here Today?

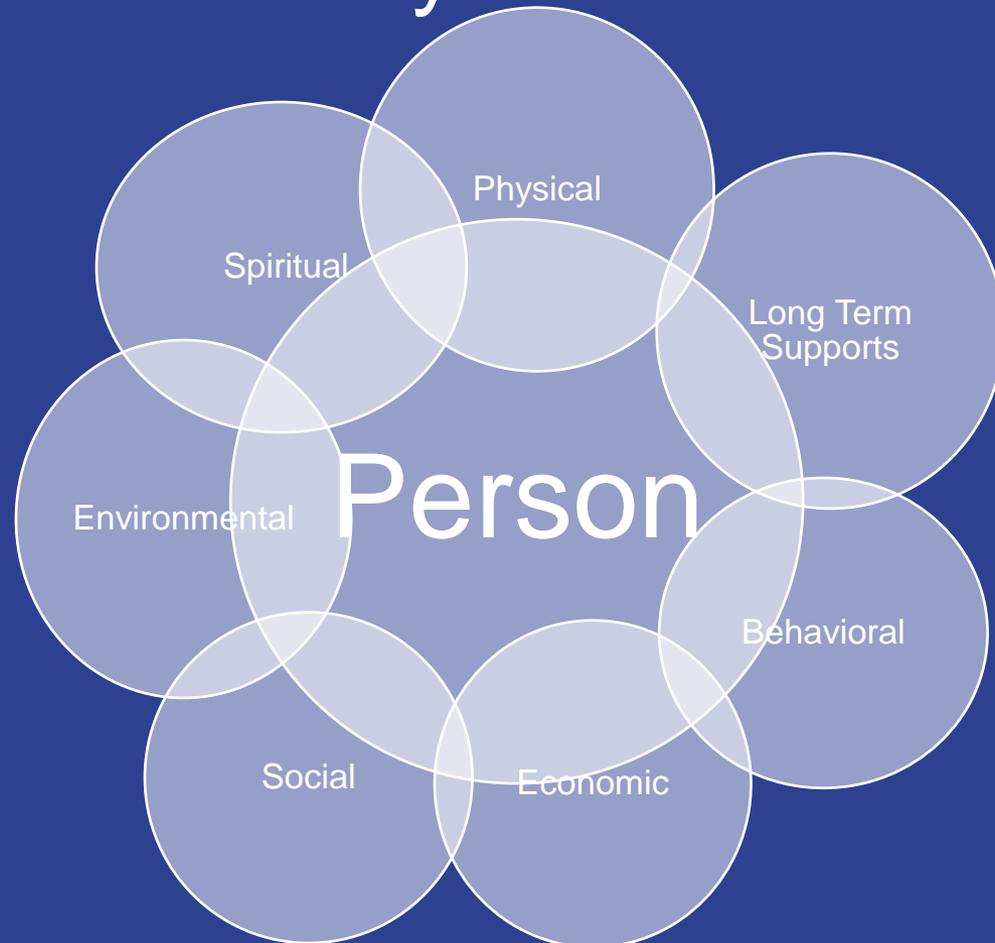
- *Shaping our Future* is the Long Term Services and Supports (LTSS) strategic planning effort under the Department's *Medicaid Reform* initiative.
- LTSS for this purpose= those services managed by DMA's Facility, Home and Community Services Section.
 - Long Range: CAP DA; CAP C; PDN; PCS; SNF; PACE
 - Intermittent: Hospice, HIT, Home Health and post-acute SNF
- AS part of strategic planning process, each services' stakeholder group (providers, families, beneficiaries, advocates and other state staff) conducted a SWOT.

What We Asked....

- What is Whole Person Care?
- **S**trengths: What are the strengths in our service delivery system that support *whole person care*?
- **W**eaknesses: What are the weaknesses in our service delivery system that impede whole person care?
- **O**pportunities: As our state moves toward service models that better encourage whole person care, what opportunities does this present?
- **T**hreats: What threatens our efforts to build a service delivery system that promotes whole person care?
Group recommendations for minimizing.

Whole Person Care Means...

The needs of the whole person are acknowledged in the service delivery system



Whole Person Care Means...

Considering the needs of the family caregivers.

“We work with a diverse population. When getting to what families need, we need to start at a basic level, because families needing services are already under stress.”

-family member/provider

Whole Person Care Means...

Individuals/families don't have to go looking in completely different systems, each with separate processes, and "don't have to choose between diagnoses" to get the care that is needed.

Whole Person Care Means...

Individuals and families have a clear and consistent “ally” as they navigate the system.

What does the “ally” look like?

Strong, highly competent, consistent case manager or case management entity that follows the person through services and across lifespan and serves as the person’s/family’s ally.

possible role of family peers/parent coaches
“guide by your side”

Whole Person Care is...



Seamless coordination of services across settings and across the lifespan that effectively ensures continuity of care.

What Does “Seamless” Look Like?

- People can keep the same supports as they grow older.
- Service design anticipates changing needs.
- Professionals talk to each other to better ensure they are making conflicting recommendations or are omitting key information.
- Particular note of transitions across settings, including out of hospitals.

“The person who helped me for years, can’t talk to me anymore.”

-family member

“People come with 100 pages of medical records, but there is a lack of information sharing about the patient.”

-SNF stakeholder

Continuity of Care:

A note about the service “cliff”

“It feels like it’s either full services or no services.”

--family member

- Some services currently have inability to adjust services gradually
 - Discourages people from working towards goals
 - Some families anxious about making clinically indicate changes, because afraid will lose ALL services.

Whole Person Care Means...

- People have a collaborative assessment and planning process.
 - Better information, more practical and more equitable.
 - Assessments and planning efforts are “conversation based.”
 - Integrate the assessor into the planning process.
 - Ensure assessor is using tool that is statistically valid and reliable.



“Not eight different meetings, but one meeting.”
-family member

Whole Person Care Means...

“Part of whole person care is remaining connected to the community and not relying completely on state level support.”

-PCS Stakeholder

Whole Person Care Means...

A more unified data set...

Unified quality and performance metrics....

All used to evaluate outcomes related to health, cost and quality of life.

Which requires....

- An IT system that allows different entities to communicate and incorporate information.
- Examples of models include: CCNC Analytics, CAP IT system through (“ECAP”), Division of Public Health

Right now, we can't see what other services a shared client may be getting.

--state employee

Strengths to Build
On....

Theme: Build processes that promote individual and family empowerment and responsibility

- Look to families to recommend their own solutions.
- Families can help identify ways to make system more efficient.
- Ensure supports promote family unification and involvement.
- Promote self-directed options.
- Make sure needs of family caregivers are integrated into the assessment process.
- Recognize the role the system and providers play in helping family members “plan for the future.”

Theme:

We Have Some Great Resources to Pull From in NC



And some of our
weaknesses
supporting *whole
person care...*

Theme:

The Critical Need for Meaningful Data

- Who is getting served and who needs services but may not be getting them?
- How do we measure *return on investment (ROI)* in LTSS services?
- How do we track prevention and compare against alternatives?
 - Hospitalization avoidance
 - Institutionalization
 - Lower health outcomes
- What are the true costs of providing whole person care?
- Difficult to conduct whole person data analysis—inability to track care across services.
- No uniformity in dataset.

Theme:

Challenges in Making Sure People Understand Their Options

- Front line staff don't always know what options are available.
- Web-based information is also fragmented and often confusing for families.

Theme:

Assessments in services remain fragmented and are frequently not conducted in real time.

Theme: The Critical Role of Workforce Development

- Workforce continuity promotes whole person care: families have peace of mind, staff know person well and can recognize the subtleties in preferences and support needs.
- Direct workforce challenges:
 - Keeping up with hospitals related to reimbursement and clout
 - Ensuring RNs are competent in the realities of home-based LTSS (misconception “it’s a step down before retirement,” lack of training, “I’m just here to do meds”)
 - Need for stronger examination of scope of practice.
- Need for workforce analytics
- Workforce Opportunities:
 - Build off current good practices (i.e. simulation, College of Direct Support).
 - Partnering with community colleges to push people into tracks that we need in the system.
 - Build education track enhancement.
- Nurture direct support workforce. “We’re competing against McDonald’s”
- Opportunity to better leverage technology (Simply Home, Rest Assured)

Theme: Better Ensure Services are Flexible and Robust

- Need for flexibility in case management function to better meet the changing dynamics over the course of a person's life.
- Rates and service definitions don't always reflect what a person actually needs or the fact that needs may fluctuate daily.
- Examine the link between rate cuts and continuity of care.
- Build capacities to better serve folks who have complex/multifaceted needs (TBI, individuals with mental health with attendant care needs, etc.)

We have an Opportunity to...



- Support a cultural shift in keeping people in the least restrictive, most cost effective setting possible.
- Build stronger provider networks.
- “By lowering the silos and integrate care and create information that is available to right provider at the right time will allow us to meet the goal of whole person care.”

Insight and Questions as We Move Forward....

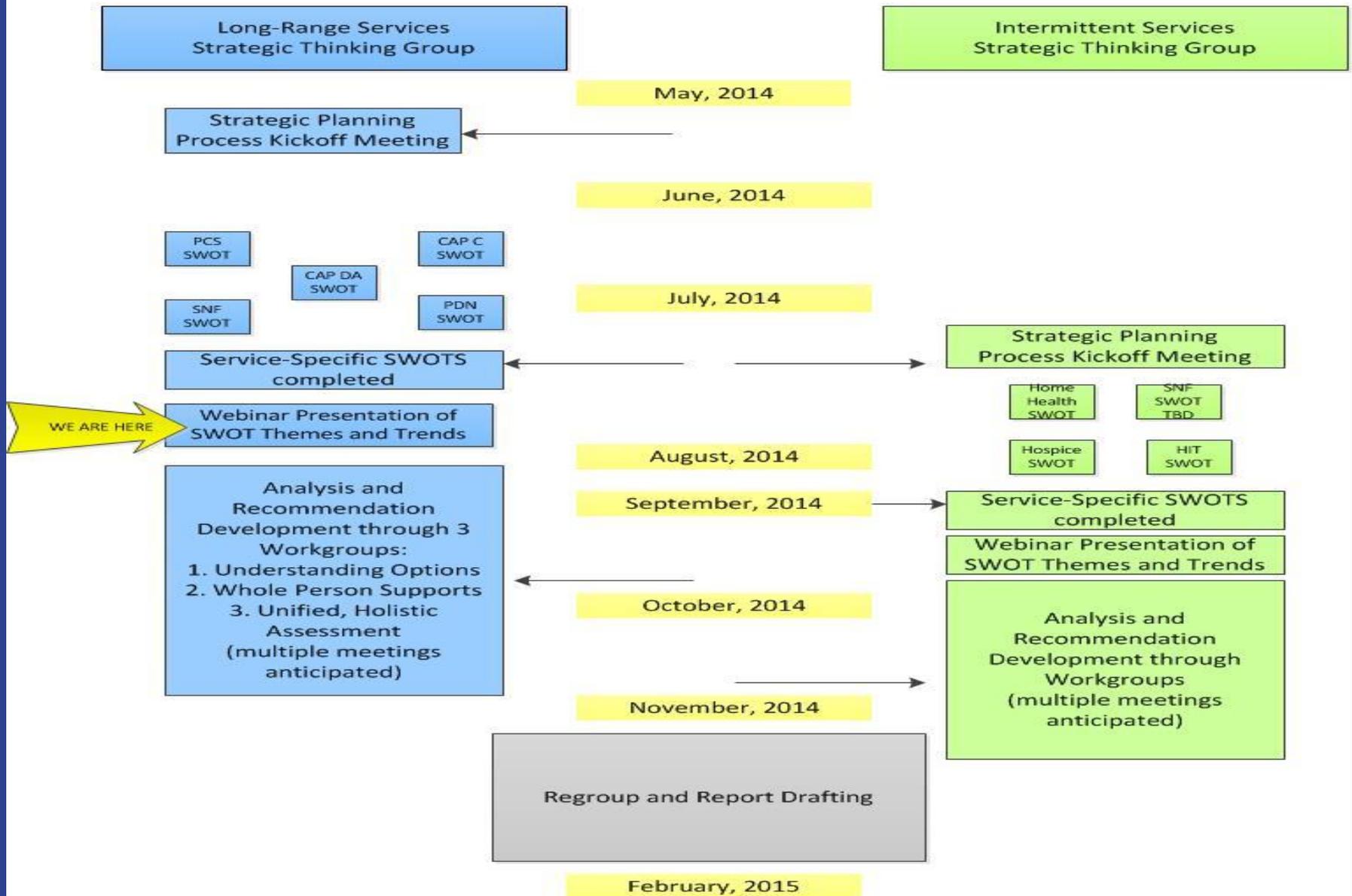
- As we explore new service models, what has been the experience in other states?
- How do we ensure we don't rush this process and also not lose momentum?
- How do we make sure what we build, we can afford?
- How do we ensure the local DSS workforce has the resources to effectively advise beneficiaries and ensure services activation practices are responsive?
- How do we ensure systems can be responsive to the need for innovation?

"I've been on so many committees and looked at the same efforts. It would be a shame to fail to look at the work that has already been done."
--SNF stakeholder

“Don’t forget who we’re working for.”

Next Steps

Shaping Our Future: Medicaid LTSS Strategic Planning



Organizing Our Work: Preliminary Workgroup Design

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Upcoming Meetings

- Intermittent Services Strategic Thinking Group
Kick Off: 9:00-11:00, Wednesday, July 23rd
 - Dix Campus
 - Travel reimbursement available for beneficiaries and families.
- Intermittent SWOTs through August
- Workgroups to begin late August.

How to Stay Informed

- *Shaping our Future* materials posted on Medicaid Reform Website:
<http://www.ncdhhs.gov/medicaidreform/>
- To Register for Intermittent Services Kick Off (limited space) or to make a commitment to join a workgroup, please email Laura Ross at:
 - Laura.m.ross@dhhs.nc.gov

Thank You!

MFP/CIL Contract

Core Indicator Questions

#1 Consumer Control

Q3. How did you first learn about services that you are getting? (Maybe not for the contract, but good information when analyzing the data)

Q4. Did you get enough information about the services you are getting now?

Q6. Did you help plan the services you are getting now?

Q7. Do you have a case manager – someone whose job it is to help set up and coordinate services with you? (Again, maybe not necessary to put in the contract, but good information for analysis)

Q8. Can you reach your case manager?

Q9. Do the services you receive meet your needs?

Q11. Has your case manager talked to you about the services that might help with your needs?

Q12. Are you in charge of the services and supports you receive (for example, can you determine what kind of services you get and when you can get them?)

Q13. If you have a question about the services you are getting, do you know who to call?

Q14. If you have a complaint about the services you are getting, do you know who to call?

Q15. In general, how satisfied are you with the services you receive?

Q29. Do you feel that the people, who are paid to help, treat you with respect?

Q32. Overall, how satisfied are you with the people who are paid to help you?

#2 Economic

Q20. Do you generally need help with keeping track of your finances or doing bills?

Q21. Do you get enough of that help?

Q49. Do you feel that someone around you has been using money in a way that you did not give them permission to?

#3 Health

Q84. Do you have a primary care doctor?

Q85. Can you get an appointment to see your primary care doctor when you need to?

Q88. When leaving the hospital or the rehab/nursing facility, did you feel comfortable going home/ready to go home?

Q89. After leaving the hospital or rehab/nursing facility and going home, did someone follow-up with you to make sure you had the services, supports, and help you needed?

Q92. Do you get enough information and support to help you manage your chronic condition(s)?

Q93. Do you get enough help with understanding your medications?

Q94. Do you ever split or skip a pill because of price?

#4 Safety

Q46. Are you concerned for your safety at home?

Q47. If you are concerned for your safety or if you were ever to feel unsafe, do you have somebody to talk to that could help you feel safe?

Q31. Do you feel safe around the people who are paid to help you?

#5 Community

Q33. In general, do you like where you are living now?

Q34. Why don't you like where you live?

Q35. Would you prefer to live somewhere else?

Q36. What prevents you from living somewhere else?

Q37. Would you have to live somewhere else if you didn't have the services and help you are receiving?

Q38. To continue living here, do you need more or different types of supports or help?

Q55. In the last 30 days, have you participated in some type of social activity, either inside or outside your home?

Q56. If no, why not?

Q59. Do you have transportation when you want to do things outside of your home, like visit a friend, go for entertainment, or do something for fun?

Q60. Do you have transportation to get to medical appointments or pick up medications when you need it?

Additional Questions of Interest?

Q95. Have you planned or are you planning for your future need for services or supports?

Q96. Do you know how to get information or help when you are planning for your future need for services or supports?

Q99. Please tell me, out of these four things: 1) Health, 2) Safety, 3) Being Independent, 4) Feeling like you are in Control, which one is the more important to you right now?



**Preliminary Concept Paper for the
NC DHHS *Transition & Coordination Institute***

Overview:

Across the country and within our state, an increasing number of long-term care facility residents are choosing to transition back into their homes and communities, with the supports they need to do so. Effectively supporting an individual to transition requires strong coordination between the resident, the resident's family, and the professional network that will support him through the transition and once he returns to his community. In addition, as an increasing number of individuals transition—many of whom experience significant clinical and social complexities—the need for strong transition supports becomes increasingly apparent.

Quality transition practices ensure the effective integration of physical, behavioral, and long-term services for transitioning individuals. Strong, coordinated transitions are also more likely to facilitate improved health outcomes and quality of life once a person has transitioned.

Strengthening the state's "transition capacity" means strengthening three key functions related to the transition experience:

1. Ensuring individuals have the information necessary to make informed decisions about where they receive services ("options counseling").
2. Ensuring a transitioning individual has comprehensive, coordinated transition planning to identify support and resource needs and to facilitate securing community-based resources to meet these needs (i.e. clinical and re/habilitative services, housing, benefits transfers, crisis services). This transition function is often known as "transition coordination".
3. Ensuring individuals *continue* to receive the services and supports necessary to maximize positive quality of life outcomes and to minimize the risk for recidivism. This concept is often referred to as "follow along" and is typically coordinated between transition coordination (for the short-term) and a care coordinator/case manager (ongoing).

Despite the Department's increased activity related to all three functions, there is currently no consistent, department-wide, competency-based standard or curriculum to ensure consistency on core transition concepts across the long-term care communities. As the need for transition capacity becomes increasingly recognized, we wish to establish a Departmental pilot project, the *NC DHHS Transition and Coordination Institute*. This effort furthers the workforce capacity development priorities outlined as part of the *Partnership for Healthy NC, Medicaid Reform* initiative.

We are proposing designing the *Institute* in two phases. Phase I includes curriculum development and a pilot *Institute*. The outcomes of Phase I will drive the development of Phase II, which will focus on scaling and replicating this initiative to ensure statewide, multi-disciplinary access.

The *Institute* concept fortifies the current work of five divisions within DHHS: Medical Assistance, Mental Health, Developmental Disabilities & Substance Abuse, Vocational Rehabilitation-Independent Living, Aging & Adult Services, and State Operated Health Facilities.

To effectively integrate into current related activities, we also seek to partner with the Department's hospital discharge planning initiative, *North Carolina Alliance for Effective Care Transitions (NC ACT)*.

While the full required budget will be conceptualized through the planning process, we intend to access *NC Money Follows the Person's Rebalancing Fund* resources to fund the initial pilot *Institute* and potentially future *Institutes* if appropriate. These resources are restricted grant dollars generated through the Money Follows the Person Project's enhanced federal match on MFP-sponsored waiver services. The Rebalancing Fund is intended to support efforts that strengthen access and utilization of home and community services.

Managing Structure:

We will establish a standing *Institute Steering Committee*, which will guide the design and implementation of both Phase I and Phase II of this initiative.

Steering Committee members will likely include representatives from entities with direct experience in both curriculum design and evaluation or in transition best practice.

Anticipated membership includes:

- State level staff from DMA, DAAS, DMH, DVR-IL, DSOHF, and the Department who have direct oversight of current options counseling, transition, and care coordination initiatives.
- Partners from the Quality Center, NC Alliance for Effective Care Transitions (NC ACT)
- Adult Education collaborators from NC's state university network.
- Service beneficiary/self advocate(s)
- Identified representatives of NC's current options counseling and transition coordination networks.

Possible Partnership with an Adult Education Doctoral Program:

Capitalizing on resources available through the state's university system, DHHS is exploring using MFP *Rebalancing Funds* to fund a fellowship for an individual, who can, in partnership with *Institute* Steering Committee,

1. Assist in curriculum design, ensuring it is aligned with adult education concepts.
2. Serve as "project manager" for establishing and managing the pilot training initiative, which is anticipated to be a multi-day, interdisciplinary learning experience. See *Preliminary Framework of Institute* below for additional information.
3. Design and implement the evaluation methods for determining the continuation and scalability of the *Institute*.

Preliminary Outline of Phase I Key Outputs and Timeframes: Curriculum Design, Development, Training, and Testing/Evaluation

- By May, 2014: *Institute* Steering Committee established
- By August, 2014: Target populations clearly identified; develop the preliminary curriculum, evaluation methods, and pilot training structure established; budget developed; prerequisites *Institute* participation established.
- By November, 2014: Pilot *Institute* occurs, targeting entities currently engaged in transition work
- By December 2014: Evaluation and recommendations finalized.

Preliminary Outline of Phase II Key Outputs and Timeframes: Evaluation, Scalability and Sustainability

- By February, 2015: Steering Committee and Department considers evaluation and determines if viable and effective to explore sustainability and scalability considerations.

If yes, then:

- By April 2015: Sustainability plan presented to the Department. Department identifies funding for SFY 2016 continuation and expansion.
- By July 2015: Sustainability partnerships in place.
- By November, 2015: *Institute* occurs, potentially in multiple sites to better ensure state access.
- By December 2015: Ongoing training schedule is established and released.

Anticipated Framework of *Institute*:

- Multi-day training for transition coordinators, care coordinators and others to receive certification to perform transition functions under Department initiatives (i.e. MFP, *Transitions to Community Living*) and to receive on-going continuing education.
- Multi-track to address both initial training and ongoing continuing education needs.
- Targeted sessions will be designed to allow staff from representing different LTSS populations (i.e. aging, MH, physical disability, I/DD) to participate and learn together, while other sessions will be specific to a particular transition initiative or the population that an attendee represents.

- Sessions will cover such topics as [SAMPLE ONLY, NOT COMPLETE]:
 - Quality Transition Planning 101
 - Understanding NC Housing Options
 - Partnering with facility staff
 - Effective integration of medical and behavioral services
 - The Value of Peer Support
 - Family Caregiver resources
 - Understanding Social Security
 - Overview of MH crisis services
 - Ensuring linkages with non Medicaid services
 - Motivational interviewing
 - Effective follow along practices
- The *Institute* will incorporate continuing education component, with identified CEUs being available.
- We also anticipate utilizing a *learning management system (LMS)* platform for web-based learning opportunities. The LMS would support continuing education or to supplement the *Institute's* core curriculum.

Sponsored By:

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Kathy Nichols, Behavioral Health Contract Lead, DMA
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Trish Farnham, Money Follows the Person Demonstration Project, DMA

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N.C. Department of Health and Human Services

NC DHHS Transition & Coordination Institute
Steering Committee
Wednesday, July 2, 2014
1:00-3:00p
Adams Building, Room 264

- Welcome and Thank You
- Introductions
- General Overview of Initiative
 - General Feedback
 - Reflections on observed needs
 - Current Training/Curriculum Initiatives that Can Inform our Work
- Scope of Steering Committee's Responsibilities
- Reviewing and Revising Timeframes and Scope of Work (potentially continued into next meeting)
- Next Steps:
 - Rebalancing Fund confirmation
 - Begin Shaping Partnership for Curriculum Design
 - Next meeting: August, Date TBD by group.

Additional Materials:

- Example of the ABCs of Transition Planning Institute:
- http://www.ilru.net/html/publications/olmstead/IL_NET/ABCs_Transition/ABCs_Transition.pdf

NC MFP's Stages of Transition Planning

