

**NC MFP Roundtable Agenda**  
**Friday May 13<sup>th</sup>, 2011**  
**10:00am-3:30pm**



**Participants:**

Alston Quinn	Ashley McGill	Audrey Brown	Carolyn Temoney
Christan Poston	Ed Davis	Dorothy Bass	Edwina Thompson
Erin Russell	Janet Campbell	Jeannie Smith	Wrenia Bratts-Brown
Karen Murphy	Kathy McDonald	Kim Johnson	Lea Anne McTavish
Lorrie Roth	Max Waters	Michael Howard	William Robinson
Michelle Harvey	Renee Rader	Jill Rushing	
Trish Farnham	Linda K - Fields	Natarsa Patillo	Diane Upshaw

**Welcome & Introductions**

Members of group introduced themselves.

**NC MFP Updates and Discussion**

Transition Update:

Trish referred everyone to updates that were handed out to read.

**Discussion about Transition Update**

Natarsa talked about Benchmark data and actual transitions.

- Question: What are the reasons people are waiting?
  - Answer: Did not pull data for this meeting but housing needs, high deductible, and family concerns are many of the reasons.
- Question: How long are transitions taking on average?
  - Answer: Between 2-6 months. Some can be very quick and some it takes longer.

**Erin Russell of DVR updated Roundtable on Recent Successes**

**Discussion of MFP Rebalancing Fund**

- Trish updated group on Rebalancing Fund Parameters from DMA (outlined in handout).
- Additional Information about MFP Rebalancing Fund:
  - The state savings can be used to get federal match money.
  - Group reviewed preliminary recommendations of February Roundtable.
  - Roundtable advised that Funds be used to ensure personal involvement and accountability through transition process.
  - Roundtable advised funds also be used for long range health care planning. Help the consumer create their own health care plan.

**Benchmark Increase Discussion**

Trish updated group that in order for CMS to approve budget for the coming year, NC MFP had to increase its benchmarks by 10 transitions each year.

## **Operational Protocol Proposed Changes**

- Trish reviewed proposed changes to Operational Protocol
- Exploring Expanding NC MFP's Transition Eligibility - to include those who do not rise to the level of CAP services.
- Advisory Group Updates
  - Transition Coordination Advisory Group – we did not discuss this as time was getting tight.
  - disAbility and Housing Collaborative – Erin Russell provided update: the housing handbook, A Place to Call Home, is now finished and up on several websites including [www.nchousing.org](http://www.nchousing.org). Erin talked about a roommate home share for people who need housing.
  - Data Advisory Group – Jill Rushing provided an update. This group discussed the topics of what data we need to collect, how we share it, and what mechanisms we need to collect the data. It is important to learn from past data that others have collected. How do we tackle hard to track data such as emergency backup and community involvement? Next meeting will be June 8<sup>th</sup> in Hoey building.
  - Peer support - Trish reported that MFP is trying to resurrect this group.

## **Lunch**

### **An Exciting Snapshot of MFP Life Beyond North Carolina: Texas, Connecticut and Ohio**

#### **Video Conferencing with Fellow MFP States (Fayetteville, Asheville, Raleigh, Charlotte and Greenville)**

- Introductions – States provided overviews of their projects:
  - Texas – Receives strong support from executive leadership and through legislation reports directly to Commissioner. Texas has transitioned over 4,200 through MFP and retained relocation contractors across disability groups. Some of the key barriers have been housing, family supports and behavioral health. They have used Rebalancing funds for a number of things including voluntary conversion incentives to ICF-MR providers and funding to the ADRCs. Texas proudest of voluntary closure with ICFs-MR and national behavioral health project.
  - Connecticut – Was the 1<sup>st</sup> recipient of the nursing home grant that was precursor to MFP. Since it was not “just a grant” it took 1 ½ years to get the operational protocol done. State leadership is involved in making decisions and the Governor makes decisions about the program. Every \$ is Connecticut is new money not within existing system. Funding is appropriated specifically in state budget. Has transitioned 612 people. They are still at 6 months for eligibility. Challenges: working across the disability populations. Under the system in Connecticut MFP is located in DSS, which controls rates, but another division sets standards.

Connecticut is closing 4 nursing facilities this year from the MFP efforts. Using Rebalancing Fund to fund a “right size” initiative for facilities.

- Ohio overviews – It is very siloed services. Services are locally operated and localities have lots of say in the legislature. MFP had to break the silos down and work across disability departments. MFP stakeholders created a shared vision. They had buy-in from everyone for MFP program. Focus on all people, not just Medicaid recipients. Their success comes from how many people end up in community living over time not just how many people they get out of a facility. Between October 2008 and April 2011, OH has supported 1000 people to transition. Ohio’s Rebalancing Plan framed around the Thompson Medstat Rebalancing indicators .Using small investments to get big changes (i.e. investment in permanent supported housing website). Ohio like everyone else has a huge budget deficit

### **Specific Topics:**

The participating States highlighted their individual practices on specific topics

- Housing
  - Texas – MFP did not historically have a relationship with the public housing department. There are 475 PHAs and finance agency has no authority over any of them. MFP had only 35 section 8 vouchers for those under 62 and has been working to get more Mental Health vouchers. Texas MFP is also working with other voucher holders and networked with other to get housing. In Texas the Dept of Agriculture has housing vouchers and MFP worked with them to use some of Dept of Ag’s vouchers. They also specifically hired someone who “speaks housing” to work for them.
  - Ohio - They also hired a full time person who “speaks housing” and taught the person Medicaid. Housing and Medicaid speak a different language. The person worked with both groups to bridge the gap.
  - Connecticut – Got buy in from others and prioritized MFP HUD housing. In Connecticut rental assistance is available for almost everyone. Except for background checks and some id they do not have to do paperwork collection. Participants can keep housing during remodeling so they do not lose the housing.
- Caregiver Support
  - Connecticut – There is a Personal Care Assistance Association, but they do not have a strong system.
  - Ohio – Cannot give respite there and that was added to MFP program.
  - Texas – Respite was already built into waiver so system is now a little stronger. They do have a specific proposal written for respite care to help find support for caregivers.

- Peer Support
  - Ohio – Added community support coach to help with transition, it is available to all groups in MFP. They have an Advisory Council on peer support with 14 members. Rebalancing helps pay for travel so Council can attend stakeholder meetings. The Miami University of Ohio is helping with performance indicators.
  - Texas – In process of developing peer supports.
  - Connecticut – Do not have a peer supports in MFP Project. It is built into some other supports they use.
  
- Questions from North Carolina to the states:
  - Question - NC is tied to targeted rentals. Can we expand program to be tied to people not the program? Answer - There is a group that is focusing on that issue.
  - Question– Why are states not further along on with community supports and respite? Answer - Ohio said they have talked about it but do not have a strong peer support for DD or alcoholism. Texas said it took lots of work to get where they are and they are behind on this aspect but that is the next topic they are going to tackle. Connecticut said it is a matter of priorities and did not have a demand and is using existing volunteers.
  - Question – Connecticut stated they are closing 4 nursing homes and asker wants to make sure that was correct. Answer - Connecticut does not have any waiting list for housing because the cost benefit analysis showed it was cheaper for the state that way. They started with Section 8 housing and now it is all state funded.
  - Question – How is MFP money used as new money in Connecticut? Answer - It was written into the Operation Protocol and that is why it took so long to get off the ground. It was the way the state agreed to do it.
  - Question – Was money given to Ohio used for CIL? Answer - 100% admin and rebalancing put in sub-grant for Centers for CIL. Have ability to modify housing and support structure sharing.
  - Question – Ohio’s sustainable community living is hard to get here. Some may have to be placed too far away, how do we get that here? Answer - Started with MFP grant and service then added emergency rental assistance to help people who have trouble after they transition. In Texas Transition Coordinator follows person for 3 months after they transition.
  - Question – Just wanted to confirm that person hired in Ohio was at 100% match. Answer - Yes.

### **Specific Topics**

- Mental Health
  - Connecticut – At beginning they had a gap and did a white paper waiver for 15 different services for mental health. Moved 100 people out under this waiver. They put more intense 24hr supports in place to get people straightened out then backed off. This is for people with intense mental health issues but not addiction issues.

- Texas – They put an extension and proactive waiver program in place and partnered with mental health programs. Individuals get services from waiver. Over 20% of nursing home residents have formal relationship with mental health or substance abuse program. Got CMS to change mind about pre transition work.
- Ohio – Not as far along as other states. They are piloting mental health strategies. Do not have PRTS but have children in treatment facilities that focus on children.
- Aging and Disability Resources Centers (ADRCs)
  - Ohio – There are 356 ADRC nationwide that are managed by Department of Aging. Silo has affected MFP and ADRCs had forgotten the D(isability) part but were good with the A(ging). They asked “how do we develop ADRC to be statewide and equitable”. This brought ADRC together.
  - Texas – Extensive ADRC network and remember both A and D. Getting relationship with discharge staff to help with transition coordination to get help to the people.
  - Connecticut – Have been funding ADRC partnership since the start.
- Voluntary Facility Conversion (closures)
  - Texas – Had lots of IFC/MR but are down to 22 facilities. They incentivize facilities to relocate people and have taken 800 beds offline.
  - Connecticut – Forced the issue to close facilities and state took over one nursing home. Had to transition all the people into homes. Follow people not in waiver for a year. Connecticut’s new strategic plan includes grants to nursing facilities and a protocol to remove beds from centers and provide day services delivered in community. The plan also includes a payment bonus to facilities for people who transition and removal of the bed from system.
  - Ohio – not doing closures.
- Questions/Discussion with Roundtable Network
  - Question – Are there recommendations for relocation with closures. Answer - Marc said he would send all paperwork related to closures. This also affects job in the area.
  - Question – What is total MFP budget fro each state? Answer - Texas \$75 million this year with 4200 people transitioned. Ohio \$100 million by the end of this year total. Connecticut \$40 million.
  - Question – how did you facilitate cooperation with nursing facilities? Answer - Hospital administration was on discussion group and they gave insight to what facility would think and how to get buy-in. Approached association with a partnership.
  - Question – Does the CRC in Ohio participate in the Stakeholder process? Answer - Yes they do.
  - Question - Do ADRCs serve as LCAs? Answer - Texas - not in Medicaid population. Ohio ADRCs are not statewide. LCA are transition

coordinators. Connecticut – Area Agency on Aging for elderly adults and IL by region.

- Question – here is a need for greater workforce development. Some participants will not be able to move because do not have clinician or staff to implement behavioral plans. How are states handling that? Answer - Texas – All states have a deficit and it is hard to get money for direct services.

Connecticut – Trying to engage workplace in personal care assistance.

Looking to develop training for workplace may require less certification.

Ohio – work with direct service workforce. They will have an HHS lag in people to do job. Direct services workers can work their way up in workforce.

- Wrap Up/Feedback/Closing
  - What worked well?
    - Liked being able to hear feedback from others – Asheville
    - Like turn taking and eliminating travel – Asheville
    - Kept on time in topics – Greenville
    - Great for traveling or not – A – G - C
  - What would you do differently?
    - Could there be sites in Boone or Siler City? Asheville
    - If there are not 4 people at a site then cancel the site as there is no discussion among the participants at the site. Raleigh
    - Hard being quiet all the time – Fayetteville
    - Too much info for one session. – Fayetteville
    - Maybe the video could be in morning? Fayetteville
    - Put all sites in main body of email of announcements.
  - What energized you?
    - Sustainable Community living – Asheville
    - State funded rental assistance – Asheville
    - Post Transition Services – Asheville
    - Loved working with other state on issues – Raleigh
    - Family Support should be priority for NC – Raleigh
    - New ideas from other states about housing – Greenville
    - Housing – Fayetteville
    - Success from other states – Charlotte
    - Transition work and advisory group – Charlotte

Next Meeting will be August 12<sup>th</sup> in Statesville.