

NC MFP Roundtable Meeting Notes

Friday, August 9, 2013

10:00 - 3:00pm

Statesville, NC



Attending:

Bailey Liipfert, Craige Brawley, Liipfert and Walker

Joanna Otundae, Iredell CAP DA

Tosha Breland, Disability Rights & Resources

Christan Postan, DVRIL

Martha Are, NC DHHS- Housing

Ashley McGill, DVRIL

Sheryl Zerbe, Community Alternatives

Tracey Thompson

Teresa Jarret

Bob Cleveland, Piedmont Triad AAA

Charisse Porter, Mecklenburg DVRIL

Katie Kutcher, Centralina AAA

Sylvia Nance, Mecklenburg DSS

Rachel Noel, DHHS-DMH

Lorrie Roth—DHHS--DAAS

Mike Howard, DHHS—DAAS

Marianne Nadeau, Centerpoint

Lydia Cosgrove, Disability Rights and Resources

Tracie Thurman, Sandhills

Tiffany Mills, Sandhills

AJ Kerley, Comfort Keepers

Susan Brunson, MeckLink

Kim Johnson, Piedmont Triad COG

Craig Weaver, MeckLink

Georgia Wood

Al Frye, Sandhills

Kim Emery, Upper Coastal Plain AAA

Linda Kendall Fields, Facilitator

Christy Blevins, DHHS MFP

Diane Upshaw, DHHS MFP

Trish Farnham, DHHS MFP

Welcome

Trish welcomed everyone and thanked the people of Iredell County- repaid the coffee that was used by MFP last year. Diane Upshaw mentioned housekeeping items.

Introductions with favorite rainy day activity (G/ PG)

Why This Matters: Real People, Real Impact

Ashley McGill introduced Troy, MFP client, who transitioned out of the nursing home. He is now in an apartment on his own. The next part of the meeting was dedicated to listening to Troy's story of perseverance and partnership with MFP.

MFP Update and Discussion

Transitions Report

Natarsa normally makes this report, but she is on a well-deserved vacation (see Attachment A). Although challenging at this point, we're making headway towards meeting our benchmarks

Christy noted that "physical health support needs" is matching the deductible as a challenge. The top two challenges continue to be 1) Housing and 2) Lack of natural support.

Diane highlighted stability funds spending chart - 79% of funds used for home mods, items, adaptive equipment.

Director's Report (see Attachment B)

Lots of major changes in Department and at the Division of Medical Assistance

Medicaid Reform - planning groups still working on strategic direction. General Assembly weighed in on reform, requesting a research process.

NC Tracks started on July 1st for Medicaid - has had major challenges. This does not affect MFP.

The MFP budget was approved by the feds in June/July - table included in handout

Working on an IT systems to make life easier for transition coordinators/LCA counselors.

Laura Ross is contact for MFP administrative questions; Natarsa Patillo is contact for status of application. Diane Upshaw is contact for any payment issues that are not NC Tracks related.

Outreach overview and Trish introduced a draft of the new MFP application (small group worked on this over the past few months). About 8 people volunteered to pilot this over the next two weeks and provide feedback to Laura Ross.

Trish provided information about proposed operational protocols and tentative benchmarks (See Attachment C). Group discussion about IDD waiver slots - point made that slot allocation is unknown per MCO for coming years, though MFP slots are known. Trish is getting more clarification. Trish asked for group reaction to these benchmarks.

MFP Rebalancing Report - (see attachment D) Family Caregiver-to-Caregiver Peer Support Pilot. Lifespan Respite staff will present in Boston in October re: mini-grants and relationship between MFP and Lifespan Respite.

Partnerships with NC Housing Partners - Martha Are's presentation (Power Point)

There are presently three initiatives that may help with housing: 1) Targeted housing; 2) DOJ settlement housing; and, 3) 8-11 units. Good news is that the division is hiring new staff to serve 9 sections of the state to manage the waiting list for these three initiatives and work across programs to solve consumers' issues. All nine of these people will have an MFP component to their work. Trish anticipating great opportunity for transition coordinators to work with these regional housing coordinators.

Medicaid Options Counseling Materials

Mike Howard presented an update on the IMOA (Inter-departmental Memorandum of Agreement) between NC DMA and NC DAAS (PowerPoint) and then spoke specifically

to a Medicaid Orientation Training Module. Mike asked the group to consider reviewing the training module as the pieces are drafted.

Transitions Advisory Group

The group is being reconstituted to think through transition process and protocols. No date set yet - estimated start time: September 2014

Other Systems Updates

Lorrie Roth of DAAS spoke about the sequestration and its impact on services (see Attachment E) entitled "Status of Home and Community Care Block Grant Services for Older Adults." What can be done? Advocacy is important - tell the stories. Bob Cleveland from Region J (Greensboro area) is working on articulating the message for the AAAs - will share this message with MFP Roundtable.

"The Second Half of the Transitions Football Game"

Examining the Practice of Follow Along and Ensuring Successful Transitions

Trish introduced the subject by sharing the MFP experience - pre-transition/transition practices are getting stronger. The majority of folks really do well post-transition. If there is going to be an issue, it usually happens soon after transition, (within 3 months) but not always.

Trish introduced challenges in the post-transition period. The Round Table attendees divided into small groups to address the following challenges and make recommendations:

1. Residential Staff not able to effectively address "behaviors"

- Cause: Lack of a true behavioral plan and lack of local capacity to develop a true behavior plan.
- Lack of community-based psychologists. Lack of qualified psychologists. LMEs used to have. Staff has never seen significant behaviors. Even with pre-transition staffing, may not "behave" the same way once out of Murdoch. Staff consistency.

Recommendations:

- Do effective transition plan: residential staff meet with Murdoch.
- Make sure staff is trained in behavior plan.
- Can Murdoch Center consult with person/team/reach back? Murdoch Center Outreach.
- Actual "hands on" staff need to meet with specialty unit staff – not administration
- Good match to provider (e.g. employment, school) – something similar in structure for the person.

2. Families become fatigued - Recommendations:

- Set up respite time – helps to have the same person
- Develop contract with family ahead of time to spell things out pre-transition, including trial visits

- Walk through what is done by the caregiver at the nursing facility – what does that look like at home?
 - Recognize signs and symptoms of caregiver burnout
 - Know caregiver resources – beef this up
 - * Linda KF mentioned that the Lifespan Respite Grant is developing an on demand webinar through UNC Cares on these issues.
3. Back-up Staff Doesn't Show Up - Recommendations:
- Agency should contact care manager so that he/she can contact other agency in case of a “no show.”
 - More than one back-up staff designated
 - * Many parents decline back-up staff because they're an unknown, untrained person.
 - Arrangement with adult daycare for back-up
4. Person refuses assistance post-transition – Recommendations:
- * Sometimes due to resistance to change
 - Enlist help of partners such as LCA Options Counselor and Peer Supporter at transition conferences
 - Get support from other family members
 - Remind them of what's important to them
 - Get CCNC care manager involved
5. Travel Expense Issues – Service to many people – Recommendations:
- More telephone conversations
 - State-based smart phone – face-to-face encounters
 - Rest Assured – telecommunication
 - Additional staff – smaller regions

Closing

Save the Date!

Annual Roundtable, Raleigh, Friday, November 8, 2013

Attachment A

MFP – NC Transitions August 9, 2013 Update

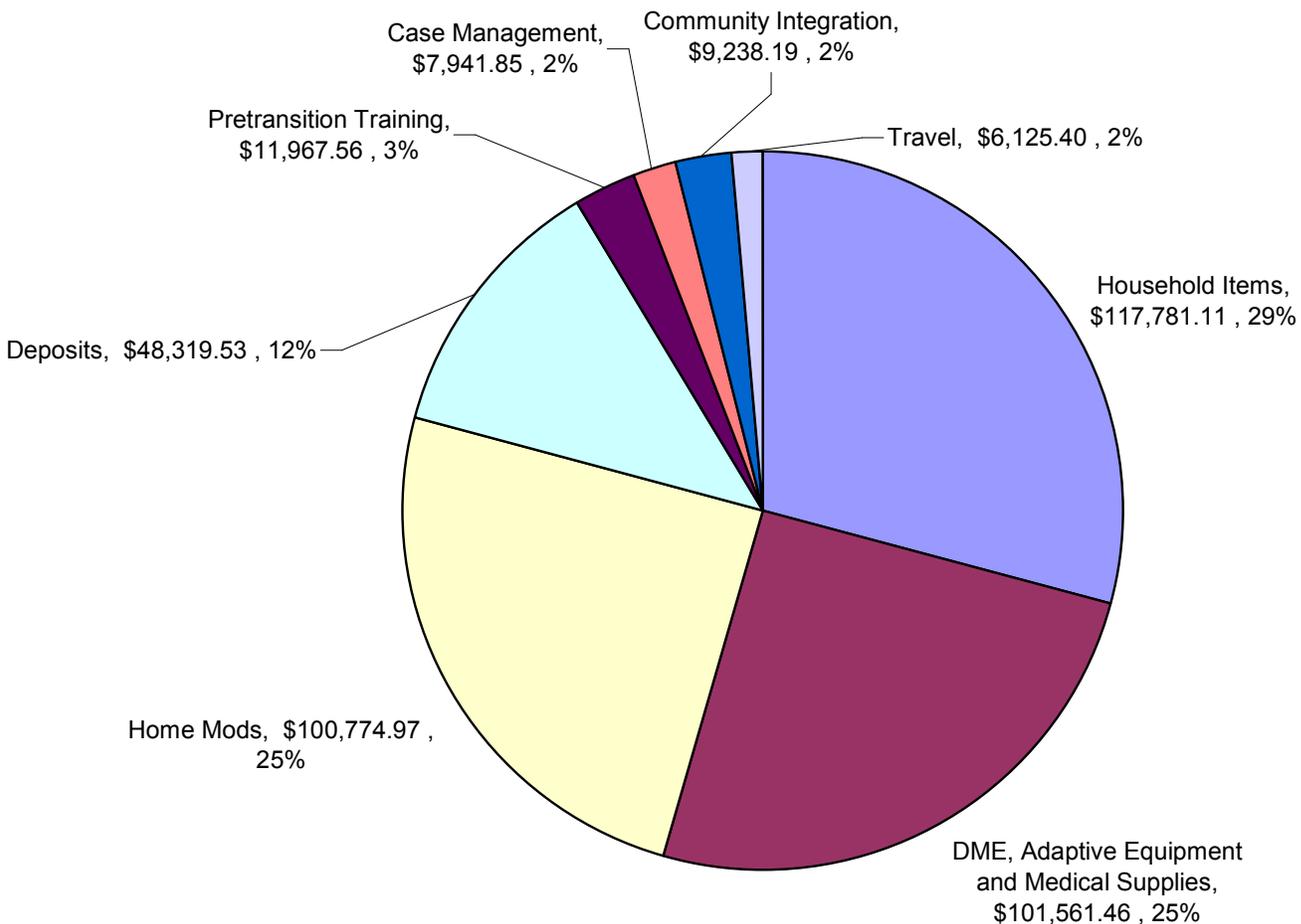
Transitions Information:

Total Transitions:*	334**
Total Aging and Physical Disability Transitioned:	211
Total Development Disability Transitioned:	123
Number of participants enrolled who have not transitioned:	194
Number of active participants who have currently returned to facility:	5*** (2.82 % of total active transitions)
Number of active participants who have passed away since transitioning home:	2 (This data is from self report only. No DRIVE information was pulled for this report)

Additional Information about our Benchmarks:

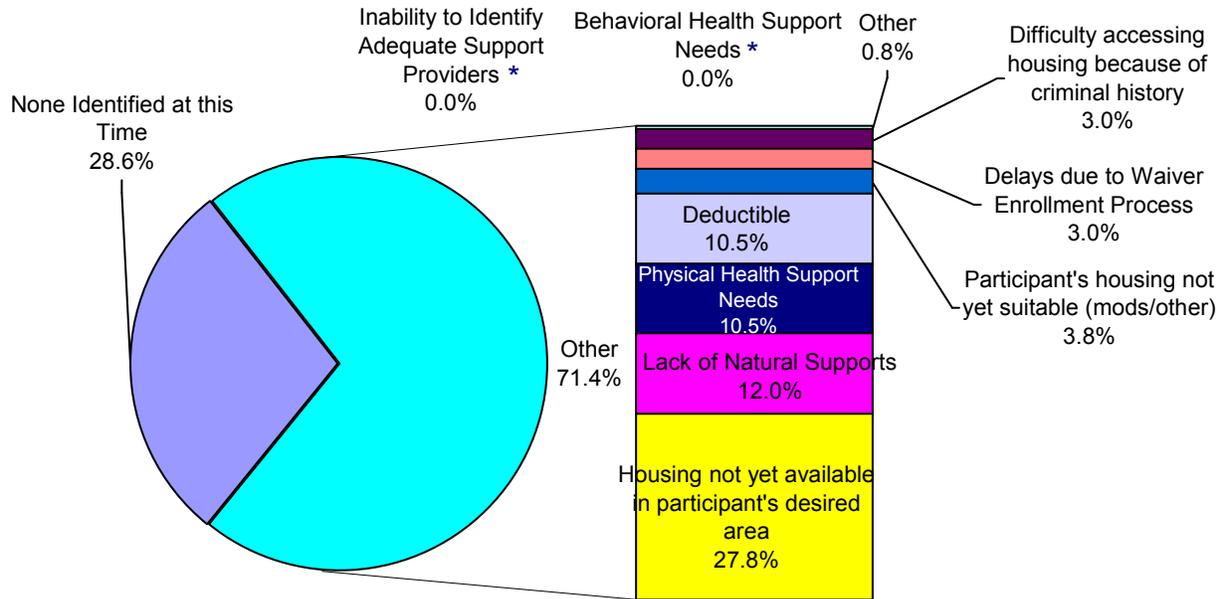
NC MFP Projected Revised Benchmarks				
	Aging and Physical Disability		Intellectual/Developmental Disability	
YEAR	Projection	Notes	Projection	Notes
CY 2013	105		30	
CMS requires placeholder benchmark projections through 2015. These placeholder projections are based on CY2013 projections but will be revised through informed, collaborative decision-making.				
Maintained Benchmark Commitment from Original Operational Protocol			304	
Revised Benchmark Commitment Through 2013			397	
Revised Benchmark Commitment 2014-2019* 2019=last year of MFP slot allocation			To be determined with thoughtful, collaborative decision making.	

Transition Year Stability Funds Spending Chart



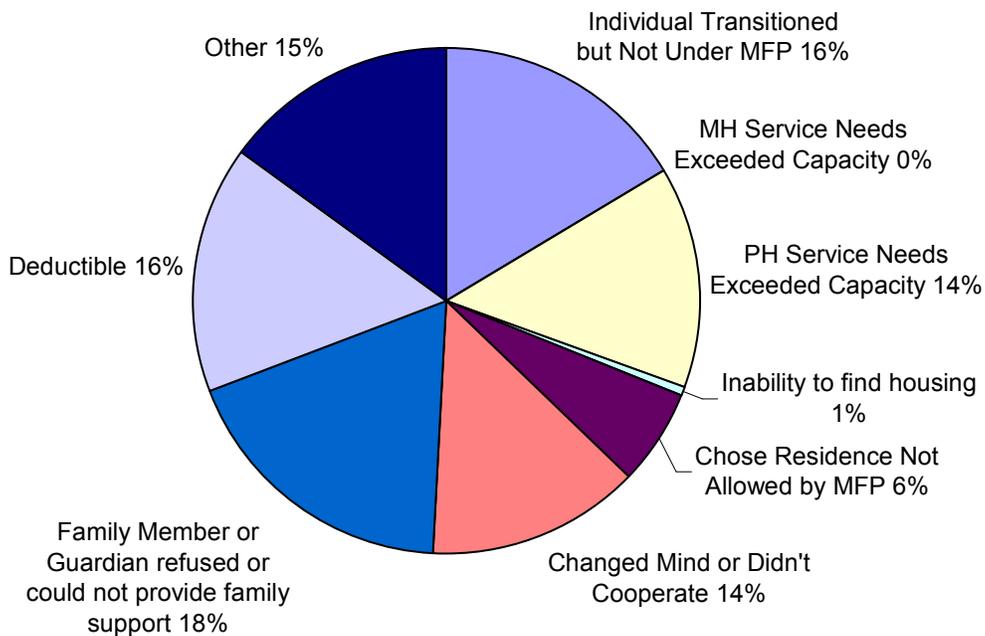
- 219 participants have used TYSR Funds.
- \$409,878.18 has been accessed.
- \$1871.59 average used per person.

Delays in Transitions Among Current MFP Participants August 9, 2013 Update



*Data not aggregated in time for report.

Reasons Identified for Pre – Transition Withdrawals from MFP



Attachment B

**NC MFP Roundtable
August 9, 2013
Director's Report**

BIG THANKS!

The Times, They Are A Changin'

- Since May Roundtable
 - Change in DMA Leadership
 - COO now Sandy Terrell
 - Clinical Policy unit reconfigured
 - Established Long-Term Services Section
 - Sabrena Lea

Status of *Partnership for a Healthy NC* (Medicaid Reform):

- Still in development
- See page 161-163 of <http://ncleg.net/Sessions/2013/Bills/Senate/PDF/S402v6.pdf> for statutory parameters.

The Summer of the CSC/NC Tracks Transition

- As of July 1, 2013, MFP demonstration services paid through electronic transfers, not through claims.
- Partnering with IT and Financial staff and federal partners to ensure continued data reporting compliance and ability to draw down EFMAP.

CY 2013 Project Budget Approved

Category	Budgeted Amount	Notes
Qualified HCBS	\$7,780,089.00	
Demonstration HCBS	\$585,000.00	
Admin (50%)	\$270,160.00	
Admin (100%)	\$1,780,837.00	Includes LCA funding
ADRC Grant	\$108,900.00	Remaining Op. C
CY 2013 Operating Budget	\$10,724, 986.00	

Returning HomeBase Development

- Long, long effort.
- Short-term goal: to develop basic IT system that will better enable LCAs and MFP transition coordinators to access and submit information in a “cloud-based” system.
- Long-term goal: system designed in partnership with Transitions to Community Living (DOJ) Initiative.

Transition Coordination Training Capacity Building Efforts

In partnership with Transitions to Community Living, working to build/expand Transition Coordination learning opportunities.

Staffing Updates:

- MFP Admin Awesomeness: We're thrilled Laura Ross is with us!
 - Laura can serve as your admin support point of contact for MFP (not transitions)
 - 919-855-4339
 - laura.m.ross@dhhs.nc.gov
- New IL (temp) transition coordination position anticipated to be in the West.
- Projected: September-ish.

Outreach:

- LCA—In-Reach Capacity Building
- Upcoming Department publicity series on transitions

Application Pilot

- Interested in participating?
- 2 week pilot
- New Application “goes live” on 9/1/2013

Operational Protocol Revisions

- Tentative Benchmarks

TENTATIVE NC MFP BENCHMARKS		
Transition YEAR	IDD	Aging & Physical Disability
CY 2014	30 (68)	105
CY 2015	30 (68)	125
CY 2016	30 (68)	150

Attachment C
NC Money Follows the Person Demonstration Project
Summary of Changes to Operational Protocol
August, 2013

Proposed Change	Original Location In Operational Protocol (2012 version)	Summary of Current Policy	Proposed Change	Reason/What this Will Do
Revise Benchmarks to include benchmarks for CY2014-CY2016	Pg. 22	MFP's transition benchmarks set the annual transition expectation by disability population.	See Director's Report	Set transition performance expectations for Project. Can be revised.
Update Outreach barriers	Pg. 24	Tracks number of presentations conducted to Hospitals, Medical Associations, Nursing Facilities and Senior Centers	Will revise with recommendation of Outreach Committee	Better capture what we actually want to capture
Update Service Package to reflect current services allowed in CAP DA, Innovations and PACE	Pg. 46-47, pg 50, 51	Reflects old benefits package and also lists AT and Family Support as demonstration services, though they have now been incorporated into CAP DA.	Will revise table on page to reflect current benefits package in Innovations, CAP DA, CAP CHOICE Services	
Revise Pre-transition Staffing and Consultation description	Pg. 50	This is a targeted use of "TYSR" start up funds. Provides guidance to those teams who choose to utilize TYSR funding for the purposes of pre-transition staff training and clinical assessments not covered by the waiver.	Incorporate expectation that funds are to be utilized to cover the costs of person-specific staff training (i.e. shadowing facility staff to learn person's support needs), not general staffing training costs (i.e. CPR, etc.)	To clarify intent of service.
Revise Pre-Transition Case Management specifications	Pg 51	Provides guidance on pre-transition case management allowed as a Demonstration Service	<ul style="list-style-type: none"> • Remove CAP MR/DD reference • Provide additional clarification that CAP DA pre-transition case management may not be covered by both MFP and CAP DA annual waiver allocation. 	<ul style="list-style-type: none"> • Reflect the fact that in MCO landscape, care coordination functions are no longer considered a separate function. • Clarify intent of service.
Incorporate Appeals language			<ul style="list-style-type: none"> • Will incorporate language clarifying right to appeal MFP denial 	

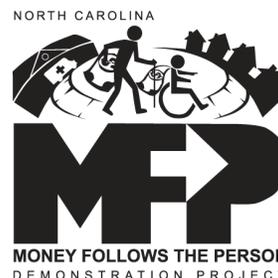
Anticipated Future Changes:

- Appeals
- Revision to Consumer Supports section to reflect current/revised practices on Incident Report Management etc.
- Revision/tweaking of AT benchmarks, based on Roundtable feedback
- Revise outreach benchmarks
- Adding CAP-C

Attachment D

**Rebalancing Fund update
August 9, 2013**

**Family Caregiver-to-Caregiver
Peer Support Pilot**



Chinese Peer to Peer Caregiver Support Program

Established a program leadership team and a Program Advisory Committee which is formed of several RSVP 55+ volunteers, a geriatrician from Duke University, a researcher, the director of the Duke Family Support Program, and religious leaders.

Defined program goals, objectives, and mission. The program team has designed program outreach and volunteer recruitment materials in both English and Chinese. The program team also has determined its community outreach strategies. They have hired an intern and will start in August.

The China Star newspaper, the most popular Chinese newspaper in the U.S., interviewed the Orange County Department on Aging about available programs and services. The director of China Star was very surprised and excited when she learned about this caregiver program. They will continue working with Chinese newspapers to reach out to their target population, and to increase awareness of caregiving issues.

The program coordinator conducted key informant interviews at a Chinese church, CCMC, Seymour center, and an independent living facility to get insight into Chinese caregivers' experience and their perspectives on receiving caregiver support.

Also, the Chinese Peer to Peer Caregiver Support Program provides new volunteer opportunities for Chinese speaking RSVP volunteers to contribute their strengths.

Aging, Disability & Transit Services of Rockingham County

Has completed the planning phase of the project and begin the recruitment phase
Have Held Community Outreach Activities

- Developed Brochures and disseminated to CRC collaborative partners and the Service Providers Meeting (Rockingham County)
- ADTS disseminated the Caregivers-to Caregivers brochure at "World Elder Abuse Awareness Day Conference" – HELP, Inc. and "Bridging the Gap" exhibit – City of Reidsville.

2) Relevant Activities of Staff Leadership:

- Identified staff, developed job description and identified support persons
- Developed "peer support specialist", "respite volunteer" and "peer caregiver" job descriptions and applications.
- Developed program reporting tools:
- Developed Educational Program
- Develop evaluation forms for training sessions

North Carolina

HCCBG Survey Results – June 2013



Status of Home and Community Care Block Grant Services for Older Adults

To meet requests of federal and state officials, the Senior Tar Heel Legislature and others, the NC Division of Aging and Adult Services (DAAS) has surveyed the statewide network of Home and Community Care Block Grant (HCCBG) providers to assess service needs and learn about related strategies and issues. DAAS has surveyed the network five times since February 2009, most recently in April 2013. Of the 315 local HCCBG providers contacted, 271 responded (86%).

About the Home and Community Care Block Grant

Established in 1992 under NCGS 143B-181.1(a)(11), the HCCBG was devised to provide a “common funding stream” for a comprehensive and coordinated system of home and community-based services and opportunities for older adults. HCCBG services are available to people age 60 and older, although the “average” client is nearly 80 and the program targets individuals who are socially and economically needy.

HCCBG is administered through the NC Division of Aging and Adult Services and the Area Agencies on Aging. It combines federal and state funds with a local match, and it gives county commissioners discretion in budgeting and administering aging funds.

Results

The results of the survey continue to suggest the negative effect of stagnant, and in some cases, diminished funding, given the increasing demand for HCCBG services. The survey points to providers’ anxiety about the effect of the federal sequester/reduction, which just started as the survey was under way. The HCCBG reduction, due to the federal sequester of the Older Americans Act, is about \$2 million.

“We are facing increased demand while being asked to work with reduced resources. [We] are working diligently to identify sources of additional revenue.”

“We are closing our meal site beginning on May 15 every Wednesday until further notice due to the sequester funding cut.” [Congregate meals provider]

“[We] dropped service as of April to cover reduction due to sequester cut.” [Housing/home repair provider]

“If funding reductions continue, we may discontinue service completely or serve only those in one area of the county.” [Home-delivered meals provider]

“With more and more individuals and families demanding/requiring assistance, we are stretched to the limit.”

“With sequestration—[this] is the worst year the agency has experienced in its existence of almost 40 years.”

HCCBG Services at a Glance

- adult day care and day health care
- respite
- information & assistance
- congregate and home-delivered meals
- senior centers
- housing and home repair
- health promotion and disease prevention
- care management
- in-home aide services
- general and medical transportation
- senior companion
- health screenings
- skilled home health

Agencies Further Tighten Administrative Belt, Largely Due To Decreasing Federal and Local Support

As they did last year, more than half (57%) of agencies that receive county funds report reduction or elimination of this support; nearly two-thirds (64%) say the same about municipal funds, as do 42% of those looking to United Way. More than one-third using volunteers report a shrinking number (39%) and reduced hours (34%).

“[Our] county is in a severe budget crisis heading into next fiscal year. I foresee severe cuts to . . . senior services.”

“The county manager has proposed eliminating additional funding for congregate and home-delivered meals.”

“We review our budget weekly and make critical fiscal decisions when needed; we are doing everything . . . to stretch our dollars.”

Service Needs and Wait Lists Remain High

Only about a third (35%) of providers report that they have been able to increase the number of people served over the past year (down from 40% in 2012).

About 16,000 seniors are waiting for home and community services through HCCBG providers (based on projecting responses to 100%). This is about a 9% increase over last year's survey and a 27% increase since the spring of 2010.

71% of Information and Assistance (I&A) providers report increased requests for their services, while nearly half (46%) say that community resources to which clients can be referred have decreased.

81% of senior centers report increased demand for their programs and services; 11% of centers report that other providers who make HCCBG services available at the center are reducing or ending this center connection (up from 7% last year).

"The average length of time on the waiting list [for congregate meals] is currently 8 months [and] 3 months [for home-delivered meals]. This length of time will most likely be extended."

"We are a very rural county . . . we do not keep a waiting list for people who live in an area that we cannot serve with our existing routes." [Home-delivered meals provider]

"[We are seeing] more Adult Protective Service referrals and clients are being placed [in facilities] due to the funding cut."

About 2 Out of 3 Needing Services Wait for In-Home Aide or Home-Delivered Meals

Of those in need of services, 66% are waiting for an in-home aide or home-delivered meal. In-home aide services—providing help with basic personal care and homemaker tasks—continue to have the most people waiting for services, with a projected overall need of 6,175, or 39% of the projected need. In response, 73% of providers are prioritizing applicants; 60% are reassessing clients to reduce or end services; 47% are capping the amount of service that can be used; 46% are reducing the number of service hours they provide; and 41% are not adding new clients from the wait list when an existing client ends service (up from 31% in 2012).

"We will offer placement services if providing in-home services is not a possibility and the person is not able to remain at home without [them]."

"We limit the number of clients and the number of hours . . . to stay within budget."

Home-delivered meals (HDM) remains the service with the second highest wait list—projected at over 4,400, or 28% of those waiting for services. Over 71% of HDM providers are prioritizing applicants according to need (up from 53% in 2012); and 32% are not adding a new client when the service ends to an existing one (up from 20% last year).

"We are not adding any new clients to HDM at this time due to the sequester cut."

"We are thinking of stopping our extra box meals to some of the clients. We hate to do so, because there are clients that don't have anyone to buy groceries for them."

Housing/home repair (e.g., building wheelchair ramps, installing grab bars) continues to have the third longest wait list, projected at about 1,900—up 71% from last year. There were unmet service needs for other areas as well: adult day services (nearly 850), transportation (about 870), and congregate nutrition (over 620). These wait lists and service reductions can have significant consequences.

Providers Take Initiative

. . . to Reduce Wait Lists

Providers continue to ask for more help from families and volunteers; increase their marketing, fundraising, and partnerships; expand use of technology to assure efficient service delivery; and are good stewards.

"We assist families in looking for alternative means of service."

"We have started trying to find funding from other local sources. So far that has not been enough to allow us to add additional clients."

"[We started a] new tiered support/sponsorship program for businesses to support the senior center."

. . . and to Promote Efficiencies and Meet Challenges

"We are very careful with all allocations to ensure that monies are being spent to provide the most services."

"[We expect to] make cuts in every possible area (supplies, personnel, etc.) to avoid cutting services."

"The biggest factor that affects us is the inability to afford a staff person designated to recruitment, retention, and development of volunteers."

"[There is] not a lot more we can cut. We make every effort to trim overhead and spend wisely."

"[There are] no pay increases, [have] stopped pension match."

"Volunteers have warned that they will not be able to continue if gas prices continue to rise."

"We have one day per week denoted as pot luck, asking for donations of food at the three centers in the county." [Congregate meals provider]



N.C. Department of Health
and Human Services

Money Follows the Person Roundtable

Friday, November 8, 2013



Welcome!

The Department of Health and Human Services will strive to develop a complete continuum of care that focuses on rebalancing our treatment and service system to promote individual choice, individual responsibility and access to housing opportunities.

Project Update to
Roundtable:
The Abridged Version
November 8, 2013

The Direction We Set in 2011

Immediate Priorities: Ensuring the Project We Want	Mid-Range and Long-Range Priorities: Building the Supports and Communities We Want
<ol style="list-style-type: none"> 1. Ensuring the quality of the transition process. <ul style="list-style-type: none"> • Strengthening the transition coordination function • Strengthening the advancement procedures 2. Ensuring continued integrity of financial, data and reporting systems and practices. 3. Expanding the Project: <ul style="list-style-type: none"> • Collaborating with B/C waiver catchment areas. • Exploring expansion into supporting people with severe and persistent mental illness. • Continued outreach 1. Supporting the Development of the MDS 3.0 Referral and Transition Team Process, strengthening the local infrastructure to effectively perform these functions. 2. Assisting public housing authorities that support MFP participants. 3. Develop mechanism for self-advocacy/family support groups to conduct follow-up visits and follow up Quality of Life surveys. 	<p>Emerging Mid-Range Questions</p> <ul style="list-style-type: none"> • How do we create additional flexibility within services? • How do we better collaborate around data collection? • How do we better support families who care for their loved ones at home? • How do we build a stronger network of community-based medical, behavioral, therapeutic supports? • How do we better utilize assistive technology? • How do we better support people to live in their own homes? • How do we support voluntary organizational expansion/conversion in order to strengthen the community? <p>Long-Range Questions</p> <ul style="list-style-type: none"> • How do we fit into our state's Olmstead strategy? • How do we most effectively address institutional biases codified in statute? • How do we build a plan that most effectively rebalances our long-term care systems?

Our 2013 Environment



*Ensuring the Quality of the Transition
Process:*
Where We Were This Time Last
Year

- Transitions began in 2009
- From November 9, 2012
 - Transition Number: 232
- As of November 7th, 2013
 - Transition Number 358
- In one year, MFP transitions increased by 54%.

“Ensuring the quality of our
transition process.”

Transition Process:

Accomplishments in 2013:

- Stronger transition coordination trainings
 - Scenario-based; dialogue-based; in-person
- Spearheaded DOJ Transition Coordination training series, which has built stronger relationships with other colleagues.
- New Application
- CAP DA waiver renewal 
 - Role of Transition Coordination Strengthened
 - CAP DA Lead Agencies who have led the way
- Partners in the O'Berry Project
- Thanks to a few additional folks.

The Transition Process: Lessons Learned

- NC Tracks had an impact had a notable impact, particularly on aging and disability populations.
- State administrative systems often the biggest challenge in securing necessary services.
- The transition is only the “first half of the football game.” The importance of follow along.
- Recidivism is very real and highest among dually diagnosed participants. Ensuring coordinated, community capacity is critical.

What We're Doing About It:

- Strengthening transition coordination training
- Strengthening coordinated handoffs
- Strengthening transition protocols for high risk transitions
 - Thanks August Roundtable and Transition Advisory Group!

**“Ensuring continued integrity
of financial, data and reporting
systems and practices”**

Quote of 2013 for Systems:
“Smooth seas do not make strong
sailors”

HP to NC Tracks Conversion

- You may have heard about it?
- In an effort to meet deadlines for larger initiatives, MFP removed from implementation list in early 2013.
- Project's automated payment, financial and data reporting mechanisms were not going to exist after July.

Meet Bill...and John...and
Patsy...and Wendy...and
Wayne...and Paul...and
James and Sri and....



Perhaps a better quote:

“Individual commitment to a group effort -- that is what makes a team work, a company work, a society work, a civilization work, [a transition effort work].”

Vince Lombardi, with
NCMFP enhancement

Because of the teamwork between DMA's IT/Financial Staff and MFP Staff...

- MFP demonstration services are paying on time.
- MFP's financial reports reconciled and were submitted on time.
- MFP's quarterly data files are on schedule to be submitted appropriately and on time.
- Thanks to a few additional gals.

A Few Other Key Areas of Attention in 2013

- LCA Capacity Building
 - Big thanks to our DAAS partners and our local AAAs!
- Strengthening Housing Partnerships
- At the Table in Systems Design Efforts:
 - Medicaid Reform
 - Blue Ribbon Commission
 - Transitions to Community Living

NC MFP Rebalancing Fund

- Where We Didn't Make As Much Progress:
 - Rebalancing Fund's Housing Crosswalk initiatives tabled by former leadership.
 - Voluntary conversion initiative delayed because of DOJ work and leadership turnover but....
- Where We Did Make Some Headway:
 - Partnership with DAAS Lifespan Respite Project
 - Piloting efforts that support family caregivers.
 - Introduction of grantees

Other Areas Where We Didn't Make As Much Progress As We Would Have Hoped

- Supporting people to have strong information and linkages to employment.
- Supporting people to strong information and access to assistive technology.
- “Growing Pains”
 - Our technology of faxes, excel spreadsheets and email can no longer keep pace with our increasing volume.
 - We need a data system that can ensure MFP staff and all transition coordinators can enter and track information in an efficient way. Period.

We still have a lot to do, but....



Outreach Update

- Big thanks to Linda and the Outreach Committee!
- Sharing the Story
- Building the Capacity

The Preliminary Plan for 2014

Continue what we have already started.

2014 Transition Priorities

- Support transition coordination capacity development of CAP DA case managers.
- Support transition capacity of PACE organizations.
- Reconstitute our Partnership with CAP for Children
- Continue our support of the O'Berry Project.

Projected Benchmarks

NC MFP TRANSITION BENCHMARKS		
Transition YEAR	I/DD	Aging & Physical Disability
CY 2014	30	105 (53 Aging, 52 Physical)
CY 2015	30	125 (63 Aging, 62 Physical)
CY 2016	30	150 (75 Aging, 75 Physical)

Continue to Work On

- Supporting the design of systems that facilitate DHHS vision.
- The Role of Assistive Technology
- Opportunities for employment
- IT development for transition and LCA practices.
- Continuing to get the word out...

A parting wish for everyone



NC MFP Roundtable, November 2013

The Additional Information

“Expand our Project” through
“Continued Outreach” in part by
“Supporting the Development of the
MDS 3.0 Referral and Transition
Team Process, strengthening the
local infrastructure to effectively
perform these functions.”

LCA: A Work In Progress

Early LCA Development: The Need to Go Wide

- Establish LCAs
- Statewide Coverage
- Basic Outreach and Training

Current Focus: The Need to Go Deep

- Increased attention to specific facilities
- Inreach
- Stronger LCA Training and Capacity Building Initiatives

Progress in Other Areas

- Housing: now funding 1 FTE housing coordinator as part of state's housing staff network.
 - Better “birddogging” of affordable, accessible units for transitioning individuals.

Lessons Learned:

This List Grows

- Do not rush a transition. Period.
- State systems unrelated to services are often big challenges (i.e. HR, contract, procurement).
- Trust in people's ability to work together to create good outcomes: Roundtable, Advisory Groups, Learning Communities.
- Competing priorities and initiatives make inter-agency collaboration challenging at times and yet, people have given wonderful support to this effort.
- The transition represents only the first half of the football game.

A Collection of Our Words of Wisdom...

- 2010: "Just keep swimming"
» Dorie the Fish, Finding Nemo
- 2011: "Don't rush, don't stop."
» Brought to us by Linda Kendall Fields
- 2012: "To go fast, go alone. To go far, go together."
» "African" Proverb

2013 Quote:

“Individual commitment to a group effort -- that is what makes a team work, a company work, a society work, a civilization work, [a transition effort work].”

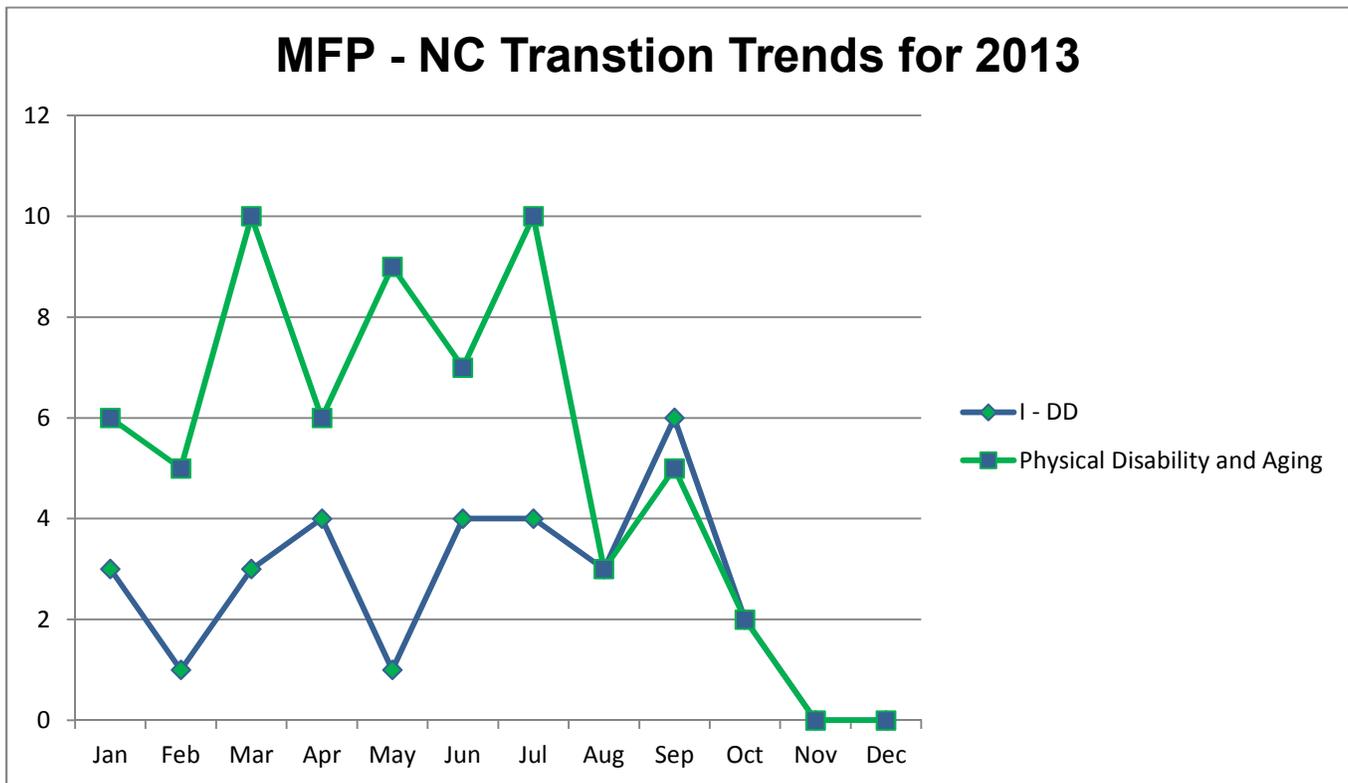
Vince Lombardi, with
NCMFP enhancement

MFP – NC Transitions

At a glance - as of November 6, 2013

Total Transitions to date: 356
Total for 2013: 95

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	31	30	26	2	--
2012 = 104	26	42	35	--	1
2013 = 95	31	43	16	--	5



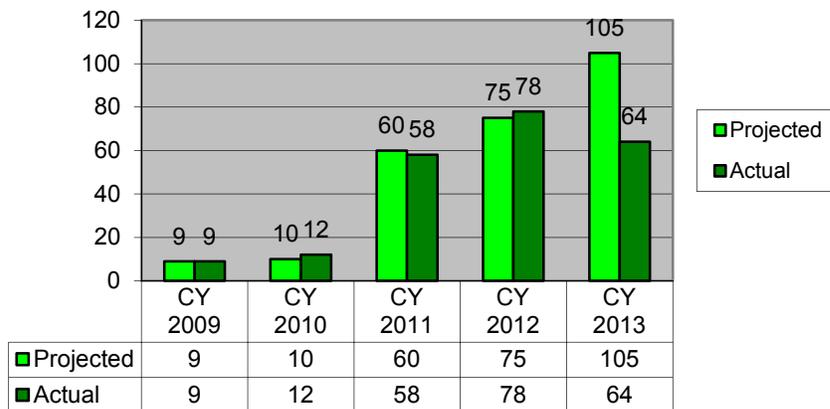
MFP – NC Transitions

At a glance - as of November 6, 2013

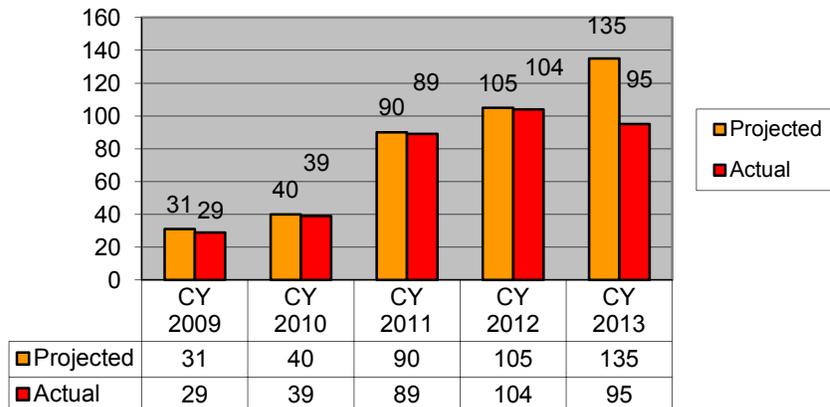
MFP I-DD Goals vs Actuals



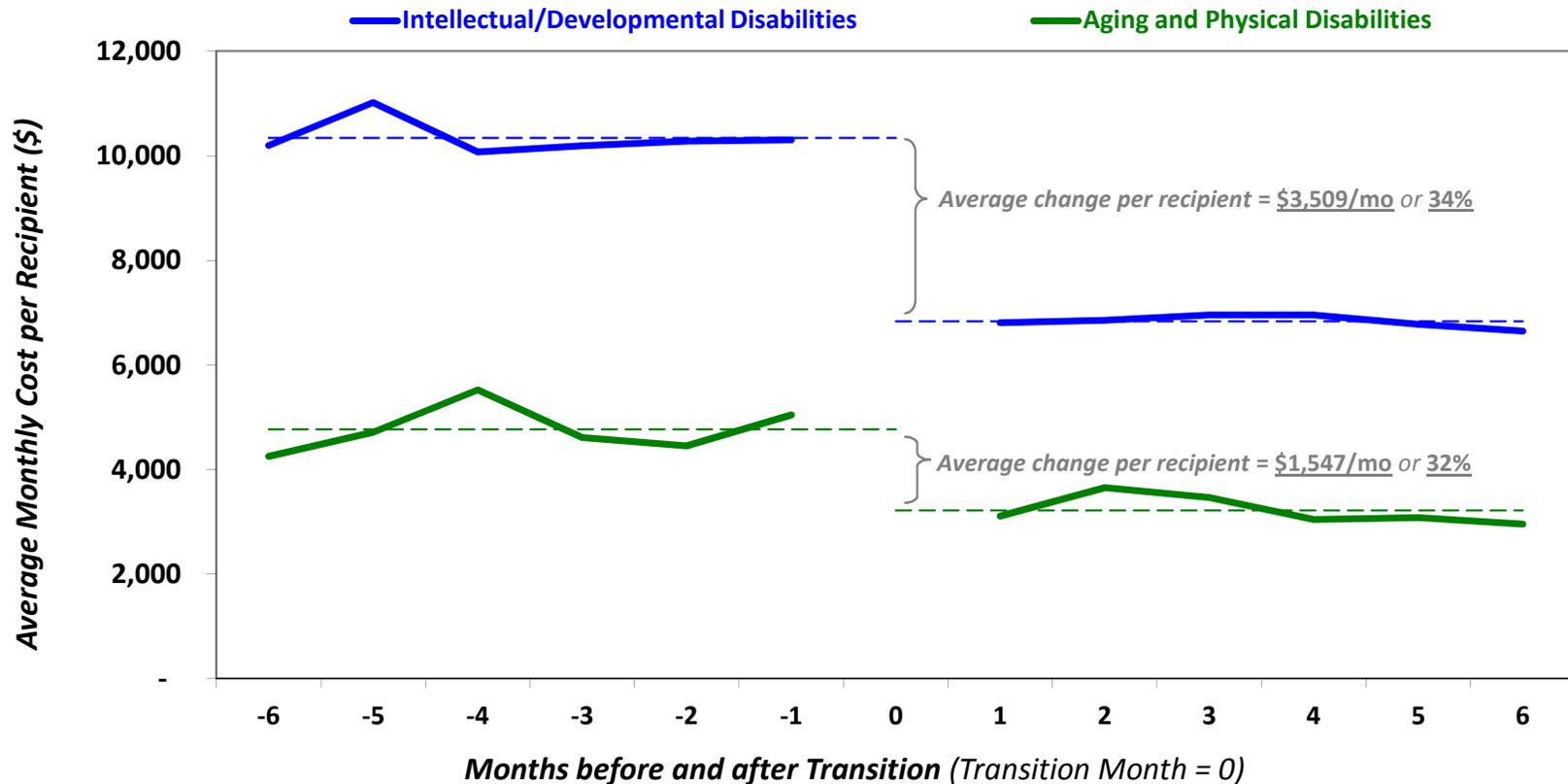
MFP Aging and PD Goal vs Actual



MFP Yearly Goals vs Actuals



Average monthly Medicaid cost per recipient, before and after MFP transition



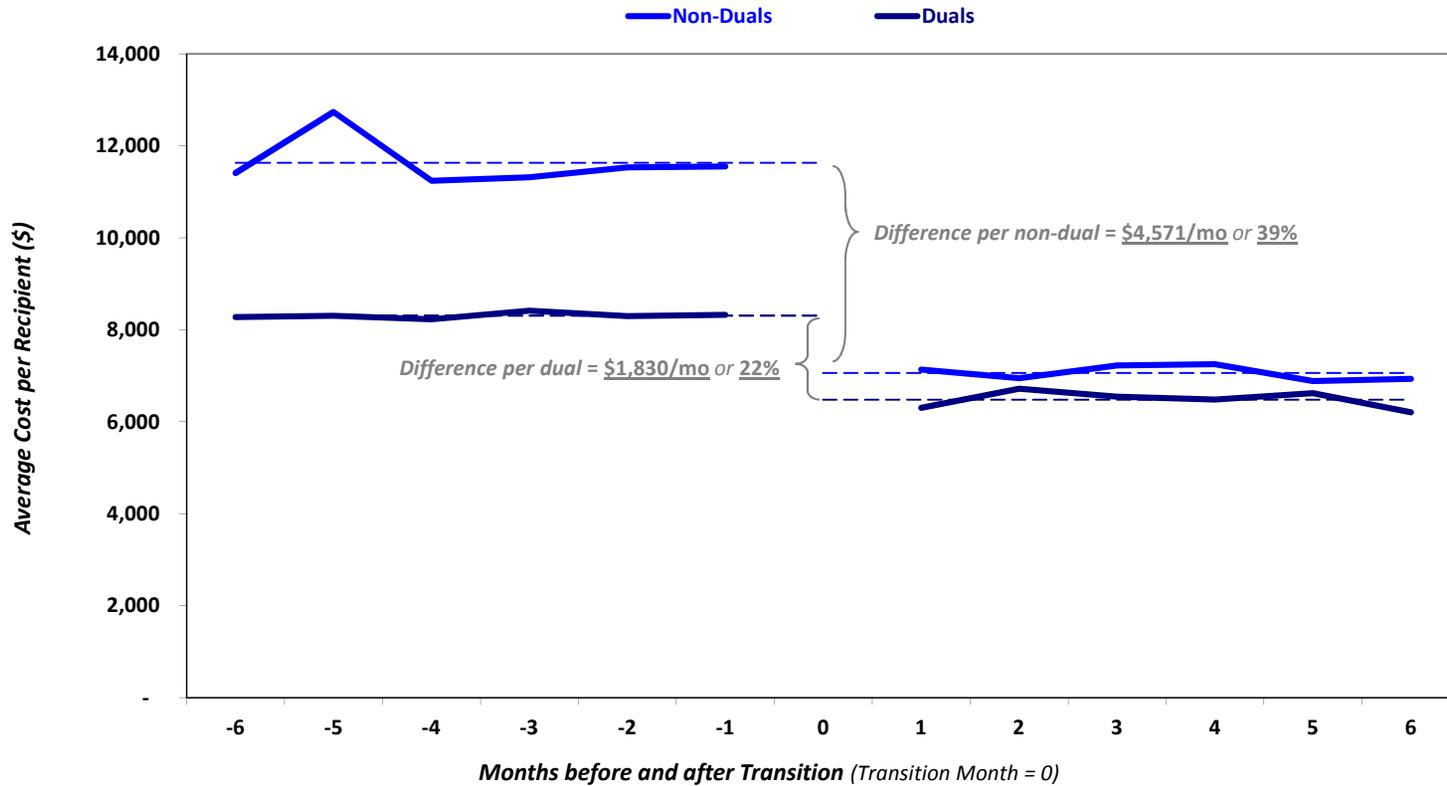
Month	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
Intellectual/Developmental Disabilities													
<i>n</i>	80	80	80	80	80	80	80	80	80	80	80	80	79
Avg Cost (\$)	10,195	11,019	10,073	10,190	10,279	10,300		6,807	6,856	6,957	6,952	6,779	6,648
Aging and Physical Disabilities													
<i>n</i>	91	96	96	96	96	96	96	96	96	96	96	95	96
Avg Cost (\$)	4,250	4,715	5,524	4,614	4,451	5,046		3,112	3,656	3,467	3,047	3,080	2,958

Notes :

- * Includes 176 recipients who transitioned by 9/30/2012. (Subsequent submission of claims for period extracted could affect final results).
- * Excludes recipients who died or returned to an institutional setting within 6 months after transition; all others were enrolled for at least 5 of the 6 months both before and after transition.
- * Includes both duals and non-duals, but excludes recipients whose dual status changed during the interval under analysis.
- * Dashed lines are pre- and post-transition averages.

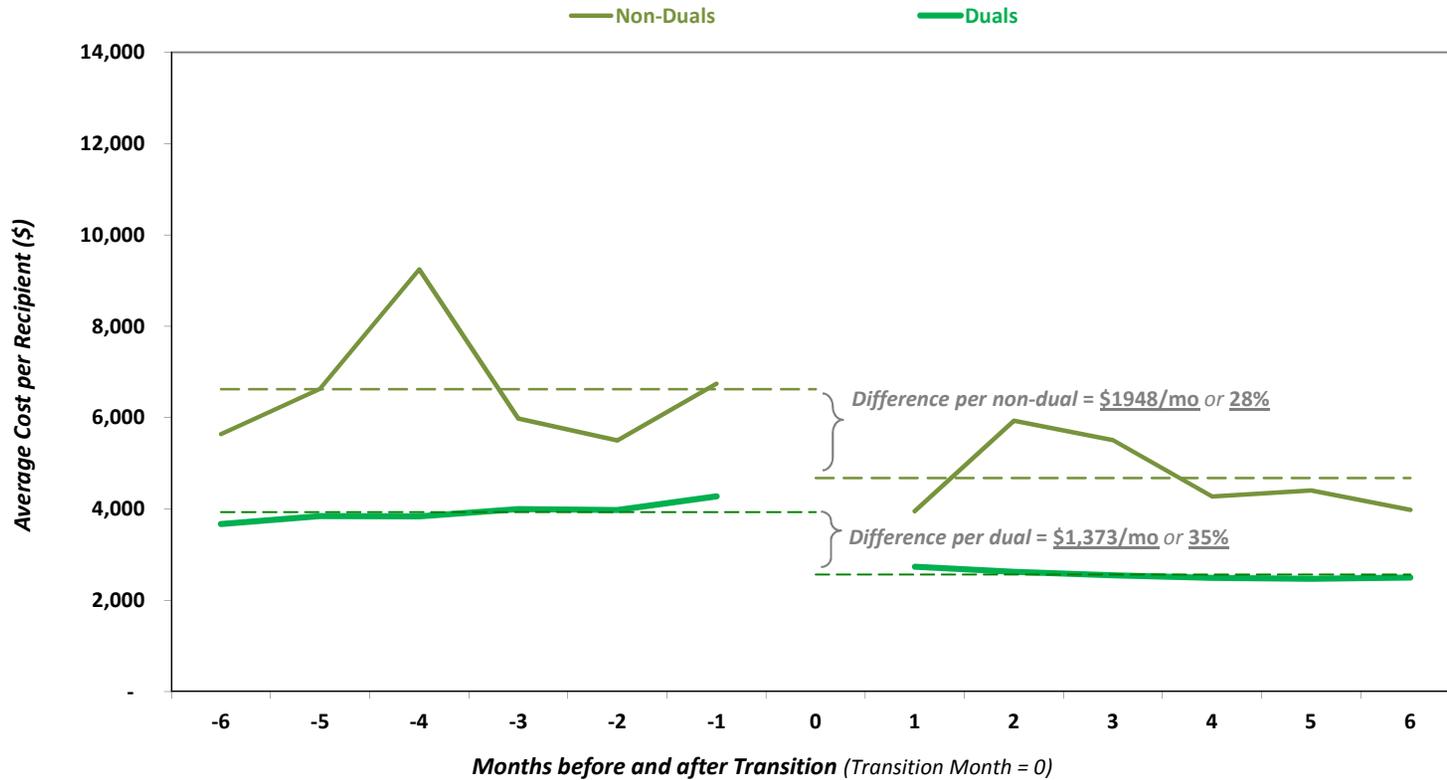
Intellectual/developmental disability recipients only:

Average monthly Medicaid cost per recipient, before and after MFP transition - Dually-enrolled vs. Non-Duals



Month	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
Intellectual/Developmental Disabilities - Dual Enrollees													
<i>n</i>	31	31	31	31	31	31	31	31	31	31	31	31	31
Avg Cost (\$)	8,277	8,302	8,230	8,415	8,299	8,327		6,299	6,718	6,544	6,483	6,618	6,206
Intellectual/Developmental Disabilities - Non-Dual Enrollees													
<i>n</i>	49	49	49	49	49	49	49	49	49	49	49	49	48
Avg Cost (\$)	11,409	12,739	11,240	11,313	11,532	11,548		7,129	6,943	7,219	7,250	6,881	6,933

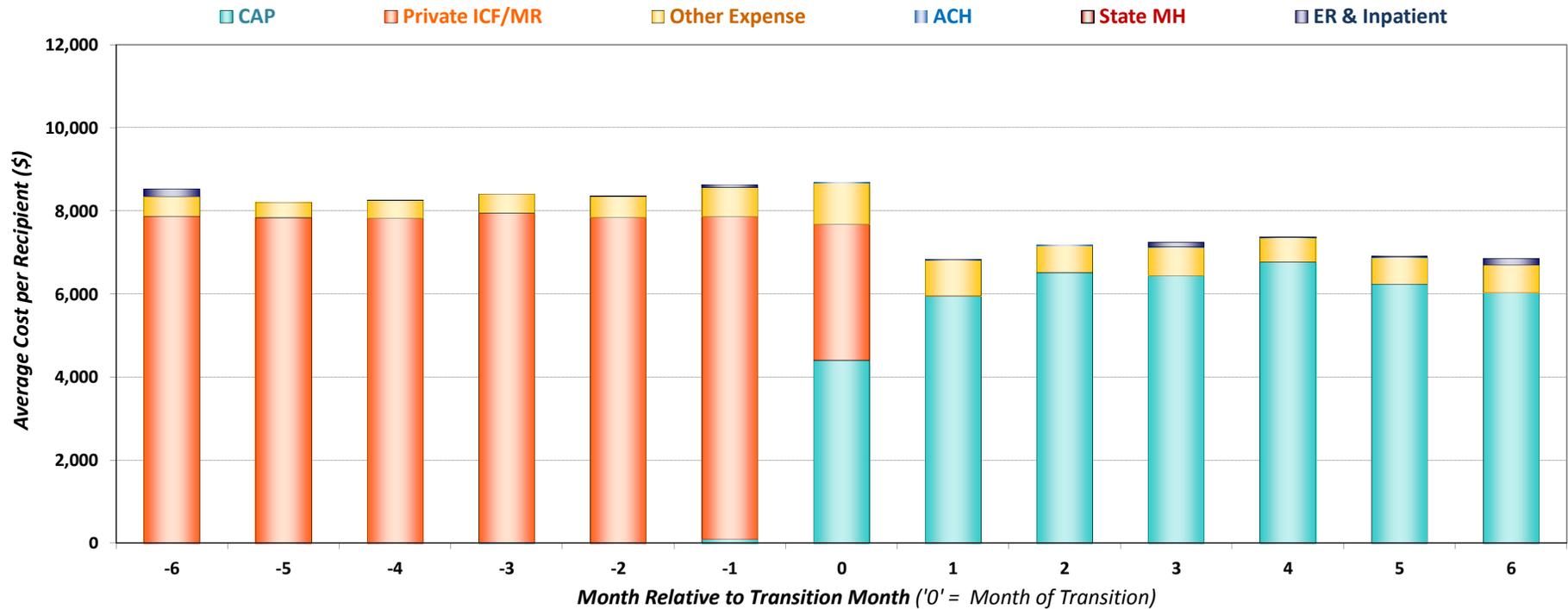
**Aging and physical disability recipients only:
Average monthly Medicaid cost per recipient, before and after MFP transition - Dually-enrolled only**



Month	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
Aging and Physical Disabilities - Dual Enrollees													
<i>n</i>	64	66	66	66	66	66	66	66	66	66	66	65	66
Avg Cost (\$)	3,665	3,845	3,834	3,993	3,976	4,276		2,733	2,622	2,540	2,490	2,470	2,495
Aging and Physical Disabilities - Non-Dual Enrollees													
<i>n</i>	27	30	30	30	30	30	30	30	30	30	30	30	30
Avg Cost (\$)	5,638	6,631	9,243	5,979	5,496	6,739		3,947	5,932	5,507	4,271	4,403	3,979

Breakout of Cost focused on specific institutional settings. (Please note change in scale in moving from one chart to the next).

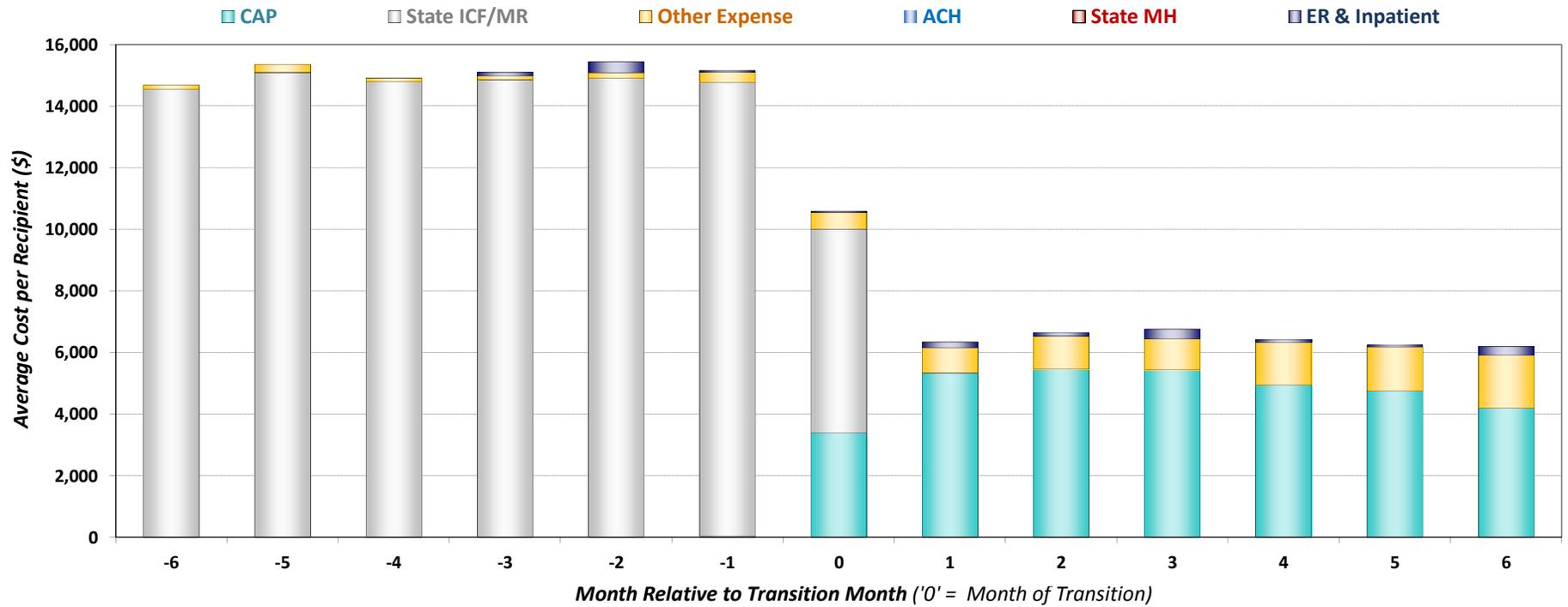
IDD : Breakout of Average Monthly Medicaid Cost per Recipient for Private ICF/MR Residents Only (Both Dual + Non-Dual)



Intellectual/Developmental Disabilities - Average Cost per Recipient for each Month:

	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
ER & Inpatient	181.58	0.00	2.38	0.00	0.60	58.23	0.00	13.05	0.00	106.42	5.89	22.50	148.30
State MH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ACH	0.00	0.00	0.00	0.00	0.00	0.00	10.74	12.03	13.32	12.89	13.32	12.89	13.32
Other Expense	477.54	366.99	431.23	453.85	506.20	695.81	994.93	857.26	654.63	677.24	588.71	638.74	663.39
Private ICF/MR	7,873.28	7,838.22	7,821.97	7,946.30	7,847.94	7,765.75	3,277.76	0.00	0.00	0.00	0.00	0.00	0.00
CAP	0.00	0.00	0.00	3.61	0.00	102.24	4,404.76	5,952.71	6,515.26	6,444.61	6,765.42	6,239.94	6,034.19
Total	8,532.41	8,205.22	8,255.59	8,403.76	8,354.74	8,622.03	8,688.20	6,835.05	7,183.22	7,241.17	7,373.34	6,914.08	6,859.20
n	40	40	40	40	40	40	40	40	40	40	40	40	40

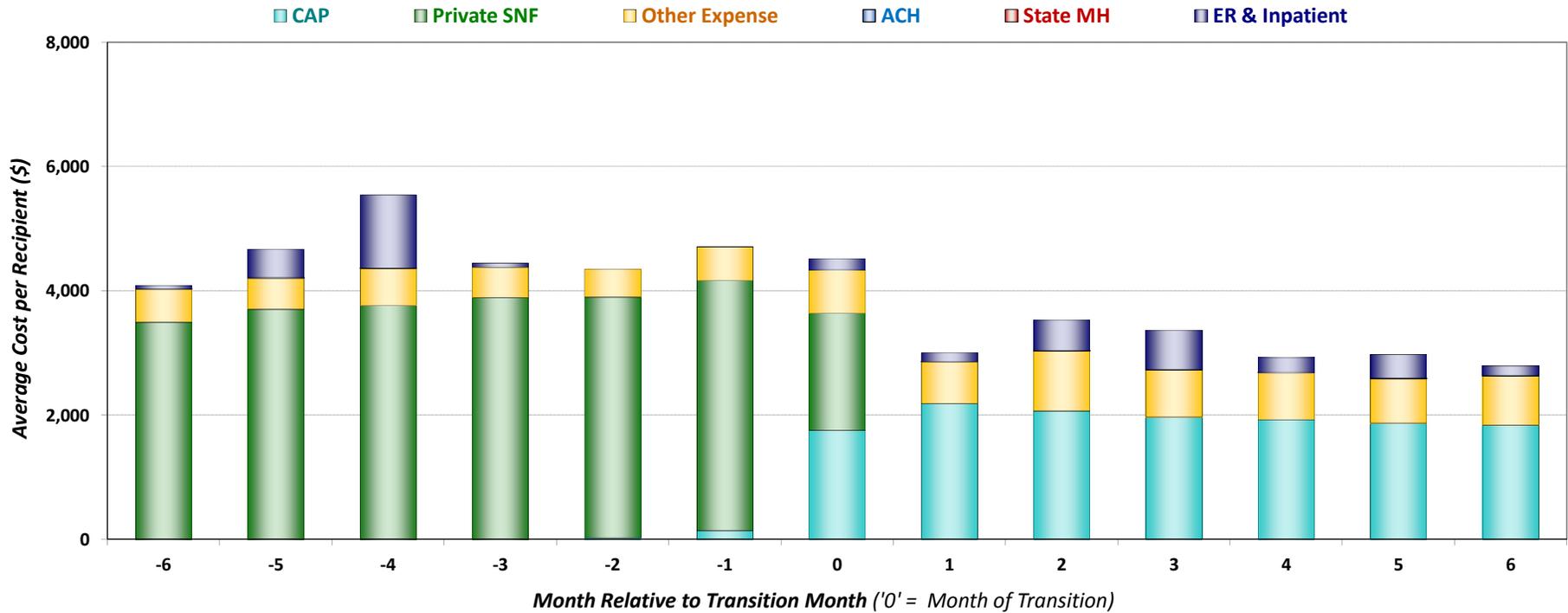
IDD : Breakout of Average Monthly Medicaid Cost per Recipient for State ICF/MR Residents Only (Both Dual + Non-Dual)



Intellectual/Developmental Disabilities - Average Cost per Recipient for each Month:

	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
ER & Inpatient	0.00	0.00	0.00	102.49	360.51	42.45	42.29	186.74	96.24	322.69	87.84	52.73	279.42
State MH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ACH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Expense	140.46	258.97	112.34	129.20	184.58	327.16	537.79	823.83	1,078.79	1,006.24	1,378.89	1,437.80	1,721.08
State ICF/MR	14,546.47	15,092.14	14,799.92	14,860.62	14,901.16	14,724.89	6,621.05	0.00	0.00	0.00	0.00	0.00	0.00
CAP	0.00	0.00	0.00	0.00	0.00	49.43	3,388.53	5,335.37	5,462.66	5,435.94	4,948.16	4,746.76	4,194.64
Total	14,686.93	15,351.11	14,912.26	15,092.30	15,446.25	15,143.92	10,589.65	6,345.94	6,637.69	6,764.86	6,414.88	6,237.29	6,195.14
n	28	28	28	28	28	28	27						

APD: Breakout of Average Monthly Medicaid Cost per Recipient for Private SNF Residents Only (Both Dual + Non-Dual)



Aging and Physical Disabilities - Average Cost per Recipient for each Month:

	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
ER & Inpatient	46.74	453.92	1,177.18	63.21	0.00	5.78	174.42	135.99	485.05	629.11	235.95	380.40	147.72
State MH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ACH	6.40	6.19	4.95	0.00	0.00	0.00	0.00	2.27	5.78	6.40	6.19	9.14	9.17
Other Expense	531.56	504.96	594.93	490.49	450.41	543.20	700.22	680.31	967.33	760.18	754.62	714.59	791.14
Private SNF	3,494.95	3,703.34	3,767.59	3,891.47	3,869.97	4,019.58	1,883.75	0.00	0.00	0.00	0.00	0.00	0.00
CAP	0.34	0.00	0.00	0.00	29.66	142.98	1,756.28	2,182.28	2,067.61	1,969.39	1,929.05	1,872.63	1,842.29
Total	4,080.00	4,668.41	5,544.66	4,445.18	4,350.04	4,711.55	4,514.66	3,000.85	3,525.77	3,365.08	2,925.80	2,976.77	2,790.31
n	88	91	90	91									