



MFP Roundtable - May 8, 2015 Wilmington, NC

Attendees:

- Trish Farnham, DHHS-MFP
- Kendra Dixon, UCPCOG-AAA
- Lydia Cosgrove, DR&R
- Lorrie Z. Roth, DAAS
- Sheila Brown, KerrTar-AAA
- Betsy Callahan, NHRMC-CAP/DA
- Linda Kendall Fields, DHHA
- Lakeisha Laporte, DHHS
- Megan Roberson, ECBH
- Holly Pilson, CapeFear AAA
- Halona Locklear, LRCOG AAA
- Diane Upshaw, DHHS-MFP
- Christy Blevins, DHHS-MFP
- Georgia Wood
- Dena Cannon, Alliance
- Megan Yeats, Disability Resources Center
- Lorie Winn, CoastalCare
- Diane Ferguson, Rescare
- Amber Rogers, VR/IL
- Tonya Cedars, ECC-AAA
- Jillian Hardin, ECC-AAA
- Danielle Andrews, VR-IL

Welcome – Trish’s hometown - appreciation for people who have travelled to get here

Thanks to Lorrie Winn for hosting the meeting at Coastal Care, the MCO in the area

Question: “mothering” gift for Sunday

Why This Matters: Real People, Real Impact

Invitation to share

Many in the room have been part of transitions

Thanks to Shane - last two Success Stories from MFP participants living in Wilkesboro

Stories:

From Jillian - 58 year old in Wayne County - transitioned back home with his wife from facility down the road. Described the day of the transition & how things came together in the very last minute.

Shane - thankful for the program; talking about ResCare group home and AFL

Danielle - Assisted man in returning home - Mobility Specialist and Services for Blind played key roles in achieving successful transition. Shout out to Danielle - one year with MFP - fearless!

MFP Updates
(See handouts)

521 total transitions (327 Aging and Physical Disability; 194 Development Disability). Discussion about 262 participants enrolled who have not transitions
Recidivism rate under the 10% national standard - 9.02%; A couple situations that have resulted in returns to facilities (behavioral; I/DD)

Attention on Housing Benchmarks - goals and benchmarks are low; MFP now has priority access to Targeting Key Program Units; Request for streamlined payment for housing application.

Transition Year Stability Funds Spending Chart - 1) Mostly for household items, including clothing; 2) home modifications; 3) Durable Medical Equipment; 4) Steadily increasing pre-transition training - avg. of 10 - 15 requests a week. Encourage use of these funds - call if you have ideas/questions. Discussion about "hair hygiene".

Reasons for Delays - 1) Housing - participants not able to go where they want to go; not yet suitable; difficulty accessing because of criminal history (working on letters of reasonable accommodation); lack of natural supports

Reasons people leave MFP before transitioning - Sometimes leaving w/o MFP services; sometimes physical health needs exceed capacity of what's doable at home; family caregivers cannot logistically do it. Have not scratched the surface on the possibilities for tele-support. For Aging/Disabilities, consideration of AFL option for this population – CAP/DA professional noting the increasing numbers of younger people with mental health issues using these services. Difficult to clearly delineate "populations" - argument for addressing cross disabilities.

MFP - Transition Numbers by Month - Transitions flattening; consistent with national trends (have transitioned the "low hanging fruit") but why might this be in NC? Maybe because Innovations Waiver is in technical amendment; compliance with Home and Community Based Services Rule; consolidation; Medicaid Eligibility. Recently, there have been discussions about MCOs receiving slots that are underused by other MCOs. Probably have better sense of where slots will go by June.

Aging and disability transitions are going down. More complexity; technology problems. Nursing homes still do not make the referrals, (call the MDS hotline) even with the LCA Options Counselors making in-reach/outreach efforts. In some other states, there are proactive initiatives to actually look at MDS assessment tool and look for "yes" responses; social worker turnover. Idea:

partner with Ombudsman. Do we need local contact instead of national call line; there are a lot applications coming into the pipeline (MFP office); also, how about number posted for residents to see; sometimes problems with deductible.

Sustainability Plan

Follow-up to the Sustainability Plan, launched in November; developed more fully in February - all this and small group work - 50-page document has been sent out. And it will be posted on website when approved by CMS.

1. State remains committed to transition activities
2. CAP-DA and Innovations committed to continuing with the work of MFP

We will transition people through summer 2018. Starting this year, hoping to double our
125 people this year in Aging/Disabilities
150/per year for next two years.

Demo services

- 3 K included in CAP DA - will be able to do pre-transition consult & training for Innovations
- CAP-DA & CAP-C will merge in June 2015 - creates more continuity. Limits of case management for CAP-DA increasing to 72 hours

Rebalancing Fund Priorities (spending): Some happening soon; others happening later

PHASE I - launching within Calendar Year 2015

- Family Support - Collaborating with Lifespan Respite Project on study and pilot on supporting family caregivers who have experienced (or are experiencing) having a loved one return to the community.
- Institute - launching in two weeks; two-day symposium; later in summer - 2 +1 Person-Centered Applications (enhanced person-centered planning)
- Housing - Crosswalk analysis of how Medicaid can support housing options still supported
- Supported Living - Resources to people who own and rent their own home - still going through rate setting
- Evaluation
- CCNC - involvement in-transition meetings
- IDT - One MCO will pilot a transitions-specific Inter-Disciplinary Team that stays with the person 90 days after transition - maybe 60 or more days before transitions.
- Integrated TC and Case Management - Pilot a full-time Transitions Coordinator within one or two CAP-DA unit.

PHASE II

- Transportation
- Conversion - pick-up with ICFs and add skilled nursing to this conversation
- Medicaid Reform - Several competing pieces of legislation - will be resources allocated to assisting LTSS network to respond to eventual outcome.

“True Confessions” moment, when participants admitted to what they secretly still didn’t understand about MFP – written anonymously on Post-It notes:

* See attachment entitled “MFP Roundtable List of Things Participants Don’t Know – May 8, 2015.” Will use to create future Lunch and Learn webinar topics.

Reviewing and Providing Feedback on Transition Coordination & Options Counseling Evaluation Components

How to make sure these functions are most effective when MFP go away. What where do we stand on this?

E.g., Processes that make things harder, easier; salaries for TCs are all over the map; qualifications for TCs

| Options Counseling | Transitions Coordination |
|--|--|
| What’s Going Well? | |
| Benefit of presenting options to resident at bedside | Deliberate meetings where we come together to learn/share |
| Robust Options Counseling Training | Development of curricula for transitions coordination (i.e., CTI) |
| OC gives information – they (consumers) initiate and carry out the steps | Helpful to have TC as the point person |
| | MFP application process is democratic – anyone can do it! |
| | Transitions planning document is comprehensive |
| | Pre-transition calls with Trish and Christy are helpful and flexible |
| | With TC experiences, learning how to break down silos |

| Options Counseling | Transitions Coordination |
|--|---|
| What could we improve on? | |
| SNFs not using the MDS referral line | Transitions more cohesive in MCO than Aging/Disability network – MCOs working mostly w/Developmental Centers <ul style="list-style-type: none"> • More difficult to be cohesive with different setting • MCOs are clearly the points of contact |
| Need to have the “right fit” for the Options Counselor position – can’t be just assigned | Aging/Disability community struggles with Transition coordination over counties and regions |
| Training needs and clarifications e.g., Thomas S – diagnosis vs. transition – focus on training. Understanding between systems (MCOs – CAP/DA) | Challenges collaborating w/local DSS & statewide system glitches (differs from county-to-county) |
| | Need “right fit” for TC position |
| | Training needs and clarifications |
| | Need common language/understanding between organizations serving different populations |

| Evaluation for Options Counseling & Transitions Coordination |
|--|
| • Range of salaries for TCs – What should it be? |
| • How do salaries (per transition vs. straight salary) relate to outcomes? |
| • Educational requirements |
| • What state processes are getting in the way of transitions? |
| • Differences between TC, OC & CM <ul style="list-style-type: none"> ○ Difference between TC & Discharge Planning ○ Consultant role for TC? Access others for specific functions? ○ Clearer level of authority for TCs within DVRIL and other |
| • Appropriate ratios (TC serving # of people) |
| • Best practices for TC helpful to DVRIL – for CAP/DA too |
| • “We’re constantly running into brick walls we can’t change” |
| • How does MFP integrate, particularly Transitions Consultant, after pilot, into DMA infrastructure |

Trish's notes from the discussion:

Strengths to Continue:

- TC: Options to come together across disability process
- TC: Development of a curriculum/training and looking at best practices and what works
- OC: options available to people
- TC: Clearly defined point person
- TC: Democratic application process
- OC: already have a robust training curriculum
- OC: empowering resident, but don't do it for them.
- TC: transition format, goes beyond ISP and place to document decisions.
- TC: Pre-transition briefing calls—good check and balance
- TC: flexibility
- TC: “the more you do it the, the easier it gets.” and “with experience we’re breaking down silos.

Challenges with our System:

- A and D transition: less cohesive whereas I/DD are usually working with same I/DD facilities
- Interstate transitions
- Cross county transitions (A and D)
 - ambiguity in who coordinates what
- Clearer points of contact across states within MCOS
 - state-wide provides
- DSS Medicaid workers/NC TRACKSs/NCFASST statewide systems/county variance
- local variance in building collaborations among counties
- OC/TC: if people are just assigned to do it, it's not going to work
- Lack of organizational understanding of what OCs do
- Need for TC: 1) good modeling of how SNF transition works 2) what are team members doing—who does what.
- Need for TC: Thomas S—training on case managers—6 week certification/curriculum. “Everyone wants to do well at their job.” ‘
- Thomas S: “wrapped around these folks”—met weekly with IDT team every single week.
- Deliberate how do we develop a common language?
- Connections with each group—develop relationships so know IDT knows who to pull in outside standard team
- Stronger training on dxs and disability types?
- MH TRAINING
- Cardinal Innovations offers a lot training that is very helpful for OC.
- In a perfect world, it works better if people are specifically assigned to transition/MFP.

What are the differences in outcomes?

- Based on salary? Based on reimbursement? Based on education level? State vs. Community?
- What state processes get in the way of the most efficient transition?
- Do processes need to be consistent across populations and organizations?
- Distinction of transition coordination and case management?
- Distinction between TC and discharge planning?
- Appropriate ratios/regions
- Clearer channel of authority/“we’re constantly running into the brick walls we can’t change.” “How do we get out of our own way?”
- Guidance on Best Practice/Standards
- Across ILs
- Across CAP DA
- How do we embed

MFP Roundtable List of topics: Things RoundTable participants don’t know enough about – May 8th Roundtable in Wilmington, NC

- CAP-DA spend down
- I know nothing about the physical disability and aging MFP process
- Specifics of what CAP Medicaid and Innovations all do
- Not sure how “involved” TCs should be in process – not taking the job of SW, CAP-DA, IL...
- I don’t know what I don’t know
- How the IL process works
- More knowledge of CAP-DA rules, regulations, policies, procedures
- Supports & services for people with mental health & substance abuse available through MCOs
- I would like to know where to start when someone calls and wants to transition in from another state? The social workers are often not clear on the process as well.
- Examples of tele-supports you spoke of earlier? Am assuming monitoring tools, etc. for persons
- CAP eligibility
- Qualifications for CAP-C & CAP-DA
- Roles of lead agency and CAP-DA & VR/IL – Who’s on first?

- How to make Pat McCrory or legislators to make decisions to increase CAP-DA budget
- Why would we have waiting list for CAP when it is cheaper for people to be on CAP?
- What is an LCA?
- How do you decide who takes lead on transition – (to be coordinator)
- Why people with IDD can transition into host home using MFP but people with physical disabilities cannot.
- The CAP-DA transition process for individuals moving out of SNF
- How are local providers selected?
- How do you link up with employment?

Meeting Adjourned