

Supporting the Return to Home and Community: North Carolina's Money Follows the Person Transition Coordination Handbook



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Special thanks to those who helped in the development of the transition coordination role, the tools used and the framework for this handbook. Particular thanks to NC MFP's Transition Advisory Group.

**Money Follows the Person Transition Coordination Handbook
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SECTION ONE

INTRODUCTION

Money Follows the Person (MFP) is a demonstration project that supports qualified individuals to transition out of inpatient facilities and back into their homes and communities.

The process of supporting an individual to transition and begin building a community-based life is a deeply meaningful experience. Because of transition efforts like MFP, North Carolinians are moving into their own homes; reuniting with their families; attending public schools; getting real jobs and becoming part of their local communities.

This handbook is intended to serve as a guide for those who provide transition coordination services to MFP participants in North Carolina.

North Carolina's Money Follows the Person Demonstration Project's (NC MFP) goal is to fund and support thoughtful, collaborative efforts that support individuals to return to their homes and communities. Transition coordination plays a vital role in accomplishing this goal.

Thank you for being a part of this effort.

Explanation of Terms:

- North Carolina Money Follows the Person Project ("MFP" or "NC MFP): A federal and state demonstration project that assists people living in in-patient facilities to transition into their own homes and communities. MFP also works to address the systemic barriers to individuals receiving home and community-based supports and services.
- MFP Participant: The individual who is transitioning out of an inpatient facility and into her home or community under MFP.
- Transition Coordination: the process of supporting an MFP participant to collaborate with others in identifying and securing the services and supports needed to transition into his home or community.
- MFP Transition Coordinator: The eligible individual providing transition coordination services to NC MFP participants.
- Lead Agencies: CAP DA Lead Agencies or Local Management Entities
- DVR-IL: Division of Vocational Rehabilitation's Independent Living Program. A state division under the NC Department of Health and Human Services that assists eligible individuals with disabilities to transition out of facilities.

SECTION TWO

NC-MFP Transition Coordination: Philosophy & Parameters

The MFP Transition Coordinator:

- serves as a guide to a person who is interested in transitioning into his or her community with supports;
- models respectful, positive, “can do” attitude throughout the process;
- is honest about what the challenges may be, but works to overcome those challenges;
- sees the person and her family as central participants in the transition process, taking on responsibilities in the transition work;
- is willing to be flexible to meet the specific transition needs of the person involved;
- should be a person who genuinely enjoys the process of supporting a person to return to his home and community and the efforts involved in supporting a person to build a community-based life;
- The NC MFP Transition Coordination function works to build off the strengths of existing entities that support transition work. It is NC MFP’s expectation that NC MFP Transition Coordinators can philosophically “hit the ground running.”

“I can’t make any promises, but I commit to walking with you on your journey to get home.”
-Karen Murphy,
transition specialist

An Invitation of Collaboration and Commitment

MFP Transition Coordinators invite others involved in the transition process to:

- keep the participant’s wishes, rights and well-being at the center of the effort;
- work towards the goal of supporting a person to transition into his/her home and community;
- collaborate to develop creative, person-centered solutions to challenges;
- respect the contribution of all members;
- acknowledge that respectful disagreement is sometimes inevitable and provides an opportunity for learning;
- create a sense of “collective accountability,” with each member (including the person transitioning and family members) committing to being responsive and flexible throughout the process;
- adopt a “don’t rush, don’t stop” pace when setting the transition date. Thoughtful transition work is neither chaotic nor sluggish.

SECTION THREE

MFP Transition Coordination: The Role in North Carolina

In 2010, NC MFP developed a transition coordination demonstration service. This service is only available to MFP participants. The role of the MFP transition coordinator is to support the MFP participant through the process of transitioning from an inpatient facility into their home or community.

MFP Transition Coordinators shall follow the transition processes outlined in this Handbook, which include but are not limited to:

- Having ongoing, respectful communication with the MFP participant, his/her supports, facility and community provider staff throughout the transition process;
- Have a clear understanding of state/waiver-specific transition practices.
- Holding at least two face-to-face transition planning meetings with the participant and others on her transition team;
 - While every transition circumstance is unique, when providing transition coordination services for individuals transitioning out of the NC Developmental Center Specialty Unit Programs, Lead Agencies are strongly encouraged to bring transition coordinators into the transition planning process no later than three months prior to the transition.
- Working with the participant, the participant's family and supports to develop a thoughtful, organized transition plan that addresses his/her community-based support needs;
- Coordinating with the participant, his/her family and supports to identify and secure the community resources necessary to transition. This includes but is not limited to: housing, medical care, financial management (setting up a bank account, etc), and other community supports that are needed for community living;
- Coordinating *Transition Year Stability Resource* (TYSR) requests;
- Conducting the MFP Quality of Life Survey with individuals prior to the transition.
- Maintaining regular follow up with the MFP participant for at least three months after the transition;
- Notifying the Project of any critical incidents impacting the MFP participant.

Important MFP Transition Coordination Parameters:

- Transition Coordination under Money Follows the Person is a *demonstration service*. That means that it is not formally incorporated into North Carolina's Medicaid service packages, but rather is funded with MFP federal and state dollars. This demonstration service provides an opportunity to "try out" this transition coordination service before deciding whether to formally incorporate it as a permanent service.

- If the transition coordination demonstration service does not meet its intended purpose, the demonstration service may be modified or changed to better meet the transition needs of MFP participants. In collaboration with stakeholders, MFP staff will formally evaluate the transition coordination service at the end of Calendar Year 2012.
- MFP Transition Coordination protocols outlined in this handbook are intended to complement but do not replace existing transition policies and protocols developed by the Division of Medical Assistance or other DHHS divisions.

Being Designated an MFP Transition Coordinator

To provide MFP-funded transition coordination services, an individual/entity must,

- Be committed to the process of supporting individuals to live in their own homes and communities and commit to following the processes and expectations outlined in this handbook;
- Be designated by the applicable lead agency as a transition coordinator;
- Have completed the MFP Transition Coordination training process;
- Be confirmed as a transition coordinator (or applicable lead agency) on the approved MFP application form.

Pre-Transition Case Management and Transition Coordination

Currently, case management services are offered up to sixty days prior to transition under CAP MR/DD and thirty days prior to transition under CAP/DA and CAP/Choice services. MFP allows as a demonstration service, that CAP/DA and CAP/Choice case management services may be provided for an additional thirty days prior to transition. The case management services that occur prior to a person transitioning are called “pre-transition case management.”

The NC MFP transition coordination service is intended to support and complement case management functions. Transition coordination services may be performed by a case manager but are separate and distinct services from case management. Each service has its own billing requirements. MFP’s Transition Coordination service billing requirements are outlined in Section Nine of this handbook. These transition coordination services are also distinct from other one-time services allowed under MFP’s Transition Year Stability Resources (TYSR) and must be billed separately. Examples of other one-time services allowed under TYSR include but are not limited to: behavior support consultation and individualized staff training. TYSR is more fully explained later in this handbook and in the North Carolina Money Follows the Person Operational Protocols, 2nd Ed.

Everyone in the Mix: Who Does Transition Coordination Work under NC MFP

Some History....

The NC MFP preliminary transition coordination structure works to plays to the strengths of everyone involved in the transition process.

Through observation, data and experience, it became apparent that case managers were often performing the role of transition coordination when NC MFP's formal transition coordination role was not yet developed. Stakeholders and research have consistently iterated the importance of strong case management in transition work. This preliminary transition coordination structure attempts to reflect the importance of the case management function.

It was also clear that supporting non-elderly people with physical disabilities in the transition process often posed additional challenges, as often resources and supports (including housing) were not immediately available and had to be developed in order for a person to transition back into his community under MFP. Accordingly, NC MFP provides transition coordination services to individuals with physical disabilities through a partnership with the Division of Vocational Rehabilitation's Independent Living Program. The Project will continue to work to develop partnerships with other entities that may be able to strengthen the transition coordination function for this particular population.

Who Can Do Transition Coordination under NC-MFP?			
Population	Transition Coordination	Billing	Notes
Participants over the Age of 65	CAP-DA Lead Agency	Through Medicaid claims process	<p>There may be times when a participant has an existing relationship with a group not designated to provide transition coordination support (i.e. a non-elderly person with physical disabilities who is on the CAP-DA waiting list). In these instances, the agency with the existing relationship may assume transition coordination responsibilities but will need to coordinate this with Project staff before services begin.</p> <p>CAP-DA Case managers will still participate with transitions of people who have physical disabilities, performing regular case management responsibilities. Case managers are still able to access enhanced case management time through MFP even if they do not perform transition coordination functions.</p>
Participants with Physical Disabilities	Division of Vocational Rehabilitative Services' Independent Living Transition Coordinators	Administrative reimbursement	

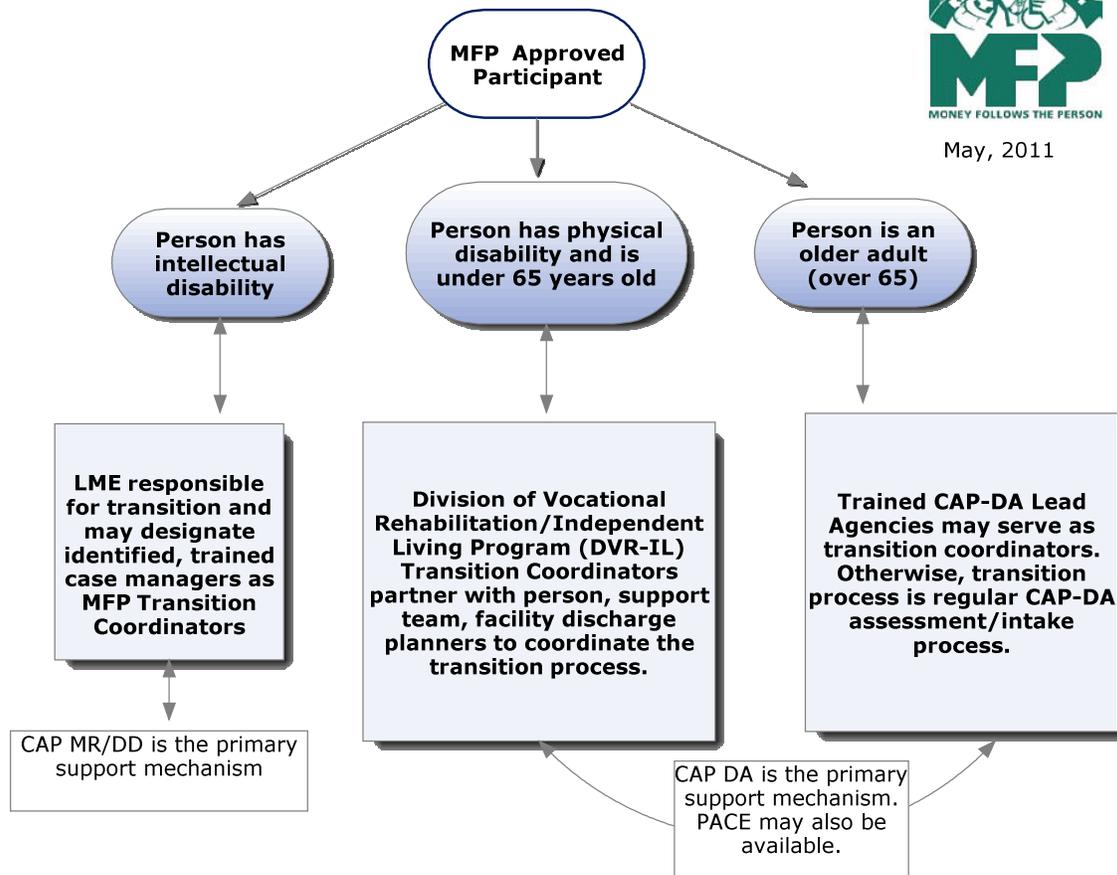
Participants with Developmental Disabilities	Identified Case Managers through the Local Management Entities	Through Medicaid Claims Process	Nursing facility residents with a cognitive disability will be directed to the LMEs for assessment for CAP-MR/DD
Importantly, NC-MFP does not represent the only transition effort in North Carolina. Other groups also assist individuals to transition out of facilities and into their communities. NC-MFP works to collaborate with these entities wherever possible.			

NC MFP Transition Coordination: A VISUAL REPRESENTATION

NC MFP Transition Coordination Who Does What?



May, 2011



MFP Transitions Between Counties/Catchment Areas

MFP largely follows the current practices under CAP-DA and CAP-MR/DD regarding cross county transitions.

General Points of Information about Transitions Between Counties/Catchment Areas:

- Cross county transitions require additional collaboration and coordination between applicable Lead Agencies.

- Pre-transition **case management** services (**not** MFP transition coordination services) under CAP-DA may be provided by two case management entities for the same transition, so long as the billing does not overlap. Because each transition is unique, the Lead Agencies should work together to determine “who will do what” and seek guidance from applicable CAP management teams and MFP if there is any ambiguity
- In extraordinary cases, MFP’s Transition Year Stability Resource fund may be available to compensate for additional case management time.

IMPORTANT POINT

While two lead agencies may be involved in the transition process, only ONE entity may provide MFP-funded Transition Coordination.

While each transition is unique, it typically makes sense for the Lead Agency that will be providing ongoing oversight (“receiving agency”) to provide transition coordination services because of the receiving Lead Agency’s familiarity with local resources and support options.

THE TRANSITION COORDINATOR WILL BE CLEARLY IDENTIFIED BEFORE THE MFP REFERRAL FORM IS APPROVED AND RETURNED

Notes Specific to CAP-DA Transition:

- While MFP slots are reserved at the state level, the receiving Lead Agency is expected to fold the MFP participant into its current slot allocation pool. If the Lead Agency does not have any slots vacant, the Lead Agency may borrow against a slot.

Notes Specific to CAP-MR/DD:

- MFP slots are reserved at the state level and do not belong to a particular LME.

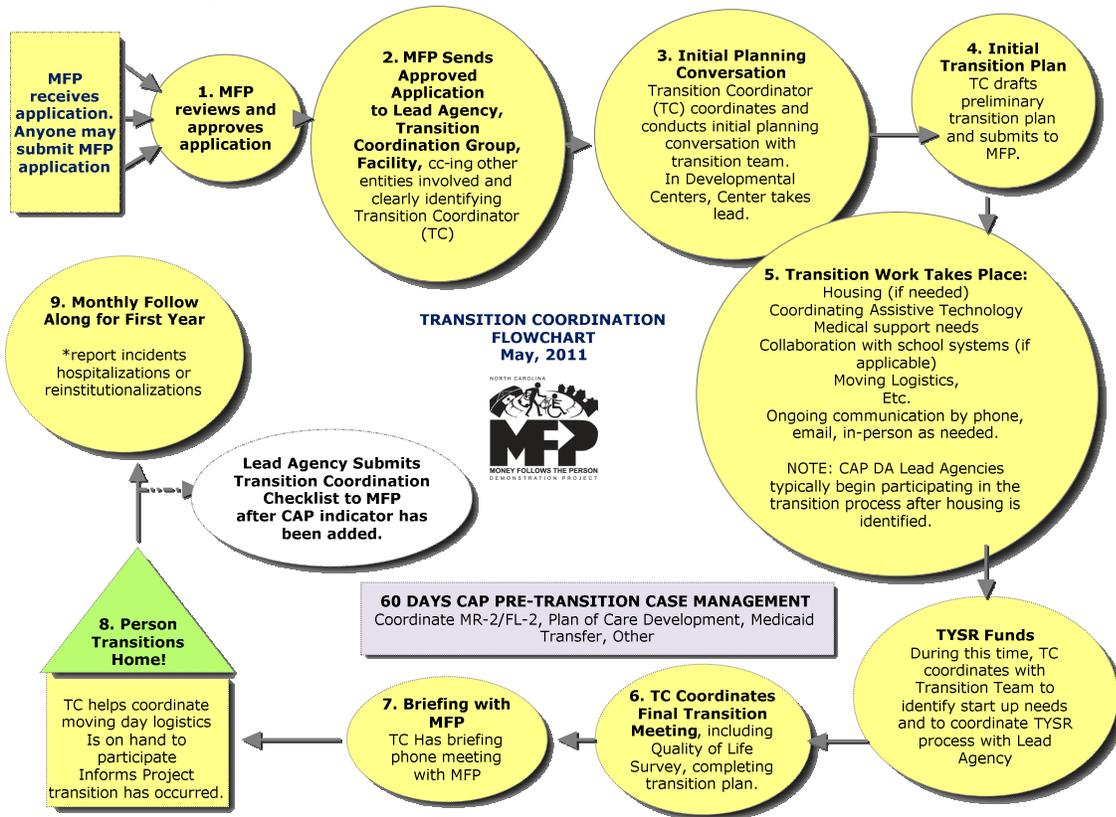
SECTION FOUR

The NC MFP Transition Process

This process is still considered preliminary and may vary slightly among populations and among regions. The diagram provides guidelines and highlights the core functions that must be present in any NC-MFP funded transition.

Importantly, this process is intended to harmonize with, but does not replace other transition protocols established by the Division of Medical Assistance or other NC DHHS divisions.

The NC Money Follows the Person Transition Process



SECTION FIVE

Transition Planning Meetings

The Meetings

NC MFP expects Transition Coordinators to coordinate and hold **at least two** in-person transition planning conversations: one at the beginning of the transition effort and one just before the transition occurs.

Additional meetings may be necessary to meet the specific transition needs of the participant. Transition coordinators use their professional judgment to determine if additional in-person meetings are needed.

Transition planning conversations are intended to be structured but relaxed, with sufficient time allocated to encourage thoughtful conversation about building a transition plan that adequately reflects the person's interests, the realities of what is available and a thoughtful plan for identifying and securing the supports needed.

IMPORTANT POINT

When providing transition coordination services for individuals transitioning out of the NC Developmental Center specialty units, transition coordinators should be identified by the LME and participate in planning meetings **no later than three months before the mandatory discharge date.**

A few suggestions:

- Develop email groups to coordinate meeting arrangements
- Take time to talk informally about why a person wants to transition and his/her hopes for community life.
- Take time to get to know each other personally and consider having the planning meeting over a meal and outside conference room settings.
- Enjoy the ride. While transition coordination can be challenging, stressful, and sometimes frustrating, it also facilitates an enormous (hopefully wonderful) milestone in the participant's life.

Who Should Participate in the Planning Meetings:

- The person (if s/he indicates interest in participating)
- Relevant family members and/or guardians
- Facility staff
- Case manager to be invited (if not otherwise involved)
- Other people as appropriate (provider agency, friends, behavioral support specialists, etc.).

The NC MFP Transition Planning Tool

While use of this specific tool is still voluntary, the MFP Transition Planning tool is designed to be a simple tool to help ensure the transition planning process meets MFP's expectations. Transition coordinators are encouraged to try it.

The NC MFP Transition Planning Tool is available online at:
www.mfp.ncdhhs.gov
under "Transition Coordination Services and Materials"

The tool should be fairly self explanatory, but a few guidelines may be helpful:

- The table represents the primary domains that need to be considered when supporting most people to transition.
- As a general rule, discuss all of the sections at the first transition planning meeting. The three columns in most sections follow the following logic:
 - 1st column: identifying what the support needs are.
 - 2nd column: if the supports are not yet in place, developing an initial plan for addressing (this is where a lot of the first transition planning meeting conversation will be reflected).
 - 3rd column: Mapping out the finalized plan. Sometimes, this is known early in the transition planning process and can be included after the first meeting. Often, it is only finalized after transition coordination work occurs and can be finalized after the final transition coordination meeting. This column should represent what the **final arrangements actually are**.
- When in doubt how to best complete the transition plan, let your common sense be your guide and ask for help from MFP staff.
- This tool can help guide and support the plan of care development process.

Using Your Own Planning Tool

If you would like to use your own tool, you may do so, but it must reflect planning in the following domains.

- Housing
- Medical Supports
- Adaptive Equipment (as applicable)
- Mental Health/Behavioral Support needs (as applicable)
- Health and Safety considerations
- Financial Management and Planning
- Transportation
- Community Involvement (mitigating loneliness and isolation)
- Education (as applicable)
- Staff Selection and Training
- How natural support networks will be supported.
- Contingency planning for: family fatigue, staff "no shows," service disruption, medical emergencies

SECTION SIX

Transition Year Stability Resources

A Description of Transition Year Stability Funds

Transition Year Stability Funds (TYSR) is “start up” funding to assist individuals is transitioning home with supports needed.

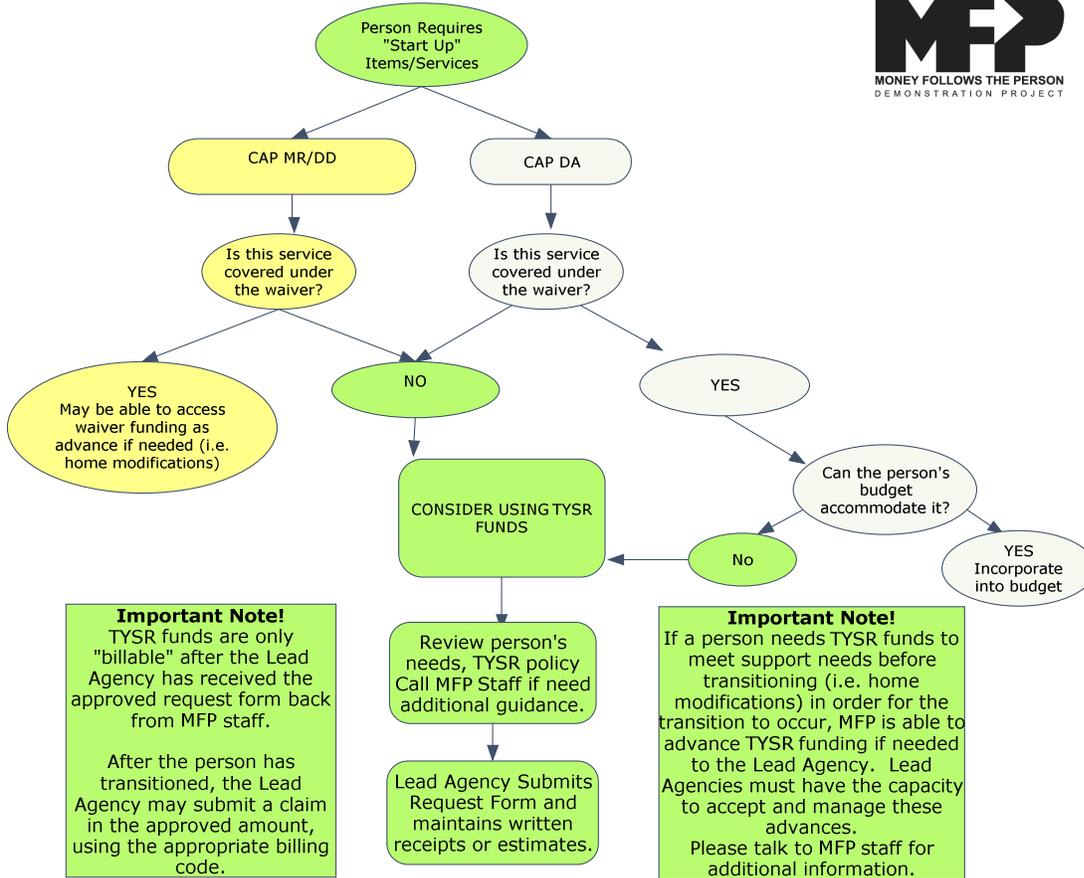
For a complete description of the TYSR fund’s scope and purpose, please review North Carolina Money Follows the Person *Operational Protocol*, 2nd Ed.

Transition coordinators are responsible for coordinating the identified needs and are encouraged to construe these support needs broadly, to include staff overlap for pre-transition training and additional therapy consultations as needed. Additional case management funding for complex transitions may be available through the TYSR funding. All requests are reviewed individually and authorized on a case by case basis.

IMPORTANT POINT

- For TYSR resources to be available for CAP-DA participants, the person’s budget must be largely needed to meet ongoing support needs. If this is the case, TYSR resources are **excluded** from the CAP-DA budget.
- Transition Coordinators organize the requests in coordination with the participant and transition team.
- Resources may be submitted before or after the transition occurs.
- See flowchart for additional information.

NC MFP Transition Year Stability Fund Flowchart
May, 2011



SECTION SEVEN

The Quality of Life Survey

What is a Quality of Life Survey?

As a condition of participation in the Money Follows the Person Demonstration Initiative, states are expected to conduct Quality of Life surveys with every MFP participant. Survey data are aggregated at the federal level to assess trends in the quality of life of MFP participants over time.

Each MFP participant participates in three surveys:

1. Prior to transitioning out of the qualified facility
2. Eleven months after transitioning
3. Twenty four months after transitioning

Participation in the survey is completely voluntary and does not impact the participant's ability to transition under MFP.

The Transition Coordinator's Role in Quality of Life Survey

MFP Transition Coordinators are responsible for:

- receiving training from MFP staff about the survey prior to conducting the survey
- conducting the initial survey
- submitting the hardcopy to the MFP staff

SECTION EIGHT

Final Transition Responsibilities

Meeting with MFP Staff Before Transition Occurs

Before the participant transitions, transition coordinators and MFP staff will have a final phone conversation to answer any last minute questions and to identify any final unfinished business that needs to occur before the transition can occur.

Participating in “Moving Day”

Transition coordinators are encouraged to participate in moving day activities, celebrate the event. Transition coordinators must be available by phone to answer any last minute questions or help address unexpected issues.

Because a person may serve as both case managers and transition coordinators, an MFP participant is anticipated to experience a greater degree of continuity. After the participant transitions, the role of transition coordinator is largely complete.

Follow Along after the Transition

:Lead Agencies shall:

- Notify MFP staff that transition has occurred
- Notify MFP staff of any critical incidents or if the participant is reinstitutionalized during the participant’s MFP year.

Ongoing Learning

We are constantly looking for ways to get better at what we do. Transition coordinators are strongly encouraged to participate in the NC Money Follows the Person *Transition Learning Series*, a series of monthly conference calls that will provide coordinators an opportunity to learn from other coordinators and receive information on topics relevant to transition coordination and building strong, inclusive communities.

SECTION NINE

Billing for Transition Coordination Services

Billing for Successful Transition Efforts

The Lead Agency will be reimbursed a flat rate of \$2,000.00 for each successful transition performed by a case manager authorized by the Lead Agency to provide this service and who has met the transition coordination criteria outlined in this Handbook..

The Final Transition Checklist both indicates that the core functions of the transition coordination service have been completed and serves as the Lead Agency's authorization to bill for services provided.

The Final Transition Checklist and current billing instructions are available online at: www.mfp.ncdhs.gov under "Transition Coordination Services and Materials"

Steps for Submitting the Transition Coordination Checklist:

- Person Transitions
- Lead Agency submits to MFP:
 - MFP Final Transition Checklist after the participant's CAP indicator has been entered in the EIS system.
 - Completed Quality of Life Survey
 - Final Transition Plan
- MFP reviews, enters relevant data and adds MF identifier to CAP indicator.
- If all transition steps have been met, MFP staff approves Final Transition Checklist and returns signed copy to the Lead Agency.
- Lead Agency should wait 24 hours for "MF identifier" to take effect and then may bill for Transition Coordination Services.
- For additional guidance on submitting a claim, including billing claim, please see the most current guidance on the Project's website under Transition Coordination materials.

Important Point: Only Lead Agencies and DVR-IL are authorized to bill for MFP transition coordination services. MFP expects that transition coordination funds be forwarded to the appropriate case management entity for services rendered.

Transition Efforts that Do Not Result in A Transition:

Under NC MFP, a participant is considered "transitioned" once s/he is discharged from the facility and has moved into his/her "qualified residence."

Occasionally, the transition process does not result in the participant transitioning (a person dies before transitioning, etc.). In these cases, the Project may reimburse the Lead Agency a prorated rate up to \$1,000.00 for services rendered by the transition coordinator. Transition coordinators will be required to provide written documentation outlining the reason the transition will not occur and transition coordination activities performed.

Importantly, transition efforts that do not result in an actual transition compromise the participant's ability to transition under MFP in the future. A transition effort that does not result in a transition should be limited to times when circumstances fundamentally change during the course of the transition, not simply because the transition process is more difficult than expected.

For a reimbursement chart for failed transitions, please see Appendix A of this Handbook.

SECTION TEN

Frequently Asked Questions

When does CAP-DA case management get involved when DVR is conducting transition coordination?

CAP DA Lead Agencies have told the Project that it's helpful for the case manager to have a "heads up" that a transition may be occurring. As a result,

- MFP will provide Lead Agencies with a signed copy of the referral form once approved.
- Transition coordinators will invite case managers to participate in initial planning meeting. The case manager's participation may be informal (by phone).
- Importantly, under our current Project structure, CAP-DA case managers have ultimate determination of MFP eligibility, though MFP participants may formally appeal the decision of CAP-DA determines an MFP participant is ineligible, following regular Medicaid appeals protocols.

What if I Don't Think a Person Can Transition Safely?

- Importantly, just because a transition may be challenging doesn't mean it can't be done.
- Transition coordinators are expected to guide others in showing how community living can work for the person, including exploring assistive technology and natural support options.
- Transition coordination may take longer because resources are not yet available (i.e. housing) but do not necessarily end.
- A transition coordinator may withdraw from services if s/he feels s/he can no longer participate and must inform the appropriate Lead Agency and MFP staff of his/her intent to do so.
- CAP-DA case managers make the final determination of whether an MFP participant will utilize CAP-DA. MFP participants can appeal this determination, following applicable Medicaid appeals procedures.
- MFP staff will work with the participant, transition planning team members and Lead Agencies to determine if a participant becomes ineligible for MFP for health and safety reasons.

What if Families are Opposed to the Transition, What Do I Do?*

Family support is often (but not always) critical to ensuring a transition is successful. Transition coordinators are encouraged to engage families in the process and ask for guidance from the Lead Agency or MFP as needed. While each situation is different, asking the questions below may be useful.

- Is the family member the person's guardian?
 - If yes, the guardian's wishes must be considered, but transition coordinators are encouraged to learn why the guardian opposes the

transition. The reasons may be adequately addressed through the transition planning process.

- If no, transition coordinators are encouraged to engage families in the discussion, but if the participant has the capacity to make his/her own decisions, those decisions guide the process.
- Is the participant relying on the family to provide support and assistance?
 - If yes, the transition coordinator needs to support the participant in having dialogue with his/her family to develop mutually acceptable solutions. The transition coordinator and family members need to be very clear with the participant about the role the family will or will not play.
 - If no, does the person need natural support assistance?
 - If yes, the transition coordination can assist the participant in identifying other support networks and in developing safety plans as appropriate.
 - If no, the transition coordinator can support a person to develop safety plans.

If our agency provides transition coordination services, how many transitions are we required to handle at one time?

- We anticipate that, over time, transition coordination will become an activity that Lead Agencies have an increasing capacity to provide.
- The Lead Agency determines its day-to-day capacity to provide transition coordination services that are responsive, well-paced, thoughtful and organized.
- While MFP staff will look for ways to increase and encourage local capacity building, the Lead Agency makes the final determination about how many transitions it can accommodate at any given time.

Appendix A:

MFP Administrative Reimbursement Rates for Transition Coordination Services if a Participant Dies or Decides Not to Transition

Milestone	Reimbursement	Running Total			Notes
Transition planning meeting has occurred	\$100.00	\$100.00			
Initial plan has been submitted to MFP	\$50.00		\$150.00		
Person dies or person/family changes mind during transition period but before final transition planning meeting	\$450.00			\$600.00	Between the 2 planning meetings is where the bulk of the transition coordination work occurs (housing, etc.)
Person dies or person/family changes mind after final transition meeting but before transition occurs.	\$400.00			\$1000.00	
Additional Notes:					
*All transition work that does not result in transition is eligible for 50% administrative match rate.					
* Please see MFP Transition Coordination Handbook for requirements and parameters for accessing these resources					