

**The MFP Roundtable  
Meeting Notes - Statesville  
August 26, 2010**

“Don’t rush, don’t stop...”  
--wise words from the last Roundtable meeting

**Participants:**

|   |  |
|---|--|
| Jesse Smathers, Western Highlands LME   | Linda Kendall Fields, Facilitator  |
| Jeanine Moran, Joy A. Shabazz CIL   | Nichole Watson, Surry County Senior Services                                   |
| Jacinta Johnson, Community Alternatives of NC                                 | Jen Branham, Western Highlands LME   |
| Trish Farnham, DMA  | Gene Clodfelter, Family Member   |
| Natarsa Patillo, DMA  | Martha Clodfelter, Family Member   |
| Vivian Leon, DSOHF  | Debra Caudle, Surry CRC  |
| Judy Taylor, Team Daniel  | Jill Rushing, DD Council   |
| Annaliese Dolph, DRNC   | Gayla Woody, Centralina AAA  |
| Michelle Harvey, Community Alternatives of NC                                 | Tracy Colvard, Assn. for Home and Hospice Care                                 |
| Pam Davis, Team Daniel  | David Taylor, DD Council   |
| Kay Zwan, disAbility Resource Center CIL                                      | Kim Johnson, PTCOG – Area Agency on Aging                                      |
| Bob Rickelman, UNCC and Chair of the NC Council on Developmental Disabilities | Representative from Community Alternatives in Wilkes Co. (signature illegible) |
| Ed Walsh, RHA Howells   | Jeff Payne, Center Point   |
|   | Janet Breeding, GHA Inc  |

**Welcome and Introductions** – Participants were welcomed to the third MFP Roundtable, held at the Iredell Library in Statesville.

**Really, really brief recap....**

- Objectives/benchmarks – quick review by Trish Farnham of project objectives, MFP timeline extension to support services to 2019 and invitation to think about shifting the benchmark numbers for each target population (i.e. People with developmental disabilities; People with physical disabilities and the Senior population).

- Our recent Roundtable conversations – Linda KF reviewed the past Roundtable meeting notes from Raleigh in February, 2010 and Wilmington in May, 2010 in order to bring everyone up-to-date on the process and create continuity with the focus of today’s meeting.

**Successes! (What is going well?) – from group discussion**

- ICF internal focus on MFP (DD Centers)
- Tracking transition planning
- Monthly calls with “Local Management Entities” re: MFP
- Identifying specific barriers-strategies
- Staff working with/connecting with person transitioning out.
- Hope that staff can work in community too.
- Bringing people together.
- ICF/MR providers – increasing awareness – taking the lead in “how to figure this out”
- Working with families (fear of risk)
- Mother’s perspective – community has accepted/welcomed daughter
- Shift in regard for MFP (provider perspective)

**The Work Before Us...**

**Objective 1: Increase the Use of Home and Community-Based, Rather than Institutional, Long-Term Care Services**

**Housing Update:**

- Over 2000 “NED” vouchers applied for – find out how many awarded in October, 2010
- MFP possibly supporting workshops to educate consumers re: vouchers – Housing Authority needs info/ed about people w/disabilities.
- Working Committee working on HUD grant apps. For non-MFP participants.
- Home Ownership Process Experts: David Taylor and Judy.

**CRC & MDS 3.0, Section Q Update:**

- CRC – Community Resource Connections. CRCs are a Collaboration of providers – “No Wrong Door Model” “Service Hospitality Network”

- MDS 3.0, Section Q refers to “Minimum Data Set,” used as an assessment tool in nursing facilities. Beginning October, 2010, persons residing in a nursing home will be asked if they are interested in learning about community resources. If they answer “yes”, the “Local Contact Agency” in the appropriate county will be asked to meet with the person to share community resource information. The CRCs that currently exist in North Carolina will play the initial role in meeting with the person and will then “hand off” to MFP and/or a transitions team for follow-up.
- More CRC info later...

**Transition Update:**

- 50 people transitioned
- New Transitions/Housing Specialist at Division of Vocational Rehabilitation. Looking for people in the fall – 3 coordinators across the state – focus on people with physical disabilities.

**Objective 2: Eliminating Barriers or Mechanisms, Whether in the State Law, the State Medicaid Plan, the State Budget, or Otherwise, Which Prevent or Restrict the Flexible Use of Medicaid Funds to Enable Medicaid-Eligible Individuals to Receive Support for Appropriate and Necessary Long-Term Services in the Settings of their Choice.**

**Update on Changes to Operational Protocols**

- Trish will send information about all changes listed below via e-mail:
  - Removing Piedmont exclusion
  - Removing specialty unit exclusion
  - Transition year start up resources
  - Transition coordination
- Work has begun/is underway to eliminate 5600 Licensure barriers to people living in their own homes.
- Need group to discuss/think through MFP & Mental Health  
\*\*\* EMAIL TRISH if interested

**Objective 3: Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term**

care services to eligible individuals who choose to transition from an institution to a community setting

### **Updates and Discussion:**

- “Seeing Is Believing” ICF/MR strategies for transition. Educating Families and Staff; budget considerations; from 3 to 8 providers currently involved.
- MFP support ICF providers to convert to community-based.
- Meeting/Dialogue at Riddle Center - want to meet again.

**Objective 4:** Ensure strategies and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement of such services.

**Lessons Learned: “I didn’t know what I was getting into...”**

\*\*\*Four people transitioned into community and have returned.

### ***ISSUES***

- Insufficient support for family
- Medical Issues
- One Proposed Solution/Option from Roundtable: PACE (for younger people w/disabilities)

### **Roundtable discussion: Framework for evaluation when transition does not work**

1. Systems
  - a. What was in place, what was not.
  - b. Menu of Services: Housing - Transportation
2. Orientation for Consumer/Family/Caregiver
  - a. Training
  - b. Micro-board – Formal/Structured group overseeing financing/other services of Village
3. What constitutes an Effective Transition?
4. Get to the “Quality” of the project through the consumers quality of life assessment.
  - a. Family’s perspective too

5. One night out – how person describes experience – make changes before permanent. “Shop for New Home”
  - a. Flexible timeline
  - b. Use ICF & leave time to experience community living.
6. Support team quickly following up with person (team) after move.
  - a. First 30 days.
  - b. At One Week - Peer Support
  - c. Six Months
7. Develop micro-board within an MFP community – not provider vested in the outcome. Connect with individual's micro-board.
  - a. Look up Tennessee Micro-board Assn.
  - b. Quality of Life Findings – Intern
8. Add “Option B” to Transition plan.
  - a. Where can a person go if this doesn't work?
  - b. Back-up care.

### **How are most recent Medicaid rate cuts affecting people?**

- ICF/MF Staff transitioning without funding.
- Less hours for consumers
- Fear of more cuts in future
- Must fill beds quickly & “Fall Back” for consumer in community disappearing
- From hourly to “Event” Reimbursement

### **Transition Projections**

Why lower numbers in physical disability population?

- At six months, needing to build a lot of support
- Not enough CAP funds, especially after using \$ on medical equipment.

\*\*\*Wait until October to reconfigure projections.

WHY?

- Know about housing vouchers
- VRILRP Coordinators in place?

Is there flexibility between the 3 waived programs? (more discussion here at a later meeting)

- Easier to meet benchmarks in I-DD with specialty units.
- Could Piedmont numbers apply retroactively?
- Need to coordinate housing/CAPDA timing > Upfront Expenses

Outcome:

- Make more informed choices in October – Reconfigure after reviewing landscape.

### **Systems Updates:**

Within MFP:

- Referral Processes to better track deductible status, etc.
- Administrative fronting: working to address challenges
- MDS 3.0, Section Q – discussed earlier – “1-800 Transition Hotline” to be operational October 1, 2010.
- Increased Collaboration with CRC Network
  - Local CRCs
  - MDS 3.0
  - Grant submission (Outreach) – results known by the end of September

### **For Next Time:**

- Format and Discussion – interest in involving key state policy-makers at MFP Roundtable meeting
- Date – **Friday, November 12, 2010 – time to be determined**
- Location – **Raleigh/Durham – AARP room**
- Topics to Include:
  - Rebalancing Fund – “money talk”