

Managing Transitions with Adults with Disabilities

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March 28, 2018

The 2018 Disability-Competent Care Webinar Series: Managing Transitions with Adults with Disabilities



Webinar Overview

- The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to develop the 2018 Disability-Competent Care webinar series. This is the sixth webinar in the series.
- This webinar series builds on the 2017 Disability-Competent Care webinar series, that introduced the model of care and its seven foundational pillars. To view this series, please visit:

https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2017_DC_C_Webinar_Series/Series_Overview

- Each session will be interactive (e.g., polls and interactive chat functions), with 45 minutes of presenter-led discussion, followed by 15 minutes of presenter and participant discussions.
- Video replay and slide presentation are available after each session at:

<https://www.resourcesforintegratedcare.com>

Continuing Education Accreditation

- The Centers for Medicare & Medicaid Services is accredited by the International Association for Continuing Education and Training (IACET) for Continuing Education Units (CEU) and by the Accreditation Council for Continuing Medical Education (ACCME) for Continuing Medical Education (CME, AMA PRA Category 1 credit for physicians and non-physicians).

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- Complete the post-test through CMS' Learning Management System and score a 80 percent or higher by midnight April 16, 2018.
- https://resourcesforintegratedcare.com/sites/default/files/DC_CWebinar6_CMSCECreditGuide_Pre_Webinar.pdf

Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.
- To learn more about current efforts and resources, visit Resources for Integrated Care at:
<https://www.resourcesforintegratedcare.com>

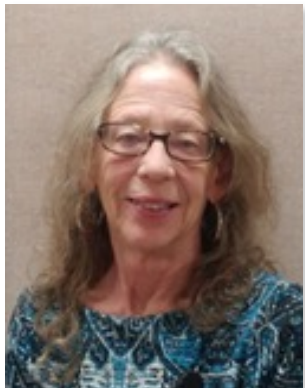
Introductions



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Webinar Learning Objectives

This webinar will emphasize:

- The scope of transitions in health care settings and how the disability-competent care model addresses transitions
- Challenges and barriers to successful transitions as faced by dually eligible beneficiaries and participants with disabilities
- Community partnerships and provider strategies for successful transitions from institutions back into the community

Agenda

- Understanding Transitions
- CMS Money Follows the Person (MFP) Demonstration Program
- The Texas MFP Program: Building Partnerships
- Delivering Transition Services
- Audience Questions

Understanding Transitions



Christopher Duff
Disability Practice and
Policy Consultant

Defining Transitions

- In the disability-competent care (DCC) model, transitions are referred to as a change within the participant's life that can affect their care. A transition can also affect the participant's ability to function in the community.
- Transitions include changes in:
 - Care settings
 - Providers and care partners
 - Medications
 - Financial situations
 - Housing
 - Employment status

Transitions within the DCC Model

- In the DCC model, transitions are a primary focus of the interdisciplinary team (IDT):
 - All transitions require attentiveness by the IDT to oversee the change and ensure the safety of the participant and success of the transition.
 - The IDT is responsible for developing and implementing the transition plan and should ensure that all aspects of the transition, including setting up supports in a new setting, are addressed.
 - The IDT should ensure all care transitions are well-documented and should follow up to address any unanticipated needs.

Transitions and Participants with Disabilities

- Health disparities and social determinants of health can impact the frequency and complexity of participant transitions. Individuals with disabilities are less likely to:^{1,2}
 - Receive comprehensive preventive care, including health screening tests
 - Receive recommended care (due to socioeconomic barriers and industry biases)
- Dually eligible participants with disabilities generally encounter:
 - Greater occurrences of unpredictable health care needs (e.g. hospitalizations)
 - Increased pressures within the health care delivery system that result in short term placements (e.g. reduced inpatient stays)
 - Numerous changes in individual care and support needs (e.g. progression of disability)
 - Restricted housing availability (e.g. financially and physically accessible)
 - Limited availability and consistency of resources (e.g. care partners, transportation and health care supports)

Sources: 1) Office of the Assistant Secretary for Planning and Evaluation. (2016).

2) Disability and Health. Healthy People 2020.

Social Determinants and their Impact on Transitions

- For dually eligible beneficiaries and participants with disabilities, factors such as limited finances, transportation requirements, and care partner availability may result in fewer options during transitions.
 - Participants with disabilities often rely on multiple services and supports and are required to navigate complex, segmented delivery systems for health care and home and community-based services.
 - Dually eligible beneficiaries generally have limited incomes, lower socio-economic status, and poorer health outcomes. This can result in limited opportunities to participate in the community and overall isolation. Assisted living settings can also be inaccessible financially.
 - Multiple funding sources and regulations for services, including limited selection of providers, can result in difficulties understanding and navigating health care and support services programs.

Assessing Your Ability to Meet Transition Needs

- The Disability-Competent Care Self-Assessment Tool (DCCAT) helps health plans and health systems evaluate their present ability to meet the needs of adults with functional limitations and to identify strategic opportunities for improvement. Evaluating your ability to perform care transitions includes answering questions such as:
 - Is a transition plan developed and implemented for all significant participant changes?
 - Assign one person to follow up and ensure success of the transition.
 - Are there protocols to assist IDT members in managing key types of transitions?
 - Provide protocols for different types of transitions and use a checklist of actions.
 - Are peer support and counseling services available to participants considering or undertaking a care transition process?
 - Provide information on for these services including local centers for independent living and transitions counseling offices.

To access the DCCAT, please visit:

https://www.resourcesforintegratedcare.com/physical_disability/dcc/tools/self_assessment

Transitioning from Institutions

- The Olmstead decision (1999) upheld the integration mandate of the Americans with Disabilities Act (ADA) requiring public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."³
- Transitioning from an institution to the community is the most challenging of transitions. Currently, 2.2 million individuals on Medicaid reside in institutions.⁴
- Participant accountability and engagement are key components for achieving care goals. However, being institutionalized can lead to a loss of independence and can limit the accountability and engagement a participant feels. Transitioning from an institution back into the community is therefore important to achieving the participant's care goals.

Sources: 3) The Center for an Accessible Society; June 22, 1999.

4) Medicare Payment Advisory Commission (MedPAC); January 2018.

Transitioning from Institutions

- A successful transition back into the community goes beyond relocation; it includes establishing services and supports for the participant to meet their needs:
 - Engagement and education to establish successful transitions is required of all involved parties, including participants, family members and care partners, providers, and community-based supports.
 - Partnering with community resources to meet the participant's needs can decrease social isolation and ultimately improve health and quality of life.

CMS Money Follows The Person (MFP) Demonstration Program



Todd Wilson

Team Lead, Money Follows the Person, CMS Division of Community Systems Transformation



Money Follows the Person

- The CMS Money Follows the Person (MFP) Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems. The program reflects a growing consensus that long-term supports shift from an institutional to a person-centered, community-based model.
- MFP objectives:
 - Increase the use of home and community-based services (HCBS), rather than institutional long-term care services and supports.
 - Eliminate barriers and mechanisms that may restrict the use of Medicaid funds to enable eligible individuals to receive long-term care services and supports in the setting of their choice.
 - Strengthen the ability of Medicaid programs to provide HCBS and support transitions to the community.
 - Ensure quality assurance and continuous quality improvement.

Population Served by MFP

- Dually eligible beneficiaries represent over 90 percent of the MFP eligible participants.⁵
- Over 75,151 people with chronic conditions and disabilities across 43 states and the District of Columbia have transitioned from institutions back into the community through MFP programs as of December 2016.⁶
- In 2015, the majority of participants who transitioned back into the community were under the age of 64 with physical disabilities (37 percent) or older adults (36 percent).⁶
- In 2016, this number increased to 40 percent.⁶
 - Other participants included older adults (36 percent), individuals with intellectual and development disabilities (ID/DD) (12 percent) and individuals with mental illness (9 percent).⁶

Source: 5) Mathematica Policy Research Report; May 11, 2017.

6) Mathematica Policy Research Report; June 15, 2016.

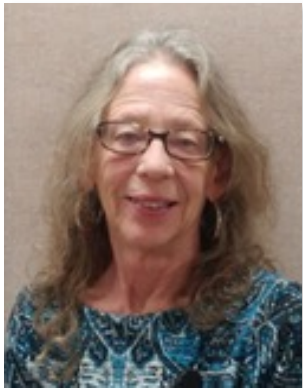
Transitions to the Community

- Most MFP participants transition to their home or one owned by a family member (38 percent) or an apartment (40 percent).
 - 14 percent moved to a small group home (4 or fewer people).
 - 7 percent moved to an apartment in a qualified assisted-living facility.
- Younger adults with physical disabilities who transition from institutions tend to move to apartments (48 percent).

MFP Participant Outcomes

- Participants reported large and sustained improvements in quality of life after moving to the community:
 - Satisfaction with their living arrangements increased from 62 percent while in institutional care to 91 percent one year post-transition
- Participants reported substantial improvements in choice and control over daily activities, such as when and what to eat and the ability to get needed sleep.
- Participants reported increased community integration and engagement across several domains after transitioning into the community.
 - Participants reported an increase in the ability to do “fun things” in the community, getting to places they needed to go, not missing events due to lack of transportation, and being able to do things they wanted to do outside of the facility/home.

The Texas MFP Program: Building Partnerships



Elizabeth Jones

Money Follows the Person
Project Director, Texas Health
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TEXAS
Health and Human
Services

Texas MFP Demonstration

- As of December 2017, the Texas MFP program has transitioned 12,533 participants from institutions into the community.
- Close to 10,000 of these participants are dually eligible beneficiaries and about 5,000 participants have physical disabilities.
- Target population in Texas:
 - Older adults (generally 65 years and older)
 - Individuals with physical disabilities
 - Individuals with an intellectual or developmental disability (I/DD)

Texas MFP Demonstration

- Texas developed its MFP program on an existing system of services and supports that promote the following principles among participants:
 - Independence and productivity
 - Meaningful opportunities for a person with a disability to live in the most appropriate care setting
 - Individual choice
 - Person-centered planning and practices
- To achieve successful transitions and promote these principles, the Texas MFP model's multifaceted infrastructure includes the following services and components:
 - Transition assistance – household setup in the community
 - Community transition teams
 - Transition contractors

Transition Challenges Faced by Participants

- The MFP demonstration was established to address the following short falls, gaps, and challenges experienced by participants.
 - Availability of physically accessible housing
 - Financial support / assistance for household setup (e.g., required deposit, pest eradication)
 - Obtaining necessary government identification
 - Transportation for accessing the community
 - Addressing participant fears
 - Accessing financial assistance (e.g., SNAP)

Transition Assistance Services

Transition assistance is a one-time grant of up to \$2,500 to assist an individual in setting up a household in the community

- A Medicaid service authorized on the individual's service plan
- Allowable expenses are those necessary to enable individuals to establish basic households and include:
 - Security deposits required to lease a home, including an apartment, or to establish utility services for the home;
 - Purchase essential furnishings for the home, including table, chairs, window blinds, eating utensils, and food preparation items;
 - Moving expenses required to move into or occupy the home, and
 - Services necessary to ensure the health and safety of the individual in the home, such as pest eradication, allergen control, or a one-time cleaning before occupancy.

Regional Community Transition Teams

- Community transition teams are public-private regional community resource coordinating groups who meet monthly to address individual and systematic barriers to community relocation (e.g. transportation, housing or financial).
 - Meetings led by the state and involve multiple MCOs
- Community transition team members include:
 - Health and human services commission staff
 - Relocation contractors
 - Health plan representatives
 - Housing specialists
 - Adult protective services
 - Providers

Community Partnerships

- Successful transitions depend on partnerships with community organizations.
- The Texas MFP program worked with the following independent contractors to identify individuals in institutions who wished to transition back to their communities:
 - Centers for Independent Living (CILs)
 - Area Agencies on Aging (AAAs)
 - Local transition and relocation specialists
- Independent contractors usually serve as the lead with addressing non-medical transition components.

Relocation Activities

- Guidelines for promoting successful transitions include:
 - Promote independence
 - Inform individuals of community options
 - Assess service needs and coordinate transitions
 - Provide training to staff on transitions and the promotion of independence philosophy
- Within the Texas MFP program, the community transition teams were tasked with:
 - Providing identification of and outreach to interested participants
 - Transition assessment and planning
 - Development and coordination of community supports
 - Navigation housing services and options
 - Post-transition follow-up with participants

Successful Integration Following Transitions

- Successful transition programs do not end once the participant is in their new setting. The transition process includes setting up services and supports that the participant relies on.
- To complete the participant's transition into a new setting, there is a heavy reliance on long-term services and supports (LTSS) and HCBS.
- Service coordinators assume responsibility for service planning for transitions of adults from institutions to the community.
 - Coordinators develop the individual plan of care for LTSS and acute care services.
 - The relocation specialist focuses on "non-medical" or community-based aspects of transitions, such as accessible housing.

Lessons Learned

- Administrative attention at all levels
 - State: attending to program developments; quarterly check-in calls with MCOs and relocation contractors; reviewing quarterly performance measures
 - Regional: identifying and determining systemic barriers
 - Local: ensuring service coordination is achieved through weekly meetings between the MCO and its relocation contractors to discuss cases and referrals
- Understand the key roles / differences between medical care coordinators and non-medical transition specialists
 - Provide trainings to MCO staff and relocation specialists
 - Prepare CBOs for partnering with MCOs

Lessons Learned

- Build relationships between managed care and community care organizations
 - Learn to understand and respect different cultures
 - Provide ongoing training to MCO staff and relocation specialists
 - Focus training on participant needs
 - Meet weekly with relocation contractors
 - Have a referral system in place
- Encourage community supports to work with participants to obtain goals
 - Reach out to local food banks and churches to support participant needs
 - Develop training for nursing facility staff regarding transitions

Delivering Transition Services



Doni Green

Director of Aging Programs,
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Council of Governments



North Central Texas Council of Governments

- The North Central Texas Council of Governments (NCTCOG) is a voluntary association of, by, and for local governments. It was established to assist local governments in planning for common needs, cooperating for mutual benefit, and coordinating for sound regional development.
- NCTCOG serves a 16-county region of North Central Texas, which is centered around the two urban centers of Dallas and Fort Worth.
- The NCTCOG:
 - Has provided transition and relocation services since 2007 to participants with physical disabilities and complex care needs
 - Is under contract with five MCOs (as of September 1, 2017) to provide transition and relocation services
 - Advocates for participants throughout the transition process

Preparing for Transitions: Assessment

- The transition/relocation specialist completes the psychosocial assessment prior to the transition to identify the participants' strengths, needs, preferences, and desires, as well as the types of supports that will be needed.
- This assessment captures:
 - Reasons for entering the nursing facility
 - Medical condition and professional care needs
 - Functional condition and personal care needs
 - Housing situation
 - Financial situation
 - Family supports
 - Transportation
 - Government and private supports needed and potential providers identified
 - Assistive technology
 - Complex service needs and barriers to transition and relocation
- A template for this assessment is available at:
https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2018_DC_C_Webinar_Series/Managing_Transitions

Preparing for Transitions: Person-Centered Plan

- Develop and implement a person-centered plan that focuses on the non-medical pieces to enable a successful transition. Assess the following:
 - Housing
 - Non-medical transportation
 - Money management
 - Access to providers and home and community-based services and supports
- The person-centered plan is developed in partnership with the participant to document steps for the transition, including:
 - Transition objectives
 - Participant's responsibilities
 - Transition/relocation specialist's responsibilities
 - A target date for each objective and a plan for following-up that includes frequency of contact
- A template for the person-centered plan is available at:
https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2018_DCC_Webinar_Series/Managing_Transitions

Post-Transition Follow-up

- Transition contractors are required to follow-up and serve the participant for 90 days post-transition. A follow-up occurs prior to closing the case.
- The main goals are:
 - To ensure that the participant is receiving the services that were initially authorized
 - To identify any new or previously overlooked barriers to be addressed

Addressing Transition Challenges

- Locate affordable, accessible, and integrated housing
 - Many states and MFP programs struggle with providing sufficient housing for their participants. The Texas Health and Human Services Commission developed partnerships with the state housing agency to dedicate Section 8 housing vouchers to MFP participants (restricted to nursing facility residents as the primary population and persons in state hospitals as the secondary population).
- Serve residents with complex needs, e.g., lack of housing, severe mental illness, I/DD, need for ventilator care, etc.
 - Partnerships with local organizations can help to meet these complex needs, such as home care agencies and DME providers. NCTCOG coordinated with local I/DD authorities to assist nursing facility residents with I/DD.
 - Develop a mental health crisis plan and resources for participants.

Transition Successes

- High volumes of successful transitions, despite targeting those with complex needs.
- Creation of robust systems of supports, including counseling for residents with Medicaid pending and on behavioral health demonstrations.
- Coordination with long-term care ombudsmen to:
 - Identify participants for transitions
 - Advocate for participants' rights to transition and provide assistance with involuntary discharges

Provider Strategies for Successful Transitions

- Establish monthly meetings with key stakeholders (e.g., relocation contractors, health plan representatives, housing specialists, LTSS providers) to collaborate on challenging transitions, identify resources, and resolve policy barriers.
- Educate the participant about using the Consumer Directed Service (CDS) option to leverage family support.
 - There are other states with similar options under self-directed Medicaid services where participants, or their representatives (if applicable), have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

Provider Strategies for Successful Transitions

- Consider overnight services
 - Overnight services accommodate participants with high acuity levels who live alone. The participants are able to pay attendants to be on standby and summon help for tasks, such as using the bathroom. This may be particularly practical in the first few months following the transition.
- Invest in behavioral health services
 - People with serious mental illness and substance use disorders experienced more barriers to successful transitions. Integrating mental health and substance abuse services with HCBS can improve transitions for this population.
 - The Texas behavioral health pilot provided Cognitive Adaptation Therapy to participants with severe mental illness, up to one year before and after transition.

Provider Strategies for Successful Transitions

- Conduct targeted outreach to facility residents with specific needs, e.g., participants utilizing ventilators
 - Health plan staff and providers can meet to discuss the barriers to independent living for these specific members and work to address them.
 - MCOs in Texas did this for participants in facilities who require ventilator care. Participants were contacted to assess their interest in transitioning. Only about 10 percent expressed interest and plans assisted those participants in pursuing transition.

Participant Experience: “Cowboy”

- Cowboy had cerebral palsy and suffered a stroke. He had been in a nursing facility for over six months when he requested transition services.
- Cowboy required assistance with all ADLs and lacked housing. He was willing to consider any housing options but was ineligible for assisted living, given his high acuity.
- The transition specialist found a manufactured home that had been foreclosed and helped Cowboy purchase it for \$1,000. The specialist assisted Cowboy in getting it modified for his electric scooter.
- Since the participant was unable to write or sign his name, the transition specialist found a volunteer money manager to support him.
- Cowboy referred to his transition as “breaking out of jail” and he quickly became reengaged in the community. He had been a gifted bowler before his stroke and enjoyed returning to the sport with the help of his attendant. Cowboy would “eye” the ball as instruction to the attendant, who threw the ball on his behalf.
- Cowboy called the relocation specialist each year on the anniversary of his transition.

Audience Questions



Next Webinar

Building Partnerships: Health Plans and Community- Based Organizations

Date: April 4, 2018

Time: 2:00pm-3:00pm ET

Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at:

<https://www.resourcesforintegratedcare.com>

where you can also find additional resources on the topic of Disability-Competent Care.

- For more information about obtaining CEUs via CMS' Learning Management System, please visit:
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Webinar Evaluation Form

- Please take a moment to complete a brief evaluation on the quality of the webinar. The survey will automatically appear on the screen approximately a minute after the conclusion of the presentation.

Send Us Your Feedback

Help us diversify our series content and address current Disability-Competent Care training needs – your input is essential!

Please contact us with your suggestions at

RIC@Lewin.com

What We'd Like from You:

- How best to target future Disability-Competent Care webinars to health care providers and plans involved in all levels of the health care delivery process
- Feedback on these topics as well as ideas for other topics to explore in webinars and additional resources related to Disability-Competent Care

Sources

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6. Mathematica Policy Research Report. "Money Follows the Person Demonstration: Overview of State Grantee Progress, January to December 2015". June 15, 2016.
 - <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/2015-cross-state-report.pdf>

Additional Resources

- Money Follows the Person Demonstration
 - <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html>