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HEALTH POLICY CENTER




Stakeholder Input Regarding the Sustainability of the MFP program

Presented to the Georgia Department of Community Health
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Georgia Health Policy Center

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Executive Summary

In October 2014, the Georgia Department of Community Health engaged the Georgia Health Policy Center to assist the organization in a systematic sustainability planning process that was inclusive of interested stakeholders. The goals of the sustainability planning process were to clarify the importance of the Money Follows the Person (MFP) Program and allow partners and stakeholders to make informed recommendations about its future.

Over several months, MFP staff and partners were able to:

- Identify the long-term impacts that will endure beyond the current funding period;
- Discuss project improvement opportunities; and,
- Clarify the roles and commitments of current partners and suggest additional agencies needed to ensure the project's long term sustainability and impact.

Planning Process Components

During the information planning process the stakeholders assessed and reflected on the continuing need for the program, project outcomes, sustained impact, and future program activities. The following sections summarize the key findings for each component.

Assess the Continuing Need*:* During a training conducted for Transition Coordinators and Regional DBHDD staff, the group was asked the following question to help establish a clear picture of the current need to make certain that the approach going forward would be relevant to the target populations given the community context: *Has the need [for which the MFP program was created to address] changed since the program was implemented?*

<u>Key Findings</u>

- An overwhelming majority of training participants asserted that the need still remains constant. Community members require the resources necessary to transition from institutional care settings back into the community.
- There was recognition that the population of individuals who have transitioned has included younger clients with severe behavioral health needs, which may need more or different services.

- The training participants suggested that the next iteration of services include more focus on ensuring that those who are transitioned back into the community have the resources and tools necessary to maintain long-term stability.

Review Project Outcomes: During this phase of sustainability planning, the Evaluation Team and the Transition Coordinators who participated in the training were able to reflect on how well the MFP program is meeting the need. Reviewing program evaluation data helped provide a picture of what has been accomplished and allowed them to take stock of the effect the program is having on the people it serves and the system as a whole. The following summary of responses helped to clarify the impacts the program has had to date and how effective and efficient the approach has been.

<u>Key Findings - MFP Successes</u>

- *Completed Transitions*: The stakeholders have successfully transitioned a high number of individuals from different target populations.
- *Improved Quality of Life*: The stakeholders considered the Quality of Life survey results, which indicate that quality of life is improved post-transition. In addition, program participants have a low likelihood of returning to an institutional setting after transition.
- *Increased Community Support*: The program has created an increase in community awareness and engagement from various community members (e.g. landlords, transportation providers, and home care agencies) to support transitions. In-person visits with nursing home staff and the MDSQ process have created a more collaborative network among facility and ADRC staff.
- *Multi-Sectoral Partnerships*: Various collaborating agencies have offered expertise and resources to support the successful transition of individuals back to the community. This has resulted in better cross-agency communication and strengthened relationships.
- *Staff Capacity*: Transition Coordinators and Options Counselors have the skills and expertise necessary to successfully fulfill their roles.
- *Diverse Service Mix*: Services offered through the MFP Program are varied in the types of support available and in the amount of funds allocated to each participant.
- *Cost Savings*: Stakeholders recognized the reduction in cost to Medicaid as a result of successful transitions from institutions to community settings.
- *Evaluation*: Having a statewide evaluation helped to demonstrate the program's value. The evaluation provided state-level data by target population, which allowed stakeholders to make meaningful program modifications in real time.

Key Findings - MFP Challenges and Opportunities for Improvement:

- *Policy Context:* A lack of flexibility within both the MFP program and Medicaid was identified by several participants. Examples included the Medicaid eligibility determination and conversion process, housing settings rules, and the reimbursement process.
- *Insufficient Community Services and Supports:* A lack of community mental health services, transportation, and housing opportunities were key areas cited as opportunities for improvement.
- *Infrastructure:* The collaborating agencies have different processes, protocols, and databases which lead to inefficiency, reduction of accuracy, and duplication of effort.
- *Circle of Support:* More focus on strengthening the "circle of support" is needed to provide participants with the backing and reinforcement needed from family and friends to be successful on their own, post-transition.
- *External Communication Strategy:* Establishing a statewide marketing and communication plan might increase education and awareness and provide an opportunity for MFP to share successes and demonstrate the program's value. This would ultimately facilitate a greater level of support by decision-makers and funding agencies.
- *Wait Time:* Stakeholders reported that some program participants experience long wait times due to program and community resources factors (e.g., shortage of Transition Coordinator, housing wait list).

Reflect on Sustained Impact*:* There was time set aside time for the Evaluation Team to discuss the program's long-term impacts that would sustain beyond the funding period. Almost all initiatives and collaborations leave some type of legacy or impact on a system or in the wider community, even when the direct services are not continued.

- Partnering agencies described new ways of serving that are now in place. A summary of their responses included: the provision of a community Ombudsman program and DBHDD and DAS continuing to work with institutional settings to identify residents who want to move out. In addition, new partnerships will continue such as those among the Centers for Independent Living, nursing homes, the Long Term Care Ombudsman, the division of Healthcare Facility Regulation, and the Community Care Service Program (CCSP).
- The group also described new capacities created that will remain after this funding period and a summary of their responses are as follows: the role, skills, and experiences of Options Counselors and Transition Coordinators; a person-centered philosophy and practice; respect for an individual's right to choice and independence; identification of employment and

volunteer opportunities; the development of resource networks; and, adding resources for transition services to the ADRCs' database.

- Changes in institutional, local, or state policy include some minor changes to the CCSP waiver; the integration of person-centered planning; structure that encourages rebalancing, standards related to transitions; and, managing the terms of the DOJ settlement.

Determine Next Iteration of Program Activities*:* Participants were separated into two groups, one focused on pre-transition activities and the other focused on post-transition activities. Each group was provided a chart detailing pre- and post- transition program activities, along with how each activity is accomplished and those responsible for implementation. Based on the identified successes and challenges, each group was asked to offer recommendations for program improvement.

<u>Opportunities for Program Improvement: Pre-Transition</u>

- Improve the identification process for determining program eligibility through increased communication among partner agencies.
- Streamline the Medicaid conversion process in order to improve the seamlessness of Medicaid coverage during transition.
- Build additional database categories and/or resources to make the housing search quicker and more thorough.
- Create a registry for reporting housing availability, modeled after the Massachusetts law, to more easily identify housing options.

<u>Opportunities for Program Improvement: Post-Transition</u>

- To facilitate program continuity, embed transition services into a waiver.
- Dedicate Medicaid eligibility staff to the MFP program to expedite the process.
- To shorten wait times, increase the number of case managers.
- Ensure there is an adequate circle of support to prevent re-institutionalization.
- Appoint one entity with the responsibility of managing sentinel event reporting and follow-up.
- Develop a communication and marketing strategy to increase community engagement.
- Develop a provider vendor team using the CCSP model to more easily identify quality vendors.
- Share access to human service data systems to enable retrieval of the most accurate and up-to-date participant contact information.
- Embed adaptive technology in waiver programs.
- Create and implement a strategy for engaging public-private partnerships to address the accessibility and availability of affordable housing.

Confirm current partner roles and brainstorm potential new partners: The group assessed the aspects of the partnership structure to determine what changes might be needed to achieve maximum efficiency and impact. The partners will provide program guidance and support and are key factors in the program's ultimate success. The following questions were posed to the group to guide discussion: What new partners will be needed to continue our program activities? Should current partners play a different role?

<u>New Partners</u>

- Mental Health
- Housing
- Transportation
- Office of Policy & Budget (OPB)
- Division of Families and Children Services (DFCS)
- Public Health
- Non-Profits (e.g. Nobis Works, Wounded Warriors)

<u>Existing Partners in New Roles</u>

- Aging & Disability Resource Connections (ADRCs)
- Community Based Alternatives for Youth (CBAY)
- Centers for Independent Living (CILs)

Evaluation Advisory Team, March 19, 2014

During the Evaluation Advisory Team meeting held on March 19, 2014 the participants discussed program sustainability with the following questions in mind:

- What are we going to do?
- Who will do it?
- How much does it cost?
- Where will the $ come from? What are the resources/legal structures?

The participants were asked to provide their thoughts on the successes and challenges/opportunities for improvement. The participants provided their ideas to the whole room and facilitators' documented their feedback on flip charts. The transcribed responses from the flip charts follow.

Successes:

- QoL appears to be higher post-transition
- Re-institutionalization rate is low
- Landlords / Community / provider engagement to support transitions
- Increased community awareness
- Diversion opportunity
- Technology (Harmony)
- Number of transitions (successful)
- Collaboration
- Focus on quality
- Multiple target populations
- Involving more support to transition individuals
- Transparency – Evaluation, Steering Committee, partnership w/ universities
- External Evaluator

MFP Challenges/Opportunities for improvement

- Separation of power/control between non-Medicaid & Medicaid for staff (i.e. no control over case management)
- First year, there's a dip QoL in some indicators. (What to focus on during Y1?)
- Rules & regulation assumed personal care prohibit living in more personal care settings (no provider network to support that model yet program enforces it)
- No infrastructure budget to help retain people in diversion programs.
- Help larger number of people who need a little less help or a smaller number of people who need the most help
- Lack of community mental health services.
- Need for more education through marketing
- Lack of manpower to transition individuals (transition coordinators, case managers…)
- Lack of housing opportunities

- Communication within agencies TC's and case managers
- Medicaid eligibility determination
- Medicaid structure is too rigid (need for a more fluid structure)
- Different agencies have a lot of different databases that are not always harmonious
- Circle of support. Many participants lack this support to be successful on their own (post transition)
- External communication telling the MFP story

Transition Coordinators & Regional DBHDD Staff Training, September 3, 2014

During a training of transition coordinators and some regional DBHDD staff, the participants were asked to discuss the need for MFP, the successes, and challenges related to the program. The participants worked individually, had group discussions, and provided their ideas to the whole room where the facilitator documented their feedback on flip charts. The transcribed responses from the individuals' handouts follow.

Has the need for the MFP program changed since the program was implemented? Yes or No
If yes, how?

- No. The need has not changed itself for the program. It has been needed for a long time, but not available.
- I think the need for the program has increased. The need for housing has increased. People see the value for the program and seek to transition consistently.
- Yes. It has added a lot of new services.
- Yes. Not enough group meetings/trainings for all TC's to share and learn best practices.
- No.
- Yes.
- Yes. More flexibility in how program addresses removal of transition barriers.
- The need remains –
- No.
- No.
- No. The need hasn't changed but the program has – we were flying a plane as it was being build, we have built the plane but we continue to improve it as it hasn't flown at the same altitude at times!
- Yes. Numbers have shown that the program is needed… and successful. Funding caps have been unreleased, providing for more services to ensure successful transitions and longevity in the community.
- No. There is still the need for help to transition to the community from a facility setting for residents.
- No.
- Yes. Initially, we were focused on transitioning with little attention to sustainability.
    - Master report spreadsheet eliminated.
    - Embraced person centered.
- No.
- Yes. The workload for one person has increased, very demanding and overwhelming.
- No?
- Yes. We are seeing more clients who are younger & having severe mental illnesses. With few mental health resources available and/or lack of knowledge on how to access these services, transitions have been challenging. Clients w/ substance abuse issues have also increased.

- Yes. As more people learn about the program → increase in # if folks wanting to transition out.
- No.
- Yes. The need has increased because more people realize that there is a chance now that they can get out of a nursing home and go back to the community.
- No.
- No.
- Yes. Yes, younger people are now being placed in NHs and do not have the resources and means to live independently or with family. There is now more awareness of the program and more are now interested since there are funds to assist.
- Yes. Due to current resources or lack thereof, the number of transitions are now limited.
- No. The need was always there. The program has just grown from people being educated on its existence.
- Yes. We know that NF beds are not being closed and we know that baby boomers are beginning to need LTSS. I think these 2 factors mean that the need for MFP (Transition Assistance) is & will continue to grow.
- No.
- Yes. The program's original basic goal was to move people out of facilities. Now, it needs to focus on moving those clients into the community & sustaining them there.
- Yes. Seems to be going in right direction for person centered flexible budgets but still need budget improvements.
- No. The need has not changed and I don't see the changing. However, the implementation process has and will continue to have to evolve, based on consumer need and available resources.
- Yes. Now that the outreach services are being provided in the community, more individuals are aware of the program. These individuals are knowledgeable of what the program entails.
- No.

What are the MFP program's successes?

- Successes to me are the vast amount of people that have used MFP & have made their own lives successful out in the community.
    - The growth of the program & the amount of new resources that can be purchased to extend the client's life – line in the community.
- The successes are providing medically complex individuals who have their resources the opportunity to reach their goal of living in the community.
- Helping to cut long term care costs getting people into their own independent living situations.
- All transitions.

- Providing clients with a voice to advocate for their needs outside of the nursing home. As well as providing a way out for those most in need of external support.
- Getting younger adults who are disabled out for a life-time.
    - Adapting houses after accidents to return people home.
    - Person centered.
- Number of transitions.
    - Documented improvement in quality of life.
- Successes are any of the many people whose quality of life has been improved- perceived or real. The person who is terminally ill yet who only wants to die at home with his family… the 86 year old woman who wants to "live on my own one more time before I die"… the 46 year old who suffered a stroke then got "stuck" in the nursing home… not to mention the financial savings to the state…
- Giving individuals a better quality of life outside the nursing home. Allowing families to be together.
- More people in the community.
    - More freedom of choice for people.
- Moving individuals from institutions to the community & keeping them there.
    - Giving individuals a second chance to live independently of institutional care in some instances.
- Success: transitions to the community (client)
    - greater sense of well-being (client)
    - Medicaid savings
- I recently had a client state that I helped him gain his life back. Can't get more successful than that!
- They are providing people with disabilities with more options and ways to maintain while being out of the nursing facility.
- Individuals are successfully living in the community.
    - Leading meaningful life
    - Focused on sustainability.
    - Changes to Appendix B.
    - More flexibility & computer database.
- The program has provided opportunities for individuals with absolutely no resources and/or support system to successfully transition to community living and, in the process, they changed their life.
    - The program is serving millions of dollars in Medicaid funds.
- Moving participants out of nursing homes and improving their quality of life. Away from desk!!
- Sustaining community.
- We have been able to transition & sustain people who truly need & want to be in the community.

- Proof that it is cheaper for the states to serve people in their homes & more satisfying for the person's life goals.
- The number of successful transitions back to the community now verses years before MFP.
- The successes are the people that move back into the community with loved ones that are capable of supporting them, even with some assistance. A success is also the person that can now live alone, with support.
- The joy that you see when consumer/client tells you that they are living their life again.
- Overall growth of MFP
- Any person that successfully transitions back to the community to live out their final days independently.
- Those that were being placed in a NH and are younger, now have a chance to transition.
- Raising awareness of community options vs NH.
    - Raising ADRC awareness of person centered work.
    - Giving people real options for community living.
    - Rebalancing HC.
- The successes of MFP are the people that have re-gained quality of life and a reason to live people who had given up and could see no hope. That is the success!
- Meets Olmstead vs.LC Mandate.
    - Ensures that PWDs Civil Rights are protected.
    - People don't want to live in N.F. so MFP is a way to help them live in their community.
- Giving someone the support to live on their own.
- MFP has identified the main financial and physical health barriers to people staying institutionalized & found ways to remove them.
- The ability to help or enable life changing events for individuals who are stuck inside facility.
    - The ability to let individuals get a "redo" of their life.
- The low attrition rate
    - The lower cost of care for independence v. institutionalization
    - The aspect of people once again having control over their lives.
- Transitioning individuals into the community with a positive support system to assist with maintaining an individual's independence.
- Saving money, changing quality of life for clients. Even clients that go back to nursing home are more content.

What are the MFP program's challenges/opportunities for improvement?

- Finding willing vendors for variety.
    - Challenges would be mostly in the transition resources of housing, transportation, etc.
    - Challenges would also be difficulty finding family/friends to help support clients out in the community.
- Utilization of some service categories & more transition coaches to facilitator more transitions.
- Help people to understand the need for certain services that are not being used properly or at all in some cases.
- Challenges: shared transitions
    - poor communication amongst community liaisons
    - poor knowledge of community resources.
- Working across disciplines & having all involved working towards the same goals with the same understanding of the program & capabilities within the program. Having other professionals understand how to work with MFP & not using it as a catchall.
    - Process & protocols for reimbursement.
- Not being able to bill until P/C (Home mods).
    - Transition of Medicaid – Huge!
    - Getting reimbursed.
    - Very bureaucratic & paper intensive without much admin money.
    - Dealing with constant changes.
- Sustainability after grant funds expanded.
    - Supporting individuals w/ significant mental health needs.
    - Integration of MFPs, 1915© waivers.
    - Provider capacity for waiver services as well as MFP transition services.
- Challenges are not to get discouraged when we can't keep someone out of the NH… Challenges we continue to face with affordable housing and transportation…
- Housing,
    - Medicaid conversion.
    - Getting all players on board with the program.
- Challenges are political buy in – and community buy in – judges, doctors, etc that make decisions to put people in long term care.
- Continue to organize, move money to vendors quicker, continue beyond 2016 and possibly 2020.
- Developing the Life Skills Coaching is key. Removing funding (individual) caps was a big step forward in supplying the needs of clients who transition.
- Paperwork! Need less paperwork and more time in the field. Helping MFP clients.
- Just communication with options, counselors and TC could be better.
- Payments to vendors on time.
    - Medicaid challenges ongoing.

    - DD referral process?
- Challenges: obtaining needed/necessary DME without “fighting” with Medicare/Medicaid.
    - Getting individuals to take (accept) responsibility.
    - HOUSING!!!
- Helping the client make use of the program in the most efficient way possible.
- *See question #1 in addition to housing, peer support services (lack of), & life skills coaching (lack of).
- Pipeline. More money to serve more people. We could transition more people each month with more money for additional transition coordinators. Limits to how much 1 transition coordinator can do. I wish some of the savings could go to increase staff $ to do transitions.
- Moving toward, Medicaid HCBs entitlement verses waiver. Then it can be on equal apt footing to nursing home Medicaid entitlement.
- Challenges involve being able to get everything the person needs in the limits of the program. Other challenges are limited resources in rural areas and clients that don’t count to help themselves. An opportunity for improvement would be to offer Peer Support and other services before they come out of the nursing home to give them an idea of what to expect when they get out of the nursing home.
- Housing- Challenge.
    - Realistic conversations and training to ensure that a consumer can and will live independently. These conversations offer improvement toward goal to transition out.
- Nursing home physicians who refuse to assist client in returning to the community, insist of client leaving AMA.
- Challenges – having referrals opportunities to allow those that feel like they have no way out of the NH, an open door along with resources and supports that will make them success.
- Demand exceeds resources, managing MFP pipeline of folks wanting to transition, MFP and challenge of working seamlessly to waiver programs, ability to transitions those whose needs exceeds wants available in community, limited resources and man power and $$.
- Balance true community inclusion with service/ program data/paperwork needs.
    - Still not person-centered enough.
    - Not enough staff to meet workload.
- The challenges are finding housing in the royal areas for people who have background issues that even date back 40 years ago.
- Sustain MFP past the end of the grant.
    - Rebalancing HTSS in favor of HCDS.
    - Reduce the % of participants that don’t complete the MFP year from 20% to 5%.
    - Spend more $ on MFP services.
    - Understand the real cost for transition of an individual to the community.

- Future funding??
    - Should program become part of state budget?
- It does not address the large portion of clients whose issues are based in mental health & addition.
- Need to evaluate the total budget with increasing costs in our society.
    - Need more housing for low income
    - Need transportation (cheap) in areas (rural)
- The way Medicaid conversions occur. This is an ongoing issue.
    - Agreement between ALL entities involved in transition that this is about personal choice, whether or not we agree.
    - Continued funding and need to develop stronger community partnerships to ensure better transitions.
- Medicaid Conversions
- Finding Housing

Evaluation Advisory Team, October 1, 2014

On October 1, 2014 during the Evaluation Team meeting the participants were asked to describe ways in which the MFP program would have a sustained impact. The participants listed their ideas in three categories: new ways of serving, new capacity created, and policy changes. The information provided by the participants is transcribed below.

New ways of serving: Describe how organizations will continue to collaborate to address relevant issues; system changes that have occurred, new processes or procedures that are now in place; changes in practice standards

- Community ombudsman
- DBHDD and DAS
- CILs
- Less costly/affordability
- Housing (HUD)
- LTC will continue to work with ADRC, OCs, and SNFs to identify residents who want to move home
- DAS and DCH will continue partnership to identify fund sources for NH transitions
- More Medicaid funds are needed to sustain individuals in institutions than community
- Makes fiscal sense to continue transitions individuals to communities
- New partnerships: CIL, NH, LTCO, HFR, CCSP
- New Procedures: Person-centered methods
- Organization collaboration: don't see practical application
- Collaboration between DBHDD, DAS, and DCH
- Changes to hospital transitions and education regarding MFP
- Cost—cheaper to live in community
- Increase amount per service in waiver to accommodate MFP demonstration services
- NH
- LTCO, HCO
- HFR
- DD → partner with CCSP
- HUD
- Legal Aid

New capacity created: Describe new skills people have obtained; resources that will remain following this grant

- OC
- TC
- Person-centered

- Independence
- Community living/sharing of stories, employment, volunteer/community asset
- Quality providers
- All will be more willing to help residents with complicated health needs
- More individuals moving to community increased demand for long term services
- Supports agencies and workers
- Advocating for people in community besides long-term care facility
- HCO brochures
- Stakeholders have developed collaborative opportunities and solutions
- TCs and OCs are trained on how to do the work
- Role of ADRC will continue
- Feeling of contribution to society
- Skills: self-management (employment, health, life skills)
- Resources: networks (contractors and other community partners)
- Transition coordinators/field staff trained on person-centered planning
- Participants gain knowledge on how to transition into the community with support
- Working on creating better functioning, aware, provider capacity to serve clients safely
- Families back together—youth are at home with families instead of in institutions
- Resource networks
- Employment Opportunity
- Transitional services added to ADRC

Policy changes: Describe any institutional, local, or state policy changes that have occurred from your efforts

- CMS and ACL: Person-Centered Planning, Rebalancing, Person-directed
- From Pilot programs to statewide HCO service
- Some NHs have understood the transition process is positive
- State policy changes with CCSP because of MFP
- Some minor changes in CCSP waiver
- Extending the MFP demonstration fund to soften impact on GA health care system
- Working on Medicaid Policy and standards of transitions
- DOJ settlement

Participants also completed a formative assessment and the results were presented at the December meeting.

Evaluation Advisory Team, December 10, 2014

Participants completed a formative assessment that provided them the opportunity to rate the program's progress and identify areas of opportunity using a four-point scale across nine elements: strategic vision, collaboration, leadership, relevance and practicality, evaluation/ ROI, communication, efficiency and effectiveness, capacity, and resource diversification. The results were presented during the December meeting.

Sustainability Formative Assessment Individual Responses

	Strategic Vision	Collaboration	Leadership	Communication	Evaluation and ROI	Capacity	Efficiency & Effectiveness	Relevance & Practicality	Resource Diversification
Participant A	2	1	4	4	3	3	3	1	4
Participant B	4	3	3	2	4	4	3	4	3
Participant C	2	3	2	2	3	3	3	2	1
Participant D	3	3	2	3	3	4	2	3	2
Participant E	2	3	2	3	3	3	3	3	3
Participant F	2	2	2	3	3	3	2	2	1
Participant G	2	2	2	1	3	2	2	2	1
Participant H	2	3	1	3	4	2	1	2	1
Participant I	3	2	2	2	3	3	3	3	1
Participant J	3	3	2	2	3	2	2	3	2
Participant K	2	2	3	2	2	3	3	3	2
Participant L	2	2	3	2	3	1	2	2	1
AVERAGE	***2.42***	***2.42***	***2.33***	***2.42***	***3.08***	***2.75***	***2.42***	***2.50***	***1.83***
Mode	***2***	***3***	***2***	***2***	***3***	***3***	***3***	***2***	***1***
Variance	***0.45***	***0.45***	***0.61***	***0.63***	***0.27***	***0.75***	***0.45***	***0.64***	***1.06***

Sustainability Formative Assessment Results, (Red represents the mode for each element)

	Pre-Awareness	Awareness	Interaction	Mastery
Strategic Vision				
Collaboration				
Leadership				
Relevance & Practicality				
Evaluation/ROI				
Communication				
Efficiency & Effectiveness				
Capacity				
Resource Diversification				

The participants were separated into two groups, one focused on pre-transition activities and the other focused on post-transition activities. The following charts were provided to provide a common ground to guide the groups.

MFP Pre-Transition

Program Area	How	Who
MFP Program Marketing	-Posters -Pamphlets/flyers -Collateral materials -1:1 meetings -Group presentations	-DCH -DAS -DBHDD
Identification of possible MFP participants	-Phone calls -Fax forms -MDSQ	-Self-referrals -Family/friend referrals -Health care and LTSS Providers -Options Counselors -DBHDD regional staff
Assessment and eligibility determination for MFP	-DBHDD forms -DAS/AAA forms -DCH forms -DFCS Medicaid eligibility -Electronic vs. paper	-DBHDD -DAS: Options Counselors & Transition Coordinators -DCH -DFCS
Transition individuals - Identification of housing -Provision of pre-transition services	-Housing search -Use of vouchers/HUD housing supports -10 pre-transition services	-HUD -Transition Coordinators -DBHDD regional staff -Contractors who provide services

DBHDD: Department of Behavioral Health & Developmental Disabilities
DAS: Division of Aging Services
DFCS: Department of Family & Children Services

MFP Post-Transition

Program Area	How	Who
Transition individuals -Provision of post-transition services	-8 post-transition services	-Transition Coordinators -DBHDD regional staff -Contractors who provide services
QoL Administration	-Mathematica survey administered over the phone and in-person -State-level analysis by GHPC -Submitted to Mathematica	-DBHDD regional staff -Transition Coordinators -GHPC staff
Identification and reporting of sentinel events	-Reports of incidents such as hospitalizations or reinstitutionalizations made to DCH	-Transition Coordinators -DBHDD regional staff

DBHDD: Department of Behavioral Health & Developmental Disabilities
DAS: Division of Aging Services
DFCS: Department of Family & Children Services
GHPC: Georgia Health Policy Center

The groups were asked to identify what is working well, what the challenges are, what solutions could be offered for the challenges, and if new partners were needed and/or if current partners could play different roles.

Pre-Transition

Working Well

- Referral using MDSQ
- Calling on nursing homes face-to-face
- MFP Marketing
- Identification of participant
- Assessment for eligibility
- Forms work well-changes as needed
- Development/training of OC & TC

CHALLENGES	SOLUTIONS
• ID of those who are eligible – requires research	• Better checks & balances at both DBHDD, CBAY - DAS
• Completing Forms – Who needs? • Due to separation of Medicaid – inst to home & community. IT Issue	• Need a way to streamline process of changing Medicaid status from inst to home & community
• Finding housing & searching. Lack of affordable housing	• Update data base in timely manner • Connection between age wise & GA Housing Search, HUD, others
• Waiting List for Housing	• Look at Mass law regarding reporting of available housing
• Transportation • Bad Nursing Home Referrals • Forcing people into nursing homes • Form conversion to Harmony – Reporting • Time from assessment to transition • Independent living training	

NEW EXISTING PARTNERS	ROLES
ADRC	Redefine their roles
CBAY	$ Must follow flexibility
CILs	Increased funding
More TCs	

Post-Transition

Working Well

- Participants happier
- Well educated TC role & works
- Participants have sense of independence
- Participants have a lot of personal engagement
- Diverse service mix (transition)
- Amount of services offered (vast majority of waiver)
- Case management waiver working well
- QoL easily understood & communicated
- Sentinel event reporting informative
- Cost of Medicaid rebalanced
- Move to aging network (DAS & Partners)
- Harmony database
- Incorporation of CILs

CHALLENGES	SOLUTIONS
• Services outside of waiver end 365 days	• Embed into waiver as much as possible
• Medicaid eligibility process	• Dedicated MFP/MAG case managers
• Amount of TC time to get a single individual out (>100 nvs)	1. Streamline the process 2. More case managers
• # people waiting to move out (pipe line)	• Diversion programs • Streamline process • Include TC services as part of the waiver
• Reinstitutionzed (NH + Hospitals)	• Through engagement process address delay in participant reporting • Circle of support
• Lack of community engagement	• Educate social support • Microboard engagement
• Identifying quality vendors	• Develop provider vendor teams (CCSP model)
• Finding 2nd Yr. QoL	• Pan access to human service data systems
• Current process of sentinel event reporting/lack of follow up	• One entity responsible who ensures transparency and that is connected to participant
• Lack of adaptive technology	• Embed in waiver
• Housing inventory accessibility affordability	• Engaging public, private, non-private at macro level

PARTNERS	ROLES

Mental Health Housing Transportation Budget Office (OPB) DFACs Public Health Non-Profits (Tommy Nobis, Wounded Warriors)	