**Strategies for the Implementation of Disability-Competent Care**
**Flexible Long-Term Services and Supports**
**June 17th, 2015 - Transcript**

Lia: Ladies and gentlemen, thank you for standing by. Welcome to the Strategies for the Implementation of Disability-Competent Care conference call. At this time, all participant lines are in a listen-only mode. Later, there will be an opportunity for your questions. Instructions will be given at that time. If you should require assistance, please press * then 0. I'd now like to turn the conference over to Chris Duff. Please go ahead.

Chris Duff: Thank you, Lia, appreciate it. On behalf of The Lewin Group, I would like to welcome you to the 7th 2015 webinar session on Flexible Long-Term Services and Supports. My name is Chris Duff and I am a disability practice and policy consultant working with The Lewin Group.

The Medicare and Medicaid Coordination Office at the Centers for Medicare & Medicaid Services has contracted with Lewin to develop technical assistance and actionable tools to support providers and their efforts to deliver a more integrated, coordinated care to Medicare, Medicaid enrollees.

First I'd like to introduce you to our platform for this presentation. If your slides are not advancing, press F5 on your computer keyboard. Also please note the icons at the bottom of the screen, the second icon from the right, allows you to download the slides for this presentation. The Q&A window is open next to your slides. Please enter any questions you have regarding the material and we look forward to discussing them during the Q&A portion of the presentation.

We have a Q&A feature though through which you can submit questions and comments at any time. We will be using instant polling to ask specific questions to help guide our presentation. To demonstrate the process, here is the first question. In what context do you interface with persons with disabilities? Please choose one of those and select it and we'll look at the results in just a minute.

We would like to solicit your comments and opinion on the entire series as well as this webinar and previous webinars as important resources. Please take the time to complete our survey at the end of this webinar and send us your ideas for future topics and content. Contact information is listed at the end of this presentation.

Why don't we look at the results of the first poll? So most people -- that's actually more than of the previous webinar are with health plans. Actually I'm very pleased to hear that because health plans are being asked to assume responsibility for LTSS which for the most plans in most states, it's something they haven't been asked to do before. So I'm really glad that the majority of our people here are with health plans.

This series has consisted of eight webinars concluding next Wednesday at this time. All the webinars will be recorded and available along with a PDF of the slides at this link, www.resourcesforintegratedcare.com, all one word.

In 2013, we published a comprehensive Disability-Competent Care Self-Assessment Tool describing disability-competent care in three pillars -- individualized care coordination provided by an interdisciplinary care team, redesigned primary care delivery and flexible long-term services and support. This is our third webinar series focusing on specific components of disability-competent care, resources from past webinar series as well as the Disability-Competent Care Assessment Tool itself are available on the website I just mentioned.

Today's webinar will be presented by Joe Groshens and Carol Ambers. Joe has 35-plus years in a variety of settings involved with disability. He founded Options for Independence in 2008 to be able to work with persons with disabilities in achieving their goals of community living. As Joe tells the story, it began when his grandmother was placed in a nursing home in 1970s. And he spent time visiting with her and the other residents. At that point he realized that things could be better for many of those individuals.

Since then he has worked as a physical therapy aide, as a program director in a senior center, as a social worker for three Minneapolis Public Housing Units in Minneapolis and other positions. His experience in housing courts, evictions and property management have taught him how complex and difficult the system is to navigate.

While overwhelmed with all that needs to be done, he has exciting and creative fiscally responsible options as we look forward to helping people navigate their way to a better future.

Carol Ambers has 20 years' experience in working with adults in the area of LTSS in a variety of roles. This included a very large area agency on aging, manager of an assisted living program of Volunteers of America and with Options for Independence. Together, along with their colleagues, Joe and Carol have successfully relocated over 900 persons from long-term care and other settings in the settings of their choice in the community.

Our last two webinars are focused on the third pillar of disability-competent care. One of the inherent presence of risk, one on the inherent presence of risk when enabling truly person-centered care and the other on the value of community participation and its role in the overall health and well-being of participants.

This webinar will build on those two webinars focusing on helping persons regardless of whether they have been disabled from birth and sheltered during their childhood and adolescence or have experienced the later onset of disability. In either situation, providers and family members have generally focused on health and stability with little attention nor support to helping them return to the community and creating a life for themselves.

Today, the presenters will demonstrate the value of LTSS in supporting persons in the community and the relocation and transition process through the use of first-person stories.

Historically, medical providers and health plans have had no incentives nor ability to influence community-based service and supports. LTSS services have existed in a silo, separate from the delivery or management of healthcare services and supports. Each silo had their own objectives and drivers resulting in barriers in achieving the right care at the right time in the right setting. Hospitals assess and stabilize individuals and then discharge them as soon thereafter as possible.

Meanwhile, primary care is structured to diagnose and treat episodes of illness with the assumption they will simply return to their previous life. Today, we will focus on LTSS services, specifically, transitional and relocation services. Next week, we will conclude this series and hear from a team who's been working to coordinate and manage care and services across these silos.

Traditionally, LTSS is seen as a range of Medicaid and Medicare services, ranging from skilled nursing and personal care assistants, home-delivered meals, home modification and others. These services are generally viewed as an optional alternative to institutional living and thus a cost-effective way to live in the community. If an individual qualifies for LTSS which is generally through a Medicaid waiver, they are eligible for the services as needed to support their function in the community.

I put this slide in to simply remind the participants, the viewers here of the concept of Maslow's hierarchy of needs which is based on the premise that foundational elements must be in place for an individual to achieve well-being and a life and community as they choose. The first base is health and then mobility and function must be addressed. Many examples of mobility are obvious such as canes and wheelchairs but they're also others such as home modifications or adaptive equipment.

All are focused on helping a person function in their home and community. Once these are in place, the individual may need to be provided additional support such as personal care assistants or transportation support. Relocation and transition services, the focus of today's presentation are charged with putting the pieces in place for the individuals so they can live their lives as they choose in their community.

To provide the presenters additional context, I'd like to ask another polling question. How much awareness do you have of LTSS services? If you could make a choice and submit, I'd appreciate it.

Relocation and transition services were initially developed in the 1970s when states began to close institutions for persons with IDDD or mental illness. This became a rallying call for the disability community culminating in the Olmstead decision from the US Supreme Court in 1999. This integration mandate as it is known is based on Title 2 of the American with Disabilities Act and calls for individuals with disabilities to be offered

the opportunity to live in the most integrated setting of their choice. Due to the lack of progress, President Obama issued a proclamation in 2009 intended to fashion an effective nationwide program to enforce the integration mandate. Public agencies across the country operationalized this mandate through relocation and transition services.

At this point, let's go back and review the last poll. So very few of you have lived with a disability yourself but there's actually more experience with -- as they provide a coordinator and navigator and that is anticipated. There's moderate awareness in 25% and 30 -- almost about a third of you have minimal awareness in any -- in your current role with LTSS services. So I think they will give the presenters a bit of a sense of your backgrounds.

So at this point, I would like to turn the presentation over to Joe.

Joe Groshens: Thanks, Chris. Hi, my name is Joe Groshens, and I'm the owner and founder of Options for Independence. Options for Independence is what we call a nursing home relocation or a transition agency. Our primary focus is to relocate people and institutions of certain types, mostly rehab facilities and skilled-nursing facilities, to relocate them back to the community. And my history, I've probably, as Chris said, been involved in almost 1,000 relocations between my 10 years as a country social worker with Hennepin and my seven-plus years of running the agency.

We currently have five staff that facilitate the process. We get our referrals from county agencies and new referrals and we're starting a new process to work with managed care agencies. Again, what we do is -- on books looks very complicated and with a lot of complicated terminology -- but the bottom line is we assist people in getting back to their real life. Sometimes institutionalization takes over when somebody has been in the facility a little too long.

So our goal is to meet the person and to meet their needs and to create plans and work with agencies, housing agencies, homecare services, government agencies and family and friends, and actually, the facility staff to relocate these people.

What we use is the process -- the Olmstead Act is to be all about individual's rights. So I'm going to hand it off to Carol and she's going to explain how we proceed with our assessment and implementation of plans focused on that whole idea of it being client-centered.

Carol Ambers: Thank you. Hi, my name is Carol Ambers. I have been working in relocation for about six years, previously assisted living. So, I have a great knowledge of assessing what the individual needs in the community and especially coming from nursing homes. The first step is we do a consult together, Joe and I, and we actually meet the person and we listen to their story. They have a life story. We want to find out where they came from and also where they would like to go. And so, the first visit is somewhat like a life story and we discuss options with them that would work for them in the

community and try to discuss what exactly they are looking for to move forward at this stage.

Joe Groshens: And as Carol says, our assessment, we continually realize that these people in this situation had been assessed several times in the last few months. And in order to start building that relationship with our client, we feel it's important to not take their temperature but to maybe ask where they're from. So our assessments tend to be a little more informal and are centered around the presentation that the client gives us. And then we actually have some basic questions we always ask and then we'll check with staff and read charts, those kinds of things.

Developing the plan, as I said and as Olmstead said, is all about client choice and client rights. When we meet the client, we are the agency that's been assigned because that client shows our agency to provide the relocation services. So we remind that client in our first visit that every choice that they make from there on is ours. We are only there to give them the tools and information and options, but the decision is actually theirs.

Carol Ambers: During the process, there are certain steps that we take to establish a relationship with the individual. One of things is we let them take charge of some of the pieces and have them make phone calls maybe or if they're not on disability at this point, we refer them to a number and have them call or sit with them and have them call to get that process going.

So basically, we try to create a plan with them and we want to work with their goals but we also make them aware that this is a transition and maybe not the final goal but we're moving out of the nursing homes, so then we go to the next step and we may complete applications for subsidized housing, whatever their wishes are for the future. So it's just a step forward for them.

Joe Groshens: Okay, when implementing the plan, it's difficult, the communication world, I later will explain a story that talks about having 12 agencies working with my client on date of discharge. And it's important to keep all that communication in mind and to keep realigning those stars that may fall out of the sky in our plans.

Carol Ambers: Supporting the participants in evaluating identified options, some participants do have specific options in the community. We also can suggest options for them when doing the evaluation. And then, as we go along there's lots of problems that arise during our meetings. And so, we advocate, as needed, to problem-solve for them and with community people and providers.

Once the plan is finalized, we put it all together, communicate with all involved parties and then support the success of the participant and a lot of times the places that we place individuals, we will go back there again to tour with another person. And then we'll be able to see that person and how they are doing in the community and if everything has followed through as we had set up the plan.

Joe Groshens: With Carol's points, I think one of the things with clients is making sure that that plan is documented and that their goals are documented. It's a confusing road full of roadblocks and obstacles that they travel and often need to be reminded of what their actual goals are. And giving those plans to the future agencies working with that person allows them to not have to redo the whole plan with another agency and to stay focused on their original goals.

Next, both Carol and I are going to share a story of one of our situations. Placing over 900 people sometimes brings back interesting stories. But this gentleman was a gentleman who was involved in a motor vehicle accident and was a total quadriplegic. Could move his head and one hand -- one finger on one hand, but his goal was to have his autonomy, his privacy and his own apartment. He was a professional businessman for years and this was an instantaneous change in life. And with his support, meaning, financial community, family and his cognitive ability, we let him run the show. He ended up in one of the nicest places that I moved people to, it's a brand-new apartment building.

He had very, very affordable two-bedroom apartment. His goal was to possibly have live-in staff. But in the meantime we had to set up services as if he was going to be there on his own at night as he was. This was the gentleman that they have moved. I think I worked with between 12 and 14 vendors, people from -- everything from the transportation to pick him up and get him to the new apartment, to the property manager, to the maintenance gentlemen, to the PCA agency, to the gentlemen who installed the electric door opener. And to the agency who put a great deal of equipment so that the client could verbally answer the phone and hang it up and it had to be installed in both his living room and his bedroom. Hi goal was to use PCA help during the day which he was very successful doing and he set up his life so that if he needs help during the night, he has the ability to do that.

Obstacles, road blocks, this was one of those eye-opening situations that we, as providers in healthcare, know that some of this might come up. I remember having a conversation with him about finances and explained to him at that time he would be living on $94 a month. Difficult conversation to have with someone who has two children in college and has been somewhat --they've been reliable on financially on meet their goals.

He is doing incredibly well. This is over two years ago at his place. He's still in his apartment. He's still using the same services. And his goals are completed and ongoing. He has family. He has agencies. But more so he does it on his own. And he learned a lot through us explaining things through the navigating process, the rules, who to contact. Oftentimes people ask me how I know what to do. It's not me. It's, I know who knows what to do. And I think that's what it takes.

So, Carol's client.

Carol Ambers: My client had lived with his mom, Mr. Brown, most of his life and his mother took care of him. And he actually was going to the food shelf. His mother had passed away. Let me say that first. His mother passed away and he was on his way to the

food shelf and was in a car accident; was then sent to the nursing home. He was diagnosed with obsessive-compulsive disorder, congestive heart failure and he also had numerous bed-bug bites all over his body. And he was unable to pay the rent because his mother was no longer contributing at this point.

When I first met him at the nursing home, he decided that he should stay there and the staff had made that decision also. And so, it took quite a few visits for Mr. Brown to open up and he was fairly passive and socially isolated because he lived with his mom all his life. And he just thought that was a good place for him at the nursing home because he had individuals to speak with. He had activities. He kind of saw them as a family support system for him.

So what we had to do is I continued meeting with him and we talked about being creative and what might work in the community for him, what he was looking for basically. And eventually, he agreed to look at some options in the community. He was going to stay at the nursing home and then we decided that assisted living would be a good option because that's similar to a nursing facility services because he was afraid of living on his own. So assisted living was our choice to go out in the community with him after discussing what was out there.

And after about five months, we toured an assisted-living facility which had a package of services in place and actually included most of housekeeping, meals, whatever, there was a nurse there eight hours a day but the RN was on call 24/7. And he actually had a two-room apartment and he had his own bedroom but there was someone next door to him. They also had the pull cords in case something happen which made him feel safe.

And I saw Mr. Brown about two years after his move to the assisted-living facility and he approached me and said -- thank you so much for convincing me to relocate to the community. I love it here. I still miss my mom but I have made new friends and I am very happy. And when I saw him, initially, at the nursing home he had the institutionalized look and just not really taking care of himself. But when I ran in to him two years later, he had bought new clothes, changed his hairstyle and a total different person, very kind. He was joining in activities with people and he loved where he was at currently. And that was his goal to just stay there.

Joe Groshens: These are just two examples of a multitude of clients that are placed from all of our agencies. And it's just good as a relocation specialist to get back out there. That is the piece that's missing from our programs here is an ability to follow up and to make sure that their goals are still maintained and that they're still in charge of the system. Sometimes when you get things organized like that and you work with a particular vendor you fall back into some of those institutionalized behaviors.

But my favorite part, I guess, is the challenges to all of this. I'm a person that if you give me a problem, I'll do everything I can to figure out a way to meet that particular client's needs. Because again, going back to Olmstead it's all about what they want and their wishes and requests.

When I'm training and working with my staff, they quickly learn how confusing and complex the system is. And after 30-some years, it has gotten no easier, if anything, it's gotten more difficult. So a big part of our job is to be knowledgeable and to be able to articulate our knowledge to our clients to assist them in meeting their goals and their plans.

Financially, it's another huge challenge, trying to live on actually $97 while you're in a nursing home, I guess, I've got some words about it but my big thing is it's pretty inhumane to have to live on that amount. But an example was I -- Chris explained my grandmother went to facility in the mid-70s and at that time the personal needs or the allowed money to keep while you're in a nursing home was $48. Well, I can do the math even as a social worker and it's now up $97. That makes it very difficult just as far as their mood and their attitude.

But probably our biggest problem and nationally is the options for housing. Affordable housing, subsidized housing, they're just not there. You know that wait lists are years long. And it's not getting any better.

So, we have to learn to be creative in some of our options and some of our housing programs. Whether it's getting two clients to live together or finding a new vendor in the community who has an apartment building that's willing to do some of this. So that will continue to be a big part of my focus and my job that I do aside from case management. Probably my biggest piece is the relationships and how to work together. I worked for Hennepin County, the large agency or the biggest county in the state of Minnesota and I also worked for the housing authority for seven years before that. Those two agencies do not speak to each other.

Those are the kinds of things that are going to cause a lot of problems and hopefully those are the changes that we're going to be making in the future. Everybody needs to come together to realize that housing authorities, home care agencies and social service agencies are all going to have to work to meet the requirements of the Olmstead Act. And so some of that is beginning, an example of that is a lot of the managed cares are now starting to do relocation and transition.

And then come the challenges of the client. The mental health challenges, the chemical health challenges. About 85% of our clients that we relocate are both dual-diagnosis with either chemical, mental health or physical health needs. So when we're creating plans, we have to make sure that those goals are met and their needs are supported in the community. So when the client would tell us where they would like to live, we would say -- That's fine. But there are agencies that are going to require you to have additional services in order to live there. So, you may have to accept some of those things.

Carol Ambers: We also advocate a lot on behalf of our clients regarding when we submit applications and their criminal history, evictions. We try to explain to the providers what happened. Sometimes they end up in the nursing home and lose their apartment therefore

they received the eviction notice. And they do not even receive it because they're in the nursing home but the court is ordered to the courts and landlord. So we usually try to talk the landlord into meeting them and getting to know that person a little bit. So we'll just take them there on a tour and introduce them and then go from there.

Joe Groshens: It's important to understand the background of housing. We have been discussing using case aides to complete things like housing applications. And I have an issue with that and I've explained to my staff, because they may ask a question, write a simple answer down and you have to be able to, Carol says, advocate for that person. Tell that person's story. And oftentimes, landlords with documentation and a period of life with no evictions and no criminal background, they realize that they probably have to give this client a reasonable chance at this. So they're willing to participate with us.

Lessons learned, it's been a long road. I don't know if much has changed since the mid-'70s in skilled nursing facilities. I think the documentation, reporting and requirements have but the day-to-day life events and the process of how you end up here and how you discharge from a facility have not really changed all that much. So, when we're working with people, we've learned that their plan has to be their plan. We've written plans that we kind of maybe are towards our side a little more and halfway through we realize maybe we should readjust things.

But we've also got to work with the client's disabilities when it comes to be able to advocate for themselves. The system, let alone, the system is not setup to do this process as long-term care agencies and advocate social workers and relocation agencies, we're going to have to slowly get the system to change and to be more flexible for clients' needs. Probably my biggest challenge and lessons learned is that just as the client has no idea what this process is going to be and how it's going to happen, same with a lot of the vendors. We will go out and work with vendors who have gotten into the business for one particular reason and it's often for these type of vendors we are struggling with, it is a financial reason.

And when you start to explain the rules and it's amazing how much the actual vendors don't know or the facility doesn't understand. Our agency gets the big picture, from the day we walk and see that skilled nursing facility room and the bedroom, all the way until we furnish their apartment with furnishings and household items and shake their hand and say -- welcome home. But providers and social service agencies amazingly, they don't know how to do it. I mean, that's the bottom line. They just don't know how to do it. And it's something that you learn through repetition and experience. And case-by-case episodes and you can use that knowledge in the future for other cases.

Probably the most important thing is our relocation, we're pretty successful. I feel that with competency; we here that daily from skilled nursing facilities and county agencies that use our agency. But the relocation is a one piece of this whole individual plan and goal. Once the relocation is done, the worst thing to do is have somebody sit in their apartment all day. So, when they're comfortable, when they're a little healthier and a little stronger after a few weeks, we make a call to them.

But it's always good that they have a portion of their person-centered plan be related to once the discharge is completed and what are their interests going to be in the community. Whether they may like horses, not everybody likes to play cards and not everybody likes to dance. So, some of those things may not be obtainable for them because of a new disability. But using services and IOS agencies and ARMHS services, we get them to maybe a portion of that wish. Maybe we can get them to the stable. And they can build beyond that. But it is very important that there would be a plan and that that plan stay with that client after discharge to be able to articulate their needs to any agencies that they work with.

Carol Ambers: Also, when we initially meet the individual, we talk about their interests and during the whole process we continue researching options out there that would work for them in order to at least support some of those activities that they have chosen. I think that we do educate providers and help problem solve when they get back in the community and make suggestions according to what we have discussed during our relocation process and transition into the community with the client.

Joe Groshens: Chis?

Chris Duff: Thank you, Carol and Joe, I appreciate your presentation. So I made a few observations, first of all, the two people you used to explain your process were wonderfully chosen, because one is a man who had been independent, successful, raised a family, had kids off to college. And for him, he was pretty much, kind of, take charge and wanted to move on. And your role with him was to help him with the connections and take him through the process and giving him a sense of hope.

The first step was to get him into a place where he could be independent, have some privacy and then later he can work on getting a job and some autonomy. So that's great. Meanwhile the other person is a 50-year-old gentleman who's been living with his mother his whole life. And your role with him was really very different. You needed to do a lot of educating with him and give a sense of hope also but it was a different kind of sense of hope. And I think that's the key.

I think the lessons of both of these are that you can't just make a referral. You can't just give an individual a bunch of applications and say -- go and apply to some of these places. Because these people end up in nursing facilities or end up getting in institutions because they haven't been able to not be there. So they need help to get to where they do want to be. And I think the art of what Carol and Joe do is that they start with the individual, figure out what's going on. And then intervene as needed not so much with the two clients but intervene with the system around them, the financial system, the legal aid, the getting on Medicaid if needed, the housing, dealing with felonies on their history which eliminate them being available for some services or setting, that kind of thing.

And so it's really more stepping back and helping them deal with all the barriers that they face. And I think the two examples you had were wonderful and were great. Thank you

very much. What that demonstrates here in the summary slides, independence and achievement of goals is a journey and a destination. And I think the first person, Calvin it was a first step for him. And then he'll get on with his life which is a job] and get back to participating with the family more. You got to involve all the parties as Joe talked a lot about at the end, advocacy that he just mentioned and linking to community resources. Just getting them out in the community is not sufficient. You need to make sure that they're setup for success.

With that as the foundation, we already have a bunch of questions coming in which I'm thrilled with. But before we do that, I'd like to turn it back to [Elsie] to open up the phone lines and give people instruction on how to call in.

Lia: Ladies and gentlemen, if you like to ask a question, you may press * then 0 on your phone. You will hear an acknowledgement tone. And if you're using a speaker phone, please pick up the handset before pressing the numbers. Once again if you have a question, you may press *, 0 at this time. And please hold for the first question.

Chris Duff: Thank you. Why don't we take the first question from June. And Joe, why don't you start with this -- what are the range or timeframes involved in the work you do, from starting working with the participant to moving into and staying in the community?

Joe Groshens: Regulations allow six months, 180 days. We in Minnesota have two different types of programs so we can actually tap into one. And if we need to tap into the next, do that. The longest it would take us would be a year. The type of client we have related to their particular needs or their particular issues also is somewhat of determining how long it will take. If they have criminal backgrounds, if they have evictions, unlawful detainers, those are going to be a little bit more difficult nowadays to place, especially depending on the type of criminal activity. Timelines, we tell people -- we'll never get you out under a month and hopefully before six months.

Chris Duff: Thank you. Another question that came in is kind of a follow up with that, and Carol, maybe you could take this. Do you stay involved with the participants post moving them into the community? And if so, who picks up in a key supporting or problem-solving resource with the individual after the transition or relocation is over and you're no longer formally involved?

Carol Ambers: Right. A lot of times if they're going into assisted living, they would have a social worker there, director, an RN and they have all the services that they need. They have a CADI waiver also which then would give them the option of having the case manager in the community that they would choose on their own. If they are going into their own apartment, it would be, maybe PCA, ILS, ARMHS worker. Some of them do continue to have a case manager through a health insurance program or through the county.

So basically, after we move them, I would say for approximately one month, we do receive phone calls and get questions from where we place them or from the clients

themselves asking specific questions and we usually help them through that and solve them.

Joe Groshens: That's a piece that when you're creating a plan, it's really important to involve some of those agencies that are going to be working with the client in the future. Whether it is an individual living skills worker or if it is the assisted living program, to maybe put special needs or special requested services on their care plans.

And -- but as far as our agency doing ongoing case management. We are under the new money follows the person program that Minnesota has gotten involved in. We are allowed to do case management for up to six months. And then an additional six months if the client requires it. And it is huge.

Unfortunately, we have clients we feel and know that had we been there for them, we could've worked through the issue. And there wasn't that person there with the trust and the relationship that they built. So the client lost their apartment again. And now they're back in the facility. So, follow-up case management is huge. These people are at great risk of returning to these facilities. And they're going to need some assistance in the community.

Chris Duff: Okay. If there's anything I think we're hearing from both of them is people who do this work are not young social workers out of school. These are experienced individuals who know how to listen. And -- but even more so, have relationships in the community that they can bring.

Joe said to me in a previous conversation -- when I take someone to a facility, the facility may on paper say no, there's no way we could take them and we can't meet his needs. And because Joe has a relationship with that facility, he doesn't look it. I understand this person. I think he'll fit in well. And that facility was an apartment setting or whatever is going accept it because Joe has been involved, they trust Joe. And that's really what it takes is those relationships. So I think to do LTSS relocation work, you really need relationships in the community just as much as relationship skills with the client.

Joe Groshens: Knowledge and relationships and assistance in the community is hugely important. We often get calls back from agencies upset said that how come this other relocation didn't do this piece or how come they didn't? And we don't answer. We just say -- well, that's not us. And oftentimes, what happens is those agencies will call us when they have an opening, saying -- we really like working with you. We think you know the type of clients our facility needs. And so it's helpful for us from an agency standpoint.

Chris Duff: Now that's ideal. If you have housing settings that are calling you, that's great. It is a situation that I didn't give to Carol and something that I certainly faced when I was doing some of this work way long ago. When you work with the participants who's working with a provider, and the provider say -- this person is very involved, needs 24-hour care or supervision.

But the health plan, that's simply not in their benefit set. How does the health plan or the care coordinator handle that when what probably happened -- because they've been put in a nursing home? So how do you work with that? Consider yourself, especially in the position of being a health plan care coordinator or a relocation person you're with.

Carol Ambers: I guess that's where you have to be creative. And one option would be an assisted-living facility because they provide 24-hour staff. The other option would be moving in the community with PCA services, a nursing service. And then if they move with the family member, they would have that family member also part of their team to help coordinate their care. So it just depends upon where they are relocating to in the community.

Joe Groshens: Hopefully that client is ready to do some of the work and to follow through with their plan if they really invested in making the plan. That is something that by the end, we explain to them, you've been through a lot. You know the system is not all that friendly. You need to watch out for yourself and you need to have advocates and you need to speak up. And you need to focus on the plan.

Chris Duff: And also as we talk about in many of our webinars, there is risk involved in this and work for the individual. And yes, it probably would be safer to live in a totally supervised environment.

Carol Ambers: Right.

Chris Duff: But with having choice, providers, especially the medical system providers need to accept and understand that there's risk involved. And so I think part of your role is helping the rehab people or whoever understand that this is a decision that Mr. Brown made or whoever and let's see how we can set them up for success versus denying his request for 24-hour care of whatever it may be.

Why don't we check back to the phone lines? Elsie, is there anyone waiting on the phone line?

Lia: And once again, ladies and gentlemen if you like to ask a question. Please press * then 0 at this time. If the operator has collected your name, you may press *, 1. Once again, press *, 0 at this time and there are no pending questions.

Chris Duff: Great. Thank you.

Lia: You're welcome.

Chris Duff: Joe, I'm going to give this question to you. Do you have any other examples of this kind of -- two questions I'm merging here, informal support that you've used beyond the kind of formal paid support, TCA, independent living skills or whatever? So one question is informal supports. Secondly is give an example of really creative, flexible

strategy that you have deployed for a complex situation just to give people the mindset of how you go about it.

Joe Groshens: I've seen that question asked a couple of times here. And it's, I guess, at the moment, it's really hard to think of those creative ones. But I think the informal supports as much as it may be unethical, other clients we've relocated.

One of the things I do if I move somebody to a building, the way we get in is not through management to see the apartment because there's waitlists and they won't let you in. But it's through a client that we previously relocated there. And clients like helping each other out. I mean, they establish relationships with other people in the nursing facility. And they're all trying to get the same thing done. So when they're out, they're always willing to help another person who's also gotten out.

As a property manager, probably the most important worker you have is your building maintenance man. We've asked maintenance men to do things because they like us and our clients that they probably shouldn't do but they'll do. So I think it just depends on the site or that particulars individual's needs. And at this point I'm kind of blocked on some really creative options.

Flexible, I remember Carol relocating a client in the middle of a snow storm. And her electric wheel chair broke down. And Carol is not a very big woman as you can see in the picture. And it was about eight inches of snow on the sidewalk. And you couldn't get to the sidewalk.

Carol Ambers: It was snowing.

Joe Groshens: And Carol pushed her all the way down. Carol did everything she could to make that successful relocation. We had the person upstairs checking on the person downstairs in the duplex. Unfortunately, that client made it one day at home because of a choice that she made. And she ended up back in the facility the next day. But Carol could've left her at the end of the street in the van and said -- we can't do this. But she got out and she did what she had to do to get it done.

Chris Duff: Or may I say she could have not done it to start with and not given that person the choice to give it a shot. And that person learned. And it's not ready.

Carol Ambers: Right.

Joe Groshens: Correct.

Chris Duff: So that, I got to get back. And I want to go back to your question about perhaps unethical, because nothing I heard in what you said that was unethical. What you're doing is you have been engaged by that client to get their needs met.

Carol Ambers: Right.

Chris Duff: And you're bringing your relationship to the table. I mean, we all do that. No matter where we are, if we're going to a hardware store, we're going to go to the guy who worked in a hardware store who will figure out how to get this done.

Joe Groshens: Yeah.

Chris Duff: It's no different than that. So I want to be very clear, there's nothing unethical about how you're approaching this. It's the mindset that's getting through the barriers that I think is what's really important.

Joe Groshens: Yeah. We used to call them obstacles, barriers. People give up. And we just keep going. It's going to be something else tomorrow. There's good and bad days. We explain to the client in our first visit. When they're the happiest in their life in a long time, we leave and people are smiling.

But I remind them as they smile, this is going to be a rollercoaster. This is a big rollercoaster. You've already been on it since you got involved in your issue or your first hospitalization and it's not going to get much better, but there is nothing better than giving people hope and a chance, because it is amazing what happens to people when they're in the institution.

These people are afraid of staff. And not because they're going to be abused but because they do the wrong thing -- or they did. It's pretty sad. And then I remind my staff that if the clients are difficult or they're making poor choices that they're at their most difficult points in life. And we have to remember that. Take that into consideration and give them some time and maybe explain another option to them. But we like our job.

Chris Duff: That is evident and I appreciate that. I'm going to ask two quick questions. First is kind of follow up on you like your job. Carol, have you ever been fired by a client?

Carol Ambers: No. I haven't been fired. I was involved with a woman that had chemical dependency issues. And so she was very nice one day, but if she had some vodka then she was very aggressive towards me and very rude and told me I wasn't doing my job.

And so one day, I said to her -- do you want to fire me? And she wouldn't answer. And I said -- if you think I'm not doing my job, you have that right. That's your choice to fire me. And she didn't say anything. She just kept talking. And the next time I came to see her she was a sweet as could be. I relocated her. And I did see her about six months later. And she was doing great.

Chris Duff: What I love about that story, Carol is that all of us in this field, I mean, we can all think of a couple of clients that we're always working with -- oh, god, once I get through Sally; once I get through Jill. And the tendency is to try to fire them ourselves. But you don't usually have to do that.

Carol Ambers: Right.

Chris Duff: And you kind of turned that back to her. And, a, put her in charge and try to hold her accountable. But did so in a nice way. And that's great. That's like a great response.

Another question for you Carol is how do you address -- I mean, we all have come across a lot of people with very unrealistic plans, how do you work with that, especially family members who may view the plan as unrealistic but the person really wants to do it?

Carol Ambers: I think the first step is to remember that it's the client's choice and not the family members' choice. And what we do is like I said, we have lots of visits. We don't initially make that decision and state where they're going or this is it. We tend to explain options and be realistic with the person.

Joe Groshens: If we've got a family member who feels that the placement isn't appropriate, a big piece of that is to ask that family member to come along with the tour. We often have to convince our clients to go look at somewhere because geographically they tend to place themselves in a small area. And with few choices, we have to open doors.

So involving people who are being somewhat of a roadblock or unrealistic, if it's not going to be possible, then we just have to explain to that client again that it's their choice. We are here to support them. And that a parent might not like it. Significant other might not like it, but it is their choice.

Carol Ambers: And eventually, I think that once you work with these people and you get to know the family, the family does respect our opinion and what we're doing for them. We provide a safe environment. That is always important that it is a safe environment. And therefore, the family eventually understands as we go along with the process and they attend meetings, what our goals are and what we can and cannot do and provide for that person.

Joe Groshens: It's not always successful as I explained. One, we've had people who make it one day. We've had people who make it less than one day. I had a gentleman who we put together an incredible plan for. He was a very brittle diabetic. The nursing home director of nursing looked at me as I left with him that day and said it's not going to work. It was the day before Christmas Eve.

And Christmas Eve morning, like 12 hours after we had moved him, there was an ambulance at the site. And that nurse happened to actually live in that neighborhood. So my client begged to be back into the facility in the same bed within 13 hours of discharge. And this unfortunately was because of a staff incident that was very serious. Didn't wake up my brittle diabetic in the morning to do blood sugars and document that they did.

So there was -- but eventually. That client, I placed him in a very close family setting. He's been there six years with only one ER visit. So you just keep attempting and try other options.

Chris Duff: That's a great closing response actually. Because you say, okay, that didn't work. But you stepped back, you look at it. And then the family option is great. Thank you.

I need to wrap it up at this point because we're running out of time here, but before I do so. I want to quickly ask two final polling questions if I may. These are designed to help us figure out where we go from here. This is the next to the last webinar in this series. We want to get a sense on where we go.

So to assist on developing additional information about this for the content services. What would be the best means or vehicles to provide this information or material to you and your colleagues? Please choose what you prefer and feel free to choose all of them if you prefer.

I'll give you just a minute to complete that. And then we'll move to the second one. Last one is -- are you interested in additional webinars on the topic of transitioning or relocating persons with disabilities in the community-based setting? Leave that up for you to go over while I close our presentation here.

I'm going to wrap this up. I appreciate everyone taking their time to participate in this webinar. As you can hear, advocacy and creativity and problem solving is your key to success in relocation. Any questions that we receive that we were unable to answer, we will handle offline with individuals.

Next week at this time, we will explore the functioning of the care coordination team. Everyone who signed up for this webinar will receive notice of each webinar as well as tools and other resources we are able to provide.

Again, I would like to thank Joe and Carol for their participating with us and presenting. I think their creativity and attitude is what makes them successful in their work.

On behalf of Lewin and The Centers for Medicaid and Medicare, I appreciate your attendance with us. Please take just a minute to fill out the questionnaire on the link on your screen at this point. And hopefully, you can join us next week at this time.

Thank you very much.

Lia: Ladies and gentlemen, that does conclude our conference for today. Thank you for your participation and for using AT&T Executive Teleconferencing. You may now disconnect.