The Lewin Group
Managing Transitions with Adults with Disabilities
March 28, 2018
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Jessie Micholuk: Thank you and good afternoon, everyone. Welcome to the Disability-Competent Care webinar, *Managing Transitions with Adults with Disabilities*. My name is Jessie Micholuk, and I'll be getting us started today.

Should you have any questions now or throughout the presentation, please feel free to enter them into the Q&A feature on your platform. We'll be addressing your content-related questions during the discussion portion of this webinar.

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 webinar series builds on the 2017 DCC webinar series that introduced the model of care and its seven foundational pillars. You can view this series and related resources at our website, resourcesforintegratedcare.com.

As I mentioned, this webinar will be interactive, with 45 minutes of presenter-led discussion, followed by a 15-minute presenter and participant question-and-answer session. As always, a video replay and slide presentation will be available after the session at our website.

We're pleased to be able to offer credits for Continuing Education Units and Continuing Medical Education for this webinar. For information about how to obtain credits, please access the CMS Continuing Education Credit Guide, which is located on the left-hand side of your platform in the Resource Library.

To receive credit, the post-test must be completed through the CMS Learning Management System with a score of 80% or higher by midnight on April 16, 2018. Further information is also available at our website.

This webinar is supported through MMCO to help beneficiaries enrolled in Medicare and Medicaid to have access to seamless high-quality healthcare that includes the full range of covered services in both programs.

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I'll now hand the presentation over to your moderator, Chris Duff.

Chris Duff: Thank you, Jessie. I would also like to welcome everyone to this sixth webinar in the 2018 series.

I am a Disability Practice and Policy Consultant who has been working with The Lewin Group and several colleagues to develop the Disability-Competent Care model and related webinars and materials.

Today, we will have three speakers. First will be Todd Wilson. Todd is a Health Insurance Specialist in the Division of Community Services Transformation at the Centers for Medicare and Medicaid Services.

He is the Team Lead for the Money Follows the Person Demonstration Grant Program, a Project Officer with -- for several of the state grantees, and is the Contracting Officers Representative for the Demonstration's Technical Assistance Contract. Todd has extensive experience in program management and implementation of home and community-based services and support for persons with disabilities.

He is a Fellow in the American Association on Intellectual and Developmental Disabilities and is actively involved in National Leadership Committee's initiatives. Todd holds a Bachelor's degree in psychology from Edinboro University of Pennsylvania.

He will be followed by Elizabeth Jones. Elizabeth has over 30 years of experience researching, developing, and implementing public policies to foster individuals' independence. Prior to becoming the Money Follows the Person Demonstration Project Director for Texas at the Health and Human Services Commission, she provided policy guidance and managed the expansion of options for consumer direction in Texas Medicaid programs.

Elizabeth has Bachelor's and Master's degrees of Art from Baylor University and a PhD in Sociology from Northwestern University.

Lastly, Doni Green will close out the presentation. Doni is Director of Aging Programs for North Central Texas Council of Governments and has responsibilities for the Area Agency on Aging, the Aging and Disability Resource Center, and nursing home relocation programs.

She's been with the agency for more than 20 years and has prior work experience as a medical social worker and manager of a group home for adults with intellectual and developmental disabilities. She received a Master's degree in Gerontology from Baylor University.

Needless to say, these speakers bring a wealth of experience to our webinar today.

The learning objectives for this webinar are fairly forthright. We will start by framing transitions within the DCC model, followed by identifying the barriers and challenges commonly faced by care coordinators and transition specialists in working with dual eligible beneficiaries as they move from an institutional setting to the community. We will close focusing on a range of strategies to address the identified barriers.

As this agenda shows, we will start by describing the broad range of transitions experienced by persons with disabilities. Perhaps one of the most complex of these transitions is moving from a nursing facility into the community.

The federal Money Follows the Person Demonstration which you will refer to as the MFP program from hereon was designed for that very purpose, to rebalance the dollars from institutional care to community-based supports, to the use of a range of Medicaid waivers.

Texas will describe their very successful program, and we will hear their efforts to implement the services and problem-solve barriers at the state and local levels. We will leave 15 minutes at the end for Q&A.

Transitions, in their many and varied forms, are fraught with opportunities for errors, miscommunications, unintended consequences, unmet expectations and others. Due to the vulnerability of the population being served and the complexity of their needs, there are simply many more details to attend to during transitions than for the general population.

Examples include needing accessible homes, changes in medications and figuring out how to get them delivered, and new and often additional home-based care and supports. There are also many more people involved and many more hand-offs.

Most people think of transitions as those from a hospital to a nursing home or from a nursing home into the community. These are certainly among the most complex because of the status of the participant and what is often an urgency in the transition.

In the Disability-Competent Care model though, transitions are viewed much more broadly as any change in the participants' life that affects their care and wellbeing. This includes their ability to function in their community, being able to be as independent as possible in their home and to access the community for work, social activities and medical appointments.

As this list shows, transitions are not only changes in care settings and providers, but also changes to medication, financial issues, housing, employment status and others.

Within the DCC model, transitions are one of the primary functions of the interdisciplinary team. Consistent with what you will see in the MFP program, transition activity starts with talking with the participants to identify their desires and priorities.

That often evolves into a transition plan where all the steps are identified and assigned to a member of the IDT to work with the participant. For example, a social worker or community health worker may explore housing alternatives and availability that are financially and physically available to the participant and arrange for visits accordingly.

Dually eligible participants face far more transitional barriers than other populations due to a range of health disparities and social determinants. They have greater occurrences of unpredictable health needs or progression of illness, resulting in in-patient episodes of care.

When stabilized, providers are often eager to discharge the participant, and many of whom go to rehabilitations or nursing -- rehabilitation settings or nursing facilities for their recovery. There are unintended consequences of this process such as the loss of housing or care partners, which must be addressed before returning to the community.

In addition to the disparities, dually eligible beneficiaries with disabilities also commonly experience a range of social factors that significantly influence transitions. Accessibility requirements, transportation options, limited finances, and

care partner availability can result in fewer options for transitions with longer wait times for services and supports needed for successful transitions.

These beneficiaries rely on multiple services and supports, making planning far more complex, especially considering the need to coordinate segmented delivery systems of healthcare and home and community-based supports.

Whether a transition is from an institutional setting to the community or just between community settings, this population's limited income, socio-economic status and poor health outcomes can limit options and complicate planning. The multiple funding sources and regulations for services can also limit access to some providers and settings of care.

As you've heard throughout the webinars in this series and previous series, we have created a Disability-Competent Care Self-Assessment Tool. This tool helps providers and plans alike to evaluate their ability to meet the needs of this population and identify opportunities for improvement. No provider or plan will ever be completely disability-competent, for it is always a process of self-assessment and strategic prioritization of quality improvement activities.

On the lower part of this slide, we have some examples of the DCCAT, Disability-Competent Care Self-Assessment Tool, identifying some key transition-related activities. The remainder of this webinar will focus on transitions or relocation from institutions into the community.

The US Supreme Court issued the Olmstead decision in 1999 applying the integration mandate of Title II of the ADA. In the ruling, public agencies were mandated to provide services in the most integrated setting appropriate for the needs of qualified individuals with disabilities. This is the policy mandate that has driven the rebalancing of long-term services and finances towards community settings.

There are currently 2.2 million individuals on Medicaid residing in institutions. Now certainly, some of these individuals are quite satisfied living in facilities and are not interested in moving into the community.

In starting the process of considering a transition, the Care Coordinator or Relocation Specialist of the MFP program, all of them, focuses on participant engagement and accountability, helping the participants understand and see their options and the relationship between where they reside and their larger life goals.

Moving into the community goes well beyond a simple move. It requires engagement of the participant and their key support persons to identify their preferences and requirements and in truthidentifying housing that is accessible physically and financially, it involves setting up a range of in-home and community-based services and supports and includes re-engaging them in community life.

As is obvious in this and the previous slides, transitions are much more than a physical change and require support of the IDT with a range of skills and competencies. This transition support is commonly needed for many months prior to and following a transition, as well as timely re-engagement as new or re-occurring issues arise, as they always will.

The key, once the participant is established in the community, is to keep the relationship between the participant and their IDT strong so as to put preventive strategies in place and hear of problems as they surface.

Through the MFP program -- though the MFP program provides the participant more targeted and time-limited assistance, their function is very similar to the IDT and the DCC model.

I will now turn the presentation over to Todd Wilson who will introduce the MFP program.

Todd Wilson: Thank you, Chris. I'm here to talk to you a little bit about the Money Follows the Person program which is administered by CMS as a Federal Demonstration Grant program.

Money Follows the Person, or MFP, is a $4 billion demonstration and it's currently in its 11th year of implementation. There are 43 states and the District of Columbia currently participating.

The focus of MFP is to shift long-term supports from institutional settings to a person-centered community-based model. MFP does not endorse a specific model or program, and states are really encouraged to develop their own innovative operational procedures to achieve this overall goal.

MFP has four primary objectives. The first, to increase the use of home and community-based services or HCBS rather than institutional long-term care services and supports.

Second, to eliminate barriers and mechanisms that provide or -- prevent or restrict the flexible use of Medicaid funds to enable eligible individuals to receive long-term care services and supports in the settings of their choice.

Third, to strengthen the ability of state Medicaid programs to assure continued provision of HCBS to eligible individuals who choose to transition to a community setting.

And finally, to ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide continuous quality improvement in such services.

The population groups that are served through MFP vary by state, however, may include persons who are older adults over 65, individuals with physical disability, persons with an intellectual or developmental disability, and persons with mental illness. Overall, beneficiaries who are dually eligible comprise approximately 90% of individuals eligible for participation in MFP. As of December 31, 2016, over 75,000 people have transitioned from institutional care to home- and community-based services through Money Follows the Person.

In 2016, data show that the majority of people transitioning had at least one physical disability, which represents approximately 40% of MFP participants. Older adults were next at 36%, and then persons with intellectual or developmental disability at 12%, and finally, people with mental illness at 9%.

In implementing MFP, we have collected data on what type of community setting individuals transition to. We understand that most participants choose to move to an apartment, about 40% choose to do that, or to a home either owned by the participant or a family member, which is about 38%.

Other housing options include small group homes of four or fewer people, about 14%, and apartments in a qualified assisted-living facility at 7%. Overall, almost half of younger adults with physical disabilities who transition from institutions tend to move to apartments.

Quality of life was another key component assessed for people who transition through the -- through Money Follows the Person. The survey was to be administered to all participants at three points in time; just prior to transition, again at about 11 months after transition, and finally at about 24 months after transition.

We are pleased to report that participants identified large and sustained improvements in quality of life after moving to a community-based setting. Satisfaction with living arrangements increased upon transitioning to the community. One year after transitioning, 91% of participants reported liking where they lived, as compared to 62% pre-transition. This increase will sustain two years after transitioning.

Participants also reported substantial improvements in choice and control over daily activities, such as when and what to eat, and the ability to get needed sleep. After moving to the community, participants reported improvements across nearly all domains of community living.

Community integration increased in several areas with higher proportions of participants reporting that they were able to do fun things in the community, get to places they needed to go and not to miss events due to lack of transportation.

Overall, the Money Follows the Person program has provided a valuable opportunity for states to identify, demonstrate and evaluate successful transition strategies and to eliminate barriers for individuals in accessing home- and community-based services.

Later in the presentation, we will touch on some of the challenges state grantees have experienced in implementing the program and approaches employed to address them.

At the federal level, and with grantees at the state and local levels, we are looking -- we are involved in ongoing collaboration and policy development efforts to address some key focus areas, including community integration, direct service workforce, employment, housing, no wrong door access to home and community-based services, person-centered planning and service delivery, transportation and quality assurance and improvement.

I will now turn the presentation over to Elizabeth Jones who is the Project Director for the Texas Money Follows the Person program. Elizabeth?

Elizabeth Jones: Thank you, Todd and good afternoon everyone. I'm pleased to be here to share information about the Texas Money Follows the Person Demonstration.

Texas was one of the first states funded during the first round of funding in 2007. And as of December 2017, I am proud to announce that we have transitioned over 12,000 participants from institutions into community living. Approximately 80% of those were dually eligible beneficiaries and about 38% were individuals with physical disabilities.

Texas opted to focus on three populations in our MFP program; older adults, generally aged 65 or older, individuals with physical disabilities, and individuals with an intellectual or developmental disability.

Texas implemented its Money Follows the Person program on existing long-term services and support structure.

And what that means is individuals transitioned from facilities into either our 1115 managed care long -- home- and community-based services waiver or to 1915(c) waiver for individuals with intellectual or developmental disabilities.

The guiding principles of our MFP program included focusing on the individual's independence and productivity as defined by the individual, and that's critical -- as defined by the individual, creating meaningful opportunities for a person with a disability to live in the most appropriate integrated setting of the individual's choice.

Our demonstration also focused on using person-centered planning and practices throughout the transition process beginning with that initial meeting in the institutions such as a nursing facility and following through services delivered in the community.

To achieve the successful transitions that we have accomplished, Texas really used a three-pronged approach for our transitions; and these were essential. And the first was transition assistance, which I'll talk more about in a minute, community transition teams, and transition contractors.

But before I talk about the three-pronged approach, I want to mention some of the challenges faced by our participants as they wanted to transition.

By far, the largest challenge was the availability of physically accessible and affordable housing. Financial support to provide things to set-up your household, for example, dishes, how do I work, how do I get furniture, eating utensils.

Many people did not have government identification, didn't have a state identification card that is so needed to live in the community and to have your utilities hooked up, for example, nor did they have the background documents to receive these to obtain this government identification so they needed support with obtaining that.

Transportation to accessing community activities, as Todd was just talking about, to get to the grocery store, to go to the community center, to visit with family and friends.

And also addressing participant fears about what will this be like and can I actually do this, and then accessing financial assistance for other services such as emergency food or help with utilities.

And the demonstration really helped us to identify many of these barriers and to begin to address them. So, how did we do this?

Transition assistance services. We obtained CMS approval to add transition assistance services to our 1915(c) waivers and our 1115 managed care service array. Transition assistance is a one-time grant of up to $2,500 to assist an individual in setting up a household in the community.

It is a Medicaid service and it is authorized on the individual's service plans or home- and community-based services plan. It pays for things that are necessary to enable the individual to establish a basic household.

And that would include things like a security deposit for utilities or rental security deposit, purchasing furniture, tables, chairs, windows blinds, eating utensils, food prep and food preparation items.

It also covers moving expenses, and it covers services necessary to ensure the health and safety of the individual in the home. And this would include things such as pest eradication, allergen control, or a one-time cleaning before moving into the individual's home.

Community transition teams also played a critical role in the success of the Texas transition model. And these community transition teams were public-private regional community resource groups who met monthly to identify and talk about some of the challenges that individuals faced as they wanted to move from institutional-based services to the community.

And many of the challenges that I just mentioned were identified by these groups. And these groups were -- the meetings were led by the Health and Human Services Commission by state office staff and included all of the partners that would be involved in helping someone transition.

So, it included representatives from the health plans, our relocation contractors, housing specialists, some of our local housing navigators, adult protective services, and providers. And we found it was critical to bring people together who had the knowledge of local resources in order to support an individual's transition.

The final component of our successful transition model, going to next slide, is community partnerships. And this is very important to develop partnerships with community-based organizations.

In the Texas MFP program, we work with the following types of community-based organizations; Centers for Independent Living, Area Agencies on Aging, and other local transition and relocation specialists.

We worked with these individuals to help identify people who requested to move out of facilities, and these agencies are also responsible for serving as the lead in addressing non-medical transition components.

So, let's talk a little bit about some of the relocation activities.

The guidelines for our relocation activities really focused on promoting independence. It was critical to inform individuals of community options so those who requested information about moving to the community was very important that they were met with individually and community options were discussed.

It's important to assess the individual service needs and transition needs and coordinate those transitions, and to provide training to staff on transition and promotion of the independence philosophy.

And I want to say a little bit about sort of focusing on promoting independence. And as you work with your own staff, it's very important to keep this in the forefront and make it a priority as you do your business.

So within that Texas MFP program, the relocation contractors, in coordination with the health plan service coordinators and others if needed, 0were tasked with the following relocation activities.

Conducting outreach at nursing facilities and other institutions to interested people, identifying those who requested to obtain more information about community transitions, conducting a transition needs assessment, so what types of support did the individual need and developing a transition plan. Development and coordination of community supports, and that'll be things such as housing so that working with the housing navigators and post-transition follow-up with the participants.

So, it's very important to follow-up with participants once they moved into the community to make sure that services were established and our relocation contractors follow people for up to 90 days once they had moved to the community.

Going to the next slide. So, successful integration into program does not end once the participant is in their new setting. A critical part of setting up a transition is to establish the community-based long-term services and supports that the individual will need to be successful in the community.

And so services coordinator in Texas -- service coordinators with the health plans assume the responsibility for service planning, so they will assess the individual's need for services such as, do they need an attendant, any nursing services. So they will do an assessment, develop the service plan to help people live successfully in the community.

And so that service plan would include long-term services and support and possibly some acute care services. So -- and the relocation specialists are really focused on the non-medical community-based aspects of the transition such as accessible housing.

Now, want to I talk a little bit about some of the lessons that we learned from the state level in implementing our MFP program, and particularly about transitions. The first one is to really have a focused administrative attention on all levels, and on the state level, to attend the program development.

And recently, we just moved our relocation contractors. We just folded them into the managed care umbrella, so they're part of managed care service coordination. Previously, they had contracted with the state and now those contracts are with the managed care organizations.

So in order to monitor this implementation we hold quarterly check-in calls with MCOs and relocation contractors. We also look at some of the currently performance measures such as the number of assessments conducted, the number of relocations just to make sure that the service has been implemented as designed and to also look at where it might need to be tweaked and improved.

On the regional level, I talked about the community transition team. It's very important for them to come together and identify systematic barriers and begin to address those.

On the local level, it's important to assure that service coordinators and some of the MCOs meet together to discuss cases, so they hold weekly meetings, each MCO with its own relocation contractors, discuss specific cases and referrals.

It's also important to understand the key roles and differences between the medical care coordinators such as the health plans service coordinators and the non-medical transition specialists, what we call our relocation specialist in Texas. So

it's very important to understand and respect those particular roles and to provide training to MCO staff and relocation specialists about each other's expertise.

When you think about making a transition that we just made in terms of moving relocation into managed care, it's important to work with the community-based organizations and to begin to prepare them for partnering with the managed care organizations. One of the areas of especially challenging were additional support would be needed would be in the contracting process.

Other lessons learned. Again, focusing on building relationships between managed care and community care organizations, learning to understand and respect the different cultures. And what we found that it was important to focus on the common goal which is to assist the participants in making that transition from the facility into community-based living.

And respecting the different perspectives, because it's those two perspectives together that come together that provide the full array of supports needed for an individual to transition and to live successfully in the community.

Again, it's important to provide ongoing training. And we also have learned that a lot of a training sort of takes place with the different groups sharing how they do their work and sharing their perspectives, to have a referral system in place, to make sure that all the parties work together and that the individual's needs are met and that they are told about their options for Community Living.

And finally to encourage community supports to work with participants to obtain their goals, so reaching out to any of your local community areas, such as local food banks or churches to support the participants' need. And also developing training for nursing facility staff, that's another partner we haven't really talked about in this presentation. To let them know that Olmsted requirements that were mentioned earlier and to help train them on the importance of transition.

So now I'm going to turn it over to Doni Green who will really give you some specifics about the Texas transitions. Doni?

Doni Green: Thank you, Elizabeth. So I will do my best to provide a view from the trenches. My organization has been providing transition services for 11 years and we're a bit of a nontraditional provider in Texas.

Most of the transition providers are centers for independent living or CILs. We owe a tremendous debt to the CILs. For 10 years we provided transition services under contract with the state. And as Elizabeth mentioned, we recently started contracting directly with the MCOs that provide Medicaid waiver services to adults with disabilities.

Our role during the transition process is to advocate for participants. And as Elizabeth mentioned, to put into place those community-based services and supports that are required for non-medical reasons.

The plans will focus on the health and safety related needs and the transition specialists will work on just about everything else.

So when we get a referral for transition services, within two weeks we will go out and do an assessment. And our purpose in gathering that data is to determine not only what the participant needs, but I think more important her wants, preferences and desires.

So we're looking at medical condition, we're looking at a need for care. We're looking at supports, we're looking at housing preferences. Is this person interested in returning to her own home, living with family, going to an assisted living facility, and all of that information is used in order to develop a person-centered plan.

Again the plans will typically take the lead on the health and safety related issues. The pieces of the transition plan that usually consume most of our energy would be housing. We also work on arranging non-medical transportation. Money management services for those who may have difficulty managing their personal finances.

We're reaching out to food pantries. We're connecting people with federal, state and local resources, in some cases volunteer programs. So all of that information is transferred into a person-centered plan and that plan includes the discrete tasks that are necessary for the transition process.

The plan will assign responsibility to either the participant or the transition specialist or in some cases family members, nursing facility staff and then the plan will also establish a target date for each objective as well as for the overall transition.

One of the things I really love about the Texas program is it doesn't target those participants who are most likely to transition. It targets those who face the greatest barriers to independent living. And because of that, the transition process is rarely quick and easy.

So after that plan is developed, the transition specialist will remain in contact with the participant, typically making contact at least monthly until such time as the participant either successfully relocates or withdraws from the program.

When all of the pieces are in place, the transition specialist is responsible for being present on the date of relocation, ensuring that everything is ready to go. That grant purchases have been made, that all of the items have been delivered, the utilities are on, the DME is in place, the providers are showing up. And meet with the health plan service coordinator just to do a final check.

As Elizabeth mentioned, the transition specialist is responsible for following up for 90 days post relocation and confirming that all of the services that were outlined on the transition plan, on the health plan, service plan are in place. But also to determine how well that participant is adjusting to relocation, to see if she's experiencing any issues with social isolation or requiring additional services.

Some of the challenges that we confront include locating affordable, accessible and integrated housing, and certainly this is not unique to the Dallas/Fort Worth area. Although in rapid growth areas such as ours, it can be a tremendous challenge.

And one of the things that the state has done to address this issue, which has been very, very successful, is develop a partnership with the state housing organization, the Texas Department of Housing and Community Affairs.

And that agency has set aside some Section 8 housing choice vouchers for the benefit of nursing home residents who are returning to the community as well as individuals who are exiting the state psychiatric hospitals.

But those vouchers have been invaluable in the Dallas Fort Worth area. All of the public housing authorities are frozen, not accepting applications and typically folks are seeing waits of two years and longer for vouchers through the housing authority. So this state administered housing voucher program has been invaluable.

Another challenge is, given the nature of the Texas program, it does target individuals with complex needs. Most of the participants have been in the facilities for six months or longer. Most are without housing, a disproportionate share have severe mental illness, intellectual and developmental disabilities.

We also target those who require assistance with five or more activities of daily living. Those who require ventilator care. And in working with participants who have multiple complex needs, it really does take a village.

So if an individual has intellectual or developmental disabilities, there are established protocols for coordinating with the local authority for intellectual and developmental disabilities. And that local authority case manager is a key member of the treatment team. If an individual has severe mental illness, oftentimes the local authority for mental health is involved as well.

Now, some of the successes that we've realized are high volumes of successful transition, despite targeting those with complex needs. And high is a relative term. So within our region we're transitioning about 30 to 40 individuals a month.

So, no not big numbers, but some of those individuals have been in nursing facilities for 15 years or longer. The vast majority are without housing. So what we see is, of those people who come into the program, about half successfully transition. So each month we're assessing about 70 individuals, relocating about 35 individuals a month.

We've done well at creating a comprehensive network of supports. Texas has invested funds in providing options counseling to nursing home residents who have Medicaid pending or in -- or are using their Medicare benefits for nursing home stay.

And that provides an opportunity for residents to have access to wise counsel to start identifying needs and cobbling together a transition plan even before the individual will be approved for Medicaid and assigned to a health plan.

The state has also invested in some behavioral health services that I'll mention. I think we've also done well within the state at coordinating with the long-term care ombudsmen, who are invaluable resources in terms of identifying residents who may be interested in relocating, as well as advocating for residents' rights.

If the facility is blocking their transition efforts or if the facilities have issued them involuntary discharge notices and have not followed the procedures for doing that, the Ombudsman can get involved and advocate for the residents.

Elizabeth talked in some detail about the community transition teams which are really helpful forums. I think they work well on two levels, not only addressing the policy barriers, but also providing an opportunity for teams to collaborate on behalf of participants with multiple complex needs.

Texas has also done well at promoting the Consumer Directed Service option. That's a wonderful delivery option for participants who may have family members or friends who are willing and able to provide services that require some kind of compensation in order to do so. Consistently participant satisfaction with the Consumer Directed Service option is much higher than it is for the more traditional agency managed service option.

Texas has also invested in overnight services for participants with very high acuity levels. That pilot allowed attendants to be available, in some cases, 24 hours a day on standby during the night.

Also, Texas has invested in some behavioral health pilots, one that provided cognitive adaptation therapy to participants with severe mental illness up to one year before transition as well as one-year post transition.

Also, Texas has conducted targeted outreach to nursing facility residents who require ventilator care. And this was a response to some concerns that were raised by the disability community.

The state Medicaid agency brought together all of the health plans, the transition contractors, also brought in family members of individuals who required ventilator care and had successfully transitioned and they provided advice, counsel, and kind of best practices.

As a result of that, the health plans reached out to all of their members in nursing facilities who were on ventilator care to determine their interest in transitioning. Only about 10% were interested and at that point the plans convened the interdisciplinary teams to assist those participants in returning to the community.

So I would like to end my remarks with a case study of a successful transition. This participant had cerebral palsy, and had been managing fairly well in the community until he experienced a stroke.

He went into a nursing facility, was there for several months and was miserable. He had some family, but was estranged, really alone in the world. He required assistance with all of his activities of daily living.

As is often the case, he had to give up his apartment and he was willing to go anywhere, but was having difficulty finding housing he could afford. He was willing to consider assisted living facilities, but they declined based on his care needs.

The transition specialist who was with the Center for Independent Living found a manufactured home that had been foreclosed and helped him purchase it for $1,000, even though he received SSI only. They were able to work out a payment plan that worked for him.

The home did require some modifications. The transition specialist was successful in finding community partners who were willing and able to make those modifications. This participant was not able to manage his own checks, because he couldn't sign his name. So the transition specialist found a volunteer money manager.

So it took months and months and months of planning, but really turned out beautifully. Shortly after transitioning, the participant joined a bowling league and with the help of his attendants, he would eye the ball, and the attendant would throw the ball. The participant saw his transition as a life changing event and started going to nursing facilities and mentoring participants who are interested in relocating.

Every year on the anniversary of his transition, he would call his transition specialist and thank her for, in his words, "breaking me out of jail." This participant has since passed away, but he passed away in the community on his own terms.

So with that I will turn the program back to Chris.

Chris Duff: Thank you very much Doni. Great presentation from everyone. We have an amazing list of questions here, and we can't begin to get to all of them. Many of them are just kind of really specific details that we'll handle offline with people, and so we will get back to everyone and Jessie will explain that later on.

But there's two kind of overarching sets of questions that I want to get at. One is housing availability. We've been hearing that everywhere in many webinars, and have certainly came up from all of these speakers. There were some questions around that.

Before we get there even is the question of assessing candidates for relocation. One person, in particular, framed it very nicely, and that's RoAnne from the Michigan Disability Rights Coalition.

Now, of course, she is a National Disability expert so she would frame it well. Her question is, how does the model address the person's right to determine their own level of risk, otherwise known as the distancy of risk? Can risk be mitigated rather than safety ensured?

So it's the whole issue of helping the participant figure out what level of risk they're comfortable with and the distancy of the risk versus all of us feeling comfortable with them being safe. I'm going to start with maybe Elizabeth and then Doni if you can weigh in on that too?

Elizabeth Jones: Right. So thanks. It's Elizabeth and that's a great question, and let me start out and see if Doni wants to add something else. I think it's an important question. I think it is part of what goes on during the assessments and the conversations around transition with the individual.

That is where that community-based organizations sort of bring in their skill level and then the health plans bring in their skill level, and the individual's needs are also discussed.

The plan is set up as much as possible to mitigate any particular risk that may occur for the individual to live safely in the community. And so safety is considered, but we try to work very closely as we can with individuals to ensure that some of that risk is mitigated. Doni?

Doni Green: Yes. I think that's a good response. I do think that, at times the different parties will put greater or lesser emphasis on risk. I think our role as a transition specialist is really to advocate for the participants' rights.

The health plan is certainly concerned with participants' rights as well. But as they're arranging the clinical services, I think they have a tendency to give a little more weight to the risk. What we tell folks is we are not here to say no. We are here to help you find a yes and to advocate for your wants, preferences and desires.

With that said the stars really have to align. So your doctor will have to agree to follow you in the community. The waiver will have to be determined sufficient to meet your needs. And so we really are working with all of those parties.

We're working with providers. We're working with health plans, doing our very best as a group to arrange those services that will respect participants' rights. But also provide services that are necessary to mitigate risk.

Chris Duff: Thank you. Because our time is so limited, I'm not going to be able to get to the housing question, though I know it's a big one and we will figure out some way to respond to those questions offline.

What I am going to get to is a question about finding people. I mean, Texas has a great system in place at the state, local and very local level resource of transition specialists. How do you find those organizations or individuals?

So I'm going to take a first shot at that quickly. I would start at the Health and Disability Resource Center in your community, additionally, the Center for Independent Living or the Area Agency on Aging and Disability. Well, I believe all communities would have one of those.

If they don't feel prepared to provide that service, they would certainly know who would be. So that's where I would start. Elizabeth, would you want to add anything to my response here?

Elizabeth Jones: I think you have covered everything essentially. Thank you.

Chris Duff: Great. OK. With that I'm going to need to turn it back to Jessie so we can complete this webinar. Thanks everyone for attending.

Jessie Micholuk: Thank you, Chris, and thank you everyone for attending today, especially your contribution to our discussion. Feel free to keep sending in those questions. We will be responding to them.

After the webinar, we'll compile the questions and make sure to provide answers and post them on our website. You can also email any questions to us that do come up after the website -- the email address, I would say, would be at the end of this presentation.

I'd also like to thank our presenters, Todd Wilson. Elizabeth Jones, and Doni Green. Thank you for your contributions.

Our next webinar and our last webinar in this series will be held next Wednesday, March 28 and we'll discuss building partnerships between health plans and community based organizations.

For more information about obtaining CEUs or CMEs and for additional resources please visit our website, resourcesforintegratedcare.com. And you can access the CMS continuing education credit guide again on the left-hand side of your platform in the Resource Library.

As always your input is essential in developing new trainings and resources. Please answer our brief survey that will appear automatically on your screen when this webinar ends.

And again you can send any additional comments to our inbox, that's at RIC@lewin.com -- R-I-C at L-E-W-I-N dot com. You can also follow us on Twitter for updates @Integrate_Care.

Once again, thank you for attending today's webinar and have a great rest of your day.