Question & Answer (Q&A): Managing Transitions with Adults with Disabilities Webinar

Webinar participants asked these questions during the Q&A portion of the Managing Transitions with Adults with Disabilities Webinar held on March 28, 2018. Please note, the responses in this document have been edited for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website:
https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2018_DCC_Webinar_Series/Managing_Transitions

Featured Webinar Speakers:

- Christopher Duff, Disability Practice and Policy Consultant
- Todd Wilson, Team Lead, Money Follows the Person, CMS Division of Community Systems Transformation
- Elizabeth Jones, Money Follows the Person Project Director, Texas Health and Human Services Commission
- Doni Green, Director of Aging Programs, North Central Texas Council of Governments

Q1: How does the care team address the person's right to determine their own level of risk, otherwise known as the dignity of risk?

Elizabeth Jones: The topic of risk is discussed during assessments and meetings with the participant prior to the transition. The health plan and community-based organizations are set-up to mitigate any particular risk that may occur for the participant as he or she transitions to living in the community. Safety is always considered during the assessment of the participant's needs and preferences, and we work as closely as we can with the participant and their family to ensure that any risks are mitigated.

Doni Green: At times, the different parties (i.e., the care team and the participant and care partners) will put greater or less emphasis on risk. Our role as transition specialists is to advocate for the participant's rights. As health plans are arranging for clinical services, they have a tendency to give more weight to mitigating risks. Therefore, we are here for the participant to advocate for their wants, preferences, and desires. We must work with all parties involved to ensure that the provider will follow up with the participant in the community and that the transition plan will be sufficient to meet the needs of the participant. We do our best to work with providers, plans, and programs to arrange services necessary to mitigate risk and respect participants' rights.

Q2: How can one find information about programs within their state government that can help provide transition services? What agencies in the community would have transition teams or relocation specialists that we could work with?

Christopher Duff: The best place to start would be with your local Aging and Disability Resource Center, Center for Independent Living, or Area Agency on Aging. These organizations will either be able to assist you with services or connect you to another local resource that could provide necessary services.

Q3: Do long term services and supports (LTSS) include daily home care?

Resources for Integrated Care: According to the CMS definition, LTSS includes a wide range of services to help people live more independently by assisting with personal and health care needs as well as activities of daily living such as eating, bathing, medication management, grooming, ambulation, toilet use, cooking, driving, dressing and managing money. Supports provided by your local transition specialist will vary. Other services offered through local agencies may include adult day centers, counseling, financial assistance, housing, and transportation support.

Q4: How do you address the challenge of housing affordability and availability for low-income seniors?

Todd Wilson: Throughout the Money Follows the Person (MFP) Demonstration, state grantees reported several challenges around securing affordable and accessible housing for participants. To address this, states employed several strategies to improve housing options, including supporting health-housing collaborations and hiring housing specialists.

Elizabeth Wilson: Many states and MFP programs struggle with providing sufficient housing for their participants. The Texas Health and Human Services Commission developed partnerships with the state housing agency to dedicate Section 8 housing vouchers to MFP participants (this program is restricted to nursing facility residents as the primary population and persons in state hospitals as the secondary population). These partnerships use monthly meetings with key stakeholders (e.g., relocation contractors, health plan representatives, housing specialists, and LTSS providers) to address individual and systematic barriers to community relocation, such as transportation, housing, and financial needs.

Q5: How do you address challenges faced when working with participants who are in need of languages other than English?

Resources for Integrated Care: Care partners and participant family members are a valuable resource to ensure services are provided in the language of the participant. Additionally, partner agencies in the community may offer services in multiple languages as well as culturally competent services. Being aware of the needs of your population and the services available locally is important for developing complete transition plans.

Q6: Where are participants usually placed after they transition into the community?

Todd Wilson: Many MFP participants, 38 percent, transition to their home or one owned by a family member. Another 40 percent transition to an apartment. Fourteen percent move to a small group home (which is defined as a home with four or fewer people), and 7 percent transition to an apartment in a qualified assisted-living facility. Approximately 48 percent of younger adults with physical disabilities who transition from institutions, move to apartments.

Q7: Can one apply to provide care for an adult with a disability in his or her home and be compensated financially? If so, what are the qualifications and what is the process?

Doni Green: Texas has promoted the Consumer Directed Service option. This a service 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. Participant satisfaction with the Consumer Directed Service option is consistently much higher than it is for the more traditional agency-managed service option. For similar programs in your area, please check with your local agencies.

Resources for Integrated Care: Through Medicaid, states have several options to provide enrollees with the option to self-direct services. Self-directed Medicaid services allows participants (or their designated care partner) to have decision-making authority over selected services. With self-direction, participants can take direct responsibility to manage their services. For more information, please visit: https://www.medicaid.gov/medicaid/ltss/self-directed/index.html.

Q8: Does MFP provide funds for transportation services?

Resources for Integrated Care: States have employed a wide variety of strategies to meet the transportation needs of their residents, such as teaching people how to use public transportation, linking them with public transportation systems, or effective volunteer and voucher programs that utilize creative funding streams. For more information, please visit the

MFP Rebalancing Demonstration Technical Assistance Center transportation site:
http://www.mfp-tac.com/grantee/toolkit/transportation