NEW YORK ASSOCIATION ON INDEPENDENT LIVING

OpenDoors

Transition Center Project

Peer Outreach and Referral Program

A project of NYS Money Follows the Person

New York Association on Independent Living (NYAIL)

- NYAIL is a statewide, not-for-profit membership association of Independent Living Centers (ILCs).
- ILCs are unique disability-led, cross-disability, locally administered not-for-profit organizations, providing advocacy and supports to assist people with disabilities of all ages to live independently and fully integrated in their communities.
- ILCs have been transitioning and diverting people from institutions for more than 20 years.

Money Follows the Person (MFP)

- MFP is a federal demonstration originated under the Deficit Reduction Act of 2005 and expanded by the Affordable Care Act.
- MFP involves:
  - Transitioning eligible individuals from facilities to the community
  - Using enhanced funding for rebalancing activities

MFP Eligibility

- To be eligible for MFP, an individual must:
  - Have Medicaid at least one day before transition
  - Reside in institution for at least 90 days
  - Transition to a qualified setting, including:
    1) Home
    2) Apartment
    3) Group home with four or fewer unrelated individuals

- **Transition Center Project Goal:** Identify potential participants in nursing facilities, developmental centers and intermediate care facilities and commence successful transitions to one's community of choice.

Transition Center Structure

- 9 Regional Lead ILCs and 14 Auxiliary ILCs
  - Regional Transition Coordinator/Liaison
  - Transition Specialist(s)
  - Over 40 Transition Specialists statewide
    - Range of 3 to 8 Transition Specialists per region
- NYAIL Staff
  - Project Director
  - Statewide Transition Specialist
  - 2 Nurses
  - Social Worker

Referral Sources

- Section Q of the Minimum Data Set (MDS)
- Nursing Home Discharge Planners
- OPWDD
- Self
- Regional Resource Development Centers (RRDCs)
- Conflict-Free Evaluation and Enrollment Centers (CFEEC)
- Family/Advocate
- MLTC Care Managers

The Minimum Data Set (MDS) and Section Q

- The MDS is administered to all nursing facility residents
  - Upon admission, yearly, and whenever there is a significant change in condition
- Section Q of MDS is designed to explore the potential for a resident's return to a community setting

Q0500: Return to Community

  - "Do you want to talk to someone about the possibility of returning to live and receive services in the community?"

The Minimum Data Set (MDS) and Section Q

- All nursing facilities in New York are required by CMS to notify their Local Contact Agency (LCA) within 10 days when a resident answers yes to this question
  - Person-Centered Planning
  - Nursing facilities should not be determining feasibility prior to referral (this is a change in previous CMS policy)
  - In New York State, NYAIL's Transition Centers are the LCAs*

**DOH issued a Dear Administrator Letter describing Section Q requirements and identifying NYAIL as the contact for referrals* (http://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_15-02_mds_3_change_of_designation_lca.htm)

Transition Specialist Role

- Meet in the facility with individuals and family or guardian
- Create Person-Centered transition plan
  - Collaboration with Nursing Home Discharge Planners, Care Managers and Service coordinators
- Identify community resources
  - ILC staff in all areas of state are knowledgeable about community resources
  - Provide objective information about services available
  - Help link individuals to programs that best meet their needs

Transition Specialist Role

- Resolve barriers to transition
  - Lack of affordable, accessible housing
  - Lack of aides
- Follow-up
  - Administer MFP ‘Quality of Life’ survey after transition to assess an individual’s adjustment to the community

Community Preparedness Education (CPE)

- What will an individual need help with on his or her first day in community?
  - Budgeting/bill paying
  - Medication – self administration
  - Meal preparation
  - Feeding self
  - Shopping
  - Bathroom use
  - Dressing self

MLTC and *Open Doors* Common Goals

- Promoting choice
- Enhancing quality of life
- Expanding access to community-based services

Increase HCBS Services = Improve Quality Of Life

Decrease Institutional Services = Decrease Costs

MLTC and *Open Doors*

- *Open Doors:* an asset to MLTC plans
  - Care managers may have members who express a desire to return to the community ➡ Transition specialists can assist with the discharge process
  - Transition Specialists can provide the bridge from the facility to the community ➡ MLTC plans can provide the services needed for people to return to the community

A natural, mutually-beneficial, cross-referral relationship

- **Peer Outreach and Referral Program Goal:** Provide one-on-one peer support to individuals and families interested in transitioning to community living

Statewide Peer Network

- ILC Statewide Network of Peers:
  - Peers will share experiences of living with a disability in the community with participants
  - Peers approximate the characteristics of the MFP participants (age, physical and/or developmental disability)
  - When possible, peers will have transitioned from an institutionalized setting into the community
  - Peers complete a mandatory training prior to providing peer services

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