

**Implementing Recommendations from**  
***Quality Care, No Matter Where: Successful Nursing Home Transitions***  
**A How To Guide for State and Local Advocates**

**July 2015**



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The Consumer Voice is the leading national voice representing consumers in issues related to long-term care, helping to ensure that consumers are empowered to advocate for themselves.

We are a primary source of information and tools for consumers, families, caregivers, advocates, and ombudsmen to help ensure quality care for the individual.

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## Introduction

In its report, *Quality Care, No Matter Where: Successful Nursing Home Transitions*, The National Consumer Voice for Quality Long-Term Care (Consumer Voice) examined transitions nationwide from the perspective of both the individuals who had transitioned from a nursing home and the programs that assist them. Information was collected from former nursing home residents and from state Money Follows the Person (MFP) Program Directors, State Long-Term Care Ombudsmen (SLTCO), and local transition coordinators and ombudsmen. The report discusses the findings and presents ten policy recommendations based on the experiences and observations of the individuals surveyed and interviewed.

The purpose of this “How To Guide” is to provide state and local advocates with concrete strategies and suggestions for implementing the ten recommendations in the report.

## Structure of the “How To” Guide

Each of the 10 recommendations is addressed in its own section and each section includes suggested advocacy steps and one or more model programs that exemplify action to support the recommendation. The models are current at the time of this publication. The appendix to this “How To” guide begins on page 14 and contains 11 documents from these state models.

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## RECOMMENDATIONS FOR IMPROVEMENTS AND ADVOCACY STRATEGIES FOR IMPLEMENTATION

### Report Recommendation #1: Form a state advisory group for nursing home transitions

Collaboration, coordination, and on-going communication with partners in a team-based process was reported to contribute to the success of nursing home transitions. Several SLTCO and MFP Program Directors who were interviewed or surveyed noted that their state has a Nursing Home Transition Advisory group. A strong advisory group should be comprised of state agencies responsible for Medicaid, Disability Services, Aging Services, Housing, Developmental Disabilities and Mental Health, as well as advocacy groups, Long-Term Services and Supports (LTSS) provider agencies, representatives of the SLTCO Program, Centers for Independent Living (CILs), representatives from the Aging and Disability Resource Connection (ADRC), consumers, family members of consumers, and caregivers. In order to ensure that the voice of consumers is heard and well-represented, a significant number of consumers should serve on the state advisory group. The focus of the advisory group should be on policy development, sustainability planning, and coordination of services.

In response to a question about what aspects of state coordination have worked well, one SLTCO stated, "Having the stakeholders group means you always have those resources available if you need them." This strengthens the transition process at every level.

#### Advocacy steps:

- ✓ Research states with strong nursing home transition advisory groups/councils.
- ✓ Reach out to the lead contact agency (LCA - the agency the state contracts with to provide transition services) to inquire about establishing an advisory group for nursing home transitions.
- ✓ Consider linking with stakeholder groups, advisory groups, or task forces that already exist in your state such as an Olmstead Task Force or Home and Community Based Services (HCBS) waiver advisory group.
- ✓ Search for and invite consumers to serve on the advisory group.

#### Model(s):

- Ohio utilizes the Ohio Olmstead Task Force (OOTF) as the Nursing Home (NH) Transition Advisory group. There had been a specific MFP advisory group, but there was so much overlap between the two groups that leaders decided the existing OOTF (<http://www.ohioolmstead.org/>) would serve as the advisory group. The group collaborates on policy development, sustainability planning, and coordination of services and is made up of professionals, including representatives from state agencies; advocates; and consumers.

## **Report recommendation #2: Create and disseminate to nursing home staff written information about community options, resources, and programs that assist consumers to transition**

Not only are residents and family members often unaware of their options, nursing home staff are as well. Facility staff need to know where consumers who want to return to the community can turn for assistance. They also must have at least an understanding of the local housing and service options and resources in order to provide consumers with general guidance. The need for distributing such information to nursing home staff was clearly illustrated by one consumer's statement that "it felt like the blind leading the blind" when talking about the lack of information her social worker had on community options. Another consumer had to learn about the state's waiver program himself and then explain it to his facility's social worker.

### **Advocacy steps:**

- ✓ Collect examples of written materials of community transition options and information.
- ✓ Work with the LCA and/or nursing home transition advisory group to draft initial document (e.g. factsheet, FAQ, or brochure format). Include: program overview, eligibility requirements, enrollment process, services offered and contact information.
- ✓ Ask 2-3 social services directors to review and provide feedback.
- ✓ Work with the LCA and/or nursing home transition advisory group to determine how the information will be produced, regularly updated, and disseminated.
- ✓ Share information with Options Counselors, Transition Coordinators, and Long-Term Care Ombudsmen and encourage them to distribute information to nursing home staff.

### **Model(s):**

- Wisconsin's Department of Health Services Division of Long Term Care developed the *Connections to Community Living (CCL) Frequently Asked Questions for Nursing Home Staff*. The document provides responses for nursing home staff to frequently asked questions related to the CCL. (Appendix 1a)
- The Virginia Department of Medical Assistance Services created a factsheet for providers. The *MFP Overview and Facts for Providers* factsheet includes eligibility requirements, required forms, participant enrollment process, services offered, and contact information. (Appendix 1b)

### **Report recommendation #3: Require nursing homes to post in a public and easily visible place information about programs that help residents transition**

Consumers were clear that they needed information about transition services. Many consumers said they had problems getting any information from nursing homes. According to one consumer, “The nursing home didn’t offer any information on transitioning to independent or home care living. They wanted me to stay and never leave. They should offer a way for residents who don’t need to stay in the home to find the programs that help them leave.”

One woman suggested, “Post information in the nursing home about transitioning and who you can call for information and help.”

To that end, we recommend that information stating that consumers can transition, along with contact information for transition programs, be posted in facilities in public places where residents, family members, and visitors can easily see it.

#### **Advocacy steps:**

- ✓ Gather examples of posters from other states.
- ✓ Pull together a group of nursing home residents to give advice and input.
- ✓ Work with the LCA and/or nursing home transition advisory group to develop a draft poster.
- ✓ Ask the group of nursing home residents to provide feedback on the poster
- ✓ Work with the LCA and/or nursing home transition advisory group to determine how the poster will be produced and disseminated.
- ✓ Ask Options Counselors, Transition Coordinators and Long-Term Care Ombudsmen to distribute the posters to nursing homes in their area and request that facilities voluntarily display the poster.
- ✓ Assess success of voluntary posting after one year using a sample of nursing homes. If fewer than 75% of facilities are displaying the poster, create coalition to seek legislation requiring posting. Include individuals who have transitioned on the coalition and have a consumer ask his/her state legislator to introduce legislation.

#### **Model(s):**

- The Georgia Department of Community Health (DCH) produced a poster that is visible in many nursing homes in Georgia. The posters are distributed to nursing homes by Options Counselors, Transition Coordinators, Long-Term Care Ombudsmen, and Centers for Independent Living representatives. Georgia’s poster includes contact information for the Aging and Disability Resource Connection, Office of the Long-Term Care Ombudsman and Department of Community Health. (Appendix 2a)

- The Texas Department of Aging and Disability Services (DADS) created a poster to inform consumers about MFP and community living options. The poster includes a toll-free number for the DADS Office of Consumer Rights and Services. (Appendix 2b)

#### **Report recommendation #4: Increase affordable and accessible housing options**

Consumers, long-term care ombudsmen, and transition coordinators alike listed the lack of affordable and accessible housing as a problem that slows down and complicates the transition process. One ombudsman stated, “Increase available housing! If we're advocating for people to remain in the community, there needs to be housing for them to live in.” One consumer expressed frustration that he had to remain in the nursing home for an additional 2-3 months solely because he could not find housing. One individual said looking for accessible housing was a challenge because a place may be listed as accessible but sometimes that “just meant you could get through the door; it didn’t guarantee the bathroom was handicap accessible.”

One possible strategy is to leverage the [Medicaid HCBS rule](#) to increase affordable housing options. This rule defines home and community-based settings to ensure that Medicaid’s home and community-based services programs provide full access to the benefits of community living and offer services in the most integrated settings. Another option is to work with the state agency responsible for safe and affordable housing to assign housing vouchers specifically for persons transitioning from a nursing home into the community. This could be accomplished using the [Section 811 Project Rental Assistance Voucher Program](#).

#### **Advocacy steps:**

- ✓ Work with the LCA and/or nursing home transition advisory group to explore housing solutions.
- ✓ Request that the State Housing Agency assign housing vouchers specifically for persons transitioning from a nursing home into the community.
- ✓ Identify internet sites to search for housing options and develop a resource document (Appendix 3a).
- ✓ Advocate for state and/or regional staff to be designated to work exclusively on developing housing resources.
- ✓ Advocate for additional financial resources for housing in order for the state to comply with the Medicaid HCBS rule requiring integration into the community of individuals receiving Medicaid-funded HCBS services.

#### **Model(s):**

- In Michigan, the Michigan Department of Community Health, Money Follows the Person (MFP) project funds Nursing Facility Transition (NFT) Housing Specialists (Appendix 3b). NFT Housing Specialists work at the regional level to assist individuals transitioning from nursing facilities with housing options. Successes attributed to the NFT Housing

Specialists include: locating increased number of accessible housing, housing resources, and housing opportunities for participants; development and maintenance of a housing directory available to the general public; involvement in [Continuums of Care](#) (a collaborative made up of representatives from agencies with the mission of providing housing-related services to those who are homeless or living in substandard housing) to keep the needs of nursing facility transition participants in the forefront; development of collaborative efforts with stakeholders and housing providers; and collaboration with the Michigan State Housing Development Authority to implement Housing 811 Voucher Program.

- The Georgia Department of Community Affairs offers three different types of housing vouchers that are set aside for individuals returning to the community from institutional stays:
  - 1) Non-Elderly Disabled (NED) Vouchers are available to individuals with disabilities under the age of 60 who wish to live in Dekalb County. The vouchers are administered by the Decatur Housing Authority. Georgia MFP has dedicated access to 34 vouchers.
  - 2) Rental Assistance Division's Housing Choice Vouchers (commonly referred to as "Section 8" vouchers) are available in all but 10 Georgia counties. Most major metro areas are excluded. There are no age restrictions. Georgia MFP has access to 25 vouchers.
  - 3) HUD 811 Project-oriented vouchers are being developed to serve individuals transitioning with the Money Follows the Person program MFP and others as well. Approximately 300 vouchers will be available in five major metro areas and are designed to assist areas not served by the "Section 8" vouchers.

These vouchers combined with Georgia's MFP Transition Services, such as Environmental Modifications and Adaptive Technology, are enabling GA MFP to transition many low-income Georgians with disabilities.

- The Colorado Department of Local Affairs (DOLA) has launched a coordinated effort with the Colorado Housing and Finance Authority (CHFA) called the 2015 Permanent Supportive Housing Program Pilot. The purpose of the pilot is to increase the production of Permanent Supportive Housing (PSH) for homeless people and other special needs populations. The resources offered by both agencies can be found by clicking [here](#).



## Report recommendation #5: Increase transportation options in the community

As described in this report, transportation was one of the biggest problems faced by consumers after their move back into the community. “Transportation is of the essence. People need to be free to go and not sitting at their home” explained one consumer. Another individual reflected that she was fortunate that the public bus stop was near her home so she could get out to talk to and meet new people. She said that without access to transportation, “she didn’t know how she could cope.”

In order for consumers to successfully live in the community, they must have access to readily available transportation. The Medicaid HCBS rule, mentioned in recommendation #4, could be leveraged to develop and expand transportation options in the community.

### Advocacy steps:

- ✓ Find out what transportation options are available in your state.
- ✓ Research transportation options/programs in other states.
- ✓ Interview consumers to determine common transportation needs/concerns.
- ✓ Work with consumers, the LCA and/or nursing home transition advisory group to explore and implement state and/or local transportation solutions, such as funding options under the Affordable Care Act, finding ways to subsidize routes, and/or alternative transportation options.

### Model(s):

- Connecticut is using the Section 1915(i) State Option under the ACA to increase transportation. Section 1915 (i) allows states to provide Medicaid-funded HCBS to individuals whose income does not exceed 300 percent of Supplemental Security Income (SSI) and serves Medicaid recipients who are 65 years of age or older and require assistance with one or two critical needs, such as bathing, dressing, toileting, eating, transferring, meal preparation, and medication administration. Transportation services provide access to social services, community services, and appropriate social or recreational facilities. This service is offered in addition to medical transportation under the state plan and does not replace it. Taxis, buses, volunteers, or other individuals or organizations can provide transportation when necessary to provide access to needed community-based services or community activities as specified in an individual’s plan of care.<sup>1</sup> Connecticut is the only known state that specifies community transportation for older adults or adults with physical disabilities in its state option.

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<sup>1</sup>Expanding Specialized Transportation: New Opportunities Under the Affordable Care Act. Wendy Fox-Grage and Jana Lynott, AARP Public Policy Institute January 2015.

- In Rochester, NY, Medical Motor Services forged partnerships with a grocery store chain to provide a fully subsidized shopping shuttle.<sup>2</sup>

Additional information that could be helpful in implementing this recommendation follows:

- The [Community Transportation Association of America's \(CTAA\) website](#) offers information and provides links to numerous resources such as:
  - The [National Center for Mobility Management, which](#) is an initiative of the United We Ride program, and is supported through a cooperative agreement with the Federal Transit Administration. Search the **States at a Glance** map for links to regional and state transportation: <http://web1.ctaa.org/webmodules/webarticles/anmviewer.asp?a=1036&z=90>
  - [Transit Planning for All](#)
  - [Strengthening Inclusive Coordinated Transportation Partnerships to Promote Community Living .](#) The mission of this project, sponsored by the Department of Health and Human Services' Administration for Community Living is to demonstrate the value that inclusive processes can bring to transportation efforts. CTAA in partnership with Easter Seals, National Association of Area Agencies on Aging, and Westat is developing, testing and demonstrating ways to empower people with disabilities and older adults to be actively involved in designing and implementing coordinated transportation systems.

### **Report recommendation #6: Provide greater support to individuals returning to the community**

Connecting with someone who has already successfully transitioned to the community or others who are in the process of doing so can be a particularly powerful source of support and assistance. Approaches include:

- **Peer mentoring.** A peer mentor can provide the consumer with suggestions and ideas based on his/her own personal experience and first hand experiences – something a transition coordinator cannot do. Peer mentors can also provide knowledge, information, and understanding, while creating a meaningful and supportive relationship during this transitional process. This relationship can be particularly important following the move out of the nursing home since a number of interviewees reported feeling isolated and lonely after being around many other people in the facility.
- **Buddy System.** If a paid peer-mentoring program is not feasible, a one-on-one “buddy system” could be created to connect a consumer who is transitioning to a person who has already transitioned.

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<sup>2</sup> Weaving It Together: A Tapestry of Transportation Funding for Older Adults. AARP Public Policy Institute. April 2013.

- **Support group.** Instead of a one-on-one approach, support groups bring a number of people together who are going through similar experiences. This gives them the opportunity to share their own experiences, compare notes about resources, talk about their feelings, and improve coping skills.
- **Community Support Coach.** Although Community Support Coaches are not mentors or peers, they provide services and supports to consumers who have transitioned. Coaches work to assist consumers as they adapt and adjust to being independent and responsible for their daily lives.
- All four approaches would provide skills building, guidance, emotional support, and encouragement to the person leaving the nursing home.

### Advocacy steps:

- ✓ Contact your Statewide Independent Living Council (SILC) to learn if peer mentoring, a buddy system, support groups, or community support options are available in your state.
- ✓ Ask your National Alliance on Mental Health (NAMI) State Organization, NAMI Affiliate, local department of mental health, or community mental health center where to locate peer mentoring resources.
- ✓ Work with the LCA and/or nursing home transition advisory group to develop support services.
- ✓ Engage former nursing home residents who are now living in the community to serve as peer mentors, buddies, or support group leaders.
- ✓ Partner with your SILC and/or local Center for Independent Living (CIL) to provide training.
- ✓ Provide support and ongoing assistance to individuals serving in these roles.
- ✓ Advocate for Community Support Coaching to be added as a waiver service.
- ✓ Advocate for peer mentoring to be expanded to people transitioning, in addition to persons with developmental disabilities and advocate for funding.

### Model(s):

- The [Arizona Bridge to Independent Living](#) serves as one model for providing peer support. The agency offers peer support in two ways: the majority of the direct service staff have disabilities; and they train Peer Mentor volunteers who work with individuals, including people who are transitioning, to help them achieve their independent living goals. Additional information, including the Peer Mentoring program brochure (Appendix 4), is available at <http://www.abil.org/peer-mentoring-services/>.
- “Community Support Coaching” (CSC) is a service available through [Ohio’s HOME Choice program](#). CSC provides education and assistance to qualified individuals during the home transition/relocation process by helping an individual make informed and

independent choices, setting and achieving short and long term goals, managing multiple problems, and identifying options and problem solving. The [Services for Independent Living, Inc.](#), located in northeast Ohio, offers many support services for consumers transitioning into the community, including community support coaching, peer support, and peer support groups.

### **Report recommendation #7: Establish local groups of peers/advocates**

One way to both inform consumers in nursing homes about their options and support them during the transition process is through the creation of a group of individuals who have already moved out of a nursing home. Former nursing home residents who are now living in the community are the true experts. Such a group is exactly what one consumer recommended; she felt there should be a program where people who have lived in a nursing home and transitioned go into nursing homes to 1) talk to residents about moving out; 2) connect them to a program to help them; and 3) keep in contact with residents who want to move out to see if they are receiving the help they need.

#### **Advocacy steps:**

- ✓ Contact your SILC to learn about peer advocacy opportunities.
- ✓ Recruit someone to serve as leader of this peer advocacy group.
- ✓ Engage former nursing home residents who are now living in the community to serve as peer advocates and be part of a group.
- ✓ Partner with your SILC and/or local CIL to provide advocacy training.
- ✓ Provide support and ongoing assistance to group members.

#### **Model(s):**

- A model example of such a group is the [SunShine Folk](#) (Appendix 5), an organization of Marylanders who assist consumers in transitioning back into the community. Members of the group are mainly former residents themselves. Established in 2005 by the Maryland Disability Law Center, the group works to assist its peers by entering institutional settings and speaking with residents one-on-one about Medicaid programs and their options for moving back into the community. The group supports individuals throughout the complete transition process by letting people know of their options and then mentoring them through each step it takes to get back to the community.

## Report recommendation #8: Seek written guidance about the role of nursing home staff from the Centers for Medicare and Medicaid Services (CMS) and/or state survey agency

Several consumers, as well as ombudsmen and transition coordinators, reported having problems with the transition process because nursing home staff did not provide the necessary assistance. Examples include failing to prepare and make available at the time of discharge the necessary resident paperwork and medications. One consumer said, “The nursing home was no help.”

Under [federal nursing home regulations](#) (§483.12(a)(7) Orientation for Transfer or Discharge), a facility must provide *sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility*. It must also *assure that sufficient and appropriate social service are provided to meet the resident’s needs* (§483.15(g) Social Services), which includes discharge planning services.<sup>3</sup>

We recommend that CMS issue a Survey and Certification (S&C) letter to state survey directors detailing what the nursing home must do to comply with these requirements as part of the discharge planning process. The S&C letter should specifically address the facility’s role in transitions, including keeping residents informed, assisting residents with phone calls, packing, having medications and paperwork ready upon discharge, etc.

Should CMS fail to write an S&C letter, state survey agency directors should provide such guidance directly to nursing home providers.

### Advocacy steps:

#### Survey and Certification letter

- ✓ Document examples of lack of nursing home assistance and its impact on consumers.
- ✓ Engage State Long-Term Care Ombudsman and MFP Program Director to bring this issue to the National Association of State Long-Term Care Ombudsmen, National Association of Local Long-Term Care Ombudsmen, Consumer Voice, and the National Disability Rights Network. Ask these organizations to advocate directly with CMS to issue a Survey and Certification letter on this issue. Provide examples collected earlier.

#### State survey agency guidance

- ✓ Bring organizations/groups together that support this effort. Possible groups include LCA, nursing home transition advisory group, SILC, state Area Agency on Aging association, citizen advocacy groups, and consumer transition group, if any.
- ✓ Work together to send the state survey agency a letter requesting that the agency issue guidance regarding the role of facility staff in transitions. Include list of the points the group thinks should be part of such guidance.
- ✓ Advocate as a group to obtain this guidance. Start by meeting with officials of the state survey agency.

<sup>3</sup> [https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/som107ap_pp_guidelines_ltcf.pdf);  
See F204, p. 47-48

### Model(s):

- Information letters issued by the Texas Department of Aging and Disability Services (DADS) in 2004 and 2007 could be used as a model for state survey agency guidance. These informational letters (Appendices 6a and 6b) informed providers of the DHS Promoting Independence Initiative to offer enhanced community options for individuals receiving long term services and supports. The letters specifically informed providers of the role of Relocation Specialists and their access to nursing facility residents and clinical records. The content of these letters could be revised to set forth the specific assistance nursing home staff must provide to residents who are transitioning back into the community, such as helping them to pack, ensuring they leave with prescriptions for the medications they will need, etc.

### **Report recommendation #9: Identify and/or develop creative, flexible funding to ensure that housing, services, and supports are in place prior to transition**

As mentioned in the report, several consumers had problems with services and supports not being set up prior to their move, often because services cannot be paid for while the person is still in the nursing home. This creates a stressful and possibly dangerous situation. Transition programs at both the state and local level should actively explore ways to cover these expenses. Potential resolutions include: developing state and local funding sources and creating a repository for used medical equipment and household items.

### Advocacy steps:

- ✓ Work with the LCA and/or nursing home transition advisory group to explore flexible funding options.
- ✓ Develop tips for cultivating new funding sources for local transition programs, such as Social Services Block Grant (SSBG) money.
- ✓ Contact your SILC to learn about equipment re-purposing and loan programs.
- ✓ Partner with your local CIL, Area Agency on Aging (AAA), local social service agencies, Transition Coordinators and Long-Term Care Ombudsmen to develop a repository for used medical equipment and household items.

### Model(s):

- Several CILs assist with durable medical equipment and household items by operating their own repository for used items. Examples of repositories include [disABILITY LINK's Loan Closet](#), [The Ability Center's](#) web resource for individuals seeking to buy or sell disability equipment, and [Services for Independent Living, Inc.](#)
- One local program obtained SSBG funding.

**Report recommendation #10: Provide residents, based on their choice, with a team to support them from the time they decide to transition through, at a minimum, the first 90 days after the transition**

Consumers should have the option of working with a well-defined, formally recognized transition team to create a thorough transition plan that carefully considers their home and community support needs. The composition of the support team would change as the consumer progresses through the transition process. During the planning phase, the team might consist of the consumer, transition coordinator, ombudsman, nursing home social worker/discharge planner, family and friends. After the move, the consumer's team members would likely include the case manager, transition coordinator, home care ombudsman (if available), peer mentor, family and friends. The team would provide assistance with addressing issues and concerns, including modifying the consumer's plan of care and advocating for more service hours if needed. The team would support the consumer for at least ninety (90) days post-transition.

**Advocacy steps:**

- ✓ Interview consumers who have transitioned about the process and their experience with a transition team.
- ✓ Work with a group of consumers to make recommendations for establishing a support team to work with them through and post transition.
- ✓ Work with the LCA and/or nursing home transition advisory group to implement consumer recommendations for providing team support.

**Model(s):**

- The Ohio HOME Choice Program provides an effective model for supporting consumers throughout the transition process. The support team consists of different individuals who work together during the various stages of the transition (pre-transition, the actual transition, and post transition up to 365 days) (Appendix 7). The [Community Living Specialists "How To" Guide](#) is a training resource for team members, while the [Ohio Choice Relocation Workbook](#) is a planning resource for consumers to assist with determining needs and desires for community living.

## APPENDICES

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Appendix 1a - Wisconsin – Connections to Community Living Initiative (CCL) FAQ  
<https://www.dhs.wisconsin.gov/ccl/nursing-home.htm>

# Connection to Community Living

## Frequently Asked Questions for Nursing Home Staff

2013



State of Wisconsin

Department of Health Services

Division of Long Term Care

<http://www.dhs.wisconsin.gov/ccl>



## **Connections to Community Living (CCL) Frequently Asked Questions for Nursing Home Staff**

This document provides responses for nursing home staff to frequently asked questions related to the Connections to Community Living Initiative (CCL).

1. What is Connections to Community Living (CCL)?

The Wisconsin Department of Health Services and local Aging and Disability Resource Centers (ADRC) are working with older adults and people with disabilities who live in nursing homes, state Centers, and ICFs-ID to provide information about community living. The Connections to Community Living (CCL) initiative helps older adults and people with disabilities understand that they have a choice as to where they will receive their care.

Through Connections to Community Living, an individual learns about options for living in a home environment while receiving the services needed to be healthy and safe. The person-centered planning process includes “an exploration with the person’s preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.” Persons who are living in institutions are encouraged to choose the least restrictive and most integrated setting. They may have discussed this with the facility social worker, the MDS coordinator, staff from the ADRC or a Community Living Specialist who works with the CCL program.

The Connections to Community Living Project is intended to help residents explore options, discuss with guardians and other family members a resident’s preferences, and work with residents and their families to choose among the long term care options available to them. CCL connects individuals and their families to the ADRC for options counseling and, if eligible, public long term care benefit programs.

The CCL Project assists with identifying and reducing barriers to relocation, such as income and housing challenges, and may continue to provide support in the person-centered planning process to ensure that a resident’s preferences are expressed within the interdisciplinary team (IDT).

The CCL Project works with all residents in an institution who are interested in community living. This includes, for example, residents who have recently been admitted to a facility, either for rehabilitation services, respite, or skilled nursing services, as well as residents who have been living in a facility on a long-term basis. It also includes all residents regardless of payment source (i.e. those who are recipients of Medical Assistance and/or Medicare as well as those whose expenses are paid for with private funds or insurance). For those residents receiving Medical Assistance, CCL services are available whether or not a resident is a member of an Managed Care Organization (MCO).

As needed, the CCL Project works with the facility discharge planner and social worker, the ADRC options and enrollment counselor, the care manager or other IDT staff, and the family and other individuals and agencies assisting the individual.

2. Who is eligible to participate in this program?  
Anyone who currently lives in a Wisconsin licensed nursing home or facility for the intellectually or developmentally disabled is eligible to participate in this program. There are some public funding restrictions depending on which county the nursing home is located in.
  
3. Why is this initiative being implemented?  
Consumer advocates, states, and the federal government are advancing nursing home transition programs to help older adults and people with disabilities leave nursing homes and return to their homes and communities if they so desire. An essential component of nursing home transition efforts is assertive identification of the nursing home residents who prefer a home- or community-based setting rather than the nursing home. One potential way to help identify individuals who want to transition is better use of the Long Term Care Minimum Data Set (MDS); especially Section Q that addresses discharge potential and overall status of the resident. Using this process, the nursing home staff will regularly ask the resident if they would like to talk to someone about returning to the community, since resident needs and the services available in the community may change over time.
  
4. Who are the Community Living Specialist (CLS) and what is their role?  
The overall responsibility of the Community Living Specialist (CLS) is to:
  - provide quality outreach to nursing home residents and providers;
  - develop an outreach plan designed to identify and engage residents who are interested in relocating to the community;
  - provide outreach to residents of nursing homes in assigned service area and develop working relationships with key facility staff;
  - collaborate with nursing home staff to identify potential relocations;
  - collaborate with discharge planners on addressing barriers to relocation;
  - advocate on behalf of residents who encounter barriers to relocation;
  - connect residents with advocacy organizations, such as ombudsman programs, as necessary;
  - provide formal education and training to nursing facility staff about community living alternatives and options for addressing health and safety in community based settings;
  - provide informal and formal opportunities for residents to learn about community options and ways to overcome barriers associated with transition;
  - make presentations to resident councils and other groups as assigned;
  - develop a process, in collaboration with ADRCs in assigned service area, for receiving MDS Section Q referrals;
  - work with the nursing homes to understand the purpose, requirements and the process for making referrals;
  - work with private pay nursing home residents;
  - successfully complete options counseling and other relevant training required to perform duties;
  - as appropriate and in collaboration with the nursing home, work with individuals (and their representatives) who have been admitted to the nursing home for rehabilitation or short-term stays, ideally while the individual has a home, apartment or other community residence;

- for people who will be discharged as private pay, work with discharge staff in the nursing home to provide information, help overcome barriers and ensure that a safe, sustainable discharge plan is in place;
- provide options counseling as appropriate or required beyond typical discharge planning;
- follow up with people shortly after discharge to the community to see how they are managing and whether there is additional information or assistance that would be helpful and
- collaborate and coordinate with Aging and Disability Resource Centers, according to policies and procedures developed locally, to ensure timely referrals between the ADRC and the Community Living Specialist.

5. Who should I talk with if there is a resident interested in moving to the community? You should first talk with your local Aging and Disability Resource Center (ADRC). A staff person from the ADRC will come to visit the resident and their family member at the nursing home to talk about options. More information about the role of an ADRC can be found at the [ADRC website](#).

6. So if the resident decides they want to move back to the community then what are the next steps?

The next steps depend on the resident's payer status.

If the resident currently uses private funds or insurance to pay the nursing home, then the resident would work with the social worker from your facility who would get them into contact with the local ADRC (see question #5). The ADRC and the nursing home social worker would research the best options to meet the resident's current and on-going needs in the community.

If the resident requires public funding, and your nursing home is in an area served by Family Care or IRIS, then after meeting with a representative of the ADRC (see question #5) the resident would enroll in one of the managed care organizations. The resident would then work with an interdisciplinary team with the managed care organization to explore the best options to meet current and on-going needs in the community. Staff of the nursing home would be consulted as you are most familiar with the resident. More information about Family Care and the role of the managed care organization can be found on the [IRIS](#) or [Family Care website](#).


If the resident requires public funding, and your nursing home is in a non-Family Care County, then after meeting with a representative of the ADRC (see question #3) the resident would meet with a care manager from the county department of human services. Together they would explore the best options to meet the resident's current and on-going needs in the community. Staff of the nursing home would be consulted as you are most familiar with the resident. More information about Waiver County Services and the roll of the care manger can be found at: [http://www.dhs.wisconsin.gov/LTC\\_COP/CONTACTS.HTM](http://www.dhs.wisconsin.gov/LTC_COP/CONTACTS.HTM)

In all these scenarios the goal will be to move the person to a home or an apartment with supports if that is feasible. The team will look into available services (like help with personal and medical care) and programs that may help pay for needed services when appropriate. They'll also look into housing options and/or home modification services.

7. Through this initiative, can a resident move to an assisted living community?  
A primary goal of Wisconsin's long term care programs is to support people to live in their own homes or with family. Services in facilities are only provided as a last resort. If a resident requires public funding, there are a number of conditions that would have to be met for the resident to relocate to an assisted living facility such as a Community Based Residential Facility (CBRF). These conditions ensure that home-care and residential options are explored and discussed with the individual, that the person prefers an assisted living setting over other settings, that it is cost effective, and that it is a quality setting.
  
8. Can a resident who has started a plan to leave the nursing home change his or her mind if and stay in the nursing home?  
Absolutely. This initiative is about resident choice and trying to eliminate barriers to a move for those interested. A resident decides whether or not to start the plan to leave the nursing home and can change that decision at any time. Staff administering the MDS assessment will periodically ask the resident if she or he wishes to talk with someone about returning to the community.
  
9. What is my role as a social worker of the nursing home related to this initiative?  
You have an extremely important role in discharge planning. Discharge planning should begin as soon as the resident enters the facility. The ultimate goal for some residents may involve transfer to another facility, admission to alternative treatment programs or returning home to an independent level of functioning. Whatever the ultimate goal, discharge planning is a critical part of the resident's overall plan of care and can be a useful tool in determining progress towards the goals identified in the care plans. The social worker should always encourage and support the resident's effort to function at the highest possible level. For those residents leaving the facility to return home or to placements in other facilities, discharge plans should focus not only on the immediate care needs of the resident but also on the transition and relocation needs of both the resident and their family or support system. These may include visits to the new facility, family orientation or training to the care needs of the resident or introduction to home-based caregivers. Discharge planning should be an interdisciplinary assessment process that includes and encourages physician, dietary, therapy, nursing, and family involvement. The plan should be specific, relevant and individualized to the overall needs and abilities of each resident.

## Appendix 1b – Virginia MFP Overview and Facts for Providers

[http://www.dmas.virginia.gov/Content\\_atchs/ltc/ltc-mfp\\_pfs2.pdf](http://www.dmas.virginia.gov/Content_atchs/ltc/ltc-mfp_pfs2.pdf)

 <h1 style="text-align: center;">Money Follows the Person (MFP)</h1> <h2 style="text-align: center;">Overview and Facts For Providers</h2> <p>Department of Medical Assistance Services 600 East Broad Street, Suite 1300 Richmond, Virginia 23219 <a href="http://www.dmas.virginia.gov">www.dmas.virginia.gov</a></p>	
<b>MFP Overview</b>	<p>In 2008, Virginia launched Money Follows the Person (MFP) to provide extra supports and services to Virginians who choose to transition from long-term care institutions into the community. MFP moves Virginia closer to a rebalanced long-term support system that promotes choice, quality, and flexibility for participants by paying for necessary start-up expenses during the transition period out of a long-term care institution. Virginia receives funding and support for this program from the Centers for Medicare and Medicaid Services (CMS).</p>
<b>MFP Participant Eligibility Requirements</b>	<p>To qualify for MFP, the potential participant must:</p> <ul style="list-style-type: none"> <li>• Have resided for at least 90 consecutive days in a long stay hospital, nursing facility (<i>any days spent in short-term skilled rehabilitation services do not count towards the 90 days</i>), intermediate care facility for individuals with intellectual disabilities (ICF-IID), long-stay hospital, institute for mental diseases (IMD), psychiatric residential treatment facility (PRTF), or a combination thereof <b>and</b>;</li> <li>• Be a resident of the Commonwealth of Virginia <b>and</b>;</li> <li>• Have received Medicaid benefits for inpatient services for at least one day prior to MFP enrollment <b>and</b>;</li> <li>• Qualify for, and enroll into upon discharge, a Program for All-inclusive Care for the Elderly (PACE) or one of the four following waiver programs:             <ul style="list-style-type: none"> <li>○ Elderly or Disabled with Consumer-Direction Waiver (EDCD),</li> <li>○ Individual and Family Developmental Disabilities Support Waiver (DD),</li> <li>○ Intellectual Disabilities Waiver (ID), or</li> <li>○ Technology Assisted Wavier (TECH) <b>and</b>;</li> </ul> </li> <li>• Move to a “<b>qualified residence</b>.” A <b>qualified residence</b> is: 1) a <i>home</i> that the individual or the individual’s family member owns or leases; 2) an <i>apartment</i> with an individual lease, with lockable access and egress, that includes living, sleeping, bathing and cooking areas over which the individual or the individual’s family has domain and control; or 3) a <i>residence in a community-based residential setting</i> in which no more than <i>four (4) unrelated individuals</i> reside.</li> </ul>
<b>Important MFP Forms</b>	<p>The following forms must be completed for <b>each MFP Participant</b>.</p> <ul style="list-style-type: none"> <li>• MFP Informed Consent Form (DMAS-221)</li> <li>• MFP Enrollment Form (DMAS-222)</li> <li>• MFP Quality of Life Survey (DMAS-416)</li> </ul> <p>These forms can be found on the <b>Virginia Medicaid Web Portal</b> in “<b>Providers Form Search</b>” under the “<b>Provider Services</b>” tab.</p> <p><i>*These forms are completed by the Transition Coordination Provider (TCP).</i></p>

<b>MFP Participant Enrollment Process Breakdown</b>	<p>MFP Participant Enrollment Process:</p> <ul style="list-style-type: none"> <li>▪ Individual selects and informs Transition Coordination Provider (TCP) or institutional staff of interest in enrolling in MFP;</li> <li>▪ TCP meets with individual and determines MFP eligibility;</li> <li>▪ TCP completes the MFP Informed Consent Form (DMAS-221), and the MFP Enrollment Form (DMAS-222), maintains a copy in the individual's record and <u>sends a copy to DMAS</u>;</li> <li>▪ Individual and TCP develops an Individual Support Plan that includes a back-up plan for essential services; and</li> <li>▪ TCP administers Quality of Life Survey (DMAS-416) once, prior to discharge from the facility, and <u>sends a copy to DMAS</u>.</li> </ul> <p>* Please Note: Completion of the forms and enrollment steps does not mean MFP participants will be able to transition out of the institution immediately. While all circumstances vary, participants, facilities, and TCPs should anticipate at least <u>6-8 weeks after enrollment in MFP</u> for successful transitioning of the participant out of the institution.</p>
<b>Services Offered through MFP</b>	<p>Individuals participating in MFP have access to the following services:</p> <ul style="list-style-type: none"> <li>▪ <b>Transition Coordination</b> up to two months prior to and 12 months following discharge from an institution, for a total of 14 months (<b>Only for individuals transitioning to the EDCD Waiver</b>);</li> <li>▪ <b>Transition Services</b> up to nine months, two of which can be prior to discharge from an institution where the TCP will assist the client in making essential household purchases, and paying for moving costs, and one-time deposits (<i>when such funding cannot be obtained from other sources</i>). <ul style="list-style-type: none"> <li>○ Items are purchased and deposits are paid on behalf of the participant by the TCP and reimbursed to the TCP. <b>At no time are MFP funds ever given or paid directly to MFP participants by Medicaid.</b></li> </ul> </li> <li>▪ <b>Assistive Technology</b> for individuals who are enrolled in the EDCD waiver for up to 12 months after discharge from an institution;</li> <li>▪ <b>Environmental Modifications</b> for individuals who are enrolled in the EDCD waiver for up to 12 months after discharge from an institution.</li> </ul> <p>*Please Note: Individuals also have <u>access to supports</u> offered within the waiver (or PACE program) they use.</p>
<b>DMAS MFP Contacts</b>	<p style="text-align: center;"> <b>Department of Medical Assistance Services (DMAS)</b>  <b>Long-Term Care Division</b>  <b>Phone: 1-800-552-8627</b>  <b>Email: <a href="mailto:MFP@dmass.virginia.gov">MFP@dmass.virginia.gov</a></b>  <b>Webpage: <a href="http://www.dmass.virginia.gov/Content/pgs/ltc-mfp.aspx">http://www.dmass.virginia.gov/Content/pgs/ltc-mfp.aspx</a></b> </p>

**Appendix 2a – GA MFP Poster**

[https://dch.georgia.gov/sites/dch.georgia.gov/files/related\\_files/document/MFPposter\\_July2012\\_FINAL.pdf](https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/MFPposter_July2012_FINAL.pdf)

**Are you interested in living at home,  
rather than a nursing home?**

*If so, the Georgia Department of  
Community Health may be able to help.*

# Money Follows the Person (MFP)

*“MFP is the best  
thing the state  
has ever done.”*

Cathy, MFP participant



*“[I’m] happy to be  
independent, and the  
MFP program is the*

*best program  
in Georgia.”*

Brenda, former MFP  
participant



Call the Department of Human Services (DHS),  
Aging and Disability Resource Connection at  
**866-55-AGING (866-552-4464)**, the Office  
of the Long-Term Care Ombudsman at  
**888-454-5826** or DCH at **404-651-9961**.  
You can also log on to [dch.georgia.gov/mfp](https://dch.georgia.gov/mfp)





## Appendix 2b – TX MFP Poster

[http://www.dads.state.tx.us/news\\_info/publications/brochures/DADS201-mfp.pdf](http://www.dads.state.tx.us/news_info/publications/brochures/DADS201-mfp.pdf)



# You may not have to live in a nursing facility



The Texas Department of Aging and Disability Services (DADS) has a policy called “Money Follows the Person” that allows people who are eligible for Medicaid and living in a nursing facility to choose an appropriate community setting and receive community services and supports.

## You have options

Under Money Follows the Person, Medicaid-eligible nursing facility residents who prefer to live in their own homes and communities can do so.



### Your options to live in the community could include:

- Participation in waiver programs that provide a wide range of community long-term services such as personal care, nursing, therapies, adaptive aids, medical supplies, and minor home modifications or
- Participation in community services programs that provide limited care in your own home, the home of a relative, an adult foster care home, or an assisted living residence.

### Things to consider when choosing your options:

- Services and supports available to meet your needs in the community are limited. Twenty-four hour services are not available.
- Funds for your community services and supports are limited and cannot exceed the cost of providing similar services in a nursing facility.



To learn more about community options that may increase your independence, please call your local Texas Department of Aging and Disability Services office or the DADS Office of Consumer Rights and Services at 1-800-458-9858.

DADS Media Services - 3/26/07 - #453280 - Publication 2/01



## Appendix 3a – Virginia Housing Resource List (page 1 of 3) 5/2015

[http://www.dmas.virginia.gov/Content\\_atchs/ltc/Housing%20Search%20Tools%20DMAS%20website%20version2PDF.pdf](http://www.dmas.virginia.gov/Content_atchs/ltc/Housing%20Search%20Tools%20DMAS%20website%20version2PDF.pdf)

1. **VHDA Housing Search** - <http://www.virginiahousingsearch.com/>
2. **Pad Mapper** - <http://www.padmapper.com/>
3. **HUD Affordable Apartment Search** - <http://www.hud.gov/apps/section8/step2.cfm?state=VA%2CVirginia>
4. **The Better Housing Coalition** - <http://www.betterhousingcoalition.org/>
5. **Center for Housing plus Services** - [http://www.leadingage.org/Center\\_for\\_Housing\\_Plus\\_Services.aspx](http://www.leadingage.org/Center_for_Housing_Plus_Services.aspx)
6. **Virginia Easy Access** - <http://easyaccess.virginia.gov/>
7. **Elder Care Services Locator** - <http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx>
8. **Resources for Felons** - <http://www.boazandruth.com/>
9. **Virginia Cares Programs for Felons** - <http://www.swva.net/nrca/va-cares.html>
10. **VA Centers for Independent Living (VACIL)** – [www.vacil.org](http://www.vacil.org)
11. **Access VA** - <http://www.accessva.org/>
12. **Homestretch (Fairfax County)** - <http://homestretchva.org/>
13. **Housing Opportunities Made Equal (HOME)** - <http://www.phonehome.org/>
14. **VA Congregate Living** - [http://www.retirementhomes.com/homes/Congregate\\_Living/USA/Virginia/index.html](http://www.retirementhomes.com/homes/Congregate_Living/USA/Virginia/index.html)
15. **Virginia Supportive Housing** - [www.virginiassupportivehousing.org](http://www.virginiassupportivehousing.org)
16. **VA Dept. Aging and Rehabilitative Services (VDARS)** – [www.darsvirginia.gov](http://www.darsvirginia.gov)
17. **Housing and Urban Development (HUD)** – <http://portal.hud.gov/hudportal/HUD>
18. **VA Board for People with Disabilities** - <http://vaboard.org/>
19. **Virginia Division for the Aging Website** - <http://www.vda.virginia.gov/links.asp>
20. **Senior Navigator** - <http://www.virginiannavigator.org/sn/Default.aspx?.m=z&.f=1&.ct=25Senior Navigator>
21. **Money Follows the Person (MFP) Program** - [http://www.dmas.virginia.gov/Content\\_pgs/ltc-mfp.aspx](http://www.dmas.virginia.gov/Content_pgs/ltc-mfp.aspx)
22. **HUD Housing Counseling** - [http://portal.hud.gov/hudportal/HUD?src=/i\\_want\\_to/talk\\_to\\_a\\_housing\\_counselor](http://portal.hud.gov/hudportal/HUD?src=/i_want_to/talk_to_a_housing_counselor)
23. **Virginia Department of Housing and Community Development** - <http://www.dhcd.virginia.gov/>
24. **Good Shepard Housing Locator** - <http://www.goodhousing.org/housing-locator>
25. **KETTLER** - [http://www.kettler.com/apartments/affordable\\_apartments\\_program](http://www.kettler.com/apartments/affordable_apartments_program)
26. **Military By Owner** - <http://www.militarybyowner.com/>
27. **Apartment Guide** - <http://www.apartmentguide.com/>
28. **Virginia Supportive Housing** – [www.virginiassupportivehousing.org](http://www.virginiassupportivehousing.org)
29. **Low income Virginia Housing Search** - <http://www.lowincomehousing.us/VA.html>
30. **RRHA** - <http://www.rrha.org/index.shtml>

## **Appendix 3b – MI Job description Nursing Facility Transition (NFT) Housing Specialist**

Job description for the Michigan Nursing Facility Transition (NFT) Housing Specialist:

*Expectations, Duties and Responsibilities:*

- Work as part of a team to accomplish the goals of Nursing Facility Transition Program.
- Assist individuals transitioning from nursing facilities into the community to find suitable, affordable, available housing. Work with staff at MI Choice Waiver Agency and Centers for Independent Living in the area to find housing options for those wishing to transition.
- Work with property developers and managers to influence the availability of housing for individuals desiring to transition from a nursing facility.
- Develop and/or coordinate a comprehensive database for available rental housing and make it available to individuals desiring to transition from a nursing facility. Directly engage landlords and property managers to list their rental properties.
- Create/coordinate a registry of existing housing that is handicapper accessible.
- Quickly identify and engage in outreach activities to grassroots stakeholders (Continuums of Care, township supervisors and county commissioners, hospital and nursing facility discharge planners, Chambers of Commerce, service organizations, such as the Rotary, nonprofit organizations and families) determine their scope of activity, work collaboratively with them, be a resource, and bolster each entity's efforts.
- Actively participate with grassroots stakeholders, local housing authorities and Fair Housing Commissions to develop housing options for individuals transitioning from nursing facilities.
- Collaborate with other Housing Specialists to develop best practices to secure housing for individuals transitioning from nursing facilities.
- Collaborate with the Michigan Department of Community Health, the Michigan State Housing Development Authority, and other stakeholders to develop increased housing options for individuals transitioning from nursing facilities.
- Engage in advocacy efforts at the local, state and national levels to increase housing options for individuals desiring to transition from nursing facilities.
- Develop unique solutions to meet the housing needs of individuals desiring to transition from nursing facilities.
- Attend quarterly Nursing Facility Transition Housing Workgroup meetings.
- Submit quarterly reports on activities.

12/2012

## Appendix 4 – AZ ABIL Peer Mentoring Brochure

<http://www.abil.org/peer-mentoring-services/>



### MORE ABOUT ABIL...

Arizona Bridge to Independent Living is a non-profit 501(c)(3) organization and the largest center for independent living in Arizona.

Since 1981, ABIL has offered a wide variety of empowering programs, including: Advocacy; Information & Referral; Independent Living Skills; Peer Support; Personal Assistance Services; Work Incentive Employment; Home Modification; Early Intervention; Reintegration; and Sports, Fitness & Recreation.

### ABIL'S MISSION

ABIL offers and promotes programs designed to empower people with disabilities to take personal responsibility so that they may achieve or continue independent lifestyles within the community.

### DISABILITY EMPOWERMENT CENTER (DEC)

ABIL is co-located with 11 other disability services organizations on the DEC campus at 50th St. and Washington in Phoenix.



## PEER MENTORING

**ABIL – MAIN OFFICE**  
5025 E. Washington St., Suite 200  
Phoenix, AZ 85034  
602-256-2245 (v)  
AZ Relay Service 7-1-1  
1-800-280-2245 (toll-free)  
602-254-6407 (FAX)

**ABIL – CENTRAL OFFICE**  
1229 E. Washington St.  
Phoenix, AZ 85034  
602-296-0551 (v)  
602-256-0184 (FAX)

**ABIL – MESA OFFICE**  
2150 S. Country Club Dr., Suite 10  
Mesa, AZ 85210  
480-655-9750 (v)  
480-655-9751 (FAX)

**ABIL – GLENDALE OFFICE**  
6829 N. 57th Ave.  
Glendale, AZ 85301  
602-424-4100 (v)  
602-424-4118 (FAX)

info@abil.org  
www.abil.org



[www.abil.org](http://www.abil.org)

## WANT TO BE A PEER MENTOR?

### ABIL PEER MENTORS ARE INDIVIDUALS WHO:

- Have a disability or are close to someone who does
- Successfully achieved independent living
- Assist others to achieve their own independent living goals

### ABIL PEER MENTORS:

- Listen and provide support
- Take part in solving problems that all people with disabilities have in common
- Share their knowledge of community resources



### MENTOR OPPORTUNITIES:

- One-to-one contact
- Outreach to people at rehabilitation centers and nursing homes
- Advocacy for individuals and community
- Participation in group mentoring sessions and disability awareness presentations

### PEER MENTOR VOLUNTEER QUALIFICATIONS & TRAINING

ABIL Peer Mentor Volunteers must complete an application and provide three character references. All volunteers must successfully complete a fingerprint and background check. Peer Mentor Volunteers must attend the ABIL Peer Mentor Training Class.

### TO REQUEST A MENTOR APPLICATION

- Call April Reed, LMSW at 602-296-0533
- Apply online [www.abil.org](http://www.abil.org)



## WANT TO MEET WITH A PEER MENTOR?

If you think you or a family member could benefit from the experience of having a mentor, please contact us.

### TO REQUEST A MENTOR

- Call Darrel Christenson at 602-296-0530
- Apply online [www.abil.org](http://www.abil.org)

### MENTEE REQUIREMENTS

- You must be 18 years or older
- You must have a disability
- You will need to apply for ABIL services

**MENTORING: LISTENING, SHARING, MAKING A DIFFERENCE**



## Appendix 5

The Sunshine Folk (SSF) is a group of people with disabilities who have prior nursing facility (NF) or other institutional experience and a passion for helping others find their way out of institutions into the community.

The SSF inform NF residents with disabilities about community- based service alternatives, help NF residents safely transition into the community with needed supports, alert Maryland Disability Law Center (MDLC) staff to potential legal barriers. During the development and implementation of Maryland’s new Community First Choice (CFC) Program, designed to deliver expanded Medicaid state plan services to help beneficiaries avoid NF placement and to leave NFs and return to the community, they gathered essential information and provided consumer feedback about the program. SSF educated policymakers during this critical time period about the necessity for more state support to meet the needs of the anticipated number of CFC participants, particularly those with more intensive service needs. As a result, the state came to recognize that an additional \$27,000,000 would be necessary for the CFC program and provided the funds.

MDLC and SSF concentrate on the most deficient facilities housing the lowest-income residents to ensure that those who are typically overlooked will also understand their rights and opportunities, and receive support for their choices. In addition to making these critical linkages, the SSF function as peer mentors who inspire and empower residents to make their own choices and speak out regarding their concerns with conditions in the NFs and other issues.

The SSF provide information regarding community service options and residents’ rights, and make referrals to:

- The State’s new CFC Program, Medicaid waiver programs, and other agencies or programs that provide services to facilitate discharge from NFs;
- Long term care ombudsmen, for help with quality of care issues, residents’ rights violations and complaints;
- The Office of Health Care Quality (OHCQ) regarding potential abuse and neglect;
- MDLC, to address legal barriers to community transitions from NFs.

In addition to MDLC’s training, technical assistance and ongoing support, SSF volunteers are assisted by a part-time Direct Support Worker, who accompanies several of the SSF volunteers on their visits to facilities to provide the ongoing support and disability-related accommodations that enabled the SSF to work more efficiently, better plan and manage their workloads, and improve their ability to assist numerous NF residents.

In 2014 the SSF met with over 330 NF residents, successfully transitioned 25 individuals from NFs into the community, and provided general and/or personalized information about rights in facilities and community-based options to hundreds more residents, family members, facility staff, ombudsmen and other state and local officials.



## Appendix 6a – TX Information Letter from Licensing Agency

<http://www.dads.state.tx.us/providers/communications/2004/letters/pl04-18.pdf>



June 28, 2004

**BOARD MEMBERS**  
Jerry Kane  
Chairman, Corpus Christi  
Menson B. Johnson  
Vice Chairman, Houston  
Abigail Rios Barera, M.D.  
San Antonio  
John A. Cuellar  
Dallas  
Terry Durkin Wilkinson  
Midland

To: All Nursing Facility Administrators

Re: Provider Letter #04-18 – Relocation Services Contract Staff Access to Nursing Facility Residents and Clinical Records

The purpose of this letter is to remind providers that the Texas Department of Human Services (DHS) Relocation Services contract staff are visiting nursing facilities. They should be granted contact with residents and access to clinical records.

DHS has contracted with the following organizations for conducting relocation services for nursing facility residents, including children, as part of the DHS Promoting Independence plan:

- Accessible Communities, Inc. -- Regions 6, 8 and 11;
- ARCIL, Inc. -- Regions 3 and 7;
- Crockett Resource Center for Independent Living, Inc. -- Regions 4 and 5; and
- LIFERUN, Inc. -- Regions 1, 2/9 and 10

Relocation services are being provided statewide.

Promoting Independence was developed in response to the United States Supreme Court ruling of *Olmstead v. Zimring*, the Governor's Executive Order 99-2, issued to the Texas Health and Human Services Commission, and Senate Bill 367 from the 77<sup>th</sup> Legislature.

Upon entering nursing facilities, contract staff will identify themselves, request to speak to the person in charge, and explain the purpose of the visit.

If you have questions about the content of this letter, please contact Debbie Hightower at 512/438-2561.

Sincerely,

[signature on file]

Marilyn Eaton  
Long Term Care Services

ME:dh

## Appendix 6b – TX 2<sup>nd</sup> Information Letter from Licensing Agency

<http://www.dads.state.tx.us/providers/communications/2007/letters/IL2007-67.pdf>



COMMISSIONER  
Adelaide Horn

July 12, 2007

To: All Nursing Facility Administrators

Re: Information Letter # 07-67  
Relocation Contractor Staff Access to Nursing Facility Residents and Clinical Records

This Information Letter updates Provider Letter # 04-18 issued on June 18, 2004.

The Promoting Independence Initiative (Initiative) was developed in response to the United States Supreme Court Ruling in *Olmstead v. L.C.*, 110 S. Ct. 2176 (1999), and is supported by two Governor's Executive Orders (GWB 99-2 and RP 2002-13) and state legislation (Senate Bill 367, 77<sup>th</sup> Legislature, Regular Session, 2001). The purpose of the Initiative is to provide enhanced community options so individuals will have more residential choices in receiving their long term services and supports.

Money Follows the Person (MFP) is a significant policy resulting from the Promoting Independence Initiative. MFP allows nursing facility (NF) residents to move back into the community to receive services without being on an interest list or using a community "slot" to access services in the community.

One aspect of MFP is the creation of "relocation specialist" activities. Relocation specialists perform outreach and education activities for NF residents and identify individual residents who want to access community services through MFP. In addition, relocation specialists can assist in the facilitation and coordination of transition activities into the community.

The Department of Aging and Disability Services (DADS) contracts with relocation contractors; the contractors hire relocation specialists to perform activities related to community transition. As contractors of the state, relocation specialists have the authority to enter a NF and work with residents to explore interest in MFP; *this activity is not considered solicitation.*

NF administrators must allow relocation specialists access to their facilities and support them in this activity. Relocation specialists must provide adequate identification. DADS expects each NF administrator and NF staff to support and assist in all MFP activities, including the relocation specialists, relocation specialist activities, and transitional services.

It should be noted that NF residents are under no obligation to speak to relocation specialists. NF residents must be *provided with the opportunity* to interact with the relocation specialists to obtain further information, should they so desire.

Relocation specialists will be visiting nursing facilities throughout the state. Upon entering a NF, a relocation specialist must identify themselves, request to speak to the Administrator or the person designated in charge in the absence of the Administrator, and explain the purpose of the visit.

Relocation specialists should be granted access to visit with residents, along with the resident's family members or other representatives with the resident's approval, and have access to clinical records and any other documentation, with the resident or resident's legal representative's written approval, and those activities and processes necessary to facilitate the residents' transition into a community setting.

DADS contracts with the following organizations to provide relocation services for nursing facility residents, including children residing in a nursing facility:

Relocation Contractor	DADS Region(s)	Subcontractors
ARCIL INC. (512) 832-6349	Regions 4, 5, 7	<ul style="list-style-type: none"> <li>• Crockett Resource Center for Independent Living</li> <li>• East Texas Center for Independent Living</li> <li>• Heart of Central Texas Independent Living Center</li> <li>• Resource, Information, Support, and Empowerment</li> </ul>
The Valley Association for Independent Living, Inc. (956) 668-8245	Regions 8, 11	The Center on Independent Living (COIL)
Houston Center for Independent Living (713) 974-4621	Region 6	None
LIFE/RUN-1 (806) 795-5433	Regions 1, 2	Panhandle Independent Living Center (PILC)
LIFE/RUN-5 (806) 795-5433	Regions 9, 10	VOLAR Center for Independent Living ABLE
North Central Texas Council of Governments (NCTCOG) (817)695-9193	Region 3	<ul style="list-style-type: none"> <li>• REACH</li> <li>• Community Council of Greater Dallas' Area Agency on Aging</li> <li>• United Way of Metropolitan Tarrant County's Area Agency on Aging</li> <li>• Texoma Council of Governments' Area Agency on Aging of Texoma</li> </ul>

MFP is an important DADS' policy initiative that requires the cooperation of all of our contractors. If you have any questions about this letter, Promoting Independence, or the MFP policy, please contact Steven Ashman, MFP Program Specialist, at (512) 438-4135.

Sincerely,

*[signature on file]*

Tommy Ford  
 Section Director  
 Institutional Services

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**Appendix 7 – OH HOME Choice Services Spring 2015 training**  
[Ohio HOME Choice Roles and Responsibilities](#)

## Roles and Responsibilities: HOME Choice Team

	NF	Pre-Transition	Discharge	Community 1 <sup>st</sup> 90 days	Community 365 Participation days
NF Discharge Planner	●—————●				
PTCM	●—————●				
TC	●—————●				
Community Support Coach		●—————●			
HC Case manager			●—————●		
MC Plans		●—————●			
My Care Ohio		●—————●			
Other HC Providers			●—————●		
MH/AoD Providers		●—————●			

6/29/2015

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