

Preparing to Come Home: Recommendations for Transition Planning from North Carolina's Money Follows the Person Demonstration Project

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When Christina moved back home to live with her family after years of residing in an institution, her mother noted, "She's so much happier now." When Ronald transitioned back into his community after years in a state hospital, he soon became a regular at his local Starbucks. After Jabreel moved out of an institution and into an apartment with a support companion, his mother observed, "My son now has a warm, broad network of people in his life."

These life-changing experiences were facilitated by the state, regional and local partners of North Carolina's Money Follows the Person (MFP) Demonstration Project. The federal MFP program has since its inception in 2005 become an increasingly robust vehicle that North Carolina and other states have used to strengthen and expand their home- and community-based service structure. It is used to help Medicaid recipients transition from institutions back to the community. In North Carolina, MFP participants have priority access to certain community-based support services; currently, all of them qualify for one of the Community Alternatives Programs or the Program of All-Inclusive Care for the Elderly [1]. They also have access to additional resources, such as "start-up funds" and transition coordination services.

MFP assistance is available only to individuals who meet the project's federal criteria; to qualify, an individual must be Medicaid-eligible and have resided for at least 90 days in a skilled nursing facility, an intermediate care facility for individuals with intellectual or developmental disabilities, an acute care hospital, or a psychiatric facility (if they are under the age of 21 or over the age of 65) [2, 3]. However, the practices that have been developed and adopted by the project can be used in transition efforts of all kinds. Many of these practices are based on experience gained in earlier transition efforts (such as North Carolina's Nursing Home Transition Grant) and were recommended in reports from the North Carolina

Institute of Medicine [4], Mathematica Policy Research [5], and other organizations [6, 7]. These practices are grounded in basic, common-sense principles that serve as the foundation of every quality transition experience: person-centered transition planning, establishment of a clear locus of responsibility, continuity of care, and clear communication among transition team members.

Insights gained during the implementation of North Carolina's MFP Demonstration Project can help shape the state's transition practices as the state renews its commitment to provide community-based services to persons with disabilities (as required by the US Supreme Court's *Olmstead* decision [8]) and works to strengthen its home and community service options for individuals in adult care homes.

Recommendations Based on Lessons Learned From MFP

Learning from its own experience and the experience of other transition initiatives, the North Carolina MFP project has come up with 11 suggestions for those supporting individuals to transition from an institution to home- and community-based supports. (1) Keep the person who is transitioning at the center of the transition effort by supporting his or her active participation in the planning process and empowering him or her to assume responsibility for completing transition-related tasks whenever possible. (2) Have a clearly designated, well-trained transition coordinator who enjoys supporting people as they return to their communities and has a strong understanding of both the formal services and the informal resources available. (3) Have a clear, documented transition plan that addresses the person's community-based needs; it should not only plan for the "essentials" (housing, medical care, and attendant care) but also explore employment, transportation, and financial management options, consider the needs of family caregivers, and build a community net-

an IMD. Federal Medicaid funding for a facility will cease the day it is determined to be an IMD. A transition plan and process are in place to help individuals identify alternative living arrangements and to support their transition to a new setting.

Personal Care Services

CMS alleges that North Carolina's eligibility criteria and payment rates for Personal Care Services (PCS) are not "comparable" between ACH and in-home settings. A combined total of approximately 45,000 individuals receive such services at an annual cost to the state's

Medicaid Program of more than \$400 million (DMA, unpublished data). North Carolina has worked with CMS to develop a 1915(i) Medicaid state plan option that will address these comparability concerns and try to meet the demands for PCS across both settings while meeting state budget expectations. The state's agreement with CMS and its plan of correction allow the current PCS program to operate through the end of December 2012. Effective January 1, 2013, a new PCS program operating under the 1915(i) authority will be in place. This new PCS program will address the "comparability" issues by basing PCS eligibility on a set of target population criteria and by requiring

work. (4) Set up agreements and schedules that ensure ongoing conversation among transition team members and make it clear who is doing what. (5) Because strong collaboration between those providing medical and social supports is essential for individuals with complex support needs, make sure the person in transition is enrolled in Community Care of North Carolina (CCNC) and signed up for behavioral health services (if those are needed) before discharge. (6) Engage peer support wherever possible. Recently transitioned individuals say that access to peers—individuals who have also transitioned—is useful while they are adjusting to being back in a community setting. The peer support model has been demonstrated to be particularly effective with individuals experiencing severe and persistent mental illness [9]. (7) Finding affordable accessible housing is often the biggest barrier to transition. In addition to applying for subsidized housing, members of the team should explore other services and supports (such as shared living arrangements, adult foster care arrangements, and telesupport options if appropriate) that may help meet the transitioning person's housing needs. (8) Give people in the community who will be assisting the person after transition—attendant care staff, therapists, and other clinicians—an opportunity to get to know the individual before the transition happens. To better ensure continuity of care, staff training and consultation should take place before the transition occurs. (9) Procure start-up funding before the transition takes place. Start-up funds are often used to pay rent deposits or to meet other household needs, but consider using them to fund additional pre-transition training and consultation. (10) Have transition coordinators follow an individual's progress for several months after transition occurs. Individuals often experience unforeseen challenges immediately after the transition is made. (11) Do not rush. North Carolina's MFP program has made its biggest mistakes when it allowed the sense of urgency that is inevitable in any transition endeavor to eclipse the principles and practices outlined here.

Although each transition will have its unique elements and individual dynamic, these practices and principles form a strong, unifying foundation that ensures successful, effective transitions for people wishing to return to their homes and rejoin their communities. NCMJ

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ACHs to meet the standards for home- and community-based care. An independent assessment will be required to receive PCS under the 1915(i) state plan option.

Standards for Home- and Community-Based Services

CMS has issued a proposed rule requiring that individuals receiving funding for home and community-based services (HCBS) live in residences that have an environment that is not institutional in nature [4]. The proposed rule specifies that PCS funding can only be used in residential settings that reflect the requirements contained in HCBS. North

Carolina has worked with CMS to develop an understanding of HCBS that will meet the new requirements, which include the expectation that facilities be integrated into the community and the expectation that residents be allowed the same freedom to exercise personal choice that is typical of home settings. For instance, residents must be allowed to choose treatment providers, roommates, and room decorations, and to decide when and where to go on community outings, when to eat and sleep, and when to receive visitors and engage with others.

In order to continue to receive Medicaid funding, ACHs will need to attest that they meet HCBS characteristics by