

MARYLAND -- 2001 Nursing Facility Transitions State Grant

Identified Problems with the State's Long-Term Care System

- Nursing facility residents lack sufficient and accurate information about community programs and resources to make informed decisions about moving into the community.
- Historical tendency of nursing facility discharge planners and community service providers to focus on people who are perceived to have less significant disabilities.
- Lack of resources to obtain and coordinate a complete package of community services.
- Lack of accessible, affordable housing and support services in many jurisdictions, especially in the rural areas of the state.
- Limited coordination and collaboration between the disability and housing systems.
- Nursing facilities experiencing fiscal difficulties.
- Staff at rehabilitation and acute care hospitals lack knowledge of community resources.
- Shrinking labor pool from which to draw quality direct care, professional and support staff.
- Complex eligibility and enrollment process for HCBS waivers.

Perceived Strengths

- Experience and expertise in the non-profit community in utilizing local resources and providers for eligible applicants.
- Experience in the public sector in providing and coordinating community support services.
- An emerging philosophy by stakeholders that individuals with varying levels of significant disabilities can be effectively supported in communities of their choice.
- A demonstrated understanding of effective mechanisms for obtaining input from stakeholders in the design of system reform initiatives.
- A track record of utilizing Medicaid state plan services and 1915(c) waivers for both children and adults to expand community services.
- A contract with a nationally recognized accessible housing expert to review Maryland's system and develop recommendations.

Primary Focus of Grant Activities

- Develop the *Home Team* to coordinate/collaborate with local housing authorities and housing providers, outreach workers and case managers in order to obtain housing for 150 Medicaid beneficiaries residing in 253 nursing facilities.
- Educate and assist individuals and their support systems to understand, identify, and procure local community resources.

- Develop and sustain working relationships with public housing authorities and other housing resources in all Maryland jurisdictions.
- Systemically address the expansion and development of new housing resources.
- Compile and distribute listings of affordable, accessible housing resources, and community support services.
- Provide grant funds not otherwise available for transitional costs associated with moving to the community.

Goals, Objectives, and Activities

Overall Goal. Establish a model program in Maryland that can be replicated and sustained, which will successfully transition people residing in nursing facilities to community housing of their choice.

Goal. Meet a minimum of 150 individuals' preferences and housing needs in a manner that allows for flexibility, choice, and self-direction.

Objectives/Activities

- Offer individual and group training opportunities to consumers outlining their rights and how to exercise them.
- Provide written materials that supplement training.
- Training Specialists will assist consumers with decision-making and the transition process.

Goal. Provide better coordination of community housing and support services.

Objectives/Activities

- Link transitioning individuals and, when appropriate, their families and support systems, to community resources and services.
- Establish and maintain collaborative working relationships with DHCD, state, and local public housing authorities and other housing providers to locate, develop, and procure appropriate accessible and affordable community-based housing

Goal. Improve quality of transition services.

Objectives/Activities

Assist in transition planning and implementation, including, but not limited to, providing small grants when needed to cover moving and settlement costs.

Goal. Expand community housing alternatives.

Objectives/Activities

- Increase the number of accessible, affordable and integrated community housing options, including specific housing and funding set-asides.
- Improve coordination and collaboration between public housing authorities and other housing providers and disability support/services providers.

Key Activities and Products

- Create the *Home Team* consisting of a Project Coordinator, six Transition Specialists and an administrative aide. The Project Coordinator will be responsible for the overall administration of the program. The *Home Team* will provide outreach to approximately 6,000 people, assist in transition planning and implementation, and present informational programs and disseminate educational resource materials.
- The Housing Developer will create and disseminate a Housing Resource Directory, containing a list of all local public housing authorities and other housing providers, different government subsidized housing programs and eligibility requirements, and a list of affordable/accessible housing.
- On-Site visits by the *Home Team* program Staff. Utilization of brochures and fact sheets, video, and web site information.

Consumer Partners and Consumer Involvement in Planning Activities

A Community Access Steering Committee was formed in July 2000 to develop a planning process to enhance efforts to serve people with disabilities. Four task forces, (Developmental Disabilities Community Access, Mental Hygiene Community Access, Medicaid Community Access, Systems Integration), were created, with CIL representatives to develop recommendations to be submitted to the Governor in July 2001. The Steering Committee's recommendations focused on three major goals: building community capacity, helping people currently in institutions move to the community, and helping people stay in the community. To assure consumer participation, state used a planning grant from the Center for Health Care Strategies to provide transportation and other accessibility assistance for task force members and stipends for consumers that led focus groups in institutional settings.

Consumer Partners and Consumer Involvement in Implementation Activities

- Primary consideration will be given to hiring individuals with disabilities to be Transition Specialists on the *Home Team*.
- The Grant's Advisory Committee will have at least 50 percent of the membership consisting of consumer representatives and the remainder representing public and private agencies. The Committee will meet quarterly to evaluate design and implementation of the project.
- *Home Team* program staff will conduct focus groups and on-site visits with consumers.

Public Partners

- Maryland Department of Human Resources (DHR).
- Maryland Department of Health and Mental Hygiene (DHMH).
- Maryland Department of Housing and Community Development (DHCD).
- Public Housing Authorities.

Private Partners and Subcontractors

Procurement of subcontractors is in process; no other information available at this time.

Public and Private Partnership Development/Involvement in the Planning Phase

This program will be administered through the Department of Human Resources, Office of Personal Assistance Services, which will also provide program coordination. The Department of Housing and Community Development will house and recruit a “Housing Coordinator” position; and the state will award contracts to the six CILs who will provide Housing Transition Services.

Public Partners

- Maryland Department of Human Resources (DHR).
- Maryland Department of Health and Mental Hygiene (DHMH).
- Maryland Department of Housing and Community Development (DHCD).
- Public Housing Authorities.

Private Partners

Six Maryland CILs.

Public and Private Partnership Development/Involvement in Implementation**Public Partners**

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- Public Housing Authorities.

Private Partners

- Six Maryland CILs.
- The Coordinating Center.

Existing Partnerships That Will Be Utilized to Leverage or Support Project Activities

This program will be closely linked with Maryland’s Independent Living Partnership Grant through coordinated outreach and peer counselors to target individuals with physical disabilities, 65 years and younger, who are living in nursing facilities and want to move into the community. To maximize collaboration and resources, the two programs will have one advisory committee, comprising individuals with disabilities and agency representatives. It will also be linked to all existing Medicaid waiver programs and other collaborative state initiatives.

Oversight/Advisory Committee

An Advisory Committee, with at least 50 percent of the membership consisting of consumer representatives and the remainder representing public and private agencies, will meet quarterly to evaluate design and implementation of the project, provide advice to the State Partners on needed changes, and share information related to the *Home Team* program.

Formative Learning and Evaluation Activities

It is expected that lessons will be learned in the areas of identification and analysis of needed resources, system and agency policy changes, prevention and/or decrease in nursing home admissions due to change of attitudes of caregivers, and an analysis of the utilization of resources provided. The Project Coordinator will compile statistics monthly and provide a written status/progress report quarterly to the Advisory Committee and the State Partners.

Evidence of Enduring Change/Sustainability

There is an array of community support services already in place through either the HCBS waivers or state-only funded programs. Significant efforts are made by case managers in the LTC community system to assure the provision of ongoing supports. This grant will bridge the gap between nursing homes and community services. Transition services will be provided until community resources are in place. At program's end, funding from other sources will be sought to continue the program.

Geographic Focus

Statewide for individuals with physical disabilities, 65 years and younger, who are currently residing in nursing facilities and want to move into the community.