

No Wrong Door Planning Group  
Meeting Transcripts (unedited)  
March 31, 2015



**Opening Comments**

- Need to clarify line between NWD and case management
- Need to remember the crisis management needs (Stop gaps? Prioritization?)
- Concerns about implementation; will our work here matter?
- Need to work on the awareness building pieces
- Need to watch for our own biases
- Time to discuss logistics of the next 2 meetings
- Addendum 5 – work around?
- Meeting 4 items:
  - Hooking up with other HCPF and DHS initiatives
  - How NWD connects with advocates/ peers
  - RCCO/ dual eligible (meeting 3?)
  - TEFT/ IT system needs of NWD
- Meeting 3 items:
  - Managing relationships w/ hospital discharge given timeline pressures

**Streamlined Access Discussion**

- Includes assessments, etc.
- Being too streamlined means we might miss things
- Ensure consumer is in the right county
- Can we do away with the issue of needing to get “recertified” when you move across counties? County transfers
- Financial, functional, assessments happening simultaneously
- Educate the consumer
- A statewide program (vs. county)
- Advocates available – have training available (compensation?)
- Options counselor to have access to financial eligibility data

- All assessments/ eligibility across systems coordinated
- A single assessment
- Understand the boundaries/limitations/brick walls across systems

### *Data Sharing*

- Forms to be simple and easy to comprehend
- Data systems/ sharing of data – consumer data around eligibility/universal HIPPA form
- System to share the data electronically/ securely
- Database of providers to track where space is available/ who’s taking new clients
- No phone stacking systems
- Consequences for not adhering to standards (grievances)
- Align level of data access and relative security roles
- Consumer “owns” their file and they grant the access to the staff person/ counselor/ advocacy/ etc.
- Co-located, dedicated county person to do financial eligibility
- Consumer works with one person through this process
- The forms the same across departments/agencies/etc. (PEAK)
- Electronic options for forms, applications, etc. – consumer can start filling things out before they walk in the door -
- CORHIO/ QHN systems might be something to build on?
- Consumer knows who their information will be shared w/ and able to opt out of that sharing (authorization release form)
- Backfill – what the agencies need to gather informs what’s collected
- At appropriate reading level
- A guide to help understand the applications and forms
- Is there a way to pull the SSA into the Medicaid form?
- Nothing about us without us as the data sharing philosophy
- Standard forms/ processes across all entry points
- Tracks advanced directives/ care plan related to times of crisis to streamline process
- Ability to expedite/ fast-track for crisis situations:
  - Hospital discharges (when there’s time pressure)
  - Homelessness/ at risk of homelessness
  - Nursing home discharges
  - Death/ incapacitation of a primary caregiver
  - Hospice/ terminal illness

- No longer able to live independently
- Aging out of system/ transition to nothing

### *Consumer-Centered*

- I interact with knowledgeable, well-trained, staff who are person-centered/ consumer-directed
- Unified, user-friendly application/ paperwork/ electronic/ secure options
- I control my data, it flows between the agencies I approve w/o my having to do anything cumbersome
- I experience functional, financial, assessments, etc. as one application process
- I get updates/ informed about the status and what's next

### *Assisting with Applications*

- Certified Medicaid Application sites or programs
- Sign up to be a site and do a lot of the work eligibility tech does
- Have access to CBS; determine eligibility (not yet for LTSS)
- Beneficial to have interaction between functional and financial
- The process to become a sight is not easy
- Colorado Access does all Medicaid apps
- Currently unfunded program
- Need to have separation of duties
- Can a NWD do just the specialized LTSS applications (not all Medicaid)
- They can't take over for
- Hospitals contract with someone who does the Medicaid application/ SS long-term disability/ buy-in programs for those consumers
- Cash assistance programs would still be with the counties
- Financial eligibility for LTSS only

### *When Someone Is Found Ineligible*

- Still move along to the next stage of exploring options they might qualify for now
- Might be referred to less-intensive services
- Explain why they aren't eligible
  - Troubleshoot – are there things they can do to become eligible (easier with co-location)
- Inform about right to appeal and the appeals process

### *Co-Location Discussion*

- 100.2 – whatever that turns into needs that capability to pass it on (like if the consumer changes their mind and switches agencies mid-stream)
- Going to have to customize the coordination between functional and financial depending upon consumer's situation
- Jefferson County sends financial techs out with the SEP case manager at the same time – able to answer questions right on sight – see who you are working with on both sides; helps with communication
- From the financial side – more information on who's doing what on the functional side; being able to see in BUS and knowing where the functional person is in their process
- The flow of communication/ information between functional and financial needs to be seamless – see where each other's processes are
- Each system is automatically populated with the other system's info
- That's what we do in Larimer – we are co-located; we have a liaison who makes sure the consumer has their needs met getting the documentation together, etc. We can get daily updates if we want/ need it
- Models in place
- Boulder ADRC will act as “unofficial” liaison to financial
- NWD doing the eligibility determinations
- Make it “conflict free”

### *Team Approach*

- Coordination around appeals
- Timelines sync up between the functional and financial
- Current status is always known
- Communication (across functional and financial; across agencies)
- Not duplicating work
- Automated
- Coordination around gathering data and documentation
- Waitlist management
- Co-location needs to be flexibly structured
- Targeting criteria for waivers (e.g., DD determination)

## Round 1: Defining Person-Centered Counseling and Transitions

### *Person-Centered Counseling*

#### *Needs/ Interests by Segment*

Segment	Their Needs/ Interests Relative to PCC
Older adults (60+) entering the system for the 1 <sup>st</sup> time  ** Not all systems use age 60**	Information and awareness (process) of: <ul style="list-style-type: none"> <li>• What’s available</li> <li>• What does “the system” mean</li> <li>• Qualifying/ eligibility options</li> <li>• Normalize using the system</li> <li>• Understanding of rights and responsibilities</li> </ul>
Older adults, likely Medicaid eligible	<ul style="list-style-type: none"> <li>• Service access/provider education</li> </ul> Explanation of: <ul style="list-style-type: none"> <li>• Benefits</li> <li>• Limitations of insurance</li> <li>• Provider access and waitlists</li> <li>• Process of application including documentation and appeal</li> <li>• Timeframe</li> <li>• Other supportive services</li> <li>• May need “stop gap” services</li> </ul>
Older adults, not Medicaid eligible	<ul style="list-style-type: none"> <li>• Information</li> <li>• Referral</li> <li>• Options counseling</li> <li>• See #1 including private pay, informal supports, other public programs (e.g., PACE) etc.</li> <li>• Let them know about spend-down (long-term future planning)</li> </ul>
Adult children of older parents who need assistance	<ul style="list-style-type: none"> <li>• Caregiver support including</li> <li>• Support group information</li> <li>• Referral</li> <li>• Education</li> <li>• Awareness (see all answers above)</li> <li>• Opportunities for consumer</li> <li>• Direction and alternatives to institutionalization</li> <li>• Rights and responsibilities of a caregiver</li> <li>• Sort personal caregiver needs from consumer needs</li> </ul>
Families/children with disabilities	<ul style="list-style-type: none"> <li>• Dual purposes – on for children and one for parents</li> <li>• Dual needs – parents think long-term, kids think short-term</li> <li>• Peer mentors desired, for both the children AND parents</li> <li>• Sibling support</li> </ul>

	<ul style="list-style-type: none"> <li>• Parents want a roadmap (IHSS, waivers, CDAS, EPSDT, IEPs, systems, insurance, therapies, medical home, ESY waivers, diagnosis information, how to interact with the system)</li> </ul>
14-21 year olds with Disabilities	<ul style="list-style-type: none"> <li>• Kids want to be with peers and have equal opportunities</li> <li>• Parents want to know the options</li> <li>• Person trained in all disabilities</li> <li>• Don't treat them as children and set expectations where they want to go</li> <li>• Many school transition issues</li> <li>• Transition into adulthood (housing, employment, social)</li> <li>• Aging out of waivers</li> <li>• Foster care transitions (access to medical records)</li> <li>• Options for post-secondary education</li> <li>• Who are these new agencies/ regulations? (DVR, CCB, differences between child and adult Medicaid, etc.)</li> <li>• Guardianship/ advanced directives/ medical POA/ trusts</li> <li>• Again, parents want a roadmap</li> </ul>
Adults with Serious Mental Health Concerns	<ul style="list-style-type: none"> <li>• Meet person where they're at – crisis, comorbidity, insurance</li> <li>• Define options available</li> <li>• Define needs for housing, transportation, doctor</li> <li>• Assistance with follow-up – paperwork, warm hand off to case manager</li> <li>• Self-identify team treatment group</li> <li>• Teach how to self-direct and how to prioritize and plan</li> <li>• Rights protection</li> </ul>
Families and children with serious mental health concerns	<ul style="list-style-type: none"> <li>• Involve child in process</li> <li>• Approach holistically – support family system</li> <li>• Coordinate care with schools, docs etc.</li> <li>• Knowledge about tools/models current being used</li> <li>• Identify systems issues</li> <li>• Advocate forum?</li> <li>• Respite assistance</li> </ul>
Adults with Disabilities	<ul style="list-style-type: none"> <li>• Not aware of PCC is</li> <li>• Not sure of what needs are</li> <li>• Home environment might not meet client or parent choice</li> <li>• Independence might be a scary concept</li> <li>• Opportunities may increase</li> <li>• Unbiased information of available options</li> </ul>
Parents of adults with	<ul style="list-style-type: none"> <li>• SAME AS ABOVE</li> </ul>

disabilities	<ul style="list-style-type: none"> <li>• Very important to notify clients and families about consequences of not fully and honestly disclosing financial assets</li> </ul>
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*Define Success*

<b>Segment</b>	<b>Their Desired Outcome</b>
Older adults (60+) entering the system for the 1 <sup>st</sup> time	<ul style="list-style-type: none"> <li>• Consumer is informed of their options and choices, is empowered set goals, make choices, and plan, and their needs are met to the greatest degree possible</li> </ul>
Older adults, likely Medicaid eligible	<ul style="list-style-type: none"> <li>• Same as above AND</li> <li>• Has needed support to walk through the NWD process</li> </ul>
Older adults, not Medicaid eligible	<ul style="list-style-type: none"> <li>• Same as above</li> </ul>
Adult children of older parents who need assistance	<ul style="list-style-type: none"> <li>• Both the needs of the caregiver and the consumer are met to the greatest degree possible</li> </ul>
Families and children with disabilities	<ul style="list-style-type: none"> <li>• Real dialogue</li> <li>• Practical action</li> <li>• Family and child are on same page – or at least give/take is achieved</li> <li>• Understanding of next steps/ systems involved</li> <li>• Family needs/ goals addressed</li> <li>• Treated with respect/ empathy</li> </ul>
14-21 with disabilities	<ul style="list-style-type: none"> <li>• Skills knowledge, options, resources to make decisions</li> <li>• Confidence in self and process</li> <li>• Parents are able to let go</li> <li>• Treated as an adult (age and development-level appropriate)</li> <li>• Focus on the consumer’s needs/ interests</li> <li>• Don’t talk about the children when they’re not there</li> </ul>
Adults with Serious mental health concerns	<ul style="list-style-type: none"> <li>• Living independently with customized wrap around services – introduced early on</li> <li>• Connected to needed resources</li> <li>• One person to call in crisis (after connected)</li> <li>• Help choosing team</li> <li>• Know all service options to present to client and team</li> <li>• Education about prognosis</li> <li>• Right protections</li> <li>• Identify need for advocate</li> <li>• Warm hand off to trusted, permanent person</li> </ul>

Families/children with mental health concerns	<ul style="list-style-type: none"> <li>• Education to family about diagnosis/prognosis</li> <li>• Education about LTSS to make informed choice</li> <li>• Know choices for family/team/child</li> <li>• Parents feel supported</li> <li>• Assemble team</li> <li>• Identify need for advocate support</li> <li>• Identify other systems/people who need to be involved – coordination</li> </ul>
Adults with Disabilities	<ul style="list-style-type: none"> <li>• Approach will be ability competent – i.e. pictures, symbols etc.</li> <li>• Trust will be developed</li> <li>• Immediate needs will be met, regardless of payer source</li> <li>• Waitlist may be diminished</li> <li>• Clients feel empowered</li> </ul>
Parents of adults with disabilities	<ul style="list-style-type: none"> <li>• SAME AS ABOVE</li> <li>• Whole family feels empowered</li> </ul>

*Implications*

Segment	Implications for PCC Design
Older adults (60+) entering the system for the 1 <sup>st</sup> time	<ul style="list-style-type: none"> <li>• Listen to consumer</li> <li>• Probe for unmet needs/ consumer direction</li> <li>• Strength-based</li> <li>• Explore for natural supports</li> <li>• Leave knowing what they need to do next (a clear plan)</li> <li>• Or that they can come back for further processing</li> <li>• Check in processes along the way</li> </ul>
Older adults, likely Medicaid eligible	<p>Same as above, AND:</p> <ul style="list-style-type: none"> <li>• Develop an interim plan until determination occurs</li> <li>• Possibly avoiding Medicaid for other options (prolonging or avoiding the spend down)</li> </ul>
Older adults, not Medicaid eligible	<p>Same as above, AND:</p> <ul style="list-style-type: none"> <li>• Utilizing their options/ also looking at appropriate timeline for functional reassessment and information and Medicaid and spend down</li> </ul>
Adult children of older parents who need assistance	<p>Same as above, AND:</p> <ul style="list-style-type: none"> <li>• Knowing there is support</li> <li>• Knowing the limitations of caregiving (legally and emotionally)</li> </ul>
Families children with disabilities	<ul style="list-style-type: none"> <li>• Be knowledgeable about services possible</li> <li>• Crisis intervention</li> </ul>

	<ul style="list-style-type: none"> <li>• Future for the child</li> <li>• Conflict free</li> </ul>
17-21 with disabilities	<ul style="list-style-type: none"> <li>• Get them what they want from the age mindset</li> <li>• Honoring the consumer's goals</li> </ul>
Adults with mental health concerns	<ul style="list-style-type: none"> <li>• 2-3 meetings</li> <li>• Truly client directed – individual rights protections</li> <li>• Recovery model versus medical model</li> <li>• Knowledgeable about multiple systems of care – training and education, empathetic toward families/persons experience</li> <li>• Reasonable caseload size for PCC staff</li> <li>• Warm hand off</li> </ul>
Families and children	Same as above AND; <ul style="list-style-type: none"> <li>• Understand family dynamics and needs, not just clients.</li> </ul>
Adults with Disabilities	<ul style="list-style-type: none"> <li>• Effective assessment of critical needs</li> <li>• Approach needs to match abilities/ needs of consumer</li> <li>• May require flexible hours/meeting locations</li> <li>• Sensory issues acknowledged and addressed</li> <li>• Language and cultural consideration addressed</li> <li>• Adequate access</li> <li>• Priorities determined by immediate needs</li> <li>• Assess danger to self or others</li> <li>• Effective communication – cognitive or physical tools used</li> </ul>
Parents of adults with disabilities	<ul style="list-style-type: none"> <li>• SAME AS ABOVE</li> </ul>

*Customize Delivery*

Segment	Time between 1 <sup>st</sup> request & PCC starting	How long does PCC engagement take?
Older adults (60+) entering the system for the 1 <sup>st</sup> time (& likely, not likely Medicaid eligible, and adult children)	Consumer direction, preferences, ability based on available staffing	“ ”
Families/children with disabilities & 17-21	Hard to predict	“”
Adults and families/children with Serious	ASAP from the time they speak to NWD person	As long as needed

Mental Health Concerns		
Adults with disabilities/ Parents of adults with disabilities	Simultaneous process Needs established Initial referrals established	Until connected to case management – start to finish maximum 30 days

Segment	Where is PCC delivered?	How is PCC delivered?
Older adults (60+) entering the system for the 1 <sup>st</sup> time (& likely, not likely Medicaid eligible, and adult children)	Home, office, community, setting of choice, facility	In person; internet based (website, email); phone
Families and Children with Disabilities	Home, most natural place for family, depends on situation	With the people that can provide the best information
17-21	Wherever they choose	With whoever they choose
Adults AND Families/children with serious mental health needs	Phone, office, where client is at, client chosen location, mobile unit	In person, electronic/online, transparent process, tele-health, paper
Adults with Disabilities/ Parents of Adults with Disabilities	Based on need of client, flexible location and time	Based on need of client – in person, kiosk, web-based, telephone

### *Person-Centered Transitions*

#### *Needs/ Interests by Segment*

Segment	Their Needs/ Interests Relative to PCT
Older adults (60+) entering the system for the 1 <sup>st</sup> time  ** Not all systems use age 60**	<ul style="list-style-type: none"> <li>• Functional change/ adaption</li> <li>• Financial changes/ adaptation</li> <li>• Home accessibility</li> <li>• Interested in remaining independent and staying in current living situation</li> <li>• PCT is no longer a one-size fits all</li> <li>• Design Medicaid programs to address gaps in other pay sources</li> </ul>
Older adults, likely Medicaid eligible	<ul style="list-style-type: none"> <li>• H1B1 so that non-Medicare eligible older adults can keep their other insurance in place</li> <li>• Variety of outpatient services available through other agencies</li> </ul>
Older adults, not	<ul style="list-style-type: none"> <li>• Access to other resources of various agencies</li> </ul>

Medicaid eligible	
Adult children of older parents who need assistance	<ul style="list-style-type: none"> <li>• System for education of what's available</li> <li>• Support groups for caregivers</li> <li>• Personal response systems for older adults</li> </ul>
Adults w/ serious MH concerns	<ul style="list-style-type: none"> <li>• Outside advocate/ civil rights</li> <li>• Rural or urban</li> <li>• Medication management/ coordination with medical side</li> <li>• Access to services varies across the state</li> <li>• Mental Health care plan may be in place</li> <li>• May need to be empowered that they can make their own decisions</li> </ul>
Families/ children w/ serious MH concerns	<ul style="list-style-type: none"> <li>• Planned respite</li> <li>• Parent and child education</li> <li>• Transitioning from child to adult services</li> <li>• Regularly weekly contact w/ case manager</li> <li>• Mandated Foster Parent training and follow up supervision</li> <li>• Ongoing training</li> </ul>
Families/ children w/ disabilities	<ul style="list-style-type: none"> <li>• To learn about their opts</li> <li>• Get needs met</li> <li>• Address cultural barriers</li> <li>• May not ask for help</li> <li>• Barrier buster = access</li> <li>• Peers/ social/ emotional support (including child)</li> <li>• Knowledge of systems/ entitlements,</li> <li>• Early interventions</li> <li>• Insurance</li> <li>• Therapies</li> <li>• Medical home</li> </ul>
(14) 17-21 year olds w/ disabilities	<ul style="list-style-type: none"> <li>• Understanding entitlements of IDEA/ Transition programming</li> <li>• Peer mentoring</li> <li>• Guardianship/ advanced directives/ medical/ POA trusts</li> <li>• Child may not be able to communicate well</li> <li>• Understanding the "cliff"/ having a roadmap</li> </ul>

*Define Success*

Segment	Their Desired Outcome
Older adults (60+) entering the system for	<ul style="list-style-type: none"> <li>• Resources and how to contact the resources, access to information, confided that they are empowered to navigate their needs and</li> </ul>

the 1 <sup>st</sup> time	wants
Older adults, likely Medicaid eligible	<ul style="list-style-type: none"> <li>• Fee they can navigate the process to get uniformly accurate information and individualization</li> </ul>
Older adults, not Medicaid eligible	<ul style="list-style-type: none"> <li>• Offer alternatives and then proceed on desired outcomes as noted above</li> </ul>
Adult children of older parents who need assistance	<ul style="list-style-type: none"> <li>• Find support and respite</li> </ul>
Adults w/ serious MH concerns	<ul style="list-style-type: none"> <li>• Decreasing # of transitions</li> <li>• Independent living within the community and/ or care coordinator support</li> <li>• People living in lowest LOC appropriate for them</li> <li>• Consumer develops and works on recovery plan with team</li> </ul>
Families/ children w/ serious MH concerns	<ul style="list-style-type: none"> <li>• Stable school attendance</li> <li>• Children can stay with families</li> <li>• Transitioning</li> <li>• Holistic</li> </ul>
Families/ children w/ disabilities	<ul style="list-style-type: none"> <li>• To be treated w/ respect and empathy</li> <li>• Resolution of issues w/ appropriate services being provided or understanding of parameters/ why not eligible</li> <li>• Undersigning systems (IEP's how to get help, how to appeal, who to contact, next steps)</li> <li>• Understand and able to access what your eligible for and meeting your needs</li> <li>• Family goals addressed</li> <li>•</li> </ul>
(14) 17-21 year olds w/ disabilities	<p>Same as above, AND:</p> <ul style="list-style-type: none"> <li>• To be treated as an ADULT with dignity and respect</li> <li>• Systems that support young adult to reach their goals</li> <li>• No unpleasant “surprises” (SSI app, Medicaid @ 18, access to adult services, etc.)</li> </ul>

*Implications*

Segment	Implications for PCT Design
Older adults (60+) entering the system for the 1 <sup>st</sup> time	<ul style="list-style-type: none"> <li>• One stop shop for all segments</li> <li>• Highly trained individuals trained in customer service and PCC to assist each and all segments</li> <li>• Comprehensive resource guides and keeping it updated</li> </ul>
Older adults, likely	

Medicaid eligible	<ul style="list-style-type: none"> <li>• Screening questions (in a triage-type software) that triggers when to escalate to another/ higher level</li> <li>• Highest priorities is to have the most current, accurate, comprehensive information to guide the other adult to give information</li> <li>• Alliance of Information Referral Systems (AIRS) training to ensure consistency</li> </ul>
Older adults, not Medicaid eligible	
Adult children of older parents who need assistance	
Adults w/ serious MH concerns	<ul style="list-style-type: none"> <li>• More empowerment w/o coercion</li> <li>• Multidisciplinary, holistic care</li> <li>• Consumer choice and safety</li> <li>• Be able to think outside the box</li> <li>• Identify barriers and how to overcome them</li> </ul>
Families/ children w/ serious MH concerns	<ul style="list-style-type: none"> <li>• Respite</li> <li>• Ability to follow child in different settings</li> <li>• Consistency from setting to setting</li> <li>• Holistic care</li> </ul>
Families/ children w/ disabilities	<ul style="list-style-type: none"> <li>• Empathy and treating family w/ respect</li> <li>• Skilled/ informed navigator who can operate conflict free is most important for the rest of the work</li> </ul>
(14) 17-21 year olds w/ disabilities	<ul style="list-style-type: none"> <li>• Collaboration so can prepare for a step/ transition and make the warm hand off</li> <li>• Honor consumer's goals</li> <li>• Avoiding delays/ waitlist, etc. by starting transition planning at 14</li> </ul>

*Customize Delivery*

Segment	Time between 1 <sup>st</sup> request & PCT starting	How long does PCT engagement take?
Older adults (60+) entering the system for the 1 <sup>st</sup> time	<ul style="list-style-type: none"> <li>• Available 24-7</li> <li>• 24 hours from 1<sup>st</sup> request to initiating PCT</li> <li>• Flexibility to handle various timelines</li> </ul>	Depends upon individual
Older adults, likely Medicaid eligible		
Older adults, not Medicaid eligible		
Adult children of older parents who need assistance		
Adults w/ serious MH	The minute they hit NWD	6 weeks – 6 months, depending

concerns	(less than 24 hours)	
Families/ children w/ serious MH concerns	Less than 24 hours	90 days, 6 weeks, 6 months
Families/ children w/ disabilities	<ul style="list-style-type: none"> <li>Varies</li> <li>Needs to be able to respond immediately in emergency situations</li> <li>14 days or less to intake/ sit-down</li> </ul>	Same
(14) 17-21 year olds w/ disabilities		Same

Segment	Where is PCT delivered?	How is PCT delivered?
Older adults (60+) entering the system for the 1 <sup>st</sup> time	<ul style="list-style-type: none"> <li>Wherever the consumer is</li> <li>Telephone</li> <li>Computer</li> <li>Home</li> <li>Hospital</li> <li>Etc.</li> <li>Internet esp. for adult children , out of state</li> </ul>	<ul style="list-style-type: none"> <li>Incorporate several different methods of service dependent on individual</li> <li>Triage by phone</li> </ul>
Older adults, likely Medicaid eligible		
Older adults, not Medicaid eligible		
Adult children of older parents who need assistance		
Adults w/ serious MH concerns	<ul style="list-style-type: none"> <li>In their chosen community</li> </ul>	<ul style="list-style-type: none"> <li>Face to face unless they request otherwise</li> <li>Personalize to consumer preferences</li> </ul>
Families/ children w/ serious MH concerns	<ul style="list-style-type: none"> <li>In home or in school</li> </ul>	<ul style="list-style-type: none"> <li>Face to face</li> </ul>
Families/ children w/ disabilities	<ul style="list-style-type: none"> <li>Meet them where they want (home, school, community office) as long as it's safe</li> </ul>	<ul style="list-style-type: none"> <li>Options based on family/ consumer choice</li> <li>Financial and functional together or separate at location of choice</li> </ul>

## Round 1 Summary

- Time between 1st contact and 1st response = 24 hours
- Channel of delivery chosen by consumer
- Assess critical needs/ safety
- Consumer-directed

- The consumer’s needs and interests are understood
- Listening/ motivational interviewing
- Future-focused, strength-based (not needs based)
- Clear next steps and interim/ stop-gap options
- Confident that support exists
- Deep knowledge of services and systems
- Needs drive everything – the priorities, the process, its length, etc.
- Communicatively, culturally, linguistically appropriate (tools, skills are in place)
- Areas of customization
  - Clear role of caregiver (legally, emotionally)
  - Young adults – independence, changes going into adulthood
  - Family dynamics/ needs

## Round 2: Unpacking Implications

**Note:** There was a great deal of overlap in input given by all groups. The tables offer a compilation of that input (i.e., not a raw transcript). Input that was unique from transitions small groups is highlighted in bold.

Quality	Input
What qualifies as PCC? What’s the standard? (approx.. frequency order)	<ul style="list-style-type: none"> <li>• Well-trained staff (certification; knowledge of systems, options; P-C thinking; culturally competent; able to manage/ deescalate crises; empathetic; <b>trained in transitions and community resources</b>)</li> <li>• Regular evaluation</li> <li>• 100% unbiased referrals</li> <li>• Use ADRC’s national standards for options counseling</li> </ul>
Quality assurance priorities (approx.. frequency order)	<ul style="list-style-type: none"> <li>• Consumer satisfaction (self-reported; recovery framework)</li> <li>• Well trained staff (and ongoing training)</li> <li>• Follow up protocols</li> <li>• Shift from system- to person-centered</li> <li>• Improved data collection methods</li> <li>• <b>Completion of transition plan by consumer</b></li> <li>• <b>Timeliness of referrals</b></li> </ul>
Consistency requires...	<p><i>Staff-related:</i></p> <ul style="list-style-type: none"> <li>• Counselors who meet minimum qualifications/ certification</li> <li>• Continuing education requirements (best practices)</li> <li>• Adequate staff compensation (merit-based; rural areas)</li> <li>• Adequate staff for manageable caseloads</li> </ul>

	<p><i>Infrastructures:</i></p> <ul style="list-style-type: none"> <li>• Common training, tools, software, <b>language</b></li> <li>• External audit/ oversight system (“secret shopper”)</li> <li>• Process flow standards</li> <li>• Q.I. standards with feedback loop</li> <li>• Technical support and assistance</li> <li>• NWD as separate, independent entity (conflict-free)</li> <li>• <b>Consistent regulations and documentation</b></li> <li>• <b>Transfer of benefits when consumer moves to new county</b></li> </ul> <p><i>Overall Capacity:</i></p> <ul style="list-style-type: none"> <li>• Adequate access in urban and rural areas/ across the state</li> <li>• Braided funding (max. supports based on location, natural supports, etc.)</li> </ul>
Possible metrics (approx.. frequency order)	<ul style="list-style-type: none"> <li>• Consumer satisfaction (quality of life improvement, treated respectfully)</li> <li>• Timeliness/ responsiveness indicators</li> <li>• Connection to/ enrollment in LTSS, Medicaid</li> <li>• Follow up indicators (still living in community of choice, etc.)</li> <li>• Audit results</li> <li>• Acute care/ ER utilization; hospitalization rates; <b>decreases in out-of-home placements</b></li> <li>• Gab analysis/ duplications</li> <li>• Stories/ qualitative data</li> </ul>

Regulation/ Policy	Input
New policies/ regulations needed	<ul style="list-style-type: none"> <li>• Too many regulations already</li> <li>• <b>Money follows consumer as statewide policy</b></li> <li>• Check for unintended consequences of changes to system</li> <li>• Access to financial eligibility information</li> <li>• Staff credential standards/ timeliness standards</li> <li>• Regulations/ rules around URC functions?</li> <li>• Braided funding options</li> <li>• MOU’s/ partnership agreements between agencies and systems</li> <li>• Change from fee-for-service to capitated system or other option</li> </ul>
Updates needed	<ul style="list-style-type: none"> <li>• Inclusion of person-centered language in all relevant state policies and regulations (comprehensive review)</li> <li>• Coordination of state policies and regulations across programs/ agencies; statewide policies rather than by county</li> <li>• <b>Reduce response time from 48 to 24 hours (7 days a week)</b></li> <li>• <b>Consistent timelines for functional and financial assessments</b></li> </ul>

	<ul style="list-style-type: none"> <li>• DHS, DIDD, SEP rules and regulations (numerous)</li> <li>• HIPAA guidelines to enable sharing of information</li> </ul>
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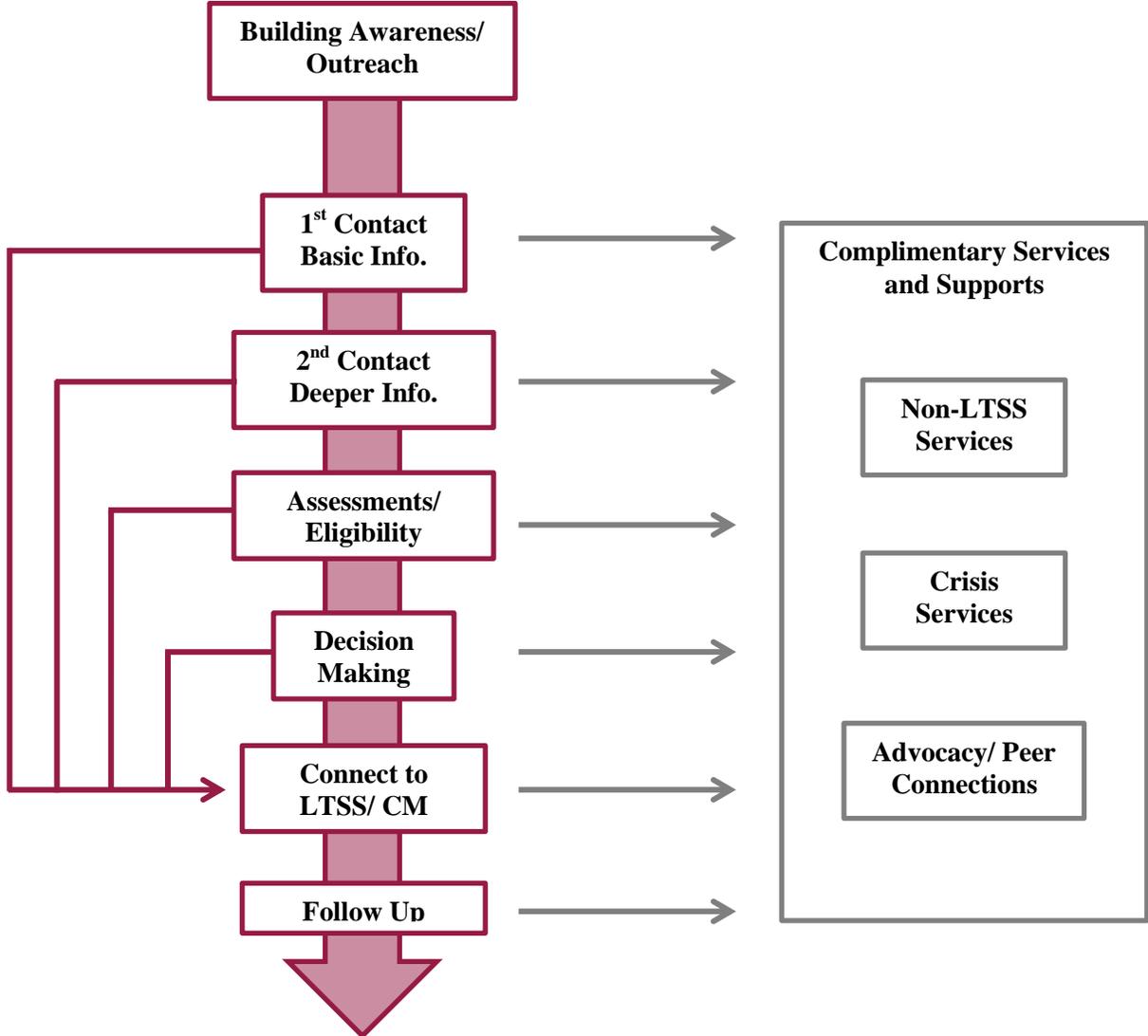
Qualifications	Input
Education	<ul style="list-style-type: none"> <li>• HS diploma or equivalent</li> <li>• Bachelor’s degree (human services, social sciences, gerontology)</li> <li>• <b>Master’s degree</b></li> <li>• PCC certification</li> </ul>
Experience	<ul style="list-style-type: none"> <li>• Lived experience in recovery (self or family member)</li> <li>• 2 years professional experience</li> <li>• Experience in customer service, technology, business, human services, <b>transitions/ community services</b></li> <li>• Less experience okay with PCC certification</li> </ul>
Skills	<ul style="list-style-type: none"> <li>• People skills (empathy, compassion, able to build rapport)</li> <li>• Calm under pressure/ unflappable; crisis intervention</li> <li>• Communication/ listening skills</li> <li>• Research/ interview skills/ motivational interviewing skills</li> <li>• Critical thinking/ problem solving skills</li> <li>• Adaptable; able to think on your feet</li> <li>• Customer service skills</li> <li>• Tech savvy; computer skills</li> <li>• Able to multi-task; detail-oriented</li> <li>• Group facilitation/strategic planning</li> </ul>
Content Expertise	<ul style="list-style-type: none"> <li>• Cultural competency</li> <li>• Older adults and people with disabilities</li> <li>• Knowledge of “the system”; Medicaid; LTSS, community resources</li> <li>• Mental health, first aid, or “emotional CPR”</li> <li>• <b>MI, DBT</b></li> </ul>
Etc.	<ul style="list-style-type: none"> <li>• Age 18+</li> <li>• Background check required</li> <li>• Strong work ethic/ willing to go the other mile</li> <li>• Genuine, authentic, confident</li> <li>• Preferred – people who look like those they serve</li> </ul>

Workforce Issues	Input
How many providers?	<ul style="list-style-type: none"> <li>• Ratio of 1:25 (maybe different in rural areas)</li> <li>• Based on size by county</li> <li>• Depends on the system, service, and type of provider</li> <li>• Caseload rate from Case Management Soc. of America</li> </ul>
Certifications/ training minimums	<ul style="list-style-type: none"> <li>• Yes!</li> <li>• Systems</li> <li>• Cultural competency</li> <li>• Assessments</li> <li>• Crisis intervention</li> <li>• Customer service</li> <li>• <b>No, but weekly supervision/ ongoing training</b></li> </ul>
Training capacity needed	<ul style="list-style-type: none"> <li>• Centralized resource training per region</li> <li>• Mentoring/ shadowing</li> <li>• Developed and presented by people w/ lived experience</li> <li>• Peer training</li> <li>• Based on best practices</li> <li>• Online modules available on demand</li> </ul>
Keys for provider success	<ul style="list-style-type: none"> <li>• Organization is bought in to PCC and has sufficient support staff</li> <li>• Adequate staffing</li> <li>• Leadership/ direction/ regular supervision</li> <li>• Support, ongoing education, culture that values employees</li> <li>• Assume a rolling caseload (length of PC engagement will vary by consumer)</li> <li>• <b>Ongoing updates to community resource information</b></li> </ul>

Infrastructure	Input
Implications for IT	<ul style="list-style-type: none"> <li>• Access, transparency, ease of ongoing training/ support</li> <li>• Mobile version (mountains/ plains)</li> <li>• Able to pull personalized reporting</li> <li>• Mandatory and limited access</li> <li>• Compatible with other systems/ auto-populate?</li> <li>• Website/ 508 compliant</li> <li>• Up to date/ robust information</li> </ul>
Implications for paperwork	<ul style="list-style-type: none"> <li>• Auto-fill</li> <li>• Intake and assessment questions tie to data analysis needs</li> </ul>

- As universal as possible
- HIPAA compliant
- Person-centered (not system-centered)
- Shorter
- Paper and electronic

**Refined Workflow Diagram**



## Debriefing Discussion

- Trust building needed
- Informed about options/ resources
- Empowered to make decisions
  - Some consumer segments may need to be educated/ have their confidence and/or skills developed so they feel they are able to make decisions – this may be where peers or advocates come in
- Dialog that leads to coordinated action across agencies/ domains
- Listen to and address consumer/ family/ caregiver
  - For some consumer segments (esp. when family is involved), there is a need to balance the needs/ interactions between the consumer and caregiver (i.e., not that caregiver needs are ignored, but they don't come first)