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Sustaining New Jersey's Evolving Community Choice Counseling Program

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STATE POLICY IN PRACTICE……

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Summary

With support from the Centers for Medicare & Medicaid (CMS), most states are developing nursing home transition programs to help older adults and persons with disabilities return to their homes and communities. New Jersey developed such a program in 1998, initially without federal support. Since then, New Jersey has obtained three CMS grants and substantial state support to refine its Community Choice Counseling Program. This ***Policy in Practice*** brief describes how this state is sustaining this evolving program. It describes the statutory foundation of the program rooted in pre-admission screening for nursing homes, and how state leaders used that 1988 law to reduce resistance from nursing homes and obtain a sustainable funding source for the Community Choice Counseling staff. This brief also summarizes new innovations, evaluation findings, lessons learned and potential future directions. It is intended to help state policy and program leaders, advocates, and providers learn from their peers and colleagues across the states. Similar briefs feature others states, such as Washington, Minnesota, and Indiana. They can be found at www.cshp.rutgers.org and www.hcbs.org.

Major Points

- Consistent with 30 other states at the time, New Jersey enacted a Nursing Home Pre-admission Screening law in 1988 (P.L. 1988, Chapter 97); all persons who will become eligible for Medicaid within six months following admission to nursing homes must be assessed.

- Implementing regulations (NJAC 10:63) created a system to "track" people who are "nursing home level of care" and periodically reassess them and recommend alternatives to nursing home care.

- Once New Jersey consolidated policy, funding and oversight of long-term for older adults into one department in 1996, state leaders in New Jersey's Department of Health and Senior Services (NJDHSS) sought new ways to promote "independence, dignity and choice" and pro-actively help make their choices a reality.

- Based on site visits to Oregon and Washington, NJDHSS launched a "Community Choice Counseling" pilot in 1998 to help 300 persons of all ages leave nursing homes to return to their homes and communities.

- The statewide expansion of the Community Choice Counseling program included extensive staff training, a state-funded transition fund, and marketing materials for "options counseling" so people could better understand their choices.

- State employed nurses and social workers staff this effort with federal matching funds.

- An independent, external evaluation of the program found the overwhelming majority of those interviewed were satisfied with their post-transition living arrangement.

- Although the Community Choice Counseling program has always worked with consumers of all ages, since 2002 the state has dedicated substantial effort to developing new ways to work with younger persons with disabilities by collaborating with Independent Living Centers and developing "Round Tables" in nursing homes.

- New Jersey will sustain its evolving Community Choice Counseling program by obtaining federal matching funds for state staff and forging new partnerships with Independent Living Centers.

- State leaders are exploring new ways to link the Community Choice Counseling program to the New Jersey EASE, the state's single entry point for long term care.

Background

New Jersey's Community Choice Counseling is a statewide nursing home transition program for people of all ages. Although summarized in several sources (Eiken, 2003; Medstat, 2005; Reinhard & Fahey 2003; Reinhard, Howell-White & Quinn, 2005), there has been limited attention to the details of the statutory and regulatory framework that has helped shape and sustain the infrastructure for this program. A more detailed description may be helpful to other states that are exploring ways to develop sustainable nursing home transition programs.

Statutory Foundation

A 1988 state law and its implementing regulations provided the opportunity to create the Community Choice Counseling program a decade later. Consistent with 30 other states at the time, New Jersey enacted a Nursing Home Pre-admission Screening law in 1988 (P.L. 1988, Chapter 97). This law required a determination that individuals seeking admission to a nursing home met the Medicaid level of care criteria. The broad sweep of this law made it possible for state leaders in the decade that followed to re-tool the pre-admission screening program into the Community Choice Counseling program. We excerpt key provisions from the law to help those states that are interested in enacting or amending mandatory pre-admission screening (PAS) laws that can under-gird a strong nursing home transition program.

Legislative intent to establish state policy

"The Legislature finds and declares that: (a) A substantial proportion of nursing home residents do not need the level of medical care provided in skilled nursing…facilities, and to the extent these inappropriate placements occur, there are adverse financial and social consequences; (b) After entering a nursing home, many residents become dependent on that facility, experiencing depletion of their financial resources and erosion of their social contacts in the community…"

State agency authority

"The commissioner[1] shall establish a Nursing Home Preadmission Screening Program…(and) develop standards for permission screening[2]…(and) shall contract with appropriate agencies for the performance of preadmission screening or perform the screening directly through the division."

These provisions gave the implementing state agency the authority to develop details of the program through regulations, which helped later officials develop the Community Choice Counseling program through the "tracking" system (see below). The statute also provided flexibility to contract out the performance of PAS. Although the state chose to "perform the screening directly" through state personnel, the statute would allow the state to contract with area agencies on aging, independent living centers, or other "appropriate agencies" without amending the law.

Broad scope of mandatory PAS

"A skilled nursing...facility is responsible for ensuring that preadmission screening has been performed with respect to **every individual** who, at the time of application for admission to that facility, is eligible for medical assistance…. **or will become eligible within six months following admission**, **as a condition of reimbursement by the Medicaid** program…."

Unlike many other states, there are no loopholes in this PAS law**. All persons who will become eligible for Medicaid within six months following admission to nursing homes must be assessed or Medicaid will not pay for their nursing home stay.** This is a key provision for Community Choice Counseling for two reasons.

- The vast majority of people who stay in a nursing home for six months will become eligible for Medicaid. Therefore, **this state law mandates that virtually all people going into a nursing home for a projected long stay will be assessed by a state nurse or social worker. The nurse or social worker also discusses community options with individuals who are interested in returning to the community.**

[1] Now the Commissioner of the Department of Health and Senior Services.
[2] See NJAC 10:63.

- **This provision provides the legal framework for the state to claim a federal match for the salaries of staff performing PAS for almost all people entering a nursing home for a projected long stay.**

This section also makes it clear to nursing home providers that state personnel have the right, in fact the mandate, to talk to their nursing home residents about their long-term care needs and options. This mandate made it easier to overcome later resistance from nursing homes when the Community Choice Counseling program was launched 10 years later.

Voluntary PAS Provision

The law allows NJDHSS to offer a screening for a fee to any individual who falls outside the scope of the mandatory PAS program.

"Preadmission screening shall be made available, upon request and for a reasonable fee to be established by the commissioner, to a private pay individual, whether or not the individual expects to become eligible for the Medicaid program."

Since most people fall within the mandatory provision of this act, the state never implemented a voluntary program.

Regulatory Framework Supporting the Evolution to Community Choice Counseling

The state agency charged with promulgating regulations (NJAC 10:63) for this statute created a system for "comprehensive needs assessment" conducted by the state Regional Staff Nurses (RSNs) who talk with nursing home residents about their long term care needs and the most appropriate setting for those needs to be met. Based on that assessment, the RSN will designate individuals into one of three "tracks" for periodic reassessment and recommend alternatives to nursing home care. Since this tracking system later became the starting point for the Community Choice Counseling program, we offer both a summary and actual regulatory language

Track I residents are unlikely candidates for nursing home alternatives, although staff reassess to see if the situation changes. At the other end of the tracking system is **Track III,** which is the category for those individuals who are diverted from nursing home residence to long-term care in a community-based setting. In between is the category known as **Track II**. This targeted group includes individuals who cannot be immediately diverted from nursing homes, but might be able to return home or to a more home-like alternative like assisted living or adult foster care. This was the target group for the 1998 Community Choice Counseling pilot and the initial roll-out of this program because the state employed nurses already had a legal mandate to periodically assess and counsel these nursing home residents. Indeed, **the regulations stipulate that "Recipients designated as track II (short-term) shall be monitored closely by Medicaid District Office professional staff to assure active participation by the facility in the discharge planning process."**

The actual regulatory language may be helpful to those who are seeking mechanisms to sustain a statewide program for nursing home transitions (see link to the electronic version at http://www.state.nj.us/health/seniorbenefits/documents/reg_njac_10-63.pdf.) Section 1.1 of NJAC 10:63 details the nursing facility authorization process and the tracking system for periodic review of residents needs and options.

"(c) As part of the PAS determination, the RSN will assign the track of care based on the following criteria:

- **Track I** designates long-term NF care and shall be assigned in situations when long-term placement is required because clinical prognosis is poor, and when, during the assessment process, short-term stays are neither realistic nor predictable…. A Track I designation shall not preclude the possibility of future discharge. The Medicaid Social Care Specialist will monitor those individuals with discharge potential and consult with the RSN who will reassess the individual and update the Health Services Delivery Plan (HSDP) for a track change if appropriate.

Track II designates short-term NF care and shall be assigned in those situations when comprehensive and coordinated NF services are required to stabilize medical conditions, promote rehabilitation, or restore maximum functioning levels and to provide a therapeutic setting which assures family counseling and teaching in preparation for discharge to the community setting…**Individuals shall also be assigned to short-term NF stays, in spite of technically complex care needs and guarded prognosis, particularly when the individual is motivated towards NF alternatives** and/or when caregivers, through case management intervention, may obtain services which make return to the community a viable option. A Track II is assigned if the CCC feels that the individual has good potential for rehabilitation or the reasonable expectation or likeliness that the individual can be restored to the previous level of functioning and can then return to the community.

Track III designates "long-term care in the community …with supportive health services."

NJAC 10:63 mandates that staff periodically reassess nursing home residents and addresses discharges:

> "The RSN will authorize initial NF services **after consideration and rejection of possible means of alternate care**. Similarly, the possibility of alternate means of care will be a prime consideration in every reassessment of the care required by the individual….The (Medicaid) staff will examine resident records for **proof of continued vigilance and effort by the facility to utilize alternative means of care for all long-term residents."**
>
> "The Medicaid RSN shall periodically assess Medicaid recipients…and may recommend alternatives to NF stay…(f) Medical Social Care Specialists employed by the Division shall provide case management to Medicaid recipients, on an ongoing basis, following placement to monitor the provision of NF care in order to: Assure that services are rendered as recommended … Assure the delivery of timely and coordinated

services…and…**facilitate discharge planning** and promote appropriate placement to alternate care settings…."

CCC staff works closely with the AAA case management site to monitor level of care of individuals enrolled in a waiver program. Individuals can be moved from a Track III to a Track II if there is change in condition. CCC will work with that individual, their family and the AAA care manager to quickly return these individuals to the community.

Some individuals move from track to track depending on their current medical condition, ability to perform self care and amount of support by family and friends. Tracking is a fluid process which allows for changes in various aspects of the persons condition and social supports.

New Jersey's statutory and regulatory framework for nursing home preadmisison screening provides a strong starting point for bringing external experts into the nursing home to talk to virtually all those who might become long-stay residents. Under the leadership of the PAS program director, the state nurses adhered to this tracking system, although the lack of nursing home alternatives in the late 1980s and early 1990s made it difficult to offer nursing home residents real choices (Cetrulo, 1996).

Moving from PAS to Community Choice Counseling

To promote the development of more nursing home alternatives and help people find those options, New Jersey consolidated policy, funding and oversight of long-term for older adults into one department in 1996 (Reinhard & Fahey, 2003). State leaders in NJDHSS turned to two pioneer states in the field, Oregon and Washington, to find better ways to promote "independence, dignity and choice" and to pro-actively help make their choices a reality. After sending managers and front line staff to see how staff in those two states conducted nursing home diversions and transitions, New Jersey piloted a Community Choice Counseling program in 1998. Two state staff "preadmission screening nurses" helped 300 "Track II" nursing home residents return to their homes and communities over a four-month period. Management staff conducted an internal evaluation of this pilot through telephone follow-up of 10 percent of the former nursing home residents; findings included high consumer satisfaction and low costs to the state and consumer for community placement (Reinhard, Howell-White and Quinn, 2005).

Encouraged by this experience, the Governor announced in her "State of the State" speech on statewide priorities that her administration would help 1,000 people of all ages leave nursing homes and return to their homes and communities. With federal matching administrative funds of 75% for nurses and 50% for all others, the state hired more than 50 new staff, mainly nurses, to expand the pilot statewide. Candidates were interviewed with very explicit details about transition work, with an emphasis on the fact that it is not easy, and required skills that may be unrelated to the candidate's formal education. For example, they may be expected to buy furniture and groceries, and hold "showers" for kitchen utensils and sheets because many transitioning nursing home residents did not have any household items. Some individuals who were interviewed did not take the job (Parkoff, 2005).

A state-funded transition fund was set up to help with furniture, rental deposits and other one-time costs for transition. A $500,000 CMS nursing home transition demonstration grant in 1999 provided additional support for extensive staff training and marketing materials for "options counseling" so people could better understand their choices.

As described below, the Community Choice Counseling Program has been externally evaluated (Eiken, 2003; Howell-White, 2003). The program continues to evolve in response to these evaluation findings, program staff experiences, and consumer input. Additional funding from CMS in 2002 is helping the state refine its capacity to serve people under the age of 65 and work more collaboratively with Independent Living Centers.

Current Program Practices

Community Choice Counseling Staff

The Community Choice Counselors are state staff members that are cross-trained to do nursing home pre-admission screening, options counseling, and transition support. Successful Community Choice Counseling staff need to be very creative and motivated by challenge. The program seeks people who do not want routine jobs and appreciate a challenge each time that they meet with a client. Those who understood the challenges thrive and get much personal satisfaction from helping people return to the community (Parkoff, 2005).

Currently, there are 73 clinical staff (12 social workers and 61 registered nurses) who are funded with a federal Medicaid administrative match (50% for social workers and 75% for RNs). They are organized into three regions, with specific assignments to specific hospitals and nursing homes in those regions. Staff are well known to these facilities and are able to walk around and have conversations with residents at their discretion because they are state employees. They work with people regardless of their financial situation, but also follow a specific caseload of "Track II" persons who have been screened and determined to need short-term NH care and are potentially able to return to the community.

Among these staff are those who are currently dedicated to the 2002 CMS grant project that focuses on younger persons with disabilities. These staff include six social workers and two nurses who are disability specialists, a relatively rare nursing specialty.

Identification of NH Residents for Transfer

Targeting

As described above, the PAS process leads to a triage system in which individuals are "tracked" into three levels and monitored by the Community Choice Counselors. The actual track designation is determined by the PAS staff at the regional field office level, in part through analysis of hospital discharge profiles and their own professional judgment. Central Office staff members maintain records for follow up. Those records include spreadsheet lists of all tracked individuals, including nursing facility information and discharge status.

Each counselor has a responsibility for nursing facilities within the field office area A counselor will generally spend the morning in one nursing facility and the afternoon in another nursing facility.

The Community Choice Counselor enters the assigned nursing facility with a list of Track II individuals, but engages in conversation with anyone who is interested in transitioning. As state staff, they are free to circulate throughout the nursing home and talk to residents. They also have access to all residents' charts, including the Minimum Data Set (MDS) responses to the question about desire to return to the community (Reinhard, Henderson & Bemis 2005) that they check on a regular basis. The caseload ranges from 20 or 30 residents, although some are working more intensively with 10 people at a time depending on the transition needs of those persons. In general, Community Choice Counseling staff members transition two to three people at a time.

The Community Choice Counseling staff members work directly with the client and always ask about family supports and if they can contact them. They need written and verbal permission to include family and others. Once that occurs, these informal support persons are included in the transfer discussions.

Transition Assistance

The Community Choice Counseling staff member focuses on the development and implementation of goals for a relocation plan. The plan is based on the individual's preferred living arrangement, and concrete plans to facilitate the transition. The focal point is the client and what the individual does with their lives. As the Independent Living Centers emphasize with younger persons with disabilities, if you do nothing in the nursing facility, are you still going to do nothing in an apartment? Together, the individual and staff create lists of what needs to be done next, such as vocational rehabilitation, education, employment, housing—and how long it will take.

Since 1998, New Jersey has made transition funding available to those who need support for one-time expenses to establish a community residence. Using state funding, the Counselors have arranged for payment of furniture for assisted living residence, one-time security deposits, and clothes. The state has secured CMS approval to include these expenses as a Medicaid waiver service, but the state has not yet created the infrastructure to do so.

It is important to note that a large number of those transferred do not need the full resources of a Medicaid HCBS waiver. Some leave and do not need services. Some fully recover and do not need services. Others may need limited Medicaid state plan or other services. According to state officials, about 40% of people transferred out of nursing homes do not need Medicaid waiver services, but some people on Medicaid do use state plan services (Sorrento, 2005).

New Innovations

In 2002, the Community Choice Counseling Program initiated a pilot to develop more effective strategies to help younger persons with disabilities relocate to the community. In partnership with the state's Independent Living Centers, state officials collaborated with consumers and nursing homes to create "Round Tables" to address the broad and complex needs of consumer who need substantial assistance to find housing, social services and other community connections for sustained community residence.

The Round Tables are designed to empower consumers as Round Table Leader to "take charge" of their transition process. The intent is to ensure that the consumer makes a transition that has the opportunity to be longstanding.

Appendix 1 provides an executive summary of the Round Table strategy. According to those who helped develop them, the Round Tables are much more fluid than the process in Appendix 2 would suggest (Parkoff, 2005). They cannot be replicated exactly with each client because of the personalities and disabilities involved. There are many factors that weigh in during the transition process (e.g. how long a person has been in the nursing home, the ability of the client to "buy" into the process, family and other support, type of disability and extent of disability, financial resources, and the cooperation of the nursing home staff). All of these factors play a part in the effectiveness of the Round Table.

Financing

As described above, the 1988 PAS law provides the policy structure for federal administrative matching funds for the Community Choice Counseling staff (75% for nurses and 50% for all others). The state plans to sustain the Community Choice Counseling program state staff through this allocation in the future. For example, the state will assume funding for the two disability nurse specialists that have been funded by their 2002 CMS grant.

First, New Jersey is currently partnering with Independent Living Centers and plans to sustain this partnership. Currently, another 2002 CMS grant is supporting the partnership of the state and one of the Independent Living Centers. The State-ILC partnership has created a Round Table format that can be replicated statewide, and the ILCs are incorporating this work into their scope of work with their federal finding sources (Sorrento, 2005).

Second, New Jersey is interested in exploring more articulation with the Aging and Disability Resource Centers (ADRCs) that they have piloted in two counties (Polansky, 2005). Built upon the 1996 NJEASE program (Reinhard & Fahey, 2003), the ADRCs are currently developing more effective ways to include resources for younger persons with disabilities and improved methods to influence the "critical pathways" to a nursing home. To help develop sustainable ways to do this, New Jersey is beginning to incorporate the 2002 CMS nursing home transition staff into the ADRC pilot.

The success of this experimentation will depend in part on how the state can finance it in the future. Past efforts to fund NJEASE implementation uncovered difficulties in establishing a

Medicaid cost allocation at the county level (Walsh, 2005). These hurdles are not insurmountable, and not impede by federal obstacles. However, it will take a concerted state-county effort to establish sound methods for Medicaid cost allocations for nursing home relocation and ongoing case management.

Program Results

Number of People Transitioned

From its inception in 1998 to 2004, the Community Choice Counseling program has transferred more than 5,000 persons of all ages from nursing homes (Medsat, 2005). In fiscal year 2005 (July 2004 to June 2005), the state transferred another 504 people (Sorrento, 2005).

Over the past seven years, the number of persons transferred has fluctuated each year. The main reason for this fluctuation is the level of staffing. Whereas in state fiscal year 2004, New Jersey transferred about 500 people, in the past, they have transitioned more than 1,000 in a year (Reinhard & Fahey, 2003). When staffing levels are frozen, particularly when a new administration assumes office (a frequent occurrence in New Jersey the last several years), Community Choice Counseling productivity fell and the Medicaid nursing home census rose. With support from the current administration, the state is currently staffing up to resume the success of prior years.

Evaluation Findings

Evaluation findings have shown that most former nursing home residents are very satisfied with their current living situation and their quality of life has improved (Howell-White, 2003). As part of an evaluation of the Community Choice Counseling program, former nursing home residents were interviewed about their experience with the Community Choice Counselor, current living situation, use of services and needs, and health care service use.

Replication Requirements

New Jersey's Community Choice Counseling Program is built on its long-term care pre-admission screening program. Those states that have similar laws may be able to follow New Jersey's path or amend their laws to make replication possible.

States that are exploring more decentralized methods (area agencies on aging or independent living centers) face particular challenges. For example, New Jersey has found that when state staff are not present, the independent living center staff does not feel welcome.

Regardless of who staffs this effort (state, area agency on aging, independent living center, or contracted agency staff), the state needs to identify a source of dedicated staff and a way to pay for them. They need training and ongoing support—and articulation with state Medicaid efforts.

Lessons Learned

The most significant lesson learned from New Jersey's nursing home transition experience is that systems changes can help nursing home residents move to community settings. There is a significant population of nursing home residents who can live in community with some supports. Major service barriers to relocation are the lack of appropriate housing, transportation, and employment opportunities for younger persons. The numerous streams of funding for specific populations make it a challenge to develop a coherent system for nursing home transition.

Despite these systemic barriers, people can be transitioned successfully and are able to live in their communities. New Jersey has almost eight years of experience in making this happen. The major challenges are staffing and financial allocations at the state and local levels.

A strong state-staffed effort has eased nursing home resistance and promoted the legal access to residents and records. The current collaboration with Independent Living Centers may help bring together the talents of those who can help translate the needs of younger persons with disabilities. More collaborations with the area agencies on aging and Aging and Disability Resource Centers will help move New Jersey's Community Choice Counseling Program to the next level of local-state-consumer collaboration. The greatest challenges remain consistent funding for staffing and housing at the local level.

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Web Links

For information on the Community Choice Counseling program, see New Jersey's web site at http://www.state.nj.us/health/consumer/choice/topfaqs.shtml.

To view the regulations that under-gird this program, see
http://www.state.nj.us/health/seniorbenefits/documents/reg_njac_10-63.pdf

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Appendix 1

Round Table

Executive Summary

Purpose:

- To provide the consumer with an ongoing opportunity to meet with the individuals assisting in the transition.
- To empower the consumer as Round Table Leader to "take charge" of the transition process.
- To ensure that the consumer makes a safe transition that has the opportunity to be longstanding.

Participants:

Initially: Consumer, Nursing Facility (NF) Social Worker, Community Choice staff person, representative from the Center for Independent Living where the NF is located.

At Subsequent Round Tables: Individuals who are assisting the consumer to make a safe transition. This can include: NF Occupational Therapist, Physical Therapist, Nutritionist, other disciplines that relate to the client's disability, Vocational Rehab, family or interested friends, and a mentor.

Attendance at a round table should depend on the consumer's status regarding a particular issue.

Focus: "What life do you want in the community?"

Helps the consumer define his/her expectations and brings a realistic step-by-step approach to the goal(s) articulated.

This broad question is the basis for increasing specificity until it is clear how the consumer sees him/herself living in the community. It includes possibilities of education, employment, community involvement, advocacy, socialization and increased independence.

The First Round Table Meeting

The consumer is encouraged to articulate the goal(s) and to see what strategies it will take to achieve the goal(s).

The consumer must agree to the steps necessary to achieve the goal(s).

Write down information on whom is responsible for various phone calls or applications, who will follow up and when on the Independent Living Plan (ILP) document. Timeframes must be stated and a follow up meeting date set, if possible. This will be given to the consumer at the conclusion of the meeting.

Please provide the consumer with a folder to keep the ILP and other papers that will be part of the transitioning process. Include DHS's New Jersey Resources and your business card in the folder.

The discussion around the table is to assure that all possible issues are raised, discussed and a reasonable resolution is determined.

Appendix 2

ROUND TABLE PROCESS

The following process was developed to assist consumer's interested in transitioning from the nursing facility to the community.

- The Community Choice Counselor speaks to the consumer about his/her interest in leaving the Nursing Facility (NF).

- When a consumer expresses interest, during discussions about how to make a transition happen, the counselor suggests a meeting be arranged with those individuals interested in the consumer's welfare and wanting to assist in the planning. The counselor also suggests inclusion of NF staff and other agency staff with skills that will make the transition smoother.

    - Ask the consumer if there are family members and/or friends to invite to the "Round Table."

Who should be invited to attend the Round Table

- Determine who from the NF should be included – discharge planner, RN, OT, PT, Nutritionist.
- Consider other agencies that might be included. This is decided based on specific needs. (For example, for consumers who have expressed an interest in being employed, invite someone from the Division of Vocational Rehabilitation. If specific equipment is needed, ask staff from NJP&A ATAC.)
- Include the Center for Independent Living (CIL) located in the area the consumer wants to live. If this is not the same county as the NF, and the CIL cannot send staff, request a conference call for at least a part of the meeting.
- After consultation with the consumer, family or friends should be invited to either the first or subsequent Round Table meetings.

The individuals invited to the Round Table can be modified as the process moves forward. People can be added when it is determined that their input is relevant to the process.

Everyone does not have to attend all Round Tables – only the consumer, the Community Choice Counselor, and those specifically identified with a task to be accomplished for each successive meeting.

PRIOR TO THE FIRST ROUND TABLE MEETING

The individuals contacted and expected to be at the Round Table should be asked to *get to the NF about ½ hour before the scheduled appointment* with the consumer. This provides an opportunity for the Community Choice Counselor to provide background regarding LOS, disabilities, potential limitations in the transition process, and explain what the counselor understands to be the desires of the consumer.

The Round Table process is an opportunity to identify specific consumer goals that will ultimately result in transition to the community. Each Round Table meeting may have a different focus (i.e. meeting housing needs, education or job opportunities.)

The Consumer needs to take ownership of the meetings. This begins at the first meeting with an understanding that he/she directs the process. The consumer should take part to the greatest extent possible by making appropriate efforts to effect transition (for example, telephone calls to agencies to get applications.) The consumer should be aware of what people working on the transition are doing and receive updates on a regular, identified basis.

The Round Table must meet periodically to discuss progress. Follow up meetings should be expected. If appropriate, the meeting date for the next meeting can be set at the conclusion of the current meeting.

During the Round Table, it is important to remember that the dynamics within the group will change. People who were cooperative can become more assertive; the consumer may be interested and then lose interest; roadblocks can and will be raised by anyone in the group. The facilitator must be prepared to handle all the various situations that the group dynamics present.

FIRST MEETING ***Time Frame:*** ***One Hour***

Introductions:

At this first meeting the Community Choice Counselor, as facilitator, introduces everyone who is present, reviews what has occurred at previous meetings with the consumer and articulates what the Counselor believes the consumer is interested in regarding housing.

The CIL is explained, very briefly. The community involvement and opportunities for the consumer to become an advocate can be explained at this time, if appropriate.

The CIL staff has the best opportunity to talk about how the consumer has control. The concept of a time line that states who will be responsible for various actions and phone calls can be developed. Also covered is the importance of developing a support system within the community both during and after the transition.

Options and partnerships are discussed.

Family/friends need to be supportive but cannot take over the meeting. (When a parent, relative, friend states what he/she wants, the facilitator must refocus the discussion to elicit what the consumer wants.)

At some point in the process, discussion and identification of a mentor should be part of the Round Table Agenda and Transition Plan. A mentor is a person with a similar disability presently living in the community. This person can identify with the consumer's concerns and fears, can offer practical advice and support for the consumer.

Goal Setting: "The Plan"

Encourage the consumer to discuss goals – "what do you want; what don't you want " to happen to your life. Within this context, explore the possibility of the consumer becoming a volunteer within the disability community to assist others in a similar situation. This, of course, would most likely occur once the consumer has been relocated.

The CIL person needs to connect with the consumer over their disabilities – create a bond. This should be done regardless of the differences in their disabilities.

Identify ADL and IADL needs that will need to be met in the community.
There is a need to review the nature of the consumer's illness regardless of what the Community Choice counselor related prior to the meeting or what appears obvious. It is important to know what the consumer believes is the reason for the NF placement.

Explore the direction the consumer wants. Explore the support the consumer has in community, through family, or around the specific illness or disability the consumer identified.

Discuss asking a community mentor to stop by the NF or call the consumer to make a connection.

Help the consumer reach a conclusion at to what will make for "good" living. (Example – determination of where one will live is based on what the consumer wants to do and where the consumer wants to go when living in the community. The constraints presented by mobility deficits must be a factor in selecting communities and housing.

Responsibilities:

There is a need to go slow but to encourage the consumer to assume responsibility (it this is possible.)

Discuss life style – how will the consumer spend the day.

Discuss housing choices and availability of what the consumer indicates as his/her desired housing choice.

Establish financial level and medical insurance when consumer will be in community.

- Discuss what constraints finances and medical insurance will place on housing, PT/OT, etc.

Ask the discharge planner or the CIL representative to *write down who will follow up with phone calls to various agencies for information. Write down the phone numbers and people to speak to* (if this information can be obtained at this meeting.)

Ask the consumer to sign waivers so people can contact him/her and CIL and other agencies can follow up.

Subsequent Meeting

If appropriate, set date for follow up meeting.

Determine if other agencies, friends/family should be invited to next meeting. Decide who will invite these people.

Review who at the Round Table will assist and with which tasks.

Review the goals/plan list. If necessary, if the consumer is making phone calls, suggest language to use when talking to agencies and provide written "hints."

Make copies of all materials developed: one for consumer, one for Choice Counselor, and one for CIL representative.