

ATTACHMENT 6 Work Plan

Money Follows the Person Transition Center RFA # 20599

Contract Period: 07/01/2026 to 06/30/2031

Instructions:

Applicants are instructed to complete and upload **Attachment 6 – Work Plan** found in the “Attachments Section” of the Statewide Financial System (SFS) online Application/Bid Event in response to Bid Factor Question Q04a.

The Work Plan should include the Objectives, Tasks (activities/services) and Performance Measures (outcomes) necessary to meet the Money Follows the Person (MFP) program requirements. The required Work Plan Objectives are prescribed by the New York State MFP program; however, Applicants must add the Tasks (activities/services) and Performance Measures (outcomes) necessary to meet these program objectives. Tasks and Performance Measures proposed by the Applicant in the Work Plan should align with the proposed Program Model, program activities, and the program objectives outlined in the Request for Applications.

Applicants will ***not*** enter any Tasks or Performance Measures into the **SFS Work Plan Section** at the time of application but instead will complete and upload **Attachment 6 – Work Plan** in response to the Bid Factor Question Q04a. Applicants are instructed to enter Tasks and corresponding Performance Measures of their own choosing into the table below on this **Attachment 6 – Work Plan**. **Each Task must have a task description of no more than 2,000 characters. In addition, each Task must have a corresponding Performance Measure narrative of no more than 2,000 characters.**

Applicants may add additional Objectives, Tasks, and Performance Measures as described in the instructions below. **If submitting additional Objectives, Tasks, and Performance Measures, they must be attached to this document, clearly labeled, and must adhere to the character limitations as described above.**

Flexibility in programming is necessary to ensure that resources are effectively directed to the populations and communities most in need. Contract activities and deliverables may be modified at any point in this contract upon direction of the State Money Follows the Person program to address emerging needs or disparities, or to accommodate advances in best practice.

Please note that successful Applicants may be asked to modify work plans prior to initiation of the contract to address issues identified during the review process. If awarded a contract, Grantees may be instructed to insert Work Plan Tasks and corresponding Performance Measures in the Statewide Financial System (SFS) Work Plan.

A. PROJECT SUMMARY Instructions

For the **SFS Work Plan Project Summary**, Applicants are instructed to insert the Project Summary as listed below into the Work Plan Summary field in the SFS online application. **Any additional information entered in the Project Summary *will not* be considered by reviewers of your application.**

Project Summary

The goal of this initiative is to administer a statewide Transition Center structure to provide Transition Center core activities of transition assistance, education and outreach, peer support, informal support, and ancillary transition support to individuals wishing to transition from nursing homes and Intermediate Care Facilities to the community.

Activities include identification of potential participants residing in nursing homes and intermediate care facilities, obtaining informed consent to participate in Transition Center transition assistance activities and supports, providing education on return-to-community options and available home and community-based services and supports to interested nursing home and intermediate care facility residents, providing community preparedness education to transitioning participants prior to discharge to prepare them for successful transition to the community, facilitating access to needed assessments and services, transition barrier resolution, peer support, and follow-up for 365 days post-transition.

B. OBJECTIVE Instructions

Program Objectives are defined by the New York State MFP program and included in the table below. **The Applicant can add additional Objectives; however, the total number of Objectives cannot exceed 30 and the description cannot exceed the 2,000-character limit as described above.**

C. TASK (activities/services) Instructions

Applicants are required to provide a brief description of the specific activities/services that will be conducted for each Objective listed. Applicant must enter at least one Task per objective into the Tasks column in the table below. **Applicants can enter more than one Task for each Objective; however, the total number of Tasks cannot exceed 60 and the description cannot exceed the 2,000-character limit as described above.**

D. PERFORMANCE MEASURE (outcomes) Instructions

Applicants are required to provide Performance Measures for each Task and they should be entered in the Performance Measures column in the table below. **The total number of Performance Measures cannot exceed 90 and the description cannot exceed the 2,000-character limit as described above.**

Work Plan:

OBJECTIVE	TASKS	PERFORMANCE MEASURES
1. Develop and implement an integrated statewide infrastructure to carry out the Transition Center core activities of transition assistance, education and outreach, peer support, informal support, and ancillary transition support.	1.1.	1.1.1.
	1.2.	1.2.1.
2. Obtain Stakeholder feedback and input to guide barrier resolution and future planning through ongoing participation in and attendance at NY Connects Long Term Care Council meetings, semi-annual participant surveys, and other means as needed.	2.1.	2.1.1.
	2.2.	2.2.1.
3. Develop and implement a statewide outreach and marketing infrastructure that supports strategies to identify individuals residing in nursing homes and intermediate care facilities interested in receiving information about, and potentially transitioning to community settings with home and community-based services.	3.1.	3.1.1.
	3.2.	3.2.1.

OBJECTIVE	TASKS	PERFORMANCE MEASURES
4. Develop and implement a statewide outreach and marketing infrastructure that supports strategies to identify individuals residing in nursing homes and intermediate care facilities interested in receiving information about, and potentially transitioning to community settings with home and community-based services.	4.1.	4.1.1.
	4.2.	4.2.1.
5. Establish an infrastructure that coordinates all referrals to the Transition Center as the State-designated Local Contact Agency for Minimum Data Set Section Q referrals and other referrals for transition assistance.	5.1.	5.1.1.
	5.2.	5.2.1.
6. Develop and maintain a HIPAA compliant data collection and reporting system which maintains complete and accurate case information regarding participants served and services delivered and ensures the confidentiality of all personally identifiable information is protected.	6.1.	6.1.1.
	6.2.	6.2.1.

OBJECTIVE	TASKS	PERFORMANCE MEASURES
7. Track and accurately report activities, including information regarding participants and services, on a monthly, quarterly, semi-annual, and ad hoc basis, as directed by state MFP program staff.	7.1.	7.1.1.
	7.2.	7.2.1.
8. Provide oversight and conduct quality assurance/quality improvement activities to ensure that contract activities are of high quality and meet contract deliverables as directed by state MFP program staff. Priorities include development and implementation of a comprehensive quality assurance/quality improvement plan that uses data analysis on an ongoing basis to both assure compliance with program requirements and identify barriers and opportunities for improvement.	8.1.	8.1.1.
	8.2.	8.2.1.
9. Provide objective information, in a consistent manner across the statewide infrastructure, about options for home and community-based services for older adults and individuals with physical or developmental disabilities, or traumatic brain injury who express a desire to leave institutional settings and return to the community.	9.1.	9.1.1.
	9.2.	9.2.1.

OBJECTIVE	TASKS	PERFORMANCE MEASURES
10. Facilitate transition of individuals living in nursing homes and intermediate care facilities into community settings with appropriate home and community-based services and supports to enable them to remain in the community, in collaboration with facility and home and community-based services staff.	10.1.	10.1.1.
	10.2.	10.2.1.
11. Provide community preparedness education to transitioning participants prior to discharge to prepare them for successful re-entry into the community on a variety of topics including, but not limited to, accessing services, home management, self-advocacy, transportation, budgeting, etc.	11.1.	11.1.1.
	11.2.	11.2.1.
12. Follow-up with participants for 365 days post-transition to identify and resolve barriers to successful community functioning to prevent reinstitutionalization post-transition.	12.1.	12.1.1.
	12.2.	12.2.1.

OBJECTIVE	TASKS	PERFORMANCE MEASURES
13. Repatriate New York State residents who are living in out-of-state facilities to their home communities in New York State.	13.1.	13.1.1.
	13.2.	13.2.1.
14. Administer a Quality-of-Life survey to individuals transitioning from facilities to the community, as prescribed by state MFP program staff, including a baseline survey prior to facility discharge and a follow-up survey at 11 months post-discharge.	14.1.	14.1.1.
	14.2.	14.2.1.
15. Recruit and train paid peers that have experience living independently in the community and have characteristics (i.e., physical, and developmental disabilities and/or age) that approximate those characteristics of individuals requesting peer services (and, where possible, have themselves transitioned from a facility setting into the community).	15.1.	15.1.1.
	15.2.	15.2.1.
16. Provide peer support to individuals who are planning to transition from long-term care facilities to homes in the community, to support their successful transitions.	16.1.	16.1.1.
	16.2.	16.2.1.

OBJECTIVE	TASKS	PERFORMANCE MEASURES
17. Provide peer follow-up meetings during the first 60 days post transition to identify barriers and assist, through collaboration with transition specialists, with addressing issues to prevent avoidable reinstitutionalization.	17.1.	17.1.1.
	17.2.	17.2.1.
18. Increase the knowledge of nursing home staff regarding the availability of Transition Center supports and requirements related to MDS Section Q referral to the Local Contact Agency.	18.1.	18.1.1.
	18.2.	18.2.1.
19. Increase the knowledge of staff within the Office for People with Developmental Disabilities (OPWDD) service delivery system regarding the availability of Transition Center supports.	19.1.	19.1.1.
	19.2.	19.2.1.
20. Increase the knowledge of community referral sources regarding the availability of Transition Center supports.	20.1.	20.1.1.
	20.2.	20.2.1.

OBJECTIVE	TASKS	PERFORMANCE MEASURES
<p>21. Conduct outreach activities and establish collaborative relationships with statewide provider associations, consumer organizations, NY Connects' local Long Term Care Councils, and other statewide referral sources and stakeholders to provide information about the Transition Center program, the referral process, and the assistance available for individuals to accomplish community transitions.</p>	21.1.	21.1.1.
	21.2.	21.2.1.
<p>22. Provide informal backup and support utilizing volunteers for facility residents planning a community transition for whom the lack of informal support is a barrier to transition, with the goals of accomplishing a community transition, providing backup support, increasing community integration, assisting participants to develop social networks, and decreasing loneliness and the likelihood of reinstitutionalization.</p>	22.1.	22.1.1.
	22.2.	22.2.1.

OBJECTIVE	TASKS	PERFORMANCE MEASURES
23. Provide ancillary transition supports to transitioning participants to address barriers and meet identified needs.	23.1.	23.1.1.
	23.2.	23.2.1.
24. Work with state MFP program staff to plan potential strategies and solutions for identifying and addressing emerging needs.	24.1.	24.1.1.
	24.2.	24.2.1.