

Nursing Home Transition

Nursing Home Transition Program Changes
September 07, 2016

Introduction to Nursing Home Transition

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OLTL Bureau of Policy and Regulatory
Management

- The NHT program was developed to assist and empower individuals who want to move from a nursing facility back to a home of their choice in the community.
- Goals and Objectives of the NHT Program
 - Empower individuals so they are involved to the extent possible in planning and directing their own transition from a nursing facility (NF) back into the community.
 - Develop the necessary infrastructure and supports in the community by removing barriers in the community so that individuals receive services and supports necessary to transition.
 - Expand and strengthen collaborations between aging and disability organizations to provide support and expertise to the NHT Program.
 - Help Pennsylvania rebalance its long-term living systems so that people have a choice of where they live and receive services.

- **NHT Participant definition:**
 - Express a desire to return to the community to live.
 - Not scheduled to leave a nursing facility via the normal discharge process.
 - Meet one of the following criteria:
 - Resided in an inpatient facility for 90 consecutive days, receiving Medicaid (MA) services for one day and transition completed through Transition Service Coordination.
 - Has a documented barrier that was overcome through Transition Service Coordination regardless of nursing facility payer source or length of nursing home stay.

- **NHT Coordination Agency (NHTCA) and the Nursing Facility**
 - Build a solid relationship with the nursing facilities in your area.
 - Familiarize yourself with the varying state agencies involved in nursing facilities and their relationships:
 - Department of Health (DOH)
 - Department of Human Services (DHS)
 - Department of Aging (PDA)
 - Ombudsman
 - Adult Protective Services (APS)
 - Educate the facility staff about your and their role in making NHT successful.

- **NHT Coordinator (NHTC) and the Participant**

- Help individuals and their families see the full array of services and supports available to them.
- Empower individuals to identify their own goals and desired outcomes.
- Develop personal/family directed transition plans uniquely tailored to each individual.
- Identify risk factors that the individual's choices present and help them develop strategies to mitigate those risks.
- Coordinate NHT-related services and supports to transition individuals into the community in collaboration with local housing authorities and Regional Housing Coordinators (RHC).

- **NHTC and the Participant (continued)**

- Provide transition services including, but not limited to:
 - Assistance with securing housing
 - Home modifications
 - Home and community-based support
 - NF collaboration
 - Skills training and support
 - Formal and informal personal support
 - Caregiver support, ensuring that family members or friends have adequate support
- Attempt to secure funds to establish the individual's basic living arrangement to be used for:
 - Security deposits to obtain a lease on a living unit
 - Specific set-up fees or deposits pertaining to:
 - Utilities
 - Telephone service
 - Electric and/or gas heating
 - Essential household furnishings (bed, bedding, dining table and chairs, eating utensils and food preparation items, etc.).

NHT Roles (continued)



- **Service Coordinator (SC)/Service Coordination Entity (SCE)**
 - The participant has the right of Freedom of Choice of SC/SCE to serve him/her. There may be instances where the participant chooses your organization to provide NHT, but chooses a different SC/SCE to serve their community continuum of care.
 - If your organization is chosen for the community continuum of care, the following activities, while not all inclusive, are needed to support the transition:
 - Assist in development of the ISP with the participant, NHTCA and nursing facility
 - Submit the ISP to OLTL
 - Coordinate services and supports with all third-party payers, formal and informal supports, and other community resources
 - Document and justify the purchase of services or product
 - Authorize services or a combination of services selected or desired by the participant
 - Implement and monitor the HCBS ISP
 - Review and update the HCBS ISP at least annually within the re-evaluation due date and whenever the participant's needs change significantly

- **DHS, Office of Long-term Living (OLTL)** - administers and oversees the NHT Program.
- **DHS, Office Of Income Maintenance (OIM), County Assistance Office (CAO)**
 - Reviews PA 600L for participant income eligibility for MA.
 - Reviews the PA 1768 for participant eligibility for waiver.
 - Sends the PA 162 eligibility determination for waiver notice to the participant and to the IEB.
- **Ombudsman**
 - Mandated by the Federal Older American Act.
 - Protects and promotes the rights and quality of life for individuals who reside in nursing homes.
 - A nursing home ombudsman should be contacted to resolve complaints from the consumer, request better individualized care and confidentially communicate problems and concerns about care and services at the nursing facility.

NHTCA / NHTC Qualifications Highlights



Qualifications

Adhere to all responsibilities and conditions delineated in 55 PA Code Chapter 1101 and sign and adhere to the Medicaid Waiver Provider Agreement.

Comply with Department of Human Services (DHS) standards, regulations, policies, and procedures relating to provider qualifications, including 55 PA Code Chapter 52.

Be conflict free.

Have IT systems compatible to DHS systems and to be able to communicate/function with state reporting systems.

Pay for and obtain all licenses and certifications required for all staff who must access and use required systems, e.g. SAMS.

Provide NHT services to the over 60 and/or under 60 population.

Document NHT services provided and actions taken.

Assist nursing facility ineligible (NFI) and non-Medicaid eligible individuals in transitioning from nursing facilities to the community.

Be able and willing to identify critical incidents and report and document them according to the processes and procedures outlined in OLTL Bulletin number 05-15-02, 51-15-02, 54-15-02, 55-15-02, 59-15-02 effective April 16, 2015, on Critical Incident Management.

NHTCA staff must complete the trainings as required by OLTL.

NHTCA Agreement



- With regard to the NHT Program, the NHTCA agrees to:
 - Accept NHT referrals or when referrals cannot be accepted and notify the referral entity; and then, document the reason.
 - Assist transitioning participants and their families, nursing facility staff, and others in the development of the Community Living Plan.
 - Coordinate Community Transition Services (CTS) and/or any available state funding or community resources.
 - Act as a liaison between the home modification broker, contractor, and physical/occupational therapists.
 - Coordinate with medical providers to ensure a safe and healthy discharge.
 - Retrieve, sort, and enter NHT data in systems and complete required forms, including the NHT Outreach Form on participants.
 - Perform a comprehensive evaluation for the appropriateness of transition from an institution to the community.

NHTCA Agreement (continued)

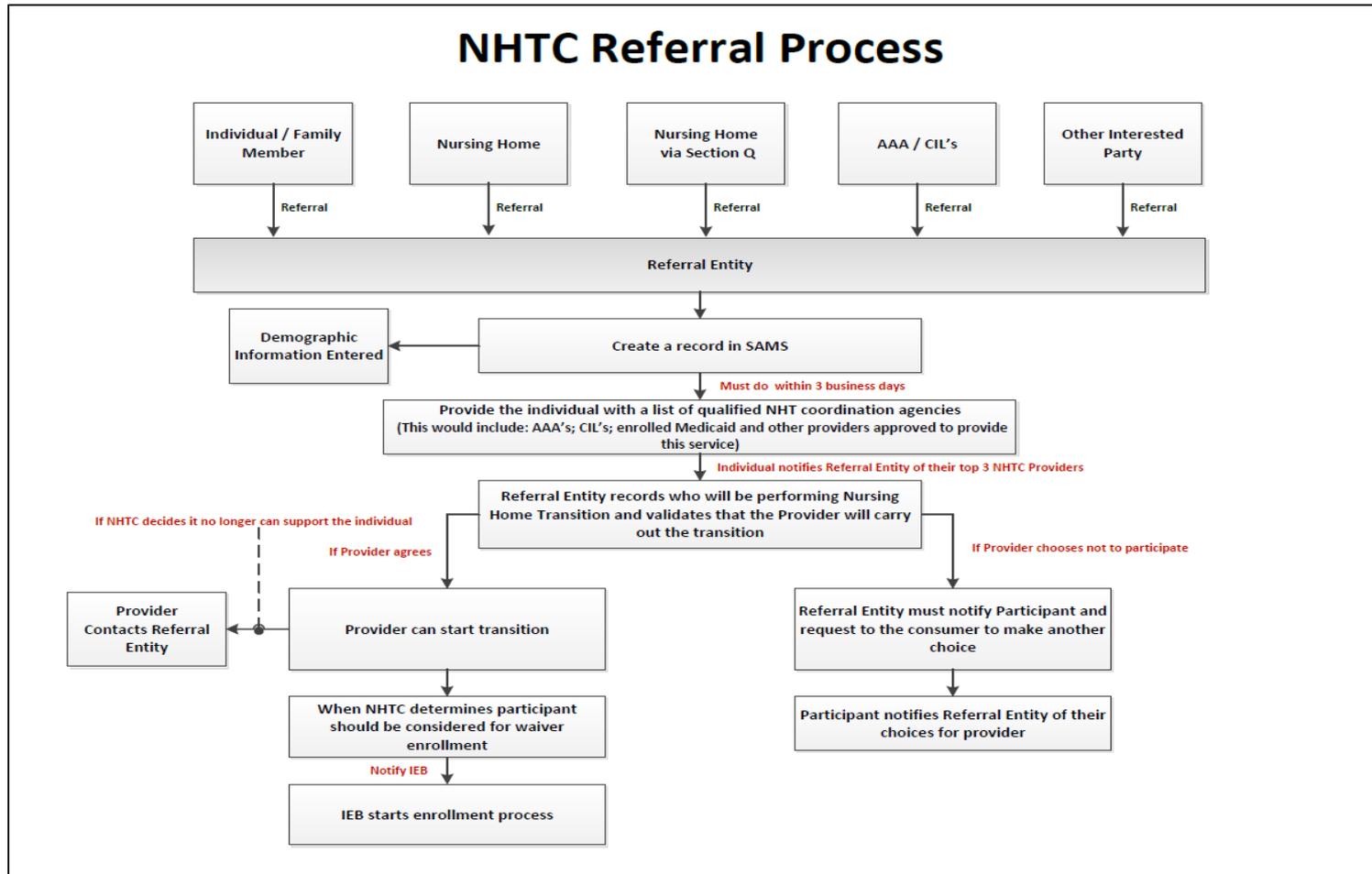


- Assist individuals in understanding the range of community-based options, including HCBS and community resources.
- Assist participants, family, nursing facility staff, and others in applying for qualified services.
- Assist participants in locating and securing housing, including the completion of housing applications, and working with private landlords, housing authorities, RHCs, or other housing entities.
- Assist participants in obtaining any needed documentation or resources required for Social Security, social services, community agencies, or housing, including coordinating with medical providers to obtain needed medical documents.
- Educate and counsel participants regarding employment programs and/or opportunities.

Money Follows The Person (MFP)



- MFP Rebalancing Demonstration is a federal initiative to assist certain individuals transition from institutions to the community with home and community-based services (HCBS) waiver services.
- The IEB handles all aspects of participant enrollment for waiver services, obtaining participant consent to participate in MFP, Quality of Life referral form, and enrollment for MFP on the 1768.
- The NHTCA is responsible for filling out the NHT Outreach Form which contains questions about MFP in Section 5 of the form.
- Provide discharge date to IEB
- Provide housing arrangement to IEB
- Complete NHT outreach form



NHTC Referral Process

Amy High
OLTL Bureau of Participant Operations

IEB

- Follow the same application process
 - Start date of application is date 600L is received by IEB
 - Date application requests to apply
- Application can remain open for 180 days
- In Home Visit
 - IEB completes at NF
 - Reviews MFP information
 - Refers to NHT coordinator if not identified
- SAMS record and enrollment information provided to SC before receipt of PA 162
- IEB issues 1768 to CAO

Service Coordinator / NHT Coordinator

- SC and NHT coordinator prepare for discharge
- SC submits service plan to OLTL for review
- NHT and/or service coordinator must notify IEB of confirmed discharge

- **Receives Referrals**
 - Referral Type
 - Phone - 1-877-550-4227
 - Website - www.paieb.com
 - Online Referral Form PAIEB@maximus.com
- **Information collected**
 - Applicant information
 - Representative information
 - Physician information
- If the referred individual does not have MA, the IEB will attempt to contact the individual and send the application packet

Clinical Eligibility

- Request completion of the Level of Care Determination (LCD) from the AAA
- Request Physician Certification (PC) from Physician

Complete in-home visit

- CMI
- Program Eligibility

Enrollment and Service Coordination Authorization in SAMS

Financial Eligibility Determination

- Send 600L to CAO (upon confirmation of discharge)
- Send 1768 to CAO (upon confirmation of discharge)



NHT Coordinator Responsibilities

- Develop community living plan which may include portion of ISP
- Coordinate Home Modification, DME, prior to transition
- Set up MH services in the community
- Set up substance abuse services
- Locate Housing
- Front funding for Community Transition Services (CTS)
- Contact IEB to notify of discharge date

Service Coordinator Responsibilities

- Develops person centered service plan with the participant
- Enters ISP in HCSIS/SAMS when enrollment is received from the IEB
- Submits ISP for OLTL review and Pre-authorization prior to discharge

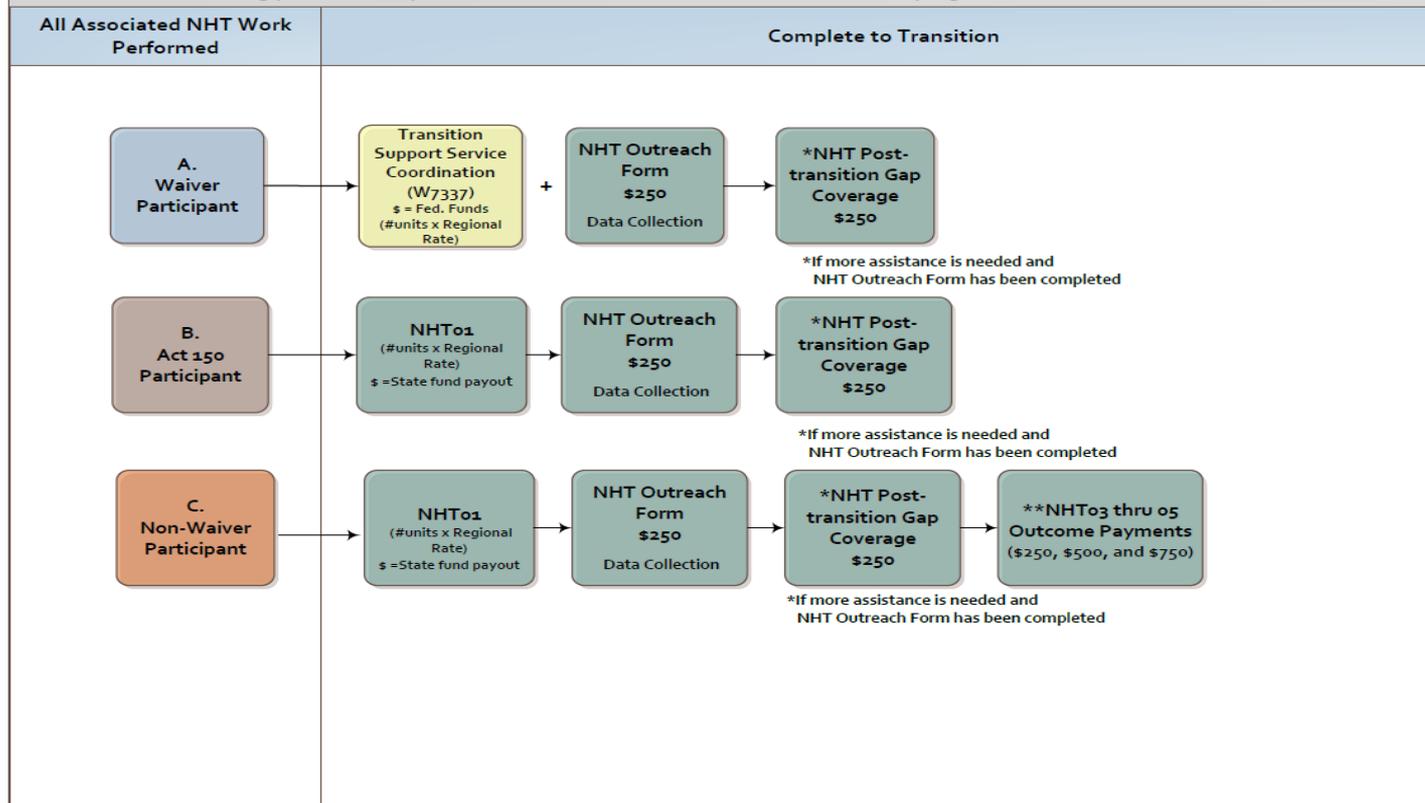
Nursing Home Transition Payment Process

Nicole White
OLTL Bureau of Participant Operations

NHT Payment Process

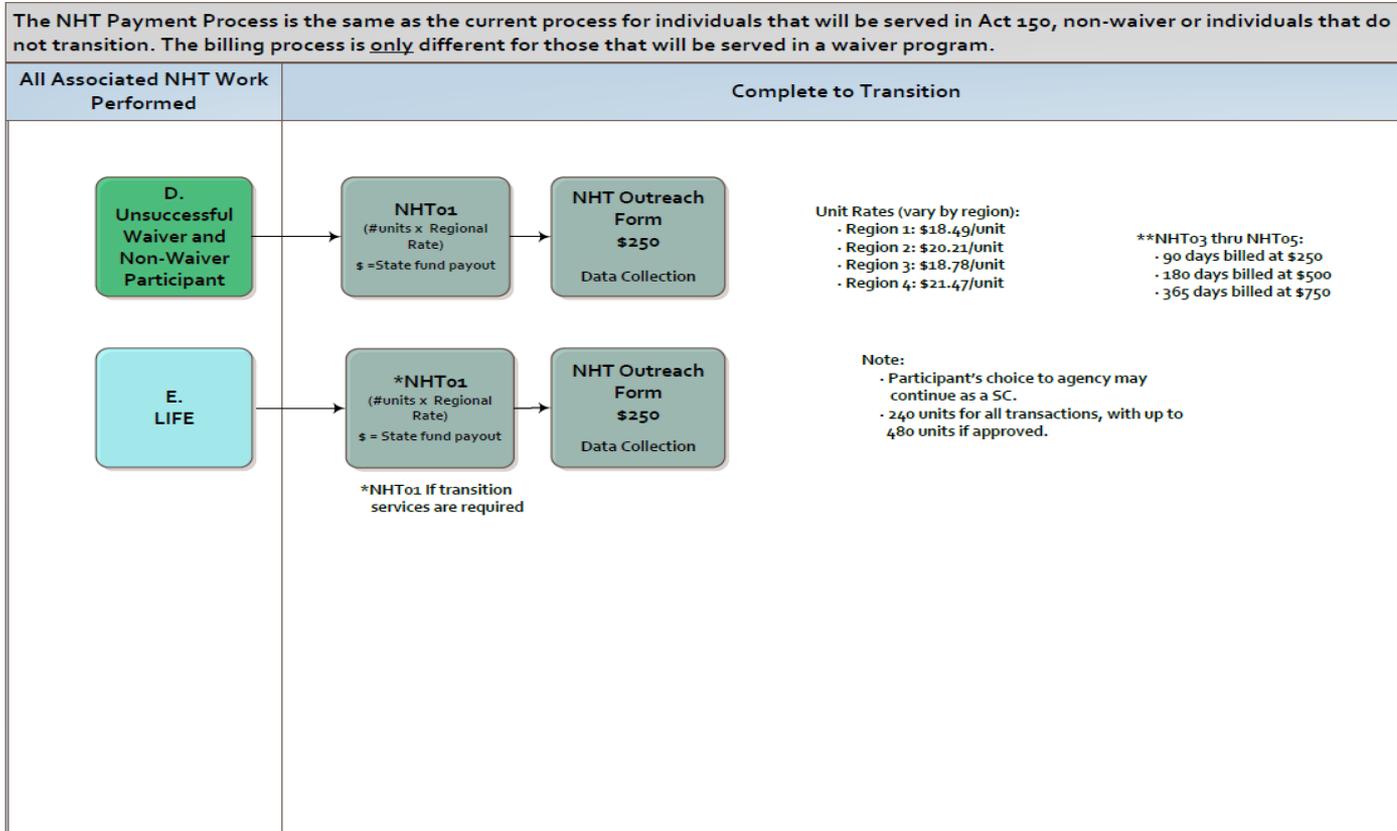
NHT Payment Process

The NHT Payment Process is the same as the current process for individuals that will be served in Act 150, non-waiver or individuals that do not transition. The billing process is only different for those that will be served in a waiver program.



NHT Payment Process (continued)

NHT Payment Process



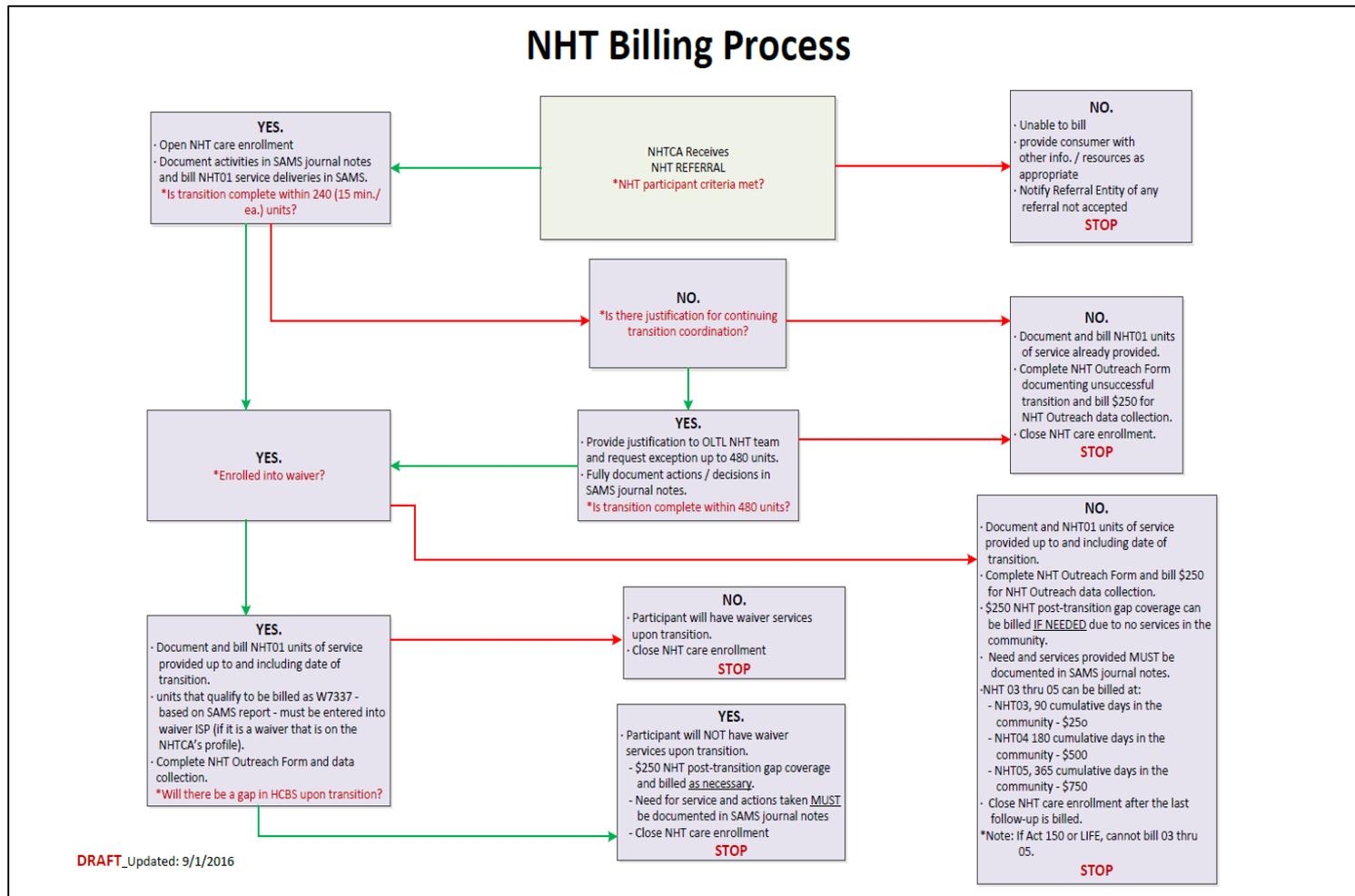


Nursing Home Transition Billing Process Decision Tree

Rachel Sink

OLTL Bureau of Participant Operations

NHT Billing Process (Decision Tree)



Nursing Home Transition Provider Enrollment

Megan Boles
Human Services Program Specialist

- Starting December 1, 2016 all Medicaid enrolled Service Coordination Entities can submit a request to become a NHT Coordination Agency.
 - All requests should be sent to RA-HCBSEnProv@pa.gov.
 - OLTL will send out a email with detailed instructions on how to complete the application process.
 - Documentation can be sent back to the resource account or faxed to 717-346-1483, Attention: Provider Enrollment.
 - Note: A 2nd request email may be sent out if you are missing documents. Please return the additional documentation requested as soon as possible.
 - Once all documentation is received and reviewed training information will be sent out.
 - You are not enrolled in Nursing Home Transition until all documentation and trainings are completed and you receive an approval letter from OLTL.

- Required Documentation
 - Provider Enrollment Information Form
 - OHCDS Form (If applicable)
 - Qualifications for the Executive Director and/or Program Director
 - Include copies of their diplomas/transcripts and resume
 - Agency Employment Job Descriptions
 - DocuShare Agreement
 - Grant Agreement
 - W16 Finance Form (Instructions included)

- Training must be completed by each individual within an agency performing tasks related to Nursing Home Transition. This includes individuals working directly with the participant in the transition planning process, any individual entering data into the SAMS system, and any individual within the agency reviewing billing records, service deliveries, or submitting funding request to OLTL.
 - NHT Online Training
 - Housing Training
 - SAMS Introductory training for NHTCA
 - Protective Services Training
 - Note: Information regarding these trainings will be forthcoming.

- 55 PA code Chapter 52.21 states
 - A provider shall meet the training requirements necessary to maintain appropriate licensure or certification, or both, in addition to meeting the training requirements of this chapter.
 - Prior to providing a service to a participant, a staff member shall be trained on how to provide the service in accordance with the participants service plan.
 - A provider shall maintain documentation for the following:
 - Staff member attendance at trainings.
 - Contents of trainings.

- Once verified all trainings have been completed the Enrollment Department will add Nursing Home Transition Services to your SAMS and/or HCSIS provider files and send out an approval email.
 - OLTL strongly encourages providers to enroll under ALL waivers to better serve all participants hoping to return to a home and community based setting.
 - Note: DO NOT begin providing services until you receive an approval letter from OLTL. Failure to do so could result in loss of payment.

- To join, make additions, or make changes to your email address please visit the ListServ Archives page at:
<http://listserv.dpw.state.pa.us/>.
 - Select Nursing-Home-Transition-Providers.
 - Click on “join”
 - Put in your name and email address
 - Choose your subscription type, mail header style, and acknowledgements. Please note: these choices are defaulted to a standard protocol.
 - Click “Join (Name of ListServ)” button.

*Please note that it is your responsibility to maintain current information on each ListServ. OLTL does not maintain the information for you or your agency.

Below is the link to the new NHT website — there is a “providers” page and a “citizens” page so this is the link to the providers.

<http://www.dhs.pa.gov/provider/nhtprogramproviders/index.htm>

NHT Contact Information



If you have additional comments or concerns regarding the content of this presentation please send them to ra-nht@pa.gov



QUESTIONS ?