



Department of Medicaid

John R. Kasich, Governor

John B. McCarthy, Director



# Redesign

**Vision, Expectations, Roles & Responsibilities**

**Tools & Resources**

**June 2013**



## The Vision & The Plan

**"The People Who Are Crazy  
Enough To Think They Can  
Change the World,  
Are the Ones Who Do"**

**- Steve Jobs**











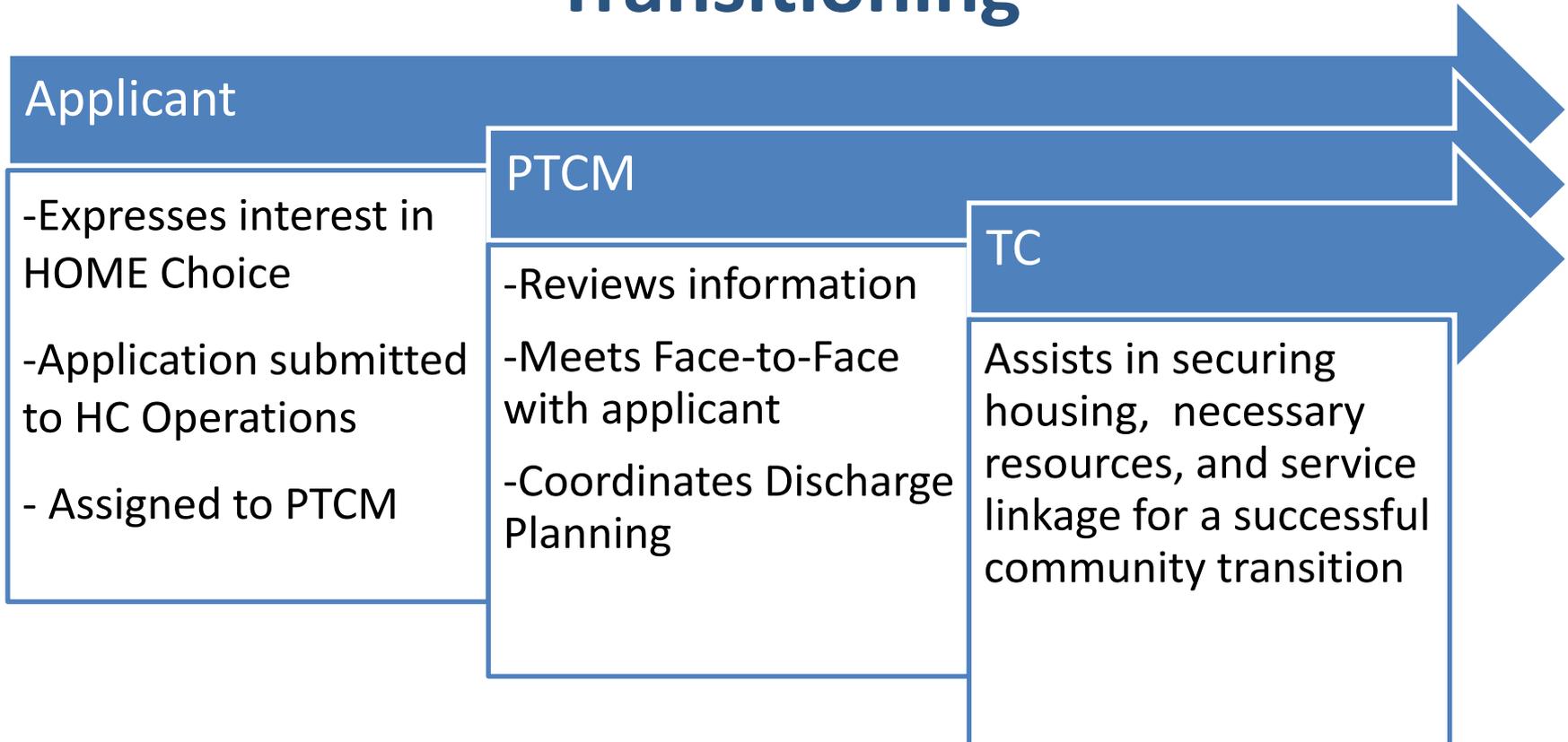


# What's Different?

- Person Centered Approach at the “Front Door” of HOME Choice
- Formalized pre-transition case management
- Transition coordination 90 days post-discharge (aka 4<sup>th</sup> Deliverable)
- Solidified Discharge Planning Team Concept



# Overlapping Roles=Successful Transitioning



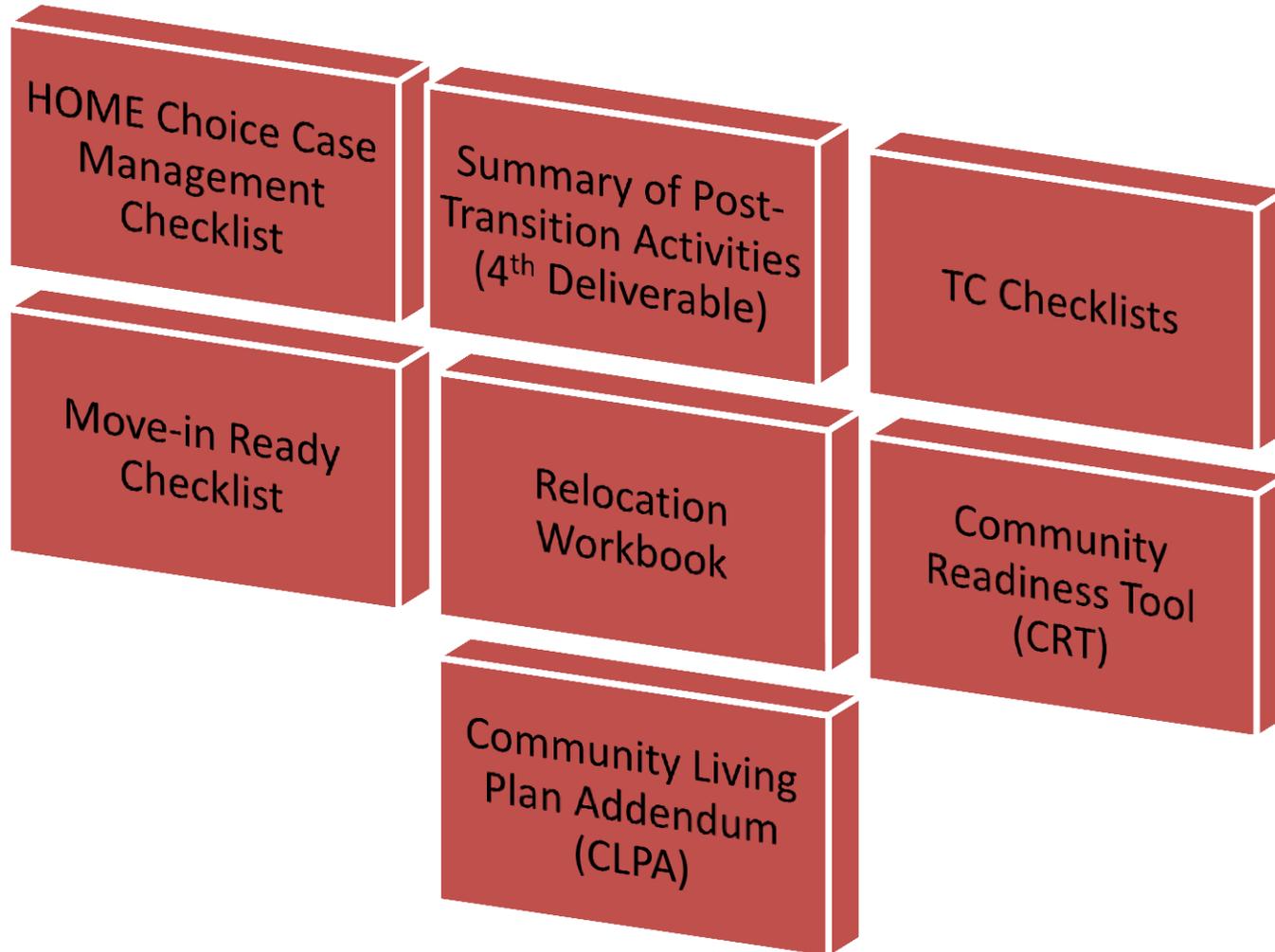


# Overlap of Roles & Responsibilities

	NF	Pre-Transition	Discharge	Community 1 <sup>st</sup> 90 days	Community 365 Participation days
NF Discharge Planner	█				
PTCM		█			
TC		█			
Community Support Coach			█		
HC Case manager				█	
Other HC Providers				█	
MH/AoD Providers		█			



# Building Blocks





# What is Pre-transition Case Management

The role of the (PTCM) is to:

- Identify the applicants' community living potential
- Ensure continuity & coordination of care



# PRE-TRANSITION

Pre-transition meetings, transition planning & discharge planning meetings



# PTCM-Initial Contact

- Contacts applicant/facility within 5 business days of receipt from HC Operations Unit.
- Addresses the Guardian question.
- Schedules initial face-to-face (F2F) meeting within 10 business days of initial contact.
- Reviews information available (i.e. Community Living Plan Addendum), prepares HC forms & resources



## PTCM 1<sup>st</sup> F2F Contact

- Completes the HC Community Readiness Tool
- Provides waiver information
- Reviews the Qualified Residence fact sheet
- Completes the Eligibility Checklist
- Completes the Informed Consent Form
- Reviews the list of Transition Coordination Agencies



# PTCM 1<sup>st</sup> F2F Visit continued

- Completes the HC Service Plan
- Provides information about HOME Choice Services
- Reviews Community Transition Services (aka Goods & Services )
- Shares other community resources/living options
- Identifies Who's Who with HOME Choice



# Transition Coordinator 1<sup>st</sup> Contact

After accepting referral,

- TC makes initial contact with the participant/guardian within 3-5 business days
- Reviews documentation (Community Readiness tool, etc.) before meeting with participant
- Conducts F2F meeting within 7-10 business days of initial contact
- Assists participant/guardian in formulating transition plan
- Arrange and/or provides transportation
- Assists in finding housing



## TC Housing Assistance Includes:

- Assessing housing options;
- Housing application assistance
- Arranging for housing related expenses (fees, deposits)
- Overcoming potential housing barriers (e.g. credit recovery, criminal convictions).
- Details relative to “Housing” on the Agenda for this afternoon



## TC Housing Assistance Continued

- The TCA shall visit the residence to ensure it meets:
  - the HOME Choice qualified residence criteria &
  - the needs of the HOME Choice participant.
- If it meets the above criteria, the TC submits the HOME Choice Qualified Resident Statement & lease verification (2<sup>nd</sup> Deliverable)
- “Lease Verification” – Residence Verification



# Other TC Activities

Helping participant:

- Establish a budget
- Determine adequacy of financial means
- Obtain benefits
- “Goods & Services/Start-Up”



# New TC Tools & Forms

- Checklists
  - Transition Planning
  - Move-in ready
- Fourth Deliverable Form
  - Post-Discharge

# Coordination & Communication during Pre-Transition

## PTCM

- Updated by TC
- Schedules & participates in discharge planning meetings
- Assists with linkages to service providers & community resources.
- Fills out & submits Change in Status Forms as needed
- Makes referrals to Behavioral Health (BH) agencies/providers

## TC

- Regularly updates the PTCM
- Participates in discharge planning meetings
- Assists with linkages to service providers & community resources
- Fills out & submits Change in Status Forms as needed
- Coordinates with mental health and/or drug/alcohol services providers



## Coordination & Communication during Pre-Transition

### PTCM

- Updates Service Plan
- Assists with Back-up plans
- Coordinates discharge date
- Schedules & facilitates final discharge planning meeting

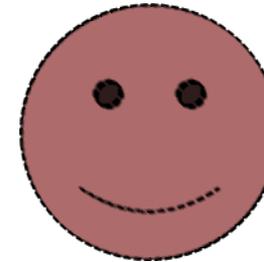
### TC

- Recommends Service Plan updates
- Assists with employment linkages
- Move-In Ready?
- Attends final discharge planning meeting



# Final Discharge Planning Meeting

HOME Choice  
Case Manager

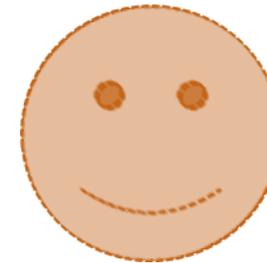


Behavioral  
Health  
Providers  
(if applicable)

TC

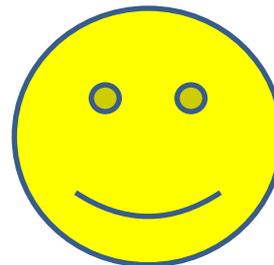


Individual/Guardian

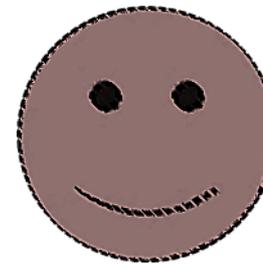


HOME Choice  
Providers (if  
applicable)

Discharge  
Planner



PTCM



Waiver  
providers (if  
applicable)



## Coordination & Communication during Pre-Transition

### PTCM

- Ensure HC services are in place if waiver/state plan services can't start at discharge
- Share information
- Assist with moving

### TC

- Ensure HC services are in place if waiver/state plan services can't start at discharge
- Assists in acquiring needed goods & services
- Share information
- Assist with moving



# Discharge to Community

- Within 24 hours of discharge the PTCM submits the HC Enrollment Form to the HC Operations Unit
- HCCM or Waiver Case Manager takes over CM responsibilities
- Within 10 business days of participant's discharge, TC submits the Summary of Pre-Transition Coordination Activities form to the HC Operations Unit
- **GOAL:** Participant will be successful & sustainable in the community!



## Transition Coordination 4<sup>th</sup> Deliverable

- Documentation of assistance provided during 1<sup>st</sup> 90 days in community
- Submitted to HOME Choice Operations Unit within 1<sup>st</sup> 100 days
- Not exhaustive list
- Includes:
  - Additional service needs
  - Additional home modifications/adaptations
  - Referrals
  - Post-discharge contacts
  - Post-discharge checklist



# Special Requests

- [Emergency Rental & Utility Assistance](#)
- [Housing Navigation](#)



**Questions? Comments?  
Thoughts?**