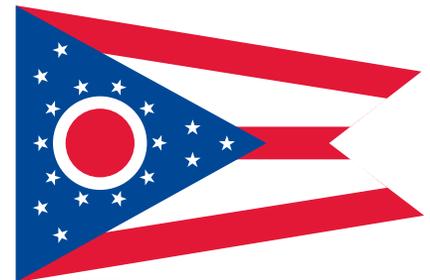


# Pre-Transition Case Management

Ohio Department of Medicaid  
HOME Choice  
Fall PTCM/TC Training 2016

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Upon receiving a referral from ODM's HOME Choice Operations Unit, the PTCM agency will complete the following actions:

- The PTCM will contact institution and/or individual within **3-5** business days of receipt of the HC referral.
- The PTCM will determine if the applicant has a legal guardian. If the applicant has a legal guardian, the PTCM will contact the guardian prior to scheduling the face-to-face.
- The PTCM will schedule and facilitate the face-to-face meeting with the applicant/guardian within **7-10** business days of receipt of the HC referral.

## During the Face to Face meeting, the PTCM will complete the following:

- The PTCM will review the HOME Choice Informed Consent form with the applicant/guardian and obtain the applicant/guardian signature.
  - There are 2 signatures required for guardians.

Suggestion: Once applicant/guardian sign the form ask NF SWK to make copies for the chart/applicant.
  
- The PTCM will review the Qualified Residence fact Sheet as it relates to the HOME Choice eligibility criteria.
  - Qualified Residence facts also are listed on the Informed Consent form (IC).

## During the Face to Face meeting, the PTCM will complete the following:

- Complete the Community Readiness Tool (CRT) with the applicant/guardian.

Ohio Department of Medicaid  
HOME CHOICE  
Community Readiness Tool

HOME CHOICE APPLICANT		
Last Name	First Name	MI
Medicaid ID #	Date of Birth	
Who is present at the meeting?		
PRE-TRANSITION CASE MANAGER (PTCM)		
Name		Date Completed
Agency	Email	Phone Number

- Provide waiver information to the applicant/guardian.
  - If applicable have the applicant/guardian sign the 2399. The completed form will then be sent to the local JFS office for processing.
  - Order Waiver applications from: <http://www.odjfs.state.oh.us/forms/>

## During the Face to Face meeting, the PTCM will complete the following:

- The PTCM will complete the HOME Choice Eligibility Checklist:
  - Based on the CRT, dialogue, observations and other information shared:
    - PTCM shall provide comments that reflect professional opinion of whether the applicant should proceed with HC process/program
    - PTCM shall indicate if the applicant may be eligible to participate in a waiver program or State Plan by marking the appropriate box
    - The comments/assessment is a recommendation not a determination

**DIAGNOSES/ COMMENTS:** Please provide details that identify strengths, needs, barriers & relevant diagnoses.

**DX:** Chronic Obstructive Pulmonary disease, schizophrenia, bipolar disorder, obesity, difficulty walking

Applicant will need assistance with locating affordable, accessible housing, home health services and connecting with a primary care physician.

Applicant is connected with community mental health services through XYZ Mental Health and currently has a mental health CM.

Applicant was assisted with completing a ROI for the Recovery Requires a Community program.

A 2399 was completed and submitted for the waiver program.

This PTCM recommends the HC program only if applicant is approved for waiver due to level of care needs in the community.

Does this person have community living potential? Do you think he/she can be successful and sustainable in the community at this time?

Yes     No, explain: \_\_\_\_\_

## During the Face to Face meeting, the PTCM will complete the following:

- The PTCM will review the Transition Coordination Agencies with the applicant/guardian
  - take into account the applicant’s disabilities and needs
  - the applicant’s “preferred” choice will be entered onto the Demonstrations and Supplemental Services Plan

Suggestion: Ask for a ‘Second Choice’ in case the first choice declines referral.

TC listing can be located at: <http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/HOMEChoice/TCList.pdf>

### Active Transition Coordinators

(by County Served)

#### Adams county

##### Populations Served

Eld PD M DD Child

- |                                     |                                     |                                     |                                     |                                     |  |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | HC1048 Center for Independent Living Options<br>2031 Auburn Ave.<br>CINCINNATI, OH 45219<br>513-241-2600, llaing@cilo.net; shopkins@cilo.net   |
| <input checked="" type="checkbox"/> | HC1429 Easter Seals Tri State<br>447 Morgan Street<br>Cincinnati, OH 45206<br>513-985-0515, 513-817-7404, dsmith@eastersealstristate.org;<br>bsears@eastersealstristate.org  |
| <input checked="" type="checkbox"/> | HC1414 National Church Residences Home and Community Services<br>2233 North Bank Drive<br>Columbus, OH 43220<br>614-457-6950, 614-395-6233, llund@nationalchurchresidences.org;<br>bmettler@nationalchurchresidences.org; aross@nationalchurchresidences.org |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | HC1061 Region 7 LTC Ombudsman<br>KAYE INOSHITA, 1644 11TH STREET<br>PORTSMOUTH, OH 45662<br>800-582-7277, kinoshita@aaa7.org; coakes@aaa7.org  |

## During the Face to Face meeting, the PTCM will complete the following:

- PTCM will review how the Community Transition Services may be used, as well as the role of the Transition Coordinator with these funds in accordance with rule.
  - Up to \$2,000 of HOME Choice transition funds may be used for furniture, start-up groceries, personal items, application fees for apartments, security deposits, etc. Funds cannot be used for electronics, uniforms or memberships.
  - Up to \$500 may be used for pre-transition transportation expenses.
  
- PTCM will provide information regarding HOME Choice process and services:
  - Community Support Coaching
  - Independent Living Skills Training
  - Nursing
  - Social Work/Counseling
  - Nutritional Counseling
  - Communication Aids

## During the Face to Face meeting, the PTCM will complete the following:

If HC is **NOT** recommended the PTCM will share any additional community resources/living options with the applicant/guardian as appropriate.

- Residential State Supplement
- Access to Success
- Recovery Requires a Community

When HC is not recommended be sure to provide an explanation on the Eligibility Checklist.

Within 3 business days of the face-to-face visit, submit to HC Operations:

- Eligibility Checklist
- Informed Consent
- Community Readiness Tool
- HC Service Plan

## During the Pre-Transition Period, the PTCM will also be required to complete the following:

- Obtain regular status updates from the Transition Coordination Agency.
- Assist with linkages to service providers and community resources. ie- Recovery Requires a Community, Residential State Supplement Program, Social Security Specialist
- When applicable, the PTCM will make referrals to the local Behavioral Health (BH) agencies/providers and schedule discharge planning meeting that include the local BH team.
- The PTCM will fill out and submit a HC Change in Status form whenever there has been a change in the participant's status that would affect their ability and/or willingness to participate in the program.

## During the Pre-Transition Discharge Planning Period, the PTCM will also be required to complete the following:

- Schedule and participate in discharge planning meetings with the applicant, guardian, TC, D/C planners, and others as requested by the applicant.
- Assess what HC services should be added to the applicant's HC DSSP at time of discharge, contact service providers, coordinate service provision and submit updated HC DSSP to the HC Operations Unit as necessary.
- The PTCM will assist with developing post-discharge Back-Up Plans in the event of a failure of an authorized services that is to be provided.

## During the Pre-Transition Discharge Planning Period, the PTCM will also be required to complete the following:

- Schedule and facilitate the final discharge planning meeting within two weeks prior to the applicant's discharge from the institution. The following shall be invited and expected to attend the final discharge planning meeting:

- Applicant/Guardian
- HOME Choice Case Manager
- Transition Coordinator
- Nursing Facility Social Worker/Discharge Planner
- Behavioral Health providers, if applicable
- Home Choice service providers, if applicable
- Waiver providers, if applicable
- Manage Care Plan

## During the Pre-Transition Discharge Planning Period, the PTCM will also be required to complete the following:

- At the final discharge meeting , the discharge checklist shall be completed and all representatives will sign off on assignments, coordinate final preparations for moving day and agree on moving day participation and responsibilities.
- Coordination of the applicant's discharge date to coincide with the start of the applicant's receipt of HCBS (waiver/state plan) and HC services.
- Ensure HC services are in place if Waiver or State Plan services cannot start at discharge.

## At the time of the Applicant's discharge from the institution, the PTCM will:

- Transfer all pertinent information about the applicant to the HCCM/Waiver CM.
- Communicate and coordinate with the applicant, the TC agency and the HCCM to ensure services and supports are in place and housing is 'move-in' ready.
- Provide necessary assistance with moving which may include:
  - Helping the applicant move out of the institution
  - Being available to assist the applicant at the applicant's new residence on move in day.
- Complete the HOME choice Enrollment Request form and submit to the HC Operations Unit. The form shall be submitted within **24** hours of the applicants discharge from the institution.
- Submit an updated HC DSSP to HC Operations Unit, if additional HC services are needed post-discharge. The PTCM will contact service providers and coordinate service provisions.

# Discharge Planning 101

# Discharge Planning Meeting:

What is the **purpose** of the discharge planning meeting?

- To assist the individual in planning the transition home
- Address possible issues/roadblocks
- Assist/educate the nursing home SW in their role in transitioning the individual into the community

## The following are to be invited and expected to attend the final discharge planning meeting.

- Home Choice participant, and/or Guardian
- Nursing Facility Discharge Planner/SW
- Transition Coordinator
- HCBS Waiver or Home Choice CM (request HC CM to attend discharge meeting if taking place before Waiver determination)
- Family Members, as available
- Community Based Case Managers: ie Behavioral Health
- Home Choice Service Provider
- Waiver/Medicaid Service Providers

## Applying for HCBS:

### **OHIO HOME CARE WAIVER (age 59 and under)**

- Nursing Home level of care
- Financially Medicaid eligible
- Consumer signs 2399 – Fax or email to appropriate County Dept. Job and Family Services
  - No Presumptive enrollment
  - MD verification signed
  - 9401 to County Dept. of Job and Family Services.

### **MyCare Ohio Plan – Dual Eligible**

- Nursing Home Level of Care for MyCare waiver
- Medicare and Medicaid eligible
- If not already identified confirm with NF if the individual is on MyCare and who the MyCare CM is. Collaboration with the MyCare CM is imperative for smooth transition.
- Request MyCare Ohio Clinical Care Manager submit the 2399 to request a LOC be completed for HCBS Waiver determination.

## Applying for HCBS:

### **Assisted Living Waiver (age 21 and over)**

- Nursing Home Level of Care
- Financially Medicaid eligible
- Income must be \$733 or more
  - If income is less, seek eligibility for SSI to increase to SSA standards
- Contact County AAA assigned with Front Door Assessments.
  - presumptive enrollment
  - 2399 signed at assessment

### **PASSPORT (age 60 and over)**

- Nursing Home Level of Care
- Financially Medicaid eligible
- Contact County AAA assigned with Front Door Assessments.
  - presumptive enrollment
  - 2399 signed at assessment time

## Discharge Planning Meeting:

### Nursing Facility discharge planner/SW responsibilities:

- **MD appointment** post discharge within 7 days. Specialist follow-up as necessary.
- **Medications:** What will the consumer take with them? How will they obtain what is necessary to get to them through to the post facility Dr. appointment? Who will pick up the Rx? Consider narcotics and controlled substances.
- **Pharmacy Selected:** Consumer selects and NF calls the pharmacy with medication orders or sends Rx with consumer
- **Durable Medical Equipment:** What is covered by insurance? What is not covered? Where DME is to be delivered? Who will purchase what is not covered by insurance? Where is it to be delivered?
- **Ensure Medicaid State Plan Services** provider will begin on day of discharge.
- Identify the individual's **back up plan**. Who will provide the individual's care until paid providers can start and in the absence of paid help? Assure it is a safe plan. Obtain contact info for the back up provider and verify the back up provider is available and agrees with the plan.
- Plan for **transportation** home on day of discharge

## MyCare CM Responsibilities:

- Provide update on **transition plan**
- Submit 2399 and report back to the team the outcome and next steps
- Share with discharge team what MyCare will provide

## TC Responsibilities

- Identify needed post discharge HC services and community services
- **Provide linkage** to community resources
- Ensure HC services in place if Waiver or State plan can't start at discharge
- **Coordinate transition** between BH and substance abuse providers
- Sign off on assignment and coordinate final prep for moving day

## HC Case Managers

- Meet with the individual within **5 business days** of receipt of the HC Service plan
- **Determine post discharge** HC services, Waiver services or State Plan services
- Identify **provider roles and responsibilities** on day of discharge
- Ensure HC services are in place if Waiver or State Plan services can not start day of discharge
- Sign off on assignments and collaborate on plans for moving day

## Home Choice PTCM Responsibilities: (discharge planning meeting)

- Complete discharge checklist
- **Assure all team members know their role**
- Identify if Waiver referral was made what the status of the Waiver application, and contact information for follow up
- Ensure that the HCBS Waiver CM or HC CM is assigned to work with the individual prior to the facility discharge
- Request that a physical therapy evaluation be completed at the home to determine any additional DME or home modification needs prior to discharge
- PTCM (or TC) shall be present for the home therapy evaluation to aid in planning and to identify any safety concerns
- Behavioral Health Services
- Determine post discharge **Home Choice services**, contact providers, update HC Service Plan and submit to HC Unit
- Verify with the TC that all household needs and goods will be available upon facility discharge
- Delay facility discharge if safe plan has not been established
- Have team sign off on assignments
- Coordinate final prep for moving day

## DAY OF DISCHARGE ....PTCM shall

- Confirm transportation plans with NF SW (May use pre-transition Transportation benefit to transport the individual from the NF to the home. Note this benefit can also be used to transfer the individual and his belongings as long as the individual is in the vehicle (See the Pre-Transition Transportation Guidelines Document for more information)).
- Assign Team Responsibilities and availability during discharge time at the nursing facility and upon arrival at the home.
- Confirms with TC goods and services are in the home
- Coordinates that **all services and supports** are in place. That the individual has what they need to be safe and healthy.
- Collaborate with HC/Waiver CM to confirm plans for the CMs F2F in the home visit
- **Ensure service support and housing are move in ready**
- Transfers all pertinent information about participant to Waiver CM or HC CM
- The PTCM is to be Available to assist with the move on the day of discharge
- Complete and submit the HC Enrollment Form within 1 business day of discharge



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