Pre Transition Case Management Training

Ohio Department of Transportation

June 14, 2017
HOME Choice Redesign 2017

Why Redesign?

• HOME Choice’s program philosophy has evolved with more emphasis on improving sustainability of individuals in community. We are tasking HOME Choice providers to thoroughly discuss, review, ask critical questions, and have value added conversations necessary for enhancing a participant’s sustainability after discharge.

• Each individual’s needs and strengths will be considered with the goal of more successful community integration.

• This philosophical change extends to an individual’s initial encounters with the program: application, meeting with a Pre Transition Case Manager and discharge planning with a Transition Coordinator.
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How this journey began...

• Re-applications were bogging us down
• Frequent Flyers
• Unrealistic Expectations
  » Individuals
  » Providers
• Services & Supports required exceeded the scope of HOME Choice
• Financial considerations
• Apply this to new applications too!
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Operational Protocol & HOME Choice Rule language

• Eligibility Criteria for enrollment
  » 90 days
  » Medicaid at time of discharge
  » Move to a Qualified Residence
  » Medicaid Claim
  » Qualified Institution

• Re-Applications
  » What has changed?
  » Thorough review of prior attempts at transition

• Don’t set people up to fail!
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What are we changing?

• A new, internal review process for HOME Choice applications and re-applications received prior to a 45 day Length of Stay (LOS) will be implemented to assess HOME Choice eligibility criteria.

• Applications resulting in a Pre-Transition Case Manager (PTCM) referral will be sent out on or after the 45th day of the LOS.

• Expectations for the timelines for completion of PTCMs and Transition Coordinator responsibilities were modified.

• We’ll get into more details later....
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Internal Review process

Role of Intake:

• Monitor length of stay (LOS)

• Call the facility at day 40:
  » Is the person still there?
  » Is there a pending discharge date? (Soon?)

• Outcome:
  » PTCM referral, or
  » Community Living Administrator (CLA) will deny
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Role of CLA for Re-applications

- Time & Benefits remaining?
- Review of previous forms
- Call the guardian/family/others
- Call the facility
  » What has changed?
  » What is different that will improve sustainability potential?
- Talk with providers
  » Work with the person again?
- Plan for success?
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Why the changes? It’s all about outcomes for the person
• Improved care coordination for individuals
• Greater potential to achieve outcomes that maintain and/or improve health
• Successful community integration for each individual
• Value-based services and quality-focused outcomes with higher levels of provider accountability
• Improved program efficiency & more effective use of available resources
• Core Values
ODM’s CORE VALUES

- **INNOVATION**
  - Continuously driving positive change to Ohio’s healthcare landscape through creativity, curiosity, and by challenging convention

- **COLLABORATION**
  - Working together openly and inclusively to reach a mutual goal

- **STEWARDSHIP**
  - Efficiently and conscientiously managing the public resources entrusted to us

- **ACCOUNTABILITY**
  - Establishing and using meaningful, measurable performance standards for all we do

- **INTEGRITY**
  - We are committed to being honest and ethical in all we do

- **PASSION**
  - We are committed to people and determined to succeed
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People’s needs change..... Programs need to change

Stewardship is an ODM Core Value – We must all:
• Be good stewards of federal & state monies
• Be good stewards of our taxpayer dollars: federal & state
• Hold ourselves accountable in all we do (It’s a core value too!)
• Give so that others may have opportunities like we do
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Accountability, Integrity, Passion...

• We work – We get paid to do and be for others

• The government pays us to:
  » Do good things for people, including the “right” thing, even when it’s hard
  » To make a difference in people’s lives
  » To make a difference in our communities

• Think about it … Pretty amazing. What an honor!

• HOME Choice: Helping Ohioans Move, Expanding Choice – What a Great Name!
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The Times They are a Changin’ (Bob Dylan)

• Changing Timelines for PTCMs and TCs
  » Improve outcomes for people
  » Prioritize & Focus
  » Reality: HOME Choice is not for everyone

• For PTCMs the changes are:
  » 10 days from referral to:
    – Meet with applicant in person
    – Submit HOME Choice forms and documents to HC Operations
  » Intense focus on the needs, strengths and challenges of the person
  » HOME Choice applicant begins to take shape
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First Encounter: PTCM makes the first and lasting impression on behalf of HOME Choice!

• Complete some forms ... A visual takes shape

• Pretty basic at this point, but it’s a start.

• Community Readiness Tool is next. The picture you create with this and the other HC forms paves the way for the TC to jump right in and get to work.
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Community Readiness Tool
• Crucial conversations
• Asking the tough questions
• Exploring the person’s journey
• Facing reality
• Designing a plan
• The picture takes shape
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*Quality Through Conversations*

With many thanks to North Carolina’s MFP Project Director:

Trish Farnham & her team

- General Conversation Tips
- Planning for the Transition:
  - A Person’s History
  - A Person’s Future:
- Ready for Transition?
- After Transition: How are things going?
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Simulation of a PTCM at work
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Putting it all together

The more information you gather....

The more dynamic and robust I become. Now we can build a fantastic transition plan.
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Communication, Collaboration & Coordination

• Coordinated Care is Critical!
• Outcome driven
• Be creative
• What does reality look like?
• Value added questions
• Community Integration
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Provider Agreement Highlights – Included in the PTCM manual

• Contractual Agreement between PTCM agency & ODM
  » Timelines
  » Payment

• In Person Assessment (Forms a bit later)
  » Crucial Conversations
  » Dig deeper (Full picture)

• PTCM staff qualifications

• Mandatory training requirements
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PTCM Provider Agreement/Contract

• Timeline Changes
  » Because we are making PTCM referrals at “Day 45”, tighter timeline to make contact, meet in-person and submit all the HOME Choice documents: within 10 business days!
  » No change to submitting the Enrollment Form within 24 hours of discharge.

• Payment
  » Important for you to know...
  » $1,000 at time of referral with completion of in-person assessment & form submission
  » $1,000 for services delivered during pre-transition & a completed enrollment form or a Change in Status with documentation of services delivered.
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PTCM Provider Agreement/Contract

• PTCM Qualifications:
  » 12 months experience delivering services in health care, behavioral health or social services setting;
  » 18 years old or older;
  » High school diploma or GED;
  » Knowledge and experience working with the local community network of resources that serve one or more population types: elderly, physical disability, intellectual/developmental disability, or behavioral health;
  » Embrace a person’s right to be self-determined: person centered thinking;
  » Have experience advocating on behalf of individuals in these population types.
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PTCM Training **Requirements - Mandatory**

- Training prior to providing services
- **Orientation** training includes at a minimum....(examples)
  - HOME Choice overview, Roles & Responsibilities of PTCM & other HC providers;
  - Administrative Code details & HOME Choice rules
  - Review of PTCM & TC manuals
  - Review of the HOME Choice website
  - Review of the concepts of self-determination & individual rights.

- Attend all ODM trainings
- Complete webinars posted on website
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In-Person Assessment

• Informed Consent Form – We suggest you do this first and here’s why...

• Community Readiness Tool – Asking the questions, having a conversation, learning all about the person...

• Qualified Residence information: Be very clear with them to ensure they understand where they can move to and with whom...

• ODM 2399 – Request for Medicaid services. You are their resource for this information and the one who can assist with the process...

• Eligibility Checklist – “Diagnoses & Comments” What we are looking for here...
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A Commercial Break for the....

SSI Ohio Project
By
Amy Lamerson
COHHIO
HOME Choice Redesign 2017
A Commercial Break for...

Recovery Requires a Community
By
Rebecca Grimm
MHAS
HOME Choice Redesign 2017

Lunch Time
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Provider Manual Highlights

• High level review

• Forms & Conversations
  » Informed Consent
  » Eligibility Checklist
  » Community Readiness Tool
  » HOME Choice Service Plan & Free Choice of Provider
    – Is there a need?
    – Has provider agreed to work with the individual?
  » ODM 2399 application form for waivers***

• Goods & Services
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HOME Choice Resources: Website Reality Show

• Moment of Truth
• One Stop Shop
• HOME Choice website
  » Game show time
  » Divide into teams with one person who has access to the internet
  » Seek & Find
• Abundance of Resources at your finger tips
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Managed Care in Ohio: Today

Another way of putting it all together...

» **Medicaid Managed Care** – non-waiver

» **MyCare** – duals waiver and community well
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Managed Care in Ohio: Today

» Medicaid Managed Care
  – Expanded populations
  – Five state-wide plans – Buckeye, Caresource, Molina, Paramount and United Health Care
  – Enrollment mandatory but individual can choose their plan
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Managed Care in Ohio: Today

» Medicaid Managed Care
– An insurance company
– Insurance card
– Makes decisions about the services that will be authorized
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Managed Care in Ohio: Today

» Medicaid Managed Care
  – Reviews NF stay Authorizations reviewed on an average of every 5-7 days
  – NF and the plan communicate by fax or phone
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Managed Care in Ohio: Today

• MyCare

« Eligibility:

✓ age 18 and older
✓ Medicare and full Medicaid benefits
✓ live in one of the 29 demonstration counties
# HOME Choice Redesign 2017

Managed Care in Ohio: Today

## MyCare REGIONS & DEMONSTRATION COUNTIES

### DEMONSTRATION REGION & POPULATION

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>Managed Care Plans Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest</td>
<td>9,884</td>
<td>- Aetna - Buckeye</td>
</tr>
<tr>
<td>Southwest</td>
<td>19,456</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>West Central</td>
<td>12,381</td>
<td>- Buckeye - Molina</td>
</tr>
<tr>
<td>Central</td>
<td>16,029</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>East Central</td>
<td>16,225</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast</td>
<td>9,284</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast</td>
<td>31,712</td>
<td>- Buckeye - CareSource - United</td>
</tr>
</tbody>
</table>

- EC: East Central
- NW: Northwest
- SW: Southwest
- WC: West Central
- NE: Northeast
- NEC: Northeast Central
Managed Care in Ohio: Today

• MyCare
  «NF authorizations can be approved for 6 - 12 months at a time
  «Care management informs member of authorized stay
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Managed Care in Ohio: Tomorrow

If approved by the Ohio Legislature, Ohio Medicaid will implement a new Medicaid Long-Term Service and Supports (MLTSS) program and begin enrolling individuals receiving community- and facility-based long-term services and supports in managed care on July 1, 2018.

This move will allow Ohio Medicaid to provide the benefits of care coordination to Medicaid enrollees who have the most complex needs and improve quality of care to achieve better health outcomes.
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MFP for Ohio beyond the Grant...

• Created a Sustainability plan in 2015
• Collaboration with others on planning 2016
• Budget Initiative submitted to Director August 2016
• Timelines we know for sure
  » December 31, 2018
  » January 1, 2019
  » Will be running parallel programs
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MFP 2.0 (Using this name to delineate the change from grant to State funded. Plan is to still call it HOME Choice.)

• Proposed Services
  » PTCM & TC combined
  » CSC & ILST combined
  » HCCM
  » Everything else available through waiver or Medicaid card

• Timelines & Budget to be determined
  » June 30, 2017 will determine Ohio’s future for many things
  » Re-group starting in July
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“We did the best with what we knew at the time and now we need to do better because we know more.”

Maya Angelou
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Details Matter ... In Compliance Reviews

Review the following:
- Data base notes & forms
- Case manager notes from CareStar or PIMS
- Morning Sun Detailed Tracking report

May request the following:
- Case notes from all providers (TC, CSC, ILST)
- Morning Sun receipts
- Morning Sun service claims

Gather and compare data from all sources in order to create a **Summary of Findings** (if there are findings) with detailed information about concerns. Providers are accountable to Provider Agreement, Provider Manual, and OAC rules.

Provider works Plan of Correction while a random review of cases may be conducted.

Summary of Findings is sent to provider for review then provider must submit a **Plan of Correction** within 2 weeks.

Receive a complaint/concern from:
- CLA
- Constituent Inquiry
- Family
- HCCM
- Incident
- Individual
- Service providers
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Details Matter . . . In Compliance Reviews

Four areas of concern:

• Incomplete HOME Choice Forms & Documentation (Case Notes)
• Lack of Coordination/Collaboration with Providers & Participants
• Lack of Discharge Planning
• Inappropriate Use of Goods & Services
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Details Matter . . . In Documentation

Agencies should create a uniform case-note template for all HOME Choice staff to use. The template should include the following:

- Provider Name
- Service Provided
- Name of Staff Person
- Name of Participant
- Date
- Location
- Type of Contact
- Notes that include “an individual-specific description and details of the tasks performed or not performed in accordance with the participant's approved HOME choice service plan” [OAC 5160-51-03 (B) (8)]
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Details Matter . . . In Planning

• HOME Choice workers should collaborate with all Providers & Participants.

• HOME Choice workers should actively participate in discharge planning with all members of the Discharge Planning Team.
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Details Matter . . . In Planning

One of ODM’s Core Values is **Stewardship**

Efficiently and conscientiously managing the public resources entrusted to us
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5160-51-04 Helping Ohioans move, expanding choice (HOME choice) program definitions of covered services and provider qualifications.

(A) This rule sets forth the covered services available to a helping Ohioans move, expanding choice (hereafter referred to as HOME choice) program participant as well as provider requirements for those services.

(D) "Community transition services" are goods, services and support for the purpose of addressing an identified need in a participant's HOME choice service plan, including improving and maintaining the participant's opportunities for inclusion in the community.

(1) Community transition services are intended to:

(a) Decrease the need for formal support services and other Medicaid services;

(b) Take into consideration the appropriateness and availability of a lower cost alternative for comparable services that meet the participant's needs;

(c) Promote community inclusion and family involvement;

(d) Improve the participant's health and welfare in the home and community;

(e) Be provided when the participant does not have the funds to purchase the services, or the services are not available through another source;

(f) Assist the participant in developing and maintaining personal, social, physical or work-related skills; and

(g) Assist the participant in living independently in the home and community.
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(2) Community transition services include:

(a) Transportation expenses up to a maximum of five hundred dollars during the participant's pre-transition period and for thirty days after transitioning to the community;

(b) **Initial transition expenses** up to a maximum of two thousand dollars including, but not limited to the following:

   (i) Security deposit and rent required to lease a qualified residence;

   (ii) **Essential household furnishings**, including furniture, window coverings, food preparation items, and bed/bath linens;

   (iii) **Set-up fees or deposits for utility or service access**, including telephone, electricity, heating and water;

   (iv) Services necessary for the participant's health and welfare, such as pest control and one-time cleaning prior to moving in to the residence;

   (v) Moving expenses;

   (vi) Necessary home accessibility adaptations; and

   (vii) **Initial grocery purchase**, i.e., food and household supplies.
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(3) Community transition services **do not include:**

(a) Experimental or prohibited treatments;
(b) **The ongoing cost of rent**;
(c) **Ongoing utility charges**;
(d) **Ongoing grocery expenses**;
(e) Cigarettes and alcohol;
(f) Electronics and other household appliances or items that are intended to be used for entertainment or recreational purposes; and
(g) Cable and/or internet access.  (*Exceptions apply, ie. bundling*)
(G) Reimbursement will be provided in accordance with the following:

(2) Reimbursement requests for community transition services must be *received by the FMS provider within thirty calendar days of the actual date goods and services were purchased*. Reimbursement requests must be in the form of either an invoice, a receipt or a purchase order.
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Details Matter ... In Compliance

A few reminders:

• Online registries should be used as a **last** resort.

• If shopping online, shipping and handling fees should not be a significant cost of the item.

• Some participants may not need to use all of the Goods and Services monies since it is based on **need**.

• Per OAC, ongoing utilities and rent are NOT an allowable expense.
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Details Matter ... In Compliance

Staff Training

• Training has always been required per OAC 5160-51-03 (B) (4):
• (B) In order to enroll as a HOME choice service provider and maintain provider status, the provider shall:
  • (4) Attend ODM-sponsored HOME choice program provider training sessions as required by ODM
• Verification of both external and internal trainings is now required.
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Details Matter ... Incidents

• “An incident is a situation that may cause harm, has the potential to cause harm or has caused harm to a HOME Choice enrolled participant. They are alleged, suspected or actual events that are not consistent with routine care or routine service delivery.”

• Please note that the incident definition refers to an ENROLLED HOME Choice participant which means those who have moved back to the community.

• Incidents should be reported to the individual’s waiver or HOME Choice case manager.
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Details Matter ... Incident Types

- Abuse
- Accident /Injury
- Back Up Plan Failure
- Death
- Environmental Emergency
- Exacerbation of Health Problems
- Exploitation
- Hospitalization
- Inappropriate Services/Unmet Need
- Involvement with Criminal Justice System
- Location Unknown
- Loss of Caregiver
- Loss of Housing
- Loss of Income
- Medication Administration Error
- Neglect
- Nursing Facility Readmission
- Other
- Sentenced to Jail /Prison
- Substance Abuse/Overdose
- Suicidal thoughts/attempts
- Theft of Medication, Money or personal Property
- Victim of a Crime, Other
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Details Matter

It’s all about working together to keep people safe in the best possible environment in the community.
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Putting it Together

• Coordination, Communication, & Collaboration
• Audience Participation time – Your thoughts & suggestions
• Regional Networking concept?
  » Help organize
  » Coordinate
  » Facilitate
  » Volunteers? Add “Contact me about networking” and provide your name and email address on the back of the evaluation.

• Evaluations Please!

THANK YOU!!  Save travels home.  Make it Happen!!
MAKING OHIO BETTER