



Ohio

Department of
Medicaid

John R. Kasich, Governor
John B. McCarthy, Director

HOME
Choice

Summer 2014 Workshops

Today is all about Team work

To meet the needs of a successful transition for individuals we must:

- Increase our Communication & Collaboration
- Increase our Knowledge & Resources
- Team approach to discharge planning
- Know who the players are
- Think bigger picture/tear down the silo's

The Teams & The Plan

PASRR

Community Options Initiative

Recovery Requires a Community

HOME Choice

Managed Care Plans

Case Management

Waiver/Non-Waiver

Housing & Benefits

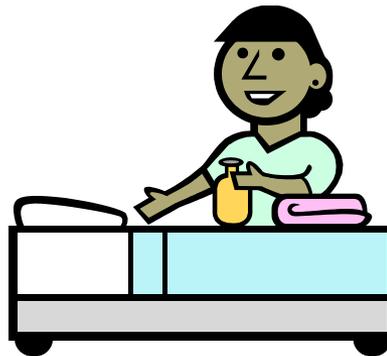
Bringing it all together

PASRR: What? Who cares...

- All about nursing facility admissions & short/ ong term stays
- PAS = Pre-Admission Screen
- RR = Resident Review
- Resident Review Extension Requests
- NF discharge notices... *Help!*
- OMHAS & ODM/HOME Choice can help
- Communication – *Making the connections*

Why Do We Need PASRR?

- The federal intent of PAS/RR: to prevent inappropriate and/or long term placement of individuals with mental illness and/or intellectual/ developmental disabilities in nursing facilities.



Level I PASRR

- **Level I – typically completed by the PAA's.**
- **Completion and submission of the *Preadmission Screening/Resident Review Identification Screen* along with supporting documentation.**



Level II PASRR

The Preadmission Screening/Resident Review Identification Screen must be submitted to the state authorities when there are indications of MI and/or DD who must make a determination about:

- Does the individual have a need for the level of services provided by a NF?
- Does the individual have MI or ID/DD?

NFs are prohibited from retaining any individual with MI and/or DD unless they need the level of services provided in a NF.

PAS/ID LEVEL I SCREEN: NEW ADMISSION

SUBMIT FORM 3622 & SUPPORTING DOCUMENTATION TO PAA

↓
Indications of SMI or DD?

NO INDICATIONS



REVIEW RESULTS PROVIDED TO NF



MAY ADMIT INDIVIDUAL

DETERMINATION GOOD FOR 180 DAYS,
IF NOT ADMITTED BY THEN, NEED NEW PAS



YES INDICATIONS



PASRR FORWARDED TO ASCEND AND/OR
COUNTY BOARD FOR LEVEL 2 FURTHER REVIEW



MH AND/OR DD LEVEL 2 FURTHER REVIEW
DETERMINATION

YES NF NEED



MAY BE ADMITTED

DETERMINATION GOOD FOR 180 DAYS,
IF NOT ADMITTED BY THEN, NEED NEW PAS



NO NF NEED



MAY NOT BE ADMITTED!



RR/ID Level I Screen: Current Residents

RR/ID is Due: NF COMPLETES & REVIEWS FORM 3622



NO INDICATIONS

NF PLACES FORM 3622 IN
RESIDENT'S FILE AT NF



YES INDICATIONS



NF FORWARDS FORM 3622
FOR LEVEL II FURTHER REVIEW



INDICATIONS OF DD:
SEND FORM DIRECTLY
TO STATE DODD



INDICATIONS OF MH:
SEND FORM DIRECTLY
TO ASCEND



OMHAS &/OR DODD ISSUES DETERMINATION



YES NF NEEDED
NF PLACES 3622,
SUPPORTING DOCUMENTATION
& DETERMINATION IN RESIDENT'S FILE



NO NF NEEDED
RESIDENT MAY NOT
BE RETAINED!



Mission of OMHAS:

To provide leadership and assistance with the discharge of individuals diagnosed with mental illness from nursing facilities.

- A PASRR program
- Proactive approach
- Focuses on individuals with complex & challenging profiles
- Builds alliances with key State & community stakeholders

Inter-disciplinary Team



NO WRONG DOOR

Individual/Guardian
Nursing Facility
Disability Rights Ohio
HOME Choice
Recovery Requires a
Community



Follow-up & Additional Activities

- Track recidivism & placement stability
- Collaborate with stakeholders to :
 - Meet the individual's needs
 - Build infrastructure
- Develop models for proactive, effective discharge planning in Nursing facilities
- Report on needs, trends and outcomes that will impact the rebalancing long-term care

Team Meetings

RESIDENT PARTICIPATES!

Asked to voice their desires, discussion of barriers, assignment of tasks, follow-up meeting set with timelines.

Stakeholders Identified / Contacted

Guardian

Discuss needs; educate on PASRR determination, resources, etc.;

County Mental Health Authority

Inform resident is returning to community; engage participation.

HOME Choice

Check on status of application; talk to providers; empower...

Nursing Facility

Consult on status of discharge planning; identify barriers; suggest solutions; request team meeting

Contact Information @ OMHAS

**George Pelletier, Community Options Coordinator,
PASRR Bureau**

communityoptions@mha.ohio.gov

Comments? Questions?



Recovery Requires a Community

- **An OhioMHAS initiative.**
- **Goal: Provide financial assistance to individuals with mental illness to transition and remain stable in community.**
- **Work closely with the HOME Choice program.**
- **Help enforce Olmstead decision**
- **Increase community linkages**
- **Reduce institutional placements (Recidivism)**

Referrals

- **Coordination between HOME Choice and Recovery**
 - Individuals “Applied, Approved, & still waiting”
 - Individuals in immediate danger of returning to a facility
- **Coordination between PASRR and Recovery**
 - Time limited approvals
 - Extensions for resident reviews
- **Coordination between providers and Recovery**
 - Work with you directly
- ***Recovery Fact Sheet on the Resource Table***

Process: Individuals & Providers

- Release of Information (ROI)
 - *Available on the Resource Table*
- Demonstrate Due Diligence towards resolution
- The “but-for” item
- A Case example.....
- *Flow Chart... (Hand out) for your review at a later time*

What do I do today?

- **Are you working with someone you think might benefit from Recovery.....?**
- **Take an ROI with you...**
 - **Recovery Requires a Community will coordinate with HOME Choice**
 - **Fill out an ROI even if a person is not eligible for HOME Choice & OMHAS will try and work with you and the individual.**
- **Grow the team**

Recovery Contact Info

Adam Anderson – Program Manager

614.466.9985

Jackie Doodley – Program Specialist

614.752.6456

Heather King – Program Administrator

614.387.2799

<http://mha.ohio.gov/>

(Tab: Initiatives/Recovery Requires a Community)

Email: First.Last@mha.ohio.gov,

Recovery@mha.ohio.gov

Ohio HOME Choice

- **Established 2008 with goal to transition 2000 individuals, the program has become a national leader**
- **As of today, over 5000 people have enjoyed new found independence through HOME Choice**
- **Ohio is nation's leader in transitioning individuals with mental illness**
- **Ohio ranks second nationally for overall transitions completed**

Ohio HOME Choice

Who is eligible?

To participate in HOME Choice individuals must:

- Have lived in a facility-based (NF, ICF-IID, Hospital or RTF for children) care setting for a least 90 days,
- Have care needs evaluated by HOME Choice staff,
- Qualify for Medicaid, and
- Move into qualified housing

Ohio HOME Choice

HOME Choice:

- Is a wrap around program to Ohio's existing infrastructure of long term services and supports
- Not a waiver program
- Offers extra services to individuals for the first 365 days post discharge
- Breaking News: CMS has extended the invitation to continue this program until 2020. (More to come)

Ohio HOME Choice

HOME Choice Services

- Community Transition Services (goods and services)
- Transition Coordination
- Case Management: Pre-Transition & Post if not on a waiver
- Independent Living Skills Training
- Community Support Coaching

Ohio HOME Choice

HOME Choice Services

- HOME Choice Nursing Services
- Social Work/Counseling
- Respite
- Communication Aids
- Service Animals
- Nutritional Consultation

Ohio HOME Choice

How Transition Works

Individuals/Guardian/Facility, etc.:

- Express an interest in HOME Choice
- Complete application and submit to ODM (HOME Choice Operations)
- Assigned to a Pre Transition Case Management Agency

Ohio HOME Choice

Pre-Transition Case Manager

- Meets Face-to-Face with Applicant
- Completes Necessary Paperwork
- Makes eligibility recommendations
- Completes Community Readiness Tool
- Supports individual in choosing Transition Coordinator
- Submits documents & Service Plan to HC Operations

Ohio HOME Choice

Transition Coordinator

- Assists in securing housing that meets qualified residence criteria
- Identifies necessary resources
- Provides service linkage for a successful community transition
- Continues 90 days post-discharge with the individual

Ohio HOME Choice

What happens after discharge?

- Individual is enrolled in HCBS program for which they are eligible and meets their needs (Waiver or State Plan)
- If enrolled on waiver, waiver service coordinator authorizes and coordinates HOME Choice services during the 365 days post discharge
- Waiver service coordinator reports certain changes in status to ODM

Ohio HOME Choice

Home CHOICE Case Manager

- Available to participants not enrolled on a waiver or waiting for a waiver...
- Assigned pre discharge & continues through 365 for non-waiver
- Authorizes and coordinates HOME Choice Services during 365 days in community

MyCare Ohio

- **Eligibility Criteria**
 - 18 and older
 - Live in one of the 29 demonstration counties
 - Receive both Medicaid and Medicare benefits (“duals”)
- **Services may include:**
 - Medicaid State Plan services
 - Medicaid waiver services
- **When Enrolled on the MyCare Ohio Waiver you cannot be enrolled on another Medicaid waiver.**
- ***Fact Sheet, Map & Contact Information available on the Resource Table***

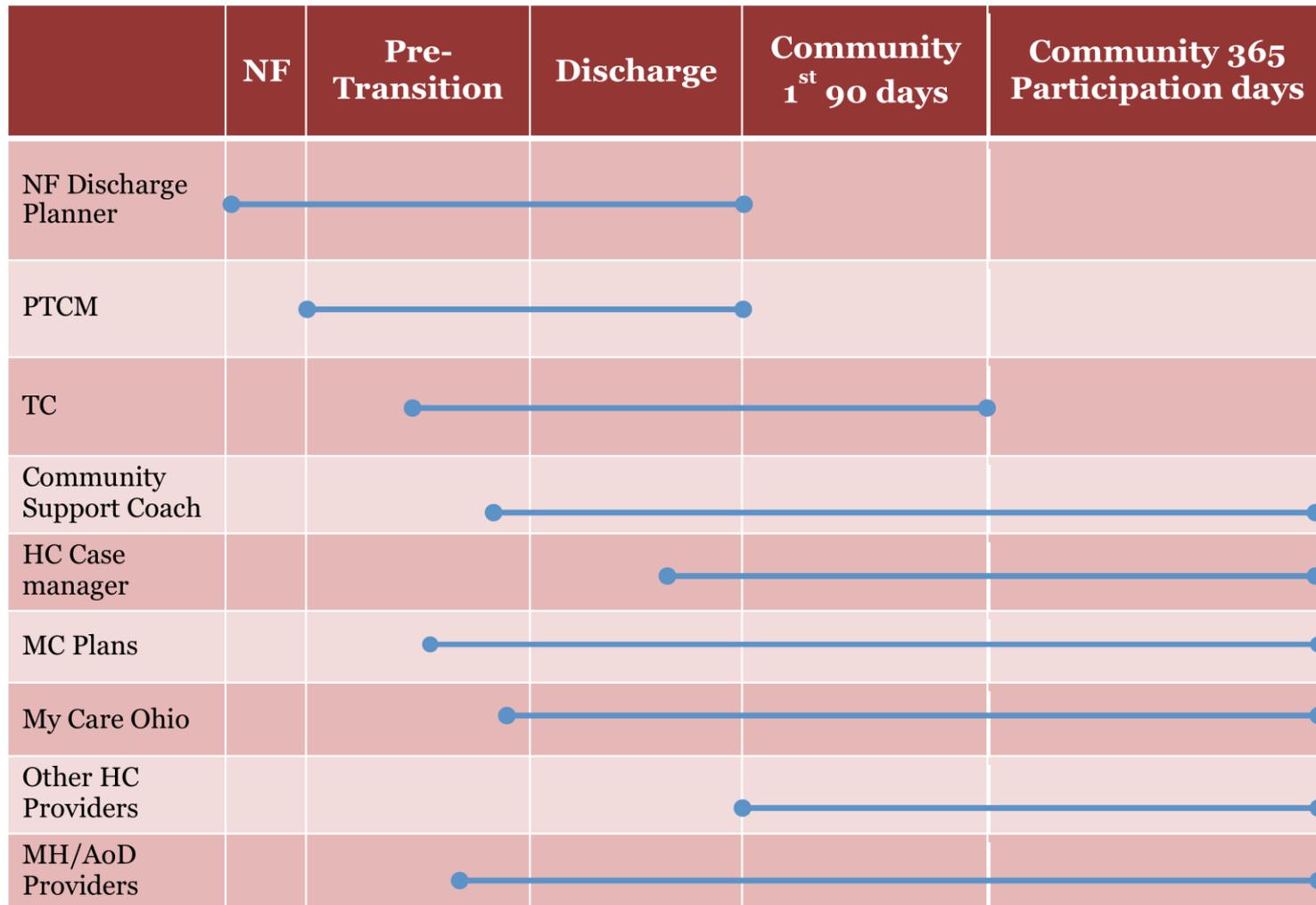
MyCare & HOME Choice

- **MyCare participant is eligible for HOME Choice (MCP could be the referral source)**
- **HOME Choice Operations is adding MCP & MyCare waiver information to the HC database & it is on the HOME Choice Service Plan**
- **Managed Care Plans have received HOME Choice & Recovery training....**
- **Help spread the word that we can work together**
- ***Implementation details are under construction***

Managed Care & HOME Choice

Managed Care Plans role in HOME Choice:

- **Manages HOME Choice services for members who are enrolled on waiver**
- **Coordinates with HOME Choice Case Manager for non-waiver HOME Choice members**
- **A work in progress**
- **Please help us educate & empower the field!!**



Ohio Access Success Project

- **Ohio's first program to assist people with transitioning from nursing facilities to community settings.**
- **Project started in May 2004 as a federal grant.**
- **Now funded by the State General Assembly with general revenue funds.**
- **To date over 722 people have relocated to community settings with assistance of the Success project**

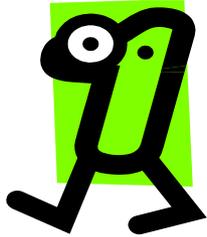
Ohio Access Success Project

- **Participants have approx. \$1900 available to help pay relocation expenses.**
- **Requirements for participation:**
 - **Must be an adult resident in a nursing facility**
 - **Must be Medicaid eligible**
 - **Must have care needs that can be met in community at no more than 80% of the average Medicaid cost of care for NF**
- ***Fact Sheet available on the Resource Table***

What's My Status?



Step



Submit the Application



HEY! I'm an applicant

(I can only be denied)



Step 

I'm approved to participate



I have a Transition Coordinator!



(I can only be pre-enrollment Terminated)



Step 

I've been enrolled 

I've discharged and met all the eligibility
criteria

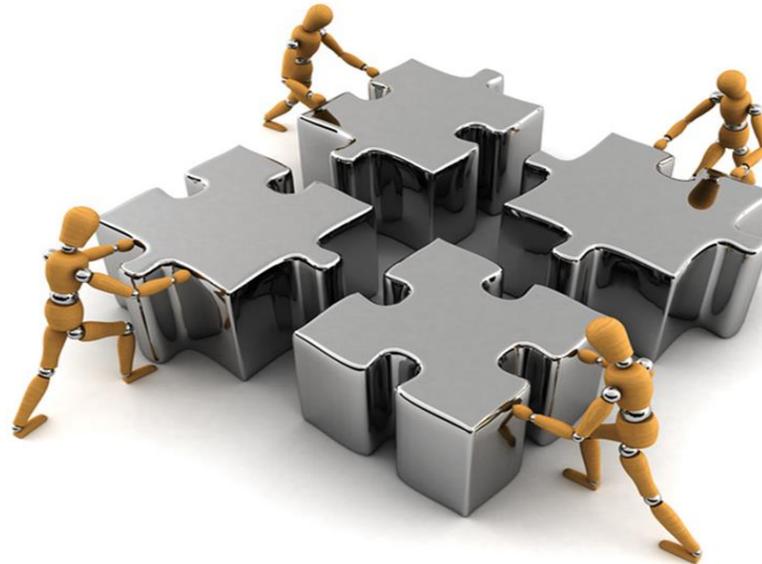


(I can only be dis-enrolled)



However, I plan on making it to 365 days!

All the pieces fit together.



Because I have a great team!

HOME
Choice