Take Me Home, West Virginia

Transition Navigator

Procedures Manual

Version 5

Contents

OVERVIEW

Money Follows the Person

Congress established the Money Follows the Person (MFP) initiative through the Deficit Reduction Act of 2005 and expanded and extended it through the Patient Protection and Affordable Care Act of 2010. The goal of the MFP initiative is to support efforts by state Medicaid programs, such as the Bureau for Medical Services (BMS), to give people with disabilities greater choice in where to live and receive long-term services and supports.

Each state MFP program consists of two parts:

- A transition program to identify Medicaid beneficiaries living in long-term care facilities who wish to live in the community and help them do so, and;
- A rebalancing program through which states make system-wide changes that allow more Medicaid beneficiaries with disabilities to live and receive services in the community.

In 2007, the Centers for Medicare & Medicaid Services (CMS) awarded MFP demonstration grants to 30 states and the District of Columbia. In 2010, Congress increased total grant funding and extended the demonstration. There are currently 47 states participating in the Money Follows the Person initiative. States have until December 31, 2017 to transition people and can continue to provide transition services and supports to these individuals through December 31, 2018.

To be eligible to participate in Money Follows the Person, individuals must:

- Live in a "qualifying institution" for at least 90 consecutive days (excluding Medicare rehabilitation days), and;
- Receive Medicaid benefits on the last day prior to transitioning from the long-term care facility to the community and;
- Choose to move to a "qualified residence".

A "qualified residence" is:

- A person's own home;
- A person's family's home;
- A person's own apartment, or
- Certain group homes with 4 or fewer people.

Take Me Home, West Virginia

In 2011, the West Virginia Bureau for Medical Services (BMS) received a Money Follows the Person (MFP) Rebalancing Demonstration Grant from the Centers for Medicare and Medicaid Services (CMS). West Virginia's Money Follows the Person initiative is called Take Me Home, West Virginia (TMH).

The Take Me Home, West Virginia program:

- Provides one-time services and supports essential to individuals who are transitioning from facility-based settings to community living;
- Makes available flexible resource pools to support individualized needs related to living in the community;
- Works to expand home and community-based service options in West Virginia;
- Employs a full-time Housing Coordinator to assist with identifying both short and long-term solutions to the lack of appropriate housing;
- Uses consumers and other stakeholders to monitor quality and drive improvement in the provision of home and community-based services, and;
- Engages stakeholders in the design of solutions to some of the existing barriers creating institutional bias in our long term care system.

Take Me Home, West Virginia Services

Individuals wishing to transition from long-term care facilities to the community often face numerous obstacles including a lack of funds for rent and utility deposits, lack of basic household items and furniture, limited community supports, and no one to help develop comprehensive plans to transition home. TMH helps address many of these barriers by providing a number of services and supports to program participants to promote a successful and safe transition to the community.

Transition Navigator Service:

The Transition Navigator service is the lynchpin of Take Me Home, West Virginia. Transition Navigators:

- Work one-on-one with TMH participants;
- Assess participant's needs for services and supports;
- Develop individualized Transition Plans;
- Facilitate the delivery of needed services and supports using a team approach, and;
- Support each participant for one year after their transition to the community.

There are a number of additional Take Me Home demonstration services that are available to support the participant's safe and successful transition from facility-based living to the community:

Demonstration Service	Category	Description	Rate	Max Cost Per Service
Extended Direct-Care (Post-Transition)	Care Supports	Extended direct care services include State Plan services, and/or waiver direct-care services and permit participants the opportunity to access these services beyond the current restrictions on amount and scope as defined in the State Plan or waiver programs. These services will be available to Take Me Home participants only after the participant has exhausted the limits on these services for which the participant is eligible absent the MFP Demonstration.	$3.75 PER 15 minute unit	$8,000

Direct-care For Trial Visits (pre-transition)	Care Supports	This service provides a brief period of hands-on direct-care for TMH participants during a "trial visit" to the community before transitioning. This service may be used post-transition by a participant whose services are arranged but delayed	$3.75 per 15 minute unit	$315
Peer Support (Pre and Post-Transition)	Care Supports	This service provides for face-to-face support before, during and after transition, from a qualified peer supporter for the purpose of discussing transition experiences, problem solving and building connections to individuals and associations in the community. This service includes Recovery Coaches.	$10 per 15 minute unit	$1,600
Respite (in-home and out-of-home; Post-Transition)	Care Supports	This service provides a brief period of support or relief for family members caring for a TMH participant. This service will pay for up to 14 days of out of home respite during the 365 day eligibility period. The out-of-home respite is provided by a qualified provider, such as a nursing facility, day-care center, etc. The in-home respite is provided by a qualified HCBS provider.	$250 per day for out of home respite care. In home respite services will be reimbursed at the Medicaid reimbursement rate for in-home direct-care services (currently $3.75 per 15 minute unit)	$2,000
Pre-transition Case Management	Community Transition Services	The purpose of the Pre-Transition Case Management service is to ensure that Waiver and/or Personal Care services are in place day one of the participant's transition to the community.	$8.50 per 15 minute unit	$204

Pre-transition RN Assessment	Community Transition Services	The Pre-transition RN Assessment is necessary to develop a Plan of Care and have it in place "day one" for participants transitioning to the Aged & Disabled Waiver and State Plan Personal Care programs and will be limited to one event per transition period except for extraordinary cases which will be reviewed and approved by TMH staff.	$120 per event	$120
Vehicle Modifications (Pre and Post-Transition)	Community Transition Services	This service enables individuals to interact more independently, enhancing their quality of life and reducing their dependence. Limited to participant's or the family's privately owned vehicle and includes such things as driving controls, mobility device carry racks, lifts, vehicle ramps, special seats and other interior modifications for access into and out of the vehicle as well as to improve safety while moving.		$6,000
Home Modifications (Pre and Post-Transition)	Community Transition Services	This service provides assistance to participants requiring physical adaptations to a qualified residence. This service covers basic modifications needed by a participant, i.e. ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications, to ensure health, welfare and safety and/or to improve independence.		$8,000
Home Furnishings (Pre and Post-Transition)	Community Transition Services	This service provides assistance to participants requiring basic household furnishings to help them transition back into the community. This service is intended to help the participant with the initial set-up of their qualified residence.		$2,000

Household Goods & Supplies (Pre and Post-Transition)	Community Transition Services	This service provides assistance to participants requiring basic household goods (e.g., cookware, toiletries) and services and is intended to help the participant with the initial set-up of their qualified residence.		$800
Initial Food Supply (Pre-Transition and Post-Transition)	Community Transition Services	This service is limited to a one-time purchase of groceries (excluding alcohol and tobacco products) within the first week of transitioning to the community.		$300
Moving Expenses (Post-Transition)	Community Transition Services	This service may include rental of a moving van/truck and staff or the use of a moving or delivery service to move a participant's goods to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout the 365 day demonstration period.		$850
Security Deposit and 1st Month's Rent	Community Transition Services	This service is used to cover rental security deposit and 1st month's rent.		$1,500

Utility Deposits	Community Transition Services	This service is used to assist participants with required utility deposits for a qualified residence.		$500
Transition Support (Pre and Post-Transition)	Community Transition Services	This service provides assistance to help participants with unique transition needs and/or expenses (obtaining documentation, accessing paid roommate match services, etc.). This service provides funding for needs that are unique to each participant, but necessary for a successful transition.		$1,000
PERS (Pre-Transition)	Community Transition Services	A Personal Emergency Response System is required of all TMH participants transitioning to the community.		$500
Individualized Skills Training (pre and post-transition)	Goods & Services	This service includes training to develop needed skills in areas such as money management, getting around in the community, bill paying, comparative shopping, doing laundry, social skills, time management, etc	Mileage reimbursement : Base on IRS Standard. Travel time: $25 per hour. + Assessment and skills training: $45 per hour.	$1,500

Equipment, Vision, Dental, and Hearing Services (not otherwise covered by Medicaid – Pre and Post-Transition)	Goods & Services	This service provides equipment, vision, dental, hearing aids and related services and certain types of assistive technology and services that are not otherwise covered by Medicaid. Items and services obtained must be justified in the Transition Plan and be necessary to enable participants to interact more independently and/or reduce dependence on physical supports and enhance quality of life. Covers normal and customary charges associated with one vision examination and one pair of basic prescription glasses. Covers normal and customary charges for one dental examination and cleaning and/or dental work necessary to maintain or improve independence, health, welfare and safety. Covers normal and customary charges for hearing aids and related services.		$4,000
Transportation (Pre and Post-Transition)	Goods & Services	This service assists participants with transportation needed to gain access to community activities, services and resources (i.e. housing). This service is used when other forms of transportation are not otherwise available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services		$500
Specialized Medical Supplies	Goods & Services	This service includes various specialized medical supplies that enable TMH participants to maintain or improve independence, health, welfare and safety and reduce dependence on the physical support needed from others. The service includes incontinence items, food supplements, special clothing, bed wetting protective chucks, diabetic supplies and other supplies that are identified in the approved Transition Plan and that are not otherwise covered by Medicaid. Ancillary supplies necessary for the proper functioning of approved supplies are also included in this service.		$1,000

Note: The total expenditures for the TMH services listed in the above table can not exceed $15,850 per TMH participant.

Supported Housing is a Supplemental Service available to some TMH participants. The service is only available for Take Me Home participants transitioning from an Institution for Mental Diseases (IMD) with a diagnosis of serious mental illness, or serious mental illness and co-occurring addiction, or serious mental illness and a co-occurring developmental disability. Supported Housing is independent housing in the community coupled with the provision of needed community mental health and support services.

Home and Community-Based Services

In addition to the services listed above, TMH participants will have access to all Medicaid home and community-based services for which they qualify when transitioning to the community. Most participants will transition from Nursing Facilities and access either the Aged & Disabled Waiver (ADW) or the Traumatic Brain Injury (TBI) Waiver program for their home and community-based services and supports. A few participants will access only State Plan Personal Care services. Participants with serious mental illness transitioning from William R. Sharpe, Jr. Hospital or Mildred Mitchell Bateman Hospital will access services through Medicaid's home and community-based behavioral health system for most of their support needs. However, it is important to note that some participants will need services from numerous home and community-based service programs to ensure a safe and successful transition home. The following sections outline many of the Medicaid home and community-based services TMH participants may utilize to promote a successful transition.

1915(c) Waivers

The Aged and Disabled Waiver (ADW) and Traumatic Brain Injury (TBI) Waiver programs are 1915(c) home and community-based waivers. Waiver services are an "optional" Medicaid service, provided as an alternative to nursing facility care. To ensure that these services are in place the first day a TMH participant returns to the community, participants must be determined both financially and medically eligible for one of these programs.

To be medically eligible for ADW and TBI Waiver services, individuals must meet the same standard required for nursing home level of care. That is, they must need hands-on assistance in at least five (5) Activities of Daily Living identified by a face-to-face assessment using the Pre-Admission Screening (PAS 2000). In addition, applicants for the TBI Waiver program must score at a Level VII or lower on the Rancho Los Amigos Cognitive Scale. For more information about West Virginia's Waiver programs, visit the Office of Home and Community-Based Services web site.

The West Virginia Medical Institute (WVMI) conducts medical eligibility assessments for individuals applying for ADW services. APS HealthCare conducts medical eligibility assessments for those applying for the TBI Waiver program. A Medical Necessity Evaluation Request (MNER) Form, signed and dated by the applicant's physician, must be submitted in order to initiate the assessment process.

MNER Forms must be submitted to WVMI for all TMH participants applying for ADW services and to APS HealthCare for those participants applying for the TBI Waiver program. Transition Navigators are responsible for submitting MNER Forms on behalf of TMH participants using the appropriate Waiver-specific Fax Cover Sheets. Use of the Waiver-specific Fax Cover Sheets is important to ensure that TMH participants are properly identified and that their request for a medical eligibility assessment and determination is appropriately processed. It is important that the MNER Form is complete, legible, dated and signed by the participant's physician.

Prior to submitting the MNER Form, Transition Navigators must review the Level of Care Informed Choice document with the participant (or their legal representative). No MNER Forms can be submitted on the participant's behalf without a review of the Level of Care Informed Choice document. The

Transition Navigator must sign and date the Level of Care Informed Choice document and place it in the participant's Master File.

The purpose of reviewing the Level of Care Informed Choice document is to provide enough information to participants to help them understand that if they are determined medically ineligible for Waiver services:

- They will no longer be eligible to participate in Take Me Home, West Virginia, and;
- Their continued eligibility for nursing home services may be jeopardized.

If the participant chooses not to request a medical eligibility determination for Waiver services, an MNER is not submitted and the Transition Navigator should consult with the TMH Office to discuss options for transition support before exploring specific options with the participant. Document these discussions in the Progress Notes.

Some TMH participants will have already been determined medically eligible for one of the Waiver programs and have a valid PAS 2000. They may:

- Have been determined medically eligible for the Aged and Disabled Waiver program and placed on the Managed Enrollment List, or;
- Be an enrolled member of either the ADW or TBI Waiver program and resided in a qualifying institution for at least 90 consecutive days.

If a TMH participant is currently on the Managed Enrollment List or is already enrolled in one of the Waiver programs, their selected Case Management Agency will be responsible for submitting the MNER for the required annual re-evaluation of medical eligibility. In either scenario, the Transition Navigator will be notified by the TMH Office. In these cases, there is no need for the Transition Navigator to submit a MNER. However, the Transition Navigator must still review the Level of Care Informed Choice document with the participant.

State Plan Personal Care

Unlike the Waiver programs, the State Plan Personal Care program does not require a nursing home level of care. To qualify for Personal Care services, participants must need assistance in three (3) activities of daily living. Medical eligibility for the Personal Care Program is assessed by Personal Care providers using the Pre-Admission Screening (PAS 2000). Based on their assessed needs, participants who qualify for Personal Care services can access up to 210 hours of hands on care each month. Personal Care providers must request prior authorization from APS Healthcare for all State Plan Personal Care Services.

Some TMH participants will require more hands on care than can be provided through the ADW and TBI Waiver programs. In these cases, members can request "dual services" from both the Waiver and State Plan Personal Care programs. The Waiver Case Manager can facilitate this process, but the request for dual services must be submitted by the Personal Care provider and approved by APS Healthcare. Visit the Office of Home and Community-Based Services web site for more information about the State Plan Personal Care program.

Home and Community-Based Behavioral Health Services

Medicaid provides a wide range of behavioral health services to support recipients in home and community-based settings. These include:

Clinic services –preventive, diagnostic, therapeutic or palliative services provided to outpatients under the direction of a physician. These services must be provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

Rehabilitation Services - medical or remedial services recommended by a physician or licensed psychologist for the purpose of reducing physical or mental disability and restoration of a member to his/her best functional level.

Targeted Case Management Services - assists certain Medicaid eligible recipients with access to needed medical, behavioral health, social, educational and other services. Targeted populations are: people with mental illness, people with substance-related disorders, people with developmental disabilities not enrolled in the I/DD Waiver program, people temporarily residing in licensed domestic violence centers, and adults over the age of 20 who are residents of long term care facilities or who need supported living arrangements. Visit the Office of Home and Community-Based Services for additional information on Medicaid reimbursed behavioral health services.

Home Health Services

Many participants transitioning from long-term care facilities will need Home Health services to help ensure a safe and successful transition. Home Health provides medically necessary and appropriate services such as skilled nursing, home health aide, physical therapy, speech therapy, occupational therapy, other therapeutic services, and nutritional services to persons in their place of residence on a part-time or intermitted basis. These services are provided by a Medicaid enrolled home health agency. For more information about Home Health services, visit the Office of Home and Community-Based Services web site.

The Olmstead Transition and Diversion Program

While not a Medicaid Home and Community-Based Service, the Olmstead Transition and Diversion program can offer support to TMH participants when TMH funds are not sufficient to meet their transition needs. The intent of the Olmstead Transition and Diversion program is to assist people with disabilities to return to or remain in their own home and community. The program is managed by the West Virginia Olmstead Office through a state funded grant. The program provides one-time start-up funding to assist people with disabilities to return to or remain in the community. The program may cover reasonable and necessary costs to support transition and diversion needs not otherwise covered by Medicaid, Medicare or other State programs. The following is a summary of what the program can cover:

- Security deposit required to obtain a lease to occupy a home;

- Essential and basic household furnishings required to occupy a home;
- Set-up fees or deposits for utility services required to occupy a home;
- Moving expenses needed to move to the community;
- Home accessibility modifications, equipment and supplies required to support the individual's disability and increase independence. Home accessibility modifications include, but are not limited to:
    - Installation of ramps or modifications to bathrooms
    - Home accessibility equipment and supplies including lift chairs, transfer boards, and shower chairs or benches
- Vehicle modifications, equipment and supplies required to support the individual's disability and increase independence;
- Health and safety needs required to occupy a home. Health and safety needs include, but are not limited to: pest eradication and cleaning.

Funding is capped or limited to $2,000.00 per participant. The funding cap may be waived when other resources are obtained or leveraged. For more information about the Olmstead Transition and Diversion program, visit the Olmstead Office web site.

THE TRANSITION PROCESS

The Transition Navigator

The transition process requires the collaboration and coordination of many "moving parts" all of which must fall into place on or immediately before transition day; all focused on meeting the individual needs, desires, and goals of the TMH participant. The Transition Navigator is not only the catalyst for this coordination and collaboration, but is the glue that holds it all together!

TMH Transition Navigators work one-on-one with eligible participants and their Transition Teams to plan and facilitate the transition process. Transition Navigators:

- Conduct Interviews to share information about the program and collect information needed to determine eligibility;
- Assess transition and community support needs (including risk factors that may jeopardize a successful transition to the community);
- Develop a written Transition Plan (incorporates specific services to meet identified transition needs, as well as, the home and community-based services and supports the participant will need once they return to the community);
- Conduct a Risk Analysis and develop a written Risk Mitigation Plan (to address and monitor all identified risks that may jeopardize the participant's successful transition);
- Arrange and facilitate the delivery of needed TMH demonstration and supplemental services (including utility and security deposits, basic furnishings, initial food supplies, accessibility modifications, etc.), and;
- Monitor the implementation of the Transition and Risk Mitigation Plans and arrange any necessary additional TMH services (up to 365 days post-transition).

The Transition Team

The transition process belongs to and must always be driven by the TMH participant. However, many individuals can contribute to a safe and successful transition. It is the responsibility of the Transition Navigator, working with the participant, to identify individuals that need to participate in the process and to organize the Transition Team.

Each Transition Team will be unique to the TMH participant and should include the people who can provide input and support to the participant during the transition process. At a minimum, the Transition Team should include the participant, the Transition Navigator, the facility social worker and the home and community-based service providers (once identified). The participant may also want to include family members and friends that are important to their successful transition to the community. Other facility staff may also be included on the Transition Team depending on participant needs and wishes. These may include, but are not limited to, medical staff, therapists, and dieticians.

While individual team members will play varying roles throughout the transition process, it is recommended that the entire Team meet regularly throughout the process to facilitate communication and address issues as they arise. At a minimum, the entire Team should meet:

- As soon as the resident has consented to participate in the Program - to answer questions and clarify expectations about the process, and to begin gathering information about participant needs and potential risks to a successful and safe transition;
- Prior to the development of the Transition Plan - to provide an opportunity to review all assessed needs and identified risks, as well as to begin the discussion about service options and potential mitigation strategies, and;
- Immediately prior to transition day - to ensure that the entire Team is familiar with and supports the participant's Transition Plan and to address any last minute or unresolved issues.

The Transition Navigator Progress Note should be used to document all issues discussed and decisions made during these meetings.

Legal Representatives

When reference is made to "participant" in this manual, it also includes any person who may, under State law, act on the participant's behalf when the participant is unable to act for himself or herself. That person is referred to as the participant's legal representative. There are various types of legal representatives, including but not limited to, guardians, conservators, power of attorney representatives, health care surrogates and representative payees. Each type of legal representative has a different scope of decision-making authority. For example, a court-appointed conservator might have the power to make financial decisions, but not health care decisions. The Navigator should verify that a representative has the necessary authority and obtain copies of supporting documentation, e.g., court orders or power of attorney documents, for the participant's file. The TMH office should be contacted if there any questions about a legal representative's authority.

Legal representatives must always be consulted for decisions within their scope of authority. However, contact with or input from the legal representative should not replace contact and communication with the participant. If the participant can understand the situation and express a preference, the participant should be kept informed and his/her wishes respected to the degree practicable.

Referrals

All referrals to the Take Me Home, West Virginia Program are initially processed by regional Aging and Disability Resource Center (ADRC) staff to determine if a person is "likely" eligible to participate in the program. Referrals can be submitted to the ADRCs in writing using the Take Me Home, West Virginia Interest Form or by contacting the ADRC by phone.

Upon receiving a referral from a resident (or a resident's legal representative), ADRC staff will:

- Complete an ADRC Transition Referral form along with the HCBS pre-screen;
- Contact the social worker from the facility to verify the information provided by the resident (or their legal representative);
- If the resident is likely eligible to participate in TMH, notify the resident in writing and send copies of the notification letter to the nursing facility social worker and the Transition Navigator. Copies of the completed Transition Referral Form and HCBS pre-screen will also be sent to the Transition Navigator and the TMH Office;
- If the resident is determined not likely eligible for TMH participation, notify the resident in writing and send copies of the notification letter to the nursing facility social worker;
- Discuss other options and resources to support transitioning to the community if the resident wishes.

If the referral is made by facility staff, ADRC staff will:

- Complete an ADRC Transition Referral Form along with the HCBS pre-screen;
- Contact the resident to confirm their interest in participating in Take Me Home, West Virginia;
- If the resident confirms interest in participating in TMH, verify the information provided by the facility staff;
- If the resident is likely eligible to participate in TMH, notify the resident in writing and send copies of the notification letter to the nursing facility social worker and the Transition Navigator. Copies of the completed Transition Referral Form and HCBS pre-screen will also be sent to the Transition Navigator and the TMH Office;
- If the resident is determined not likely eligible for TMH participation, notify the resident in writing and send copies of the notification letter to the nursing facility social worker;
- Offer to discuss other options and resources to support transitioning to the community if the resident wishes.

If the referral comes from any other party (e.g., an HCBS provider), the ADRC staff will:

- Contact the facility to determine if the resident has capacity and, if not, obtain contact information for the resident's legal representative;
- Contact the resident to confirm their interest in participating in Take Me Home, West Virginia;

- If the resident confirms interest in participating in TMH, complete an ADRC Transition Referral form along with the HCBS pre-screen;
- Contact a social worker from the facility to verify the information provided by the resident;
- If the resident is likely eligible to participate in TMH, notify the resident in writing and send copies of the notification letter to the nursing facility social worker and the Transition Navigator. Copies of the completed Transition Referral Form and HCBS pre-screen will also be sent to the Transition Navigator and the TMH Office;
- If the resident is determined not likely eligible for TMH participation, notify the resident in writing and copy the facility social worker;
- Discuss other options and resources to support transitioning to the community if the resident wishes.

Initial Contact and Monthly Status Reports

Residents referred to TMH are understandably anxious to move forward with their decision to explore options and transition from the facility to their own home in the community. Once a Transition Navigator receives a referral, it is important to initiate contact quickly and maintain regular communication with the participant and their Transition Team throughout the entire transition process. Initial contact with the resident should be made within three (3) business days of receiving the referral from the ADRC. The purpose of this initial contact is for Transition Navigators to introduce themselves, confirm that the resident is interested in participating in Take Me Home, West Virginia and if possible, schedule the Intake Interview. The Intake Interview should be conducted within seven (7) calendar days of the initial contact.

For those who are determined eligible and choose to participate in TMH, ongoing communication is important, not just for the participant, but for the entire Transition Team supporting the participant's return to the community. (See the Transition Team section for instructions on when to assemble the transition team and who should be involved.). The Monthly Status Report can be an effective tool in promoting good communication. The Transition Navigator is required to complete this report each month for every TMH participant who has consented to participate in TMH but has not yet transitioned to the community. The report must be Emailed to the participant in care of the facility's social worker or advocate (if applicable). Copies of the report must be Emailed to the TMH Office and to the Regional Ombudsman if they have been involved in the transition process.

Effective communication is Critical throughout the transition process!

The Intake Interview

The Intake Interview is the first face-to-face meeting the Transition Navigator will have with the resident. The Intake Interview should be conducted within seven (7) calendar days following the initial phone contact from the Transition Navigator to the resident. The purpose of the Intake Interview is to:

- Introduce the Take Me Home, West Virginia program to the resident;
- Discuss the resident's interest in and potential for transitioning to the community within a six (6) month period, and;

- Gather the information necessary for the Take Me Home, West Virginia Director to determine if a resident is eligible to participate in the program. (The Transition Navigator should explain that none of the information collected on the Intake Form will be used to establish eligibility for Medicaid or Medicaid services.)

The Transition Navigator should explain that Take Me Home, West Virginia is a demonstration initiative sponsored by the federal Centers for Medicare and Medicaid Services (CMS) and that:

- The purpose of Take Me Home, West Virginia is to assist eligible participants with transitioning from facility-based living to their own homes and communities;
- Participation in Take Me Home, West Virginia is completely voluntary;
- If they are determined eligible and decide to participate in the Take Me Home, West Virginia program, they can withdraw at any time;
- If they decide not to participate in the program, they will continue to be eligible for any Medicaid state plan or waiver services for which they qualify;
- If they are determined eligible and decide to participate in Take Me Home, West Virginia, they will have access to Take Me Home, West Virginia services and supports to help them successfully transition to the community. These demonstration services will be available for up to 365 days after they transition;
- Take Me Home, West Virginia demonstration services will not be available to them after the 365 day eligibility period;
- They must be eligible for and access services from the Medicaid Aged and Disabled Waiver program, the Medicaid Traumatic Brain Injury Waiver program, the State Plan Personal Care program, or the Bureau for Behavioral Health and Health Facilities Supported Housing service when they transition to the community, and;
- If they lose eligibility for Medicaid, eligibility for Medicaid home and community-based services, or decide to move to a residence that is not a qualified residence, they will no longer be eligible to participate in the Take Me Home, West Virginia program.

The Transition Navigator should review the Take Me Home, West Virginia eligibility requirements with the resident and explain that, in order to qualify for the program, individuals must:

- Have resided in a qualifying institution for at least 90 consecutive days (excluding Medicare rehabilitation days) prior to transitioning, and;
- Have received Medicaid benefits for the last day of inpatient services prior to transition, and;
- Qualify for the home and community-based services and supports they need for a safe and successful transition to the community, and;
- Choose to move to a “qualified residence.”

Explain that a qualified residence is:

- A person’s own home
- A person’s family’s home
- A person’s own apartment, or
- Certain group homes with 4 or fewer people

Stress that:

- They are under no obligation to move;
- They do not need to make a decision at this time;
- If they need more information, the Transition Navigator will help them explore their options, and;
- Family members and friends can be involved in the transition process if they wish.

Review the transition process and the role of the Transition Navigator. If they are determined eligible and decide to participate in the program, explain that the Transition Navigator will:

- Review with them and have them sign the Informed Consent Form;
- Work with them (and anyone else they choose) to assess what they will need to transition out of the facility and successfully live in their own home;
- Work with them and the facility to develop a comprehensive Transition Plan that outlines the specific services and supports they will need to successfully transition to the community;
- Oversee the delivery of the services and supports included on the Transition Plan, and;
- Follow-up with them for 365 days after transition to help address any problems.

Explain to the resident that Transition Navigator support is only available for 180 days prior to transitioning to the community. If the resident hasn't transitioned home in 180 days, their case may be closed. Explain that they can reapply to participate in Take Me Home, West Virginia at a later date. Further participation in the program, however, will depend on the determination of whether there is a reasonable expectation that they can safely and successfully transition to the community within a 180 day period.

If the resident chooses to proceed, have them sign the Protected Health Information Authorization form and obtain a copy of the resident's face sheet from the Nursing Facility. In addition, review the Informed Consent Form with them and give them the opportunity to sign the form. (It is important to note that the resident can choose not to sign the Informed Consent Form at this point if they need additional time to consider their decision.)

All items in sections A through F of the Intake Form must be addressed. Email the completed Intake Form to the TMH Office at TakeMeHome@wv.gov. At the same time, Email scanned copies of the signed and dated Protected Health Information Authorization Form, the face sheet from the participant's medical chart, and the Informed Consent Form (if the resident chose to sign it at the conclusion of the interview) to the TMH Office using the Email above or fax copies of these documents to (304) 957-7508.

The Transition Navigator must keep the original signed Intake, Informed Consent and Protected Health Information Authorization forms and a copy of the face sheet in the participant's electronic Master File.

When an eligibility determination is made, the Intake Form with Section G completed and signed by the TMH Director (or designee) will be returned to the Transition Navigator. The Transition Navigator must sign and date the returned Intake Form and place it in the participant's Master File.

If a resident is determined ineligible to participate in Take Me Home, West Virginia, notification of this determination and information regarding their rights to a Fair Hearing will be mailed to them in the facility.

Informed Consent and Protected Health Information Authorization (PHIA)

Review the Informed Consent Form with each resident (or their legal representative) at the conclusion of the Intake Interview and address any questions or concerns they may have before requesting their signature. Residents are not required to sign the Informed Consent Form at this point. Those wishing to take more time to consider whether or not to participate in Take Me Home, West Virginia must be given this opportunity.

The signed and dated Informed Consent Form must be Emailed or faxed to the TMH Office at TakeMeHome@wv.gov within two business days from the date of signature. NOTE: The Informed Consent Form must be signed and submitted even if the resident declines participation in Take Me Home, West Virginia. If the Transition Navigator is unable to obtain the signature on the Consent Form and it is obvious that the resident cannot or chooses not to participate in the program, the Transition Navigator must Email documentation of this to the Assistant Director at Brian.L.Holstine@WV.gov.

During the Intake Interview, review the Protected Health Information Authorization with each resident and address any questions or concerns before requesting a signature. If at the conclusion of the Intake Interview, the resident decides not to participate in the Program, there is no need to have the PHIA form signed.

The signed and dated PHIA form, along with the Informed Consent form, must be Emailed or faxed to the TMH Office at TakeMeHome@wv.gov when submitting the Intake Form and face sheet.

Both the signed and dated Informed Consent Form and the signed and dated PHIA Form must be maintained in the participant's Master File.

Assessing Participant Needs

The most critical step in the transition process is a comprehensive assessment of the participant's transition and community support needs. An assessment is not a single meeting, but rather a process that allows the participant to develop a relationship with the Transition Navigator and trust in the transition process. The assessment consists of face-to-face meetings with the participant; review of medical records; and interviews with facility staff, family, and others.

The purpose of the assessment is to identify the participant's strengths, abilities, wishes and needs in order to promote a successful return to the community. Information gathered during the assessment is critical to the development of the participant's Transition Plan which details the specific services and supports needed for a successful return to the community.

The Transition Assessment Tool consists of eight components:

- Background & Advocacy;
- Housing;
- Physical & Mental Health;
- Daily Living-Personal Assistance-Assistive Technology;
- Transportation;

- Social-Faith-Recreation;
- Employment-Volunteerism, and;
- Financial & Personal Resource Management.

Information necessary to complete the assessment may be obtained directly from the participant, the participant's representative, the participant's family, facility staff, and/or the resident file.

Address each item thoroughly. If anything is checked "yes" and has a corresponding "notes" section, use this section to elaborate. No items are to be left blank.

Submit the Assessment Tool, along with the Transition Plan, Risk Analysis and Mitigation Tool, 24-Hour Emergency Backup Plan, and Budget Worksheet to the TMH Office at TakeMeHome@wv.gov no later than thirty (30) days prior to the anticipated transition date.

A copy of the completed Assessment Tool must be maintained in the participant's Master File.

Risk Analysis and Mitigation

A crucial step in the assessment process is the comprehensive analysis of risks to a successful transition. A risk analysis is not a "one time" proposition, but rather a process by which the analysis of risk and the development of risk mitigation strategies are continually revisited.

Section A of the Risk Analysis and Mitigation Tool allows the Transition Navigator to identify specific risks to a successful transition. The areas include:

- Health, Medical & Nutrition
- ADLs and Safety
- Behavioral and Lifestyle
- Medications
- Home and Informal Supports
- Other Possible Risks

Much of the information necessary to complete this section will come from the Transition Assessment Tool, the participant's facility records and the Pre-Admission Screening (PAS 2000 if applicable). However, discussions with the participant, their family, their representatives, and staff from the facility are also essential to identify potential risk factors.

In Section B of the Risk Analysis and Mitigation Tool, the Transition Navigator must evaluate and document the frequency and severity of the potential outcome for each risk factor identified in Section A. To complete the severity of outcome column, indicate the likelihood of the risk to cause harm to the participant's health and welfare using the scale provided. To complete the frequency of risk column, indicate how often this risk may affect the participant. Finally, indicate whether the identified risk could jeopardize the participant's Home and Community Based Services (Aged and Disabled Waiver, Traumatic Brain Injury Waiver, State Plan Personal Care program, etc.) by placing a simple yes or no in the appropriate column. For example, if the identified risk is history of inappropriate sexual behavior, this could jeopardize the HCBS services as the provider agency may refuse to provide in-home services because it could pose a health and safety risk to their staff.

In Section C of the Risk Analysis and Mitigation Tool, the Transition Navigator should develop risk mitigation strategies for each identified risk factor using the questions provided in each column as a framework. Be as specific as possible.

In Section D of the Risk Analysis and Mitigation Tool, the Transition Navigator must identify individuals who are engaged in the transition process and who will have knowledge of how the participant can be contacted in the event the Transition Navigator is unable to contact the participant.

The participant must agree to all risk mitigation strategies prior to submission to the TMH Office. The Transition Navigator must submit the Risk Analysis and Mitigation Tool, along with the Transition Plan, Assessment Tool, 24-Hour Emergency Backup Plan, and Budget Worksheet to the TMH Office at TakeMeHome@wv.gov, no later than thirty (30) days prior to the anticipated transition date. Once approved, the participant and Transition Navigator must sign and date the finalized Risk Analysis and Mitigation Tool which must be maintained in the participant's Master File.

Once the participant has returned home, the Risk Analysis and Mitigation Tool should be revisited at least monthly during regular contacts to ensure that risks are being effectively mitigated and no new risks are present.

The Transition Navigator can make adjustments to the plan at any time as needed. All amendments to the Risk Analysis and Mitigation Tool must be submitted to the TMH Office. Amendments must be signed and dated by the participant and Transition Navigator and maintained in the participant's Master File.

24-Hour Emergency Backup Plan

The purpose of the 24-Hour Emergency Backup Plan is to ensure that critical services and supports are provided to safeguard participant health and safety whenever there is a breakdown in the delivery of planned services. There are four categories of critical services and supports that must be addressed in the Emergency Backup Plan:

- Direct-Care Assistance (For example, in-home services and supports)
- Critical Health-Supportive Services (For example, IV therapy and wound care)
- Equipment-Maintenance (For example, oxygen supply)
- Transportation (For example, dialysis appointments)

For each category, information must be provided on the four required levels of backup support:

- Level 1 - Formal Support (Include provider name and telephone number)
- Level 2 – Informal Support (Include names and telephone numbers)
- Level 3 – Personal Emergency Response System (Include access information/instructions)
- Level 4 – Extreme Emergency (911)

The participant must agree to the 24-Hour Emergency Backup Plan prior to submission. The Transition Navigator will submit the 24-Hour Emergency Backup Plan, along with the Risk Analysis and Mitigation

Tool, Assessment Tool, Transition Plan, and Budget Worksheet to the TMH Office at TakeMeHome@wv.gov no later than thirty (30) days prior to the anticipated transition date. Once approved, the participant and Transition Navigator must sign the Plan, which must be maintained in the participant's Master File.

The participant must notify the Transition Navigator when the 24-Hour Emergency Backup Plan is utilized. The Transition Navigator must then complete and submit the 24-Hour Emergency Backup Utilization Form to the TMH Office at TakeMeHome@WV.gov. The Transition Navigator will inquire during monthly contacts whether the 24-Hour Emergency Backup Plan has been utilized and make adjustments, as needed.

All amendments to the 24-Hour Emergency Backup Plan must be submitted to the TMH Office. A signed and dated copy of all amendments must be maintained in the participant's Master File.

The Transition Navigator must Email the TMH Office at TakeMeHome@wv.gov Attn: Assistant Director, immediately upon learning that the 24-Hour Emergency Backup Plan is utilized and attach the 24-Hour Emergency Backup Plan Utilization Form that documents the event.

The Transition Plan

The purpose of the Transition Planning Tool is to identify services and supports needed by the participant to safely transition from the facility and successfully live in their own home and community. The sections of the Planning Tool correspond with the sections of the Transition Assessment Tool. Each need identified on the Transition Assessment Tool must be fully addressed on the Transition Plan.

The Transition Planning Tool includes:

- What needs to be done to Address Identified Needs? – Identify the action steps to be taken in addressing each need. For example, every participant will need to have in-home supports established and in place the first day they transition. Some of the action steps required to arrange in-home supports will likely include:
    - Submission of MNER
    - Selection of agencies
    - Completion of the service plan
    - Requests for extended direct care, if needed, and
    - Verification on a continual basis that the service plan is meeting the participant's needs

- Who is Responsible? – Identify the individual who has primary responsibility for arranging, implementing and/or monitoring the completion of each action step. For example, while the submission of the MNER to the appropriate Waiver Office is the responsibility of the Transition Navigator, selecting the direct-care service provider is the responsibility of the participant, and developing the Waiver Service Plan is the primary responsibility of the selected Case Management Agency. Monitoring and ensuring the completion of each step are the responsibility of the Transition Navigator.

- By When? – Indicate when each action step is to be completed. Give projected dates based upon the anticipated transition date. If the transition date cannot be projected, it will be easier

to use benchmarks. For example, completion of the service plan by the case manager should be done approximately "2-4 weeks prior to transition."

- Will TMH Funds be requested? – Indicate a simple yes or no as to whether TMH Funds will be requested and the category of service (i.e., Community Transition Service, Goods & Services, or Care Supports). Specific items with estimated costs for the TMH funds being requested should be indicated on the Budget Worksheet and attached and submitted with the Transition Plan. The Transition Navigator must also indicate whether Extended Direct Care Services are being requested. If so, the Transition Navigator must contact the TMH Assistant Director for technical assistance, approval, and authorization.
- Date Completed – Indicate the exact date when each step is completed. Throughout the process, the Transition Navigator will need to continually update the Transition Plan to fill in the dates as each step is completed.

NOTE: If there are identified needs not otherwise addressed within the Transition Planning Tool, the Transition Navigator can use the Other field(s) available.

Review the Transition Plan and Budget Worksheet with the participant and their entire Transition Team prior to submission to the TMH Office. Submit the plan and Budget Worksheet along with the Transition Assessment Tool, Risk Analysis and Mitigation Tool, and 24-Hour Emergency Backup Plan to the TMH Office at TakeMeHome@wv.gov, for review and approval no later than thirty (30) days prior to the anticipated transition date.

When submitting the Transition Plan, indicate the anticipated date of transition. If the exact date is not known, give a general indication of when the transition will occur (e.g., by the end of November).

Once the plan has been approved by the TMH Office, the Transition Navigator and participant must sign and date the plan. The plan can be approved and signed prior to entering "date completed" for specific action steps, however, the Transition Navigator must enter dates as each step is completed.

Amendments to an approved Transition Plan must be submitted and approved by the TMH Office when substantive changes to the plan are necessary. Generally, a substantive change to the plan will include a change in the participant's needs and/or services. For example, a change in the desired type of housing would likely require additional services. If a participant expected to move in with family but now has decided to find his or her own apartment, it is likely that help will be needed to locate affordable and accessible housing, initial food supply, essential household items, utility deposits, etc. The Transition Plan would need to be amended to incorporate these additional services.

Another substantive change that would require an amendment to an approved Plan might be if an additional need is identified. For example, if at some point after the Transition Plan has been approved, it becomes evident that behavioral health services are needed to ensure a successful and safe transition, the plan will need to be amended to include these services and supports. In this scenario, it is likely that the Risk Analysis and Mitigation Plan will also need to be amended and submitted with the Plan amendment.

When is it not necessary to amend an approved Plan? If the TMH Office has approved "Essential Household Items" as part of a participant's Transition Plan, the plan does not need to be amended if the participant determines that they now need a complete set of pots and pans. The Transition Navigator

will need to verify that there are adequate funds to purchase the item, submit a Supplemental Fund request with the appropriate documentation and then update the Budget Worksheet to reflect the additional costs.

The signed and dated Transition Plan and up-to-date Budget Worksheet must be maintained in the participant's Master File. All amendments to the Transition Plan must be approved by the TMH Office. A signed and dated copy of those amendments must also be maintained in the participant's Master File.

The Home Visit and Housing Checklist

As soon as a participant has selected housing, the Transition Navigator and Housing Coordinator, if requested, should visit the location to verify that it not only meets the standards of a qualified residence under the program guidelines, but also accommodates the participant's accessibility needs. The Transition Navigator should consider inviting the Occupational Therapist and/or Physical Therapist from the nursing facility to participate in the home visit. The Housing Checklist must be completed when the Transition Navigator conducts the home visit.

In Section A of the Housing Checklist, the Transition Navigator will indicate the type of housing, identify the address, and indicate whether the participant will live alone or with family at the residence.

If the identified housing is an apartment, the Transition Navigator must answer the questions in Section B of the Housing Checklist and indicate the property name (if an apartment complex or other named property), the name of the property manager or landlord, and a contact number for that property manager. The Transition Navigator must answer each of the 9 questions. Use the "notes" section to provide more detail, explain processes or lease provisions that may seem irregular and, in the case of a notice of absence listed in the lease agreement, describe the provisions and process for notification of absences. This information may be gathered from the participant, through review of a copy of the standard lease agreement for that property, or by asking questions of the property manager or landlord.

For all types of residences, the Transition Navigator must fill out sections C and D of the Housing Checklist. Section C asks whether or not the home meets the accessibility needs of the participant. Obviously, the participant's accessibility needs may be different from the accessibility needs of other participants, therefore it is important for the Transition Navigator (and Housing Coordinator, if assisting in the home visit) to consider the needs of the individual when walking through the home. The Transition Navigator should consider things like (this is not an all-inclusive list):

- Whether the participant can gain access to the home;
- Whether the participant can access needed community supports (such as doctor's offices) and desired community activities (such as movie theaters, restaurants, etc.);
- Whether the participant has access to and can maneuver around living area, bathrooms, bedrooms, and the kitchen;
- Whether the participant can access light switches, outlets, countertops, stove controls, thermostats, and any other necessary environmental controls throughout the home;
- Whether the furniture, if any, suits the needs of the participant, and;
- Whether the participant would be able to reach all items and storage areas they will need to access on a regular basis.

If those needs are not met, the Transition Navigator should indicate possible modifications that could be made to the home and/or recommend assistive devices to meet the participant's needs.

NOTE: In the case of rental units, the participant may need a reasonable accommodation (a change to the regular processes set forth by management) or a reasonable modification (a change to the physical structure of the property – such as installation of grab bars, the addition of a ramp, widening of doorways, etc.).

In Section D of the Housing Checklist, the Transition Navigator should indicate whether there are issues in the unit that pose a risk to the health and safety of the participant. This could include serious problems such as exposed wiring or leaking pipes. It could also include other risks. For example, the presence of throw rugs could cause a risk to a person with mobility and balance issues. Indicate in the box provided how those risks might be mitigated or addressed through modifications or services.

Use the Additional Comments box in Section E of the Housing Checklist to describe any concerns or issues not otherwise addressed elsewhere in the document. The Transition Navigator must indicate whether or not a follow-up is necessary. Any modifications should be reflected on the Transition Plan and a follow-up visit should be conducted once modifications are complete.

Submit the signed and dated Housing Checklist to the TMH Office at TakeMeHome@wv.gov, within two (2) business days of the home visit. The Housing Checklist should be submitted as soon as it has been completed, but no later than thirty (30) days before the anticipated transition date when the Transition Plan is due. Please note that no TMH funds can be released for housing related costs prior to the submission of the Housing Checklist. The completed Housing Checklist must be maintained in the participant's Master File.

The Transition Checklist

The purpose of the Transition Checklist is to confirm that all required and necessary components of the Transition Plan are in place at the time the participant leaves the facility. The checklist is not intended to be used only on the day of transition. It should be used and constantly updated by the Transition Navigator to ensure that all essential services and supports are, or will be, in place the day the participant leaves the facility. The Transition Navigator should review the Transition Checklist with the entire Transition Team immediately prior to the participant transitioning home.

The Transition Navigator must confirm that rent and utility deposits have been paid, essential DME orders have been written and submitted, essential household items have been identified and will be in place, arrangements have been made for the purchase and delivery of initial food supply, the participant has been enrolled in one of the Waiver programs and that services will be in place when the participant returns home, etc. Other services and supports not essential to have in place transition day must be noted as "in progress" on the Transition Checklist.

The signed and dated Checklist needs to be submitted to the TMH Office at TakeMeHome@wv.gov or via fax at (304) 957-7508, within two (2) business days of the participant's transition. The signed and dated Transition Day Checklist must be maintained in the participant's Master File.

Congratulations! The TMH Participant Has Returned Home

Transition Navigators are responsible for monitoring each TMH participant for 365 days after transition. Regularly scheduled face-to-face meetings and telephone calls are required.

Required Contacts

- Three days - telephone
- One week - face-to-face
- One month - face-to-face
- Two months – telephone
- Three months - face-to-face
- Four months – telephone
- Five months – telephone
- Six months - face-to-face
- Seven months – telephone
- Eight months – telephone
- Nine months - face-to-face
- Ten months – telephone
- Eleven months – telephone
- Twelve months - telephone

Contact is to be made directly with the TMH participant. If direct contact with the participant cannot be made within one week of the scheduled contact, the Assistant Director must be informed via Email at Brian.L.Holstine@WV.gov.

During the 9 month face-to-face meeting, it is important to initiate the discussion with the participant concerning the "phase-out" of the Take Me Home, West Virginia Program. If at all possible, the participant's Case Manager should be involved in this meeting. The Transition Navigator should:

- Clarify that Take Me Home, West Virginia services and supports will not be available after the participant has successfully lived in the community for 365 days;
- Explain that the participant will continue to receive all Medicaid home and community-based services for which they qualify after their participation in TMH;
- Explore any immediate service or support needs that need to be addressed prior to the participant's successful completion of 365 days in the community;
- Explore any issues or concerns the participant may have with service and support needs following their participation in the TMH Program.

The Contact Form

A Contact Form must be completed for each regularly scheduled contact, whether it be face-to-face or by phone. Each contact attempt must be documented in the "Comments" section at the bottom of the form. All Contact Form questions must be addressed. (If the participant answers "yes" to Number 4 on the Contact Form, the Transition Navigator must complete the 24-Hour Emergency Backup Plan Utilization Form. If the participant answers "yes" to Number 5 on the Contact Form, and the participant

have at least one (1) overnight stay in a qualifying institution, then the Transition Navigator is to complete the Re-institutionalization Form. The 24-Hour Emergency Backup Plan Utilization Form and Re-institutionalization Form must be submitted to the TMH Office at TakeMeHome@WV.gov Attn: Assistant Director.) No items are to be left blank. Completed and signed Contact Forms must be maintained in the participant's Master File.

Suspended Activity

Transitioning from facility-based living to one's own home in the community can present numerous challenges for the participant as well as the Transition Navigator. There are times when these challenges result in an impasse and the transition process stalls. An impasse may result from:

- The inability or unwillingness of a participant to commit to or engage in the transition process, or;
- The inability of the Transition Navigator and the participant to identify effective strategies to meet support needs or mitigate risks to a safe and successful transition.

The following procedure is to be followed when it becomes evident that the transition process for a TMH participant has reached an impasse. It is assumed that the Transition Navigator has already discussed the impasse with the participant. This procedure may be initiated by the Transition Navigator or by the TMH Office:

- The TMH Office and Transition Navigator will discuss the case fully, the impasse that has presented itself, and brainstorm options for the possibility of continuing the transition process.
- The Transition Navigator will then have an open discussion with the participant regarding the impasse and present any additional options (if any) identified in the consultation with the TMH Office for continuing the process.
- If, based on the discussion with the participant, the Transition Navigator affirms that there are no viable options for moving forward, they will contact the TMH Office to formally request that the case be placed in Suspended Activity status.
- If in agreement, the TMH Office will notify the Transition Navigator in writing that they may suspend case activity.
- The Transition Navigator will provide written notification to the participant, the facility social worker, and the case manager and direct-care agency, if involved, that the transition activity on the case has been suspended, including the reason for the status change. The Transition Navigator will ask the participant if s/he would like to speak with the Ombudsman.
- If the impasse is a result of a system failure to meet the needs or an inability to properly mitigate a risk, the case will be presented at the next quarterly Quality Committee meeting to brainstorm further strategies for meeting the participant's needs.
- The TMH Office will notify the state's Long-term Care Ombudsman when a case has been placed in Suspended Activity status.
- If the participant has requested referral to the Ombudsman, the appropriate Regional Ombudsman will follow-up with the participant as the participant requests (once a month for 3 months and a final contact at 6 months or as the participant directs) to discuss the participant's desire to and/or feasibility of resuming transition activity. If at any time during the follow-up period, the participant wishes to request approval to continue the transition process, the Ombudsman will notify the TMH Assistant Director if authorized by the participant to do so.

- If the participant did not request a referral to the Ombudsman, the State Ombudsman will provide the appropriate Regional Ombudsman with the names of any participant in Suspended Activity Status. The Regional Ombudsman will visit with these participants during the next quarterly monitoring visit to determine if the participant desires further contact. If the participant wishes to request approval to continue the transition process, the Ombudsman will notify the TMH Assistant Director if authorized by the participant to do so.
- If, after 6 months, transition activity has not resumed, the TMH Office may close the case.
- The TMH Office will notify the Transition Navigator and participant that the case has been closed. The participant will be informed of their hearing rights and their right to re-apply for TMH services at any time.
- The Transition Navigator will notify the facility social worker, and the case manager and direct-care agency, if involved, that the case has been closed.

DOCUMENTATION

Status Changes

In order to provide the Centers for Medicare and Medicaid Services (CMS) all required data for the Money Follows The Person Demonstration Grant, we must know when the status of TMH participants change, particularly once they have transitioned to the community. The following sections outline specific procedures the Transition Navigators must follow in reporting these changes to the TMH Office.

Re-institutionalizations

When a Take Me Home participant is readmitted into an inpatient facility for a period of time less than 30 days, the participant remains enrolled in the program. When a Take Me Home participant is readmitted into an inpatient facility for 31 days or more, the participant's eligibility for Take Me Home will be suspended. If the participant is re-institutionalized for 90 days or more, the Transition Assessment, Risk Analysis and Mitigation Plan, 24-Hour Backup Plan, and the Waiver Member Assessment Tool must be thoroughly reviewed and necessary revisions made to the Transition Plan prior to the participant's return to the community.

Following a re-institutionalization, the participant will be re-enrolled in Take Me Home. The participant will be eligible for the remaining balance of 365 days of TMH eligibility. The participant will also be eligible to use any remaining balances in their designated demonstration service resource budgets.

Take Me Home participants who complete their 365 days of post-transition participation will be disenrolled from the demonstration. If they are subsequently readmitted to an inpatient facility, they may be considered for the Take Me Home program provided they again meet the length of stay, Medicaid eligibility, age, and level of service requirements of the program.

Transition Navigators must complete a "Re-institutionalization Form" for any TMH participant who, after transitioning to the community, is readmitted for at least one overnight stay at a Nursing Home,

Hospital, or Institution for Mental Disease (IMD) or other long-term care facility. The form must be submitted to the TMH Office at TakeMeHome@WV.gov within three business days of the Transition Navigator learning of the re-institutionalization.

All fields on the form must be completed. For those fields that are not applicable, the Transition Navigator must enter an "NA". The Transition Navigator must document the name of the facility, facility type, which is categorized as Nursing Home, Hospital, "IMD" (Institution for Mental Disease) or "Other". If "Other", the Transition Navigator should indicate the facility type in the summary section. Both the Admission Date and Discharge Date must be documented. If the participant is re-institutionalized and admitted to more than one facility, with no discharge home, then the Navigator must document each facility name, facility type, and the Admission Date and Discharge Date for each facility.

The Transition Navigator must document the date the re-institutionalization was reported to them. The Transition Navigator should check only one of the reasons indicated on the form for the re-institutionalization. A detailed summary must outline why the participant was re-institutionalized and describe how the Transition Navigator learned of the re-institutionalization. The Transition Navigator must also indicate if the participant's 24 Hour Emergency Backup Plan was utilized, and if so, complete the "24 Hour Emergency Backup Utilization Form".

If the participant is still in the facility at the time the re-institutionalization is reported to the Transition Navigator, the Transition Navigator will need to complete all sections of the form except the "Returning Home" section, and submit to the TMH Office. Once the participant returns home, the Transition Navigator must then complete the "Returning Home" section of the form and resubmit it to the TMH Office with the updated information. In this section the Transition Navigator must document the date the participant returned home and check whether the participant was re-institutionalized 30 Days or Less OR 31 Days or More. The Transition Navigator must also document if any other services or equipment had to be put in place for the participant as a result of the re-institutionalization. If other services and equipment were ordered, the Navigator must document and explain what services or equipment were ordered.

In some cases the Transition Navigator may be notified of the re-institutionalization after the participant has already returned home. In this case, the Transition Navigator can complete the "Returning Home" section of the form at the time of initial submission. The Transition Navigator must sign, document their agency name, and date the form upon submission, and resubmission of the Re-institutionalization Form.

Change of Residence

Some TMH participants may choose to change residence during their first 365 days in the community. However, in order to remain eligible for the Program, their new residence must meet the Program's definition of a "qualified residence".

Ideally, the Transition Navigator will know that a participant plans to change their residence prior to the move. If so, the Transition Navigator should visit the home if at all possible to conduct a Housing Checklist. The Housing Checklist, along with a completed Change in Residence Form, must be submitted

to the TMH Housing Coordinator to verify that the new residence will qualify. If the Transition Navigator is not informed of the change prior to the move, they must conduct a Housing Checklist and complete a Change in Residence Form immediately upon learning of the move and submit the documents to the Take Me Home Housing Coordinator.

Change in HCBS Services

Take Me Home participants may make changes in their home and community-based services during their first 365 days in the community. For example, some participants will transfer from the TBI Waiver to the Aged & Disabled Waiver Program. Some may decide to direct-their services and transfer from the traditional model of Waiver services to Personal Options. Others may simply choose to change Case Management Agencies. These changes must be documented on the HCBS Program Change Form and submitted to the TMH Office at TakeMeHome@WV.gov by the Transition Navigator immediately upon learning of the change.

Progress Notes

All Transition Navigator activity on behalf of TMH participants must be documented using Transition Navigator Progress Notes. Progress Notes must be thorough, legible (if handwritten) and up-to-date. Progress Notes for each participant must be maintained in their Master File.

Closed Cases

When a Take Me Home, West Virginia participant's case is closed (after they have consented to participate in the Program), the Transition Navigator must complete and submit a Closure Form. TMH Cases may be closed either pre- or post-transition. Please mark only one reason why participation has ended and provide additional details as needed in the comments section at the bottom of the page. If "Other" is selected indicating that none of the other available options accurately reflect the reason for closure, a detailed explanation for closing the case MUST be provided in the space given.

The Closure Form, along with a copy of the participant's Master File, must be Emailed to the TMH Office at TakeMeHome@wv.gov within 5 business days of the closure date indicated on the form. Copies of requests and supporting documentation for fund disbursements need not be included in the final submission of the Master File.

Note: Transition Navigator Services provided after the date of closure cannot be reimbursed.

The Master File

Transition Navigators are required to maintain a Master File on each TMH participant. Because most TMH forms have been developed in fillable PDF, the Master File must be maintained in electronic format using the File Naming Convention provided by the TMH Office. Certain forms, such as those requiring

signatures, may be scanned in order to include them in the participant's Master File. The Master File must include all documentation related to the participant's case.

Note: Not all documentation listed throughout this manual will be used for every participant. For example, not every participant will have signed a Level of Care Informed Choice Form and many cases will be closed prior to drafting or approval of a Transition Plan.

FUND REQUESTS AND DISBURSEMENT

Throughout the transition process, the TMH participant has access to demonstration service funds to assist in establishing a safe and secure home and help promote a successful transition into the community. While most fund requests will be made using the standard process, the TMH Office and Metro Area Agency on Aging, who handles all fund disbursements, recognize the need for both supplemental and emergency requests for funds. Read the instructions below carefully, fill out the Request for Funds Form completely and correctly, and then follow the process listed for the type of fund request submitted.

Filling Out the Form

Before submission, every Request for Funds Form must include and/or indicate:

- Date of Fund Request;
- Type of Fund Request being made;
- Participant name, address, Medicaid ID number, phone number and date of birth;
- Type and amount of funds being requested;
- Current available funds that the participant has remaining before the request is filled;
- The Transition Navigator's signature and date certifying that these needs and costs have been discussed with the participant;
- The Vendor name, address, phone number, and vendor tax ID #;
- The way these funds should be disbursed – whether to the Vendor directly, to the Transition Navigator, or if, in fact, those funds have been accessed through the use of a pre-arranged credit account between Metro AAA/TMH and the vendor;
- Attach supporting documents to verify the cost of the goods and/or service for which funds have been requested. (This could include a certified register receipt, an invoice, a price guarantee, or qualified bids for work.)

Note: Only one Request for Funds Form per vendor!

Standard Fund Request Process

In the standard fund request process, the Transition Navigator has already received notification from the TMH Office that the Transition Plan and attached TMH Budget Worksheet have been approved and include the items or services for which the Transition Navigator seeks payment.

- The Transition Navigator must obtain actual costs in order to complete the Request for Funds Form. Actual costs can be obtained through the use of a vendor invoice, a certified register receipt and/or via a price guarantee wherein the company has signed to verify that it agrees to honor the current price within a set time frame in order to allow for processing of fund requests. This documentation MUST be attached to the Request for Funds Form upon submission.
- The Transition Navigator must then verify that funds are available for the item or service being requested and must indicate the current remaining balance in the participant's budget. (This balance is available on the participant's Budget Worksheet, which must be maintained in the participant's Master File.)
- The Transition Navigator will fill out the form, marking Standard at the top to indicate the submission of a Standard Fund Request. All sections must be completed and the document signed and dated by the Transition Navigator upon submission.
- The Transition Navigator will then submit a signed and dated copy of the Request for Funds Form, as well as the supporting documentation listed above, to Metro AAA via secure Email to Brenda.K.Landers@wv.gov. The Transition Navigator will copy the TMH Office.

NOTE: Any submissions that are incomplete or do not contain adequate supporting documentation will be returned to the Transition Navigator for correction and resubmission, which will delay the fund disbursement process and could compromise timeframes for price guarantees.

- Metro AAA will verify vendor qualifications, sufficient funds and adequate supporting documentation before processing. If verified and approved, a check will be sent within three (3) business days of receipt of request. Metro AAA will notify the Transition Navigator when funds have been disbursed. NOTE: Transition Navigators may request to have vendor checks sent directly to them, but they must indicate this clearly on the Request for Funds Form.
- The Transition Navigator must verify receipt of purchased items and services by the participant using the Receipt of Items & Services Form for each fund disbursement.
- Once the fund request has been processed, the Transition Navigator must update the participant's Budget Worksheet maintained in the participant's Master File.

NOTE: When a Transition Navigator's assigned charge card is used to purchase items and/or services, a Request for Funds Form must be submitted within 3 business days of the date of transaction. In these cases, it is the responsibility of the Transition Navigator to verify that there are sufficient funds to cover the request. Please ensure that goods for each participant are purchased as a separate transaction from goods purchased for any other participant. Charge accounts can only be used *prior to* the submission of a Request for Funds when the items being purchased have already been approved on a Transition Plan and Budget Worksheet. For supplemental and emergency requests, the Request for Funds Form must be submitted and approved before a charge account can be used to purchase those goods or services.

Supplemental Fund Request Process

A Supplemental Fund Request is made when the need for items and/or services is identified after a final Transition Plan and Budget Worksheet have been approved. The needed funds were not indicated on the approved Transition Plan and Budget Worksheet, but are necessary to purchase items and services to meet the participant's assessed needs.

- The Transition Navigator must obtain actual costs in order to complete the Request for Funds Form. Actual costs can be obtained through the use of a vendor invoice, a certified register receipt and/or via a price guarantee wherein the company has signed to verify that it agrees to honor the current price within a set time frame in order to allow for processing of fund requests. This documentation MUST be attached to the Request for Funds Form upon submission.
- The Transition Navigator must then verify that funds are available for the item or service being requested and must indicate the current remaining balance from the participant's budget. (This balance is available on the participant's Budget Worksheet, which must be maintained in the participant's Master File.)
- The Transition Navigator should fill out the form, marking Supplemental at the top to indicate the submission of a Supplemental Fund Request. In addition, the Transition Navigator MUST indicate a justification for the request by identifying the need(s) the item might meet and how it might help to meet that need. All other sections must also be completed and the document signed and dated by the Transition Navigator upon submission.
- The Transition Navigator should then submit a signed and dated copy of the Request for Funds Form, as well as the supporting documentation listed above, to the TMH Office at TakeMeHome@wv.gov. The Transition Navigator should NOT submit this request to Metro AAA, as the fund request has not yet been approved by the TMH Office.

NOTE: Any submissions that are incomplete or do not contain adequate supporting documentation will be returned to the Transition Navigator for correction and resubmission, which will delay the fund disbursement process and could compromise timeframes for price guarantees.

- If the TMH Office approves the use of funds, TMH will forward the request to Metro AAA with notification of approval. A copy of this approval will be sent to the Transition Navigator.
- Metro AAA will verify Vendor qualifications, sufficient funds and adequate supporting documentation before processing. If verified and approved, a check will be sent within three (3) business days of receipt of request. Metro AAA will notify the Transition Navigator when funds have been disbursed. NOTE: Transition Navigators may request to have vendor checks sent directly to them, but they must indicate this clearly on the Request for Funds Form.
- The Transition Navigator must verify receipt of purchased items and services by the participant using the Receipt of Items & Services Form for each fund disbursement.
- The Transition Navigator must update the participant's Transition Plan and Budget Worksheet maintained in the participant's Master File.

Emergency Fund Request Process

An Emergency Fund Request can be made for items or services of a time sensitive nature that need to be purchased or provided prior to the approval of a Transition Plan and Budget Worksheet.

NOTE: Emergency Fund Requests can only be approved if the Transition Navigator has already submitted an MNER for the participant (or the participant is an active waiver member or currently on the Managed Enrollment List).

- The Transition Navigator must obtain actual costs in order to complete the Request for Funds Form. Actual costs can be obtained through the use of a vendor invoice, a certified register receipt and/or via a price guarantee wherein the company has signed to verify that it agrees to honor the current price within a set time frame in order to allow for processing of fund requests. This documentation MUST be attached to the Request for Funds Form upon submission.
- The Transition Navigator must then verify that funds are available for the item or service being requested and must indicate the current balance remaining in the participant's budget. (This balance is available on the participant's Budget Worksheet, which must be maintained in the participant's Master File.)
- The Transition Navigator should fill out the form, marking Emergency at the top to indicate the submission of an Emergency Fund Request. In addition, the Transition Navigator MUST indicate a justification for the request by identifying the need(s) the item or service will address and why it is an "emergency" request. All other sections must also be completed and the document signed and dated by the Transition Navigator upon submission.
- The Transition Navigator should then submit a signed and dated copy of the Request for Funds Form, as well as the supporting documentation listed above, to the TMH Office via secure Email to TakeMeHome@wv.gov. The Transition Navigator should NOT submit this request to Metro AAA, as the fund request has not yet been approved by the TMH Office.

NOTE: Any submissions that are incomplete or do not contain adequate supporting documentation will be returned to the Transition Navigator for correction and resubmission, which will delay the fund disbursement process and could compromise timeframes for price guarantees.

- If the TMH Office approves the use of funds, the approval will be forwarded to Metro AAA with notification of approval. A copy of this approval will be sent to Transition Navigator.
- Metro AAA will verify vendor qualifications, sufficient funds and adequate supporting documentation before processing. If verified and approved, a check will be sent as soon as possible, but in no more than two (2) business days of receipt of request. Metro AAA will notify the Transition Navigator when funds have been disbursed.

NOTE: Transition Navigators may request to have vendor checks sent directly to them, but they must indicate this clearly on the Request for Funds Form.

- The Transition Navigator must verify receipt of purchased items and services by the participant using the Receipt of Items & Services Form for each fund disbursement.
- The Transition Navigator must update the participant's Transition Plan and Budget Worksheet maintained in the participant's Master File. The use of Emergency Funds should be reflected on the Transition Plan and Budget Worksheet when these documents are submitted to the TMH Office for Transition Plan review and approval.

Home and Vehicle Modifications/Requests/Requiring Bids

Only those requests requiring the work of qualified and certified vendors (contractors and licensed mechanics) require contract bids for work. This will mostly be done in the case of home modifications. The participant, with the assistance of the Transition Navigator, must obtain no less than two qualified bids for the work to be completed from certified licensed contractors and mechanics. When submitting

a request for fund disbursement on contract work, the Transition Navigator must fill out the Contract Bids section on page two of the Request for Funds Form in addition to the rest of the form and indicate the amount as well as all other necessary sections of the form. Both bids must be listed in the Contract Bids section of Request for Funds Form and an indication made (via checkmark beside the appropriate bid vendor's name) as to the participant's choice of vendor. The Transition Navigator must also provide the reason the participant has chosen this vendor to do the work.

NOTE: Fund requests for contract bid work for home and vehicle modifications should be submitted through the Standard Fund Request process. A Transition Plan should be on file detailing the need and the modification to be completed.

- The Transition Navigator must obtain actual costs in order to complete the Request for Funds Form. In the case of contract bid work, actual costs will be obtained via competing bids (no less than two) from certified and licensed contractors and mechanics qualified to do the type of work required. Both bids/estimates MUST be attached to the Request for Funds Form upon submission. In addition, the Transition Navigator must obtain proof of the selected contractor's Worker's Compensation Insurance Policy, which must be attached to the Request for Funds Form upon submission.
- The Transition Navigator must then verify that funds are available for the item or service being requested and must indicate the current balance remaining in the participant's budget (This balance is available on the participant's Budget Worksheet, which must be maintained in the participant's Master File.)
- The Transition Navigator should fill out the form, indicating a "Standard" type of request at the top of the form. In addition to completion of the form as in each process listed above, the Transition Navigator must also complete the Contract Bids section of the form on page two. The Transition Navigator will list the contractor and/or company names from both bids, will indicate the estimate from each bid, and will indicate via checkmark beside the appropriate vendor which bid the participant has selected for the contract work. In addition, the Transition Navigator must indicate the participant's reason for choosing that vendor. All other sections must also be completed and the document signed and dated by the Transition Navigator upon submission.
- The Transition Navigator should then submit a signed and dated copy of the Request for Funds Form, as well as the supporting documentation listed above to Metro AAA. Metro AAA will verify vendor/contractor qualifications for both bids, as well as the appropriateness of the reasons given for selection of the vendor by the participant. The Transition Navigator should NOT submit this request to Metro AAA if lacking vendor qualifications and Workers Compensation Insurance Policy information.

NOTE: Any submissions that are incomplete or do not contain adequate supporting documentation will be returned to the Transition Navigator for correction and resubmission, which will delay the fund disbursement process and could compromise timeframes for price guarantees.

- If Metro AAA approves the vendor qualifications and selection of the vendor, the fund request will be forwarded for disbursement.
- Metro AAA will verify sufficient funds and adequate supporting documentation before processing. If approved, a check will be sent within three (3) business days of receipt of request to cover the initial payment for the contract work. Metro AAA will notify the Transition

Navigator when funds have been disbursed. NOTE: Transition Navigators may request to have vendor checks sent directly to them, but they must indicate this clearly on the Request for Funds Form.

- The Transition Navigator must verify the completion of contracted work with the participant using the Receipt of Items & Services Form.
- Once the completion of work has been verified and the Receipt of Items & Services Form has been signed by the participant, the Transition Navigator may request the disbursement of the final payment of funds for the contract work by completing an additional Request for Funds Form and indicating "final payment" on the form. The Transition Navigator should submit this request directly to Metro AAA for processing and copy the TMH Office. The signed and dated Receipt of Items & Services form must be attached to that Request for Funds Form.
- The Transition Navigator must update the participant's Budget Worksheet maintained in the participant's master file.

ROLES OF KEY PARTNERS

Case Management

Waiver Case Managers play an integral role in the transition process by ensuring that Waiver services are in place day one of the participant's transition to the community. Take Me Home, West Virginia can reimburse Waiver providers for up to four (4) hours of Pre-Transition Case Management services. Prior to the participant's transition from the facility, Case Managers can:

- Participate in the transition assessment and planning process;
- Conduct the appropriate Waiver Member Assessment;
- Complete the required Waiver Service Plan;
- Facilitate the completion of the RN Assessment and Plan of Care by the selected Personal Attendant/Homemaker Agency (if the participant has been determined eligible for and plans to access services from the Aged and Disabled Waiver and/or State Plan Personal Care program);
- Work with the selected ADW, TBI Waiver and or Personal Care direct-care provider to ensure that services are in place for the first day the TMH participant returns home;
- Work with the TMH participant to establish or verify financial eligibility for Medicaid by facilitating the issuance of the DHS-2, and;
- Enroll the TMH participant in the Waiver program immediately prior to the participant's transition home.

Pre-Transition Case Management services must be documented by the Case Manager on the TMH Case Management Progress Note and faxed to the Transition Navigator to be maintained in the participant's Master File.

The responsibility of the Case Manager after the TMH participant has transitioned to their own home is the same as for any other Waiver member. However, because the Transition Navigator supports the participant for one year post-transition, regular and ongoing communication between the Transition Navigator and the Case Manager is important. This is particularly true if issues arise with the Risk Mitigation Plan or if there are unmet service needs that may jeopardize the successful transition.

To ensure that Aged & Disabled Waiver and/or Personal Care services are in place the first day the participant returns home, the direct-care provider agency must conduct an RN Assessment and develop a Plan of Care. Take Me Home, West Virginia reimburses Aged & Disabled Waiver and State Plan Personal Care providers (if applicable) to conduct the RN Assessment and develop the participant's Plan of Care. It is the responsibility of the ADW Case Manager and State Plan Personal Care RN (if applicable) to ensure that the assessment is completed and the Plan of Care developed.

Facility Staff

The importance of the facility in planning the transition of residents to the community cannot be understated. Facility staff, which is responsible for the resident's day-to-day care, has a thorough understanding of the resident's needs, goals and desires, as well as their strengths and challenges. Only by working together can Transition Navigators and facility staff help ensure the resident has the best chance for a successful and safe transition to the community by identifying and fully addressing all service and support needs throughout the transition process.

Discharge planning is a key responsibility of all long-term care facilities. Since most TMH participants will transition from nursing facilities to the community, this section focuses specifically on nursing home discharge planning requirements.

The nursing facility's responsibility for discharge planning is no different for TMH participants than it is for any other resident wishing to return to the community. Chapter 514 of the Nursing Facility Services of the Medicaid Provider Manual defines discharge planning as:

> "… the organized process of identifying the approximate length of stay and the criteria for exit of a resident from the current service to an appropriate setting to meet the individual's needs. Discharge planning begins upon the day of admission to the nursing facility and includes provision for appropriate follow-up services."

The Medicaid Provider Manual also states that "Before the nursing facility transfers or discharges a resident, the administrator or designee must notify the resident and/or the responsible party verbally and in writing, in a language that is understandable to the parties, of the intent and reason for transfer or discharge. The same information must be recorded in the resident's medical record and a copy of this written notice must be sent to the State Long-Term Care Ombudsman or his/her designee. Except in the case of immediate danger to the resident and/or others as documented, the notice of transfer or discharge must be provided at least 30 days prior to the anticipated move to ensure a safe and orderly discharge to a setting appropriate to the individual's needs." *Chapter 514, Nursing Facility Services, p 42.*

The West Virginia Nursing Home Licensure Rule *(W. Va. Code of State Rules, tit. 64, ser. 13, rule 7.4.b.)* requires that, when a resident is discharged to another nursing home or location or to his or her home, the nursing home shall prepare a discharge summary prior to the discharge. The summary shall be conveyed to the receiving nursing home or location at the time of discharge. The summary shall include:

- The resident's name and identifying number;
- The name of the attending physician;
- The date of admission;
- The date of discharge;
- A provisional and final diagnosis;
- The course of treatment and care in the nursing home;
- Pertinent diagnostic findings;
- Essential information regarding the resident's illness or problems;
- Restorative procedures;
- Medication instructions, and;
- The nursing home, agency or location to which the resident was discharged:

When a discharge is anticipated, a nursing home shall prepare for the resident a discharge summary that includes:

- A recapitulation of the resident's stay;
- A final summary of the resident's status, prepared at the time of the discharge, that is available for release to authorized persons and agencies with the consent of the resident or legal representative;
- Thirty (30) day notification of the discharge as appropriate and in compliance with other provisions of this rule; and
- If the resident is discharged to his or her home, the resident shall be given appropriate information concerning his or her needs for care and medications including a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

Long-term care facilities typically schedule the discharge meeting(s) with the resident, their families, and other key staff prior to discharge. This is an excellent opportunity for the Transition Navigator to review the Transition Plan, verify that all needed services and supports are in place, and address any "last minute" issues or concerns with the participant and their families, facility staff, and the home and community-based service providers that may arise. Transition Navigators should collaborate with facility discharge planners and/or social workers to plan the discharge meeting(s).

State Long-Term Care Ombudsman Program

Long-Term Care Ombudsman programs were established in each state by the Older Americans Act. The mission of the West Virginia Long-Term Care Ombudsman Program is to enhance the quality of life, improve the level of care, protect individual rights, and promote the dignity of each senior citizen and/or person with a disability, of any age, housed in a long-term care facility. Long-term care facilities include nursing homes, assisted living facilities, and other types of care homes.

Long-term care ombudsmen are not employed by the long-term care facilities. The West Virginia State Long-Term Care Ombudsman is employed by the Bureau of Senior Services, and the Bureau contracts with Legal Aid of West Virginia to conduct the day-to-day operation of the program via an Ombudsman Supervisor and nine Regional Ombudsmen.

Ombudsmen play a vital role in Take Me Home, West Virginia, particularly in supporting residents of nursing facilities wishing to transition to the community. Specifically, the Regional Ombudsman:

- Provide information about Take Me Home, West Virginia and outreach to nursing home residents, families, and staff;
- Make referrals to the Aging and Disability Resource Centers (ADRCs) from consenting residents who are interested in participating in Take Me Home, West Virginia;
- Facilitate introductions and on-going relationships between Transition Navigators and relevant nursing home staff;
- Monitor the progress of residents who are candidates for Take Me Home, West Virginia to assure nursing home staff is doing whatever is necessary and appropriate to prepare the resident for a successful transition;
- Support residents who are candidates for Take Me Home, West Virginia as they desire, to assure that their preferences and needs are heard and addressed;
- Attend discharge planning, care planning, and other multi-disciplinary team meetings, as needed, to identify needs and develop strategies for a TMH participant's successful transition;
- Investigate complaints related to Section Q referrals and related activities or reluctance on the part of nursing home staff to actively promote the right of a resident to participate in Take Me Home, West Virginia, and;
- Investigate complaints that individuals' legal guardians have opposed the Take Me Home, West Virginia participation.

Additionally, Long-Term Care Ombudsman staff:

- Participate in the Take Me Home, West Virginia Quality Improvement efforts;
- Maintain necessary data and statistical information to provide the program with quarterly reports consistent with statutory provisions relating to confidentiality and consent;
- Participate in educational and training sessions to develop knowledge and skills related to Take Me Home, West Virginia, and;
- Attend planning, team, advisory and other meetings to develop and promote the Take Me, Home, West Virginia initiative.