

**Take Me Home Transition Program**  
**Transition Coordination**  
**Procedures Manual**

Effective December 2019

## Contents

OVERVIEW.....	4
Community Transition Services .....	4
Exclusions.....	6
Home and Community-Based Services .....	6
1915(c) Waivers .....	7
State Plan Personal Care .....	8
Community-Based Behavioral Health Services .....	9
Community-Based Home Health Services .....	10
The Olmstead Transition and Diversion Program.....	10
THE TRANSITION PROCESS.....	11
Legal Representatives .....	11
The Transition Coordinator.....	12
The Transition Team .....	13
Referrals.....	13
Initial Contact.....	15
The Intake Interview .....	16
Informed Consent .....	17
Protected Health Information Authorization (PHIA) .....	18
Pre-Transition Planning and Documentation.....	18
Pre-Transition Assessment.....	18
The Risk Analysis and Mitigation Plan.....	19
The 24-Hour Emergency Backup Plan.....	20
The Transition Planning Tool.....	21
Transition Plan Amendments.....	23
Pre-Transition Case Management and Resource Consultant Support .....	23
The Housing Assessment .....	23
Monthly Status Reports .....	26
Post-Transition .....	26
Required Transition Coordinator Contacts .....	26
Documentation Requirements .....	27

Progress Notes .....	27
Case Closure .....	27
The Master File .....	28
FUND REQUESTS AND DISBURSEMENT .....	29
Filling Out the Request for Funds Form .....	29
Standard Request For Funds Process.....	30
Home and Vehicle Modifications/Requests/Requiring Bids.....	31
ROLES OF KEY PARTNERS .....	33
Case Management and Resource Consultant Services.....	33
Facility Staff.....	34
State Long-Term Care Ombudsman Program.....	35

## OVERVIEW

The Take Me Home (TMH) Transition Program is a program of the West Virginia Bureau for Medical Services (BMS). The purpose of TMH is to identify qualifying residents of long-term care facilities who wish to return to their own homes and apartments in the community and provide them the supports and services they need to do so.

Individuals wishing to transition to the community often face numerous obstacles including a lack of funds for security 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 services and supports including Transition Coordination, Pre-transition Case Management and Community Transition Services to qualified applicants.

Transition Coordination is the lynchpin of TMH. Transition Coordinators work one-on-one with TMH participants and their Transition Teams to develop person-centered transition plans and facilitate delivery of necessary services to support TMH participants' transition to the community. Pre-transition Case Management is available to members of the Aged and Disabled Waiver (ADW) and Traumatic Brain Injury Waiver (TBIW) programs to ensure that direct-care services are in place day-one of the TMH participant's return home. The Community Transition Service is a Waiver service that can cover many one-time expenses needed to establish a home in the community for TMH participants. To qualify for these services, individuals must:

- Live in a nursing facility, hospital, Institution for Mental Disease or a combination of any of the three for at least 90 consecutive days, and;
- Have been determined medically and financially eligible for either the Aged and Disabled Waiver (ADW) or Traumatic Brain Injury Waiver (TBIW) program, and;
- Wish to transition from facility-based living to their own home or apartment in the community consistent with the CMS Settings Rule (1915(I)), and;
- Have a home or apartment in the community to return to upon leaving the facility that is consistent with the CMS Settings Rule, and;
- Require Waiver transition services to safely and successfully transition to community living, and;
- Can reasonably be expected to transition safely to the community within 180 days of initial date of transition service.

### Community Transition Services

Allowable Community Transition Service expenses are those necessary to address barriers to a safe and successful transition identified through a comprehensive Transition Needs Assessment and included in an approved individualized Transition Plan. The components of the Community Transition Service include:

- Home accessibility adaptation modification - assistance to individuals requiring physical adaptations to a qualified residence. This service covers basic modifications such as ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications needed to ensure health, welfare and safety and/or to improve independence.

- Home furnishings and essential household items - assistance to individuals requiring basic household furnishings to help them transition back into the community. This service is intended to help with the initial set-up of a qualifying residence.
- Moving expenses - includes rental of a moving van/truck or the use of a moving or delivery service to move an individual'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 transition period to relocate a member.
- Security deposit - used to cover rental security deposit for a qualified residence.
- Utility deposits - used to assist individuals with required utility deposits for a qualifying residence.
- Transition support - provides assistance to help individuals with unique needs based on assessed needs and necessary for a successful transition.
- Personal Emergency Response System (PERS)- One-time payment that includes installation upon transition to the community and service for the initial transition period (one year). PERSs will be available as an option under the Waiver Community Transition Service and PERS will be provided to all TMH participants who qualify for Money Follows the Person (MFP) as a demonstration service.
- Equipment - Items and services necessary to enable individuals to interact more independently and/or reduce dependence on physical supports and enhance quality of life (e.g. Lift Chairs, bathing aids such as handheld showers, shower chairs, transfer boards and portable showers).
- Transportation - assists individuals with transportation service prior to transition in order to gain access to services and resources (i.e. food pantry) that is necessary for the transition. This service is used when other forms of transportation are not otherwise available.
- Specialized Medical Supplies - includes purchases of various specialized medical supplies that enable individuals to maintain or improve independence, health, welfare and safety and reduce dependence on the physical support needed from others. The service includes one-time purchases of incontinence items and food supplements needed as a bridge until Medicaid covers once the participant transitions home.

Services or supports that address an identified need in the Transition Plan, and decrease the need for other Medicaid Services, or increase the person's safety in the home, or improve and maintain the individual's opportunities for full membership in the community may be considered.

The total expenditures for Waiver Community Transition Services cannot exceed \$4,000 per transition period. All services or supports must be justified in the TMH Transition Plan.

## Exclusions

Community Transition Services cannot be used to cover the following items. Please note that this is not intended to be an all-inclusive list of exclusions:

- Rent;
- Home improvements or repairs that are considered regular maintenance or upkeep;
- Recreational or illegal drugs;
- Alcohol;
- Medications or prescriptions;
- Past due credit card or medical bills;
- Payments to someone to serve as a representative;
- Gifts for staff, family, or friends;
- Electronic entertainment equipment;
- Regular utility payments;
- Swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items;
- Travel;
- Vehicle expenses including routine maintenance and repairs, insurance and gas money;
- Internet service;
- Pet/Service/Support Care, including food and veterinary care;
- Experimental or prohibited treatments;
- Education;
- Personal hygiene services (manicures, pedicures, haircuts, etc.);
- Assistive Technology, or;
- Discretionary cash
- Groceries
- Appliances

Any service or support that does not address an identified need in the Transition Plan, or decrease the need for other Medicaid Services, or increase the person's safety in the home, or improve and maintain the member's opportunities for full membership in the community is excluded.

## Home and Community-Based Services

The following sections outline many of the Medicaid home and community-based services TMH participants may utilize to promote a safe and successful transition. All TMH participants must qualify for either ADW or TBIW Program (described below) to receive TMH services, but participants may qualify for additional HCBS services as well. For example, 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 many of their support needs. Please keep these additional services in mind when assessing the participant's needs during transition assessment and planning.

## 1915(c) Waivers

The Aged and Disabled Waiver (ADW) and Traumatic Brain Injury Waiver (TBIW) Programs are 1915(c) home and community-based service 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 TBIW 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 TBIW Program must score at a Level VII or lower on the Rancho Los Amigos Cognitive Scale (or Level II or higher for children assessed via the Rancho Los Amigos Pediatric Level of Consciousness Scale). For more information about West Virginia’s Waiver Programs, visit the [Office of Home and Community-Based Services](#) web site.

KEPRO conducts medical eligibility assessments for individuals applying for ADW and TBIW Program services. A complete and legible Medical Necessity Evaluation Request (MNER) Form, signed and dated by the applicant’s required medical professional(s), must be submitted in order to initiate the assessment process.

If an applicant for the TMH Transition Program has not yet been determined medically eligible for Waiver services, Transition Coordinators may facilitate the Waiver application process by submitting MNER Forms on the TMH applicant’s behalf during the pre-planning phase using the appropriate Waiver-specific Fax Cover Sheets. Use of the Waiver-specific Fax Cover Sheet is important to ensure that individuals interested in participating in TMH are properly identified and that their request for a medical eligibility assessment and determination is appropriately processed.

Prior to submitting the MNER Form, Transition Coordinators must review the Level of Care Informed Choice document with the TMH applicant or their legal representative (if applicable). The submission of MNER Forms cannot be facilitated by the Transition Coordinator without a review of the Level of Care Informed Choice document with the TMH applicant. The participant must sign and date the Level of Care Informed Choice document and it must be placed in the TMH applicant’s Master File.

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

- They will not qualify to participate in TMH, and;
- Their continued eligibility for nursing home services may be jeopardized.

If the TMH applicant chooses not to request a medical eligibility determination for Waiver services, an MNER is not submitted. The Transition Coordinator must document these discussions in the Progress Notes and close the case (see Case Closure section). The Coordinator should refer the resident back to the ADRN if they are interested in pursuing other options for transitioning to the community.

Some applicants for TMH 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 either the ADW or TBIW Program and placed on the Waiver's Managed Enrollment List, or;
- Be an enrolled member of either the ADW or TBIW Program and resided in a qualifying institution for at least 90 consecutive days.

If a TMH applicant is already enrolled in one of the Waiver programs, their selected Case Management Agency and/or Resource Consultant (if applicable) will be responsible for submitting the MNER for the required annual re-evaluation of medical eligibility as defined in the respective Waiver Provider Policy Manuals. In either scenario, the Transition Coordinator will be notified by the Transition Manager. In these cases, there is no need for the Transition Coordinator to facilitate the submission of an MNER. If, however, the enrolled member resides within the facility 180 days (and, therefore, goes 180 days without services in the community), their Waiver slot will be closed and a new MNER will need to be submitted so that the participant can be reassessed. (In this case, the Transition Coordinator should review the Informed Choice document with the participant, and have it signed for the file.)

### 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, individuals must need assistance in three (3) activities of daily living, be a resident of WV and meet Medicaid financial eligibility criteria for the program as determined by the county DHHR office. Initial and annual re-evaluations of medical eligibility for the Personal Care Program are conducted by KEPRO 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.

Some individuals require more hands-on care than can be provided through the ADW or TBIW Program. If the waiver participant has maximized their waiver services, they can request "dual services" from both the Waiver and State Plan Personal Care Programs. A Waiver Case Manager, RN, and/or Resource Consultant can facilitate this process or the PC applicant by submitting a complete and correct Initial PC-MNER to KEPRO for approval via fax or mail.

While all TMH participants must access ADW or TBIW, they may qualify for dual services immediately following their transition to the community. These additional services may be provided by any agency that provides Personal Care services to qualified individuals. The Case Manager and/or Resource Consultant should assist the individual in applying for PC dual services as soon as it becomes clear that additional services are required to provide the hands-on care needed to serve the participant.

As a Transition Coordinator, you may recognize early on in the assessment and planning process that dual services are needed for some individuals who have been assessed at the highest level of care under ADW or TBIW. On the Monthly Status Report you will note if the participant has a preferred agency to provide those services and notify the Case Manager and/or Resource Consultant as soon as they become involved so that they can anticipate the need to file a PC-MNER for the participant and notify



the preferred agency that such an application will be submitted so that they may begin to ensure they have staffing available to serve the individual.

Note: TMH participants can no longer transition from a facility with only the Personal Care Services program.

Visit the Personal Care Services Program website at <https://dhhr.wv.gov/bms/Programs/PCS/Pages/default.aspx>

for more information about the State Plan Personal Care Services Program.

### **Community-Based Behavioral Health Services**

Clinic services –preventive, diagnostic, therapeutic or palliative services provided to patients on an outpatient basis, that meet the medical necessity criteria for services. These services are provided by Community Mental Health Centers and Licensed Behavioral Health Centers in West Virginia

Rehabilitation Services - These services are provided by Community Mental Health Centers and Licensed Behavioral Health Centers and West Virginia Rehabilitation Services and cover 2 levels of care:

- **Focused Care:** Members receiving focused services have been determined to have a behavioral health disorder which may be addressed through the provision of low frequency (generally a maximum of once per week, ranging as rarely as once each six months) professional treatment services. Services are provided by a behavioral health professional with at minimum a master’s degree in a behavioral health service field, excluding Mental Health Assessment by a Non-Physician. The treatment team consists of the professional and the member and/or member’s designated legal representative who together establish a treatment strategy which is documented in the member’s record. The treatment strategy is a flexible tool guiding treatment which may consist of one or more of the following Medicaid services:
  - Medical office services (billed as E/M codes);
  - Professional Individual therapy;
  - Professional Group therapy, and;
  - Assessment and Screening codes.

The treatment strategy must relate directly to the behavioral health condition(s) identified as being medically necessary to treat. Documentation of on-going therapeutic and/or medication management contacts must relate directly to the treatment strategy.

**Coordinated Care:** Members-requiring coordinated care are those with severe and/or chronic behavioral health conditions that necessitate a team approach to providing medically necessary care. The treatment is usually provided on a more intensive basis, several times a week if not daily. A full range of individuals may be employed in providing care, ranging from paraprofessionals through psychiatrists. The treatment team consists of the personnel involved in providing the care and includes the member and the member’s guardian if any. The member is likely to have a case manager, who is responsible for coordinating and facilitating care.

Services falling under Coordinated Care may include but are not limited to the following:

- Assertive Community Treatment;
- Professional Individual Therapy;
- Professional Group Therapy;
- Crisis Stabilization and detoxification services;
- Targeted Case Management;
- Comprehensive Community Support Services;
- Basic Living Skills;
- Intensive Service Programs;
- Supportive Counseling;
- Professional therapy and medication management provided in the context of the Coordinated Care services;
- Residential Care for Children and Youth, and;
- Emergency Shelter Care.

Targeted Case Management Services - assists Medicaid eligible recipients with access to needed medical, behavioral health, social, educational and other services. Targeted populations and those meeting medical necessity for this service are: people with mental illness, people with substance-related disorders, people with developmental disabilities not enrolled in the I/DD Waiver Program (however those on the wait list for I/DD Waiver Program may access this service), 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](http://www.dhhr.wv.gov/bms/programs/pages/default.aspx) at <http://www.dhhr.wv.gov/bms/programs/pages/default.aspx> for additional information on Medicaid reimbursed behavioral health services.

Note: Targeted Case Management services provided through a behavioral health center cannot be duplicated for waiver recipients utilizing Case Management services. The Case Manager's cannot be working on the same issues.

### **Community-Based 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 intermittent basis. These services are provided by a Medicaid enrolled home health agency. Visit the [Office of Home and Community-Based Services](http://www.dhhr.wv.gov/bms/programs/pages/default.aspx) at <http://www.dhhr.wv.gov/bms/programs/pages/default.aspx> for additional information on Home Health services.

### **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 Waiver transition service funds are not enough 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, and;
  - 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, and;
- Health and safety needs required to occupy a home. Health and safety needs may include, but are not limited to, pest eradication and initial cleaning.

Funding is limited to \$2,500 per individual. The funding cap may be waived when other resources are obtained or leveraged. Visit the [Olmstead Office](https://www.wvdhhr.org/oig/olmstead.html) website at <https://www.wvdhhr.org/oig/olmstead.html> for more information on the Olmstead Transition and Diversion Program.

## THE TRANSITION PROCESS

### Legal Representatives

When reference is made to TMH "applicant" or "participant" in this manual, it also includes any person who may, under State law, act on their behalf when the applicant or participant is unable to act for himself or herself. That person is referred to as the 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 Transition Coordinator must verify that a legal representative has the necessary authority and obtain copies of supporting documentation, e.g., court orders or power of attorney documents, for the participant's Master File. The Transition Manager should be contacted if there are 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 applicant or participant. If the applicant or participant can understand the situation and express a preference, they should be kept informed and his/her wishes respected to the degree practicable.

## The Transition Coordinator

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 Coordinator is not only the catalyst for this collaboration but is the glue that holds it all together!

Transition Coordinators:

- Work one-on-one with residents and their Transition Teams;
- Accept and follow-up with referrals from the Aging & Disability Resource Network (ADRN);
- Conduct face-to-face interviews with applicants to share information about options for returning to the community, including the availability of Waiver transition services;
- Assess the resident’s readiness to begin the transition assessment and planning process;
- Assess the resident’s transition support needs, including risk factors that may jeopardize a safe and successful transition to the community;
- Facilitate the development of a Transition Team consisting of the resident, the Transition Coordinator, the Waiver Case Manager (A Case Manager is required for the TBIW, a participant on the ADW may choose to have a Case Manager or not), the Resource Consultant (for residents planning to self-direct their Waiver services), the Ombudsman (if applicable), the facility social worker and other appropriate staff and anyone else the resident chooses to include in the transition process;
- Work with the resident and his/her Transition Team to develop a written Transition Plan which incorporates specific services and supports to meet identified transition needs. (which may or may not become part of the Waiver Service Plan);
- Conduct a Risk Analysis and develop a written Risk Mitigation Plan to address and monitor all identified risks that may jeopardize the resident’s successful transition, (which will become part of the Waiver Service Plan) and;
- Arrange and facilitate the procurement and delivery of needed services and supports including, but not limited to, Waiver transition services prior to transition.;
- Conduct outreach and serve as a liaison with nursing facilities to foster effective communication with facility staff and troubleshoot any issues that may create barriers to a safe and successful transition, and;
- Work with the Case Manager and/or Resource Consultant on any identified needs 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 Coordinator, working with the resident, 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 resident during the transition process. At a minimum, the Transition Team should include the resident, the Transition Coordinator, the facility social worker and the home and community-based service providers (once identified). The resident 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 resident 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 assessment and planning 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 transition assessment and planning process begins - to answer questions and clarify expectations about the process, and to begin gathering information about resident needs and potential risks to a successful and safe transition;
- Prior to the submission of transition planning documents - 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 resident's Transition Plan and to address any last minute or unresolved issues.

The Transition Coordinator is encouraged to coordinate with facility staff for Transition Team meetings. Transition Team meetings may be conducted in conjunction with facility care plan meetings, which are conducted on a routine basis and may be requested at any time by the participant while they reside in the facility.

Members of the Transition Team, including their contact information and relationship to the resident, must be documented on the Intake Form. The Transition Coordinator Progress Note should be used to document all issues discussed and decisions made during these meetings.

## Referrals

All referrals to the TMH Transition Program are initially processed by regional Aging and Disability Resource Network (ADRN) staff. Referrals can be initiated by phone or in writing by submitting a TMH Interest Form to the ADRN.

Upon receiving a referral from a resident (or a resident's legal representative):

- The ADRN will complete an ADRN Transition Referral form along with the HCBS pre-screen;

- The ADRN will contact the social worker from the facility to verify the information provided by the resident (or their legal representative);
- The ADRN will send the referral on to the TMH Transition Coordinator if:
  - The resident currently resides in a qualifying institution, and;
  - The resident has resided in the qualifying institution for at least 60 consecutive days, and;
  - The resident has, or wishes to transition to, a home or apartment that is consistent with the CMS Settings Rule, and;
  - The resident is currently eligible, or likely eligible, for either the ADW or TBIW program.
- The ADRN will notify the resident and the nursing facility Social Worker that a referral has been made and that a Transition Coordinator will be contacting the resident to schedule an Intake Interview;
- If the referral is not appropriate for TMH, the ADRN will notify the resident in writing and send copies of the notification letter to the facility social worker;
- The ADRN is responsible for discussing other options and resources to support transitioning to the community if the resident wishes.

If a referral is made by facility staff:

- The ADRN will complete an ADRN Transition Referral Form along with the HCBS pre-screen;
- The ADRN will contact the resident to confirm their interest in participating in TMH;
- If the resident confirms interest in participating in TMH, the ADRN will verify the information provided by the facility staff;
- The ADRN will send the referral on to the TMH Transition Coordinator if:
  - The resident currently resides in a qualifying institution;
  - The resident has resided in the qualifying institution for at least 60 consecutive days;
  - The resident has, or wishes to transition to, a home or apartment that is consistent with the CMS Settings Rule, and;
  - The resident is currently eligible, or likely eligible, for either the ADW or TBIW program.
- The ADRN will notify the resident and the nursing facility Social Worker that a referral has been made and that a Transition Coordinator will be contacting the resident to schedule an Intake Interview;
- If the referral is not appropriate for TMH, the ADRN will notify the resident in writing and send copies of the notification letter to the facility social worker;

- The ADRN will 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 ADRN will contact the facility to determine if the resident has capacity and, if not, obtain contact information for the resident's legal representative;
- The ADRN will contact the resident to confirm their interest in participating in TMH;
- If the resident confirms interest in participating in TMH, the ADRN will complete an ADRN Transition Referral form along with the HCBS pre-screen;
- The ADRN will contact the social worker from the facility to verify the information provided by the resident;
- The ADRN will send the referral on to the TMH Transition Coordinator if:
  - The resident currently resides in a qualifying institution, and;
  - The resident has resided in the qualifying institution for at least 60 consecutive days, and;
  - The resident has, or wishes to transition to, a home or apartment that is consistent with the CMS Settings Rule, and;
  - The resident is currently eligible, or likely eligible, for either the ADW or TBIW program.
- The ADRN will notify the resident and the nursing facility Social Worker that a referral has been made and that a Transition Coordinator will be contacting the resident to schedule an Intake Interview;
- If the referral is not appropriate for TMH, the ADRN will notify the resident in writing and send copies of the notification letter to the facility social worker;
- The ADRN is responsible for discussing other options and resources to support transitioning to the community if the resident wishes.

## Initial Contact

Individuals 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 Coordinator receives a referral, it is important to initiate contact quickly and maintain regular communication with the resident 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 ADRN. The purpose of this initial contact is for Transition Coordinators to introduce themselves, confirm that the resident is interested in participating in TMH and if possible, schedule the Intake Interview. The Intake Interview should be conducted within seven (7) calendar days of the initial contact.

## The Intake Interview

Effective communication is critical throughout the transition process. The Intake Interview is the first face-to-face meeting the Transition Coordinator will have with the resident. The Intake Interview should be conducted within seven (7) calendar days following the initial phone contact by the Transition Coordinator to the resident. The purpose of the Intake Interview is to:

- Introduce the TMH Transition Program to the resident;
- Discuss the resident's interest in and potential for transitioning to the community, and;
- Gather the information necessary to assess the resident's readiness to begin the transition process.

The Transition Coordinator should explain that TMH is a program of the West Virginia Bureau for Medical Services that helps residents of long-term care facilities such as nursing homes return to their own home or apartment in the community...

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 Coordinator will help them explore their options, and;
- Family members and friends can be involved in the transition process if they wish.

Explain that, before beginning the transition assessment and planning process for their transition home, they must:

- Be medically and financially eligible for either the ADW or TBIW Program, and;
- Have a home or apartment to return to or,
- Have initiated the search for housing by submitting at least one housing application.

Explain that if they have not yet been determined eligible for one of the Waivers, the Transition Coordinator can provide information on how to apply for Waiver services and assist them if needed with the application process. Further explain that if they do not have an apartment or home to return to and have not yet applied for housing, the Transition Coordinator can provide them information about potential housing resources and options in the community. The Transition Coordinator may assist the participant if needed with the application process, but this is a responsibility that can be assumed by the facility social worker.

Prior to beginning transition assessment and planning, review the process and the role of the Transition Coordinator. Explain that the Transition Coordinator will:

- 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 their Transition Team 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;
- Be available to work with the Case Manager and/or Resource Consultant (if applicable) for at least one year after transition to help address any needs that may arise.

Explain to the resident that some of the reasons their case may be closed before they transition home include, but are not limited to:

- They did not establish Waiver eligibility within 90 days of the Intake Interview, or
- They have no home to return to or did not submit at least one housing application within 90 days of the Intake Interview, or
- They have no home or apartment to return to within 180 days of beginning the transition assessment and planning process, or;
- They did not transition home within 180 days of first accessing Waiver transition services (Pre-Transition Case Management or Community Transition Service), or
- They choose to no longer pursue transitioning to the community, or
- They choose to not participate in the assessment and planning process.

Explain to the resident they will have access to a Waiver slot upon completion of the transition program and return to the community. If their TMH case is closed before they transition home or if they return to the community without completing the TMH transition program, they will return to the Aged and Disabled or Traumatic Brain Injury Waiver's Managed Enrollment List based on the date of their original referral for Waiver services.

Explain that if their case is closed, they can reapply at a later date. (See section on Case Closure for more information.)

All sections of the Intake Form must be addressed. Email the completed Intake Form to the Transition Manager at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov). The Transition Coordinator must keep the original signed Intake in the TMH participant's electronic Master File.

## **Informed Consent**

Most TMH Transition Program participants will be eligible to participate in the Money Follows the Person (MFP) Demonstration program. MFP is a federal demonstration that provides support for home and community-based living. MFP reimburses the State's long-term care system when individuals transition from long term care facilities to their own homes and apartments in the community. A signed consent is necessary to include participants in the MFP Demonstration. Review the MFP 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 consent at this point. Those wishing to

take more time to consider whether or not to participate in the MFP Demonstration program must be given this opportunity.

The signed and dated Informed Consent Form must be Emailed or faxed to the TMH Office at [WaiverTMHTakeMeHome@wv.gov](mailto:WaiverTMHTakeMeHome@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 MFP. If the Transition Coordinator 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 Coordinator must Email documentation of this to the TMH Office at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov). The signed and dated Informed Consent Form must be maintained in the participant's Master File.

### **Protected Health Information Authorization (PHIA)**

Prior to beginning the transition planning process, have the resident sign the Protected Health Information Authorization form and obtain a copy of the resident's face sheet from the facility. The signed and dated PHIA Form and resident face sheet must be maintained in the TMH participant's Master File.

### **Pre-Transition Planning and Documentation**

The Transition Coordinator must submit a Transition Assessment and Planning Readiness Verification Form (TAPRV) once a participant has:

- Been found financially and medically eligible for either the ADW or TBIW Program, AND
- Has a home to return to in the community, OR
- Has submitted at least one complete housing application for community rental housing.

Once the TAPRV has been approved by the Transition Manager, the Manager will notify the Transition Coordinator in writing of their authorization to begin the Transition Assessment and Planning process. Key steps to that process and the documentation required for each step is described below. The Transition Coordinator cannot request a Waiver slot to be released without an approved TAPRV.

### **Pre-Transition Assessment**

The most critical step in the transition process is a comprehensive assessment of the TMH 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 Coordinator and trust in the transition process.

The purpose of the assessment is to identify the participant's strengths, abilities, wishes and needs in order to develop a comprehensive Transition Plan which details the specific services and supports needed for a safe and successful return to the community.

The TMH Pre-Transition Assessment consists of the following components:

- Background & Information;
- Housing;

- Physical & Mental Health;
- Daily Living-Personal Assistance;
- Equipment – Assistive Technology;
- Transportation;
- Social-Faith-Recreation;
- Employment or Volunteerism, and;
- Financial & Personal Resource Management.

Information necessary to complete the Pre-Transition Assessment may be obtained from various sources, including 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 Transition Assessment, along with the Transition Planning Tool, Housing Assessment (if not already submitted), Risk Analysis and Mitigation Plan, 24-Hour Emergency Backup Plan to the Transition Manager at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov) no later than thirty (30) days prior to the anticipated transition date.

A copy of the completed Transition Assessment must be maintained in the participant’s Master File.

### **The Risk Analysis and Mitigation Plan**

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” exercise, 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 Plan allows the Transition Coordinator 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, and;
- Other Possible Risks.

Much of the information necessary to complete this section will come from the Transition Assessment, 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 Plan, the Transition Coordinator 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, or Traumatic Brain Injury Waiver) 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 Plan, the Transition Coordinator 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 Plan, the Transition Coordinator 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 Coordinator is unable to contact the participant.

The TMH participant must agree to all risk mitigation strategies prior to submission to the Transition Manager. The Transition Coordinator must submit the Risk Analysis and Mitigation Plan, along with the Transition Planning Tool, Housing Assessment (if not already submitted), Pre-Transition Assessment Tool, and 24-Hour Emergency Backup Plan to the Transition Manager at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov), no later than thirty (30) days prior to the anticipated transition date. Once approved, the participant and Transition Coordinator must sign and date the finalized Risk Analysis and Mitigation Plan which must be maintained in the participant's Master File.

Once the participant has returned home, the Risk Analysis and Mitigation Plan should be revisited during regular contacts to ensure that risks, including those that develop post-transition, are effectively mitigated.

The Transition Coordinator can make adjustments to the plan at any time as needed. All amendments to the Risk Analysis and Mitigation Plan following plan approval must be submitted to the Transition Manager. Amendments must be signed and dated by the participant and Transition Coordinator and maintained in the participant's Master File.

### **The 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 TMH 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, if applicable (Include access information/instructions and, if not applicable, enter a statement to instruct the participant to proceed directly to level 4)
- Level 4 – Extreme Emergency (911)

The participant must agree to the 24-Hour Emergency Backup Plan prior to submission. The Transition Coordinator will submit the 24-Hour Emergency Backup Plan, along with the Risk Analysis and Mitigation Plan, Pre-Transition Assessment Tool, Housing Assessment (if not already submitted), and Transition Planning Tool to the Transition Manager at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov) no later than thirty (30) days prior to the anticipated transition date. Once approved, the participant and Transition Coordinator must sign the Plan, provide a copy to the Case Manager (if applicable), Resource Consultant (if applicable) and Personal Attendant Agency, and maintain a copy in the participant’s Master File.

### The Transition Planning Tool

The purpose of the Transition Planning Tool is to identify steps to facilitate necessary services and supports needed by the TMH participant to safely transition from the facility and successfully live in their own home and community. Not only will this document plan out specific necessary steps for facilitating services, it will also document the status of each step and the amount of TMH funding that will be requested/used to implement that step, if any. The sections of the Transition Planning Tool correspond with the sections of the Pre-Transition Assessment Tool. Each need identified on the Pre-Transition Assessment Tool **must** be fully addressed on the Transition Planning Tool.

The Transition Planning Tool includes:

- **What are the assessed transition 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:
  - Contact the Transition Manager and request a TMH Waiver Slot;
  - Confirm the service delivery model and agencies, selected;
  - Completion of the Interim Service Plan.
- **Who is responsible to meet this need?** – Identify the individual who has primary responsibility for arranging, implementing and/or monitoring the completion of each action step. For example, developing the Waiver Interim Service Plan is the primary responsibility of the selected Case Management Agency, but the Transition Coordinator can participate in this process and confirm it has been completed. Monitoring and ensuring the completion of each step are the responsibility of the Transition Coordinator.
- **When will this need be met?** – 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 Interim Service Plan by the case manager should be done approximately “2-4 weeks prior to transition.”

- **What is the status?** – Indicate the status of the assessed need as either “Completed” or “In Process”. This column should be updated when each planning need has been met.
- **Community Transition Service Funds Requested** -- if Community Transition Service Funds are going to be requested to meet an assessed transition need, the Transition Coordinator must provide the details of the requested items or services. Then, select a service from the service category dropdown menu field. For example, if the participant is going to need a security deposit, the Transition Coordinator will go to the Service Category Field and select Security Deposit. If Community Transition Service Funds are NOT going to be requested, the Transition Coordinator, will go to the Service Category field and select “TMH CTS (Community Transition Funds) NOT Requested”. For example, the Transition Coordinator will not have to request funds for Pre-Transition Case Management Services, such as Interim Service Plan development. The Service Category Field should never be blank when planning for an assessed transition need.
- **Estimated and Actual Cost** – The Transition Coordinator will enter the estimated cost for all assessed transition needs requiring Community Transition Service funds. Once the Transition Plan is approved, the Transition Coordinator will obtain the required vendor information and the actual cost of the service (see Fund Request and Disbursement section). Then the Transition Coordinator can request Community Transition Service Funds. Once the funds have been expended, the Transition Coordinator must enter the “actual cost” field on the planning tool document. Community Transition Service Funds cannot exceed \$4,000.00. The Transition Coordinator is responsible for ensuring the participant’s plan is within budget. The Transition Coordinator can see the Total Estimated Cost and Total Actual Cost on the last page of the Planning Tool Document. Transition Planning Tools that are over the \$4,000.00 limit will be denied.

Review the Transition Planning Tool with the participant and their entire Transition Team and obtain signatures of participant, legal representative and Transition Coordinator prior to submission to the Transition Manager. Submit the plan along with the Pre-Transition Assessment, Housing Assessment (if not already submitted), Risk Analysis and Mitigation Plan, and 24-Hour Emergency Backup Plan to the Transition Manager at [WaiverTMH@wv.gov](mailto:WaiverTMH@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 Transition Manager, the Transition Coordinator and participant must sign and date the plan acknowledging approval and any changes that may have been made. The signed and dated Transition Plan must be maintained in the participant’s Master File and a copy of the signed Transition Plan must be provided to the Case Manager. All amendments to the Transition Plan must be approved by the Transition Manager (see below).

## **Transition Plan Amendments**

Amendments to an approved Transition Plan must be signed by the Transition Coordinator and Participant and/or Legal Representative and approved by the Transition Manager 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, 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.

There are times when it is not necessary to amend an approved Plan. For example, if the Transition Manager 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 Coordinator will need to verify that there are adequate funds to purchase the item, submit a fund request to the Transition Manager with the appropriate documentation and then update the Transition Plan to reflect the additional costs.

A signed and dated copy of those amendments must also be maintained in the participant's Master File.

## **Pre-Transition Case Management and Resource Consultant Support**

Once the Transition Assessment and Planning Readiness Verification Form has been approved and the Housing Assessment (located on the Pre-Transition Assessment Tool) has been completed AND a TMH Reserved Waiver Slot has been released to the participant, the Transition Manager may authorize Waiver Pre-Transition Case Management Services. If Pre-Transition Case Management Services are needed, the Transition Manager will confirm through ADW CareConnections that the selected agency has accepted the participant before authorization letters are issued. For the TBIW, the Transition Manager may authorize Waiver Pre-Transition Case Management Services with KEPRO staff (until the TBIW CareConnection has been developed). The selected agency must accept the participant before authorization letters are issued. The Transition Coordinator should verify that the required authorization letters have been received by the selected Case Management Agency before scheduling Pre-Transition Planning meetings. Each Letter will be copied to the Transition Coordinator via e-mail. If the resident has selected Personal Options, the Transition Manager will notify Public Partnerships to initiate pre-transition Resource Consulting activities via the PPL pre-planning letter.

## **The Housing Assessment**

Transition planning and assessment cannot begin until an individual either has a home in the community to return to or has applied to at least one community housing option. Application to rental housing must be verified via a telephone call to the property manager. The Transition Coordinator should ask whether

the application received was complete. The Transition Coordinator should also inquire as to the status of the participant on the community housing's waitlist and if any additional information will be necessary at the time of leasing or before.

Once housing becomes available (either a participant's own home or rental housing that will be available for the participant to lease), the Transition Coordinator must verify that it is adequate by completing the Housing Assessment.

The Housing Assessment is used to verify that community housing:

- Meets the qualified residence requirements as set forth in CMS guidelines under the Settings Rule;
- Is accessible or can be made accessible with reasonable modifications to the home, and;
- Presents no known risks to the participant's health and/or safety in the home or community, OR if it does present a known risk, that risk can be reasonably mitigated with mitigation strategies (to be documented on the Transition Plan and Risk Mitigation Tool).
- The Housing Assessment can be utilized as a tool to expedite the processing of security deposits for individuals who meet the criteria of:
  - Security deposit is required within 10 days of an apartment becoming available

The Transition Coordinator is encouraged to invite the Occupational Therapist and/or Physical Therapist from the nursing facility to participate in the home visit and conduct their own assessment of the home's accessibility and risk factors based upon their experiences with the resident and the home's condition. The Transition Coordinator should take photographs at each home visit to be maintained in the participant's Master File. These photographs are necessary for processing funds for modifications, as indicated in the Fund Request process listed elsewhere in this manual.

When assessing the accessibility needs of the participant in the home, the Transition Coordinator should consider the needs of that particular individual as each participant's needs will be different. The Transition Coordinator 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 Coordinator should indicate possible modifications that could be made to the home and/or recommend assistive devices to meet the participant's needs.

If there are health and safety risks identified, the Transition Coordinator MUST identify these risks in the Risk Mitigation Plan and discuss mitigation strategies with the participant and Transition Team. If no mitigation strategies are suitable and the community residence presents a risk that cannot be mitigated to ensure health and safety in the community, TMH cannot approve support to transition to such a residence and the participant must consider alternative housing or risk closure of their TMH case.

Possible risks to the participant could involve many things from severe to easily mitigated. A serious risk could be caused by exposed wiring, leaking pipes, presence of mold, lack of insulation, etc. A more easily mitigated risk could include the presence of throw rugs or high pile carpeting in the home that could cause a serious risk of falls for participants with mobility issues. This risk could easily be mitigated by removing the throw rugs or replacing high pile carpeting with linoleum flooring.

Because of the limited resource amount of the Community Transition Service, it may be necessary to seek additional funding for modifications and risk mitigation strategies to address concerns in the community residence. Some possible sources of funding might include (but are not limited to):

**Olmstead Transition and Diversion Program** – up to \$2,500 per person may be available to leverage with TMH funds to complete more extensive modifications to the home.

**USDA Grants/Loans** – The US Department of Agriculture's Rural Development Department has funding available in the form of grants and loans for home modifications and repairs for qualified individuals. The amount of funding and eligibility requirements differ so the Transition Coordinator will need to instruct the participant/family to contact a loan specialist for more information.

**Community and Faith-Based Organization supports** – Many churches and community organizations may be able to assist in raising funds for an individual's modification needs. The participant and Transition Team will need to contact community supports in the area to determine if funding is available or if fundraising efforts can be organized for the individual.

**Centers for Independent Living, Public Housing Authorities, Weatherization, TBI Funds for You (only for TBI Waiver Members) and other State and/or Federal Funded Agencies** – Many state and federally-funded agencies have additional financial support available. These funds are easier to access when the agency knows that TMH funds will be leveraged as a part of the cost for modification to the home.

Use the Additional Comments box of the Assessment to describe any concerns or issues regarding community housing not otherwise addressed elsewhere in the document and to identify any additional financial supports being sought to support the modification needs of the individual. Of course, the only way a participant, Transition Coordinator and Transition Team will know the full need of the costs of modifications to the home is to obtain a bid from a licensed and insured contractor willing to assess the work and provide an estimate of the cost for the work to be completed. Where possible, the Transition Coordinator should obtain no less than two (2) of these estimates before submitting the plan for approval to the Transition Manager.

In some cases, a follow-up to the home will be necessary if modifications need to be completed or mitigation strategies are to be implemented. The Transition Coordinator must visit the home again to reassess the community setting and take additional photographs to ensure that the mitigation strategies or modifications have been completed and all addressed needs have been met.

Submit the signed and dated Housing Assessment to the TMH Office at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov). The Housing Assessment 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 release for housing related cost prior to the submission and approval of the Housing Assessment. The completed Housing Assessment must be maintained in the participant's Master File.

### Monthly Status Reports

For those who 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 Coordinator is required to complete this report each month following the Intake interview for every TMH participant who has not yet transitioned to the community. The report must be emailed to the participant in care of the facility's social worker. Copies of the report must be emailed to the Transition Manager and to the Regional Ombudsman if they have been involved in the transition process.

### Post-Transition

During the post-transition period, monitoring of TMH participants will be the primary responsibility of the Case Management and Resource Consultant staff to ensure that participant needs are being addressed. Because it is often within the first week that items/services that were forgotten or had not been considered throughout the transition planning process become apparent, the TMH program requires each participant to have post-transition follow-up with the Transition Coordinator immediately following the transition date. Required contacts and their purpose are described more below. It is important to note that some individuals will require more follow-up and involvement by the Transition Coordinator than others, but these required contacts must be completed and documented for each transitioned individual.

### Required Transition Coordinator Contacts

The Transition Coordinator will be responsible for making a follow-up contact with each participant following transition at:

- Three days (from date of transition) - telephone
- One week (from date of transition) - face-to-face

During the 1-week face-to-face meeting, it is important to initiate the discussion with the participant concerning the "phase-out" of the involvement of the TMH Transition Coordinator. The participant's

Case Manager and/or Resource Consultant (if applicable) should be involved in this meeting. The Transition Coordinator should:

- Clarify that the Transition Coordinator will no longer be involved unless participant needs have changed, and additional services are required;
- Clarify that TMH services and supports will not be available after the participant has completed the initial transition period (one year from date of transition);
- Explain that the participant will continue to receive all Medicaid home and community-based services for which they qualify after their participation in TMH ends;
- Explore any immediate service or support needs that need to be addressed prior to the end of the transition period, and;
- Stress that the Transition Coordinator should be notified if the participant is reinstitutionalized any time during the initial transition period. The Transition Coordinator must then report the reinstitutionalizations to the TMH Office.

Every contact with the participant, whether regularly scheduled or not, should be documented on the Transition Coordinator's Progress Notes for that participant. Any contacts with the Case Manager, Resource Consultant or Personal Attendant Agency for a participant should be documented in Progress Notes for that participant. (See below for more on Progress Notes.)

## Documentation Requirements

### Progress Notes

All Transition Coordinator activity on behalf of TMH participants must be documented using Transition Coordinator 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.

### Case Closure

TMH cases may be closed pre- or post-transition for a variety of reasons. If a participant dies or leaves the facility without the support of TMH, the Closure Request Form must be completed with the appropriate information (including dates) and submitted to [WaiverTMH@WV.gov](mailto:WaiverTMH@WV.gov). In cases where the participant voluntarily chooses to withdraw from the program, the Transition Coordinator should obtain a signed Withdrawal Confirmation Form from the participant whenever possible. The Withdrawal Confirmation Form MUST be signed and dated by the participant and submitted with the Closure Request Form.

There are numerous reasons that TMH may close a case... Explain to the resident that their case may be closed if (not an all-inclusive list):

- They do not establish financial and medical Waiver eligibility within 90 days of the Intake Interview;
- They do not submit at least one housing application within 90 days of the Intake Interview, or;

- They have no home or apartment to return to within 180 days of beginning the transition planning process, or;
- They do not transition home within 180 days of first accessing Waiver transition services (Pre-Transition Case Management or Community Transition Service).

When submitting a Closure Request Form for any other reason, the Transition Coordinator should mark only one reason case closure is being requested and provide additional details as needed in the comments section of the form. If “Other” is selected indicating that none of the other available options accurately reflect the reason for requesting closure, a detailed explanation for requesting the case to be closed MUST be provided.

If a case closure is being requested because the participant is not fully participating in the transition assessment and planning process, or because the Transition Coordinator believes that there is no longer a reasonable expectation of a safe and successful transition, the Transition Coordinator must consult with the Transition Manager before proceeding. If the Transition Manager agrees with the recommendation to close the case, the Transition Coordinator must convene a face-to-face meeting of the Transition Team to discuss the planned closure and answer any questions the participant or Transition Team members may have. This is an opportunity to stress that the participant can re-apply to TMH at any time in the future.

Completed Closure Request Forms, along with Withdrawal Confirmation Forms, when applicable, must be e-mailed to the Transition Manager at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov). The Transition Manager will provide written notification to each participant whose case is closed and send copies of the notification to the Transition Coordinator, Nursing Home Social Worker, when applicable and to any other individual(s) or agencies deemed necessary by the Transition Manager. Information on Fair Hearing rights will be sent when the decision to close is not that of the applicant.

The Transition Coordinator must e-mail the participant’s Master File to the Transition Manager at [WaiverTMH@wv.gov](mailto:WaiverTMH@wv.gov) within 5 business days of receipt of the Closure Letter issued by the Transition Manager. Copies of requests and supporting documentation for fund disbursements need not be included in the final submission of the Master File.

### **The Master File**

Transition Coordinators 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 Transition Manager. 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

Community Transition Service fund requests are the responsibility of the Transition Coordinator to submit in a completed format with appropriate documentation as described below. Fund Requests will be processed through the FMS Vendor, currently Public Partnerships (PPL), but must receive approval through the Transition Manager before disbursement can take place. If a fund request is submitted without all of the necessary information or documentation, it will slow down the process of receipt of funds and could hinder the transition process as the anticipated transition date draws closer. Please read through the instructions below on the submission of fund requests and proper supporting documentation and submission guidelines.

Note: Waiver transition services (Pre-Transition Case Management and Community Transition Services) will not be authorized until the participant has fully qualified as described earlier in this manual.

The Housing Assessment can be utilized as a tool to expedite the processing of security deposits, when necessary, to “save” the apartment for individuals who meet the criteria of:

- Security deposit is required within 10 days of an apartment becoming available

### Filling Out the Request for Funds Form

Before submission, every Request for Funds Form must include:

- Date of Fund Request;
- 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 Coordinator’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 number;
- The way these funds should be disbursed – by check mailed directly to the Vendor; by check mailed to the Transition Coordinator; or electronically for items/services being purchased through an online vendor.
- Supporting documents
  - Documentation 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. Items being purchased through an online vendor must include specific item numbers, sizes, colors, shipping address, etc. to ensure the FMS vendor can accurately complete the purchase. The Transition Coordinator may select the online items, put in “shopping cart/basket”, calculate applicable tax and shipping costs and then print page.
  - A completed and signed IRS Form W-9 for the vendor from which the items/services will be purchased. (For major retailers, this vendor may already be established in the FMS’ portal.) The Transition Manager can verify if the vendor is already established in the

system or if a W-9 needs to be completed and submitted for the vendor named in the fund request.

**Note: Only one Request for Funds Form per vendor.**

## Standard Request For Funds Process

In the standard fund request process, the Transition Coordinator has already received notification from the Transition Manager that the Transition Plan with attached TMH estimated funds to be requested has been approved. If the fund request is for an item that was not already on an approved transition plan, the Transition Coordinator must make the necessary amendments to the plan and have them approved before submitting a fund request for the items.

- The Transition Coordinator must obtain actual costs in order to complete the Request for Funds Form. Actual costs can be documented 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. For online purchases, the Transition Coordinator must include specific item numbers, sizes, colors, shipping address, etc. The Transition Coordinator may select to put online items in a shopping cart/basket, calculate applicable tax and shipping/handling costs, and then print that page to act as documentation for the request.
- The Transition Coordinator 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. (REMINDER: The actual costs of TMH Funds available for each participant in a transition period cannot exceed \$4,000.)
- The Transition Coordinator will fill out the form, marking Standard at the top to indicate the submission of a Standard Fund Request.
- The Transition Coordinator will then submit a signed and dated copy of the Request for Funds Form, as well as the supporting documentation listed above, to the Transition Manager for approval. Once approved, the Transition Manager will submit the request to the Fiscal Management Service (FMS) vendor. NOTE: Any submissions that are incomplete or do not contain adequate supporting documentation will be returned to the Transition Coordinator for correction and resubmission, which will delay the fund disbursement process and could compromise timeframes for price guarantees.
- The FMS will verify that there are sufficient funds before processing. If verified, approved fund requests that are submitted by 9:00 a.m. on Tuesday will be sent out on Friday and approved fund requests that are submitted by 9:00 a.m. on Thursday will be sent out the following Tuesday. The Transition Manager can monitor the processing of the payment through the FMS' web portal.
- The Transition Coordinator must verify receipt of purchased items and services by the participant when received/delivered using the Receipt of Items & Services Form for each fund disbursement. (In the case of funds for home and vehicle modifications, the Receipt of Items &

Services form must be accompanied by photographic documentation of the completed modification work. See below.)

- Once the fund request has been processed, the Transition Coordinator must update the participant's Transition Planning Tool to reflect actual costs and mark that task as completed on the form. An updated Transition Plan and signed Receipt of Items & Services form must be maintained in the participant's Master File.

## 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. The participant, with the assistance of the Transition Coordinator, 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 Coordinator 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 attached and 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 Coordinator 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. An approved Transition Plan must be on file detailing the need and the modification to be completed.

- The Transition Coordinator 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 Coordinator must obtain proof of the selected contractor's Worker's Compensation Insurance Policy and/or proof of liability covering the contractor and his/her employees while on the specified project; the contractor's license number; and a copy of the W-9 in order to process payments made out to the contractor or mechanic. Contractors with employees are required by WV State Code to carry Worker's Compensation as a part of their regular business practices. A Worker's Compensation and Liability Policy must be provided to the Transition Manager. Independent contractors, who are not required to carry Worker's Compensation, must provide documentation of liability insurance. The policy must cover, at the very least, the specific job for which the contractor is providing the estimate for work. These documents must be attached to the Request for Funds Form upon submission, and photographic documentation of the areas where work is to be completed in the home/vehicle (before pictures).
- The Transition Coordinator 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.

(REMINDER: The actual costs of TMH Funds available for each participant in a transition period cannot exceed \$4,000.)

- The Transition Coordinator 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 Coordinator must also complete the Contract Bids section of the form. The Transition Coordinator 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. All other sections must also be completed, and the document signed and dated by the Transition Coordinator upon submission to the Transition Manager. (NOTE: In rare cases it may be impossible to obtain two qualified bids for work. If the Transition Coordinator has made numerous attempts to obtain an additional bid, which should be documented in Progress Notes in the participant's file AND the qualified bid that was obtained is reasonable and meets the participant's needs and budget, the Transition Coordinator may document inability to find another bid as a justification to process the request with only one bid and reasonableness of the bid noted as justification to honor the bid given.)
- The Transition Coordinator should then submit a signed and dated copy of the Request for Funds Form, as well as the supporting documentation listed above to the Transition Manager. The Transition Manager 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. If the request lacks vendor qualifications and Workers Compensation Insurance or liability information or is in any other way incomplete, the request will be returned to the Transition Coordinator for correction and resubmission, which will delay the fund disbursement process and could compromise timeframes for price guarantees.
- If the Transition Manager approves the vendor qualifications and selection of the vendor, the fund request will be forwarded to the FMS for payment processing. A copy will be sent to the Transition Coordinator for tracking purposes and the approval should be maintained in the participant's Master File.
- The FMS will verify sufficient funds before processing. If approved, checks for fund requests submitted by 9:00 a.m. on Tuesday will be sent Friday and checks for approved fund requests that are submitted by 9:00 a.m. on Thursday will be sent the following Tuesday to cover the initial payment for the contract work. The Transition Manager can monitor the processing of the payment through the FMS vendor's web portal. NOTE: Transition Coordinators may request to have vendor checks sent directly to them, but they must indicate this clearly on the Request for Funds Form.
- The Transition Coordinator must verify the completion of contracted work with the participant using the Receipt of Items & Services Form and photographic documentation of the completed work (after pictures). By signing the Receipt of Items & Services Form, the participant is stating that the modification has been done to their satisfaction and now meets their accessibility needs and is in good working order.
- Once the completion of work has been verified and the Receipt of Items & Services Form has been signed by the participant along with pictures documenting the completed work provided,



the Transition Coordinator 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 Coordinator should submit this request to the Transition Manager and include the signed and dated Receipt of Items & Services form and photographs of the completed work must accompany the final Request for Funds Form.

- Once the fund request has been processed, the Transition Coordinator must update the participant’s Transition Planning Tool to reflect actual costs and mark that task as completed on the form. An updated Transition Plan and signed Receipt of Items & Services form must be maintained the participant’s Master File.

## **ROLES OF KEY PARTNERS**

### **Case Management and Resource Consultant Services**

Case Managers and Resource Consultants play an integral role in the transition process by ensuring that services are in place day one of the participant’s transition to the community. Prior to the participant’s transition from the facility, Case Managers and/or Resource Consultants can:

- Participate on the Transition Team;
- Participate in the transition assessment and planning process;
- Conduct the appropriate Waiver person-centered assessment;
- Complete the Waiver Interim Service Plan and work with the selected ADW or TBIW provider to ensure that services are in place for the first day the TMH participant returns home (Personal Attendant Services and training);
- Enroll the TMH participant in the Waiver program immediately prior to the participant’s transition home (Case Manager), and;
- Conduct the face-to-face Personal Options enrollment meeting and ensure that the resident is “good-to-go” before transitioning home (Resource Consultant).

A one-time reimbursement may be claimed for no more than twenty-four 15-minute units of Pre-transition Case Management services once the participant has transitioned home. Resource Consulting services for participants who self-direct their Waiver services are provided via an administrative contract with PPL. Pre-Transition Case Management services must be documented by the Case Manager on the Pre-Transition Case Management Progress Note and faxed to the Transition Coordinator to be maintained in the participant’s Master File.

The responsibility of the Case Manager and/or Resource Consultant after the TMH participant has transitioned to their own home is the same as for any other Waiver member. However, because Community Transition Services may be available for up to one year (initial transition period), regular and ongoing communication between the Transition Coordinator and the Case Manager and Resource Consultant 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. The Case Manager and Resource Consultant (if applicable) must provide the Transition Coordinator with a copy of the member's Interim Person-Centered Service Plan.

## Facility Staff

The importance of the facility in planning the transition of residents to the community cannot be understated. Facility staff, who are 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 Coordinators 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 Coordinator 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 Coordinators 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.

Regional long-term care ombudsmen are not employed by long-term care facilities. The West Virginia State Long-Term Care Ombudsman, who oversees the state’s Ombudsman program, 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 TMH, particularly in supporting residents of nursing facilities wishing to transition to the community. Specifically, the Regional Ombudsman:

- Provide information about TMH and outreach to nursing home residents, families, and staff;

- Make referrals to the Aging and Disability Resource Network (ADRN) from consenting residents who are interested in participating in TMH;
- Facilitate introductions and on-going relationships between Transition Coordinators and relevant nursing home staff;
- Monitor the progress of residents who are candidates for TMH 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 TMH 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 TMH, and;
- Investigate complaints that individuals' legal guardians have opposed the TMH participation.

Additionally, Long-Term Care Ombudsman staff:

- Participate in the TMH 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 TMH, and;
- Attend planning, team, advisory and other meetings to develop and promote the Take Me, Home, West Virginia initiative.