This presentation was provided as a Webinar for Health Home Care Coordinators which aired on August 14, 2014. This optional training was developed for Health Home Care Coordinators. It was developed and presented by Cathy McAvoy who is the Training Program Manager for the Duals Integration Project in Washington State.

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Training Objectives
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Training Objectives

- Provide an overview of Long Term Services and Supports (LTSS) available through Home and Community Services (HCS) at DSHS
- Provide information on where to request these services

In December 2013 a Webinar aired that provided an overview of Long Term Services and Supports available from the Home and Community Services and Developmental Disabilities Administration at DSHS. In January 2014 a Webinar aired that provided an overview of services available through the Developmental Disabilities Administration (DDA).

The focus of this training will be to provide you with some options for helping clients that are relocating from hospitals, nursing facilities, and certain DDA facilities. Some of these programs are available even if the client is not discharging from an institution and serve as a reminder of services whether or not your client is relocating into the community. Some of the services we will discuss are only available because a client is discharging.

One principle to keep in mind is that in your role as care coordinators we do not supplant nor duplicate services being provided by DSHS case managers and discharge planners in the hospitals and nursing facilities. By becoming aware of the wide variety of services you may be able to begin the conversation about services that could benefit your client. In your role as care coordinator you should attend care conferences. In your role you may work with family members and caregivers to plan for discharge and assist them in accessing these Long Term Services and Supports (LTSS). You may provide training and coaching to the client and their collaterals on how to request services and navigate the system.

Training Objectives

- Three Settings for LTSS
  - Discharge Resources
    - Hospital and Nursing Facility services
  - Residential Discharge Resources
    - Assisted Living and Adult Family Home (AFH) services
  - In-Home Resources
    - Services needed to assist the client in their own home

While there are specific eligibility requirements for these programs this presentation is designed to raise your aware that there is a wide variety of services available for your clients discharging from hospitals, nursing facilities, and some institutions. Working with clients in these settings provides a unique opportunity to access special services that would not be available to the client if he or she is living in the community.

One guiding principle for all of these services is that Medicare is the first payer and Medicaid is the second payer. These discharge resources are accessed when Medicare and Medicaid funding sources have been exhausted or will no longer a service or item.

Overview of the Eight Programs

- Housing Maintenance Allowance
- Community Transition Services (CTS)
- Residential Care Discharge Allowance (RDCA)
- Assistive Technology (AT)
- Client Intervention & Independent Living Consultation

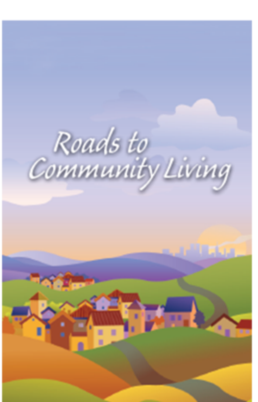
The Housing Maintenance Allowance was formerly known as the MIIE or Medical Institution Income Exemption.

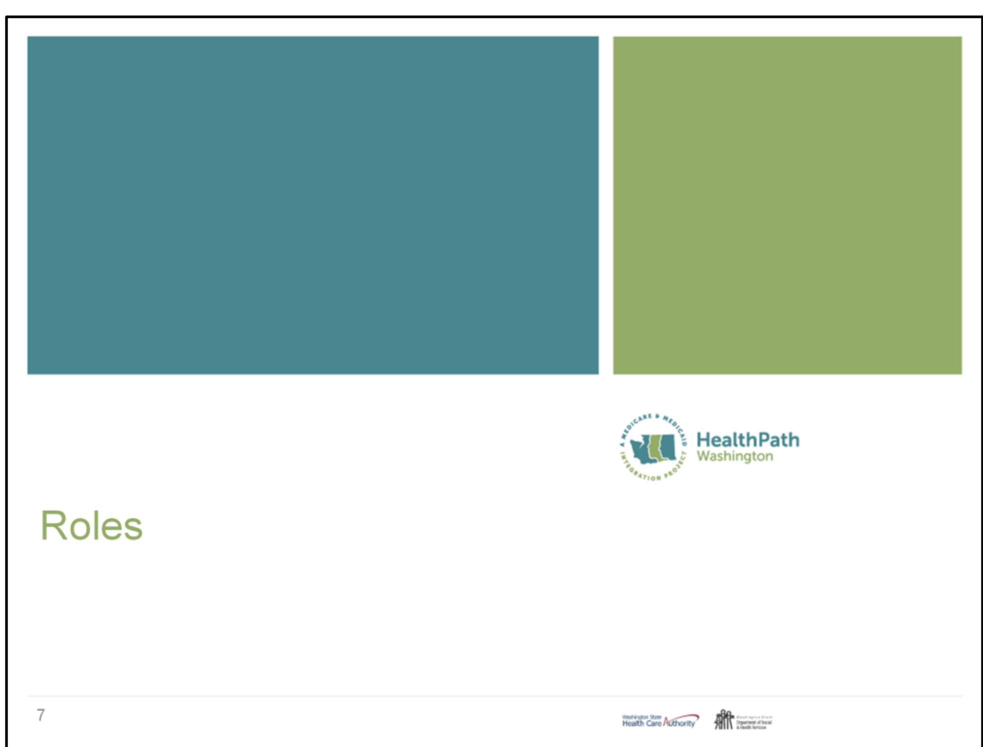
All of these programs require that the individual is eligible for Medicaid.

The important point to take away is that there are a variety of programs and funding sources, your job is not to know which service they qualify for but rather to know that there are a lot of resources for clients in hospitals and nursing facilities and that admission to these settings provides an opportunity to access additional services than what are available when living in the community.

Overview of the Eight Programs

- Social or Therapeutic Leave
- Roads to Community Living
- Washington Roads

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Roles
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Roles

Home and Community Services Case Manager: work with clients, family members, informal supports, nursing facility staff, the client's physician, and community providers to assist the client to discharge to the least restrictive setting and access community services

Roles

Area Agency on Aging Case Manager:

work with clients, family members, informal supports, nursing facility staff when placement is less than 30 days, the client's physician, and community providers after the client has returned to their own home

Advocacy. Action. Answers on Aging

Roles cont.

Hospital or Nursing Facility Discharge Planner: provide sufficient preparation to the resident/patient to ensure safe and orderly transfer. They may hold care conferences with various departments in the facility, DSHS staff, family members, caregivers, and other collaterals

Roles cont.

Residential Providers: Adult Family Home (AFH) or Assisted Living (AL): must provide discharge planning

Roles cont.

Care Coordinator: integrates services across all systems and works with professionals and collaterals

- Care Transitions is one of the six health home services which includes:
  - Ensuring that follow up appointments are made with the doctor
  - Medications are reconciled
  - Client and family education and coaching
  - Development or revision of the Health Action Plan

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Hierarchy of Services and Programs
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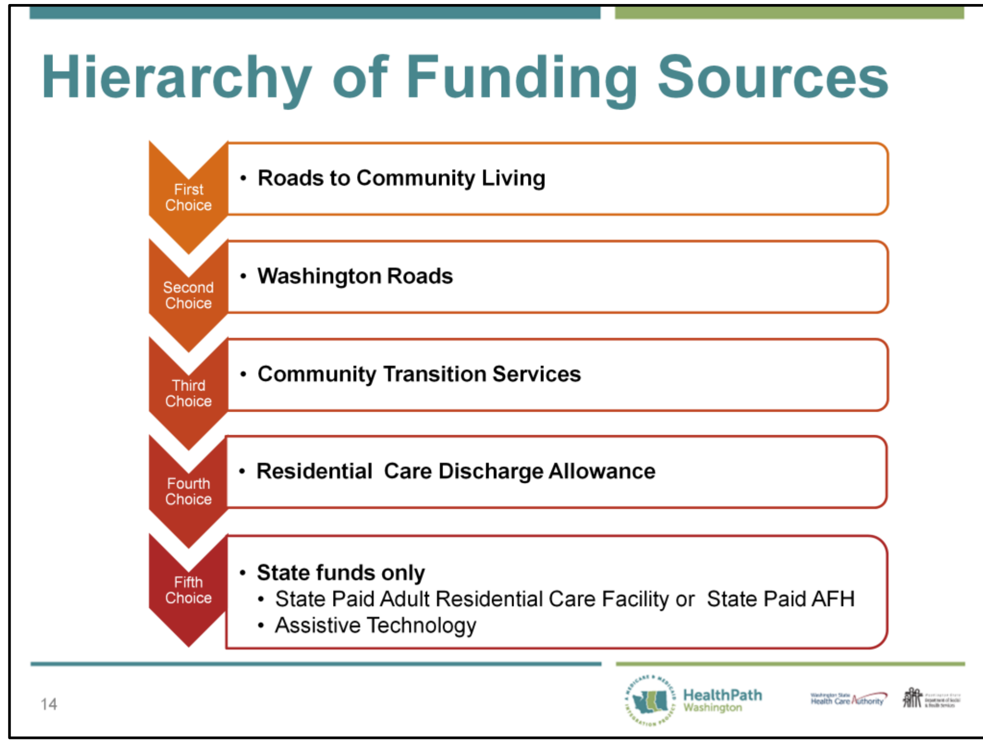


This graphic illustrates the hierarchy for accessing discharge resources. They have developed over time to fill in resource gaps for clients wishing to step down to a lower level of care

Programs for Clients Living in Hospitals, Nursing Facilities, and Residential Settings

Community Transition Services (CTS)

- Provides money to pay for one-time set-up expenses necessary to relocate clients to the least restrictive setting

  - For clients in institutional and non-institutional settings
  - Must use COPES or New Freedoms after discharge

While COPES offers a wide variety of services after discharge, this service expands the menu of services available while the client is in a nursing facility or hospital until they can discharge and take advantage of COPES services.

COPES funding cannot be used while in the nursing home and CTS serves as a bridge between settings.

Community Transition Services (CTS) cont.

- Service or items necessary to establish a residence include:
  - Fees and deposits (telephone, electricity, heating), medical equipment, security deposits, essential furnishings, health and safety assurances (pest eradication, one-time cleaning), and other basic items essential for living outside of the institutional setting

CTS cannot pay for items available through Medicaid or other programs.

Community Transition Services (CTS) cont.

- Providers must have a contract with DSHS
- Payments cannot exceed $816 in total
- This one-time benefit must be accessed within 30 days of discharge
- Clients may discharge from hospitals, nursing facilities, assisted living facilities, and adult family homes

This program will not pay for rent or diversional items such as cable or Internet.

Residential Care Discharge Allowance

- Must be discharging from a hospital, nursing facility, or other residential setting
- Developmental Disability Administration clients must be discharging from a nursing facility only

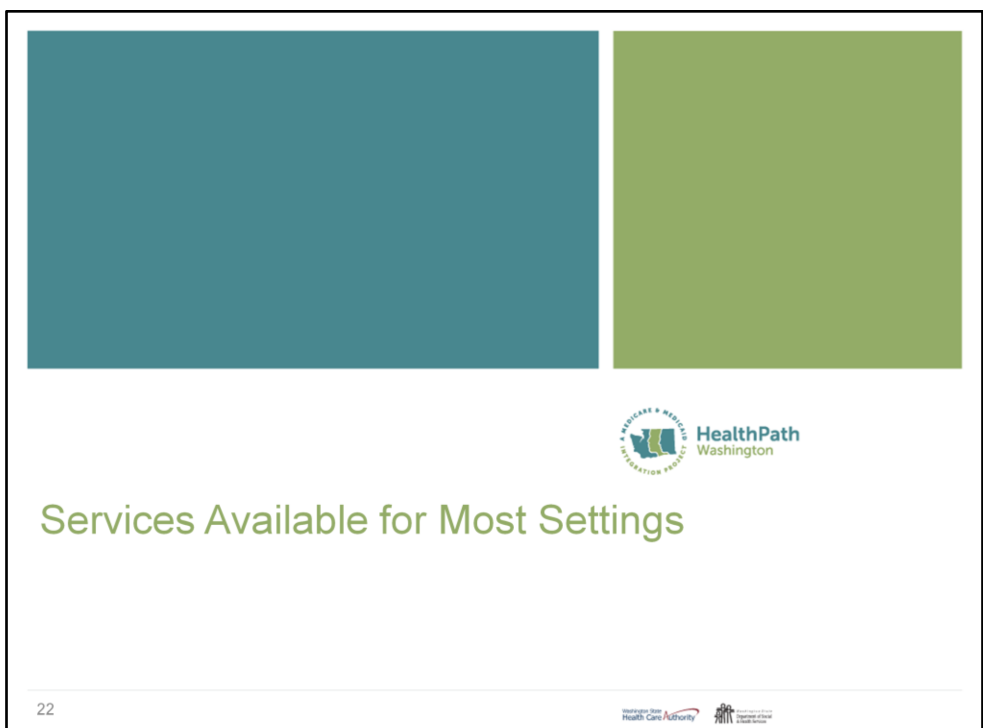
Residential Care Discharge Allowance cont.

- Covers the cost needed to establish a residence
- Covers necessary items and services such as rent, damage deposits, utilities, telephone, necessary equipment
  - Equipment includes: durable equipment, furniture, bedding, and household goods and supplies

Cannot be used for diversional services such as cable or Internet or to purchase televisions and DVD players.

Residential Care Discharge Allowance cont.

- Providers must have a DSHS contract
- The limit is $816 per discharge
- Must be used within 30 days of discharge
- Must not be eligible for other Medicaid services or other programs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Services Available for Most Settings
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Community Intervention Services (CIS) and Independent Living Services (ILS)

Are available to:

- Clients in nursing facilities
- Clients in their own home with
  - Medicaid Personal Care Services
  - COPES
- Clients receiving services from Adult Protective Services

Community Intervention Services and Independent Living Services

- Both CIS and ILC services must be provided by a contracted provider
- Funds are limited for both programs

Client Intervention Services (CIS)

Include:

- Home environment evaluations
- One-time home hazardous cleanup
- Medical consultation not available through standard Medicaid programs
- Subsidized housing or housing options evaluation
- Care planning for a client in a residential setting

For example, a consultant may work with a client at danger of being discharged from an AFH to develop a behavior plan and coordinate with the mental health provider.

Independent Living Consultation (ILC)

- Services include:
  - Interviewing skills: how to hire and supervise Individual Providers
  - Mobility training: how to access public transportation
  - Peer support: how to access and manage healthcare needs
  - Housing assistance: how to apply to various housing options

Psychotherapy and counseling are not eligible for these services. Think of these services as teaching the client life skills necessary to maintain their independence in the community.

COPES Ancillary Services

Services for clients in adult family homes and living in their own homes include:

- Nurse Delegation
- Caregiver/Recipient Training
- Community Transition Items or Services
- Adult Day Health

Caregiver/client services may be indicated when a client is:

- Adjusting to a serious impairment;
- Managing personal care needs; or
- Developing necessary skills to deal with care providers.

COPES Ancillary Services cont.

Additional services for clients living in their own homes include:

- Adult Day Care
- Personal Emergency Response Systems
- Home Delivered Meals
- Environmental Modifications
- Skilled Nursing Services
- Home Health Aide

Clients living in assisted living are not eligible for PERS, home delivered meals, or adult day care. Clients in AFHs may attend adult day health but this benefit is not available to clients living in assisted living facilities.

Assistive Technology (AT)

AT project funds may be used when no other funds are available for assistive devices and services. It is designed to:

- Increase functional independence
- Maximize health and safety
- Increase the likelihood that adults in institutional settings will transition to their own homes and communities

Assistive Technology cont.

AT Includes:

- Assistive technology
- Assistive technology devices
- Assistive technology services
- Durable medical equipment
- Non-durable medical equipment
  - Supplies used once or more than once but are time limited (e.g. catheter bags)

Program Definitions:

Assistive Technology: devices and services that facilitate the ability of people by making the most of functional opportunities in all environments.
Assistive Technology Devices: any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified or customized, that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities. AT devices include, but are not limited to: environmental control devices, communication devices and DME equipment.
Assistive Technology Services: services that assist persons with disabilities to select, acquire, or use assistive technology devices. AT services include, but are not limited to: OT and PT evaluations, short-term training and eye examinations.
Durable Medical Equipment (DME): equipment which can withstand repeated use and which is used to serve a medical purpose when supplied to individuals with an illness, injury or disability. DME includes, but is not limited to: wheelchairs, walkers, specialty beds, and mattresses.
Non-Durable Medical Equipment: supplies that are used once or more than once, but are time-limited, such as adult briefs or catheter bags.

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Resources for Hospital and/or Nursing Facility Discharge
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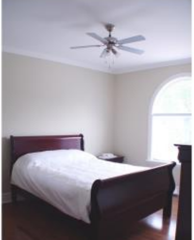
Health Care Authority

Housing Maintenance Allowance

- Allows a client in the nursing facility or institutional stay to retain income up to 100% of the poverty level to maintain their residence.
  - Currently this is $973 per month

Housing Maintenance Allowance cont.



In order to exempt income from their contribution/participation toward the cost of their care a physician must certify in writing that the client will likely be institutionalized for *no more than six months*.

Why six months? It is assumed that clients who stay in a nursing facility more than six months are more likely to be unable to return to their own home.
The rules vary for those with Supplemental Security Income or SSI only and for married couples.

Housing Maintenance Allowance cont.

This exemption allows the client to pay for such things as: rent, mortgage, property taxes/insurance, telephone, and basic utilities

- It does not allow for diversional items such as cable or Internet services
- Client must be provide receipts to verify expenses

Social and Therapeutic Leave

Social and therapeutic leave gives nursing facility residents an opportunity to participate in:

- Social and therapeutic activities outside of the nursing facility and beyond the care of nursing facility staff
- Trial visits to less restrictive settings

An example would be a client using social leave to visit family during a holiday or wedding.
An example of therapeutic leave would be a client admitting to a TBI treatment unit with a plan to return to the nursing facility when the program is completed.

Social and Therapeutic Leave

Social and therapeutic leave is limited to 18 days per calendar year

- Additional days may be approved with an exception to rule
- Caution should be used in exceeding the limit as it raises the question about the client's need for nursing facility level of care

Roads to Community Living (RCL)

Eligibility:

- Must be admitted 3 months or longer into a hospital, nursing facility, or ICF-ID OR
- A continuous stay of 3 months or longer in a psychiatric hospital and be under age 22 years or over age 65 year.
- Medicaid must solely fund the 90 days and client must be eligible for Medicaid after discharge

This demonstration project began in 2007 and has now been extended through 2016.

Roads to Community Living (RCL)

Some services are provided prior to discharge and other services are provide up to 365 days after the client leaves the nursing facility, hospital, or ICF-ID

- After 365 days the client may transfer ongoing services to COPES or Medicaid Personal Care Services

An ICF-ID is an Intermediate Care Facility – Intellectually Disabled. An example would be the Buckley School in Buckley.

RCL: Services and Items

- Personal care services by an Individual Provider or Homecare Agency
- Environmental modifications
- Skilled nursing services
- Personal Emergency Response System
- Adult family home or assisted living placement
- Community Choice Guides
- Informal Caregiver Supports

RCL: Services and Items cont.

- Challenging Behavior Consultation and Technical Assistance
- Transitional Behavioral Health Services
- Professional Therapies PLUS
- Service animals
- Adult Day Health
- Durable Equipment and Supplies
- Substance Abuse Services
- Demonstration Transition Goods
- Assistive Technology and Vehicle Adaptions

Payment to a RCL contracted Service Animal provider for services which may include:

- The provision of a trained service animal
- Specific training of the service animal to meet the individualized needs of the participant.
- Orientation of participant with service animal
- Service animal training with participant
- Consultation with participant as needed

Washington Roads

Eligibility:

- Must be 18 years of age or older
- Must have 30 continuous days or more of placement in a hospital or nursing facility
- Must be functionally eligible for COPES or Medicaid Personal Care Services
  - Even if the client does not wish to receive them after discharge

Washington Roads: Services

Professional Support Services:

- Technical Assistance: Evaluation/planning to stabilize community living
- Challenging Behavior Consultation
- Transitional Behavioral Health
- Communication Therapy
- Dietitian/ Nutritionist
- Occupational Therapy
- Physical Therapy

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Professional Support Services include technical assistance such as evaluation and planning to stabilize community living including:

- Challenging Behavior Consultation

Develop and implement services designed to facilitate inclusion into the community;

Training, behavior support planning, and/or specialized cognitive counseling.

Technical Assistance (tailored evaluation, consultation, and skill building to the client's informal and formal supports):

Assessment of the client's behavior to determine the causes, triggers, and purposes behind challenging behaviors;

Behavioral interventions, supports, or modifications to increase positive behaviors and/or decrease negative behaviors;

Case consultation regarding crisis situations;

Therapeutic techniques for the amelioration or adjustment of mental, emotional, or behavioral problems.

- Transitional Behavioral Health

Payment to a RCL contracted provider for services which may include, but are not limited to, behavioral health services for participants transitioning from institutional to community settings, such as someone experiencing mild

depression or anxiety related to their transition.

Washington Roads: Services cont.

- Community Choice Guides
- Items: items needed for transition into a new more independent setting
- Emergency Rental Assistance: one-time payment for emergency rental assistance to maintain or stabilize community placement
- Community Transition or Stabilization Services
- Emergency Rental Assistance
- Substance Abuse Consultation

Emergency Rental Assistance: provides one-time payment made directly to a landlord for emergency rental assistance to maintain or stabilize community placement.

Washington Roads

Unlike Roads to Community Living these services are available as a part of discharge and provide no ongoing services after discharge

Recall that Roads to Community Living can provide COPES and MPCS like services for up to 365 days after discharge.

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A MEDICARE & MEDICAID INTEGRATION PROJECT
State Funds Only
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State Funds Only

Limited funding available regardless of income:

- Temporary placement in an AFH for health and safety
- Temporary services until eligibility is established for other core programs

For example, a client could be in a car accident and be unable to work and pay rent. If the client lost their income and did not have financial resources in reserve they may be eligible for this program. Since this is a temporary disability the state may fund a transitional placement in and AFH or assisted living while the client recovers and is able to return to work. This client would not be eligible for SSI or Social Security since the disability is not permanent.

Settings and assistance available by program

Setting	*Community Transition Services	*Residential Care Discharge Allowance	Client Intervention Services	Independent Living Consultant	Assistive Technology	Housing Maintenance Allowance	**Roads to Community Living	Washington Roads
Hospital	X	X	X	X	X		X	X
Nursing Facility	X	X	X	X	X	X	X	X
Assisted Living	X	X	X	X	X		X	
Adult Family Home	X	X	X	X	X		X	
Home	X		X	X	X		X	

*Up to 30 days after discharge

**Up to 365 days after discharge

This matrix shows the various settings and program that a health home client may qualify for.

Takeaways from this training

- There are many services available to help clients discharge to more independent settings
- You do not need to know which program to request

Takeaways from this training

- HCS Intake and Screening staff can help identify which services to pursue
    - Be prepared to provide information about the client's supports, living situation, and Activities of Daily Living needs

Takeaways from this training

- For further information or to make a referral contact:
  - Your local Home and Community Services Office
    - Website: http://www.altsa.dshs.wa.gov/Resources/clickmap.htm

Takeaways from this training

- For further information:
  - Local Community Living Connections or Aging and Disabled Resource Centers
    - Website: http://www.adrcofwashington.org/

The local Community Living Connections (CLC) offices (Aging and Disability Resource Centers [ADRCs]) in Washington State serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. The CLCs/ADRCs are “first stops” for many consumers. They provide information about services and supports.

HCS Regional Offices

Intake Units

Region 1 – Spokane:
509 568-3767 or 1-866-323-9409

Region 2 – Seattle:
206 341-7750 or 1-800 346-9257

Region 3 – Tacoma
1-800 786-3799

If you have further questions consider sending them through the Health Care Authority's Health Home mailbox: healthhomes@hca.wa.gov

If you have specific questions contact your local HCS or AAA.

My contact information is:

Cathy McAvoy
Health Home Training Program Manager
360 725-2637
Mcavocm@dshs.wa.gov

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Next Webinar

Thursday, September 11, 2014
9:00 AM – 10:30 AM
Topic: The Pediatric Symptoms Checklist (PSC) -17
Presented by: Dr. Michelle Terry, MD

Reserve your Webinar space now at:
https://www2.gotomeeting.com/register/213625202

The PSC-17 is a new required screening for children ages 4-17 years and will be required starting October 1, 2014. Also on October 1, 2014 the PHQ-9 will be administered for those 18 years and older. The former standard included children ages 16 and 17 years of age. Children 16 and 17 years old will now be assessed using the PSC-17.

Certificate of Completion

Discharge Resources

Cathy McAvoy, MPA
Duals Integration Training Program Manager
Behavioral Health and Integration Services Administration - DSHS

Webinar aired on: August 14, 2014 in Lacey, Washington
for Health Home Care Coordinators

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