Health Home Implementation Webinars

Session #29– December 4, 2013

Health Homes and Nursing Home Transitions

NEW YORK state department of HEALTH

Agenda

- Introduction
- Presentation: Valerie Deetz, Director, Division of Adult Care Facilities and Assisted Living Surveillance
  - **Health Homes and Their Role In Transitioning Nursing Home Residents to the Community**
- Q&A

Health Homes and Their Role In Transitioning Nursing Home Residents to the Community

Valerie Deetz, Director
Division of Adult Care Facilities and Assisted Living Surveillance and the Community Transitions Program
Center for Health Care Quality & Surveillance
NYS Department of Health

Community Transitions Program

Program is charged with facilitating the transition of individuals with serious mental illness (SMI) who are appropriate for transition, to the community with housing and services. The Community Transition Program (CTP) team works closely with:

- Office of Mental Health,
- Office of Health Insurance Programs,
- Patient and resident advocates,
- Nursing homes and adult care facilities,
- Psychiatric hospitals,
- Service providers and other LTC stakeholders

To ***assess*** individuals, ***identify*** appropriate housing options and services, and ***facilitate*** resident transitions to community settings.

483.15 The Quality of Life
(b) Self-determination

The resident has the right to:

"Choose activities, schedules and health care consistent with his or her interests, assessments and plans of care"..... And

Key Point - Engage the resident and the entire Interdisciplinary Team in a person-centered approach to assessment and planning!!

Nursing Home Background Information

- The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) mandated that all individuals with **SMI** or mental retardation **(MR)** applying for nursing home placement be:
  - 1. Identified (Level I PASRR Review);
  - 2. Placed appropriately; and
  - 3. Receive the SMI or MR services they require.

- In addition, residents of nursing homes with SMI/MR must be re-evaluated (RR) when they experience a significant change in physical or mental status.

Nursing Home Settlement to Conduct Assessments

The New York State Department of Health selected a vendor, ***Transitional Services Inc. of NY (TSI-NY)*** to conduct assessments of certain nursing home residents & other individuals with serious mental illness (SMI) in order to determine whether their needs can be met in an appropriate community setting, consistent with the Stipulation and Order of Settlement in Joseph S., et al. v. Hogan, et al., United States District Court for the Eastern District of New York, No. 06-CV-1042 (BMC)(SMG) signed September 6, 2011.

Individuals to be assessed are referred to as Nursing Home Remedy Members (NHRMs).

Definition of Nursing Home Remedy Members (NHRMs)

NHRMs to be assessed by TSI-NY include:

- **New York State Medicaid recipients with SMI who meet these three criteria:**

1) were residents of NHs on September 6, 2011,

2) their nursing home care is paid by the NYS Medicaid program, &

3) immediately prior to their residence in NHs, resided in psychiatric hospitals.

- **New York State residents with SMI who meet these two criteria:**

1) were residents of psychiatric hospitals on September 6, 2011and

2) have received a Revised Level II PASRR Evaluation while in a psychiatric hospital & were determined to have total needs such that placement into Community Housing was appropriate, but it was determined that Community Housing was not available at that time, & a nursing home was appropriate & desired.

Scope & Timing of Assessments

Scope: 2,375 individuals with SMI residing in either NYS or out-of-state nursing homes.

- The majority (64%) reside in the New York City Metropolitan Region (the five boroughs, Westchester and Nassau).
- Approximately 340 live in New Jersey & 140 in Massachusetts.

Timeframe: Assessments began December 2012 and must be completed by November 2014, within 24 months of the contract execution date. To date, TSI has completed approximately 1200 assessments.

Transition Process

- Final assessment report is issued to nursing home, DOH, the NHRM, and guardian when applicable.
- Nursing home is responsible for reviewing and planning for the safe & appropriate discharge of the resident.
- Community Transition Coordinator and Team work with the nursing home and the individual to facilitate discharge by:
  - Providing education
  - Identifying resources on available community service options; and
  - Enrollment in Health Home or MLTC Plans as appropriate

Role of Health Homes & MLTC Programs

- Responsive to Nursing Home outreach.
- Recognize the potential for high intensity of care management and community services for this unique population as the residents may have received 24/7 services in a highly supervised health care environment.
- Educate the NH Interdisciplinary team on the role of the HH, how and by whom services are provided, and the role of the care manager.
- Ongoing communication with the NH and prior to discharge with the housing contractor to ensure that all required services are care planned and arranged.

Role of Health Homes & MLTC Programs

- Recognize the need for prompt enrollment and service coordination to ensure housing is not compromised.
- Recognition that NHs may be unfamiliar with transitioning individuals with SMI to the community.
- Keep resident, family, guardians involved and informed of the plan of care to ease anxiety.
- Work with NH interdisciplinary team to identify service needs based on community placement assessment in addition to HH/NH identified needs.

Role of Health Homes & MLTC Programs and Lessons Learned

- As soon as practicable, the Health Home should become an active discharge planning partner.
- The Health Home should provide one point of contact for the nursing home including the name and contact information for that individual and the name of the lead HH.
- The HH Point of Contact should provide the NH the toll free referral line.

Successful Discharge Planning

- Provide ongoing collaboration necessary for successful community transition
  - Social worker
  - Direct care staff
  - Psychologist
  - Psychiatrist
  - Peer mentors, Activities Professionals
  - Nurses and Dieticians
  - Health Home/ Managed Long Term Care Representatives
  - Housing Contractors
- Self-administration of medications
  - NH should be developing a plan of care to address educational needs.

Initial Transition Period

- The transition/discharge plan of care must be created using a collaborative approach by the HH and the NH team.

- Each Nursing Home Remedy Member transitioning to the community may require intensive case management and services during the transition period.

OMH Involvement in Housing

- Considerations:
  - Alternative to institution
  - Promote rehab and recovery
  - Consumer choice

Housing Models for Persons with Serious Mental Illness

- Congregate Housing:
  - Congregate Treatment
  - Licensed CR/SRO
  - Unlicensed SP/SRO
- Apartment Housing
  - Apartment Treatment
  - Supported Housing
- Adult Family Care
- Mixed Use Housing

OMH Community Support Services For Persons with Serious Mental Illness

- **Case Management**
- **Continuing Day Treatment (CDT)**
- **Personalized Recovery Oriented Services (PROS)**
- **Assertive Community Treatment (ACT)**
- **Clinic Services**

Health Homes will have an opportunity to share their expert knowledge on Community Mental Health Services with the Nursing Home discharge team.

Successful Discharge Planning Building Partnerships

- 35 NHs received training to access community housing & services through the NYC Human Resource Administration (HRA) since 2/2013.
- Residents must be provided information that allows them to make informed decisions regarding discharge to include: housing, location, health care and support services.
- Discharge Planners must work with the entire **Interdisciplinary Team** to consider all discharge options to recommend community placement or recommend ongoing nursing home care.

Successful Discharge Planning

- The safety of the resident's transition is paramount.
- Discharge is a comprehensive process that requires the efforts of the entire Interdisciplinary Team and the Health Home.
- The team must make provisions to meet on a regular basis to support the resident.
- Discharge planning should include periodic discussion of the approach to support a safe transition.
- Prompt assessment, enrollment, and service provision by the Health Home is crucial to obtaining OMH housing.

Successful Discharge Planning

- The individual should be fully aware of his/her circumstances and ability to make decisions.
- The resident must be fully educated about the multiple options from which to choose residential alternatives.
- The resident must understand the type of services necessary to live successfully in the community

Successful Discharge Planning
Informed Decision Making

- Residents must be educated regarding the expense of housing and services.
- Social Services staff working with the health home must complete all necessary paper work to ensure that the resident has the necessary wrap-around health and support services.
- In order to choose a health plan and primary care physician, the resident must also be aware of the varying types of MLTC Plans or Health Homes (HH).
- The social worker should be in contact with the care manager of the selected health plan to ensure an individualized plan of care is developed.

Successful Discharge Planning

- Desire
- Physical and Behavioral Health Needs
- Identify and address resident's anxiety
- Location and Level of Housing
- SPOA vs. HRA application
- Supportive and Rehabilitative services
- Activities

Role of the Community Transition Coordinator

- The Community Transition Coordinator serves as a connection between the varying organizations and agencies that will be partnering to provide a safe and successful discharge.

Please be responsive to the CTC when she contacts you.

Nia Gill is the lead CTC for the NH Initiative

Marcia Kolakoski is the lead CTC for the AH Initiative

- The CTC's role is designed to monitor and relay the progress of the discharge process while providing guidance and resource information.

Education & Training

- DOH & OMH prepared educational booklets that describe housing and service options for persons with serious mental illness. A joint DOH and OMH letter and approximately 2,000 booklets were distributed to NYS Article 28 hospitals and nursing homes on March 7, 2013.

- Information contained within the letter and booklet was designed to assist hospital & nursing home discharge planning staff & their residents become familiar with the range of services available in the community. An electronic copy of this handbook was also posted to the Health Commerce System (HCS) and may be downloaded.

Contacts

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COLLABORATION IS KEY

THANK YOU FOR YOUR COMMITMENT!!!!

WE LOOK FORWARD TO CONTINUING OUR PARTNERSHIP WITH YOU.

QUESTIONS????

Useful Contact Information

- Visit the Health Home website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- Get updates from the Health Homes listserv. To subscribe send an email to: listserv@listserv.health.state.ny.us (In the body of the message, type SUBSCRIBE HHOMES-L YourFirstName YourLastName)

- To email Health Homes, visit the Health Home Website and click on the tab "Email Health Homes" http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- Call the Health Home Provider Support Line: 518-473-5569