What is Nursing Home "Navigation"?

We use the term "navigator" because individuals who want to transition into chosen community residences from institutional settings often require assistance to *navigate* their way through the system of eligibility requirements, various provider agency processes and other aspects of getting home and community based services and supports.

Though it often does involve helping people to identify and access supports and services, we see this process as being unlike service coordination or "case management." There is no pre-determined set of services or supports that can be "ordered" for any one individual. Rather, each person's unique skill and support needs and preferences dictate the extent and nature of the work that the navigator must undertake to support the person's transition.

The range of needs can be vast; one person may simply need help acquiring a single, simple support (like a wheelchair ramp or an assistive technology item), while another may have to start the process of searching for a home from scratch and may have extensive physical and health-related needs that require numerous, complex and labor-intensive supports.

Navigation, in this sense then, can include:

- **involving** the person in assessing their situation, goals and needs;
- **assessing** their personal finances and resources;
- **understanding** available/applicable funding programs and benefits;
- **arranging** for housing and for the daily supports needed for the person to live as independently as possible;
- **getting access** to health services and acquiring supplies and equipment;
- **identifying/arranging** for transportation;
- i**dentifying** work, school, social, spiritual, recreational and other opportunities and activities;
- and possibly, **advocating or identifying advocates** to assist with them with their due process rights.

As you can see, it is important for Navigators to be comprehensive in terms of what they are prepared to do and, at the same time, highly flexible in choosing the tasks that match the individual and their situation. The information in this section and the next (*Navigator Roles and Responsibilities* and *Individualizing Transition/Diversion*) is designed to support your efforts to involve each person in their own, unique process of navigating through transition or diversion.

Traits of Successful Navigators

1. Extensive **knowledge of local and state community resources and nursing homes**

2. Working **knowledge of the Medicaid home and community-based service/support programs**

3. Demonstrated **ability to work diplomatically** with individuals and teams and to **foster collaborative relationships**

4. Working **knowledge of disability laws such as ADA, IDEA, and Section 504** as they apply to rights, services and supports to persons with disabilities.

5. A functional **understanding of the 1999 U.S. Supreme Court's Olmstead decision.**

6. Working **knowledge of Due Process/Grievance Procedures** and timelines.

7. Demonstrated **creative ability to identify, organize and access community supports and resources.**

8. Willingness to **work flexible hours** and some weekends.

9. Willing to serve as an **advocate** and be responsive to the needs and preferences of the individual (person centered).

10. A history of **commitment to civil/disability/aging rights**.

11. A **commitment to direct involvement with individuals**, including the arrangement of transportation and other supports necessary to fulfill the navigator role.

12. Demonstrated **ability to maintain necessary documentation** for successful transitions/diversions - with accommodations if necessary.

13. Demonstrate an **ability to listen and be non-judgmental**

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Navigator
Typical Duties and Responsibilities

1. Contact and visit nursing homes in West Virginia to meet with residents who currently/potentially want to live in their chosen communities; also visit community residents who wish to avoid nursing home placement.

2. Inform, educate and inspire nursing home/facility social workers, Long Term Care Ombudsmen, home and community based service providers, etc in collaborating with people who are in transition in the development of community options and strategies.

3. Assist people who are in transition in identifying and using local and state community resources.

4. Assist people who are in transition in applying for eligibility for (and in using) the Medicaid home and community based service programs.

5. Interview and gather comprehensive information with people who are in transition and their caregivers and coordinate/arrange extensive person/family-centered assessments that include: the goals of people who are in transition, functional, financial, social supports, mental/cognitive status, and risk identification.

6. Assist people who have disabilities and/or long-term care needs to exercise their rights (including their rights to due process and grievance procedures, if necessary) and to utilize services and supports, as needed or wanted, and as specified by such laws as the ADA, IDEA and Section 504.

7. Support people who have disabilities and/or long-term care needs in understanding the 1999 Olmstead Decision (and related available resources and processes) and to live accordingly in their chosen communities.

8. Develop, coordinate and, if needed, implement person/family-centered transition plans which may address: living arrangement, employment, daily routine, environments, participation in the community, confidentiality, privacy, life satisfaction, consumer rights, safety, fair treatment, health and wellness, abuse and neglect, service continuity, security, and connection to natural support networks.

9. Schedule work time in response to the needs and preferences of people who are in transition, including some evening and weekend time.

10. Arrange transportation and any other supports necessary to fulfill the role of a navigator whose primary tasks happen in direct contact with people who are in transition.

11. Document the progress of people successfully transitioning or diverting, including the acquisition and utilization of any needed accommodation to complete the documentation.

12. Follow-up for at least three months with people after they have transitioned to the community to ensure their continued success and satisfaction.

13. Consistently *demonstrate understanding** with people who are in transition, family members, colleagues, etc.

* "**Demonstrating Understanding**" is a discreet skill of what is often called "active listening," and it means *accurately stating to another person **his or her** ideas, experiences and beliefs*. Demonstrating Understanding is the primary interpersonal skill which enables helpers to consistently respond to (and work from) the perspective of another person. It is, in essence, the opposite of "Self-Disclosing" which means *accurately stating to another person **your** ideas, experiences and beliefs*. Many helpers have to work to intentionally change the balance of these kinds of responses in favor of working more from the other person's point-of-view. In the give-and-take of mutual interaction, it actually takes more conscious effort to consistently respond to the other person's perspective than it is to offer your own. By *demonstrating understanding* more frequently than you might naturally tend to, you can show evidence of your respect for the other person and more accurately advocate for their preferences. The mutual nature of interaction will often include the person's confirmation of the accuracy of your responses, as well as their clarification about any inaccuracies. *Demonstrating understanding* involves a variety of types and intensities of responses, and when it is learned and applied with consistency, it is "where the rubber meets the road" in providing person-centered/consumer-driven experiences for people who are in transition or diversion (and for people in general).

Tips for Visiting Nursing Homes

Nursing homes are often the source of our referrals; many of them are supportive of people who don't want to live in their facilities indefinitely. Our preferred approach is to **establish a positive, collaborative relationship with the person transitioning, and the staff and administration of each facility.** Sometimes, while visiting one person we meet someone else who expresses a desire to leave. And, other times we visit nursing homes in the interest of finding such people. In any case, we need to keep in mind that we are "visitors" and for many people the facility is their home. It is also important to respect each individual's right to confidentiality; so, we always complete any documentation (releases, e.g.) necessary to ensure that the person has given permission for identifying information to be provided to anyone else. Here are some additional points that have emerged from our experience:

1. **Demonstrate respect for where, when and how you communicate with persons you are assisting**. Some people may be more comfortable discussing their dissatisfaction with living in the facility out of "earshot" of facility staff. If you suspect that this is the case, ask the person if they would prefer to have you visit later in the afternoon or evening when administrative staff may have left for the day.

2. **Demonstrate generosity and understanding.** Sometimes people feel isolated from the rest of the world in a nursing home or other institution. It can be effective in terms of connecting to ask the person if there is something you can bring them that's not readily available; the simplest thing (a pack of gum, cigarettes, a video or fast food) might be perceived as a significant experience.

3. **Demonstrate active listening and understanding**. It is important that people who are considering such a significant life change feel that their perspective is being heard, respected and responded to. Listen carefully and consistently demonstrate your understanding of the person's ideas, experiences and beliefs. (See "Typical Duties and Responsibilities" in the *Navigator Roles and Responsibilities* section).

4. **Respect each individual's background and cultural issues.** Some people may be more comfortable working with someone who dresses and behaves more casually and relaxed; others may feel more respected by and trusting of someone who dresses and acts more professionally.

5. **Be flexible with your availability.** Transitioning is not an 8:00 to 5:00 job. Always provide the individual with flexible contact times and phone numbers. (People sometimes prefer to call after normal business hours.)

6. **Encourage community contacts.** There may be other people in the community who could also visit and provide more outside contact than you

can manage alone. It is important that the person feels connected to the community.

7. **Passion and commitment is a necessity.** Personal commitment from each of its members is the key to a successful team. Team members supporting someone in transition should feel passionate about helping people to achieve their goals and their dreams.

Tips from the Road…
Ideas from Navigators for Navigators

1. Nursing home transition is not a “9 to 5” process, it is a journey. A transition might take days, months or years. Each one is individualized and different. Be prepared for obstacles and setbacks. Keep in mind that this is not case management; rather, you are assisting the individual to assert his/her civil rights.

2. Successful transition is local. Get to know your local resources and how to access them. What works in Morgantown may not work in Charleston or Martinsburg.

3. There is no workshop about waivers or community supports, you learn by “just doing it”.

4. Find the knowledgeable people with disabilities/family members in your area. They are not hard to find. Ask around, hang out at the mall, go to local support groups, be open, if you don’t find them, they will find you.

5. Build your network. Who do you respect, and who is respected in your area? If you know the right people your job can be easier. Some resources know the right people and how to avoid the pitfalls?

6. People with disabilities are the best judge. What vendors/organizations do they utilize?

7. Let social service organizations know what you will be doing as a navigator. Once they know what you need, many times they are willing to contribute resources such as furniture, equipment, and start-up funds.

8. Identify allies within state agency offices. Once you have earned their respect, they are willing to help (even if it is “off the record”). They can assist you when solutions need to be developed.

9. Set up a time to meet with individual discharge planners/social workers at nursing homes and hospitals in your area. Let them know your role as a navigator. They can be a great referral source and many times are willing to work with you once they know you’re out there.

10. Your first priority should be to work toward the goals and preferences of the individual. You should help them to find their own voice.

11. Meet regularly with the individual, family and team members in order to set concrete goals that move toward a successful transition.

12. Know about due process in the community support DHHR programs, MR/DD and AD Waiver programs. Keep careful and complete documentation, make sure timelines are followed.