The Transition Process

The process of transitioning from a nursing home to community living can be fast and simple or complex and lengthy. Many nursing home residents have significant needs for services and supports, and are vulnerable to even brief problems in their service and support systems. The transition process itself can be a significant source of stress. Under these conditions, a person might not plan as carefully as needed, or follow through with plans, or cope with problems. For all of these reasons, it is critical that the person facilitating the transition (the Navigator) is effective and thorough. The information in this section are intended to help ensure that effectiveness and thoroughness.

The Navigator must be able to use the information and tools with flexibility. The process and tools do not represent simple, discrete steps to be taken one at a time. Instead, they assist with a range of issues needing to be addressed in the transition process.

Nursing home transitions should be characterized by:

1. **informed choice and**
2. **consumer control.**

"Informed choice" means that the person is informed of as many residential options as possible. Methods of ensuring informed choice vary with different residents. Transition tools may be shared to provide better understanding of the planning process, identification of ones needs and each person's responsibilities within the process.

"Consumer control" means that the person transitioning makes the decisions about his/her planning. Control may include asking others to assist with decisions, but the control remains with the consumer. The consumer decides how he/she will plan the move, who will participate in the planning, what is to be accomplished through the planning and transition, who will provide services and supports, the pace of the activities, and other issues. External variables (such as the availability of housing) will influence the consumer's choices, but that should occur in the context of informed choice.

Another aspect of consumer control is "consumer responsibility". The decisions and activities involved in transitioning should be regarded as responsibilities of the consumer. To the extent that the consumer needs assistance, team members (such as family members and friends) may contribute to the work that needs to be done. If further support is needed, professionals should be engaged in the transition activities. Whenever possible, and to the extent possible, the consumer should be directly involved in the transition planning and implementation. Transitioning is not doing “for” or “to” the person, but is working “with” the person.

TIC Transition Process

Referrals can be made by anyone —family member, self, discharge planners, etc

Referrals for transition are to a single source (at this time).

1. A referral is to **Robin Gilmore** at the Northern West Virginia CIL (NWVCIL) - **304-296-6091 (Inquiry paperwork)**

2. The NWVCIL provides **referral to the Local or Regional Navigators**

3. The regional Navigator makes **contact with the referral source and consumer within 3 business days.** (Contact with the ombudsman/family/NH social worker should also occur). (Intake paperwork)

4. Robin from NWVCIL makes **follow-up call to Navigator 7 business days** from referral date.

5. NWVCIL provides **TA/advocacy**, etc.

6. NWVCIL provides **oversight and support to Navigators**—monthly

7. Navigator Dialogue every other month – **(TIC Talk)**

8. Semi-Annual **Report** of data collection **to State Medicaid-DHHR, Olmstead Director and the Consumer Oversight Commission**

NVWCIL will provide technical assistance to navigators and others, initiate follow-up with navigators, collect data and process paperwork. NWVCIL will provide data, paperwork, etc. to TIC staff for federal and state reports and systems change activity development.

a. **Other potential points of entry – ADRC, Behavioral Health, Senior Centers/Individuals**
b. **Need a 1-800 #**
c. **Single point provides TA to navigators, follow-through, data collection, and quality assurance for program.**
d. **CED or other entity provides quantitative and qualitative analysis of data to the State**

Inquiry Form

Person completing inquiry: _____Date:_____

Name: _____Social Security #:_____

Address: _____City_____

State:_____Zip:_____ County:_____

Phone:_____Email:_____ Gender:_____

Date of Birth:_____Age:_____ Ethnicity:_____

Guardian/Conservator_____ Contact #/ email_____

Primary diagnosis/disability:_____When did this occur?_____

Diversion_____ Transition_____Other_____

Contact Information

Referral Source:_____Relationship :_____

Financial Support: Medicaid____ Medicare____ Insurance____ Other_____

Referral to:_____

Individual(s) is/are seeking information regarding:

□Transition □Housing □Employment □Recreation

□Education □Advocacy □Transportation □Medical Items

□Disability Information □Mental Health □Medication Assistance

□Assistive Technology □Personal Care . □Benefits Information

□Financial Supports □Money Management □Safety/Security

□Mobility □Legal □Respite □Health □Social Supports

□Other _____

Intake Form:
Date of initial contact_____

Name: _____Social Security #:_____

Address: _____City_____

State:_____Zip:_____ County:_____

Phone:_____Email:_____ Gender:_____

Date of Birth:_____Age:_____ Ethnicity:_____

Guardian/Conservator_____ Contact #/ email_____

Diagnosis/Disability__ _____

What is your current living situation?

Would you like to live independently?

Have you ever lived in the community? Describe?

Have you ever lived in a nursing facility? How many months (Total)? Describe?

- **1 month**
- **1-3 months**
- **4-6 months**
- **7-12 months**
- **1-3 years**
- **4-5 years**
- **6-10 years**
- **11+ years**

Have you ever lived in a hospital? How many months (Total)? Describe?

ADLS for which assistance is necessary. (Usually from the plan of care.)

- **Bathing**
- **Dressing**
- **Eating**
- **Toileting**
- **Transferring**

Describe the life you would like to have? Where would you like to live?

What types of assistance do you think you will need to stay in your community?

What are your hopes and dreams for the future?

What are your goals and what might be barriers to reaching those goals?

Of these goals, which would you most like to pursue? (Prioritize the goals.)

Who are your family/informal supports you would like to have involved? :

Name:_____Phone:_____Type of Support :_____

Name:_____Phone:_____Type of Support :_____

Name:_____Phone:_____Type of Support :_____

Name:_____Phone:_____Type of Support :_____

Who supports you from an agency?

Name:_____Phone:_____Type of Support :_____

Name:_____Phone:_____Type of Support:_____

Name:_____Phone:_____Type of Support _____

Name:_____Phone :_____Type of Supports_____

Name:_____Phone:_____Type of Support:_____

What are your Current Barriers/Problems/Issues? (Circle)

Housing Resource Coordination/Case Management
Transportation Personal Care Housekeeping
Mental Health Money Management Communication
Legal Safety Security Respite
Financial Mobility Social supports
Employment Education Decision Making/Informed choices
Other _____

What types of services or supports do you receive? Who is your primary Payor?

Food Stamps □ AFDC □ Medicaid/WV Chip □

DRS □ Veterans Benefits□ TRIP □ SSI □ Family □

SSDI □ Medicare □ Mental Health Programs □ A/D Waiver □ NEMT □

Deleted: Waiver □MR DD

EA □ LIEAP □ SCA □ WIC □ JOIN □ Other □

Resource Coordination/Case Management □ Faith Based Organization □

Primary Payor for Long Term Care Services and Supports _____

***I would benefit from information on*:**

_____Family Care/Support Services ____ Assistive Technology

____ Social Supports
____ Money Management
_____Employment Resources
_____Education/Higher Resources
_____Counseling Resources
_____Nutrition/ Health Education
_____Behavior Management Resources
_____Transportation Resources
_____Self determination/advocacy
_____Recreation resources
_____Peer Network/Support
_____Vocational Training
_____ Housing Resources

I was fully involved in the completion of this document and decisions made are a reflection of my wishes and needs.

Signature_____ Date_____

Co-Signature_____ Date_____
(Guardian)

Intake/TIC Staff_____ Date_____

Close/Review Form

Date_____ **Name**_____

□ **Successfully Transitioned** □**Successfully Diverted**

Transitioned/Diverted from □Hospital □Nursing Home □Personal Care Home

□Apartment □Home □Assisted Living Facility □Group Home

□ Other_____

How long were you there prior to transition/diversion_____ □Days □Months □Years

Transitioned/Diverted to □ Hospital □ Nursing Home □Personal Care Home

□Apartment □ Living alone in Home □ Living with spouse/family

□Assisted Living Facility □Group/Shared Home □ Adult Foster/Family Care

□ Other_____

Three months after Transition/Diversion:

- Living in Community □ Other institutional Setting □ No Data
- Returned to nursing facility □ Deceased
-

Types of <u>public supports</u> utilized for transition/diversion:

□A/D Waiver □MR/DD Waiver □Food Stamps □AFDC

□Medicaid/WV Chip □DRS □Veterans Benefits □TRIP □SSI

□SSDI □Medicare □Mental Health Programs_____

□ Service/Resource Coordination/Management_____

□ Donated items/services_____□Other_____

Types of <u>private supports</u> utilized for transition/diversion:

□Family □Friends □Private insurance □Private pay staff

□Other_____.

ADLS for which Assistance is necessary:

_____ Bathing

_____ Dressing

_____ Eating

_____ Toileting

_____ Transferring

_____ other._____

_____ other. _____

Cost for Transition/Diversion:

Planning and Navigation:	$_____
Case management (post transition)	$_____
Start up costs – utility, security Deposit, household items, etc:	$_____
Other:_____	$_____

Amount Expended for Transition :_____

Transitional Costs – Approved

Services, supports and items determined acceptable as transitional/diversion expenses.

Services:

Pre-transition coordination/facilitation
Modification of living environment
Assistive Technology
Moving Expenses

Supports:

Security Deposit
Payment for debts that inhibit transition
Initial Utility connection fees
Pre- transitional support – telephone set-up and linkage
Assistive Technology
Coordination – pre-transition, transition, follow-up, case management, services coordination

Items:

Furniture – bed, chairs, refrigerator, table, clock, micro-wave.
Household items- towels, rugs,
Clothing
Storage Fees