Office of Long-Term Living Online Training:

Nursing Home Transition (NHT) Program Overview

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# Welcome

Welcome to the Program Overview module of the Nursing Home Transition (NHT) online training series. This online training series is intended for NHT Coordinators, Supervisors, and Service Coordinators.

The purpose of this module is to provide an overview of the NHT Program, including its history, goals, benefits, and current state trends..

## Resources Document

Various websites are mentioned throughout the training modules. To ensure that the links to these sites remain accurate, we have placed them in a separate document on this website.

Whenever a link is available in the resources document, the following bar will be displayed in the training module, usually at the bottom of your screen..

## Objectives

Please take a moment to read the objectives for the Nursing Home Transition Program Overview module.

* Explain why the NHT program was developed.
* List the NHT program goals.
* List the key players and elements of successful transition planning.
* Describe how to access Home and Community-Based Services (HCBS).

# The History of NHT in Pennsylvania

Let’s begin by taking a general look at the history of NHT in Pennsylvania.

## NHT Program History

Participant direction grew out of the independent living and disability rights movement in the 1960s.

The NHT program is a participant-inspired initiative based on the concept that participants have the right to make informed decisions about their own lives and well-being, and have the right to receive long-term services and supports (LTSS) in the least restrictive setting.

The NHT program serves to identify participants and enhance opportunities for identified individuals who wish to return to the community.

## Barriers to NHT

Since the implementation of NHT, a number of significant barriers to transitioning from a nursing facility into the community have been identified.

Barriers include housing, the need for home adaptations, coordination of services, and family issues.

## Addressing Barriers

NHT Coordinators, also known as NHTCs, and sometimes Service Coordinators, also known as SCs, work to address these barriers by providing NHT participants assistance with:

* Information on community resources;
* Finding housing;
* Getting necessary home adaptations, if needed;
* Enrollment into new program services (for new program participants) or other state or federally funded programs;
* Accessing other entitlement programs such as the Supplemental Nutrition Assistance Program, or SNAP;
* Obtaining essential furnishings and necessary initial supplies to establish a household; and
* Addressing concerns that family members may have.

In addition, there are many other barriers that may need to be addressed, such as:

* Need for medical and non-medical in-home services,
* Lack of transportation,
* Need for drug and alcohol services,
* Behavioral health concerns, and
* Criminal backgrounds.

## NHT Success

What makes the NHT Program successful?

* The program has evolved over the years and it continues to strengthen transition efforts in Pennsylvania;
* Strengthened collaboration among aging and disability organizations, nursing facilities, and service agencies at the state and local level provide support, guidance, and expertise to the NHT Program;
* The majority of individuals who transition are able to return to their house or apartment or to the house or apartment of a loved one; and
* The program enhances opportunities for individuals to move to the community so that people feel they have a choice of where they live and receive services.

## The History of NHT Review Activity

Now, check your understanding by answering these review questions.

1. True or False. The NHT Program is a participant-inspired initiative based on the concept that participants have the right to receive long-term care services in the least restrictive setting.

Please pause.

The correct answer is True. The NHT Program is a participant-inspired initiative based on the concept that participants have the right to make informed decisions about their own lives and well-being and have the right to receive long-term care services in the least restrictive setting.

1. Which of the following best exemplifies a significant barrier to transition from a nursing facility to the community?

* Housing needs.
* Family apprehension.
* Lack of services.
* All of the above.

Please pause.

The correct answer is all of the above. Housing needs, family apprehension, and lack of services are significant barriers to transitioning from a nursing facility to the community.

# NHT Program Goals

Now, let’s turn our attention to the goals and benefits of NHT.

## Program Goals

The six primary goals of the NHT Program are to:

* Enhance opportunities for individuals to move into the community by identifying individuals who wish to return to the community.
* Educate individuals and families about LTSS.
* Identify and overcome barriers that prevent transitions.
* Develop the necessary infrastructure and supports in the community.
* Empower participants, so they are involved to the fullest extent possible in planning and directing their own transition.
* Help Pennsylvania re-balance its long-term living systems so that people have a choice of where they live and receive services.

## Benefits of NHT Participation

You will find that many of the goals of the NHT program are also the benefits of participating in the NHT program.

Take a moment to read about some benefits of NHT participation.

* Allows for “No Wrong Door” access to information about LTSS and transitioning from nursing facilities
* Ensures that all options are fully explained concerning long-term living choices
* Provides guidance and support in transitioning to the community
* Assists in finding and obtaining housing and setting up a household, if needed
* Provides information and assistance for HCBS and other community programs
* Makes available resources to assist an individual in establishing new or basic living arrangements, if needed
* Identifies and eliminates barriers to better serve individuals in the community

## NHT Program Goals Review Activity

Now, check your understanding by answering these review questions.

1. Which of the following are NHT program goals?

* Identify and overcome barriers that prevent transitions
* Develop the necessary infrastructure and supports in the community
* All of the above

Please pause.

The correct answer is all of the above. The NHT program goals include:

* Enhance opportunities for individuals to move into the community by identifying individuals who wish to return to the community.
* Educate individuals and families about long-term services and supports.
* Identify and overcome barriers that prevent transitions.
* Develop the necessary infrastructure and supports in the community.
* Empower participants, so they are involved to the fullest extent possible in planning and directing their own transition.
* Help Pennsylvania re-balance its long-term living systems so that people have a choice of where they live and receive services.

1. Which of the following is the correct meaning for the acronym LTSS?

* Long-Term Supplemental Supports
* Long-Term Services and Supports
* Long-Term Service and Supplements

Please pause.

The acronym LTSS stands for Long-term Services and Supports.

# NHT Participants

In this section, we will take a look at how NHT participants are referred to the NHT Program.

## Sources of Referral

Referrals for the NHT Program can come from anywhere or anyone. The nursing facility social worker or designated staff will receive referrals for potential NHT participants. Most common sources of referrals include:

* Minimum Data Set (MDS) Section Q,
* An individual (in terms of self-referral),
* Family and friends of an individual,
* Peer groups and peer specialists,
* Advocacy agencies,
* An Ombudsman, and
* Field operations staff.

## Assistance with Transitioning

CHC-MCOs assist individuals who have expressed interest in transitioning into the community.

If participants are not enrolled in CHC, they should call the NHT Helpline.

Please refer to the DHS website for more information on the NHT Helpline. A link can be found in the Resources Document.

## NHT Participants Review Activity

Now, check your understanding by answering these review questions.

1. True or False. Referrals for the NHT Program can come from anywhere or anyone.

Please pause.

The correct answer is True. Referrals for the NHT Program can come from anywhere or anyone. Some common sources of referrals for NHT participants include:

* Nursing facility staff member or social worker.
* Individual (self-referral).
* Family and friends of an individual.
* Peer groups and peer specialists.
* Advocacy agencies.
* Ombudsman.
* Field operations staff.

1. True or False. If an individual is not enrolled in CHC, they cannot receive NHT services.

Please pause.

The correct answer is False. If an individual is not enrolled in CHC, they should call the NHT Helpline.

# Money Follows the Person (MFP)

An extension to the Commonwealth’s NHT effort is the Money Follows the Person (MFP) initiative.

In this next section, we will take a closer look at MFP, including its importance, eligibility requirements, and enrollment process.

## Importance of MFP

MFP was enacted by the Deficit Reduction Act (DRA) of 2005, and is part of a strategy to make widespread changes to the long-term care service systems to help individuals living in nursing facilities, Intermediate Care Facilities, or state hospitals move back to their home or community. These individuals include the elderly and individuals with physical, intellectual and/or developmental disabilities, or mental illness.

Pennsylvania implemented MFP in July 2008. For each individual enrolled in MFP, Pennsylvania receives enhanced federal funding that will be used to create additional Home and Community-Based Services program opportunities.

MFP is the largest single investment in long-term living Home and Community-Based Services ever offered by CMS.

## MFP Eligibility Criteria

In order for individuals to qualify for MFP in Pennsylvania, they must meet certain eligibility criteria.

### Nursing Facility Resident Criterion

The individual has resided in a nursing facility for at least 60 days (not including Medicare funded short-term rehabilitation services days).

### MA or Medicaid Benefits Criterion

The individual is actively receiving Medical Assistance (MA) or Medicaid benefits for at least 1 day prior to discharge/transition.

### MFP-Qualified Residence Criterion

The individual is relocating to an MFP qualified residence:

* A home owned or leased by the individual or the individual’s family member.
* An apartment with an individual lease and private cooking, sleeping, and bathing areas as well as locking doors.
* A residence in a community-based residential setting in which no more than four unrelated people reside (e.g., Domiciliary Care or Group Home).

### HCBS Criterion

The individual is Nursing Facility Clinically Eligible (NFCE) and enrolling into an MFP qualifying HCBS program, including CHC and LIFE.

Note: MFP eligibility does not impact eligibility for HCBS or NHT services.

## MFP Enrollment Process

If an individual meets all the criteria for MFP, the next step is the MFP enrollment process.

### Step 1: IEB or MCO

The IEB or MCO enrolls the individual into MFP by indicating the appropriate MFP participation code when completing the Home and Community-Based Services Eligibility Form (PA 1768).

### Step 2: CAO

The form is sent to the County Assistance Office (CAO) for coding MFP in the Electronic Client Information System (eCIS).

### Step 3: PA 1768

A link for the Home and Community-Based Eligibility Form (PA 1768) can be found in the NHT Resources document.

# Transition Planning

We will begin this section by taking a look at planning for transition. We will review key elements that may be included in the planning process to ensure a successful transition.

## Key Elements

In order to ensure that an individual’s health and safety needs are being met once they transition into the community, the transition planning process must address key elements of living in the community. These elements include housing, finances, healthcare, transportation, household setup, and food.

## Housing

Housing considerations include:

* Does housing need to be located?
* Do adaptations need to be made to an existing home?
* Are furniture and other household items needed?
* Do utilities need to be turned on?
* Does the participant qualify for the Housing Choice Voucher Program or other financial housing assistance?
* Will a change of address need to be submitted to the United States Postal Service (USPS) and to the NHT participant’s income source?
* How will items be moved to the residence?

## Finances

Financial considerations include:

* Does the NHT participant have a source of income?
* What is the income currently being used for?
* Does the participant have or need a power of attorney (POA)?
* Is there a Representative Payee set up through Social Security?
* Are there any overdue bills that need to be paid?
* Does a bank account need to be set up?
* What benefits does the NHT participant qualify for (e.g., SNAP, rent rebate, or Low Income Home Energy Assistance Program (LIHEAP))?
* Does the NHT participant or representative require budget counseling or training?

## Healthcare

Healthcare considerations include:

* Which physician in the community will be used?
* Which pharmacy will be used?
* Are there prescriptions that will be needed immediately?
* Are current insurance cards available?
* Are skilled nursing or therapy referrals needed?
* Does the NHT participant need to see a specialist in behavioral health, cardiology, dialysis, etc.?

## Transportation

Transportation considerations include:

* How will the NHT participant travel from the nursing facility to their home? (Some nursing facilities will provide transportation; some will not.)
* Is there accessible transportation available in the community?
* Will the NHT participant need a bus pass?
* Will the NHT participant need a bus schedule?
* What transportation will be used to take the NHT participant to and from their medical appointments?
* Does the NHT participant qualify for the Medical Assistance Transportation Program (MATP)?
* For individuals with a CHC-MCO, what transportation needs will the CHC-MCO handle?

Please refer to the CHC Transportation Fact sheet for more information. A link can be found in the Resources Document.

## Household Setup

Household Setup considerations include:

* Is there furniture from a previous residence that can be used to set up the (new) living situation?
* Are the household items and setup safe for the individual at their current functional level?
* Does the NHT participant need a home evaluation once the home is set up to make sure that the environment meets their needs?
* Does the NHT participant have the necessary items to keep the home in good order (e.g., cleaning supplies, support, etc.)?

## Food

Food considerations include:

* Will a start-up of groceries be needed upon discharge?
* How will the participant shop for groceries?
* How will the participant prepare meals?
* Does the NHT participant need a nutritional consult for a special diet?
* Will further nutritional training be necessary once the NHT participant transitions?

## Community Supports

Transition planning identifies what care and service needs will need to be met and how they will be met in the community.

All resources that will be utilized in order to ensure an individual’s health and safety needs are being met are identified, including:

* All informal supports (family and friends that will be involved with the individual);
* Third-party payers, such as Medicare, Medicaid, Hospice, private insurance, Mental Health/Intellectual and Developmental Disabilities (IDD) programs, and Veteran's Affairs (VA);
* Community resources, including church organizations and other charitable community groups;
* Counseling services and peer support groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA); and
* Other federally funded or state-funded services, such as program services, SNAP, and LIHEAP.

## Accessing Home and Community-Based Services (HCBS)

Home and Community-Based Services (HCBS) are just one of the many types of services and programs that are considered when planning for transition.

A person’s physical and cognitive ability are assessed to determine if they are eligible for the HCBS program. This may be referred to as functional eligibility.

The Functional Eligibility Determination (FED) tool and Physician Certification Form (MA 570) are used to determine level of care.

The Independent Enrollment Broker (IEB) will facilitate the HCBS waiver enrollment process.

## Transition Planning Review Activity

Now, check your understanding by answering these review questions.

1. True or False. Transition planning does not address household setup.

Please pause.

The correct answer is False. Transition Planning must address key elements of living in the community such as housing, finances, healthcare, transportation, household setup, and food.

1. True or False. For HCBS functional eligibility, you only need a Physician Certification Form (MA 570).

Please pause.

The correct answer is False. For determining functional eligibility for HCBS programs, you must have a Functional Eligibility Determination (FED) and a Physician Certification Form (MA 570).

# After the Transition

In this last section, let’s look at what can be done to support an individual’s smooth transition into the community.

## Effective Transition

So, what makes for an effective transition? A transition is about much more than an individual changing where they live. The true benefit of the transition is when an individual:

* Has an increased sense of self-direction and decision-making.
* Has the ability to participate in community activities to the extent that they choose.
* Has developed and uses informal supports, as well as the more formal supports and services.

Success is dependent on the individuals themselves and their willingness to take a proactive role in the transition process, in addition to thorough planning with the assistance of the NHTC or SC.

## After the Transition Review Activity

Now, check your understanding by answering these review questions.

1. True or False. One example of an effective transition is when an individual who has transitioned has an increased sense of self-direction.

Please pause.

The correct answer is True. An effective transition is when an individual who has transitioned:

* Has the ability to participate in community activities to the extent that they choose;
* Has an increased sense of self-direction and decision-making; and
* Has developed and uses informal supports, as well as the more formal supports and services available to the individual.

1. True or False. The success of a transition is solely dependent on the NHTC.

Please pause.

The correct answer is False. Success is dependent on the individuals themselves and their willingness to take a proactive role in the transition process, in addition to thorough planning with the assistance of the NHTC or SC.

## NHT Program Overview Summary

In this module, we explored:

* A general overview of the Pennsylvania NHT Program,
* The history of the NHT program,
* The goals and benefits of the NHT program,
* Transition planning, and
* What is an effective transition.

## Congratulations!

Congratulations! You have completed the Nursing Home Transition Program Overview training.

If you have read everything in this document, you may go to [this website](https://oltl.deringconsulting.com/nht-module1/) to register completion of this training.