
# Home Modifications During Nursing Home Transition (NHT) General Overview

**Managed Long-Term Services and Supports Subcommittee Meeting**
**September 7, 2022**

# NHT Home Modifications

- Who coordinates?
  - CHC-MCO – CHC enrolled individuals
  - LIFE provider - individuals enrolled in the LIFE program
  - Kepro - individuals who qualify for NHT services through the state fee-for-service NHT program and are not enrolled in managed long-term care

- Funding sources?
  - CHC waiver - eligible participants
  - Special Nursing Home Transition Funding - individuals not eligible for managed long-term care; requests subject to funding availability and approval on a case-by-case basis and must be participants in the fee-for-service NHT program
  - Other programs, including grants and low-interest loans e.g. PA Assistive Technology Foundation (PATF), Self-Determination Housing of PA (SDHP)/Inglis



pennsylvania
DEPARTMENT OF HUMAN SERVICES

# Prior to Transition

- Assessment to determine need for home modifications and adaptations
  - Physical Therapy (PT) / Occupational Therapy (OT) evaluation
  - Care planning taking participant needs and preferences into account
  - How will personal assistance services (PAS) or other service hours be affected by the mod/adaptation or lack thereof

- Setting appropriate expectations with participant as to timeframes for approval process, construction or installation
  - Documentation needed & time to review, approve, process
  - Contractor availability
  - Weather/seasonal barriers

# Questions

# Home Adaptations

Community HealthChoices

pa health & wellness

**Steps to transition**

- The Participant contacts the Service Coordinator (SC) and makes a Home Adaptations request
- The SC completes a home assessment
- The SC adds a Home Adaptations request to the Person-Centered Service Plan (PCSP)
- SC supports obtaining Proof of Home Ownership and any supporting documentation
- Periscope completes a home assessment
- A determination is made by our Medical Directors
- Bids are requested for approved work
- A chosen contractor completes the Participant's home adaptations
- Home Adaptations are completed before Participant transitions home

# Home Adaptations

Home Adaptations are already in place when the Participant arrives home to ensure a safe transition home.

# Nursing Home Transition Home Modification Process

**Jennifer Ford-Bey, Manager of LTSS Behavioral Health and Collaboration Services**

AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK℠

Delivering the Next Generation of Health Care

# Nursing Home Transition

AmeriHealth Caritas
Care is the heart of our work

- When a Participant has self-identified the need for a home modification, a request is submitted by the Service Coordinator to the Home Modifications Team and goes through the home modification process detailed on the following slide.
- Prior to any transition, a home visit is completed by the assigned Service Coordinator or the Nursing Home Transition Agency to make sure the Participant has a safe and accessible environment to live in upon transitioning back into the community.
  - If a need for a modification is identified during the visit, a conversation is held with the Participant/representative to gain permission to request home modifications on their behalf and/or to identify and provide applicable education on housing resources available to the Participant.
- Communication between the Home Modifications Team and Nursing Home Transition Team occurs throughout the transition process to address and mitigate any identified barriers prior to the Participant's transition.

# Home Modification Process

AmeriHealth Caritas
Care is the heart of our work

The Service Coordinator refers the Participant to the Home Modification Team.

The Home Modification Team will:

- Perform an intake evaluation
- Obtain the most recent physical therapy evaluation from the nursing facility
- Refer the request to the home modification provider selected by the Participant
- Decisions will be made within 60 days and requests for additional information may be necessary

- The home modification must be in line with the guidelines for home modification as part of the Participant's discharge plan from the nursing facility to the community.
- The provision of the home adaptation is based on the Participant's eligibility for home and community-based services (HCBS) long-term services and supports (LTSS) benefits.
- Home Adaptations shall meet standards of manufacture, design, and installation.
- Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs.

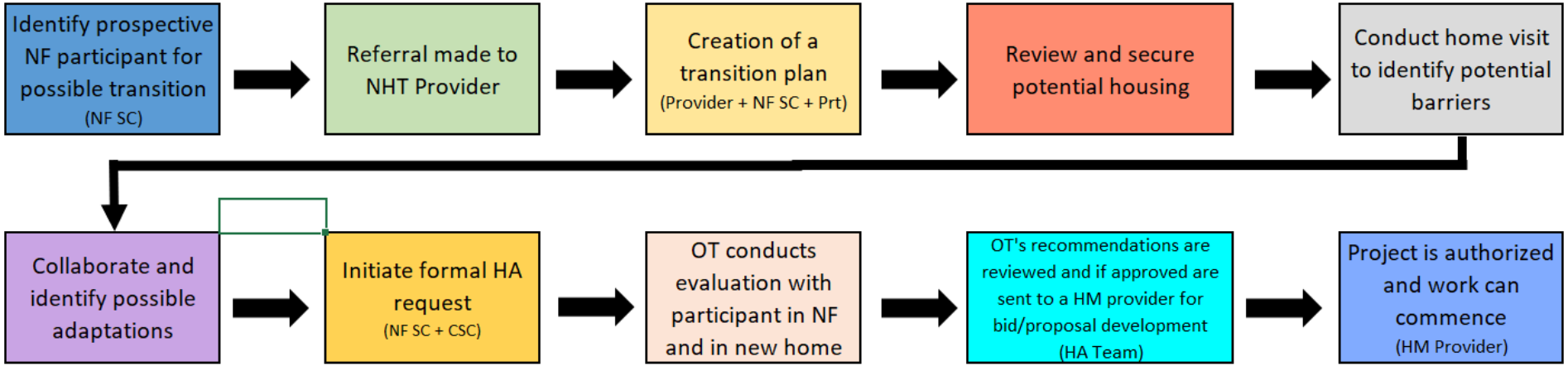
# Thank You

# UPMC Community HealthChoices
# Nursing Home Transitions (NHT) & Home Adaptations (HA)

- UPMC Community HealthChoices understands that in many instances a successful Nursing Home Transition (NHT) is directly linked to the participant's opportunity to receive a timely Home Adaptation (HA).
- It's for this reason that all parties involved in the NHT collaboratively work together throughout the process. A list of key stakeholders includes the following:
  - Participant
  - Nursing Facility Social Worker/Case Manager (External)
  - Housing Strategy team (Internal)
  - Nursing Home Transition (NHT) Provider (External)
  - Nursing Facility (NF) Service Coordination (NF SC) (Internal)
  - Community Service Coordination (CSC) (Internal)
  - Home Adaptation (HA) Team (Internal)
  - Occupational Therapist (OT) (External)
  - Home Modification (HM) Provider (External)

UPMC LIFE CHANGING MEDICINE

# UPMC Community HealthChoices
# NHT & HA Abbreviated Process Overview



# UPMC Community HealthChoices
# HA Process within NHT Process

- Before & During Transition:
  - Formal home adaptation request submitted via care management system.
  - Intake of request occurs within 1 to 3 business days.
  - Requests are flagged to ensure they are prioritized by the HA Team throughout the entire process.
  - OT evaluates participant in the nursing facility and whenever possible in the new residence and submits his/her recommendations via evaluation report.
  - The goal is to complete all approved adaptations prior to transition but priority is placed on egress / ingress if the participant can live with limited assistance once inside the home.

# UPMC Community HealthChoices
# HA Process within NHT Process

- After Transition:
  - A post completion follow-up visit is conducted by the OT within 60 days:
    - The purpose of the visit is to confirm that the participant knows how to properly and safely operate installed adaptations.
    - OT is also able to verify that installed adaptations allow participant to overcome previously identified barriers.
  - Not every transition lasts and sometimes a participant ends up back in the nursing facility. UPMC takes all measures to prevent that from happening but there are times where that’s unavoidable.

# UPMC Community HealthChoices
# Standard Home Adaptation Process

- The process laid out below doesn't account for the slight variations associated with a NHT HA. For example, UPMC would like for the independent evaluation to take place in the NF and the participant's new place of residence whenever possible.

## UPMC Community HealthChoices home adaptations checklist

| Step | Step Details | |
|---|---|---|
| 1 | Your service coordinator will assess your needs and talk with you about your goals to figure out the best solution, which may involve home adaptations. | ☐ |
| 2 | Your service coordinator will fill out a request form with you and make sure the information is correct before submitting it. | ☐ |
| 3 | A person from the UPMC Community HealthChoices (UPMC CHC) Home Adaptation team will review the request. | ☐ |
| 4 | If the request is complete and no more information is needed, an independent evaluator (an occupational or physical therapist) will visit your home to assess your needs. The evaluator or a person from the UPMC CHC Home Adaptation team will call you to schedule this visit. The evaluator will create a list of recommended adaptations, if any, that can help you meet the goals in your request. | ☐ |
| 5 | The completed evaluation report will be sent to the UPMC CHC Home Adaptation team for review. | ☐ |
| 6 | If the information in the evaluator's report is complete, the UPMC CHC Home Adaptation team will ask a provider (a construction contractor) to schedule a visit to your home. During this visit, the provider will talk to you about the project and create a proposal based on which adaptations are possible. You (and the property owner if you do not own your home) must approve the proposal in writing before the UPMC CHC Home Adaptation team completes a final review.<br><br>Make sure the provider answers all of your questions before you sign off on the proposal. In some cases, the UPMC CHC Home Adaptation team may ask more than one provider for a proposal. If this happens, more than one provider will visit your home. The provider(s) will call you to schedule a visit. | ☐ |
| 7 | The UPMC CHC Home Adaptation team will review the proposal(s) and make a final decision. | ☐ |
| 8 | Your service coordinator will add an authorization to your service plan after receiving approval from the UPMC CHC Home Adaptation team. | ☐ |
| 9 | The provider will call you to schedule the work and answer any questions you have. | ☐ |
| 10 | When the home adaptation is complete, an independent evaluator will schedule a follow-up visit with you. This is important because the independent evaluator will confirm the following:<br>• The home adaptation meets your need(s).<br>• You and/or your caregiver can safely and correctly use the home adaptation.<br>• The home adaptation meets our quality standards. | ☐ |

# UPMC Community HealthChoices
# Home Adaptation Timeframes

- The timeframes listed below are what UPMC strives to achieve but may vary based on extenuating factors such as supply chain issues, participant availability, availability to participant's new place of residence, etc.
  - Review of HA request (3 to 5 business days)
  - OT to schedule and complete the independent evaluation (15 business days)
  - Internal HA team's review of evaluation report (10 to 15 business days)
  - Completion of the provider proposal / bid (10 to 15 business days)
  - Internal HA team's review of the provider's proposal (10 to 15 business days)
  - Provider to begin work on the approved adaptations (within 4 weeks)*
  - Provider to complete the adaptations (within 8 weeks)*

***UPMC expects that providers begin work within 30 days and complete work within 60 days. In many instances, work may begin within a matter or days or weeks if the equipment is readily available.***