Take Me Home, WV

September 29, 2011

Charleston, WV

Targeted Populations

- Eligibility restricted to individuals who have resided in a Nursing Home, Hospital, or Rehabilitation Facility for at least 90 days; and
- At least one of those days have been paid for by Medicaid.

Benchmark #1

	Individuals to be transitioned			
Calendar Year	Elderly	Physically Disabled	Mentally Ill	Total
2011*	10	15	5	30
2012	30	60	10	100
2013	35	60	15	110
2014	40	65	15	120
2015	40	70	10	120
2016	40	70	10	120
TOTAL	195	340	65	600

Number of individuals transitioned each year.

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Benchmark #2

- ***State Medicaid Expenditures for HCBS increase each year.***

Year	Total LTC expenditures	Total HCBS expenditures	HCBS % of Total LTC	Qualified HCBS expenditures	Supple-mental HCBS expenditures	Demonstration HCBS
2010	1,003,381,844	466,645,341	46.51%			
2011	1,049,260,046	490,290,699	46.73%	84,464	200,000	605,879
2012	1,096,192,163	515,020,831	46.98%	435,043	400,000	3,129,269
2013	1,142,003,961	537,736,927	47.09%	746,836	600,000	3,524,228
2014	1,188,773,089	560,480,325	47.15%	1,253,819	600,000	3,132,406
2015	1,237,850,297	584,563,980	47.22%	1,483,999	400,000	3,214,931
2016	1,289,220,798	609,933,763	47.31%	1,543,233	400,000	3,258,748

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Benchmark #3

- Increase percentage of long term care expenditures that are utilized for home and community-based services.

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Benchmark #4

- The percent of transitions that are successful in keeping the individual in the community for at least 365 days without readmission to a qualified institution for more than 30 days.

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Benchmark #5

- Percent of Take Me Home program participants self-directing all or a portion of their services.

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Transition Coordinators

- There will be at least 5 transition coordinators in the state.
- Responsibilities include:
  - Educating potential MFP participants about the program;
  - Conducting a transition assessment to ensure they an appropriate transition candidate;
  - Developing a transition plan;
  - Assisting individuals in making the transition; and
  - Assisting them in accessing MFP resources.

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Benefits & Services – Existing Medicaid Services

- Personal Care Services
- Clinic & Rehabilitation - Mental Health Services
- Aged & Disabled Waiver

Benefit & Services – Grant Supported Services

- Cognitive Rehabilitation Therapy
- Case Management
- Personal Attendant and Transportation
- Transportation

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Benefit & Services – Grant Supported Services

- Supportive Housing
- Care Coordinators
- Peer Support Services

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Benefit & Services – Grant Supported Services

- ***Take Me Home Goods & Services***
- ***Community Transition Services***
- ***Extended State Plan Services***
- ***Environmental Accessibility Adaptations***

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MFP Staffing

- MFP Project Director
- MFP Assistant Project Director
- MFP Housing Coordinator
- MFP Administrative Assistant

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Stakeholder Involvement

- Stakeholder Advisory Committee
  - Subcommittee quality
  - Subcommittee on housing

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Take Me Home Advisory Committee

15 Member Committee consisting of:

- 6 people who have been, or who have a family member who has, transitioned from a long-term care facility
- The Olmstead Coordinator, or a representative from the Olmstead Council
- A representative from the Bureau of Health and Health Facilities
- A representative from a Aging and Disability Resource Center
- A representative from the Long Term Care Partnership
- A representative from a Center for Independent Living
- A representative from a housing authority
- A representative from the Health Care Association (Nursing Homes)
- 2 representatives from advocacy organizations

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Responsibilities of Advisory Committee

- Provide feedback to program staff on implementation of *Take Me Home*
- Provide recommendations on ways to improve program design or implementation
- Study and provide recommendations on long term care supports and service eligibility processes
- Develop a strategic plan for implementation of a no wrong door system to the long term care system
- Assist with the outreach/marketing/education of the program to ensure people are aware of the program.

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- Study and provide recommendations on how to build flexibility into the long term care system and to develop a sustainable infrastructure for supporting individuals who choose to transition out of institutions.
- Develop a strategy for the extension of self-direction to other state plan services such as Personal Care.
- Review benchmark data such as re-institutionalization, the services participants are utilizing, and other quality of life information to continuously improve the program.

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Quality Committee

- Will include members from the Advisory Committee as well as other interested people.
- Will meet quarterly to monitor and track trends of:
  - Benchmarks
  - Incident Reports
  - Participant and family feedback
- Will perform root cause analysis on critical system failures, including all cases of re-institutionalization.
- Will report their findings to the Advisory Committee.

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Housing Committee

- Will include members from the Advisory Committee as well as other interested people.
- Will work with the Housing Coordinator to assist with:
  - Planning and discussions with various housing organizations
  - Conducting a needs assessment
  - Identify policy barriers and ways to eliminate those barriers
  - Exploring development of rental subsidy programs
  - Developing state-wide referral mechanisms
  - Increasing access to affordable, accessible, and integrated housing

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Contact Information:

Penney Hall
304-356-4872 or
penney.a.hall@wv.gov

Marcus Canaday
304-356-4847 or
Marcus.Canaday@wv.gov

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