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DHHS, Office of Aging and Disability Services

MDS Section Q Training, June/July 2012

Money Follows the Person *National Demonstration*

- Supports states to develop a program that identifies individuals in Nursing Homes, Hospitals and ICFMR who wish to move back into the community and assists them with the transition process
- Enhances state efforts to improve community based services to help “rebalance” the system
- Opportunity to further develop community integration strategies, systems, and infrastructure for individuals with long-term support needs

Homeward Bound

- MFP in Maine is called “Homeward Bound”
- Overseen by DHHS, Office of Aging and Disability Services and developed in partnership with Adult Mental Health Services.
- We anticipate transitioning at least 25 people each year.

We are preparing for enrollment and active transition assistance to begin in August, 2012

Eligibility

Individuals must be 18 or older at the time of transition and:

- ✓ Have resided in a Nursing Home or Hospital for at least 90 days (excluding rehab.) and,
- ✓ Received Medicaid benefits for an inpatient hospital or nursing facility for at least one day and,
- ✓ Need nursing home level of care, but for the provision of home and community based services.

Eligibility cont.

Individual must be moving to a “Qualified Residence”, defined as:

- A home that is owned or leased by the individual or a family member, or
- An apartment with an individual lease, or
- A residence in a community based residential setting in which no more than four unrelated people reside

Process

- Referral
- Preliminary Assessment/Eligibility Determination
- Informed Consent/Enrollment
- Transition Planning (Resident, Family, Nursing Home Discharge Planner, Physician, Nursing Staff, MLTCOP as Advocate, Community Services as per individual needs)
- 24 hour Back Up Plan/Monitoring

Enrollment continues for 365 days post discharge

Services

A Homeward Bound Transition Coordinator works with the individual and their Multidisciplinary Team to develop and implement an Individualized Transition Plan, to include:

- Existing Home and Community Based Services as per individual needs and eligibility
- Community Support Planning (Housing, transportation, home set up, community resources and natural supports, etc.)
- Demonstration Services focused on supporting the transition

Demonstration Services

- Transition Assistance
- Specialized Clinical Assessments
- Independent Living Assistance
- Household Start- Up
- Enhanced Care Coordination
- Technology Services
- Planning Consultation
- Peer Supports

What's your role?

Nursing Home role remains the same as for any other discharge

Partnerships

Maine Long Term Care Ombudsman Program

- Initial Screening for Homeward Bound
- Transition Partner/Consumer Advocate
- Education and Outreach specific to Homeward Bound

Education and Outreach about Community Based Service and Support Resources

- Aging and Disability Resource Centers (AAA's)
- Alpha One (Center for Independent Living)

Homeward Bound

For individuals who are eligible and who choose to participate, Homeward Bound offers an opportunity for additional services and supports to assist with transition back to the community.

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Homeward Bound