

Kentucky Transition Program: Returning You Home

Kentucky Cabinet for Health and
Family Services

Medicaid & Department for Aging and Independent Living

What is Kentucky Transitions?

- Kentucky Transitions is a program designed to assist those in Medicaid institutional placements (Nursing Facilities and Intermediate Care Facilities /Mental Retardation) out into community based placement, if THEY DESIRE.
- Individuals who are elderly, physically disabled, have mental retardation or a developmental disability or have an acquired brain injury are eligible.

What is Kentucky Transitions?

- The plan is to utilize our existing community based waiver programs by adding and expanding services and providers. The program will assist the consumer in a successful transition from the nursing facility back into their home environment.

<http://www.ceap.org/senior/images/senior2.jpg>



The opportunity to live and receive services in the most appropriate care setting considering:

- The *least restrictive* care setting in which the individual can reside;
- The individual's *choice* of care settings in which to reside;
- The *availability of state resources*; and
- The *availability of state programs* for which the individual qualifies that can assist the individual.

What KY TRANS is NOT.

- KYT is not about **FORCING** anyone to move out of an institutional setting. If an individual is residing in an institutional setting and wants to stayno problem!
- KYT is about having the freedom to choose where one lives whether it is an institutional setting, a group home, alone in an apartment, or in a home with parents, other family members or friends.

KY Transitions is not about CLOSING Institutions

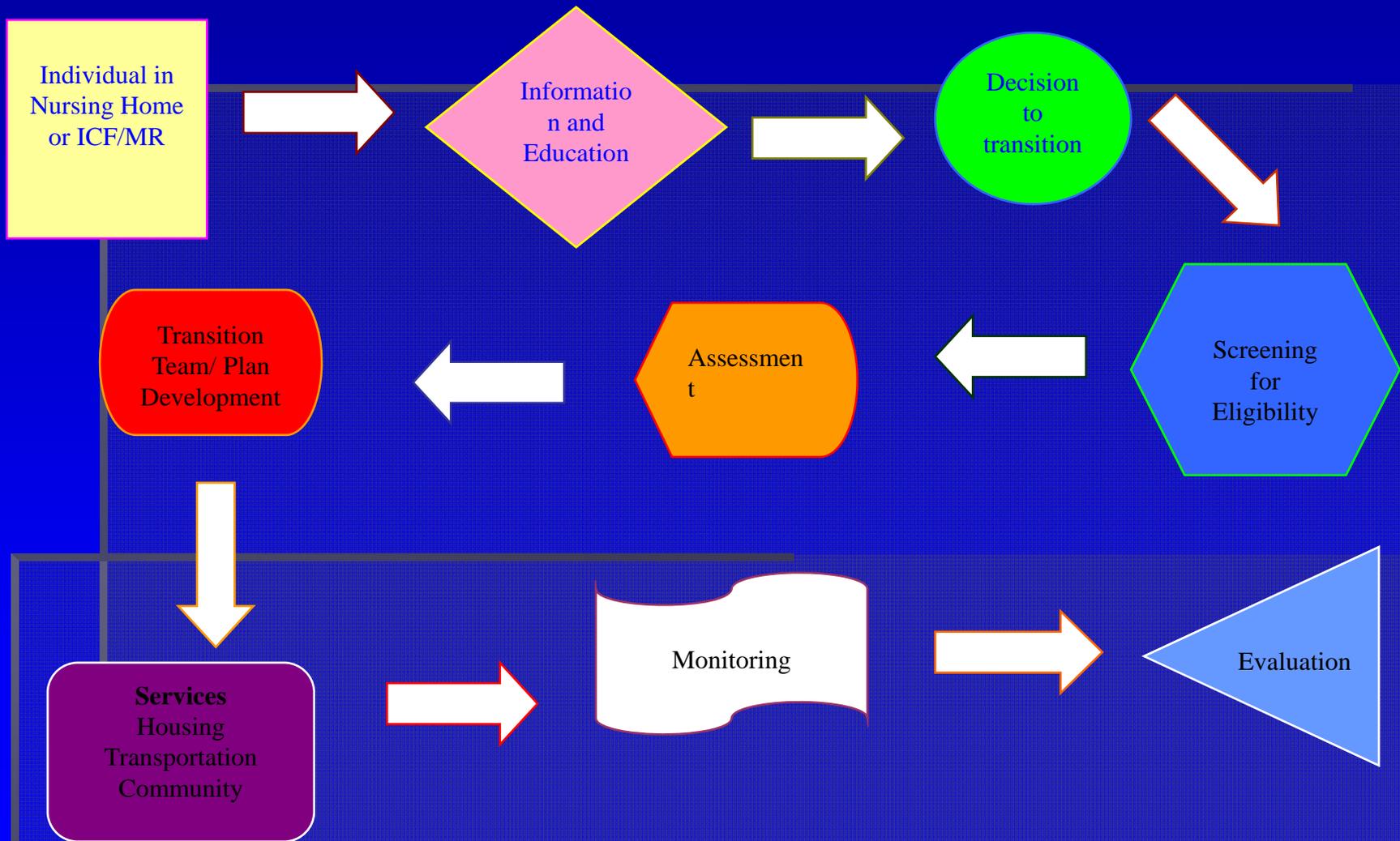
- The intent of KYT is **NOT** to CLOSE institutions or units or programs. The Cabinet is committed to not closing nursing home beds.
- The intent of KYT is to allow individuals who meet the criteria the freedom to choose where they live.

HOW WILL IT WORK?

- ✓ Identify Individual
- ✓ Identify Community Resources and Options
- ✓ Determine Fiscal Options
- ✓ Inform
- ✓ Educate
- ✓ Choose
- ✓ Assess
- ✓ Eligibility
- ✓ Transition
- ✓ Monitor
- ✓ Evaluate



HOW WILL IT WORK?



How Will it Work?

- First step will be to determine eligibility.
 - Eligible participants will have been in an LTC facilities for at least six months with the last month being Medicaid Eligible.
 - Both the individual and guardian have to agree that moving into the community is the intent.
 - After initial eligibility has been met, the participant will then meet with a transitional development team to discuss more in depth participant criteria.

Participant Criteria

- Once all criteria has been met, the individual then begins the transition process. The transition coordinators assists the consumer in finding housing, medical facilities, transportation, and personal care.

Housing

Individuals have the option of living on their own, with family members, or in approved group homes with no more than four other household members who are not related.

For those who do not have housing, the transition team will assist the individual in finding appropriate housing. The housing coordinator will also find the resources for installing the necessary modifications.



Medical Facilities

- Once the individual has moved into the community, they use doctors and medical facilities in the community.
- The Transition team will assist the individual in finding local participating medical staff and facilities.



Transportation

- The transition coordinator will assist in finding transportation for the individual.
- There will be transportation provided for a number of services including going to medical appointments, the pharmacy, the grocery, and socializing.



Personal Care

- All individuals will be evaluated for what level of need they should receive after they return to the community. Some examples would be assistances with personal care, moderate house keeping, grounds keeping, etc.



All Services

- All services will be accessed before the individual moves into the community. The goal is for the individual to have all plans developed so that after they transition into the community they will remain living at home.

Frequently Asked Questions

- **How does the Transition start?**
A Transition team will facilitate the plan by which each individual is assessed for relocation. The team will make contact with the interested individual, their family/guardian, a long term care ombudsman, and facility staff to begin the transitioning process.

What is the purpose of the Assessment Form?

The assessment form provides the Transition team with written communication and direction for the transition participant and all other supports. The signature of the participant, family/guardian, and other supports on the care plan and assessment form will grant the transition teams' permission to release information regarding the participant to community agencies and professionals.



Who will develop the individuals care plan?

- The Transition team in partnership with the community agencies will develop the care plan. If the person is Medicaid eligible, the State Transition team, and Area Agencies on Aging (AAA's) will also authorize the home care services.

Who is in charge of the transition team?

The Transition team and/or a designated family/guardian member should be in charge of securing transition goals. The assistance of a well-coordinated team effort on the part of the skilled nursing facility staff and community-based agencies is also essential.

What does an assessment consist of?

- The transition team conducts a complete medical, psycho-social assessment by reviewing the individuals' charts, interviewing staff, speaking with transition participant, and conducting other screening activities. The history of any care of the individual is reviewed and options for post-discharge care are discussed with them. From this review, transition goals are established and community agencies that can provide services are identified.

Who should be referred to the Transition Program?

- Any resident who expresses a desire to leave the facility should be referred to the Kentucky Transition Program.

Are there any financial obligations to the transition consumer?

- The grant allows each participant a transition allowance not exceeding what it cost for them to remain in a facility. After the individuals grant year is over, the financial obligation of the participant will be allocated through a Medicaid waiver program. Anything not covered under a waiver is considered to be the patient liability.

How does the individual participate?

- The interested individual or guardian can contact the State Transition Team, Nursing Home Ombudsman, or the Department for Aging and Independent Living.