

# INDIANA

## NURSING FACILITY TRANSITIONS MANUAL



Draft

## Letter of Introduction

The Indiana Nursing Facility Transition Team Manual is a compilation of a cross-agency workgroup, consisting of Family and Social Services Administration (FSSA) employees in leadership positions such as the Office of Medicaid Policy and Planning, the Division of Aging, Indiana ombudsman, and medical expertise provided by a local physician that heads the gerontology department of a local hospital.

The audience for this manual includes the company/organization hired by the state of Indiana to provide transition services, their employees (the transition team members), Area Agencies on Aging (AAA), local ombudsman, and any FSSA employees involved in the transition of nursing facility residents from the nursing facility to home and community based settings. This manual is a starting point, embracing the day-to-day activities involved in transitioning people who want to move back to their home or community from nursing facilities. Transition teams, AAA case managers, and FSSA employees are needed to collaborate on decision making for transition candidates who may have unique circumstances.

The workgroup that put this manual together realizes that each transition will be unique, and may have to cover circumstances not dealt with in this document. The safety, success, and quality of life of transition candidates are high priorities of the state of Indiana. Tough decisions will have to be made, which is why the need for a “clinical model of nurse and social worker” is emphasized.

The target population is nursing facility residents who are Medicaid eligible, and can pick up Medicaid services on the aged and disabled waiver. Any other nursing facility residents identified as potential transition candidates will be referred to a local ombudsman, and hospital/nursing facility discharge planners will provide transition services for that segment of the population.

Note that training for each transition team will be performed on an ongoing basis to ensure the safety of all transition candidates.



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# **SECTION ONE - Transition Functions**

## **Chapter 1 - Introduction**





## Introduction to Transition

Transition is about offering a choice for people to live in the community and to be in control of their own lives. As a navigator of transition, the transition team (TT) is responsible for assessing and evaluating potential transition candidates (i.e. nursing facility patients), as well as bringing the home and community based services (HCBS) lifestyle choices to transition candidates. The transition team also assists candidates in the process of moving from a nursing facility to independent living.

The transition team's goal is to build a bridge for transition candidates between the nursing facilities and, home and community based services. Relationship building between the transition team and nursing facility staff is imperative for referrals from the facility. These referrals help those transition candidates who want to transition back to the community, but do not know they have the choice.

Transitioning from living in a nursing facility to living in their own home or community can be very intimidating for transitional candidates for a number of reasons. Some transition candidates are unaware of the options available when living in the community. Others have become so disempowered by institutional living that they may not believe themselves capable of living independently. It is the job of the transition team to make an assessment and care plans of transition candidates' needs and abilities in order to promote choices available to transition to home and community based services, as well as to make these transitions as smooth as possible for the transition candidate.



## Background and History

The FSSA released a strategic agency plan on July 1, 2005, which mapped a new strategic direction that called for the growth of long-term care (LTC) services provided in home and community based settings. The plan included focused mission statement integrated with core values.

### **FSSA Mission Statement**

To use common sense compassion to help needy Hoosiers have healthier, more productive lives through developing, managing, and financing their healthcare and human services needs.

Mitch Roob, Secretary of FSSA under the Mitch Daniels' Administration, created an enhanced FSSA organizational structure designed to operate the agency as a healthcare financing organization. The entire FSSA theme is focused on the business model of reinventing healthcare that is in alignment with Governor Daniel's public dedication to performance measurement.

The road map for long-term care reform was launched through the passage of Senate Enrolled Act 493, which passed into law in March 2003. SEA 493 was never fully implemented after it was passed. In 2005, Roob directed all FSSA agencies to define their strategic objectives for the coming term. Director Smith of the Division of Aging (DA) determined that it was essential to implement SEA 493, for the state to adopt a methodology to balance the expenditure of public dollars between institutions and home and community based services that accurately reflected public demands.

The current Aging Reform Agenda evolved from the business model of reinventing healthcare and implementing SEA 493, and has been specifically designed to grow home and community based services while shifting dollars away from institutional care.

### **The Aging Reform Agenda Primary Goal**

To transform the model of long-term care to include an array of home and community based services with less dependency on institutional care.



## Aging Reform Agenda Objectives

The Aging Reform Agenda embodies three areas – capacity expansion, access coordination, and options awareness (education and awareness). Access coordination and options awareness (education and awareness) are the *foundation* for capacity expansion. Without the foundation, capacity expansion could not flourish, let alone survive.

Capacity expansion concerns the ability of the organization to add, remove, increase, or expand new and existing programs and services for the states' elderly population. While many programs exist, some may not be adequate to support the needs of clients, and some programs may need to be totally revamped or created.

Access coordination focuses on having a single-entry point into the system and ensuring that this entry point be highly assessable to all patrons.

Options awareness outlines the need for focus on home and community based service options. The plan calls for embracing and expanding this resource and making Indiana residents aware of the availability and potential services options.

The Aging Reform Agenda objectives include the following:

- Improve access to an array of long-term care services.
- Expand the capacity of community long-term care options.
- Increase public awareness for personal responsibility and actively promote transition candidates and families a choice of long term care options.

To accomplish long-term care transformation, the Aging Reform Agenda established a nursing facility transition program (NFTP). Its purpose is to help individuals transition from nursing homes safely back into the community using home and community based services.



## High Level Transition Team Objectives

To achieve the overall goal of helping transition candidates move safely to new residences while minimizing relocation stress, the transition team must:

- Remain focused on best outcomes for transition candidates throughout the process.
- Assure that transition candidates' choices and preferences are considered and honored.
- Acknowledge the candidates' and staffs' feelings of loss, mistrust, or confusion.
- Offer a people-centered approach necessary for a successful relocation process.
- Ensure a safe and timely transfer of transition candidates to new residences.
- Conduct business professionally and collaboratively.
- Support the daily routines of transition candidates and nursing facility operations.
- Create a blameless environment focusing on positive outcomes and solutions.
- Create a cost-effective care plan, while maximizing funding resources.



## Nursing Facility Transition Program Goals and Objectives

There are approximately 29,000 nursing home residents on Medicaid currently in Indiana. Successfully transitioning individuals into the community requires a solid performance measurement plan that not only identifies potential candidates, but establishes the necessary support systems required to build and maintain functional independence. The nursing facility transition program's goal is to reduce nursing home occupancy by 25% by 2011. The nursing facility transition program will be facilitated by a transition team, composed of a registered nurse (RN) and a licensed social worker, in coordination with the corresponding AAA.

Objectives for FY 2007 and 2008 regarding closure, conversion, and transition:

- Leverage the closure/conversion fund to provide an incentive for nursing facilities to close comprehensive care beds and to diversify their industry into home and community based services.
- Focus upon activities that assist the transition of candidates back into the community.

Objectives for FY 2008, 2009, 2010, and 2011 regarding diversion and options-counseling:

- Concentrate upon activities that divert discharged hospital patients from unnecessary admission to nursing facilities.
- Modify intent of the pre-admission screening (PAS) statute from screening into a nursing facility to include options-counseling for an array of long-term care services.

Objective for FY 2009, 2010, and 2011 regarding transition:

- Focus upon activities that assist the transition of candidates back into the community.

Objective for FY 2009, 2010, and 2011 regarding health optimization:

- Continue a multi-prong approach of long-term care counseling, nursing facility diversion, and nursing facility transition to promote individuals living safely at the highest level of independence in the least restrictive environment.
- Continue scrutiny, evaluation, and health-outcome analysis of long-term care placement.



## Candidates for Transition

The single, most predictive factor of a successful nursing facility transition is the candidates' desire to transition back into the community. Other states have demonstrated "where there is a will, there is a way" to be true in their nursing facility transition programs. In general, however, the transition team will need to play an active, assertive role in seeking candidates appropriate for transition. Candidates living in nursing facilities are often not aware of the housing and service alternatives to assist them in living independently. Even if the candidates and their families are aware of long-term care alternatives, the logistics necessary to make the change may seem overwhelming and may lead to fear and refusal to transition.

Candidates without certain physical conditions are often considered to be ideal candidates for integration back into community settings. The conditions listed below represent some of the factors that may slow or inhibit placement into home and community based services:

- Sleep disorders
- Eating difficulties
- Incontinence
- Cognitive impairment
- Falls
- Skin breakdown

Typically, candidates have realistic goals matched with available resources. Listed below are environmental factors often achieved with nursing facility transition candidates who successfully transition.

- Social support, depending on:
  - Availability and willingness of family or friends for active, informal support
  - Availability of recreational and leisure activities
- Medical needs, depending on:
  - Availability of skilled nursing and/or home health aide services
  - Availability of access to medical and therapy appointments
- Housing needs, depending on:
  - Availability of handicapped accessible housing
  - Availability of privacy preferences
  - Availability of meal preparation preferences
  - Availability of pet accommodations
- Community integration, depending on:
  - Availability of urban, suburban, or rural community preferences
  - Availability of transportation
  - Availability of civic organizations and communities of faith



## **SECTION ONE - Transition Functions**

### **Chapter 2 - Transition Team Role and Activity Definition**





## **Role Definition: The Transition Team in Indiana**

The transition team is a clinical team composed of a registered nurse and a social worker. The team must have a number of qualifications.

The registered nurse must possess the following qualifications:

- A current Indiana nursing license
- Experience in the care of older and/or disabled adults
- Leadership skills managing small teams of professionals
- Ability to deal with some adversity and conflict
- Good bedside manner – ability to help strangers relax when asking difficult life-changing questions
- Ability to assess and analyze the healthcare needs of transition candidates objectively
- Experience collaborating with physicians, pharmacists, and other healthcare service providers

The social worker must possess the following qualifications:

- Leadership skills managing small teams of professionals
- A bachelor's degree in social work
- Indiana state certification for social work
- Experience in the care of older and/or disabled adults
- Ability to assess and analyze the psychological, social, and personal needs of transition candidates objectively
- Experience securing housing, transportation, nutrition, and other personal needs for elderly or disabled adults who want to return to the community



**Role Definition: Skill Sets of the Transition Team**

Role	Skills	Purpose
<p><b>RN</b></p>	<ul style="list-style-type: none"> <li>• Able to objectively perform an in-depth assessment and evaluation.</li> <li>• Able to perform an assessment and analysis review of the following:                             <ul style="list-style-type: none"> <li>○ Nursing facility chart</li> <li>○ Minimum data set (MDS) results</li> </ul> </li> </ul>	<p>To objectively determine the ability of candidates to successfully transition to a home in the community</p>
	<ul style="list-style-type: none"> <li>• Coordinate medical care including, but not limited to the following:                             <ul style="list-style-type: none"> <li>○ Work with the nursing facility physician.</li> <li>○ Identify a primary care physician in the community willing to take on candidates that may have extensive needs and set up regular visits.</li> <li>○ Able to set up a connection with a neighborhood pharmacy (delivery).</li> </ul> </li> </ul>	<p>To ensure a quality outcome for transition candidates with all of the necessary medical preventative and proactive interventions in place</p>
<p><b>SW</b></p>	<ul style="list-style-type: none"> <li>• Assist in performing the in-depth assessment.</li> <li>• Create a clinical care plan (CCP) in cooperation with an RN.</li> <li>• Understand regional community connections for local housing, transportation, and work.</li> </ul>	<p>To ensure a comprehensive assessment of the transition candidates’ needs is completed with regards to the safe placement of candidates</p>
	<ul style="list-style-type: none"> <li>• Able to match needs to home and community based options.</li> <li>• Able to work with local resources including but not limited to the following:                             <ul style="list-style-type: none"> <li>○ City agencies and community services</li> <li>○ Realtors</li> <li>○ Pharmacies</li> <li>○ AAA case managers</li> <li>○ Job placement companies, etc.</li> </ul> </li> <li>• Locate and facilitate translation services, if needed.</li> </ul>	<p>To ensure a safe placement within the community with easy access to all necessary services</p>



**Process for Transitioning Nursing Facility Residents**

<b>Step</b>	<b>Transition Activity</b>	<b>Responsible Party</b>	<b>What is it?</b>	<b>Purpose</b>
<b>1</b>	<b>ID Transition Candidates</b>	DA/Transition Manager /Ombudsman	Use MDS and other self-referral methods to determine which nursing facility residents have an interest in moving back to a home and community based setting.	To preliminarily screen nursing facility residents in order to perform an assessment on only targeted individuals and perform a clinical, functional, and social assessment
<b>2</b>	<b>Options-Counseling</b>	Ombudsman /Transition Teams /Hospital Discharge Planners	Make nursing facility residents and their families aware of the home and community options available to them.	To help facilitate the decision making process on behalf of nursing facility residents
<b>3</b>	<b>Schedule Transitions</b>	DA/Transition Manager	Schedule nursing facility targets and self-referral requests.	To determine staffing needs and budget constraints
<b>4</b>	<b>Assess Transition Candidates</b>	Transition Team	Assess the clinical (medical/ Psychological), functional, and social needs of transition candidates.	To determine the needs of transition candidates
<b>5</b>	<b>Evaluate Transition Candidates' Fitness for Transition</b>	Transition Team	Analyze the MDS HC, transition candidate assessment, and nursing facility chart.	To review transition candidates' ability and willingness to make a successful transition to the home and community based setting
<b>6</b>	<b>Develop a Clinical Care Plan &amp; Review Regional Service Offerings</b>	Transition Team	List specific health issues and corresponding management plans. Ensure that regional services are available and can be used.	To ensure the potential for safe placement within the community with easy access to all local necessities and caregivers



**Process for Transitioning Nursing Facility Residents (cont.)**

<b>Step</b>	<b>Transition Activity</b>	<b>Responsible Party</b>	<b>What is it?</b>	<b>Purpose</b>
7	<b>Educate/Inform Transition Candidate and/or Family Caregiver and Facilitate Decision</b>	Transition Team	Discuss options with the transition candidates and families regarding service availability and needs. Help facilitate transition candidates and family members' decisions by offering as much honest, objective information as possible.	To facilitate the understanding of the transition candidates' complete set of circumstances, making the best and most informed decision for the transition candidates' best interest
8	<b>Make Decisions</b>	Transition Candidates and Family	Decide to pursue a home and communitybased setting.	To determine whether to move with transition or remain in the nursing facility
9	<b>Match Needs with Services</b>	Transition Team and Targeted Case Manager	Match transition candidates' preferences with available options, using as many local resources as possible including AAA.	To determine if the specific community options services are satisfactory to fulfill all of the clients' needs and preferences
10	<b>Develop a Plan of Care/Cost Comparison Budget</b>	Targeted Case Manager	Delineates all of the formal and informal services required for transition candidates to successfully move to a home and community based setting (plan of care {POC} document). Compare the cost effectiveness of putting transition candidates back into the community as opposed to keeping them in a nursing facility (cost comparison budget {CCB}).	Waiver plan of care, along with the cost comparison budget, is the task that finalizes, arranges and implements the supports needed for candidates to move from the nursing facility to the home and community based service.



**Process for Transitioning Nursing Facility Residents (cont.)**

<b>Step</b>	<b>Transition Activity</b>	<b>Responsible Party</b>	<b>What is it?</b>	<b>Purpose</b>
11	<b>Provide a Waiver Specialist Approval</b>	Waiver Specialist	Waiver Specialists do a cost comparison between nursing facility care and home and community based care	To ensure that transition candidates' cost comparison budget is budget neutral
12	<b>Write Transition Plan(s)</b>	Transition Team	A transition plan is a compilation of transition candidates' documents that details what each person needs, and what services are arranged for that person.	It is necessary for the state to record and keep this information for tracking and future reference as needed.
13	<b>Visit by the New Primary Care Physician and Access Pharmacy</b>	Transition Team	Arrange for a new primary care physician and access to prescription medications.	To ensure candidates have an established medical home and arrangements for filling prescriptions prior to being discharged from the nursing facility
14	<b>Implement Transition</b>	Transition Team and Case Manager	Move transition candidates from the nursing facility to a selected home and community based setting.	To ensure the success of the transition candidates
15	<b>Perform Follow-up Visits</b>	Transition Team	Six weeks of follow-up are required, with a personal contact each week.	To ensure that transition candidates are doing well in their new environment
16	<b>Perform Post-Transition Activities</b>	Transition Team and Case Manager	Transfer transition candidates to AAA case manager for ongoing case management, and other entities for monitoring and reporting.	To ensure continued safety and success within the community
17	<b>Report Transition</b>	Transition Team	Follow-up reporting for each transition.	To ensure that each transition follows the protocol laid out in this document



## Transition Timeline



## **SECTION ONE - Transition Functions**

### **Chapter 3 - Transition Candidates' Referral Method**





## Who Can Be a Transition Candidate?

The potential candidate for transition from a nursing facility to home and community based services will be identified by numerous means, and by a variety of sources. The only mandatory identifying information is twofold: transition candidates have the desire to move from the nursing facility back into the community, and the appropriate and needed home and community based services are available for candidates in their chosen setting.

### Bed Closure/Facility Closure/Facility Conversion

- Those identified as a result of bed closure and/or facility closure or conversion:
  - During 2007-2008, FSSA Division of Aging is using the Indiana nursing facility closure and conversion fund, along with a nursing facility moratorium, to assist in proactively rebalancing the long-term care system. The DA actively negotiates with the nursing facility, considering conversion to new business models which provide home and community based services.
  - As these and future nursing facility closures occur, the transition team will be called upon to assist the ombudsman with educating residents about their community options, determine interest, assess, and determine possibilities for home and community based services.

### Self-Referral/Rehabilitation/Short Duration Stay Post-Hospital Discharge

- Candidates who self-refer, or are referred by family members or significant others:
  - Many candidates select on their own to move back to their home and community settings following a nursing facility stay. Historically, there are approximately 200 transitions per year in which candidates have not been targeted.
  - Candidates in nursing facilities will become more aware of options, as they start becoming more educated about their options, and as more home and community based service providers are present to offer these alternatives to nursing facility placement. The DA's efforts through the options-counseling will continue to reach the wide array of customers of long-term care, which is intended, in part, on increasing the incidence of self-referral.
  - Candidates or their loved one may contact the ombudsman, local AAA, or the DA directly to initiate contact with the transition team for assessment and eventual transition.
- Candidates who are identified as a result of what is anticipated to be a short term nursing facility stay, following a hospital discharge:
  - The DA will use a protocol whereby those referred to short-term rehab or nursing facility placement as a result of a hospital discharge will be placed on a potential transition candidate list by the local AAA.
  - The information will be available to candidates through the pre-assessment screening (PAS) assessment, and the AAA targeted case manager will forward that information on to the appropriate transition team for contact and assessment.
  - Discharge planning from the nursing facility will begin upon, or shortly after admission.



## How Will Transition Candidates Be Identified?

Candidates are identified through minimum data set (MDS) and minimum data set--home care (MDS-HC). The following are MDS indicators of transitional needs:

- Indiana's Office of Medicaid Policy and Planning (OMPP) uses MDS long-term care resident assessment data from Section Q, question 1.a. of the long-term care facility resident assessment instrument to identify nursing facility residents expressing an interest in returning to the community. This data is being used to develop an interest list of individuals who are likely candidates for nursing facility transition and options-counseling. This data is maintained in the Indiana State Department of Health (ISDH) data repository, and FSSA accesses this data regularly, through reports developed for the Office of Medicaid Policy and Planning.
  - The response to Section Q during an MDS survey may be the response of the resident. The response may reflect the desires of the nursing facility or family members more closely than the desire of the resident. For this reason, Section Q is not to be considered as the sole indicator for transition interest, but rather as a starting place for the transition team in their transition candidate identification.
- Low RUG score on MDS:
  - The Resource Utilization Groups (RUG) data for candidates in nursing facilities will be accessed in the same manner as the Section Q criteria. RUG scores will be reviewed to better understand residents' needs, including those who have expressed a desire to return to the community.
  - Those with low RUGS will be contacted to ascertain interest in transition.
  - Those with higher RUGS, despite a more clinically demanding status, will not be excluded from transitioning if they express a desire, and if there are adequate formal and informal supports in place to provide a safe and successful home and community based setting placement.

The following are indicators present for success as community-residing individuals (MDS-HC):

- The MDS-HC provides information about individuals' functional abilities and limitations and can assist in the development of an appropriate plan of care.
- The transition team will use this assessment as a tool of identification as well as to assist with care plan development.



## **SECTION ONE - Transition Functions**

### **Chapter 4 - Assessment and Evaluation of Transition Candidates**





## Minimum Data Set Overview

Certified nursing facilities are required to electronically transmit minimum data set information for all residents, including residents in a noncertified bed. This information is transmitted to the Office of Medicaid Policy and Planning. It is used in establishing and maintaining a case mix reimbursement system for Medicaid payments to nursing facilities and other Medicaid program management purposes.

“Minimum data set” (MDS) means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies.

Nursing facilities are required to maintain supporting documentation in the resident’s medical chart for all MDS data elements that are used to classify nursing facility residents in accordance with the Resource Utilization Group-III resident classification system. Such reporting documentation shall be maintained by the nursing facility for all residents in a manner that is accessible and conducive to audit.

### Assessment Activities: Assessing Transition Candidates

Transition begins when face-to-face conversations between the transition team and residents in nursing facilities reveal a desire to move back to the community. This face-to-face meeting determines the residents’ level of interest in transitioning. The following list provides some suggestions for this conversation with transition candidates.

- Listen to their thoughts about living in the community.
- Speak to them in person about what potential change they want to see in their future.
- Be sure to express that transitioning is a highly involved process and that their complete investment in the process is of vital importance.
- Listen and be respectful, but be firm about the realities of transition.



## Minimum Data Set - Home Care Assessment Tool

The Indiana transition teams use the MDS-HC to assess all transition candidates. The MDS-HC was specifically designed to provide a uniform language of common measurements for assessing the health, cognitive, functional status, and care needs of frail elderly and disabled individuals living in the community and receiving home and community based services. Many of the testing criteria in the MDS-HC are based on the nursing home's MDS assessment which is required in Indiana (and nationally) of all nursing home residents. Both the MDS and the MSD-HC were chosen because of the wealth of research information and measurements available from interRAI, INC., the developers of the MDS family of assessment tools.

The MDS-HC covers multiple domains that can affect long-term care decision making and aid in the development of a comprehensive clinical care plan. The MDS-HC includes the following sections:

- Identification Information
- Intake and Initial History
- Cognition
- Communication and Vision
- Mood and Behavior
- Psychosocial Well-Being
- Functional Status
- Continence
- Disease Diagnoses
- Health Conditions
- Oral and Nutritional Status
- Skin Condition
- Medications
- Treatment and Procedures
- Responsibility
- Social Supports
- Environmental Assessment

Use of the MDS-HC tool will be detailed in the MDS-HC user manual. Enhancements to the MDS-HC tool customized to the Indiana nursing facility transition program will include assessment of advance directives, and identification of physicians providing medical services to transition candidates.



## Clinical Care Plan

The clinical care plan is a medical or clinical guide, which details the healthcare needs of individuals, and determines how those needs are to be addressed clinically when individuals leave the nursing facility. The RN on the transition team has the primary responsibility of working closely with physicians in the process of creating the clinical care plan. Using MDS-HC transition candidate assessment feedback, the nursing facility MDS, and the nursing facility chart, the transition team RN and social worker will develop individualized detailing of all healthcare issues of transition candidates and corresponding management strategies.

This plan guides caregivers through their responsibilities of contact and follow-up with the primary care physician. It also explains the role of medication regimen, home health needs, a post-transition healthcare coordinator, durable medical equipment needs, etc.

Note that the clinical care plan is the important basis on which individuals' home and community based services will be established. The transition team will assess all applicable individuals and identify all informal supports in advance of using formal supports/funding sources.





## **SECTION ONE - Transition Functions**

### **Chapter 5 - Planning and Arranging Services**





## Transition Candidate Education and Decision Facilitation

If the transition team determines that transition candidates' needs cannot be met in the community, the transition team can wait for a short time (the entire transition process should not exceed six months) to continue to pursue applicable service options. If services are not (and will not be in the near future) available, the transition team should meet with transition candidates and families to explain the factors determining the decision.

If the transition candidates' needs can be met in the community, the transition team must:

- Discuss the clinical care plan with transition candidates.
- Review the options discussed in the first meeting and provide recommendations on the alternatives that would meet transition candidates' needs.
- Discuss the steps that will need to happen to prepare the home for transition candidates, if the option selected is to return home.
- Set up appointments for transition candidates to tour at least two options (if available locally), if transition candidates select a community option.
- Facilitate final decision on whether or not the transition candidates want to pursue making the transition.



## How Services Are Arranged

The development of the clinical care plan, the use of a current medical level of care assessment, the waiver plan of care, and the cost comparison budget are the determinants that must be made in order to finalize and execute the transition candidates' move from the nursing facility to home and community based services. These determinants take full coordination of the transition team and targeted case manager working together with the nursing facility's attending physician and nursing staff, therapists, the new primary care physician to whom the candidate is being referred, and the individual under whose care will be once he/she is residing in the community setting. These steps also require close coordination of efforts between the transition team and the AAA targeted case manager.

It is imperative that the transition team is knowledgeable regarding the Medicaid waiver program, including the eligibility requirements, the intent of the program, and the limitations that one faces in working with transition candidates.

Section 1915(c) of the Social Security Act permits states to offer, under a waiver of statutory requirements, an array of home and community based services that an individual needs to avoid institutionalization. Eligibility for all waiver programs requires the following:

1. The candidate must meet Medicaid guidelines.
2. The recipient would require institutionalization in the absence of the waiver and/or other home-based services.
3. The total Medicaid cost of serving the recipient(s) on the waiver (waiver cost plus other Medicaid services), cannot exceed the total cost to Medicaid for serving the recipient(s) in an appropriate institutional setting(s).

It is this third requirement that the transition team must keep in mind while completing a care management plan, and in turn, develop a Medicaid waiver plan of care/cost comparison budget for candidates. The AAA targeted case manager submits the plan of care, along with a cost comparison budget, to the state DA for approval by the Medicaid waiver specialist. The waiver specialist considers whether the plan of care meets, but does not exceed, the needs of individuals, and weighs whether the cost comparison budget can be approved with cost effectiveness in mind. Cost effectiveness means that the total average plan of care cost for **all** individuals on the waiver does **not** exceed the total average cost of that care if provided in an institution. Therefore, some cost comparison budgets may exceed the average nursing facility cost. However, across the breadth of the waiver, the home and community based setting costs must not exceed the nursing facility costs.



## **How Services Are Arranged (cont.)**

### Clinical Care Plan

See Section One: Chapter 4, Clinical Care Plan.

### Medical Level of Care

The medical level of care is closely linked to the clinical care plan. In general, they are built together. Initially, the primary responsibility for the medical level of care is that of the transition team. The medical level of care is an important process that is electronically submitted to the state through the targeted case management process.

The medical level of care decision will be a joint effort with the primary responsibility belonging to the transition team, who should notify the transition manager with the DA if the medical level of care assessment is out-of-date. Initially, the transition team will ensure that the assessment and subsequent determination of level of care is based on input from the interdisciplinary team: physician, nurses, therapists, social workers, as well as input from the candidates and families or significant others. The transition team and targeted case manager will work together in the assessment, using the level of care screen required to substantiate that the candidate meets the medical level of care required to receive Medicaid waiver services.

Current medical level of care assessments that are within one year of submission will be accepted. Lapsed medical level of care assessments (sometimes referred to as PAS) will be referred to the transition team manager.



## How Services Are Arranged (cont.)

### Waiver Plan of Care and Cost Comparison Budget

The primary responsibility of the waiver plan of care is shared by the transition team and the transition team manager. The team works with the nursing facility physician, nursing staff, therapists, the physician to whom the candidate is being referred, or under whose care the individual will be once he/she is residing in the community setting. All parties play a vital role in this final formal task that is developed through all the work involved in the transition process. The plan of care, along with the cost comparison budget is the task that finalizes, arranges, and implements the supports needed for candidates to move from the nursing facility to the home and community based setting. Although the team will develop the plan of care together, it is the Medicaid waiver transition case manager who electronically submits this form to the state for approval to initiate services.

The plan of care is developed using the people-centered planning approach and is clearly based on the clinical care plan and the Medical level of care assessment. Based on the results of the assessment of needs, the team will develop a comprehensive plan of care delineating all of the formal and informal services that will allow candidates to successfully live in the home and community based setting of their choice. The plan is based on the services and the providers chosen by the candidates or their representative.

The plan of care includes:

- Identification of necessary services and supports, including total hours and costs.
- Documentation of what services will be provided.
- Selection of providers for each service.
- Documentation of unmet needs and how they will be addressed.

The cost comparison budget is developed by the transition team manager to address cost effectiveness issues, an important element of Medicaid waiver service provision. In general, the cost of the services provided by the home and community based setting waiver is not to exceed what it would cost to provide those services to candidates in a nursing facility setting. The state agrees to the centers for Medicare and Medicaid services that, over the breadth of the waiver, the costs will not exceed those obtained through nursing facility placement.

Non-waiver clients will be referred to the nursing facility discharge planner.



## **SECTION ONE - Transition Functions**

### **Chapter 6 - Transition Implementation Activities**





## **Transition Discharge Process**

The transition team implements the following steps in conjunction with other parties. These steps include:

1. Initiate a discharge plan meeting with transition candidates, family members, AAA targeted case manager, and ombudsmen.
2. Implement the clinical care plan and waiver plan of care in coordination with the AAA targeted case manager.
3. Implement the physical move of transition candidates as soon as all services are secured/approved.

## **Transition Plan of Care Activities**

The transition plan of care ensures information in the discharge package is complete and updated the day of discharge. It also provides the following:

- An outline of how care will be coordinated if continuing treatment involves multiple caregivers.
- A description of what agencies will be involved post-discharge and the contact individual in each agency (name, role, and phone number).
- Medications, medical procedures to follow, and the contact person in the discharging facility available for follow-up questions.
- The nursing facility transition team/AAA case manager's plan to provide follow-up of each resident after the relocation and availability for follow-up questions and consultation.



## Transfer and Discharge Records

The nursing facility transition team meets with the AAA case manager to discuss the candidates' status and develop a date to transfer the candidates to the case manager. Once the transition candidates have successfully moved into their new setting, the transition team will continue to follow and assist for a minimum of six weeks. To ensure the safety and well-being of the candidates, the nursing facility transition team must schedule follow-up visits within 24 hours of nursing facility discharge. The nursing facility transition team schedules a minimum of five weekly contacts and a final home visit with the candidates prior to discharge to the AAA case manager. During the final home visit of the nursing facility, the transition team finalizes a transition team discharge package to include the following information to be provided to transition candidates and AAA case manager:

- Transition team social worker discharge note which identifies the date of the last visit, what has been done for transition candidates since transition implementation, current status and remaining issues, and date of transfer to AAA case manager
- Transition team RN discharge note which identifies date of last visit, what has been done for transition candidates since transition implementation, current status and remaining issues, and date of transfer to AAA case manager
- Current medication list
- List of physicians, contact information, and future appointments
- List of current service providers and community resources utilized by transition candidate



## Primary Care Physician Collaboration

It is anticipated that for many transition candidates, the nursing facility's attending physician will **not** continue to provide medical care following discharge from the nursing facility and thus a new primary care physician (PCP) relationship will need to be established. To ensure that transition candidates have a secure "medical home" while transitioning to home and community based services, the transition team assists transition candidates in selecting a new primary care physician and arranges for a medical visit prior to discharge from the nursing facility.

The goals for transition team collaboration with the primary care physician are to work together in the development and implementation of transition candidates' clinical care plan. In addition, the transition team's role is to support and complement the medical care provided by the primary care physician consistent with the goals of care for transition candidates.

### Guidelines

The following are the transition team's guidelines when collaborating with the primary care physician:

- Assist transition candidates and families/caregivers in selecting a new primary care physician when the nursing facility's attending physician will not continue to provide medical care following discharge from the nursing facility.
- Orient the primary care physician and office representatives to the transition team program and contact information.
- Arrange for transition candidates to be seen by the new primary care physician prior to discharge from the nursing facility.
- Review the proposed care plan for transition candidates with the new primary care physician for approval, make revisions as appropriate, prioritize interventions, and coordinate implementation of the clinical care plan.
- Keep the primary care physician informed of progress in implementing the clinical care plan, including any difficulties encountered or needed adjustments.
- Inform the primary care physician, ahead of time, of issues he or she may want to address with transition candidates during an upcoming office visit.
- Help ensure continuity of care and follow-up with the designated primary care physician.
- If the care of transition candidates is transferred to a different primary care physician, the transition team will provide the new primary care physician with a copy and review the clinical care plan with the new primary care physician for optimal collaboration and continuity of care.
- Facilitate the primary care physician's reimbursement for transition care management.



## Continuity of Care and Care Coordination

The transition team will serve as a proactive resource to transition candidates and the new primary care physician to help facilitate continuity of care and advocate for the transition candidates' needs consistent with the clinical care plan. In addition, the transition team will serve in such a role as to optimize care coordination for transition candidates among various providers and healthcare settings using a collaborative interdisciplinary team approach across the continuum of care.

The following are the guidelines the transition team observes when providing transition candidate follow-up care after nursing facility discharge:

- Be available to assist and communicate with transition candidates and their caregivers.
- Be available to transition candidates by telephone 24 hours/7 days a week.
- Visit face-to-face for first two weeks, and the final week. The remaining weeks may include in-person visits or contact by telephone as appropriate to implement the clinical care plan with a minimum of weekly contacts.
  - a. Week 1 and 2 are face-to-face meetings.
  - b. Week 3 through 5 may be in-person or contact by telephone, depending upon client issues.
  - c. Week 6 must be a face-to-face interaction.
- During follow-up contacts, discuss with transition candidates and/or caregivers the following:
  - Progress in reaching goals and implementation of the clinical care plan
  - Any new issues/problems
  - Recent hospitalizations, emergency, or doctor visits
  - Changes in medications
  - Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL) difficulties
  - Physical activity/exercise and socialization
  - Changes in social supports
- Assist transition candidates and their caregivers with primary care physician and specialist appointments, urgent care or emergency department visits, and hospital admissions.
- Collaborate with hospital and emergency department staff, specialists, and the primary care physician on care coordination, clinical care plan revision as appropriate, and follow-up.
- Make contact with hospital or emergency department staff to share transition candidates' health and clinical care plan information upon hospitalization or emergency department visit.
- Ensure hospital and emergency department representatives are aware of the transition candidates' baseline health status, current healthcare goals and care plan, advance directives, and other information such as family, primary medical provider, and specialist contact information as appropriate.



- Collaborate, as possible, with hospital or emergency department staff in developing the transition candidates' discharge and follow-up plan.



### Continuity of Care and Care Coordination (cont.)

- Obtain a copy of the hospital discharge or emergency department visit summary and ensure copies are available to the primary care physician and specialists as appropriate.
- Make a face-to-face visit to transition candidates within one week of discharge from the hospital or emergency department to ensure continuity of care and implementation of the updated care plan. In addition, provide an updated medication list to transition candidates with copies sent to the primary care physician, specialists, and others as appropriate (e.g., home healthcare provider, or a person who is paid to provide services for the transition candidate).
- Communicate any significant changes in transition candidates' clinical care plan resulting from a hospitalization, emergency department visit, or physician appointment with the family/caregiver, to the AAA case manager, and others as appropriate.
- When applicable, communicate regularly with transition candidates' home healthcare provider to facilitate care coordination and implementation of the clinical care plan. Consideration will be given to asking the home healthcare provider to participate in transition team planning conferences.





## **SECTION TWO - Transition Support**

### **Chapter 7 - Transition Stakeholders' Role and Responsibilities**





## Parties Involved

A transition stakeholder is anyone who is involved in the transition activities or has a vested interest in the person being transitioned.

The transition stakeholders and their responsibilities include:

### 1. AAA Case Manager

#### *Role*

- State liaison to assist elderly by brokering services with provider agencies.

#### *Responsibilities*

- Coordinate with the transition team in the implementation of the care plan by identifying both formal and informal support systems and resources to meet medical, functional, and social needs.
- Assume primary responsibility for case management after transition team sign-off. Note that the first visit with transition candidates in the new location will be within two weeks, with recurring visits every 30 days/1 month thereafter, or more often as needed.

### 2. Attending Physician

#### *Role*

- Personal or nursing facility physician who regularly sees transition candidates.

#### *Responsibilities*

- Attend the facility's change announcement meeting. (optional)
- Give honest opinions regarding the efficacy of transition candidates' decisions to pursue home- and community-based services.
- Participate in development of the candidates' care plans, as needed.

### 3. Nursing Facility

#### *Facility Owner Role*

- Nursing facility owner, or associate facility principal, with the authority to legally make decisions regarding the facility.

#### *Administrator Role*

- Facilitate and/or help to coordinate transition activities as required by the transition team leader.

#### *Nursing Facility Director of Nursing/Assistant Director of Nursing Role*

- Facilitate and/or help to coordinate transition activities as required by the transition team leader.



## Parties Involved (cont.)

### *Nursing Facility Social Worker Role*

- Facilitate and/or help to coordinate transition activities as required by the transition team leader.

## 4. Indiana State Department of Health

### *Role*

- Department works with the DA and nursing facility owners to facilitate transition activities as required.

### *Responsibilities*

- Attend the change announcement meeting. (optional)
- Act on requests submitted by facility owners.
- Participate on the transition plan review committee.

## 5. Long-Term Care Ombudsman

### *Role*

- Ombudsman works directly with transition candidates and their family to help facilitate their decision. Work with the nursing facility and transition team leader to coordinate transition activities as required.

### *Responsibilities*

- Become familiar with the facility's transition agreement, including names of affected transition candidates.
- Participate in the facility's change announcement meeting.
- Determine whether transition candidates whose names were submitted by the facility in the agreement are still in the facility. If not, ask the appropriate staff person to account for the missing transition candidates and share the findings with the transition team. If possible, check with transition candidates to determine whether their move was voluntary or initiated by the facility.
- Meet with each resident and/or responsible party individually to provide information regarding options and rights, and to determine candidates' wishes.
- For candidates who choose to pursue home and community based services ask them or their responsible party to sign a release of information.
- Share information with the team with the candidates' permission.
- Establish regular hours in the facility to be available to transition candidates; be available at other times by appointment.



## Parties Involved (cont.)

- Provide a list of facilities with available beds and ensure the facility follows guidelines for transfer/discharge for those candidates who do not wish to pursue home and community based services or for whom these services is not a viable option.
- Work with the facility to ensure other facilities have access to residents upon residents' invitation.
- Assure the facility and the transition team involves the candidates' decision making.
- Work to ensure the facility arranges transportation to the possible relocation site if the candidates' wishes to visit.
- Provide transition candidates with an information sheet on how to prepare for a move.
- Ensure the facility arranges transportation and that all candidates' records, personal belongings, and personal funds are transported to the new location. (With candidates' permission, it is sometimes possible for personal items to be set up in the new space earlier so the new space is ready and welcoming when candidates arrive.)
- Attend transition team progress meetings and discharge planning meetings as requested by transition candidates.
- Keep logs of transition candidates' relocations provided by a facility social worker/transition team.
- Keep records of the things that go well in the transition process and of the things that need to be improved.
- Make a follow-up contact with relocated transition candidates or caregivers within two weeks of relocation.
- Make a face-to-face visit with relocated transition candidates within 30 days of relocation.
- Keep record of all contacts and the well-being of transition candidates contacted.

### 6. Nursing Facility Oversight Board

#### *Role*

- Board reviews and approves/disapproves all nursing facility closures and/or conversions propositions, documentation, and activities.

#### *Responsibilities*

- Review and approve/disapprove the facility transition plans.
- Assist in establishing priorities and timelines for individual facility transitions.



## Parties Involved (cont.)

### 7. Receiving Primary Care Physician

#### *Role*

- Personal physician who will assume regular care of transition candidates.

#### *Responsibilities*

- Agree to accept transition candidates as patients in a new location.
- Participate in developing a care plan to the extent desired.
- Agree with the completed plan.
- Complete, sign, and date the 450B state form, which is provided to physicians by the transition team.

### 8. Resident/Family Member(s)

#### *Role*

- Resident transitions the candidate family members who can facilitate and support the decision in the interest of their loved one.

#### *Responsibilities*

- Attend the change announcement meeting, if possible.
- Make informed decisions regarding future care and relocation.
- Participate in the relocation planning meeting(s).

### 9. Transition Team Nurse

#### *Role*

- Clinical representative of the transition team who manages the oversight of all medical and physical needs of transition candidates.

*Responsibilities:* See Chapter 2 for details.

### 10. Transition Team Social Worker

#### *Role*

- Clinical representative of the transition team who manages the oversight of all social and psychological needs of transition candidates.

#### *Responsibilities (Transition Team Nurse and Transition Team Social Worker)*

#### *On-site:*

- Meet with all transition candidates who have expressed an interest in home- and community-base services to provide a more extensive explanation of the options available and answer any questions.



- Review all medical records of transition candidates who indicate interest in home and community based services.



## Parties Involved (cont.)

- Consult with physicians, pharmacists, therapists, dietitians, facility social workers, mental health workers, other specialists, and appropriate caregivers.
- Make decisions on whether transition candidates' medical, functional, and social needs can be met by a home and community based service and which option can best meet those needs or if needs can only be met in a nursing facility setting with 24-hour access to skilled caregivers.
- Offer options to candidates.
- Make a referral to the facility social worker and the ombudsman for those transition candidates who will need to move to another nursing home setting.
- Coordinate with the AAA case manager in the development and implementation of individual care plan for those transition candidates whose needs can be met in a home- and community-base service setting.

### 11. Transition Coordinator

#### *Role*

- This DA staff member manages transition data including transition planning for individuals as well as comprehensive data on all individuals transitioned.

#### *Responsibilities*

- Report statistics and performance outcomes to state Office of Medicaid Policy and Planning, and to the federal centers for Medicare and Medicaid Services (CMS) regarding the Indiana transition program.
- Review all individual plans of care, and work closely with the Medicaid waiver specialist in the review and approval of these plans.
- Oversee the performance outcomes of the transition teams.





## **SECTION TWO - Transition Support**

### **Chapter 8 - Cultural Sensitivity**





## Cultural Competency

Cultural competency refers to a set of congruent behaviors, attitudes, practices, and beliefs that create and foster a professional and organizational culture that enables healthcare providers/organizations to do the following:

- Recognize and acknowledge the diverse groups within the service population.
- Understand the role of diverse values, norms, practices, attitudes, and beliefs about disease and treatments.
- Enhance accessibility to services by diverse groups through improving cultural and linguistic competencies and availability.
- Take a holistic view of health, inclusive of health beliefs and practices, and the physical, mental, and emotional aspects of diverse groups.
- Respect and support the dignity and perspectives of the client, patient, family, and staff to best address the health interests of the patient.
- Ensure systems of recruitment, evaluation, staff development, and retention that support an organizational culture and staff that are better able to provide health services that meet the cultural and linguistic needs of the community.
- Improve the health status of the populations and communities served.

## Linguistic Competency

A key component of cultural competency is linguistic competency, which refers to the healthcare organization's ability to provide its limited and non-English speaking patients with timely, accurate, and confidential interpreting services, and culturally appropriate translated materials.





## **SECTION TWO - Transition Support**

### **Chapter 9 - Community Resources**





## Social Supports

As discussed, transition candidates cannot transition alone. There are many programs which support a variety of crucial needs that transition candidates will face. These needs include nutrition, transportation, housing, legal assistance, and money management, as well as safety, protection, and discrimination concerns.

### Nutrition

- Indiana Food Stamp Program  
(Department of Family Resources' website <http://www.in.gov/fssa/family/stamps/index.html>)
  - Indiana's food stamp program is designed to raise the nutritional level of low-income households. Food stamp benefits are used like cash to buy eligible items at any store, supermarket, or co-op approved by the U.S. Department of Agriculture (USDA). Food stamps can only be used for food and for plants and seed to grow food to eat. Sales tax cannot be charged on items bought with food stamps.
  - To qualify, applicants must meet both non-financial and financial requirements. Non-financial requirements include state residency, citizenship/alien status, work registration, and cooperation with the IMPACT program. Financial criteria include income and asset limits.
  - The transition team can assist candidates to apply for the food stamp program by contacting the local Division of Family Resources office.
  
- Indiana Senior Nutrition Program  
(<http://www.in.gov/fssa/elderly/aging/pdf/meals1.pdf>)
  - The Indiana DA contracts with the area agencies on aging to provide nutrition program services, including the administration of the individual congregate meal sites, and home-delivered meals, throughout the state of Indiana. The program provides eligible persons with hot or otherwise appropriate, nutritionally balanced meals served at a specified meal site where surroundings promote social interaction and provide home-delivered meals to those eligible persons in need of this service. In addition to meals, the program provides for individual nutrition assessments and nutrition education, and may provide individual nutrition counseling.
  - Eligible candidates include individuals over sixty years of age and their spouse of any age.
  - Other eligible candidates may include:
    - Those with a disability who live with and attend a meal site with an older person.
    - Those of any age with a disability living in a housing facility primarily occupied by older persons.
  - Eligible candidates are not charged any fee for the meals or related services. The AAA nutrition program, however, does provide each person the opportunity to voluntarily contribute to the cost of the meal/service. Any contributions made by the participant to the AAA nutrition program are strictly voluntary. The AAA uses these contributions to help expand its nutrition program.



## Social Supports (cont.)

- The transition team should arrange for transition candidates to participate in a congregate meal site or should arrange for home-delivered meals, when appropriate.

### Transportation

The candidates' transportation needs should be addressed. Is driving a possibility? If so, what will be needed to facilitate this, availability of a car and driver's license? If public transportation will be used, do candidates know how to ride the city bus? Some local public transportation companies offer travel training for people with disabilities. The transition team should assure that candidates and their caregivers have practiced using various forms of public transportation before transition candidates leave the nursing facility.

Transportation needs will be assessed individually, and services arranged accordingly.

### Housing

Housing can often be one of the most difficult issues to address with transition candidates. The local AAA will have relationships with housing authorities, apartment managers, and realtors; and maintain lists of affordable housing that may be able to accommodate seniors or other people with disabilities transitioning from a nursing home. The transition team must coordinate with the AAA to obtain this information for transition candidates.

Options for candidates leaving the nursing home include:

- Returning to home or living with family
  - This option is ideal for many candidates. The transition team and the AAA will have to assess the home, arrange for any necessary home modifications, and set up needed home care services.
- Individual Apartments
  - Apartment complexes are good for people who have been institutionalized for a long period of time. They tend to feel less isolated and alone when there are other people around. There are many apartment complexes that target seniors and other persons with disabilities, but candidates may be served in a variety of apartment complexes. The transition team should obtain a listing of affordable complexes from the AAA. The list should identify special features of the complex including those that allow pets, have congregate meals, are wheelchair accessible, etc.
  - The first month's rent is often an issue as there is a lag time from when candidates leave the nursing home to when they receive their social security income. Some AAAs provide funding for this; others maintain strong relationships with the staff at housing authorities and the managers at the apartment complexes that often waive the first months rent.
  - The transition team and the AAA will have to assess the complex's ability to meet transition candidates' needs and set up needed home care services.



## Social Supports (cont.)

- Low income housing or other subsidized housing (such as Section 8 housing)
  - Federal subsidies supplement candidates' monthly rent, either in a designated building (which may or may not be reserved for elderly and disabled people) or through a housing voucher that the renter can use in any rental unit, provided the landlord agrees to the terms. In general, rent is calculated as one-third of the person's income, after out-of-pocket medical expenses are subtracted. If the renter leaves the unit empty for more than 30 days, he or she may lose it. There are often long wait lists for these services so the transition team must get the candidates' name on the list as soon as possible.
  - Candidates transitioning into apartment complexes may want to sign up for Section 8. If transition candidates decide later to live in a house versus an apartment, they are already on the waiting list.
  - Another option for subsidized housing is to apply for the housing authority's public housing and each project-based Section 8 apartment complex in the area.
  - As with a return to transition candidates' home or apartment, the transition team and the AAA assesses the home, arranges for any necessary home modifications, and sets up needed home care services.
- Adult foster care
  - Adult foster care is a comprehensive, residential service provided through the Aged and Disabled Medicaid waiver. Candidates who receive this service reside in a home with an unrelated primary caregiver and family, as well as up to two other transition candidates and families of this service. Adult foster care services may include, but are not limited to, the following: personal care, homemaker, attendant care, companionship, medication oversight, meals, and transportation. The services are provided in a home-like environment that includes, but is not limited to, a private bedroom, semi-private bathroom, home-cooked meals, a common living area, and assistance with activities of daily living.
- Assisted living facilities
  - Assisted living is a comprehensive, residential service provided through the Aged and Disabled Medicaid waiver. Candidates who receive this service reside in an independent setting, provided by a licensed residential care provider. It is a bundle of services, which may include, but is not limited to, the following: personal care, homemaker, attendant care, medication oversight, and social and recreational programming. Candidates live independently, or with a roommate if they so choose. Personalized care must be furnished to candidates who reside in their own living units. The apartment-like setting includes an area for a kitchenette, living area, bedroom area, and bathroom. Meals and/or nutritious snacks are also available and must meet the dietary reference intake for adults. There is 24-hour on-site response staff and an on-call nurse available.



## Social Supports (cont.)

### Legal Services

The legal assistance program provides candidates who are at least 60 years of age with help in dealing with legal issues and problems. The program also assists older candidates with understanding and maintaining their rights; assists older candidates in exercising their choices; helps older candidates benefit from available services; and resolves disputes. A directory of available services can be found at <http://www.in.gov/fssa/elderly/aging/pdf/legalassistancedirectory2.pdf>.

### Money Management

It is important to understand the candidates' financial situation especially their prior debt and credit history. These can be key barriers when a client applies for housing. Many landlords will overlook prior bad debts if the client is making an attempt to pay them off. The following are some of the most common types of benefits available to candidates transitioning back into the community.

- Social Security Disability Income (SSDI)
  - SSDI is a government-sponsored retirement program for workers who can no longer work because of age or disability. Candidates who worked at some point in their lives, and paid into the federal system, are likely to be eligible for a monthly SSDI check. The amount can range from less than \$100 to over \$1,000, depending on how long they worked and how much they contributed from their paycheck. After two years, SSDI beneficiaries also become eligible for Medicare, which provides healthcare and hospitalization coverage.
- Supplemental Security Income (SSI)
  - SSI is an income support program for disabled or elderly people with very limited incomes and resources. Candidates who have never worked are likely to be eligible for SSI. Those who receive a small enough SSDI check can also receive SSI.
- Temporary Aid to Needy Families (TANF)
  - If you are working with candidates who, after transition, will be resuming responsibility for raising their children or grandchildren, they may be eligible for monthly income support, family Medicaid coverage, and/or food stamps. The Division of Family Resources can assist the transition candidates in obtaining these services. If eligible, transition candidates will receive an electronic benefits transfer (EBT) card for these services, which is a new feature. The transition team should educate transition candidates on its use.
- Low-Income Energy Assistance Program (LEAP)
  - LEAP subsidizes public utility heating costs and also provides home winterization services. This funding is available through the local community action agency.



## Social Supports (cont.)

### Safety

The safety concerns and needs of the candidates should be addressed. This can include:

- Technologies for summoning help, such as alarm systems, cell phones, in-home electronic monitoring systems, etc.
- Lists, signs, or phone calls reminding candidates to lock doors, to look before answering the door, and to turn off the oven or stove.
- Adapted self-defense classes designed for candidates with disabilities.

### Protection and Discrimination

The Adult Protective Services (APS) hotline is always available at 1-800-992-6978. APS was created to address the protection of adults from abuse, neglect, and exploitation. The following are definitions for the three.

- *Abuse* is any touching (battery) of a person in a rude and insolent manner, including verbal abuse.
- *Neglect* is the intentional withholding of essential care or services. It may include abandonment.
- *Exploitation* is the intentional misuse of a person's property or services (financial) or may include sexual exploitation.

Transition candidates also have access to Indiana Protection and Advocacy Services (IPAS). The IPAS staff includes disability rights advocates and attorneys who have the authority to pursue appropriate legal and administrative remedies on behalf of people with disabilities, to ensure the enforcement of their constitutional and statutory rights. IPAS may be able to assist Hoosiers who have a disability and are being denied a right or are being discriminated against because of that disability. IPAS can be reached at 1-800-622-4845.

**All persons are required by law to report all cases of suspected abuse, neglect, or exploitation to either the nearest APS office or to law enforcement.**



## Other Community Resources

A successful transition plan will identify a range of community resources for transition candidates including overall support, as well as social and recreational opportunities. Such entities may include religious organizations such as churches, senior centers, and other non-governmental organizations, which include resources for seniors and persons with disabilities. The services these organizations provide can be critical to developing a long-term support system. Such services may include providing donations of household items and or clothing, or businesses that offer discounts or free items to clients. Other organizations such as churches and community-based programs may offer volunteer services that aid in a client's social support system. The transition team and AAA should also identify any adult day programs, classes, and support groups at independent living centers or other locations. These services augment Medicaid services and can be critical to long-term success. The transition team and AAA must put together a package that provides transition candidates with community information containing public transportation schedules and routes, donated grocery coupons, etc. when they move.

### Area Agency on Aging

The Area Agency on Aging (AAA) includes administrators of the federal Older Americans Act (OAA) funds. The services provided with these funds vary throughout the state. Some of the services include nutrition and supportive services, elder rights programs, legal services, outreach, and elder abuse prevention efforts. The AAA's also serve as the gatekeeper for the state CHOICE program and prepare the care plans for the Medicaid Aged and Disabled waiver program.

### Aging and Disability Resource Center

The federal Aging and Disability Resource Center (ADRC) program is intended to stimulate the development of state systems that integrate information and referrals, benefits, and options-counseling services as well as facilitate access and eligibility to publicly and privately financed long-term care services and benefits. Four AAAs have become ADRC's and others will soon become ADRCs.

<http://www.adrc-tae.org/tiki-index.php?page=PublicHomePage>



## Other Community Resources (cont.)

### 211

The 2-1-1 telephone number is the national abbreviated dialing code for access to health and human services information and referral (I&R). This is an easy-to-remember and universally recognizable number that makes critical connections between individuals and families in need and community-based organizations and government agencies. Free and confidential help is available for many needs, including housing, employment, legal aid, counseling, and more.

Active Indiana 211 centers include:

- Crisis & Information Center in partnership with InfoLink of southern Indiana: Clark, Floyd, and Harrison
- First Call for Help - United Way of Allen County (Ft. Wayne): Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wells, and Whitley
- First Call for Help 2-1-1 (Columbus): Bartholomew, Brown, Decatur, Jackson, and Scott
- First Call for Help - United Way of southwestern Indiana (Evansville): Posey, Spencer, Vanderburgh, and Warrick
- Connect2Help (formerly Information & Referral Network [Indianapolis]): Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby
- I&R United Way of Howard Co. (Kokomo): Cass and Howard
- Lafayette Crisis Center (Lafayette): Benton, Tippecanoe, and White
- LifeStream 211 (Yorktown): Blackford, Delaware, Henry, Madison, Randolph, Grant, and Jay
- LifeTime Resources (Dillsboro): Dearborn, Franklin, Jefferson, Ohio, Ripley, and Switzerland
- Northwest Indiana Community Action (Hammond): Jasper, Newton, Pulaski, Starke, and coming soon to Lake and Porter
- Vigo County Lifeline (Terre Haute): Clay, Parke, Sullivan, Vermillion, and Vigo
- United Way of St. Joseph County 211 (South Bend): St. Joseph and Marshall
- United Way of Elkhart County 211 (Elkhart): Elkhart, IN. 211 Centers
- Area 10 Agency on Aging (Ellettsville) Monroe and Owen

[www.LTCOPTIONS.in.gov](http://www.LTCOPTIONS.in.gov)

The LTCOPTIONS.in.gov website serves providers, customers, advocates, and state employees. It provides critical information from the state to the long-term care community that is available to all Hoosiers anytime day or night. LTCOPTIONS.in.gov is the only long-term care portal for the state, by the state. One of the key features of this site is a database of service providers.



## Other Community Resources (cont.)

### Long-Term Care Ombudsman

Long-term care ombudsmen are advocates for transition candidates and families of long-term care. They receive, investigate, and attempt to resolve problems or complaints made by, or on behalf of, the person or persons receiving care. They provide information and referral related to long-term care and related services. They also identify problems within the long-term care system and advocate for change.

The numbers for both the local and the state ombudsman must be posted in every nursing, assisted living, adult foster care facility, or other building where long-term care services are provided. All contacts are confidential and all services are free. The toll-free number for the state ombudsman office is 1-800-622-4484.

### Hospital Programming

Local hospitals and provider groups often have educational programming and support groups. The transition team should educate the candidates about this option.

### Indiana Family Helpline

<http://www.in.gov/isdh/programs/mch/ifh.htm> or 1-800-433-0746

Communication specialists provide information, referrals, transition candidates and families' education, advocacy, and follow-up to individual callers on a variety of topics including locating emergency housing, food pantries, and utility assistance. The helpline staff may become advocates for those callers who require this assistance. This advocacy sometimes takes the form of a conference call between the client, provider, and a communication specialist, especially for high-risk clients in areas of limited resources.

Callers' needs are assessed by trained communication specialists. These specialists refer callers to the appropriate community resource(s) based on their county of residency. The database used to provide this information presently contains over 9,500 resources. Follow-up calls are made or letters are sent to callers as needed, to ascertain if satisfactory services were received from the community resources to which they were referred. The staff forwards pamphlets, brochures, and other written materials to enhance information shared by the communication specialists over the phone.

Communication specialists are on duty from 7:30 a.m. to 5:00 p.m., Monday through Friday. Messages from callers may be left on the program's voicemail the remainder of the time.



## **SECTION TWO - Transition Support**

### **Chapter 10 - Documentation of Transition Activity Tracking**





**Nursing Facility Bed Closure Transition Documentation Protocol**

<b>Function Type</b>	<b>Functional Requirement</b>	<b>Responsible Party</b>	<b>Other</b>
<b>Activity</b>	<b>Contact With Nursing Facility Owner</b>		
Document	Letter of intent from the nursing facility	Nursing Facility	
Document	Nursing facility closure agreement - 1 <sup>st</sup> draft	DA/Nursing Facility	
Document	Nursing facility transition plan - 1 <sup>st</sup> draft	Nursing Facility	
Document	Escrow agreement - 1 <sup>st</sup> draft	DA/Nursing Facility	
<b>Activity</b>	<b>Nursing Facility Oversight Board Meeting(s)</b>		
Document	Decision log	DA	
<b>Activity</b>	<b>Nursing Facility Oversight Board Approval</b>		
Document	Affidavit from receiving nursing facility	Nursing Facility	External
Document	Affidavit stating placement capacity	Nursing Facility	Internal
Document	Statement from the nursing facility’s financial institution (lender) that the state of Indiana has no financial responsibility for any liens against the nursing facility or associated property	Nursing Facility	
Document	Description of plan for disposition of property	Nursing Facility	Closure
Document	Statement of purpose–describe new business model for facility	Nursing Facility	Conversion
<b>Activity</b>	<b>Transition Team Assessment</b>		
Document	Transition team facility plan	TT	Every Facility
<b>Activity</b>	<b>Nursing Facility Closure Completed</b>		
Document	Nursing facility transition plan completed after closure	Nursing Facility	Every Agreement
Document	Transition team transition report completed after closure	TT	
Document	Transition report for each individual transition plan completed after transition implemented	TT	



**Nursing Facility Transition Documentation Protocol (No Bed Closures)**

<b>Function Type</b>	<b>Functional Requirement</b>	<b>Responsible Party</b>	<b>Other</b>
<b>Activity</b>	<b>Facility Review Schedule</b>		
Document	Nursing facility transition review schedule (self-referral or targeted)	DA	
Review	Submitted to ombudsman	Transition Manager	
<b>Activity</b>	<b>Transition Team Assessment</b>		
Interview	Each transition candidate	Ombudsman	
Document	Transition team facility plan	TT	
Document	Completed individual transition plan submitted to transition manager	TT	
Document	Targeted case manager submits the plan of care for a cost comparison budget	TT	
<b>Activity</b>	<b>Nursing Facility Closure Completed</b>		
Document	Transition team transition report completed after closure	TT	
Document	Transition report for each individual transition plan completed after transition implemented	TT	



**Transition Documentation Protocol for Transition Manager**

Function Type	Functional Requirement	Responsible Party	Other
<b>Activity</b>	<b>Facility Review Schedule</b>		
Document	Nursing facility transition review schedule	DA Transition Manager	
Review	Submitted to ombudsman	Ombudsman	
<b>Activity</b>	<b>Transition Activity Tracking and Reporting</b>		
Track	Log of each transition candidate ID'd per facility	Transition Manager	
Compile	Log of each transition candidate ID'd per facility compilation of all facilities	Transition Manager	
<b>Activity</b>	<b>Completed Transition Activity Tracking and Reporting</b>		
Compile Documentation	Transition report by facility includes all required documentation	Transition Manager	
Upload documents to Sharepoint	Transfer all individual compiled transition documents to transition Sharepoint site	Transition Manager	
Complete Monthly Report	Transition report data - all facilities compiled	Transition Manager	
Complete Quarterly Report	Monthly transition report data rolled up by quarter	Transition Manager	



## Post-Transition Handoff Reporting Documentation Protocol

Each AAA case manager will submit quarterly candidate status reports to the transition manager. The report will summarize transition candidates' habilitative, rehabilitative, medical, emotional, social, and cognitive findings, as well as progress and plans for care. This report will track candidates' progress in their new setting. All reports will contain the following:

- Client demographic
- Client care plan
- Social history
- Discharge assessment
- Post-discharge care plan
- Transition team/AAAs discharge hand-off date
- Outcome of the visit and review of the candidates' clinical and social need with a justification if any modifications were made to the care plan

In addition to recording candidates' progress, the report will list client goals and other social and clinical needs that are being implemented to ensure candidates' successful placement. If candidates have been returned to a nursing home, the quarterly report will list the date and reason for the return.

Function Type	Functional Requirement	Responsible Party	Other
<b>Activity</b>	<b>Monthly AAA Case Manager Review</b>		
Individual Report	Monthly visit to each transition candidate to generate a post-transition status report – submit to case management system	Post-Transition Care Coordinator	
Monthly Report	Obtain a copy of the post-transition status report	AAA Case Manager	
Quarterly Report	Compilation of all visit data into one report every quarter	AAA Case Manager	
<b>Activity</b>	<b>Case Management Reporting</b>		
Quarterly Report	Compilation of all monthly case manager visit data into one quarterly report	DA Transition Manager	



## **SECTION TWO - Transition Support**

### **Chapter 11 - Quality Evaluation**





## Assuring Quality

Successful transition into the community begins with the work of the transition teams. The quality of the decisions made in this initial phase lays the groundwork for the satisfaction, health, and welfare of the candidates once they have transitioned to their new community residential setting. The quality of the initial assessment, of the plan of care developed with candidates, and of the ongoing quality oversight of candidates in that setting during the initial weeks after the transition is of utmost importance. The DA and the Office of Medicaid Policy and Planning are responsible to ensure the Center for Medicare and Medicaid services that Medicaid waiver services are provided with people-centered planning and the health and safety of candidates are at the core of all decision making. Quality outcomes for those transitioned are the priority of the DA, and is tracked and reviewed on both a comprehensive and individual basis throughout the process.

A state staff person has the full-time responsibility as the transition program manager. This staff person oversees the quality of the activities completed by the transition team and case manager, and tracks individual outcome data, as well as reviews and assesses outcome patterns, making recommendations to quality assurance/quality improvement entities within FSSA. Various state staff, as well as the contracted case managers, plan an integral part of quality assurance, as do the transition teams and the transition team entity under whose control they are employed to administer a successful transition process. This contracted transition team entity that provides nurses and social workers across the state also has an important obligation to ensure that a quality transition takes place and assures the health, welfare, and quality of life for those transitioned.

### Pre-Transition Quality Assurance - Transition Team Entity and Transition Team

- The transition team assesses candidates to determine readiness for transition and appropriate selection of service options, which assumes all necessary steps were made throughout the first seven weeks of the transition team's work with candidates.
- The transition team entity electronically submits the MSD-HC assessment and the transition readiness checklist to the transition program manager upon completion. This submission takes place prior to the submission of the plan of care/cost comparison budget from the AAA case manager and at a minimum, 14 days prior to transition candidates moving into the new home and community based service option. If any item on the assessment suggests that the transition candidate is not ready for transitioning, or that the setting to which the candidate is to reside is not ready, the transition must be delayed until the situation is resolved. The transition team social worker works with the Medicaid waiver targeted case manager to resolve the problem.
- Once the situation is resolved, the transition team resubmits the assessment/checklist to the transition program manager within two days of resolution.



## Assuring Quality (cont.)

### Post-Transition Quality Assurance - Transition Team Entity and Transition Team

- The transition team visits or contacts by phone transitioned candidates at a minimum of once a week. The transition team is available to candidates 24/7 during the immediate post transition period, following along with candidates in the community setting for a minimum of six weeks post-transition.
- The transition team entity, with whom the DA contracts to provide transition teams, sends in a consolidated report to the transition program manager with the status of all individuals that the transition team entity is following. This is done at a minimum of once every two weeks. The report indicates all contacts between the transitioned individual and transition team, and specifies whether the contact was initiated by the individual or the transition team, as well as the reason for the contact, the date of contact, and the response to any requests made during the contact. It indicates whether the interaction was by phone or in person, and narrates any unusual occurrences, complaints, incidents, healthcare or social service needs, as well as particular successes. There should be documentation of at least one contact made by the transition team nurse during the post-transition period to discuss medical follow-up with primary care physician.
- The transition team completes the nursing facility post-transition quality assurance checklist during a face-to-face meeting with transitioned individuals, prior to final discharge/transfer of care oversight to the case manager. The checklist must be submitted to the transition program manager upon completion, at a minimum of two days prior to transfer to the case manager. If any item on the checklist is suggestive that an individual is not well serviced in the current home and community based setting, the transfer of oversight responsibility to the case manager must be delayed until the deficiency in the new setting is resolved or until a satisfactory plan of action is approved by the transition program manager at the state. The transition team social worker works with the AAA Medicaid targeted case manager to resolve the problem.



## Assuring Quality (cont.)

### Pre- and Post-Transition Quality Assurance - Case Management System

- The case management system ensures that candidates have access to a case manager. Case managers are the eyes and ear of the State at the consumer level and, as such, provide quality assurance specific to the various home and community based setting programs.
- The Medicaid waiver targeted case manager works closely with the transition team to ensure that the level of care assessment is electronically submitted to the state for approval and that the plan of care is appropriate. The case manager assists the transition team as needed to identify providers in the community. Upon the transition team's completion of the assessment/checklist, the case manager electronically submits the plan of care/cost comparison budget to the state for review and approval.
- During the plan of care development, the transition team selects a Medicaid waiver case manager, which may be different than the Medicaid waiver targeted case manager assigned to the pre-transition process. The Medicaid waiver case manager will continue to work with the transition team through the first six weeks of post-transition follow-along. This case manager completes a home visit within one week of transition to the new community setting. Upon discharge/transfer of the individual by the transition team, the case manager counsels transitioned individuals to contact the case manager for ongoing concerns, and makes certain the transitioned individuals have all appropriate contact information.
- The Medicaid waiver case manager assumes front line quality monitoring for the transitioned individual level. Ninety-day reviews are completed by home visit, with timely submission to the state, within one week of visit.
- The Medicaid waiver case manager oversees the Medicaid waiver services, including the provision of the post-transition care coordination waiver service. The Transition Team RN providing this service is required to submit a monthly status report to the case manager, who submits any immediate concerns to the transition program manager. The Medicaid waiver case manager will include a narrative about this service in each ninety-day evaluation.
- If a reportable incident arises, the case manager assumes responsibility for seeing that this has been reported to Adult Protective Services and through the incident reporting process. This report must be completed within 24-hours of reportable incident. The case manager is held to the customary responsibilities for resolution of the issue.



## Assuring Quality (cont.)

### Pre- and Post-Transition Quality Assurance - State

- The state has numerous internal staffs that help oversee that quality services are provided through its programs. For the transition program, this includes the transition program manager in the DA, the State ombudsman, an Adult Protective Services supervisor and quality staff within DA, waiver specialists, the Office of Medicaid Policy and Planning, and various oversight committees.
- Reports from the transition team entity, consumer complaints, APS reports, incident reports, home and community based setting waiver, ninety-day Medicaid waiver case managers' reviews, and client satisfaction surveys will be reviewed on an ongoing basis by the transition program manager. Identified issues along with analysis and findings are provided to the appropriate quality assurance/quality improvement committee(s). In compliance with the proposed aging rule, the DA is enhancing the quality assurance system to identify issues timely, especially to prevent or rapidly address suspected or verified incidences of abuse, neglect, or exploitation for individuals who are receiving benefits through the division. This project also creates a follow-along measurement of services/plans and will provide information for senior DA staff to improve delivery of services.
- As the state progresses in its effort to increase access to medical and support services in home and community based housing settings, the responsibilities of the state ombudsman will increase and diversify. Additional monies in the DA budget have been included to increase field ombudsmen in improving consumer access to persons who can receive their complaints and advocate on their behalf, thereby providing pre-transition quality assurances.
- The transition program manager has a primary role in quality assurance for the transition process. The manager receives and reviews all submitted pre-transition reports from the transition team within five days of receipt. Transition program manager coordinates with the waiver specialists, who review the level of care and plan of care, to provide ongoing oversight support for the approval of the transition activities. During the pre-transition process, if a submission is received that indicates that all quality assurance issues are not met, the transition program manager will inform the waiver specialist that the cost comparison budget should not be approved until a resubmission of community readiness for transition exists.
- All reports, including the assessment/checklist, will be kept in electronic file under the responsibility of the transition program manager, who will implement the tracking process to oversee and ensure quality outcomes for transitioned individuals.
- During the post-transition transition process, the transition program manager review and assess reports submitted by the transition team and case manager to track both the quality of transition for each individual, as well as to discern any patterns in the overall process. The transition program manager provides recommendations to appropriate Quality Assurance/Quality Improvement Committees (Consumer/Community Advisory Committee, Mortality Review Committee, Risk Management Committee, and Sanctions Committee), which will in turn elevate the recommendations on to the Quality Improvement Executive Committee as needed for policy review and implementation of changes if indicated.



## Assuring Quality (cont.)

- The state reviews the reports designed to provide ongoing outcome information regarding all candidates transitioned from nursing facilities to the Medicaid waiver. These reports are provided to the Office of Medicaid Policy and Planning through a contractor (Milliman), and are produced from a data pull from Indiana State Department of Health data bank. These reports include information about services utilized to maintain independence in the home and community based setting, an enclosure which shows how long the individual resides in the community after transition, and tracking of health and quality outcomes. The transition program manager has access to this data and uses it to track individuals as well as patterns. The transition program manager forwards reports on to the appropriate committee structures within FSSA.
- The transition team or case manager is contacted (depending on whether or not the transition discharge/transfer has taken place) for late reports, based on an electronic status sheet, which will be developed by the transition program manager to assure timeliness and quality. At least 95% of the transition team reports are to be submitted in a timely fashion, and on schedule with the planned transition process. If the transition program manager believes there to be problems with the timeliness or quality of the reported transition activities, or if any service deficiencies are not resolved within a reasonable amount of time (determined by the transition manager) will confer with the DA management. The DA management will contact the transition team entity for resolution of deficiencies and if not satisfactory, will make changes to the transition team in compliance with contract.

### Pre- and Post-Transition Quality Assurance - Adult Protective Services and DA Quality Team

- Systems are in place for incident reporting, mortality reviews, standards surveying, quality assurance committee structure, and complaints/investigations for all consumers, including those who have transitioned from nursing facilities. On an ongoing basis, this staff will gather and report a late plan of care and level of care annually. The team oversees the quality assurance/quality improvement committees that oversee the complaints, division recommendations, etc., allowing for the analysis of the data to reach the executive committee for programmatic changes if indicated.

### Pre- and Post-Transition Quality Assurance - Office of Medical Policy and Planning

- The office oversees all current activities and participates in reviews of initial and annual level of care decisions, reviews denial rates and reasons, reviews (plan of care) for trends and timeliness, and reviews all sentinel events and other input data. The office contracts with a vendor to conduct audits and submit reports which emphasize validation of all aspects of quality, with greater emphasis on the health outcomes of these individuals.





## **SECTION THREE -**

### **Transition Candidate and Family Information**

#### **Chapter 12 - Transition Candidates and Families' Information Guide to Discharge Planning**





## Before Considering Home and community based Options

Transition candidates have the right and responsibility to be involved in their plan of care. To the greatest extent possible, transition candidates and families should be active participants in developing that plan. Below are questions to help candidates and their families with their discharge and future health needs.

- Do candidates have insurance cards or other documents?
- Do candidates or their families feel that the candidates' current medical and mental health statuses are stable enough to be discharged to home care?
- Do candidates have family or other people at home to assist at home?
  - If not, are candidates comfortable taking care of themselves as needed?
- Do candidates need people to take care of them?
- Do candidates know how they and their family will be paying for their care?
  - Do candidates think they are eligible for Medicare and/or Medicaid?
  - Do candidates have private insurance or will they and/or their family be paying for their care?
- Are candidates and/or their families comfortable that they can make important decisions about their healthcare needs?
  - Do candidates and/or their families feel it is necessary to consult a professional about their decision making status?
- Do candidates feel comfortable that they and/or their families understand the physician's expectations about their health status and decision to be cared for at home?
- What are the candidates' expectations/goals for immediate and short-term healthcare needs?
- What are the candidates' expectations for long-term care?
- What are the expectations/goals of the families and/or other informal supports assisting in the candidates' care?
- What services did candidates have prior to admission?
- Do candidates know the name of the agency or facility that provided those services?
- Do candidates expect that those services will be provided at the same level of service? Will that be sufficient or is an increase in hours needed?
  - Is the provider willing to reinstate services? If not, why?
- Do candidates know how to access services?
- Does the primary care physician or medical team person need to be contacted? Do you know which physician will be responsible for overseeing the candidates' care at home?
- Do candidates and/or their family feel that the candidates' home is adequately equipped for at-home care?



## Abilities and Responsibilities

The abilities and responsibilities of the transition candidates and their families are as follows:

- Understand transition candidates' condition from both a medical perspective and what it will mean to live with a disability for transition.
  - Physicians should discuss with the transition candidates and families any physical changes, probable care needs, possible complications, and other things to watch for related to the disability.
- Receive services in the most integrated setting available.
- Understand what assistance they will need or want, and how to best benefit from the available assistance.
- Understand what services and supports are available to meet their needs and desires.
  - The nursing facility discharge planner needs to know what services are available to meet the needs and desires of the transition candidates and families and the eligibility requirements of available services and supports.
- Obtain information on what services or supports are available, and contact information for assistance and advocacy, should their needs change. This pertains to the time of long-term planning.
- Understanding the role of any informal supports. The transition candidates, their families, and discharge planner should candidly explain this role to the informal supports in order to ensure that they understand their role.
  - If informal supports have agreed to be part of the discharge plan, the transition candidates, families, and discharge planner must ensure that the informal supports understand what will happen if they do not fulfill their roles.
- Understand what types of services and supports their medical insurance will cover and for what public benefits they may be eligible. Discharge planners should be familiar with basic guidelines for Medicare and Medicaid coverage, and refer transition candidates and families to the appropriate person or entity that can explain specific coverage benefits and limitations.
- Understand their rights to appeal adverse decisions.



**SECTION THREE -**  
**Transition Candidate and Family Information**  
**Chapter 13 - Frequently Asked Questions**





### **What is the role of Area Agencies on Aging in the nursing home to community?**

The Area Agencies on Aging (AAA) act as referral sources for the nursing home to community program. They begin the paperwork in the hospital and discuss the short-term stay with transition candidates and their families prior to leaving the hospital. Candidates and families are given the name of the AAA liaison they will see in the skilled nursing facility. The hospital liaison then transfers the case to the nursing home liaison.

### **Do any of the partners assess the transition candidates' home environment in the community prior to discharge?**

This can happen in a number of ways. Depending on the facility, some physical therapists make home visits prior to the resident returning home. Depending on the complexity of the case, AAA or transition team staff will make a home visit prior to candidates returning home. Sometimes the people are previously known to the AAA so they are familiar with the home setting.

### **Do any of the partners see the resident after they return home?**

The transition team will make contact with the transition candidate weekly for six consecutive weeks, at which time the Medical Waiver case manager will make contact every 90 days.

### **If the transition plan fails, will the skilled nursing facility readmit the person?**

Our partners believe if someone wants to return home, and there is no history of not being successful with home care in the past, we do everything possible to give that person a chance at community living. However, the complexity of care can be such that either the transition candidates and families cannot manage it or the plan may fall apart for a variety of reasons. If a plan is complex and challenging, most skilled nursing facilities are agreeable to taking the resident back if community care fails, or they can go to another nursing facility.

### **Who should be referred to the nursing home transition program?**

Any resident who expresses a desire to leave the facility should be referred to the nursing home transition program.

### **What is a level of care assessment?**

The Medicaid waiver targeted case manager uses the state-approved assessment tools to identify the abilities/disabilities/functional abilities/limitations. The results aid in determining the nursing facility level of care decision. This decision is based on the medical criteria governed by the applicable level of care codes and is applicable to all nursing facility admissions as well as said waivers.

### **What does an assessment consist of?**

The transition team conducts a complete medical, psycho-social assessment by reviewing the candidates' chart, interviewing staff, speaking with the resident, and conducting the MDS/HC. The history of any care the resident was receiving prior to admission is reviewed and options for post-discharge care are discussed with the resident. From this review, discharge goals are established and community agencies are identified that can provide the services.



**What is a clinical care plan?**

The clinical care plan is a structured overview of an individual's problems, goals, and interventions that have been jointly agreed upon by the resident (or caregivers) and the transition team evaluator(s). A transition team assessment form takes the place of the care plan during "information only" visits. It clearly lists the information given at the visit and the recommendations made to the resident/family/caregiver. The purpose of the transition team assessment form is to provide written communication and direction for the resident and all involved formal and/or informal supports. The signature of the resident, family, and/or informal supports on the care plan/assessment form grants the transition teams' permission to release information regarding the resident to community agencies and professionals.

**Who is in charge of securing discharge plans?**

The transition team or a designated family/community support person should be in charge of securing discharge goals. Of course, the assistance of a well-coordinated team effort on the part of the skilled nursing facility staff and community agencies is always essential.

**Who develops the home care plan?**

The transition team in partnership with the resident and community agencies will develop the care plan. If the person is Medicaid eligible, the State, transition team, and AAAs will also authorize the home care services.

**What does Medicare pay for post-discharge?**

Medicare will cover care delivered by a certified home healthcare agency if a skilled nursing or restorative therapy is still required after a person goes home. It is always good to err on the side of caution and make the referral to the certified home healthcare agency and let them complete an assessment to determine whether or not the resident will be covered under Medicare.

**What does Medicaid pay for post-discharge?**

If a person is Medicaid eligible, Medicaid could be the primary payer of services post-discharge, depending on a person's care needs and ability to manage his/her own care. The transition team will conduct a level of care assessment to determine what level of care is most appropriate of the resident post-discharge.

**What is a Medicaid waiver?**

States can apply to the federal government to expand services and create new programs under Medicaid that are not traditionally covered by established Medicaid programs. When a state applies to the federal government to expand services, they generally put a service package together under a waiver application. This allows states to tailor programs to meet specific state needs.



### **What is the transition team's role in Medicaid waiver programs?**

The transition team determines a resident's level-of-care eligibility for Medicaid waiver programs; however, the acting Medicaid waiver agency serves as coordinator or case manager providing the overall case management. Programs include:

- Aged and Disabled (A&D) waiver
- Traumatic Brain Injury (TBI) waiver

### **What is the definition of case management?**

Case management is an activity that promotes continuity of care and involves the process of planning, organizing, coordinating, and monitoring services and resources needed to respond to an individual's healthcare needs. It supports the effective use of healthcare, social services, and good stewardship of financial resources. Case management offers a holistic resident/family approach to meet mutually identified resident needs in a cost-effective and care-efficient manner. This systems approach is used to coordinate the assessment, delivery, reassessment, and monitoring of all services to ensure quality of care.



## **What can be done to ensure an accessible community placement for those transition candidates in wheelchairs?**

Accessibility and usability are two different concepts. Many senior/disabled housing complexes are accessible to wheelchairs, yet most apartment units and private homes are not designed to be wheelchair friendly.

While ramps and elevators provide access to homes and apartments for people who use wheelchairs, once inside, navigation can still be difficult.

Therefore, transition candidates who use wheelchairs and are planning discharge should tour the housing unit they will be moving to. If they cannot personally tour, they should instruct a friend or loved one to look at the unit and ask the following questions:

- Is there a ramp or elevator into the home?
- Are the doorways wide enough for a wheelchair to pass through?
- Is there a bathroom on the first floor?
- Is the bathroom big enough to fit a wheelchair?
- Can a wheelchair fit under the bathroom sink?
- Is the shower a roll-in versus a walk-in?
- Is the kitchen designed for wheelchair use?
- Is there at least one counter that a wheelchair can fit under?
- Can a person in a wheelchair access the storage spaces in the kitchen?

Most homes and apartment units are not designed to accommodate people who use wheelchairs. However, size does matter. Large bathrooms and kitchen space at least enable a person in a wheelchair to make personal accommodations in how they might access the space most effectively.

For advice on retrofitting a home for other conditions or disabilities such as sight impairment or limited mobility, contact your local AAA.



# Appendix A - Assessment Tool

















# Appendix B - Nursing Facility Pre-Transition Quality Assurance Checklist





## Nursing Facility Pre-Transition Quality Assurance Checklist

State Form \_\_\_\_\_

Name of resident:	Name of Transition Team member performing QA checklist (print):
Residential Provider:	Signature of Transition Team member listed above:
Home Address:	Date of visit for transition QA Checklist:
Home phone #:	Name & phone # of Case Manager:
Setting: Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Congregate Care <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Other <input type="checkbox"/> (describe below):	Name & phone # of Residential Provider contact person:
Date Individual scheduled to move into home:	Date of Support Plan used for this checklist:

**NOTE: All questions below are to be scored using the current support plan for the resident:**

“Yes” = compliance with plan “NA” = not a need in plan

“**NO HOLD EXIT**” (1 through 21) = exit delayed until compliance is reached. **Compliance must be documented on page 4**

“**NO**” on items 22 through 29 may or may not result in holding an exit, based on individual needs.

**NOTE: All “no” responses must include a narrative explaining the deficit**

Item	Support/Service	Yes	NO Hold Exit	NA
1	Home and Community Preference (type and location) met?			
2	Home Adaptations in place? (list mandated adaptations)			
3	Home clean and hygienic?			
4	Safe storage of medications, cleaning supplies, knives and other potential hazards?			
5	House, lot, yard, garage, walkways, driveway etc. free from environmental hazards?			
6	Transportation available to meet all community access needs? (describe transportation plans)			
7	Personal physician identified and appointment scheduled? (enter name, phone # & appointment date/time)			



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8	Personal dentist identified and appointment scheduled? (enter name, phone # & appointment date/time)			
<b>Item</b>	<b>Support/Service</b>	<b>Yes</b>	<b><u>NO</u> <u>Hold</u> <u>Exit</u></b>	<b>NA</b>
9	Adequate Staff assigned? (describe staffing plans)			
10	Staff received information addressing Individual's medical needs?			
11	Staff received information addressing Individual's dietary/nutritional needs?			
12	Staff received information addressing Individual's personal hygiene needs?			
13	Staff received information addressing Individual's mobility needs?			
14	Staff received information addressing Individual's behavioral considerations?			
15	High Risk issues identified and plans developed to address them? (list individual risk issues)			
16	Phone installed in home? (enter phone #)			
17	Is an emergency telephone list present?			
18	Hot water no warmer than 110° Fahrenheit (or documentation of safeguards in place to ensure that the individual is not at risk for scalding)?			
19	Does the Plan of Care identify and address all necessary services and supports?			
<b>Item</b>	<b>Support/Service</b>	<b>Yes</b>	<b>NO</b>	<b>NA</b>
20	Neurologist identified? (enter name)			
21	Other needed medical specialist identified? (enter specialty and name for each, if known)			
22	OT/PT provider identified? (enter name)			
23	Speech/Language Pathologist identified? (enter name)			
24	Dietician identified and a plan in place for meeting nutritional needs? (enter name)			
25	Medical equipment present or arrangements made to obtain equipment? (list all equipment)			



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26	Adaptive equipment present or arrangements made to obtain equipment? (list all equipment)			
27	Home stocked with food to accommodate the new occupant?			

List all participants, and titles:

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Notes: \_\_\_\_\_





# Appendix C - Nursing Facility Post-Transition Quality Assurance Checklist





**Nursing Facility Post-Transition Quality Assurance Checklist**

Name of individual:	Names of Transition Team member performing this checklist (print):
New Residential Provider:	Signature of Transition Team member completing this form:
Home Address & Phone #:	Date of visit for transition QA Checklist:_(phone)_____ Check one: 7-day <input type="checkbox"/> 30-day <input type="checkbox"/> 60-day <input type="checkbox"/> 90-day <input type="checkbox"/> other
Setting: Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Congregate Care <input type="checkbox"/> <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Other <input type="checkbox"/> (describe below):	Name & phone # of Case Manager:
Date resident moved into home:	Name & phone # of Residential Provider contact person:
Previous Residential Provider or Nursing Facility:	

- **Prior to conducting the survey** – check to see if any incidents have been reported; attach a copy of those incidents and follow up to this survey form. Note in question 45 if any incident reports do not have appropriate follow up submitted.
- All questions below are to be scored using the **current** support plan (supported living) or individual program plan (group home) for the resident:

“Yes” = compliance with plan “No” = not in compliance with plan “N/A” = not a need in plan

**NOTE: All “No” responses must include a narrative explaining the deficit**

	Yes	No	NA
1 Personal belongings in the home and available to Individual?			
2 Home adaptations in place?			
3 Is an emergency telephone list present?			
4 Medical equipment present (ex: G-tube, C-pap, Oxygen)? (list equipment per PCP/ISP)			
5 Adaptive equipment present (mealtime equipment, communicative devices, braces etc.)?			
6 Home clean and hygienic?			
7 Safe storage of medications, cleaning supplies, knives and other potential hazards?			
8 House, lot, yard, garage, walks, driveway, etc. free of environmental hazards?			
9 Hot water no warmer than 110° Fahrenheit (or documentation of safeguards in place to ensure that the individual is not at risk for scalding)?			



**INDIANA Nursing Facility Transition Manual**

10	Transportation needs met? (describe how transportation needs are being met)			
11	Opportunities for leisure relevant and promote independence?			
12	Opportunities for community experiences?			
13	If medications have been changed, is there documented justification for the changes? (list changes including dosages pre and post change. Include date of change)			
14	Medication administered and charted appropriately?(for Nursing Home placement, see guidelines)			
15	Adequate staff assigned and present? (describe staffing ratios)			
16	Staff trained on Individual's medical needs including side effects of medications?			
17	Staff trained on Individual's dietary/nutritional needs?			
18	Staff trained on Individual's personal hygiene needs?			
19	Staff trained on Individual's mobility needs?			
20	Staff trained on programs for Individual's behavioral considerations and/or psychiatric needs/symptoms?			
21	Staff trained on Individual's communication needs?			
22	Personal Physician identified and appointment scheduled and kept?(enter name, phone # & appointment date/time)			
23	Personal Dentist identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time)			
24	Psychiatrist identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time)			
25	Neurologist identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time)			
26	Other Medical Specialist identified and if appropriate, appointment scheduled and kept? (enter specialty, name, phone # & appointment date/time.			
27	Behavior Support provider identified and appointment scheduled and kept? (enter name, phone # & appointment date/time)			
28	OT/PT provider identified and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time)			
29	Speech Language Pathologist provider identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time)			
30	Dietician identified and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time)			



**INDIANA Nursing Facility Transition Manual**

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31	Is the Individual adjusting to the home (i.e. - Is there a lack of any observed or reported problems such as poor eating, sleeping disturbance, depression, etc)?			
32	If there have been any recent illnesses, injuries or hospitalizations, were they adequately and appropriately documented in the Individual's personal file? (list illnesses with dates)			
33	If there have been any recent illnesses, injuries or hospitalizations, did the Individual receive appropriate medical care including follow-up?			
34	If there has been a change in home, provider or Case Mgr., has the change resulted in positive outcomes for the Individual?			
35	Does interview &/or documentation indicate adequate involvement from the Case Manager, if on waiver? ( <i>N/A for Nursing Home</i> )			
36	Does a review of the documentation indicate that the Aging Incident Reporting Policy is being followed? (If no – document dates and types of incident on this form and assure that the incident is filed per the Aging Incident and file an incident regarding the non-reporting of the initial incident.)			
37	Are all reported incidents resolved appropriately?			



**Specialty Recommendations**

During post transition monitoring and as physician and other specialty appointments are scheduled and kept, enter recommendations resulting from these specialists in cells below including time frames for actions if pertinent. Enter N/A where appropriate. Include "Other" specialists as needed. Confirm implementation (yes or no) in column on right.

SPECIALIST	RECOMMENDATION	RECOMMENDATION IMPLEMENTED?
Primary Care MD		
Dentist		
Psychiatrist		
Neurologist		
Behavior Support		
OT		
PT		
Dietician		

NOTES:

List all participants, and titles:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_







# Appendix D - Discharge Planning Safety Considerations





Safety Concerns that Impact an Individual Wishing to Live in the Community

**Individual Capacity Issues**

- Competence and decision making capacity of the person
- Ability of the person to self-direct Non-compliance Balance - frequent falling Memory impairment Self-medication Sensory deficits Unstable clinical condition Mental health concerns Lack of education e.g. affecting ability to read instructions

**Environmental Issues**

- Unsafe housing
- Lives alone
- Lack of support
- Lack of understanding of individual 's situation
- Homelessness, housing availability and accessibility

**Provision of Service Issues**

- Geographic location
- Availability of services as a factor in determining discharge potential
- Lack of transportation
- Lack of equipment and supplies at home
- Drug and alcohol abuse
- Criminal activity
- Costs of services and perceptions of costs
- Funding constraints and inadequate financial resources.
- Insurance coverage (individual's assumption of risk may affect scope of coverage)
- Potential abuse in home
- Inappropriate use of resources
- Fear of raising issues/concerns earlier

- Language/cultural barriers
- Refusal to accept services
- Definition of safety
- Medical perspective of safety needs
- Perception - actual liability concerns
- Interpretation of standards/regulations
- Fear of litigation
- Safety of aides - have aides been exposed to criminal behavior or sexual harassment while on the job in this person's home in the past?
- Lack of coordination between discharge planner and home care agency concerning acceptance/capacity
- Consideration of the facts of a "difficult patient's" care before determining Home Care Agency's compliance with regulation





## Appendix E - Notice of Action







**NOTICE OF ACTION**  
State Form 46015 (R5 / 4-02) / HCBS 5

**NOTICE**

See the last page of this form for important information about your responsibilities and appeal rights.

Aged or Disabled     Autism     MFC     TBI     AL     AFC     DD     SupSrv     SED

Name:	SSN:	Medicaid number:
Address:		County:
City, state, ZIP:		Mailing date of notice

Cost Comparison Budget Serial Number =>

Cost Comparison Budget Dates => Start Date \_\_\_\_\_ End Date \_\_\_\_\_

**NEW APPLICATION**     **ANNUAL REDETERMINATION**     **CHANGE / UPDATE**

The Indiana Family and Social Services Administration has taken the action indicated below in regard to your application for, or change of services under the Home and Community-Based Services (HCBS) Waiver Program.

**FOR APPLICATION ONLY**

Effective \_\_\_\_\_ your application for services are  Approved  Denied  Re-started

Level of Care  NF/Intermediate  NF/Skilled  ICF/MR  Hospital  Psy Hospital  NF/TBI  NF/AL  NF/AFC

Please check who completed the Level of Care Determination:  OMPP  BDDS  AAA

Reason \_\_\_\_\_

**TO BE COMPLETED FOR ANNUAL REDETERMINATION, CHANGE/UPDATE, & DISCONTINUANCE ONLY**

Effective \_\_\_\_\_ your waiver services are:  Increased  Decreased  Discontinued  
 Continued at last approved amount  
 Denied - services will continue at last approved amount

Redetermination of Level of Care Completed?  Yes  No By:  OMPP  BDDS  AAA  Non AAA CM

Reason \_\_\_\_\_

Description of change \_\_\_\_\_

***This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!***

**SERVICES APPROVED**

AREA 7: WEST CENTRAL INDIANA ECONOMIC DE (CMGT) - CASE MANAGEMENT - (After 12/31/2003 1 unit= 0.25 HOUR @ 9.21)

Units NOT used in one month CAN be utilized in other months as long as the total units authorized for the entire plan are not exceeded.

Billing Code	Mod #1	Mod #2	Mod #3	Mod #4	Prior Cost	Start Date	Stop Date	Current Units	Current Cost



**INDIANA Nursing Facility Transition Manual**

Name: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

**SERVICES APPROVED**

**NURSE CARE, INC. (HMK) - HOMEMAKER - (After 12/31/2003 1 unit= 0.25 HOUR @ 3.00)**

Units NOT used in one month can NOT be used in another month.

Billing Code	Mod #1	Mod #2	Mod #3	Mod #4	Prior Cost	Start Date	Stop Date	Current Units	Current Cos

Signature of FSSA Representative:		Case Mgr 9 digit authorization #	Case Mgr 6 digit I.D. #
Date:	Case Manager =>		

IF YOU WISH TO APPEAL, PLEASE READ THE INFORMATION ON THE NEXT PAGE AND THEN SIGN AND DATE BELOW.

<input type="checkbox"/> I wish to appeal the above decision.	Reason:
Signature of applicant / recipient / guardian:	Date

**This Notice of Action was automatically generated by the Cost Comparison Budget approval process.**



Name:

Medicaid #:

**YOUR APPEAL RIGHTS AS AN HCBS WAIVER SERVICES RECIPIENT**

1. If you question the above action, you should discuss this matter with your waiver services case manager.
2. **Your Right to Appeal and Have a Fair Hearing:**

If your application is denied, you may file an appeal within 30 days of the date the notice is **mailed** to you.

As an HCBS waiver recipient, if you disagree with any action taken on your HCBS waiver case, you may appeal within 30 days of the **effective date** of the action. However, your HCBS waiver benefits will not continue unless you appeal **prior** to the effective date of action. If you appeal and your waiver benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the hearing decision.

3. **How to Request an Appeal:**

If you wish to appeal this decision, you may request an appeal within 30 days of the date of receipt of this decision. Sign and return this form **or** send a letter with your signature to: MS04, Indiana Family and Social Services Administration, Hearings and Appeals, 402 W. Washington St., Room W392 Indianapolis, IN 46204

If you send a letter rather than this Notice of Action, be sure that the letter contains your full name, address, and telephone number where you can be reached. Please attach a copy of this decision and state the name of the action you are appealing. If you are unable to write this letter, you may have someone assist you in requesting this appeal. A telephone request for an appeal cannot be accepted.

You will be notified in writing by the Family and Social Services Administration, Hearings and Appeals of the date, time, and place for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the waiver case manager.

You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.

Distribution of Notice of Action:

- |   |  |  |                                      |   |
|---|--|--|--------------------------------------|---|
| <input type="checkbox"/> Recipient      | <input type="checkbox"/> County DFC    | <input type="checkbox"/> Assessment Agency | <input type="checkbox"/> Provider(s) | <input type="checkbox"/> Waiver Case File |
| <input type="checkbox"/> BDDS Case File | <input type="checkbox"/> AAA Case File | <input type="checkbox"/> CMHC              | <input type="checkbox"/> Other _____ |   |





# Appendix F - Abbreviated Plan of Care/Cost Comparison





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	<b>Plan of Care / Cost Comparison Budget for the Waiver</b>		Central Office Use Only Date                      Initials OMPP                      _____ MWU                        _____ Returned                   _____	
	Area Agency #: Case Manager: Cost Comparison Type:	BDDS District:		
Name: Address: City/State/Zip:		Medicaid Number: Medicaid Elig. Date: Waiver Application Date: Social Security Number: Date of Birth:		
Level of Care: LOC Date: MAW Start Date:		Discharge Date: Diagnosis 1:                      Diagnosis 2: Previous LOC Date:		
Recommendation: Slot Number:                      Level of Service Point Total:		CCB Serial #:		
Plan of Care Beginning Date:                      Ending Date:		<b>Calculations are based on 30 days.</b>		
<b>A. Home and Community-Based Care Costs</b>				
<b>1. Plan of Care Information: Monthly Authorizations:</b>				
ADULT DAY CARE	ADC AAA		= M/Cst	
ADULT DAY CARE	ADC ILS		= M/Cst	
ADULT DAY CARE	ADC NON		= M/Cst	
ADULT DAY CARE	ADC HHA		= M/Cst	
ADULT DAY CARE	ADC AAA		= M/Cst	
ADULT DAY CARE	ADC ILS		= M/Cst	
ADULT DAY CARE	ADC NON		= M/Cst	
ADULT DAY CARE	ADC HHA		= M/Cst	
ADULT COMPANION	ADCP ILS		= M/Cst	
ADULT COMPANION	ADCP NON		= M/Cst	
ADULT COMPANION	ADCP HHA		= M/Cst	
Adult Day Service - Level 1	ADS1 AAA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 ILS	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 NON	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 HHA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 AAA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 ILS	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 NON	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 HHA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 AAA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 ILS	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 NON	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 HHA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 AAA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 ILS	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 NON	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 HHA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 AAA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 ILS	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 NON	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 HHA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 HSA	(0.50 DAY) units	x rate = M/Cst	
Adult Day Service - Level 1	ADS1 HSA	(0.50 DAY) units	x rate = M/Cst	



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TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
				Other Medical Cost
<b>3. Total of Lines</b>	+		=	
<b>4. Minus Recipient Spend-down Amount</b>			=	
<b>5. Total Home and Community Care Costs</b>			=	
<b><u>B. Institutional Care Costs</u></b>				
<b>1. Nursing facility per diem \$ _____ X 30 days = \$ _____</b>				
<b>2. Other Medical Services</b>				
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
Hospitalization	ACU	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
DENTAL SERVICES	DENT	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
Estimated OMS Costs	EST	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
OPTOMETRIC SERVICES	EYE	3 month payment	+ 3	=Est M/Cst
Health Education	HEED	3 month payment	+ 3	=Est M/Cst
Health Education	HEED	3 month payment	+ 3	=Est M/Cst
Health Education	HEED	3 month payment	+ 3	=Est M/Cst
Health Education	HEED	3 month payment	+ 3	=Est M/Cst
Health Education	HEED	3 month payment	+ 3	=Est M/Cst



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TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
TRANSPORTATION	TRAN	3 month payment	+ 3	=Est M/Cst
				Other Medical Cost
<b>3. Total of Lines</b>	+		=	
<b>4. Minus Recipient Liability Reduction</b>			=	
<b>5. Total Institutional Costs</b>			=	



# Appendix G - Discharge Planning Checklist





# Appendix H - Transition Readiness Checklist





## Transition Readiness Checklist

### Transition Team Readiness to Return to Community Checklist (contributed by REAL Services, Inc.)

**Client Demographics**

Name Male / Female                      SSN RID  
 Address  
 Mailing Address, if different  
 Phone ( )                                      DOB Age  
 Living Arrangement  
 Marital Status                              Speaks English Y / N Other  
 MR/DD                                      Mental Health Disability  
 Ct Height                                      Ct Weight  
 Monthly Income                              Spend Down  
 Medicare Other Insurance  
 Veteran  
 Primary Caregiver  
 Relationship                                      Are they POA  
 Does client have/need a Guardian  
 Caregiver Address / Phone

**Health Information Checklist**

\*\*Health History (Indicate all that apply)\*\*

- |                                    |   |
|------------------------------------|---|
| 1. ___ Cognitive Deficits          | 2. Disoriented to ___ Person, ___ Place, ___ Time     |
| 3. ___ Stroke - when               | 4. ___ HOH  |
| 5. ___ Continent                   | 6. ___ Incontinent of Bladder ___ Bowel ___ Other ___ |
| 7. ___ Arthritis                   | 8. Fractured _____                                    |
| 9. ___ Cancer - when               | 10. ___ Diabetes                                      |
| 11. ___ COPD                       | 12. ___ Oxygen  |
| 13. ___ Non-Ambulatory             | 14. ___ History of Falls - when                       |
| 15. ___ Heart Problems             | 16. ___ High Blood Pressure                           |
| 17. ___ Dialysis                   | 18. ___ Learning Disabled                             |
| 19. ___ MR/DD                      | 20. ___ Mental Health History                         |
| 21. ___ Psychotropic Meds          | 22. ___ Anti-Depressant Meds                          |
| 23. ___ History of Substance Abuse | 24. ___ Other _____                                   |

**Vision**

- |                             |                             |
|-----------------------------|-----------------------------|
| 1. ___ Macular Degeneration | 2. ___ Cataracts            |
| 3. ___ Glaucoma             | 4. ___ Diabetic Retinopathy |
| 5. ___ Legally Blind        | 6. ___ Glasses              |

**Mobility**

- |   |                   |
|---|-------------------|
| 1. ___ Number of Falls in the last 3 Months               |                   |
| 2. ___ Abnormal Gait                                      | 3. ___ Weakness   |
| 4. ___ Lack of Safety Awareness                           | 5. ___ Obese      |
| 6. ___ Neuropathy   | 7. ___ Cellulitis |
| 8. Uses: ___ Cane, ___ Walker, ___ Wheelchair ___ Scooter |                   |
| 9. ___ Needs Assistance with Ambulation                   |                   |
| 10. ___ Needs Assistance with Transfers                   |                   |
| 11. ___ Needs Assistive Devices – name them _____         |                   |



## Transition Readiness Checklist (cont.)

### Nutrition Checklist

- |   |  |
|---|--|
| 1. <input type="checkbox"/> Regular Diet                  | 2. <input type="checkbox"/> Mechanical Soft Diet           |
| 3. <input type="checkbox"/> Pureed Diet                   | 4. <input type="checkbox"/> G-Tube                         |
| 5. <input type="checkbox"/> Swallowing/Chewing Difficulty | 6. <input type="checkbox"/> Dentures                       |
| 7. <input type="checkbox"/> Supplements                   | 8. <input type="checkbox"/> Unexpected weight loss or gain |

Comments:

### ADL Assessment Tool

\*\* Circle Appropriate Answer\*\*

1. Feeding Independent Supervision Verbal Cueing Assist x1 Tube
2. Transfer Independent StandByAssist Assist x1 Assist x2 Lift
3. Dressing Independent StandByAssist Verbal Cueing Assist x1 Assist x2
4. Bathing Independent StandByAssist Verbal Cueing Assist x1 Assist x2 tub shower
5. Toileting Independent StandByAssist Assist x1 Assist x2
6. Bowel Continent Incontinent
7. Bowel Care Independent Assist
8. Bladder Continent Incontinent - Assist
9. Catheter Independent Assist x1
10. Incontinency Independent Assist x1 – self-catheterization

### Products Needed

Mobility Ambulatory Independent StandByAssist Assist x1 Assist x2

Walker Independent StandByAssist Assist x1 Assist x2

Cane Independent StandByAssist Assist x1 Assist x2

Wheelchair Self propel Staff propel

Need for Assist:  weakness  dementia  SOB  hemiparesis

other \_\_\_\_\_

Comments

### IADL Assessment Tool

#### Meal Preparation

1.  independent
2.  able to prepare if set up completed
3.  able to heat already prepared meals
4.  needs to have meal prepared and served

#### Housekeeping

1.  independent
2.  able to perform light tasks such as dishwashing, bed making
3.  performs light tasks but not acceptable

#### Safety/Cleanliness

1.  needs to have housekeeping task completed

#### Laundry

2.  independent
3.  able to hand wash small items
4.  not able to complete laundry



## Transition Readiness Checklist (cont.)

### Shopping

1. \_\_\_\_\_ independent
2. \_\_\_\_\_ able to complete small purchases
3. \_\_\_\_\_ needs to be accompanied
4. \_\_\_\_\_ not able to shop

### Transportation

1. \_\_\_\_\_ independently able to access public transportation or drives own car / family supports
2. \_\_\_\_\_ able to travel on public transportation if \_\_\_\_\_

### Accompanied assist

1. \_\_\_\_\_ needs W/C accessible travel
2. \_\_\_\_\_ does not travel

### Medications

1. \_\_\_\_\_ able to take own medications correctly
2. \_\_\_\_\_ able to take when set up in advance
3. \_\_\_\_\_ not able to take medications correctly

### Telephone

1. \_\_\_\_\_ independent
2. \_\_\_\_\_ able to contact already well known numbers
3. \_\_\_\_\_ able to answer but not able to dial
4. \_\_\_\_\_ not able to use telephone at all

### Grooming

1. \_\_\_\_\_ independent
2. \_\_\_\_\_ able to complete (washing face, shaving, washing/combing hair) with set up completed
3. \_\_\_\_\_ not able to complete personal hygiene

### Social Assessment Tool

1. Who will be the client's primary caregiver?
2. Does the client have any children, or other family supports?  
If so, is there regular contact?
3. Date of NF admission: Length of NF stay to date:
4. Residence prior to the NF stay?
5. What about returning to the community concerns the client?
6. If client returns to the community will they be living alone or with someone?

### If with someone, who, and what relationship to the client?

1. What type of family support does this person have?
2. What assistance will the family provide daily, weekly, etc.?
3. Who will assist client in finding appropriate housing?
4. \_\_\_\_\_ Primary caregiver \_\_\_\_\_ NF social worker \_\_\_\_\_ LTCC \_\_\_\_\_ other \_\_\_\_\_
5. Is the client able to set up utilities, phone account, etc, if not who will assist them?
6. Who will actually move that client out of the NF?



## Transition Readiness Checklist (cont.)

Does client need w/c accessible transportation? Ambulance Car

1. Who will provide care for them until the home care actually starts?
2. What assistance do they need for their ADL's and who will provide this assistance?
3. What assistance do they need for their IADL's and who will provide this assistance?
4. If client requires assistance with medication weekly set up or daily reminders, who will provide the
5. assistance?
6. Is the client able to call in their refills for the medications?
7. Who will assist them to get the client is getting equipment or home modifications if they require these
8. things?
9. Will client have a telephone for correspondence?
10. If the client was sick or needed help, whom would they call?
11. What hospital preference does the client have?
12. Do they have a physician within the community?
13. Who will get them to their doctor appointments?
14. What connections does the client have within the community? groups, churches, etc?
15. What will keep that client from being socially isolated? Adult Day Care?
16. Does the client have any hobbies/interests that they can focus on when they return to the Community?
17. Is the client knowledgeable about resources within the community? If not what can we, as LTCC, arm them with to assist them in finding and owning their own resources? (FYI guide, Red Cross, American Cancer Society or other agencies)

### Housing Information Checklist

1.  Owns own Home
2.  Has No Current Housing
3.  Needs Subsidized Apartment
4.  Rents \_\_\_\_\_ Where?
5.  Assisted Living
6.  Lives Alone
7.  Isolated
8.  Lives with Family
9.  Lives with Friends
10.  Weatherization Program
11.  Handy Chore Person Needed
12.  Pets
13.  Needs Home Modification
14.  Needs Medical Equipment
15.  Wheelchair Accessible
- Needs Ramped Entrance
- Bathroom Modification
- Needs Roll-In Shower
- Needs Grab Bars
- Needs Raised Toilet
- Other \_\_\_\_\_

Comments:



## Transition Readiness Checklist (cont.)

### Financial Information Checklist

1.  Spend Down
2.  No Spend Down
3.  Spend Down Amount \$ \_\_\_\_\_
4.  Has Medicare Payments/other means to meet Spend Down
5.  Spousal Impoverishment for Husband & Wife
6.  Senate Bill 30 for Children
7.  Able to Manage their own Finances
8.  Can oversee checkbook/Write Checks
9.  Has POA to Oversee Finances
10.  Needs Representative Payee Service
11.  Able to Pay for Food
12.  HDMS
13.  Food Stamps
14.  Able to Pay for Phone
15.  Refer to Energy Assistance Program
16.  Co-Payment Amount for Medications
17.  Needs Transitional Money for Rent, Deposits, House wares
18.  Other Family Members can Assist Financially
19.  Other \_\_\_\_\_
20.  Other \_\_\_\_\_

### Assessment Goals

Goals Prior to Leaving Nursing Facility

1. Obtain Accessible Housing
2. Request Transitional Dollars for Deposits, House Wares, Lifeline
3. Identify Primary Caregiver and Support System
4. Connect Ct with Home Health Agency to apply for PA Services
5. Complete the Basic Necessity Checklist
6. \_\_\_\_\_
7. \_\_\_\_\_

### Basic Necessity Checklist

- |  |   |
|--|---|
| <input type="checkbox"/> Food            | <input type="checkbox"/> Telephone/notepad/pencil |
| <input type="checkbox"/> Lifeline        | <input type="checkbox"/> Medications/Med box      |
| <input type="checkbox"/> Keys            | <input type="checkbox"/> Emergency #'s            |
| <input type="checkbox"/> Calendar        | <input type="checkbox"/> Flashlight & batteries   |
| <input type="checkbox"/> Light bulbs     | <input type="checkbox"/> Dmoke alarm              |
| <input type="checkbox"/> First Aid Kit   | <input type="checkbox"/> Clothes                  |
| <input type="checkbox"/> Working furnace |   |

### Kitchen

- |   |  |
|---|--|
| <input type="checkbox"/> cooking utensils     | <input type="checkbox"/> can opener                      |
| <input type="checkbox"/> pot                  | <input type="checkbox"/> skillet                         |
| <input type="checkbox"/> bowls                | <input type="checkbox"/> coffee maker                    |
| <input type="checkbox"/> toaster              | <input type="checkbox"/> microwave                       |
| <input type="checkbox"/> baking sheet         | <input type="checkbox"/> plastic food storage containers |
| <input type="checkbox"/> table & chair        | <input type="checkbox"/> paper towels                    |
| <input type="checkbox"/> towels               | <input type="checkbox"/> dish clothes                    |
| <input type="checkbox"/> waste basket         | <input type="checkbox"/> dishes                          |
| <input type="checkbox"/> silverware           | <input type="checkbox"/> working stove                   |
| <input type="checkbox"/> working refrigerator |  |



**Transition Readiness Checklist (cont.)**

Bedroom

- |                                       |                                       |  |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> bed          | <input type="checkbox"/> nightstand   | <input type="checkbox"/> sheets/blankets |
| <input type="checkbox"/> pillow/cases | <input type="checkbox"/> waste basket | <input type="checkbox"/> hangers         |
| <input type="checkbox"/> mattress pad | <input type="checkbox"/> lamp         | <input type="checkbox"/> alarm clock     |
| <input type="checkbox"/> dresser      | <input type="checkbox"/> curtains     |  |

Living area

- |                                      |                                   |                                    |
|--------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> couch       | <input type="checkbox"/> chair    | <input type="checkbox"/> end table |
| <input type="checkbox"/> TV/TV stand | <input type="checkbox"/> curtains |                                    |

Bathroom

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> mirror            | <input type="checkbox"/> towels                | <input type="checkbox"/> wash cloths  |
| <input type="checkbox"/> waste basket      | <input type="checkbox"/> laundry basket/hamper |                                       |
| <input type="checkbox"/> laundry detergent | <input type="checkbox"/> toothpaste/brush      | <input type="checkbox"/> toilet paper |
| <input type="checkbox"/> Kleenex           | <input type="checkbox"/> hand soap             |                                       |

Barrier Reporting Tool

Check all that apply

- |  |  |
|--|--|
| <input type="checkbox"/> fear  | <input type="checkbox"/> no home/apartment           |
| <input type="checkbox"/> setting up new home/apartment                         | <input type="checkbox"/> maintaining home            |
| <input type="checkbox"/> is client able to set up utilities, phone, cable, etc |  |
| <input type="checkbox"/> set up costs  | <input type="checkbox"/> environmental safety issues |
| <input type="checkbox"/> difficulty with meeting spendown                      |  |
| <input type="checkbox"/> lag time for services to begin once at home           |  |
| <input type="checkbox"/> equipment   | <input type="checkbox"/> social isolation            |
| <input type="checkbox"/> lack of primary support group                         |  |

IADL's

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Meal preparation | <input type="checkbox"/> Housekeeping |
| <input type="checkbox"/> Laundry          | <input type="checkbox"/> Shopping     |
| <input type="checkbox"/> Transportation   | <input type="checkbox"/> Medications  |
| <input type="checkbox"/> Telephone        | <input type="checkbox"/> Grooming     |

Finances

- |   |  |
|---|--|
| <input type="checkbox"/> stairs   | <input type="checkbox"/> nursing facility reluctance |
| <input type="checkbox"/> convincing Dr that community in-home supported living will be safe |  |
| <input type="checkbox"/> credit history/current debt or bills                               | <input type="checkbox"/> physical move out of NF     |
| <input type="checkbox"/> unmet medical care needs   |  |

Comments regarding Solutions to Barriers above:



