Senior Security Plan

Aug. 5, 2002

Seniors today wish to receive health care services in their home and in their community whenever possible. As the demand for institutional nursing home services decreases and the desire for home- and community-based services increases, the Family and Social Services Administration remains committed to providing quality care to those Hoosiers we serve – in the most appropriate care setting.

According to the nursing home industry, several nursing facilities are at risk of closing. FSSA, as needed, is voluntarily going to assist families and patients affected by sudden nursing home closures.

- There are 495 Medicaid-certified nursing facilities in Indiana, with a total of 52,620 beds; more than 13,000 of them are empty.
- At the same time, Medicaid is able to serve only about 3,300 recipients in their home or community, with thousands of others on a waiting list to receive similar services close to home.
- With about 25 percent of nursing home beds empty – more than twice the national average – Indiana has a significant overcapacity.
- Under federal (42 CFR 483.12(a)(7)) and state (410 IAC 16.2-3.1-12) laws nursing facilities are required to provide residents with at least 30 days notice and follow proper discharge planning for Medicaid-eligible residents in the event that a facility is going to close.
- FSSA has created "Senior Care Teams" to ensure that eligible, older Hoosiers continue to receive appropriate care. The Senior Care Teams consist of representatives from the Office of Medicaid Policy and Planning, the Division of Disabilities, Aging and Rehabilitative Services, the State Department of Health, the Area Agencies on Aging and the local ombudsman.
- During the federally required 30-day notice period, Senior Care Teams will do the following to ensure the safety and continuation of care for seniors:

Day 1: Immediately share information on closure with Senior Care Team to initiate Senior Security Plan.

Day 2 through 5: Local ombudsman informs resident and family members of placement options, which will include placement in home- and community-based services or transfer to another nursing facility. Each resident is assigned a case manager through the local Area Agency on Aging.

Day 4 through 10: Case manager provides application for services to resident who is Medicaid eligible and desires home- and community-based services.

Day 10 through 20: Case manager works with resident and family members to assess resident's needs, develop a plan of care for resident and coordinate necessary services. Physician certifies that community placement is safe and feasible for the resident, if appropriate.

By Day 25: Case manager forwards the planned services information to providers chosen by the recipient. Services will be initiated upon the individual's discharge. Some services, including making the home accessible (e.g., getting a ramp built) or assisting the individual with mobility (e.g., wheelchair purchase), may be initiated prior to discharge.

By Day 30: Division of Disability, Aging and Rehabilitative Services initiates quality assurance process for ongoing monitoring of resident's plan of care.

Discharge: The individual is discharged to the community or another facility. The case manager will conduct an initial face-to-face review in 30 days and every 90 days thereafter for at least one year to ensure the resident's smooth transition. After the first year in the community, face-to-face reviews will depend upon the recipient's needs.