Nursing Facility Transitions

Transition Coordination Training

Transition Goals

- Achieve Transition
- Achieve Timely Transition
- Effective Risk Mitigation
- Successful Development of Community and Natural Supports
- Successful Community Integration
- Make Effective Linkages and Build and Attain Supports for Transition Needs

Flow of Referrals

Referral Received:

OAAS generated list of residents with SMI and/or Section Q NF referrals

OAAS RO staff will assess to determine NF-LOC; if met, referral sent to OAAS TC. In LOC not met and SMI dx., sent to OBH TC.

Coordinator goes out to complete initial assessment and educate on HCBS services available.

Participant chooses which service package would be most beneficial and Transition Coordinator Notifies OAAS Data Manager

If appropriate for waiver, or offer from SRI. Offer is generated and sent to TC. If appropriate for LT-PCS, TC will refer to Conduent. If appropriate for PACE, TC will refer to PACE provider in area.

OAAS Data Manager logs in all requests and tracks progress of offers and/or services.

TC goes out and hand delivers offers and required forms to potential partici-pant

HCBS offers are scanned to SRI for SC linkage. OAAS Data Manager is copied on all returned offers for updates to tracking logs. If LT-PCS or PACE, data manager is notified for updating purposes.

SC Agency receives linkage and conducts MDS-HC for eligibility of service hours and care planning purposes.

TC continues to follow participant and assist to ensure participant can transition as expeditiously as possible.

Transition Coordinator Role

- Coordination with data manager regarding all referrals for Nursing Facility transition.
- Hand delivery of Medicaid service package options information.
  - If CCW/ ADHC is chosen, hand delivery of waiver packet
- Obtain pertinent documents from NF records while in facility (face sheet, H&P, legal documents, list or diagnosis and medications)
- Return signed documents to SRI to establish Support Coordination (SC) services. Remember to copy OAAS data manager for updating of tracking log.

Transition Coordinator Role

- Monitor data manger spreadsheet for accuracy and documentation of progress in transitions.
- Communicate with support team to ensure transitions are occurring in a timely manner
- Facilitation of conference calls or meetings with support team
- Completion of Home Visits and Transition Assessment with in 7 days post transition
- Home visit at 30, 90, and 180 days post transition
- A final phone follow up at 365 days post transition

Transition Coordinator Role

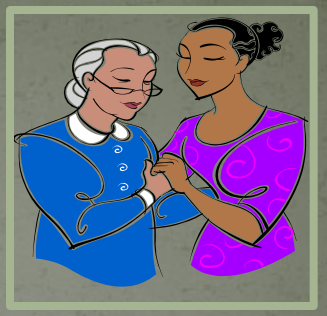
- Problem solving for special circumstance transitions/technical assistance (TA) to the support team
- Coordination with Housing team(PSH, MFP housing coordinator, etc.) to transfer documents pertinent for obtaining housing and complete housing applications (referrals, identification documents, ROIs, etc)
- Communication and TA with key Nursing Facility staff (Social Service Designee, DON, Administrator, etc.)

Transition Coordinator Role

- Communication, support and training for Office of State Ombudsman staff
- Communicate with concerned family members and others involved in the transition
- Resource Development
- Identification and communication of changes/revisions needed in current policies related to transitions
- Approval and requisitioning of funds for pre and post-move activities

Waiver Support Coordinator Role

Support Coordinator Role



- With in 3 days of linkage SC will contact individual to schedule face to face meeting
- Within 10 days of linkage SC will conduct a face to face meeting and complete a MDS-HC, if applicable.
- Meets with NF staff, family, and friends as warranted, to ensure individuals needs can be met
- If health and welfare can not be reasonably assured the SC will complete a narrative to give to the OAAS RO office
- When efforts to secure housing have been exhausted SC completes a narrative to give to OAAS RO office and they decide on inactive status

Support Coordinator Role

- Ensures timely communication and problem solving through meetings with Regional office and Transition Coordinators at regular intervals
- If it appears individual can transition POC is submitted to OAAS RO within 35 days of the linkage
- SC has the option to invite Transition Coordinator to POC meeting
- SC will conduct a monthly call with individual at NF and or personal representative to ensure transition efforts are ongoing and barriers are addressed

Support Coordinator Role

- Visit individual prior to transition to ensure:
  - D/C date
  - All needs will be met through coordination of supports and completed environmental modifications
- After 6 months, SC will hand over transition case to TC to continue working on transitioning for participant.
  - All documentation of prior activities and referrals for community services should be included with transfer of case.

Regional Office Roles and Responsibilities in Transition

- Referral to service review panel for review and guidance if questions arise concerning the sustainability of the transition in the community.
- Provide technical assistance to the support team.

State Office Role and Responsibility in Transition

- Develop training curriculum and contract with training agencies and organizations to deliver training
- Problem solve systemic issues that affect all long term care support services, including systemic problems with provider billing
- Analyze assessment data to further develop resources needed to sustain individuals in the community

Initial Visit

Initial Assessment

- To be completed upon initial visit
- Gather information from the individual, staff at the facility, supports identified by the individual, and through charts located at the facility
- Gives a quick but in depth "snapshot" of abilities, supports, barriers, and needs for successful transition

Documentation From Facility

- Face Sheet
- Diagnosis
- List of Medications
- History and Physical
- Therapy notes(PT, OT, Speech, Dialysis, etc)
- Notes specific to mental health diagnosis and treatment, including specialized services while in facility
- Any additional information that may assist in ensuring a successful transition

Review Service Options Available

- CC Waiver
- LT-PCS
- PACE
- ADHC
- Community Behavioral Health Services

Delivery of Service Package

Second Visit

Delivery of HCBS options

- Review with participant and complete appropriate services packet
  - If accepting CCW, ADHC or PACE, complete My Place informed consent forms for enrollment in program

Support Coordination and Release of Information

- Complete Recipient Identifying Information section at the top of the form
- Review form in entirety with individual
- If participant is interested in waiver services obtain signature in Section 2 (Choice of Waiver Services)
- Provide pamphlets for SC agency choices and review services offered through SC agency
- Obtain and record first and second choice for SC agency in Section 3 (SC Freedom of Choice)
- Obtain signature consent for Release of Information to SC agency

My Place Manual (Blue Book)

- Briefly review MPL with participant
  - What is the demonstration?
  - What are the goals and purpose?
  - Who is eligible?
- Provide participant with the benefits for participation in MPL

Participant Signature Form

- If participant agrees to participate in MPL review Participant Signature Form and obtain signature
- After signature is obtained sign above Signature of Witness
- Remove from book and leave the book for individual to review/reference

PSH Application

- Complete PSH application with participant
- If needed complete Birth Certificate order form and SSI request
- Obtain all needed identifying documents

ACT and FACT

- Assertive Community Treatment/ Forensic Assertive Community Treatment
- For participants who need more assistance than what clinical MH and/or SA services can provide
- Provides Community based services and supports including psychiatric treatment, medication administration and monitoring, behavioral health services, crisis intervention, employment assistance, and case management
- Services are provided in participant's home and community
- Applications to be completed on each participant with an extensive MH and/or SA history
- Please review eligibility criteria prior to completion of referral

Transition Coordinator Review

Documentation

Weekly Activity Tracking Logs

- Record of Activities performed during the work week
- Assist in updating transition progress for data collection
- Provides documentation of duties performed and interaction with participants, families, NF staff, and additional parties pertinent to successful transition
- Tracking logs to be submitted to supervisor by close of business on Friday

Weekly Activity Log Should Include

- Documentation of Initial Transitional Assessments Performed
- Documentation of 30 day, 90 day, and 180 day assessments (Time Management Tip: Record assessment deadlines in Microsoft Outlook Calendar upon Initial Transitional Assessment) 
- Documentation of 1 year post transition phone contact
- Weekly documentation of housing contacts
- Documentation of any transition or status changes for individuals in MFP program
- Documentation of any Critical Incidents you are notified of regarding participants

Meeting with Regional Office and Support Coordination Agencies

- Monthly meetings to review cases and progress toward transition
- Identifies barriers to transition and assists in the problem solving process
- Assists in coordination of resources
- Any information regarding **status change** of participants should be documented on **weekly activity log**

Minimum Data Set-Home Care (MDS-HC)

- U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes . This process provides a comprehensive assessment of each functional capabilities and helps identify health problems.
- Provide RUG Score (Resource Utilization Group) upon which individual care plans are developed
- Found in Telesys

Plan of Care (POC)

- Completed by SC
- Service Plans address all participants' assessed needs, including health and safety risk factors and personal goals
- Service Plans are revised at least annually and when participant's needs change.
- Type, scope, amount, duration, and frequency of services are delivered as specified in the POC

POC Continued

- Participants must be given a choice between waiver services and institutional care and between/among waiver services and providers.

- Establishes steps to ensure successful transition
  - i.e. A participant with a history of substance abuse should have steps to ensure sobriety built into CPOC

Critical Incident Reporting (CIR)

- CIR's are completed in **OTIS** by SC (if a critical incident is reported by a PA the PA must notify his/her supervisor and the supervisor will contact the SC agency)
- Critical incidents include, but are not limited to: falls (even if medical attention is not necessary), hospitalization, victimization or perpetration of abuse, death, reinstitutionalization, and incidents that increase/threaten risk of harm to the individual or individuals risk of harm to others
- Transition coordinators can access CIR through OTIS to gain information on critical incidents that occur with participants

Service Review Panel Referral (SRP)

- SC completes SRP Referral Form documenting reason for referral and providing a narrative with evidence for recommendation
- SC forwards to regional office for review and regional office sends to SRP
- SRP meets Wednesdays to review cases received the previous week
- SRP will notify regional office of recommendation and regional office notifies SC agency
- Supervisor will notify Transition Coordinator if one of his/her cases comes up for review and he/she may be asked to call into review and/or provide additional information to SRP