DSHS
WASHINGTON STATE
Department of Social and Health Services

Resources for Individuals in Skilled Nursing Facilities

The Role of Nursing Facility Case Management

Home and Community Services, a division of the Home and Community Living Administration, utilizes nursing facility case managers to actively work with Medicaid residents from the point of admission to a nursing facility to achieve the resident's transition goals and potential. This includes meeting face-to-face with residents early in their admission and working with families and staff at the facility to advocate for therapies, treatments and education provided in a way that supports the resident's transition goals and timelines.

The goal is for individuals to receive services in the least restrictive, most appropriate setting that meets the person's care needs while honoring choice and preference.

HCLA embraces the belief that individuals with high care needs can be supported in a variety of settings through the implementation of waivers and state plan services that provide alternatives to nursing facility care.

HCLA partners with people to shape their own lives by promoting choice, independence and safety through Home and Community Based Services.

WHAT'S INSIDE

- Role of a Home and Community Services nursing facility case manager
- Resident's rights
- Role of a skilled nursing facility professional
- Coordination of transition steps
- Frequently asked questions

A RESIDENT'S RIGHTS

- To be in charge of their transition plan and level of care.
- To choose between the following settings, if functionally and financially eligible:
  - Skilled Nursing Facility
  - Adult Family Home
  - Assisted Living Facility
  - Enhanced Adult Residential Care
  - Their own home (rented or owned)
- Receive an assessment to determine functional eligibility.
- To have a safe transition to a community setting according to laws and regulations.
- To make their own choices regarding their care, no matter what advanced directives are in place.
- To refuse all services, even if financially and functionally eligible.

Home and Community Services is a voluntary program. The individual chooses if they would like to receive assistance.

Roles of Transition Team

SKILLED NURSING FACILITY PROFESSIONAL

- Develops a safe transition.
- Coordinates resident's care needs while at the nursing facility.
- Starts discussions about returning to the community early (ideally before a resident is admitted or immediately upon admission).
- Gives frequent updates to HCS worker about transition plan, level of care changes, new admissions and notification if a resident goes to the hospital or passes away.
- Coordinates equipment needs and other doctor orders prior to transition.
- Communicates transition planning with the client and all stakeholders (family, HCS worker, providers, etc.)
- Completes self-medication programs for successful transition planning.
- Assists with finding community settings for all residents with or without Long-Term Care Medicaid Services.

NURSING FACILITY CASE MANAGER

- Provides resources, referrals and an accurate LTC assessment to determine functional eligibility for personal care and other transition services for residents moving to a community setting.
- Assist with finding community settings or housing options in the resident's chosen geographical area when available.
- May authorize a Community Choice Guide for individuals who are eligible for this service.
- Determine Nursing Facility Level of Care for all Medicaid applicants.
- Coordinate Housing Maintenance Allowance requests and decisions.
- Provide residents and SNF professionals with financial worker contact information (HCS Case Managers do not determine an individual's financial eligibility).

Coordination of Transition Steps

1 ADMISSION

- If a resident is interested in services, a SNF professional or HCS worker can assist the individual with the long–term care application.
- The resident will complete a paper application or submit an online application at: www.washingtonconnection.org.
- HCS will assist Medicaid recipients and Medicaid applicants with transition planning.

2 COLLABORATION

- SNF professionals and HCS workers work with residents to identify where long-term services and supports could assist with a transition to an individual's preferred care setting.
- SNF professionals and HCS workers report any suspected mistreatment, malpractice, abuse, neglect or exploitation.
- With all involved parties, communicates steps accomplished and steps needed to transition.
- If a transition date is discussed with a resident, HCS worker is notified immediately and transition coordination begins.

3 PREPARING FOR TRANSITION

Skilled Nursing Facility Professional Roles:

- Home Safety Assessment.
- Equipment orders and referrals to vendors.
- Assists with finding community setting for resident and communicates with HCS workers about the progress to confirm assessment is complete prior to transition.
- Arrange training with resident and family, if needed (insulin, transfers, skin care, medication management, etc.)

Home and Community Services Nursing Facility Case Manager Roles:

- Authorizes all services which may include Community Choice Guide, behavioral support and non-medical equipment and supplies.
- Assists with finding community setting for resident and communicate with SNF professional about progress.
- Completes assessment to determine functional eligibility and authorizes personal care and transition services based on the assessment.
- Support the resident's choice in services, settings and direction of the transition plan.
- Problem solve and work through challenges.

4 ACTIVE TRANSITION

SNF Professional Roles:

- Confirm with HCS worker assessment has been completed.
- Obtain physician's orders for discharge and send a copy to the HCS worker.
- Order necessary equipment and ensure all documentation and forms are sent to vendors in a timely manner.
- Set up primary care physician appointment prior to transition.
- Confirm resident has an adequate supply of medications and necessary prescription, all equipment has been delivered and that HCS coordination agency or individual provider is scheduled to start personal care.
- Keep HCS worker aware of any barriers or changes in anticipated transition plan so they can alert caregivers, agencies and other professionals.

HCS Nursing Facility Case Manager Role:

- Authorize CCG to assist with transition items and services when clients are eligible
- Coordinate with providers including nurse delegation, personal care, etc.
- Keep all pertinent parties up to date regarding anticipated transition date.

Frequently Asked Questions

What happens if the Skilled Nursing Facility believes a resident no longer meets Nursing Facility Level of Care?

A Home and Community Services worker can assess a resident for functional eligibility at any time. If a resident no longer meets the nursing facility level of care, HCS will authorize payment for up to 30 days or until the resident is discharged, whichever comes first. The resident must still meet financial eligibility.

The nursing facility case manager and SNF professional will continue to work with the resident on transition planning options and document all efforts.

What is the difference between the Intake and Referral Form and the Long-Term Care Application?

The Intake and Referral Form is used to notify HCS that a Medicaid resident has been admitted to the facility, when a patient is converting from a Medicare to a Medicaid benefit and if a resident is interested in services. It is used to trigger an assessment to verify functional eligibility.

The Long-Term Care Application is completed if a resident is not currently on Medicaid services, but is interested in them. It's also used if the resident is currently being managed by Community Services Office or Health Care Authority and is in need of a nursing facility stay for 20 days or more. Residents may apply online at www.washingtonconnection.org.

What is the difference between a resident's medical benefit and Long-Term Care benefit?

A client of HCS may receive a variety of long-term services and supports, as well as the medical benefits they receive through the Health Care Authority. HCS funds are considered the "Payor Of Last Resort" and should not be used unless all other options have been exhausted (including medical benefits).

What is the difference between Alternative Benefit Plan versus Long Term Care Benefits?

The Alternative Benefit Plan, also known as MAGI, is part of Medicaid Expansion. This program is **managed by the Health Care Authority**. It is imperative for SNF staff to notify their nursing facility case manager of MAGI residents' admission to determine functional eligibility in order to get paid for their stay. Nursing facility case managers should refer a MAGI resident for basic personal care services and assist with transition planning if the resident wishes to receive home and community services.

Medicaid residents 65 and older or blind and/or disabled, will qualify for the Long Term Care Benefits. These benefits include waiver services through HCS as well as Long Term Care benefits at the nursing facility. If a MAGI resident wishes to receive waiver services through HCS, they will need to apply for Non-Grant Medical Assistance to verify they are disabled (to qualify for Aged, Blind, Disabled Services). The SNF's assigned nursing facility case manager can coordinate the application for NGMA.

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