

Washington State Department of Social and Health Services

Transforming
Lives

Navigating the LTSS System: Part 2 – Discharge Resources

Health Home Care Coordinators

June 9, 2016



PO Box 45050, Olympia, WA 98504 | www.dshs.wa.gov

Washington State Department of Social and Health Services

Today's Presenter

Debbie Blacker has been with Home and Community Services Division since 2003. She is currently the Systems Change Specialist within the RCL program. Her duties include being the program manager over nursing facility case management.

Terms to Know

☞ Activities of Daily Living (ADLs)

☞ Routine activities that people tend to do everyday, including such things as:

- ☞ Eating
- ☞ Toileting
- ☞ Bathing
- ☞ Transfer
- ☞ Bed mobility
- ☞ Locomotion
- ☞ Medication management

Terms to Know

☞ Nursing Facility Level of Care (NFLOC)

☞ The determination that the individual meets functional eligibility for institutional care. In Washington State that means the individual:

- ☞ Requires daily care provided or supervised by an RN or LPN; or
- ☞ Has a need for assistance with 3 or more ADLs; or
- ☞ Client has a cognitive impairment AND a need for “hands on” assistance with 1 or more ADLs; or
- ☞ Needs “hands-on” assistance with 2 or more ADLs.

Long Term Services & Supports (LTSS): Terms to Know

∞ **HCBS: Home & Community-Based Services** are the services and resources available to meet an individual's needs in the community.

- ∞ **HCS: Home and Community Services:** the division of Aging and Long-Term Support Administration (AL TSA) within DSHS that is responsible to promote, plan, develop and provide long-term care services responsive to the needs of persons with disabilities and the elderly
- ∞ **DDA: Developmental Disabilities Administration:** DDA is responsible to assist individuals with developmental disabilities and their families to obtain services and supports based on individual preferences, capabilities and needs.
- ∞ **AAA: Area Agency on Aging:** AAAs help older adults plan and find additional care, services, or programs. They also provide case management for individuals on LTC HCBS in their home (not residential settings like adult family homes or assisted living).

LTSS: Terms to Know

Medicaid is a program that provides medical assistance for certain individuals and families with low incomes and few resources. **Medicaid long-term care services** are offered under two different service packages based on functional and financial eligibility:

- ∞ **State Plan:** defines how WA State will meet the mandatory Medicaid requirements and which optional services the state will provide. Community First Choice (CFC) is a state plan service. MPC is another state plan service. Clients on CFC must meet NFLOC, but clients on MPC do not.
- ∞ **Home and Community-Based Services (HCBS) Waivers:** Medicaid's alternative to providing long-term care in institutional settings. COPES and New Freedom are examples of waiver services. Clients on HCS waiver services must meet NFLOC.

The state typically receives about a 50/50 match from the federal Centers for Medicare and Medicaid (CMS) for our waiver services and some of our state plan services (CFC is a bit higher).

LTSS: Settings/Partners

- ☞ Nursing facilities (also known as skilled nursing facilities NF or SNF)
- ☞ Hospitals (state mental hospitals or acute care hospitals)
- ☞ Community residential facilities: Adult family homes (AFH) and Assisted Living Facilities (AL or ALF, ARC & EARC)
- ☞ Community in-home: in the individual's own home or apartment either alone or with family members or others

Discharge Planning 101

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Nursing Facility Case Management (NFCM) and Relocation

Purpose

- ☞ Assist residents of NFs who have the desire to move to another setting, including:
 - ☞ Providing information regarding community long-term care options.
 - ☞ Identifying barriers to discharge.
 - ☞ Working with the resident, his/her family, NF staff and others to remove or address the barriers (discharge planning).
 - ☞ Assessing, care planning, authorizing services and making referrals as necessary with other community and informal supports.

Roles: Nursing Facility Social Worker

☞ WAC and CFR require that:

- ☞ When a resident's health improves sufficiently and the resident no longer meets level of care, the resident can be discharged, with appropriate notice. The NF must provide sufficient preparation time to ensure a safe transition.
- ☞ The facility conducts initial and periodic comprehensive assessments (timeframes are in federal rule), including discussing with the client if they have a goal of discharging to the community.
- ☞ The care plan must include a post discharge plan. The NF SW works collaboratively with the HCS NF case manager (NFCM) or AAA case worker to provide and ensure a smooth transition for residents who desire to transition to the community.

Roles: Hospital Discharge Planner

- ☞ The person in the hospital responsible for ensuring patients are released from the hospital to the proper environment that can best care for the individual as they recuperate; the discharge planner functions as a consultant for the discharge planning process.

Roles: On-going Case Manager

- ☞ Work with current clients, family members, informal supports, nursing facility staff when placement is less than 30 days (unless discharge is imminent; transfer time is based on professional judgement).
- ☞ AAA Case Manager: Provides on-going case management when individuals on HCBS services receive in-home services.
- ☞ HCS Residential Case Manager: Provides on-going case management for clients who reside in a community residential setting such as an adult family home (AFH) or assisted living facility (AL).

Roles: Residential Providers

- ⌘ Adult Family Homes (AFH) or Assisted Livings (AL) must provide discharge planning when an individual expresses a desire to move to another setting.

Roles: Health Home Care Coordinator

- ⌘ Integrates services across all systems and works with professionals and collaterals.
- ⌘ Care Transitions is one of six health home services and includes:
 - ⌘ Ensuring that follow up appointments are made with the doctor
 - ⌘ Assisting to reconcile medications
 - ⌘ Providing necessary client and family education and coaching
 - ⌘ Developing or revising the Health Action Plan (HAP)

Question: What is the Care Coordinator's role in diversion or transition back home from a NF stay?

Roles: Nursing Facility Case Manager (NFCM)

NFCMs

- ☞ Document NFLOC and all work towards discharge goals.
- ☞ Verify NFLOC within 10 days and perform face-to-face visit with each newly admitted Medicaid client within 30 calendar days to begin dialog about community options and desires for discharge.
- ☞ Provide information to clients, family and facility staff what services the resident is eligible to receive.
- ☞ Work with clients, family members, informal supports, nursing facility staff, the client's physician, and community providers to assist the client to discharge to the setting of the individual's choice and access community services.

Nursing Facility Case Management (NFCM) and Relocation Philosophy

- ☞ Most people want to live as independently as possible for as long as possible.
- ☞ AL TSA embraces the belief that clients with high care needs can be cared for and supported in the community in a variety of settings by offering waiver and state plan services that provide alternatives to nursing facility care.
- ☞ Goal: Offer options to individuals requiring long-term care services in the least restrictive setting while honoring client choice and preference.

Outreach and Education

☞ The NFCM:

- ☞ Begins the discussion regarding the option of returning to the community when the NFLOC is performed at admit.
- ☞ Determines and documents an individual's goals related to relocating to a community setting.
- ☞ Assists in exploring all community options, including:
 - ☞ Returning to their own home
 - ☞ Adult family home
 - ☞ Assisted living centers (including enhanced adult residential care facilities, etc.)

Outreach and Education

☞ Based on eligibility, services available in the community might include:

- ☞ Personal care
- ☞ Home delivered meals
- ☞ Adult day care
- ☞ Client training
- ☞ Personal emergency response system (PERS)
- ☞ Specialized durable and non-durable medical equipment
- ☞ Environmental modifications
- ☞ Skilled nursing services
- ☞ Transition services
- ☞ Transportation

Working with Nursing Facilities

- ⌘ Access
- ⌘ Communication
- ⌘ Expectations
- ⌘ Consultation
- ⌘ Collaboration

Resources

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Discharge Resources

⌘ Long-term Care Ombuds Program (LTCOP)

- ⌘ Included in the Medicaid State Plan and the federal Omnibus Budget Reconciliation Act (OBRA) of 1987 which included nursing facility reform law which created the Residents' Bill of Rights and assured access to the state's LTCOP.
- ⌘ LTCOP is a resource to protect resident rights regarding admission, discharge and transfer:
 - ⌘ Resident's who meet NFLOC have the right to remain in the SNF if they choose.
 - ⌘ Residents who meet NFLOC and choose to discharge to a community setting must be provided a safe discharge.
 - ⌘ Residents who no longer meet NFLOC must be given:
 - ⌘ Adequate notice of discharge (30 days)
 - ⌘ Safe and orderly discharge
 - ⌘ Notice of right to appeal the decision
 - ⌘ Contact information for the LTCOP and Disability Rights Washington.

Discharge Resources

- ⌘ Housing Maintenance Allowance (HMA)
- ⌘ Assistive Technology
- ⌘ Client Intervention Services/Independent Living Consultation
- ⌘ Social/Therapeutic Leave
- ⌘ Community Transition Services
- ⌘ Residential Care Discharge Allowance
- ⌘ Roads to Community Living (RCL)
- ⌘ Washington Roads

Discharge Resources

⌘ Housing Maintenance Allowance (HMA)

- ⌘ Income a client is allowed to keep to maintain his or her housing (up to 100% of the federal poverty level).
- ⌘ HMA exempts the client from participating towards the cost of their care when eligibility criteria is met.
- ⌘ A physician must certify the client is likely be in the institution no more than 6 months.
- ⌘ There is a form the physician must sign.

Discharge Resources

⌘ Assistive Technology (AT)

- ⌘ AT project funds may be used when no other funds are available for assistive devices and services. It is designed to:
 - ⌘ Increase functional independence
 - ⌘ Maximize health and safety
 - ⌘ Increase the likelihood that adults in institutional settings will transition to their own homes and communities

Discharge Resources

- ⌘ Client Intervention Services/Independent Living Consultation
 - ⌘ Available to clients receiving services from Adult Protective Services
 - ⌘ Services must be approved by the HCS Regional Administrator or AAA Director
 - ⌘ Is an option solely when needs cannot be met in any other way

Discharge Resources

- ⌘ Social/Therapeutic Leave
 - ⌘ Social and therapeutic leave gives nursing facility residents an opportunity to participate in:
 - ⌘ Social and therapeutic activities outside of the nursing facility and beyond the care of nursing facility staff
 - ⌘ Trial visits to less restrictive settings
 - ⌘ Social and therapeutic leave is limited to 18 days (24 hour periods) per calendar year
 - ⌘ The NF must track the number of days spent on therapeutic leave per year and must notify DSHS if the number exceeds 18.
 - ⌘ Additional days may be approved with an exception to rule (ETR) prior to additional days being used.
 - ⌘ Frequent or excessive social/therapeutic leave may indicate the resident has potential for NF discharge.

Discharge Resources

Community Transition Services (CTS)

- ☞ Funds used to purchase one-time, set-up expenses necessary to help relocate clients discharging from an institutional setting (such as a NF) to a home and community-based setting and will be receiving CFC services upon discharge. Services may include:
 - ☞ First month's rent, deposits, safety deposits and/or utility set-up fees or deposits
 - ☞ Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning fees prior to occupancy
 - ☞ Moving fees
 - ☞ Furniture, essential furnishings, and basic items essential for basic living outside the institution
 - ☞ The provision of services that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistance, such as non-medical transportation services or purchasing a microwave.
- ☞ Maximum limit is \$850. Limit can be exceeded by a HQ ETR (or local ETR when client is enrolled in RCL or WA Roads).
- ☞ Providers must hold a contract with DSHS.

Discharge Resources

Residential Care Discharge Allowance (RCDA)

- ☞ **One-time only state funds** used to help eligible clients relocate from institutional (NF or hospital) and other residential settings (AFH or AL) to a less restrictive setting. Can be used for clients with a DDA determination only if they are moving from a NF.
- ☞ Services may include:
 - ☞ First month's rent, deposits, safety deposits and/or utility set-up fees or deposits
 - ☞ Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning fees prior to occupancy
 - ☞ Moving fees
 - ☞ Equipment, furniture, essential furnishings, and basic items essential for basic living outside the institution.
- ☞ Can be used to fund trial visits to less restrictive settings.
- ☞ Maximum limit is \$815; all providers must be contracted.
 - ☞ Because it is state funded (no federal match), other services must be used first, if available.

Discharge Resources

Roads to Community Living (RCL)

- ☞ A statewide, demonstration project funded by the federal “Money Follows the Person” grant.
- ☞ Eligibility criteria:
 - ☞ Must be admitted 3 months or longer into a hospital, nursing facility, or Intermediate Care Facility for the Intellectually Disabled (ICF-ID) OR
 - ☞ A continuous stay of 3 months or longer in a psychiatric hospital and be under age 22 years or over age 65 year;
 - ☞ AND each of the following:
 - ☞ Receiving Medicaid-paid inpatient services immediately prior to discharge;
 - ☞ Interested in moving to a qualified community setting (home, apartment, licensed residential setting with 4 or fewer unrelated individuals;
 - ☞ On the day of discharge to begin the demonstration year, RCL participants must be functionally and financially eligible for waiver or state plan services (or Fast Tracked), but participants are not required to receive services.

Discharge Resources

Roads to Community Living (RCL) (cont.)

- ☞ Some services are provided prior to discharge and other services are provided for up to 365 days after the client leaves the institution.
- ☞ After 365 days the client transfers ongoing services to CFC, CFC + COPES or MPC for HCS or a community waiver for DDA.
- ☞ HCS services include those available under CFC or CFC+COPES, such as:
 - ☞ Personal care in a home or a qualified residential setting (AFH or AL)
 - ☞ Environmental modifications
 - ☞ Skilled nursing services
 - ☞ Personal Emergency Response System
 - ☞ Informal Caregiver Supports

Discharge Resources

⌘ Roads to Community Living (RCL) (*cont.*)

- ⌘ HCA RCL services also include services that are not currently available through the waiver or state plan (known as demonstration services):
 - ⌘ Community Choice Guide (CCG)
 - ⌘ Professional Therapies such as: OT/PT, speech/communication therapy, dietitian/nutritionist, transitional behavior consultation and technical assistance
 - ⌘ Service animals
 - ⌘ Adult Day Health Trial (available while client is a resident in the SNF)
 - ⌘ Substance Abuse Services
 - ⌘ Demonstration Transition Goods
 - ⌘ Assistive Technology and Vehicle Adaptions
- ⌘ The state receives an extra match for most RCL services (75/25)

Discharge and Stabilizing Resource

⌘ Washington Roads

- ⌘ A state funded program intended to fill specific gaps to provide transitional and stabilizing supports for AL TSA clients to support community living.
- ⌘ WA Roads is used to supplement existing available services when needed.
- ⌘ There are three distinct eligibility groups for WA Roads:
 - ⌘ Cohort I are residents of an institution who do not meet the federal eligibility criteria for RCL but who need additional transitional goods or services than those offered through CTS or RCDA. Clients must be:
 - ⌘ Age 18 and older with a continuous 30-day or longer stay in a hospital or nursing facility; and
 - ⌘ Medicaid recipients in the institution for at least one day; and
 - ⌘ Eligible for home and community based services (HCBS).

Discharge and Stabilizing Resource

Washington Roads (*cont.*)

- ⌘ Cohort II are individuals eligible for WA Roads while living in the community who are functionally and financially eligible for waiver/state plan HCBS AND have any one of these characteristics:
 - ⌘ Unstable residential or in-home settings
 - ⌘ Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.)
 - ⌘ Frequent turnover of caregivers
 - ⌘ Multiple systems involvement (DOC, psychiatric institutions, etc.)
 - ⌘ Is interested in obtaining employment through the Steps to Employment (S2E) project and the project is available in the individual's geographical area.

Discharge and Stabilizing Resource

Washington Roads (*cont.*)

- ⌘ Cohort III are individuals living in subsidized housing that have been coordinated through ALISA (including NED, Bridge, 811, etc.), regardless of whether they are currently eligible for, or receiving, waiver/state plan HCBS.
- ⌘ Most of the RCL demonstration services are available through WA Roads as well as additional services only available through WA Roads:
 - ⌘ Emergency Rental Assistance: one-time payment for emergency rental assistance to maintain or stabilize community placement
 - ⌘ Bridge Subsidy: housing option for individuals discharging to the community from an institution who are on a wait list for subsidized housing.

Discharge and Stabilizing Resource

Washington Roads (*cont.*)

- ☞ WA Roads services are meant to supplement existing waiver and state plan services and should only be used when:
 - ☞ Community Transition Services (CTS) did not cover all the services or items necessary for an individual to relocate to the community from a nursing facility or hospital and the client is not eligible for RCL (CTS may be used in combination with WA Roads, when necessary).
 - ☞ All the other options have been tried and the client is at risk of losing their community setting. All other resources must be explored and maximized before authorizing WA Roads.
 - ☞ Unlike Roads to Community Living, these services provide no ongoing personal care services after discharge.

Hierarchy of Transition Funding Sources



LTC Programs: State Plan Services

☞ Community First Choice (CFC):

- ☞ Must meet NFLOC and financial eligibility
- ☞ Services available include:
 - ☞ Personal and Relief Care
 - ☞ Nurse Delegation
 - ☞ Skills Acquisition Training
 - ☞ Personal Emergency Response Systems (PERS)
 - ☞ Assistive Technology
 - ☞ Community Transition Services
 - ☞ Caregiver Management Training
 - ☞ Annual Limit (used to purchase Skills Acquisition Training and/or AT)

LTC Programs: State Plan Services

☞ Medicaid Personal Care (MPC)

- ☞ Not required to meet NFLOC but must meet financial eligibility
- ☞ Services include:
 - ☞ Personal care
 - ☞ Nurse delegation in residential settings (ARC, AFH)
 - ☞ Caregiver Management Training

LTC Programs: Waiver Services

☞ Community Options Program Entry System (COPES)

- ☞ Must meet NFLOC and financial eligibility
- ☞ Services available include:
 - ☞ Adult Day Care
 - ☞ Adult Day Health
 - ☞ Client Support Training/Wellness Education
 - ☞ Environmental Modifications
 - ☞ Home Delivered Meals
 - ☞ Home Health Aide
 - ☞ Nursing Services
 - ☞ Specialized Medical Equipment and Supplies
 - ☞ Skilled Nursing
 - ☞ Transportation

LTC Programs:

☞ Other Waivers:

- ☞ New Freedom (only available in limited areas)
- ☞ PACE (only available in limited areas)
- ☞ Residential Support Waiver

☞ State Funded Services (less frequently used)

- ☞ CHORE (group of clients grandfathered into program that ended in 2001)
- ☞ Medical Care Services (limited eligibility and services in certain residential settings)
- ☞ State-funded LTC for Non-Citizens (limited number of slots)

Takeaways from today's training...

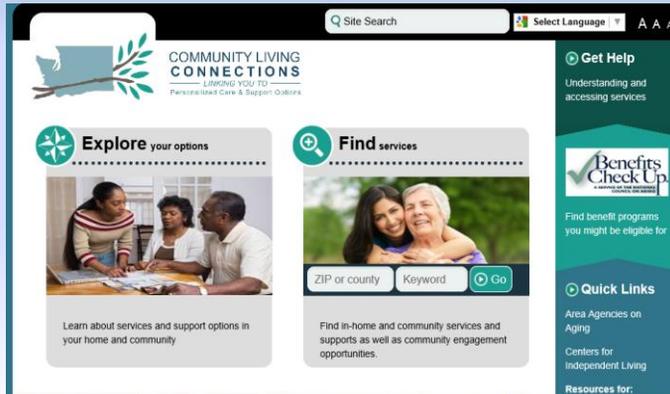
- ☞ There are many services available to help clients discharge to more independent settings.
- ☞ You do not need to know which program to request; you just need to know who to call.
- ☞ HCS Intake and Referral/Assistance and NFCMs can help identify which services to pursue.
- ☞ Be prepared to provide information about the client's supports, living situation, and Activities of Daily Living needs.
- ☞ HH Coordinators play a role in helping individuals transition back to the community and or helping them remain in the community whenever possible (diversion).

Intake and Referral

- ☞ For further information or to make a referral, contact the local Home and Community Services Office through the Intake and Referral process:
 - ☞ **Region 1 North:** 509 568-3767 or fax 509-568-3772
 - ☞ **Region 1 South:** 855-636-5541 or fax 509-575-2286
 - ☞ **Region 2 North:** Nursing Facility Intake fax 425-977-6579
 - ☞ **Region 2 North:** 800-780-7094 or fax 425-339-4859
 - ☞ **Region 2 South:** 206-341-7750 or fax 206373-6855
 - ☞ **Region 3:** 800-786-3799 or fax 1-855-635-8305

☞ **Website:** <http://www.alsa.dshs.wa.gov/Resources/clickmap.htm>

Resource: Community Living Connections (CLC) website:



📍 Located at:

<https://washingtoncommunitylivingconnections.org/consumer/>

The Win-Win of NFCM

- 📍 Most people want to live in the community.
- 📍 Helping people to transition back to the community allows WA State to put more resources into the community by saving on high cost NF care.

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Questions?

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Post Webinar Discussion

1. Please share success stories about clients you have worked with to provide care transitions out of hospitals and/or nursing facilities.
2. Have you held care conferences with case managers, social workers, case resource managers or nurses from DSHS or your local Area On Aging?
3. What local resources have you discovered while working with clients?
4. What success have you had working with clients and family members to provide care transitions following discharge using the the following supports:
 1. Coordinated follow up calls or visits
 2. Timely visits to primary care physician (PCP)
 3. Reconciliation of medications soon after transition
 4. Patient education and coaching between settings
 5. Support through increased comprehensive care management for high-risk clients (including revision of the HAP and required and optional screenings)



Certificate of Completion

Long Term Services & Supports: Part 2

Discharge Resources

presented by Debbie Blackner
Aging and Adult Long Term Service Administration
Home and Community Services
Lacey, Washington

*Webinar aired on: June 9, 2016 in Lacey, Washington
for Health Home Care Coordinators and Allied Staff*

Training Credit of 1 hour

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