

**DEPARTMENT OF HEALTH AND SENIOR SERVICES  
DIVISION OF AGING AND COMMUNITY SERVICES**

**GLOBAL OPTIONS (GO) FOR LONG TERM CARE FOR NURSING FACILITY  
TRANSITIONS (NFT)**

**SUBJECT: Discharge from the Nursing Facility to Global Options (GO)**

**PURPOSE:** The discharge process is intended to ensure that services and supports identified in the Transition Plan are arranged and coordinated prior to the individual's departure from the nursing facility.

**PROCEDURE:**

**Roles and Responsibilities for Effective Discharge**

**1. Nursing Facility Discharge Planner:**

- Assures that the discharge is planned, coordinated and executed.
- Assures that tasks assigned to IDT members are completed.
- Notifies the Community Choice Counselor (CCC) and the Care Manager (CM) of the consumer's actual date of discharge, or if changed, the new date of discharge and the reasons for the delay.
- Assures that the Transition Plan is modified to incorporate changes since the IDT.
- Faxes the Transition Plan to OCCO and the care management agency.
- Returns any Personal Needs Allowance (PNA) to the consumer.
- Ensures that the Zero PA-3L is completed so that the resident will have his or her last month's income returned as part of the Month-of-Discharge Exemption.

**2. Community Choice Counselor:**

- Instructs the Care Manager to complete a CP-23 (Notice of Program Disenrollment) if the resident is currently enrolled in AL/CAP/ CCPED.
- Completes the follow-up Discharge Profile and the Nursing Facility Discharge Check List.
- Contacts the GO participant within 48 hours to verify that services have been delivered, and that he or she is adjusting to the community.
- Makes a second contact in 14 - 30 days to ensure that services are being delivered as indicated in the Transition Plan; that the services are meeting care needs; and that overall health status is maintained.
- Contacts the CM if problems are identified and follow-up is required.

### 3. Care Manager:

- If the participant is currently enrolled in a DHSS waiver program, completes the CP-23 (when instructed by the CCC) to disenroll the client from current Waiver and forwards it to the appropriate County Welfare Agency (CWA), with copies to OCCO, and MIS/DM.
  - If a participant is on SSI, forwards the CP-23 only to OCCO with a copy to MIS/DM.
- Completes the CP-5 (Notice of Program Enrollment) to enroll the participant in GO and forwards it to the appropriate CWA with copies to OCCO and MIS/DM.
  - If a participant is on SSI, forwards the CP-5 only to OCCO with a copy to MIS/DM.
- Enters the Client Profile on the HCBS website.
- Within 30 days:
  - A. Visits the participant to affirm that the services and supports identified in the Transition Plan are appropriate;
  - B. Incorporates Transition Plan and any changes to the Plan of Care (WPA-2);
  - C. Finalizes the POC and obtains signatures of the participant/designee, CM, and CM's supervisor;
  - D. If the participant selects AL/AFC:
    - Assures that Social Security is notified if the participant is on SSI or has a gross monthly income of less than \$773.05 to ensure that the participant's monthly income is increased to pay room and board and provide a PNA.
    - Prepares the Cost Share Worksheet and gives a copy to the participant and the facility/program.

### Performance Standards and Outcome Measures

The following are performance measures that will be evaluated through the use of a survey instrument.

- Services and supports identified in Transition Plan are scheduled prior to discharge.
- The CCC and CM are notified when the participant is discharged or when the discharge is delayed.
- The CCC contacts the GO participant/designee within 48 hours of discharge and again within 14-30 days.
- The CM is contacted when the CCC identifies problems/issues with participant and/or Transition Plan.
- The CM visits the GO participant/designee and finalizes the Plan of Care within 30 days of discharge.

## Forms Associated with Discharge

1. **Transition Plan:** The CCC and CM complete the Transition Plan, which is signed by all members of the IDT prior to discharge.
2. **LTC-2: Notice of Long Term Care Admission:** The NF completes the form and forwards it to OCCO.
3. **PA-3L Statement of Available Income:** The NF Social Worker/Discharge Planner (SW/DP) gives the PA-3L to the CCC.
4. **CP-2: Long-Term Care Referral:** If PA-3L is unavailable, the NF SW/DP requests from the CWA for the CCC. If neither the PA-3L nor the CP-2 is available, the CCC contacts the OCCO for a printout of the eligibility screen.
5. **SINQ: -Social Security Inquiry:** CCC requests as proof of SSI eligibility from OCCO.
6. **CP-5 – Notice of Program Enrollment:** The CM completes the form and forwards it to OCCO and MIS/Data Unit, and to CWA if the participant is not on SSI. The CWA will enter SPC 32 into the client eligibility file. **CP-23 – Notice of Program Disenrollment:** The CM completes the form and forwards it to OCCO and MIS/Data Unit, and to CWA if the participant is not on SSI. The CWA will update participant's eligibility file to terminate the previous Special Program Code.
8. **Discharge Profile and Nursing Facility Discharge Checklist:** The CM completes when the participant is discharged from the NF.

## Administrative Responsibilities

1. The OCCO staff enters GO enrollment data from the CP-5 under program status code (331), or if participant is SSI, enters Special Program Code 32 on Medicaid Eligibility File.
2. The NF discharge planners notify the Social Security Administration of any change in the individual's address.
3. The NF discharge planners ensure that the PNA is returned to participant.
4. The NF discharge planners notify OCCO and the CM of the actual date the participant is discharged or that there is a delay in discharge.
5. The CCC completes the Discharge Profile and the NF Discharge Check List.
6. If Community Transition Services are required, they have been secured.

7. The OCCO NFT Coordinator approves Transition Services and expenditures, completes the Independent Service Agreement (ISA) and sends copies of receipts to PPL for payment.
8. The CM completes the Client Profile on the HCBS website.
9. The CM finalizes and completes the POC within 30 days of the participant's discharge from the NF.

### **Opportunities for Improvement**

1. Continuous training to ensure accuracy and timeliness of forms.
2. IT solutions for eliminating paper forms and streamlining process.