

**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: Identification and Referral for Global Options: Clinical and Financial Eligibility

PURPOSE: To ensure that individuals are appropriately referred for GO, are clinically and financially eligible to participate and that preliminary discussions are begun with individuals and families to determine their interest in returning to the community.

Impact: If eligible individuals are not referred properly, the enhanced service package provided under GO will not be available to them.

PROCEDURE:

Eligibility for GO

1. Individuals who are clinically and financially eligible for Medicaid, and wishing to return to the community must meet the GO eligibility criteria, which are that the individual:
 - Resides in a Nursing Facility (NF); or
 - Is in a NF or a sub-acute unit, either in an acute care hospital or part of a NF;
 - Has spent a minimum of 21 days in NF/SA;
 - Is aged 65+; or
 - Is 21-64 and determined physically disabled by the Social Security Administration or by the Disability Review Section of the Division of Medical Assistance and Health Services, New Jersey Department of Human Services.
 - **Is both clinically and financially approved for Medicaid.** The individual meets nursing facility Level of Care (NFLOC), and is financially eligible for LTC services.

2. Individuals who are not eligible for GO are those who:
 - Are on SSI and New Jersey Care who need Medicaid State Plan Services only;
 - Are assessed as appropriate for the Medicaid Hospice benefit;
 - Are chronically mentally ill;
 - Are mentally retarded or developmentally disabled;
 - Are Medically Needy;

- Are receiving Medicaid HMO benefits. The individual must disenroll from this benefit before enrolling in GO.

Roles and Responsibility for Effective Referral

1. **NF Social Worker:** When the NF Social Worker knows that a NF resident is interested in participating in GO, he or she contacts the Regional Office of Community Choice Options (OCCO) for GO screening using the CP-2 as a referral form.
2. **Care Manager (CM):** When the CM knows that a Medicaid waiver participant has entered a NF, she must notify OCCO to request a short-term PAS using the CP-2 as the referral form.
3. **Community Choice Counselor (CCC):** The CCC completes a MDS-HC assessment of an individual in the hospital, which may indicate in the HSDP that the client has the desire or potential to return to the community and therefore is appropriate for GO.
4. **The NF Business Office:** The NF business office informs OCCO within two working days when a person with a Medicaid number has been admitted to the facility using the LTC-2 (formerly MCNH33).

The Initial GO-NFT Screening Process

1. The goal for the CCC is to complete the PAS within 14 calendar days of receiving a GO referral.
2. The CCC will review the client's NF chart, the current PAS, and visit the resident to:
 - Determine his or her desire to return to the community;
 - Verify that all eligibility criteria for GO are met; and
 - Establish the extent to which the resident wishes to participate in the Interdisciplinary Team (IDT) meeting.
3. If resident is a candidate for GO, the CCC will:
 - Discuss the full range of services offered under GO and determines if the resident wants to re-locate to an Assisted Living Facility or Adult Family Care (AL/AFC), and that there is a potential cost share responsibility and Room and Board fee;
 - Update clinical information in the MDS-HC database;
 - Obtain the resident's signature on the Release of Information form;
 - Identify the appropriate IDT participants/agencies including the care management agency, family, nursing social worker/discharge planner,

Centers for Independent Living (CIL), Occupational or Physical Therapist, AL/AFC provider, or the Office of the Public Guardian;

- Contact the IDT participants to coordinate and arrange the meeting date(s), providing at least seven working days notice of the meeting; and
- Forward the current PAS to the NF SW/DC Planner and the CM.

4. If the resident does not meet GO eligibility criteria, the CCC will:

- Counsel the person on other LTC options including State funded programs, Medicare services, Older American Act programs, and private pay options.
- Notify the individual who made the referral that the resident is not eligible for GO and the reasons for the ineligibility.

Forms Associated with the Referral Process

1. **CP-2 – Long-Term Care Referral:** will serve as the universal Long Term Care Referral form for GO. The professional referring a potential GO participant must complete the form and forward it to OCCO.
2. **Release of Information form:** Will be signed by the resident at the time the CCC does the assessment.
3. **LTC-2 (formerly MCNH 33):** Used by NF business Office staff to notify OCCO when current or potential Medicaid individual has been admitted to the facility.

Administrative Responsibilities

1. The OCCO enters GO referral and client information into the MDS-HC database and the Unisys PAS-subsystem.
2. Once the CCC completes the PAS and the case information is uploaded to the MDS-HC database, OCCO Regional Office enters the PAS outcome into Unisys and the MDS-HC.

Improvement Process

1. Develop IT solutions – business processes, quality assurance, electronic referrals and documents, etc.
2. Monitor time frames -- date of referral, date of initial contact by CCC, date IDT members are notified about IDT meeting, etc.
3. Establish county-based, centralized, case assignment for GO participants by the NJ EASE agencies.
4. Implement a continuous quality improvement process for the GO Protocols.