

**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: The Interdisciplinary Team (IDT)

PURPOSE: Convening the IDT is critical to the GO process. It assumes that the participant will take ownership of the IDT meeting, and will direct the process of creating a person-centered Transition Plan. Team members will work together to counsel and assist the participant/designee to identify appropriate and available support services that meet their individual care needs; establish an estimated individualized budget; develop a Transition Plan that identifies the services that will allow the participant to return to the community; and coordinate and schedule services prior to discharge.

PROCEDURE:

Roles & Responsibilities of IDT Members

1. Resident/Designee:

- Directs the IDT process to the extent he or she wishes;
- Defines personal goals and preferences;
- Identifies the potential informal and formal support systems;
- Completes tasks assigned at the IDT meeting;
- Signs the required documents:
 - A. Agreement of Understanding
 - B. Transition Plan, the Consumer Choice Section

2. Community Choice Counselor (CCC):

- Facilitates the IDT process;
- Supports the participant/designee to engage in the IDT process;
- When appropriate, advocates and negotiates on behalf of the participant;
- Identifies ADL/IADL needs to be met in the community;
- Arranges for Community Transition Services as necessary;
- Locates and arranges the housing/facility;
- Serves as the timekeeper for the IDT meeting and ensures that it does not exceed one and a half hours;
- Summarizes the results of the IDT meeting with next steps, including additional IDT meetings, and identifies the tentative date for discharge.

3. Nursing Facility Discharge Planner/Social Worker:

- Reviews and updates relevant documents in NF Client Record and reconciles information with CCC;
- Notifies CCC of resident's participation in Medicaid HMO;
- Secures meeting area for the IDT;
- Notifies Social Security of change in address and other participant-related matters;
- Arranges for prescription drugs;
- Arranges for and schedules post discharge Medicare services; and
- Working with the care manager, coordinates and links discharge services.

4. Care Manager (CM):

- Serves as the community resource expert;
- Assists in locating and gaining access to needed medical, social, educational and other services identified in the Transition Plan;
- Assists in the writing of the Transition Plan; and
- Estimates the cost of services identified in the Transition Plan.

5. Other Possible Members of the IDT

- Occupational Therapist;
- Physical Therapist;
- Speech Therapist
- Representative from Center for Independent Living;
- Social Worker or other representative from the Assisted Living Provider/Adult Family Care Program;
- Representative from the Office of Public Guardian;
- Housing advocate; and
- Friend or other designee.

The IDT Pre-Meeting

The CCC convenes the meeting one half hour before the participant's arrival to review background, clinical level of care needs, degree of functional limitations, potential difficulties in the transition process, and the participant/designee's wishes and preferences.

The IDT Meeting:

1. To qualify as an IDT meeting, the resident/designee, community choice counselor, nursing facility social worker/discharge planner, and care manager must be present.
2. Limited circumstances permit IDT participation by conference call:
 - For current AL/AFC Medicaid Waiver participants that will be returning to the same facility as a GO participant, an AL/AFC designee and care manager may participate in the IDT meeting via a conference call.
 - For new GO participants, who will be entering AL/AFC for the first time, an AL/AFC designee must meet the resident prior to discharge and contact CCC to confirm the AL/AFC's acceptance of the resident on GO as of the date of discharge from the nursing facility.
 - If AL/AFC designee is unable to attend IDT, the CCC will forward a copy to him or her of the Transition Plan, which outlines the specific needs of the participant.
 - For current Medicaid Waiver participants that will be transferring as GO participants to another county, it is recommended that both the sending and receiving care managers attend the IDT meeting. If this is not possible because of time and/or distance, both must participate in the IDT meeting via a conference call. The community choice counselor ensures that the receiving care manager has a copy of the MDS-HC/HSDP prior to the call.
3. The IDT reviews:
 - ADLs/IADLs;
 - Cognitive status,
 - Personal goals and preferences;
 - Informal support system; and
 - Environmental safety, including barriers and needed adaptations.
4. The team discusses the options and choices:
 - Home and Community-Based Services (HCBS); and
 - Available providers.
5. The participant who selects an assisted living option is counseled about his or her cost share.

6. The IDT develops the Transition Plan and estimates the cost of services.

The Transition Plan

1. The Transition Plan serves as the interim Plan of Care for discharge planning purposes and is completed by the CCC in conjunction with the CM.
2. The Transition Plan must include the following:
 - Personal goals, cultural preferences, and strengths and weaknesses;
 - Desired outcomes;
 - State Plan and Waiver Services to meet assessed needs;
 - Community Transition Services (one-time purchases, security deposits) that must be arranged prior to discharge,
 - Informal supports;
 - Potential agencies to provide services and supports;
 - Number of hours approved for each service (State Plan and Waiver); frequency, and cost per unit*;
 - Estimated budget based upon approved services, rates, and hours;
 - Consumer Risk Factors,
 - Identification of environmental barriers in the participant's home that might affect the transition;
 - Back-up plans to address risk factors;
 - Consumer Choices and Responsibilities, and
 - Signatures of all IDT members.

*Although community agencies initially may not be able to schedule the total number of hours authorized in the Transition Plan, the care manager has the authority to arrange services up to budget amount authorized in the IDT without seeking additional approval.

Individualized Budgets

1. The individualized budget is based upon the level of care needs as determined by the MDS-HC assessment tool.
2. The CCC has the authority to authorize up to \$2,841 per month for waiver services. (The authorized budget does not include the cost of State Plan Services, environmental modifications/adaptations or Community Transition Services.)

3. When care needs exceed \$2,841 per month:
 - The CCC forwards the Transition Plan, which includes justification for the higher level of care needs, to the Regional OCCO Assistant Field Office Manager/Quality Manager for review and approval or denial.
 - The Regional OCCO Assistant Field Office Manager/Quality Manager reviews the documentation and the MDS-HC assessment and notifies the CCC that the increased budget request is approved or denied.
4. For GO AL or AFC participants, both the service package and Medicaid Waiver reimbursement remain the same as in the AL/AFC Medicaid Waiver. There are no increases in the per diem reimbursement or services.

Community Transition Services

1. The GO program will pay for the one-time expenses related to relocation such as moving related costs, furniture, household items, other incidentals, and security deposits for apartments/utilities.
2. The CCC must locate items and submit itemized voucher/Individual Service Agreement (ISA) with the cost of the items to the Nursing Facility Transition Coordinator (NFT) at OCCO Central Office.
3. The NFT Coordinator will review and approve or deny the proposed purchases on the voucher/ISA that was initially submitted.
4. Once the purchases or expenses have been approved, the CCC or CM will finalize purchases, security deposits, and/or moving arrangements and forward the original receipts to the NFT Coordinator.
5. Upon GO enrollment the CM must enter Client Profile on HCBS website.
6. The NFT Coordinator will set-up the Individual Service Agreements (ISA) and forward copies of the receipts to PPL for payment

Arranging for Environmental Accessibility Adaptations (EAA) or Special Medical Equipment (SME) not covered by Medicaid State Plan.

1. If the IDT identifies environmental barriers in the participant's home such as entryways or bathrooms that are not wheelchair accessible that need to be corrected, the CM must obtain at least two bids from approved CAP/JACC providers for making the modification.

2. When the resident is discharged and enrolled in GO, the CM will submit the Special Request Form to the DACS County Liaison for review and determination.

Performance Standards and Outcome Measures

1. The following performance measures will be assessed through an IDT member survey that is to be developed:
 - Clinical and financial eligibility are established before the IDT is arranged.
 - The CCC gives IDT members a minimum of seven-business days notice to schedule an IDT meeting.
 - CP-2s are forwarded to OCCO as soon as the NF discharge planners or care managers become aware that a person may be appropriate for GO.
 - Receiving care managers receive the MDS-HC/HSDP prior to the IDT meeting.
 - Arrangements are completed for participants interested in AL/AFC prior to the IDT meeting with care managers and AL/AFC designee.
 - The individualized budget is based on the assessment of level of care needs.
2. The following performance measures will be collected through a consumer satisfaction survey – under development -- that will be requested within 30 days of discharge:
 - The participant has received counseling on the full range of LTC HCBS.
 - The IDT is participant-directed and the Transition Plan has addressed personal goals, cultural preferences and desired outcomes.
 - The participant understands the full range of services and the right to assume risk.
 - Services and supports are meeting level of care needs.

Forms Associated With IDT Process

The Referral Packet is completed at the IDT meeting and distributed to the appropriate IDT members. The packet includes:

1. Nursing Facility Check-off List (IDT professional members).
2. MDS-HC & HSDP – completed by CCC (CM receives a copy).
3. Transition Plan - completed by the CCC & CM (all IDT members receive copies).
4. Transitional Services – Addendum completed by the CCC (all IDT members receive copies).

5. Agreement of Understanding (residents & CM receive copies).
6. Proof of Medicaid Financial Eligibility PA-3L or CP-2 or SINQ for SSI residents (CM receives copy).
7. Cost-share introductory letter for AL/AFC, when appropriate (resident/designee receive copy)

Administrative Responsibilities

1. Regional OCCO codes MDS-HC as Track II follow-up. CCC enters discharge progress notes into the notebook section of the HSDP and recodes the face sheet of the MDS-HC as a Track II HOLD.
3. CCC updates changes and creates a new MDS-HC and HSDP reflecting conversion to TRACK III GO-NFT.
4. CCC assures that assessment is returned to the server for data entry in UNISYS & MDS-HC (330 - approval) – (not enrollment).
5. CCC forwards LTC –13 & Transition Plan to the Assisted Living Provider (if not part of IDT).
6. Original copies are retained by OCCO.

Improvement Process

1. Continuous training.
2. 2008 GO-NFT IDT process will be included as an agenda item at CM Regional Meetings.
3. IDT Participant Satisfaction surveys & IDT Professional Surveys are continuously collected and analyzed, and results are addressed through a continuous quality improvement process.
4. IT solutions are identified and referred to STG IT Work Group Co-Chairs.