

**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: Readmission to the Nursing Facility

Purpose: The procedure will ensure continuity of support and effective lines of communication among the IDT members to facilitate the return of GO participants to the community following readmission to the Nursing Facility.

Readmission Policy for GO Participants: Once a person is enrolled in GO, subsequent stays in nursing facilities will not require the person to be disenrolled from the program. GO pays for nursing facility costs that are not covered by Medicare.

PROCEDURE:

Roles and Responsibilities

1. Care Manager:

- Notifies the OCCO manager when she or he becomes aware that a GO participant has entered a Nursing Facility (NF) by completing a CP-2 form.
- Provides care management for up to 3 months if it appears that the admission will be short term (Track 2).
- Speaks directly to the GO participant and NF social worker during the first two months of readmission to ascertain the person's progress to return to the community.
- Visits the GO participant during month three to discuss discharge plans with the NF resident, resident's representative, family members, NF Social Worker, and Community Choice Counselor.
- Plan of Care is updated to reflect changes in clinical needs identified in the most current MDS-HC assessment and services are arranged.
- Discontinues care management visits for individuals who remain in the nursing facility over three months, or who are assessed by OCCO as Track 1 while in the facility.
- When care management services are rendered, agencies may bill \$95 per month for up to three months.
- Reimbursement is not permissible for individuals who are assessed as Track 1 during readmission to the NF.

2. **Community Choice Counselor:**

- Responds to referrals from Care Managers of GO participants who are admitted to the NF.
- Reviews the patient record and current PAS to evaluate the participant's potential for returning to the community.
- Discusses the participant's desire to return to the community.
- Verifies that all eligibility criteria for GO are met.
- Updates the CM of the participant's status.

3. **Nursing Facility Discharge Planner/Social Worker:**

- Notifies the CM and the CCC that a GO participant has been readmitted to the NF.
- Reviews and updates the relevant documents on the client record.
- Shares and/or reconciles the information with the CCC and CM.
- Arranges for prescription drugs.
- Arranges and schedules post discharge Medicare services.
- Coordinates and links discharge services with the CM.

Performance Standards and Outcome Measures

The following performance measures will be assessed through the use of an IDT member survey tool, which is to be developed.

1. Care Manager contacts Community Choice Counselor regarding the readmission in a timely manner.
2. Care Manager contacts participant monthly to support and facilitate discharge.
3. Community Choice Counselor monitors participant's status and updates the care manager regarding the potential date for discharge.
4. Nursing facility discharge planner/social worker notifies CCC or CM of the participant's readmission.
5. The IDT meeting/conference call is conducted when the POC requires modification to meet the increased level of care need or caregiver support.

Forms Associated with Readmission to Nursing Facility

1. **LTC-2: Long Term Care Facility Admission:** The NF completes the form and sends it to OCCO.
2. **CP-2:** The CM completes the form and forwards to OCCO.

3. **MDS-HC/HSDP:** The CCC updates.
4. **Plan of Care:** – The CM updates.
5. **Proof of Medicaid Financial Eligibility: PA-3L, CP-2, SING.** The NF SW/DP provides the PA-3L (Statement of Available Income). If PA-3L is unavailable, the NF SW/DP requests the CP-2 (Long-Term Care Referral) 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.

Administrative Responsibilities for Return to Community

1. NF SW/DP notifies the Social Security Administration of the change in address.
2. NF SW/DP ensures that the PNA is returned to the participant.
3. NF SW/DP notifies OCCO and the CM of the actual date of discharge or delay in discharge.
4. CM finalizes and updates the POC within 30 days of discharge from the NF.

Opportunities for Improvement Process

Continuous training to ensure accuracy and timeliness of forms