Transitions

NJ Department of Human Services,

Division of Aging Services

2014

Transitions

Goals:

- To understand the transition process
- Have an understanding of transitional services provided
- Purpose of an Interdisciplinary Team Meeting
- Backup plan requirements
- Options Counseling
- Paperwork

Transition Process

MLTSS Eligibility and role of the Care Manager/Options Counselor

- Individuals must meet clinical and financial eligibility for MLTSS.
- Identify member who requests to transition to a community setting and complete a NJ Choice Assessment system
- Provide Options Counseling
- Submit the NJ Choice assessment to the appropriate Office of Community Choice Options (OCCO) office for review and eligibility determination.
- Schedule Interdisciplinary Team Meeting (IDT).
- OCCO designated staff is utilized as needed as subject matter experts for technical assistance.

Transition Process

CM to identify, authorize, and purchase transitional service needs:

- On site home visit
- Furniture
- Household goods (microwave, sheets, towels, pots, pans, silverware, pillows, etc.)
- Clothing
- Food (enough for at least a week)
- Security deposit
- Utility deposit

CM must outreach to member within five business days of NF discharge

- A face-to-face visit is completed within 10 business days of discharge
- The plan of care is formulated with all appropriate signatures within 30 calendar days of discharge.
- Monthly telephonic outreach and quarterly face-to-face visits are to be completed as per standard operational protocol.

Transition Process Continued

The following data will be submitted by the 5th of the following month via the CP-7, to the MFP Associate Program Director or designee.

- MLTSS non-MFP transitions for members younger than 65 years of age
- MLTSS non-MFP transitions for members 65 years of age or older
- All individuals who met MLTSS eligibility and wanted to transition but did not due to not meeting the cost effectiveness threshold.

New Jersey Department of Human Services

NURSING FACILITY TRANSITION TO THE COMMUNITY (NON-MFP)

Date Faxed	Name of Person/ Title Completing Form
To: Assistant MFP Director (609) 588-3510 (Phone) (609) 588-3330 (FAX)	Managed Care Organization (if applicable) Phone Number

Participant Name		Social Security Number
Date of Birth	Age	SSI Recipient ☐ Yes ☐ No
Medicaid Number	Effective Date	
Medicare Number	☐ Met MLTSS eligibility and did not transition due to meeting the Cost Effectiveness Threshold.	
Discharge Services: ☐ State Plan Services ☐ Private Pay ☐ MLTSS ☐ Medicare Services	☐ Case Conference requested Date: ____/____/_____	
Discharge Facility Name	Facility Type ☐ NF: _____	
Discharge Facility Address	☐ SCNF: Type: _____	
Date of Admission to NF/SCNF	IDT Done ☐ Yes ☐ No	Date
Date of Discharge from NF/SCNF	Discharge To ☐ Private Home/Apartment ☐ ALR/CPCH ☐ AFC ☐ RHCF	
Phone	Address	
Name of Care Manager		Phone
Email of Care Manager		

What constitutes a transition?

To be considered a discharge or transition from a NF to the community and reported to OCCO, contact must be made at the facility through a NJ Choice Assessment, follow-up, Options Counseling, and/or a Section Q referral. Options Counseling and any assistance given to the client needs to be documented in the IPOC section of the NJ Choice Assessment and your

Interdisciplinary Team Meeting(IDT)

- IDT is a collaborative meeting among the individual, family/caregiver/guardian (if applicable), care manager, OCCO MFP Liaison(if MFP transition),nursing facility(NF) social worker, nurse unit manager, therapists and other NF staff as needed. The member must attend regardless of Power of Attorney (POA)/guardianship status.

Interdisciplinary Team Meeting(IDT)

Purpose:

- To identify individuals' expectations and goals
- To discuss all options, risk factors, backup plans and risk agreements (if applicable)
- To identify individuals needs, supports and services he/she will have in the community.
- To discuss and calculate a cost effective analysis.
- To discuss family/caregiver support and training(if applicable).
- To establish contact information and supportive people in the community.
- To assign tasks to all team members for arranging medications, medical supplies, equipment and appropriate referrals.
- Ensuring the individual has an active part in the transition process and choices of service, when applicable.

IDT Continued

- Counsel the individual on options through MLTSS services, MCO services, and community resources.
- Begin formulating a plan of care encompassing Home and Community Based Supports (HCBS) and an estimate of needed hours of care and services.
- Develop the backup plan prior to discharge.
- As a team decide upon a tentative discharge date and transitional goods if needed.
- Authorize and purchase transitional services as needed and ensure delivery of goods on or prior to the day of discharge.
- **Secure HCBS within 24 to 48 hours of discharge.**

Transitional Plan

- A discussion with all members of the team addressing all possible issues of transitioning to the community and who will arrange services.
  - Consumer's expectations and goals
  - Services and supports
  - Transitional service needs
  - Participant and family training(if applicable)
  - Family and friends participation and their expectations
  - Environmental adaptions needed
  - Medications(supply, pharmacy, who will pick up/deliver)
  - Durable medical equipment
  - Medical supplies

Transitional Plan Continued

- Money Management:
  - Assurance of a zero PA 3L (month of discharge exemption)
  - Change of representative payee for Social Security (if applicable)
  - Change of address for Social Security
  - Does the client need to apply/ reapply for Social Security income
  - Return of their personal needs allowance
- Community Referrals:
  - Medicare services
  - Medical transportation
  - Access link application
  - Meals
  - Medical or Social Day Care

Risk Assessment

- The CM needs to discuss and assess risk factors:
  - Home environment
  - Physical health and wellness
  - Behavioral health
  - Personal safety
  - Emergency planning
  - Caregiver support
  - Psychosocial
  - Sufficient financial resources
  - Limited service access

Back Up Plan

- If a member is going to receive personal care, attendant care, private duty nursing, skilled nursing, respite care or any other identified essential service a back-up plan must be developed. It must include:
  - Member service preference level
  - Back-up plan
  - Who will provide the service

  The back-up plan must be completed with the initial transitional plan. It will be reviewed quarterly. A new plan is required at least once a year or when there are changes.

MLTSS Member Back-Up Plan

Member Name: _____ Member ID: _____

Physical Address: _____ Date of Back-Up Plan: _____

Phone Number _____ Date of Affiliated Care Plan: _____

Back-Up Plan is warranted as a result of the following key services being authorized (check all that apply)	Member Service Preference Level (use key below)	Backup Plan (use key below)	Provider/Care Manager/Other Name and Phone Number(s)
1) ☐ Personal Care			Name/Relation: Phone:
2) ☐ Attendant care			Name/Relation: Phone:
3) ☐ Private Duty Nursing			Name/Relation: Phone:
4) ☐ Skilled Nursing			Name/Relation: Phone:
5) ☐ Respite			Name/Relation: Phone:
6) ☐			Name/Relation: Phone:
7) ☐			Name/Relation: Phone:
8) ☐			Name/Relation: Phone:

MEMBER SERVICE PREFERENCE LEVEL – based on member's judgment for how quickly a replacement provider/aide will be needed if the scheduled provider/aide becomes unavailable. Members must be informed that they have the right to a back-up provider if they choose.

Level 1: Needs services the same day services are scheduled
Level 2: Needs services within 48 hours of scheduled services
Level 3: I prefer to have family or friends provide my care instead of another provider/caregiver.
Level 4: Can wait until next scheduled visit by provider
Member has been advised that s/he may change the Member Service Preference Level and also his/her back-up plan, as indicated below, at any time, including at the time of a gap*

CM initial and date

If my provider/aide does not show up to render services as scheduled, my back-up plan selection is as follows:

Back-Up Plan
I will contact the provider agency
I will contact my case manager and/or my Health Plan
I will contact my family/friend for support
I can wait until the next scheduled visit from my provider agency to receive authorized care
Other:

*A gap in services is defined as the difference between the number of hours of service scheduled in each individual's care plan and the hours of the scheduled type of service that are actually delivered to the individual. The following situations are not considered gaps:

- The member is not available to receive the service when the provider arrives at the member's home as scheduled.
- The member refuses the caregiver when s/he arrives, unless the provider is not able to do the assigned duties.
- The member refuses services.
- The member's home is seen as unsafe by the provider, so the aide refuses to go there.

I understand that I have the right to receive all the services in my care plan to help me with bathing, toileting, dressing, feeding, transferring to or from my bed and wheelchair and other similar daily activities as needed. These services may include Attendant Care, Personal Care, Nursing, and Respite. I understand that my Health Plan must make every effort to assure that I receive services as authorized. I understand that if I do not receive my services as scheduled I must call case manager for help. If my anticipated back-up plan must be put into place, if I contact my health plan, my health plan must ensure my Preference Level is met, unless I specify otherwise at the time of the gap. I understand I also have the right to file a written complaint about the failure to provide such services as scheduled.

I understand that in order to receive services I must be available and willing to accept the scheduled services. If I choose not to accept the services I understand I must tell my case manager. This back-up plan has been reviewed with me and I agree with it. I will keep a copy of this plan.

Please have member/representative sign here at time of <u>initial plan development</u>

Member/Representative Signature _____ Date _____

Relationship to member _____

Member Name: _____ Date of Back-Up Plan: _____ Member ID: _____

Quarterly Visit

This plan was reviewed with me by the case manager during my quarterly service review. My signature below indicates I still agree with this back-up plan and no changes are needed. I understand that I may change my Member Service Preference Level at any time, including at the time a gap may occur. My case manager and I will fill out a new Contingency Plan form if I have changes to my back-up plan, but at least once a year.

Please have member/representative sign here to indicate continued agreement with plan at the time of each 90 day service assessment. If the member/representative wishes to make changes to the information in this plan, a new plan must be written. A new plan is required at least once a year.

Date of Review: _____ Member/Representative Signature _____

Date of Review: _____ Member/Representative Signature _____

Date of Review: _____ Member/Representative Signature _____

cc: Member/Representative
Case File

Member Name: _____ Date of Back-Up Plan: _____ Member ID: _____

Completed Paperwork

- A backup plan
- A risk assessment (NJ Choice), risk addendum and if necessary a risk agreement
- All required consents are signed and dated
- A plan of care is started
- A transitional plan and the PCA tool are completed to inform client of what services and how many hours of PCA services will be allowed.
- A copy of all paperwork is given to the individual

QUESTIONS?