FLORIDA NURSING HOME TRANSITION PLAN

Section A: Background and Overview

Introduction: Building upon the legislative nursing home transition language in section 430.7031, Florida Statutes, this nursing home transition plan formalizes a process that will result in the successful transition of eligible Medicaid nursing home residents who desire to transition back into a community setting.

Definition of Nursing Home Transition: The voluntary transfer of an eligible Medicaid beneficiary residing in a nursing home for a minimum of 60 consecutive days, to a community setting such as a family member’s home, individual’s apartment or home, an Assisted Living Facility, or Adult Family Care Home.

Transition activities include the screening and prioritization of nursing home residents for transfer to a community setting. The process also requires coordination and communication among residents, community service providers, nursing home staff, family members or caregivers.

State Goals:

1. The state will develop and implement a plan to achieve the successful transition of eligible Medicaid beneficiaries 18 years of age or older from nursing homes into the least restrictive setting appropriate to their needs.

2. Increase awareness of, and provide information regarding alternatives to, nursing home care to nursing home residents, their families and/or authorized representatives, health care professionals, and organizations that promote residence in the community for individuals with long-term care needs.

3. Identify individuals who desire to transition from nursing homes to community settings by developing, enhancing or adopting assessment tools to successfully identify candidates.

Program Objectives:

Develop a nursing home transition process that:

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1 This Nursing Home Transition Plan is intended to be used as a guideline for all agencies involved in the nursing home transition process. It is not intended to replace successful existing transition processes that agencies already have in place.

2 CARES currently conducts assessments of all nursing home residents. This plan is not intended to impact or change CARES processes or assessment instruments already in place. However, supplemental tools and processes for other agencies will be addressed as needed.
Reflects best practices of other successful transition programs;
Promotes the integration of state and community supports;
Respects all individuals and their need to be treated with dignity; and
Utilizes data collection to track outcomes and improve the transition process.

Section B: Program Phases

1. **Planning and Development:** Develop an overall plan to implement a nursing home transition process for Florida Medicaid recipients. This phase includes:
   - Develop specialized materials to educate and inform residents, stakeholders, and responsible parties about community alternatives to nursing homes. The materials will include types and frequencies of services that can be provided to potential transition candidates.
   - Develop information to be used by individuals answering phone calls from nursing home residents who desire to transition. The individuals answering phone calls may include representatives of the Clearinghouse on Disability Information, the Department of Elder Affairs, CARES, the Aging Resource Centers, the Long-Term Care Ombudsman Program, the Elder Helpline, the Department of Children and Families, and the Department of Health’s Traumatic Brain and Spinal Cord Injury Program.
   - Develop policies and procedures to assist in transitioning individuals.
   - Draft and execute necessary contracts or agreements.
   - Consult with key stakeholders and define individual roles for the coordination of nursing home transition activities.
   - Identify home and community based services (HCBS) waiver programs and other Medicaid programs that will be impacted by the nursing home transition process, define the impacts and recommend amendments to the waiver programs which would be necessary to meet transition service needs.
   - Develop or modify a screening tool that will be used to prioritize individuals for nursing home transition.
   - Develop training on the transition initiative for Clearinghouse on Disability Information staff, case managers, ombudsman, and other stakeholders or adapt existing training materials.

2. **Outreach, Identification and Intake of Transition Candidates:** Describe the outreach, identification and intake processes that will be utilized in the transition program. This phase includes:

   **Outreach**
   
The state will develop and distribute outreach materials, or make the materials available on the agency’s website, to provide information about the Florida Medicaid Nursing
Home Transition Program. The Agency for Health Care Administration (AHCA) will be responsible for developing, printing, and distributing materials to partner agencies and other stakeholders. Outreach efforts will focus on:

- Educating and increasing awareness among nursing home residents and stakeholders about community alternatives to nursing home care.
- Providing persons interested in returning to the community with the appropriate contacts for obtaining additional information on what resources are available.
- Providing state agencies, advocacy groups, providers, and provider associations with program information via the Agency’s website or training sessions/workshops.

Outreach Materials (published in English and other languages as appropriate):

- Brochures: Provided to nursing home residents by Long-Term Care Ombudsman and available for download on the Agency’s website.
- Posters: Placement on bulletin boards in nursing homes, Centers for Independent Living, and senior centers. Posters will also be available for download on the Agency’s website.
- Letters: An informational letter will be sent to nursing home administrators.
- Website: Develop a website at the Agency for Health Care Administration. All waiver partner agencies will provide a link to the AHCA website. The website will include a description of the nursing home transition program, frequently asked questions, links to partner agencies, contact information, program brochures and other informational materials.
- Stakeholder Publications: Transition articles published in newsletters or on web pages of stakeholder groups.

AHCA will make outreach materials available in an electronic printable format via the nursing home transition link: http://ahca.myflorida.com/Medicaid/nh-transition/index.shtml. Entities such as those listed below may print and distribute the materials as necessary:

- Long-Term Care Ombudsman (distribution of transition program materials to nursing home residents)
- Aging Resource Centers (ARC)
- Lead Agencies
- Nursing Homes
- Centers for Independent Living
- Medicaid Field Offices
- CARES

The following entities are the primary contacts for information, referral and enrollment:
- Adults with disabilities, age 18-59
  - Department of Children and Families, Adult Protective Services
    - Centers for Independent Living

- Individuals with Brain or Spinal Cord Injury, age 18 or older
  - Department of Health, Brain and Spinal Cord Injury Program

- Elders, age 60 or older
  - Department of Elder Affairs
    - Aging Resource Centers
    - Elder Helpline
    - CARES

Identification Sources
Candidates for transition may be identified through referrals from any source, including:
- Self, friend or family
- Advocacy groups/community organizations
- Long-Term Care Ombudsman
- Centers for Independent Living (CIL)
- Aging Resource Centers
- Elder Helpline
- Lead Agencies
- Nursing home discharge planners
- CARES
- Clearinghouse on Disability Information

Candidates may also be identified through analysis of databases containing information about nursing home residents.

Intake Process
The intake segment describes “who, what, how and when” regarding the steps in handling the information gathered following the identification of persons for transition. The intake process is presented in two categories: intake from referrals and intake from data analysis.

Intake from Referrals
When transition referrals are received, the following intake/documentation process will ensue:

a) The entry will be logged, capturing information such as the person’s name, date of birth (DOB), Medicaid ID, facility name and county and the date contact was made.

Note: The logging system will be an individualized database maintained by each agency with further discussion regarding the appropriateness of a centralized database accessible to all agencies involved. Each agency will have to report
certain information from their database to AHCA for purposes of reporting transition activities, transfer of funds, monitoring and quality control.

b) From the logged entry, a report will be generated with information on how to contact the potential transition candidate.

c) The report will be used to contact the potential transition candidates to screen and determine appropriateness for transition.

Given that different agencies (e.g., DOEA, ARC, DCF, & DOH) are statutorily and programmatically responsible for serving the various Medicaid populations impacted by this transition initiative, any referral received should be directed to the agencies responsible for that population:

- Individuals age 60 and older, or their representatives who desire to transition from nursing homes to a community setting should contact the local CARES or the Aging Resource Center (ARC).

- Individuals age 18–59 or their representatives who desire to transition from nursing homes to a community setting should contact the local Department of Children and Families (DCF) Adult Protective Services office.

- Individuals age 18 and older with a traumatic brain or spinal cord injury (TBSCI) should contact the Department of Health’s Brain and Spinal Cord Injury Program.

- Individuals age 18 or older who desire to transition but need Medicaid financial eligibility determination should contact the Department of Children and Families Automated Community Connection to Economic Self Sufficiency (ACCESS).

Contacts made to entities other than those listed above will be referred to the appropriate agency.

**Intake from Data Analysis**

When individuals are identified for transition through the data sources listed below, the entity housing the data will initiate and follow the following intake/documentation steps:

a) The entry will be logged, capturing information such as the individual's name, date of birth (DOB), Medicaid ID, facility name and county and the date the individual was identified.

b) From the logged entry, a report will be generated with information on the potential transition candidate and how to contact him or her.

c) The report generated will be used for the screening of the potential transition candidates.

Note: Some intake information will need to be forwarded to AHCA for purposes of reporting, monitoring and quality control.
Other avenues (including data sources) for transition identification will include:

- Individuals currently on HCBS waiver waiting lists who reside in a nursing home. Each waiver operating agency will be responsible for logging these candidates.
- Prior transitioning efforts may be utilized to identify factors to consider during intake processes.
- Minimum Data Set (MDS): AHCA has secured a data use agreement with the Centers for Medicare and Medicaid Services and will be collaborating with the Florida State University in analyzing certain elements of the MDS to be able to identify and gather pertinent information about nursing home residents to facilitate the transition of the residents to a community setting. AHCA will continue to work with transition partner agencies regarding access to and utilization of the MDS for their target populations.
- Client Information and Referral Tracking System (CIRTS): The Department of Elder Affairs (DOEA) may add additional fields to the CIRTS database to identify and gather pertinent information on nursing home residents who wish to transition to a community placement setting and will log potential candidates identified in this way.
- Adult Protective Services Information System (ASIS): The Florida Department of Children and Families (DCF) Adult Protective Services will make modifications and enhancements to the ASIS to facilitate the identification and information gathering on nursing home residents for transition to community setting and will perform the intake process.
- Department of Health, Brain & Spinal Cord Injury Program (BSCIP) surveys: Candidates will be identified through annual surveys conducted by the BSCIP. These surveys will be a part of the BSCIP’s regular outreach to individuals in nursing homes who have brain and spinal cord injuries, to determine their desire to return to the community. BSCIP will perform the intake process.

**Comprehensive Assessment and Options Counseling**

- CARES is federally mandated to determine medical necessity of Medicaid funded long term care, including nursing home services and home and community-based services programs. CARES will perform the level of care assessment for all of the populations listed above.
• Options counseling on available home and community-based services programs may be provided by CARES, the Aging Resource Centers, Brain and Spinal Cord Injury case managers, or a designated transition case manager.

3. **Screening and Prioritization Process:** This section describes the screening and prioritization process for individuals interested in transitioning from a nursing home. This assumes that there may be more individuals who wish to transition than there are case managers to assist them and/or waiver funds to serve them. In that scenario, the state will prioritize for transition assistance those candidates who have the greatest potential to successfully transition.  

• Each agency will use its own screening instrument to collect basic information pertaining to the individual’s functional abilities, health, need for services and existing support system.

• Upon the completion of the screening, each individual’s transition potential will be determined.

• Individuals in nursing homes who have strong community support and individuals who have the greatest potential to remain in the community after transition will receive the highest priority.

The prioritization process will assess individuals’ transition potential using factors such as:

• Informal community resources available to assist the individual to live in the community;

• Whether or not the individual has a caregiver who is able and willing to provide some of the necessary care;

• The individual’s present health and how it compares to a year ago;

• How much the individual’s health affects them doing what they want to do; and

• How much assistance the individual will need with activities of daily living and instrumental activities of daily living

4. **Transition:** This section describes the manner in which transition will occur. This phase includes:

**Transition Case Management**

Transition Case Manager Qualifications and Skills:

• Experience helping individuals adjust to community living;

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3 See footnote on page one regarding CARES screening process.
A bachelors degree in health care or human services is preferred, however related experience can substitute for the preferred education;

Demonstrated expertise working with individuals with disabilities and their families;

Familiarity with 1915 (c) waivers and community-based services;

Knowledge, skills and abilities to assess, identify, network, and address gaps in community services;

Excellent communication, interviewing and presentation skills;

Ability to develop and maintain collaborative relationships with partner agencies such as the Centers for Independent Living, Florida Department of Health, Florida Department of Children and Families, and Florida Department of Elder Affairs;

Working knowledge of community-based resources for seniors and individuals with disabilities;

Ability to identify, organize, document, coordinate, monitor, and modify services needed by each individual;

Proven problem-solving and investigation skills; and

Skill in coordinating activities, evaluating outcomes and establishing priorities.

Transition Case Manager Duties and Responsibilities:

After CARES completes the comprehensive assessment and options counseling, the transition case manager is expected to:

- Meet with prospective transition candidates to explain available home and community-based services and determine whether the individual meets the criteria for a specific waiver program or for other community services;
- Work with the individual and the individual's family to develop a service plan to meet the individual’s needs and facilitate a successful transition to the community;
- Assist individuals in locating community or family support;
- Work with the waiver case manager to enroll the individuals with the greatest transition potential into the appropriate waiver (dependent on availability of funds);
- Assist the individual with exploring community housing options;
- Refer individuals to local workforce boards to identify skills training opportunities and employment opportunities (as appropriate and applicable to the individual);
- Provide resource information and education regarding community-based services;
- Track participants from identification phase to hand-off to waiver case manager;
- Maintain a detailed case record which documents all activities and interactions with the individual; and
- Report transition activities according to data collection schedule.
Transition Process:

- After CARES completes the comprehensive assessment, and DCF determines financial eligibility for waiver services, the transition case manager will work with the waiver case manager to facilitate enrollment of the individual into the appropriate waiver program.

- Individuals who seek community placement but are determined not to be eligible for an HCBS waiver will be provided notice of their due process rights. The process will include an opportunity for a Medicaid Fair Hearing and may also include an opportunity to request reconsideration.

- If the individual is eligible for transition, the transition case manager will meet with the transition candidate and their family and/or legal representative as appropriate to review the individual’s identified needs, identify the supports necessary for the individual to live in the community and to prepare a service plan and a case file.

- The transition case manager will assist the individual in locating services and service providers both formal and informal to meet the identified needs, which may include services such as housing, moving, meals, personal care, training, employment, and transportation.

- When the individual moves from the nursing home into the community and enrolled in a waiver, responsibility for managing the individual’s case will be transferred to the waiver case manager.

- Billing for waiver services may begin after the transition candidate has moved from the nursing home to the community, enrolled in a designated waiver and started receiving waiver services.

Transition Candidate Responsibilities:
To the extent possible, transition candidates and their family members or responsible parties may be expected to:

- Assist with transition activities (e.g., housing applications);
- Secure family and community support;
- Provide complete and accurate medical history, including all treatments, interventions, prescribed and over-the-counter medications;
- Provide accurate information regarding Medicaid, Medicare, VA or other medically-related insurance programs to the case manager;
- Ask questions when he/she does not understand his/her services; and,
- Report any significant changes in medical condition, circumstances, informal supports and formal supports to the case manager.
5. **Tracking**: Documentation of the transition activities, including progress and completion timeframes. This section consists of three tracking activities: operations tracking; trend analysis tracking; and post transition review.

**Operations Tracking**
Maintenance of a statewide tracking system to document transition activities for persons transitioning from nursing homes to community settings. The system will capture the following information:

- County
- Facility Name
- Recipient Medicaid ID
- Social Security Number
- Name
- Date of Birth
- Transition Referral Source
- Date of Initial Contact
- Date of Screening
- Date of Assessment and Options Counseling
- Barriers to Community Placement (if transition cannot be completed at this time)
- Date of Nursing Home Discharge
- Waiver Enrollment Date
- Waiver Disenrollment Date
- Waiver or Program Entered
- Type of Community Dwelling
- Care Giving Arrangement or Living Situation

Note: Each agency will send reports on transition activities to AHCA once a month. The reports will be maintained in a tracking database.

**Trend Analysis Tracking**
This will enable the state to determine trends or deficiencies and to improve on the effectiveness and fiscal responsibility of the transition process. A trend analysis may be performed annually or on an on-going basis. Some factors to capture in this regard may include:

- Length of time between recipient-initiated contact with agency and agency’s response time
- Estimated costs and resources used for transition
- Waiver entered
- Resource availability (e.g. Medicaid or non-Medicaid, private or community)
- Referral source
- Recipient transition destination (e.g. Personal apartment, group home, ALF, or with family)
• Number of failed/incomplete transitions and the barriers to those transitions
• Medicaid cost per member per month of transitioned individuals
• Number of individuals returning to a nursing home after community placement

The state may consider using Medicaid claims data and the Florida State University data repository as resource tools for matching queries in the trend analysis and tracking process.

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7. **Benchmarks:** Measurement of success including what constitutes a successful transition.

In addition to recording and tracking the number of individuals requesting transition assistance, and the actual number of individuals who successfully transition from nursing home care to home and community-based service programs, the state will examine the transition process. Aspects analyzed may include:

• Administrative process flow
  o Interagency coordination
  o Systems coordination
  o Communication

• Data collection
• Monitoring activities to determine consumer satisfaction with:
  o Transition coordination services
  o Access to home and community-based services

• Length of time from initial contact to screening
• Length of time from screening to waiver enrollment, or other closing of transition case
• Waiver funds management
  o Enrollment of transitioning persons into “transition-reserved” HCBS waiver slots (if applicable)
  o Sufficiency of reserved “transition” slots to meet the needs of transitioning individuals (if applicable)

• Cost and utilization
  o NHT cost comparison: Nursing Home costs vs. Medicaid costs in the community
  o Change in Medicaid nursing home bed utilization and occupancy rates