

MASTER•CARE PROCESS MANUAL

NF Workflow

You got a referral now what?

1. Tell the truth no elaboration needed!
2. We are selling nothing This is a great program but does have criteria!
3. Manage referrers expectations!
4. Never promise anything
5. Let them know you will review and check eligibility
6. Ask for all the documentation you are going to need to qualify this referral
 1. Facesheet
 2. Current Nursing Notes, MD notes, PT/OT notes
7. Enter Patient in Salesforce
8. Required Fields:
9. Name
 1. CIN (Medicaid/Medi-Cal number) 8 numbers ending with a letter sometime has 3 leading letter and 4 numbers on the end. 98765432A (XDJ98765432A or XDJ98765432A1234)
 2. DOB
 3. Name of SNF
 4. Upload all documents
 5. Status 2-pending
10. Task Lisa with Eligibility Check
11. Task Kathy with Review
12. Task yourself with follow up
13. Review the patient are they:
 1. Appropriate for this program?
 2. What are the obvious obstacles? Injections, complex med protocol, bed bound, dementia without POA or family, etc.
14. Once confirmed eligible:
 1. Get **consent** and explain the program to patient and if any family or support system
 2. Confirm income of the patient and understanding that 90% of SSI (only of SSI) must be paid for Rent (room and board) patient must agree to this.
 3. Explain that you will refer them into the program and if authorized you will follow up for an assessment.
15. IF pt. is eligible but needs help organizing finances, getting payer, applying for SSI- they need ECM first so we can get paid to assist the patient with these things. Task Lisa with ECM referral.

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16. Task Lisa with referral- assure all documents necessary are uploaded and legible.
17. Let the referrer know where you are at in the process

If Ineligible

let the referrer know why (wrong insurance, etc.) look for solutions or alternative resources to assist.

Patient is Eligible and Authorized- Transition to AL (see transition to home)

1. Connect with referrer and patient to schedule an assessment
2. Confirm willingness and ability to pay 90% of income.
3. Complete appropriate assessment- document well with narrative
4. Complete Discharge Plan-Care Plan
5. Get 602 completed
6. Task Kathy with 602 review
7. Task Patience with initial RCFE search for your patient
8. Once RCFE's have been identified-present possible options
9. Task Patience with scheduling assessments- coordinate together

Assessed and Accepted by RCFE

1. Confirm rates and get admissions agreement
2. Task Debra with review of rate and agreement
3. Confirm choice with patient- explain that we will be submitting for authorization
4. Task Debra with submitting for authorization

Authorized for Wrap Around!

1. Refer in for ECM- if not already in ECM
2. Coordinate Discharge date with SNF, Patient and RCFE
3. Gather all crucial items for discharge:
 - a. Medications- 30 day supply
 - b. Supplies- what do they need? Personal hygiene items etc.
 - c. Clothes
 - d. Personal items

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e. Paperwork

4. Arrange transportation
5. Be present at discharge to assure all goes well
6. Follow transportation to RCFE
7. Remain with patient throughout the admission process
8. Assist patient with settling into new home
9. DOCUMENT!
10. TASK FOLLOW UP
11. CELEBRATE SUCCESS!

Follow up

Create tasks to assure you follow up with the patient and the RCFE or other providers

Week 1:

- Check in with patient and RCFE or other provider to see how they are settling in
- Assure coordination between ECM and the RCFE or other providers is in place
- Assure patient's person support system is introduced to the RCFE so they can visit and support the patient.
- Work with patient and/or patient representative to request SSI increase if below the Non-Medical Out-of-Home Care (NMOHC) Payment Standard for Individuals-Licensed Facility or Without In-Kind Room and Board

First 30 days after discharge to RCFE:

- Check in with patient and RCFE provider
- Inquire about supplies and needs, assure everything is going smoothly
- Engage with patient and update a care plan to reflect current goals and needs

Patient is Eligible and Authorized- Transition to Home

1. Connect with referrer and patient to schedule an assessment
2. Complete appropriate assessment- document well with narrative
3. Complete Discharge Plan-Care Plan
4. Home inspection to assure pt. can move home safely
 - a. Is home safe? If not can it be made safe with reasonable wrap around services
 - b. Coordinate all services necessary for safe discharge, this varies by patient and patient's housing situation.
5. Who is providing care? Coordinate schedule and assure coverage is in place as part of the care plan

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- a. Who is providing medication management? Assure there is a way to have medication delivered and managed to assure pt is taking them appropriately
- b. What other services are necessary?
 - i. Make Necessary Referrals
 - ii. Assure all are authorized or if they cannot be authorized find solutions
 - iii. Coordinate timing for all referred and necessary services.
6. Refer in for ECM
7. Coordinate Discharge date with patient support and care
8. Gather all crucial items for discharge:
 - a. Medications- 30 day supply
 - b. Supplies- what do they need? Personal hygiene items etc.
 - c. Clothes
 - d. Personal items
 - e. Paperwork
9. Arrange transportation
10. Be present at discharge to assure all goes well
11. Follow transportation to Home
12. Remain with patient to assure all supports are in place and patient understand the care plan and what to expect such as appointments etc.
13. Assist patient with settling into new home
14. DOCUMENT!
15. TASK FOLLOW UP
16. CELEBRATE SUCCESS!

Follow up

Create tasks to assure you follow up with the patient and the RCFE or other providers

Week 1:

- Check in with patient and other provider to see how they are settling in
- Assure coordination between ECM and other providers is in place
- Assure patient's person support system understand the care plan and

First 30 days after discharge to RCFE:

- Check in with patient
- Inquire about supplies and needs, assure everything is going smoothly
- Engage with patient and update a care plan to reflect current goals and needs

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