



NF Transition and Diversion Training

2.22.23

Agenda

1. Meet new team members (turn on your cameras so we can all say HI!)
2. Learn NF workflows
3. What is Eligible **and** appropriate?
4. 602
5. How to help when we can't

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. Face sheet
 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?

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

Patient is Eligible and Authorized

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. Task Patience with initial RCFE search for your patient
5. Get 602 completed
6. Task Kathy with 602 review
7. Once RCFE's have been identified-present possible options
8. 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
2. Coordinate Discharge date with SNF, Patient and RCFE
3. Gather all crucial items for discharge:
 - a. Medications
 - b. Supplies
 - c. Clothes
 - d. Personal items
 - 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. DOCUMENTS
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.

1 month after discharge to RCFE:

- Check in with patient and RCFE provider
- Inquire about supplies and needs, assure everything is going smoothly

Eligible AND Appropriate

During initial contact and review we must determine if the patient is appropriate for the program. There are key factors we must pay close attention to:

Populations of Focus

For this program our patients may fall into several PoFs but the primary focus PoFs will be:

1. Nursing facility residents who want to transition to the community
2. Adults at risk for institutionalization who are eligible for long-term care services

Must be appropriate

- Our patients will also be older adults or those who have similar conditions and care needs of older adults.



- Our patients will fit in and be fulfilled living in an Assisted Living Environment
- Our patients will not be disruptive to the lives of other residents at the Assisted Living
- Our patients MUST need ADL and/or ADL/IADL assistance
- Our patients must not be drug or alcohol seeking if former SUD
- Our patients may have SMI but it must be well controlled without excessive or disruptive behaviors
- Our patients must not be violent or put other residents at risk
- Our patient must not need excessive (read that expensive) medical services as ongoing support

Criteria- who is eligible for this service?

Nursing Facility Diversion services to an Assisted Living Facility

- Is the member interested in remaining in the community?
- Are they willing and able to reside safely in an Assisted Living Facility with appropriate and cost-effective supports and services?
- Do they meet minimum criteria for Nursing Facility level of care (unable to complete ADLs without assistance)
- Are they able to pay for own living expenses?

Community Transition Services to a Home or Assisted Living Facility

- Is the member currently residing in a Nursing Facility and receiving medically necessary Nursing Facility services? (Unable to complete ADLs without assistance)
- Have they lived 60+ days in a Nursing Facility?
- Are they interested in moving back into the community?
- Are they willing and able to reside safely in a home?
- Are they willing to live in an Assisted Living Facility with appropriate and cost-effective supports and services?
- Are they willing and able to pay for own living expenses? (Room and board- has SSI or other income)
- If going home-Has appropriate housing and can afford to sustain this housing

Assisted Living/RCFE's



Residential Care Facility for the Elderly is the licensed term for non-medical assisted living facilities. They vary from the very large CCRC to the micro 4 residential home.

TIP: Don't use the f-word- Facility. Facility feels medical and sterile, Community is welcoming, more homelike, Assisted Living Providers prefer this term as they rent their apartments primarily to private pay residents.

Types of Care: Non-Medical or Custodial and Memory Care

All three can fall into a similar category that can be broken down by levels of care or level of assistance needed. This covers ADL's or activities of daily living, activities that are required to live daily, things we usually do for ourselves but after illness or with age become hard to do or even impossible without assistance. Here are some examples of ADL's

- Bathing, dressing, grooming, hygiene
- Toileting or incontinence care
- Meals- preparation and/or eating
- Medication reminders and management
- Transfer assistance- help getting in and out of bed, a chair or car etc.
- Housekeeping and laundry
- Transportation
- Making appointments
- Shopping

How much assistance you need with some, or all of these comes into play with the cost of care. This is often referred to as Level of Care.

Non "care" activities that are important for the social, emotional, and spiritual well-being are often included by senior living and senior care providers. Activities such as:

- Crafts
- Games
- Social gatherings
- Exercise class
- Movie Nights
- Outings
- Gardening
- Worship/religious services

Memory Care Only or as a Separate Area in the Assisted Living

The care of persons with a diagnosis of memory impairment due to dementia, Alzheimer's or other similar illness. This category goes hand in hand with Non-Medical Care as often times those who are memory impaired need help with ADL's even if it is simply to be reminded when and how to do these things. Additionally, memory impaired individuals need extra care to assure safety in a secured environment. Memory Care specific communities or Caregivers who



are specifically trained in Memory Care are usually the best option for memory impaired individuals. Some of the special needs of memory care impaired individuals are:

- Secured environment such as locked exterior/exit doors
- Memory care specific environment such as easy to navigate spaces, soothing colors and familiar reminders of where they are to help keep the resident oriented
- Specialized activities to help improve brain function and memory
- Caregivers specially trained in dealing with behaviors through redirection

IHSS, CBOs, County Supports and other CS providers

When transferring back to home and not an RCFE we will use a different set of providers. These include IHSS, Community Based Organizations, such as, senior centers, meals on wheels, religious organizations etc. Use of county programs that are free, and the referral to CS providers for things such as Environmental Accessibility Adaptations (EAA) Medically Tailored Meals (MTM). It also includes assisting in the coordination of the patients' personal supports, as they will be providing care.

602! The Golden Ticket:

Who fills this out? The SNF

Who Reviews and requests changed and clarification? Master•Care- Kathy for now!

How to help when we can't

If ineligible

Let the referrer know why (wrong insurance) Let them know that the patient may choose a different Managed Care Plan. **BUT!** Still not guarantee as the person must also be appropriate.

If not appropriate

Let the referrer know why:

- Age + conditions: Solution have them refer the patient into ECM for their managed care plan.
- Conditions or care needs too high/complex: Solution Will the conditions improve or can they be improved with a different treatment plan and if the patient willing to participate in the treatment plan. If so once they have completed treatment and conditions have improved, we can work reevaluate.
- No pathway to income to pay room and board: Solution Have SW or other staff work with the patient to apply for SSI
- Unwilling to pay room and board: Solution No options unless the patient is willing. The program is voluntary and this is a requirement.

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