Rhode Island Department of Human Services
Office of Community Programs
Nursing Home Transition Program (NHTP)

Presented by Ellen Mauro, RN, MPH
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Nursing Home Transition Program (NHTP)

1. **NHTP Policy & Procedure**

   Outlines the Policies & Procedures that guide the work of the Nursing Home Transition Program.

2. **Referral Form (GW-NHTP-REF)**

   Submitted by the provider to the Office of Community Programs (OCP) for identifying potential candidates for transition.

3. **Flow Chart**

   Illustrates the Transition Process.

4. **Nursing Assessment (GW-NHTP-RN-ASSMT)**

   Used by the NHTP RNs to identify client's needs and ensure a successful transition.

5. **Social Worker Assessment (GW-NHTP-SWA)**

   Used by the NHTP SWs to screen for financial eligibility.

6. **Failed Placement Language**

   Developed by stakeholders that the NHTP has adopted as criteria for failed placement.

FINAL DRAFT

GW-NHTP-P&P
Rev: 8/20/2010

Rhode Island Department of Human Services
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Nursing Home Transition Program

POLICY AND PROCEDURE

The **Nursing Facility Social Services Department** is responsible for the Nursing Facility discharge. This includes discharge planning, implementation, identifying need for and arrangement of services and equipment, home modifications and adherence to Section Q- MDS 3.0.

It is the role of the Department of Human Services (DHS) / Office of Community Programs (OCP) to have an onsite presence in the Nursing Facility, and upon the request of the client, review medical records, MDS, and any other necessary documentation, consult on potential discharges, attend discharge planning meetings with individual and family members as needed, facilitate the ordering of special equipment and home modifications and provide oversight and monitoring for a 30-day period post discharge for non medically complex individuals, and continuous oversight and monitoring for medically complex individuals.

This procedure includes the following:

- Receive referrals for potential Medicaid candidates in nursing facilities who are requesting discharge to a less restrictive setting.
- Identify Medicare clients who may also be eligible for Medicaid long term care and are expected to exhaust Medicare days or private pay.
- Confirm referral to Office of Medical Review for LOC determination for non- grandfathered clients.
- Determine that a DHS Long Term Care application has been submitted to the appropriate long term care office and that financial eligibility has been approved.
- Identify clients who are known to DHS, Department of Elderly Affairs (DEA), Mental Health Retardation and Hospitals (MHRH) or other agencies as applicable. Contact agency to discuss previous community based issues or concerns.
- Participate in nursing home discharge planning meeting(s) as necessary.
- Confirm with nursing home that arrangements have been made for home safety evaluation, special equipment needs and home modification assessment (Tri-Town, PARI, OSCIL) prior to discharge.
- Confirm that the home care agency is able to provide care and meet the service plan requirements.
- Communicate with the appropriate Long Term Care staff regarding the service plan, number of CNA and homemaker authorized hours and name of providing agency.
- Notify Long Term Care, DEA, and MHRH upon discharge and complete referral for follow up post discharge and confirm transition referral to appropriate state agency or case management staff.
- Provide client with information about the Alliance's Ombudsman program.
- Contact client by phone post discharge, then weekly and complete home visit within the 30 day follow-up period.
- Report appropriate "failed community placements" to the Alliance as necessary.
- Conduct weekly team Transition Team meetings to accomplish the following: 1) Identify clients who may be appropriate for discharge 2) Identify barriers to discharge 3) Discuss specific issues and concerns.
- Complete weekly, monthly and quarterly reports, including client statistics.

FINAL DRAFT

Office of Community Programs
Nursing Home Transition Program (NHTP)
Referral Form

Phone: 462-6393 *Fax: 462-3496*

Today's Date: _____Name of Nursing Home: _____

NH D/C Planner: _____Phone: _____

Client Name: _____ DOB: _____ SSN:_____

Address: _____Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Telephone Number: _____

Primary Language: _____ Interpreter Needed ☐ Yes ☐ No

Spouse Name: _____

Primary Contact: _____Relationship _____ Contact Phone _____

Address: _____ City/Town_____ State ____ Zip _____

Diagnosis: _____

Admission Date: _____ Reason for Admission: _____ Anticipated D/C date: _____

Admitted from: ☐ Hospital ☐ Assisted Living ☐ Home ☐ Rehab Facility ☐ Other _____

Recent Hospitalizations: ☐ Yes ☐ No. If yes, provide name of Hospital: _____

Reason for Hospitalization: _____
_____

Name of Health Insurer: _____ Secondary Insurer: _____

Has client applied for Long Term Care Assistance? ☐ Yes ☐ No. If yes, when was application submitted? _____ Where was the application submitted? _____

If not, is the family or Social Worker aware of the need to submit the application? ☐ Yes ☐ No
Please explain: _____.

What are client's care planning needs once discharged? ☐ Skilled Nursing ☐ PT/OT ☐ DME
☐ CNA/Homemaking ☐ PERS ☐ Adult Day
☐ MOW (Meals on Wheels) ☐ Med Management

Will client be ☐ Living alone ☐ With others and/or in need of 24/hr supervision? Please describe Living Arrangements upon discharge: _____.

Does client have a Legal Guardian or Power of Attorney? ☐ Yes ☐ No. If yes, provide the following information: Name: _____ Phone:_____

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GW-NHTP-RN-ASSMT
Rev: 7/2010

Rhode Island Department of Human Services

Office of Community Programs
Nursing Home Transition Program (NHTP)

NURSING ASSESSMENT

REFERRAL

Assessment Date: _____
NH Location: _____
NH Address: _____
_____

Referral Type:
☐ HCBS ☐ ASL
☐ NH ☐ Re-Assess
☐ Preventive ☐ Other: _____

NH D/C Planner: _____ Tel #: _____

CLIENT IDENTIFYING DATA

Medicare Ins Type: _____ Other Insurance: _____

Name: _____DOB: _____ SSN: _____

Address: _____Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Phone: _____

Primary Language: _____ Interpreter Needed: ☐ Yes ☐ No

Primary Contact Person: _____

Relationship: _____ Contact Phone: _____

Address: _____ City/Town _____State ____ Zip _____

Marital status:

☐ Married ☐ Divorced ☐ Separated
☐ Never Married ☐ Widowed ☐ Unmarried Partner

Advanced directives_____

INFORMAL SUPPORTS (FAMILY, FRIENDS, ETC.)

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____

PRE NH ADMISSION RESIDENCE

Housing Status

☐ Assisted Living ☐ State Institution ☐ Group Home ☐ Shelter

☐ Own Home ☐ Rents Home ☐ Subsidized Apt

☐ Lives Alone ☐ Lives w/ Spouse ☐ Lives w/ Children ☐ Lives w/ Parents

Pt Living Preference: _____

RN Clinical Recommendation: _____

OVERVIEW

LTC Social Worker: _____ Office Location: _____ Ph: _____

Case Management referred to: ☐ DEA ☐ CAP agency ☐ MHRH ☐ Preventive LOC ☐ OCP
☐ Other: _____

Discharge Date: _____

Barriers to Discharge:

☐ Client Declines ☐ Financial ☐ Housing ☐ No Informal Support ☐ Safety

Medical Equipment:

Medical Equipment Needed: _____

_____

Current: _____

Vendor: _____

HOME BASED SERVICES

Services Client Receives	Provider Name	# of hours/days per wk
☐ Homemaker		
☐ CNA		
☐ Skilled Services		
☐ MOW		
☐ Hospice Care		
☐ Mental Health Services		
☐ Senior Center		
☐ Adult Day Center		

Recommendations: _____

_____

FUNCTIONAL ABILITY/ADL'S

Key

I-independent
S- supervision
AMN-Minimal Assistance / **AMX**-Maximum Assistance
T-total dependence

1.
_____Supports for eating
_____Supports for preparing meals
Comments: _____
_____

2.
_____Supports for toileting
Comments: _____
_____

3.
_____Supports for mobility (specify with or without manual aid)
_____Supports for transferring
Comments: _____
_____

4.
_____Supports for personal hygiene/grooming
_____Supports for dressing
_____Supports for bed bath
_____Supports for showering
_____Supports for special skin care
Comments: _____
_____

5.
_____Supports for light housekeeping (including laundry)
_____Supports for heavy housework
Comments: _____
_____

6.
_____Supports for transportation
_____Supports for shopping
Comments: _____
_____

7.
_____Supports for finances
_____Supports for telephone ability
Comments: _____
_____

8.
_____Identify the degree of support needed in an emergent situation
_____Identify the degree of support needed during the night
Comments: _____
_____

Communication:
Is client able to speak and verbally express him/herself? ☐ Yes ☐ No
Comments:
_____

Name devices the client uses to communicate/understand others:
_____
_____

MENTAL HEALTH

(Check all that apply)

☐ Abusive	☐ Depressed	☐ Resistant to care
☐ Agitated	☐ Disoriented	☐ Other: _____
☐ Alert	☐ Forgetful	☐ Other: _____
☐ Anxious	☐ Pleasant & cooperative	

Comments: _____

_____

Information provided by: _____

HEARING & VISION

☐ Hearing impaired ☐ Assistive devices MD_____

Comments: _____

☐ Vision impaired ☐ Glasses or device MD_____

Indicate client's current vision quality (w/ glasses if used regularly):

1) ☐ Adequate – sees fine print 2) ☐ Impaired – sees larger print

3) ☐ Mod Impaired – limited vision 4) ☐ Highly Impaired – sees only light/shadows

Comments: _____

DIET

Diet: _____

Special instructions/preparations: _____

☐ Able to chew ☐ Able to swallow ☐ Aspiration precautions

☐ Own teeth ☐ Dentures ☐ Partial plate

Comments: _____

_____

DENTAL

Name of dentist: _____ Date of last visit: _____

HEIGHT/WEIGHT

Weight**:** _____ Height: _____

Recent gain: ☐ Yes ☐ No Recent loss**:** ☐ Yes ☐ No

HEALTH CARE & COMMUNITY SUPPORTS

Type (PCP/Specialist)	Name	Phone	Address
1.			
2.			
3.			
4.			
5.			
6.			
7.			
Dentist			
Clinic			
Clinic			
Senior Ctr/Day			
Meals			
Transportation			

SLEEP

Is client satisfied w/ sleep quality? ☐ Yes ☐ No # of hours per night_____

Comments:

_____

_____

MEDICAL ISSUES

Diagnosis:_____

_____

_____

☐ **Arthritis**	☐ **CHF**	☐ **GI issues**	☐ **MS**	☐ **Seizure d/o**
☐ **Asthma**	☐ **COPD**	☐ **Head Injury**	☐ **Parkinsons**	☐ **Skin disorders**
☐ **Cancer**	☐ **CVA**	☐ **HTN**	☐ **Psychiatric**	☐ **Thyroid**
☐ **Cardiac**	☐ **Diabetes**	☐ **Immune disorder**	☐ **Renal**	☐ **Urinary problems**

Comments:

_____

_____

Surgical History **Dates**

_____

_____

_____

_____

Smoking: ☐ Yes ☐ No

Quit: ☐ Yes ☐ No If yes, how long? _____

Cessation Classes: ☐ Yes ☐ No ETOH Use: _____ How often: _____ Meetings: _____

ENVIRONMENTAL/SAFETY CONCERNS

Home Safety Evaluation needed? ☐ Yes ☐ No

Comments: _____

Locks on doors: ☐ Yes ☐ No Comments: _____

Clutter/clean: ☐ Yes ☐ No Comments: _____

Smoke detectors present and working: ☐ Yes ☐ No Comments: _____

Neighborhood safety: ☐ Yes ☐ No Comments: _____

Has client had any recent falls in the last 180 days? ☐ Yes ☐ No Comments: _____

_____

Fall consequences: _____

Concerns that pose a safety risk: _____

_____

Animals of concern or evidence of pests: _____

_____

Emergency telephone numbers posted by telephone: _____

_____

Emergency response system in place? ☐ Yes ☐ No Comments: _____

Vendor name: _____

MEDICATIONS

Description	Dose	Frequency	Route	Why taken

Method of preparation: _____

Who administers medications? _____

Allergies: _____

Pharmacy: _____

Is client compliant/following schedule with taking medications? ☐ Yes ☐ No
Comments: _____

TREATMENTS OR SKILLED SERVICES NEEDED

Treatment or Service	Frequency	Provider

SKIN INTEGRITY

☐ Intact ☐ Open ☐ Rash ☐ Incision

Describe/Comments: _____

_____

ELIMINATION

Urinary:

☐ Continent	☐ Incontinent	☐ Ostomy	☐ Dialysis
_____toilet	_____briefs		Type: _____
_____commode	_____texas catheter		Treatment Site:_____
_____bedpan	_____indwelling catheter		Times/Wk: _____
_____urinal	_____intermittent catheterization		

Comments: _____

_____

Bowels:

☐ Continent	☐ Incontinent	☐ Ostomy
_____toilet	_____briefs	
_____commode		
_____bedpan		

Comments: _____

_____

PAIN

Location: _____

Intensity: ☐ verbal ☐ facial Comments: _____

Frequency: _____ Duration: _____

Relieved w/: _____

Outcome: _____

DIABETES

Glucometer: _____ Frequency:_____

B.S. range: _____ Hgb A1C: _____ Checked every_____

Podiatrist: _____

Diabetic shoes: _____Diabetic teaching: _____

LABS

Tests: _____

Location: _____ Frequency_____

IMMUNIZATIONS RECEIVED

☐ Flu vaccine ☐ H1N1 ☐ Pneumovax ☐ Tetanus ☐Other_____

Goals for Client:

1._____

2._____

3._____

Plan of Care for Client: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Nurse Case Manager Date

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NURSING HOME TRANSITION PROJECT (NHTP)
SOCIAL WORKER ASSESSMENT

Date: _____

Referral Type: ☐ HCBS ☐ PC ☐ Habilitative ☐ Preventive
☐ DEA ☐ Assisted Living ☐ Shared Living

DHS Social Worker: _____ Nursing Home: _____
Phone #: _____ Office: _____

Client Name: _____ DOB: _____ SSN: _____
Address: _____ Apt: _____
City/Town: _____ Zip: _____
Home Phone: _____ Cell: _____

Spouse: _____ Caregiver: _____

Primary Contact: _____ DOB: _____ SSN: _____
Address: _____ Apt: _____
City/Town: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____

Recent move to RI: ☐ Yes ☐ No If yes, relocating from: _____

Last permanent address: _____

Legal Guardian/Power of Attorney: _____

Health Insurance: _____ Monthly Premium: _____

Hospitalizations: _____

Admitted to NH: _____Proposed Discharge Date: _____

Is applicant receiving VA Services and/or income? ☐ Yes ☐ No Burial contract: ☐ Yes ☐ No Life Insurance: ☐ Yes ☐ No

Cash value $_____

Do you/spouse own property, condo, mobile home, timeshare? ☐ Yes ☐ No Equity Value $_____

Address _____

Life Estate: ☐ Yes ☐ No Rental Property: ☐ Yes ☐ No

What is the cost of your monthly rent $_____ Mortgage payment $_____

What is your avg monthly cost for: electric $_____ gas $_____ water $_____

Property Taxes $_____ Homeowners Insurance $_____ How many vehicles do you own? _____

Have you/spouse given away, sold, deeded or transferred anything of value in the past 60 mos? ☐ Yes ☐ No

If yes, please explain: _____

Any other resources not mentioned above _____

Applicant Monthly Gross Income

RSDI $_____	UNEMP $_____	OTHER $_____
VA $_____	ALIMONY $_____	TDI $_____
SSI $_____	RENTAL $_____	
SSDI $_____	CH SUPP $_____	

Assets

CASH $_____	CHKG $_____	SVGS $_____
STOCKS/BONDS $_____	CD'S $_____	IRA'S $_____

Spouse Monthly Gross Income

RSDI $_____	UNEMP $_____	OTHER $_____
VA $_____	ALIMONY $_____	TDI $_____
SSI $_____	RENTAL $_____	
SSDI $_____	CH SUPP $_____	

Assets

CASH $_____	CHKG $_____	SVGS $_____
STOCKS/BONDS $_____	CD'S $_____	IRA'S $_____

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Conditions for Failed Placement Recommendations to DHS (10/27/09)

- The time limit for a failed placement should be up to six months.
- Manifestations of Transfer Trauma: a worsening of the client's medical condition or symptoms after the transition that could be attributable to the transition. This could be due to the transfer itself or to the change in environment, including caretaker issues. The DHS policy should frame this as a rebuttable assumption in favor of the client.
- A lessening of the client's ability or perceived ability to live in the new setting might include such manifestations as anxiety, depression, lack of appetite, medication refusal, lessening mobility, frequent falls, sleep disturbance, incontinence and personality changes. These symptoms, along with other criteria, could be termed "failure to adjust"
- Another reason that could constitute a failed placement is a failure of the service plan, including inadequate service hours, service unavailability, inadequate or inappropriate housing, loss of housing, poor quality services and unanticipated changes in caretaker involvement or family support.
- A transition that was made in the absence of adequate documentation, including medical and psycho-social issues, should be allowed a failed placement designation. Clients, family, and other appropriate representatives must be provided with adequate information to make a responsible choice, and failure to provide that information should be reason to assert a failed placement. The burden of proof should be on the state agency to show that full and accurate information was provided to the client and/or the representative of the client and that transition orientation, preparation and training was adequate for both client and family members.