Santa Clara Family Health Plan™

Best practices for safe care transitions

Reprinted from live class given in August 2019

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About this presentation

In August 2019, this course was originally presented at Santa Clara Family Health Plan (SCFHP) with invited guests, including social workers, case managers, and discharge planners. It was posted on our website to share with our providers.

Please note that each community resource mentioned herein has its own criteria for enrollment, therefore decisions are determined by the organization providing the resource.

Ensuring safe discharges

Goals for today

- Identify and share best practices for safe discharges from skilled nursing facilities (SNF)
- Reach a shared understanding of partners and roles

SCFHP's role in long-term care (LTC) transitions

- Coordinated care

Who are the partners?

- Resident/member
- Family or caregiver(s)
- Providers: medical, behavioral health, Durable medical equipment (DME) home health, long-term services and support (LTSS), housing
- SCFHP Case Managers and utilization staff
- Santa Clara County Whole Person Care Program & Institute on Aging (IOA)
- Silicon Valley Independent Living Center (SVILC)
- LTC Ombudsman
- California Department of Public Health (CDPH)

Common post-discharge needs

- LTSS: In-home supportive services (IHSS), community-based adult services (CBAS), multipurpose senior services program (MSSP)
  - Visit SCFHP's LTSS webpage for information & training on MLTSS: https://www.scfhp.com/for-providers/LTSS/
- Transportation
- Pharmacy: Supply of medication for transition (e.g., 30-day supply).
- Durable medical equipment (DME): Walkers, incontinent and enteral supplies, etc.
- Home Health Agency (HHA): If having issues with finding a provider, you can submit a prior authorization request to SCFHP. Email mltsshelpdesk@scfhp.com for assistance with urgent requests.
- Other post-discharge needs:
  - Follow-up transition of care (TOC) calls for member and caregiver.
  - Referral for ongoing case management.
  - Other community resources – food access, caregiver support, etc.
  - Use the SCFHP Find a doctor tool or the SCFHP provider directories to find a provider:
    - Medi-Cal Provider Directory
    - Cal MediConnect Provider Directory

Resource sharing

COVID-19 resources:

- COVID-19 information for SCFHP providers
- COVID-19 information for SCFHP members

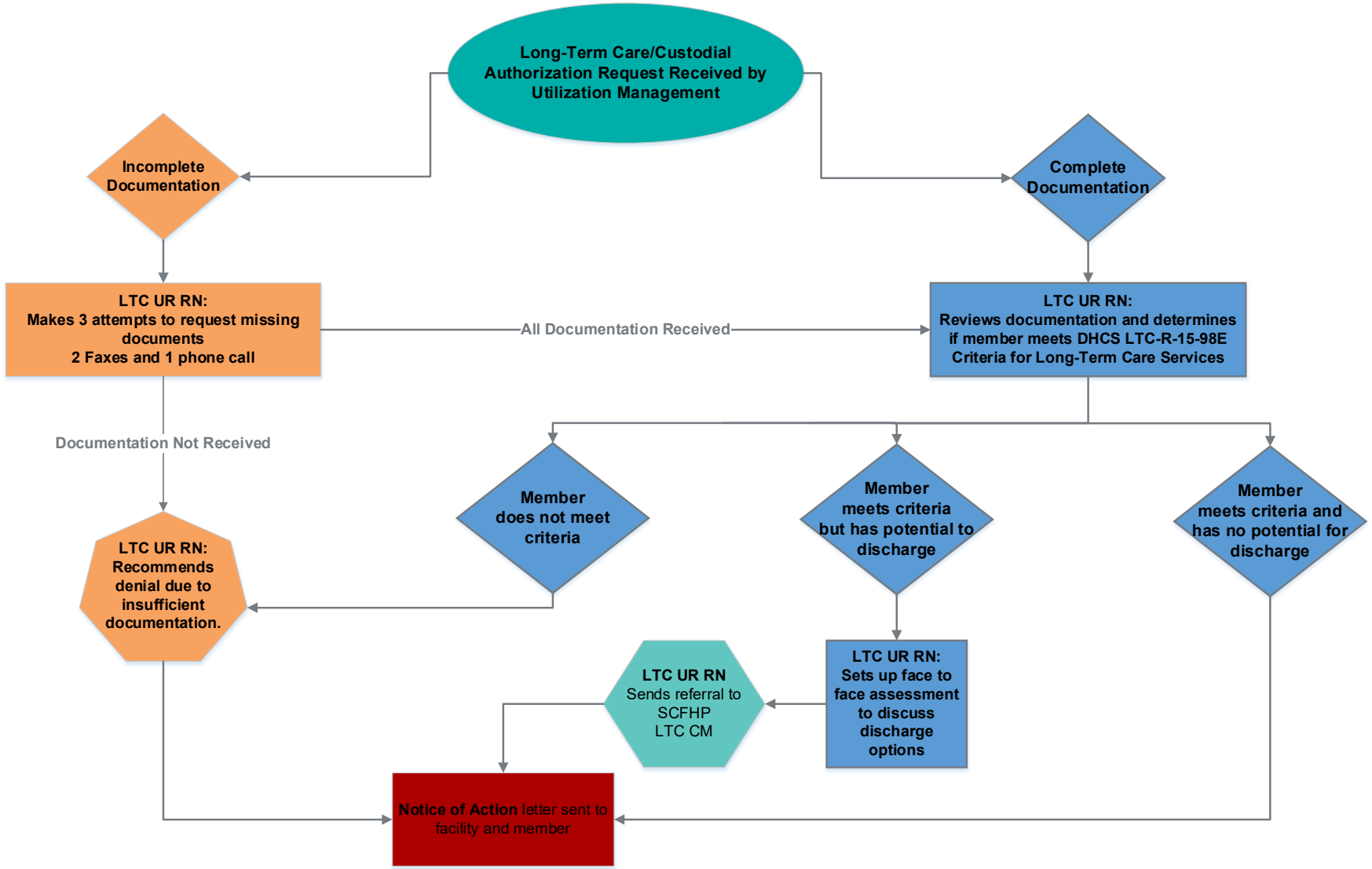
LTSS resources:

- Interdisciplinary care team (ICT) training
- Managed long-term services and supports (MLTSS) training
- INTERACT tools for skilled nursing facilities

Handouts:

- Long-Term Care Discharge Notification Form
- Contracted DME and Medical Vendor List
- SCFHP Nursing Home Pre-Discharge Checklist
- Referral Forms

SCFHP Long-Term Care Authorization Process Workflow



LTC member utilization management

LTC authorizations

- Required documentation:
  - Face sheet
  - Physician's orders with signature
  - Current care plan
  - Progress notes
- Approval or denial is based on established criteria per DHCS LTC-R-15-98E, and review of both medical and psychosocial needs; potential for transition.
- Authorization may be for one (1) year or six (6) months.
- Other factors reviewed:
  - Age
  - Diagnosis
  - Progress of treatment
  - Psychosocial situation
  - Income available
  - Housing status and need for housing
  - Informal support available – need for home or community based services or LTSS benefits

Examples of LTC approvals

6 months	1 year	2-3 months
80 year old – Activities of daily living (**ADLs) with extensive need**	80 year old – **ADLs with extensive need**	50 year old** - **ADLs with extensive need**
Muscle weakness and dementia, stable housing	Muscle weakness and dementia, Type 1 diabetes and homeless	Muscle weakness, Type 2 diabetes, and homeless
• Has family support (daughter) • Family is willing to enroll in CBAS • MD ordered Home Health • Daughter will provide IHSS	Member has no family support and is chronically homeless.	ADLs changed to limited-assist with capability for medication management training but remaining discharge barrier is homelessness.
Community discharge – feasible with family support and appropriate services • Utilization Management RN will call SNF Social Worker for assistance with transitioning member back to the community.	**Community discharge <u>not</u> feasible** due to member's age, no family support, homelessness, and need for 24 hour nursing care.	**Community discharge – feasible** • **Member initially approved for 1 year, but ADL needs changed. Registered Nurse (RN) conducted face-to-face visit and identified member for transition. Referrals to case management, housing placement, LTSS benefits (e.g. SCFHP, IOA or SVILC) • RN recommended last-covered-day (LCD) for determination by Medical Director. • **Best practice: 2-3 month lead time given for planning to ensure a safe discharge and continued care in the community, post-discharge**.

Discharges and transfers

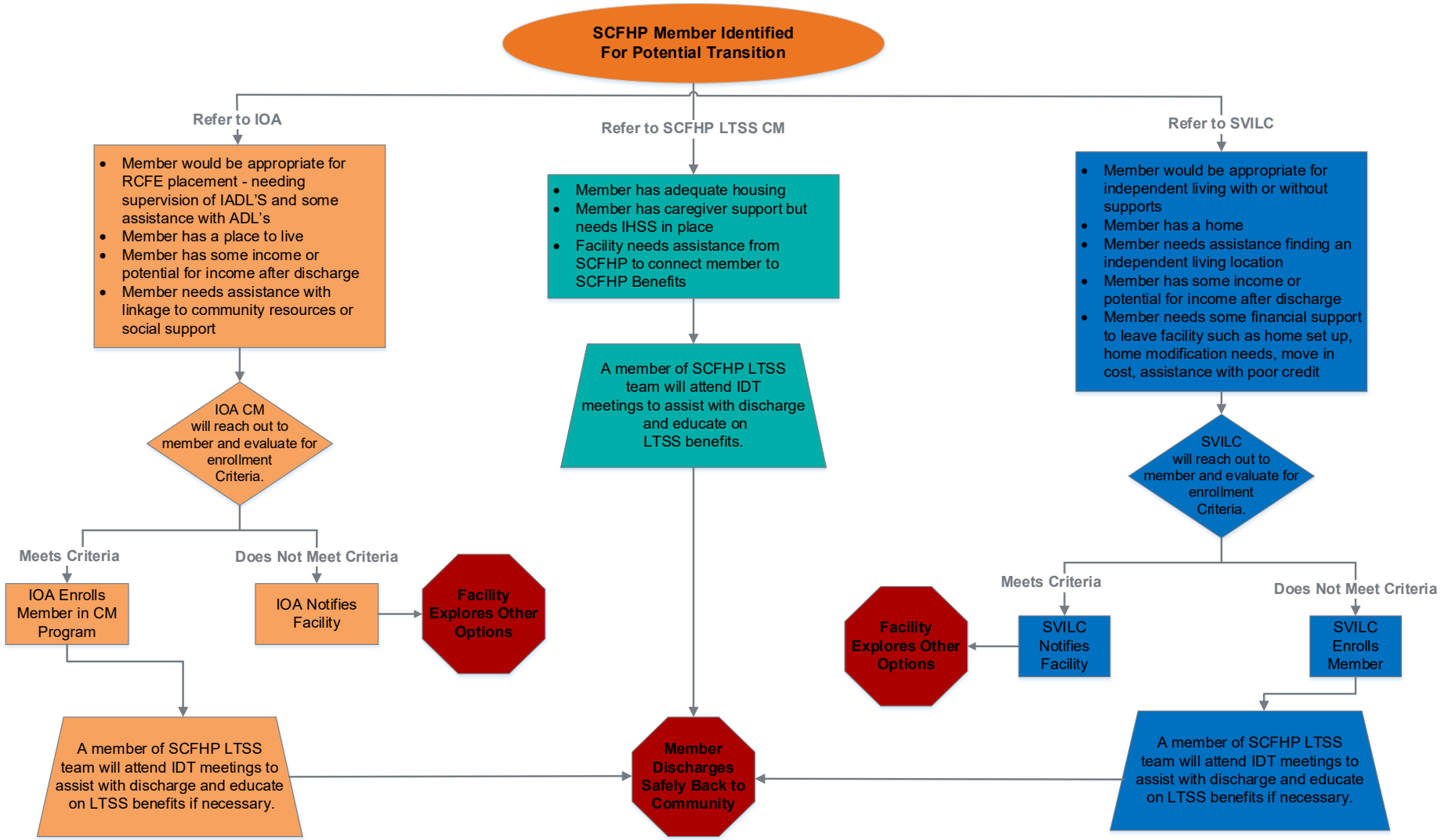
- The facility must permit each resident to remain in the facility, and not transfer or discharge the resident unless the regulatory requirements are met. This includes:
    - Documentation
    - Written notice to a member, and the exceptions to a 30-day notice
    - Appealing a transfer or discharge
    - Readmission to a nursing facility after a hospital stay
    - Converting to Medi-Cal
    - Evicting residents after Medicare coverage ends
- Every bed in a Medicare certified SNF is certified, so a facility's claim that it does not have available Medicare or "long-term care" beds is non-factual.

Resources supporting care transitions

County resources

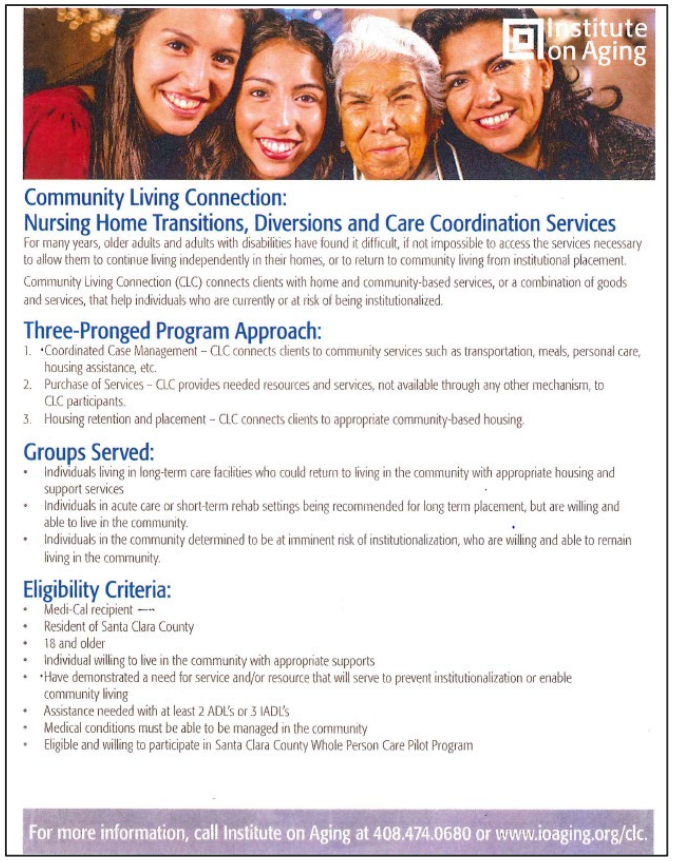
- Institute on Aging (IOA)
- SCFHP Case Management Program
- Silicon Valley Independent Living Center (SVLIC)

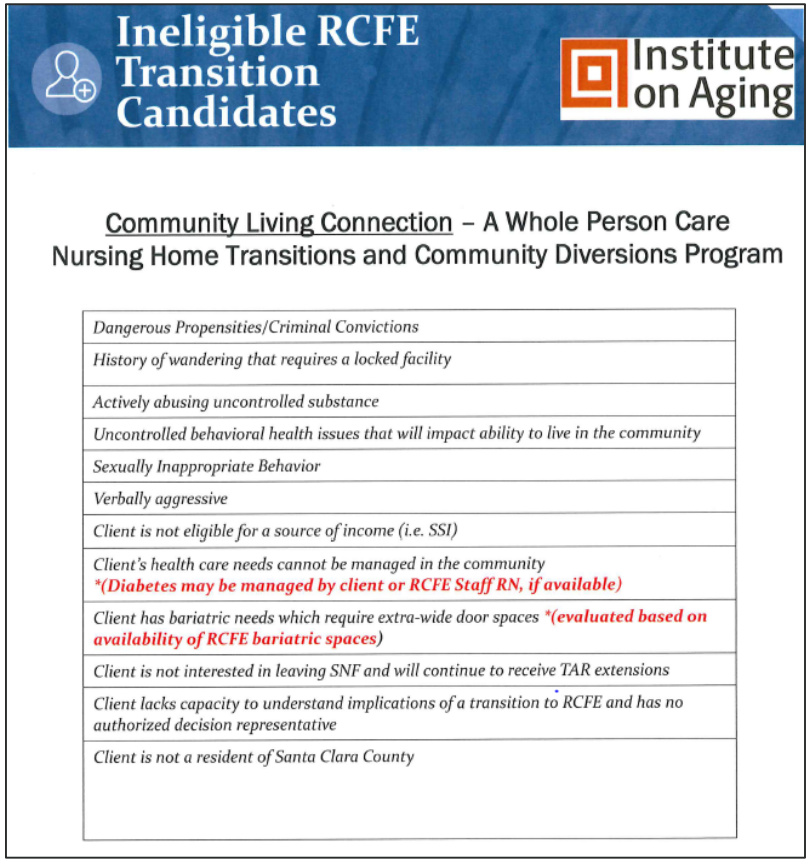
Discharge Case Management Referral Workflow



Institute On Aging (IOA) - Whole person care

See the **Discharge Case Management Referral Workflow** for best practice and referral timelines. Please note that some resources (such as IOA) may not be available or accessible due to the COVID-19 situation.





Silicon Valley Independent Living Center (SVILC)

Please use new referral form to refer for CTP program (handout). See **Discharge Case Management Referral Workflow** for best practice and referral timelines. Please note that some resources (such as SVILC) may not be available or accessible due to the COVID-19 situation.

Alive with Pride!

At the core of Silicon Valley Independent Living Center's (SVILC) organizational values is positive disability identity, culture and pride. This pride is transformative in the belief that disability is a natural and beautiful part of human diversity that should be celebrated. People with disabilities are not to be pitied, fixed or cured.

This strong sense of pride is supported by additional SVILC values that commit to:

- Transforming ourselves and each other
- Equal access
- Equality and social justice
- Self-determination and advocacy
- Interdependence and commUnity
- Inclusion and diversity

Disability Justice

Since it began in the 1960s, the disability rights movement's quest for civil and human rights continues to today. In recent years, however, another dimension of this struggle has emerged: disability justice. At its essence disability justice is the examination and acknowledgment that other identifiers such as class, race, sexuality, gender and age have an element of oppressive power, even from within the disability community. To this end, SVILC is committed to advocating not just for people with disabilities, but also for the human rights and social justice of all people.

Diverse Needs

On average, over 80 percent of SVILC community members use more than one service. In order to meet their multiple needs, the SVILC offices in San Jose and Gilroy offer "one-stop" access to a variety of programs and services. With choices ranging from independent living skills training (which includes access to technology), to housing referral and placement, SVILC's services are providing real solutions and improving the lives of people with disabilities in Santa Clara County. Additionally, with its presence in the South Bay Area for more than 30 years, the SVILC staff has built relationships with county, state and other non-profit community based organizations, furthering community members' access to resources crucial to their independent living needs.

How to Apply

Anyone who lives in Santa Clara County and has a disability may apply for SVILC services. Individuals must self-initiate the request for services; those unable to do so may request services through a chosen representative. An intake appointment will then be scheduled, where individuals will learn about the services and opportunities available at SVILC. The staff works with each person to create an Independent Living Program (ILP) that meets his/her personal needs and goals.

In Their Own Words

"Words cannot express my gratitude for your assistance in helping me get an electric wheelchair lift so I can enter and exit my home. Thank you for making seniors and the disabled be able to stay in their homes." – Kay B.

Services

For People with Disabilities and Their Allies

- Accessible computer lab
- Personal Assistant Services (interviewing, hiring and managing a personal assistant)
- Independent Living Skills Training (basic living skills, cooking, budgeting and exercise)
- Advocacy
- Peer support
- Guidance for home modifications
- Housing referral and placement
- Transition from nursing home or institution into the community
- Loan assistive technology devices from AT library
- Information and referral
- Benefits counseling
- Youth Leadership Training

For Community Organizations, Business and Government Agencies

- Disability and Diversity Awareness Training
- Complying with ADA Standards
- Accessibility Surveys
- Educational and Disability Culture Workshops
- Housing Awareness Training

Contact the SVILC offices for details on the services listed above.

Community Transition Program (CTP)

Many people feel overwhelmed in a nursing home for a number of months or years want to leave, but feel overwhelmed at the thought of moving out into their own place. SVILC's Community Transition Program (CTP) is designed to assist individuals who reside in a healthcare facility and have expressed a desire to move back into their community. CTP Care Coordinators work with seniors and persons with disabilities to develop a comprehensive plan to facilitate tailored transition services for moving into a community living setting.

CTP Staff are highly skilled professionals with expertise in delivering holistic, peer-based, wrap-around services:

- Independent Living and Health Planning;
- Care Transition and Community Living Services for those Long Term Care (LTC) facility residents choosing to live in the community;
- Options Counseling and Community Living Services;
- Crucial ancillary core Independent Living Services, including: Peer Support, Personal Care Attendant (PCA) Management, Assistive Technology, Life Skills Training, Housing Search and Home Set-up, and Self-Advocacy Training.

What to Expect after You Enroll

- Assist you with talking about CTP services with your healthcare team, family members and/or other service providers.
- Plan and coordinate with your return to a room, apartment, or house in the community.
- Work with you to find and manage accessible, affordable, and integrated housing, transportation, and other community supports.

- Explore needed services and supports, such as home and vehicle adaptations, home set up, assistive devices, self-care, healthcare and nursing visits, and how to hire and manage a personal care attendant.

Benefits You May Qualify

Non-Elderly Disabled (NED) Housing Voucher Program through a partnership with Housing Authority, CTP assists people with disabilities, who are between the ages of 18 and 61, with applying to receive a subsidized Section 8 Housing Choice Voucher (HCV) to support them in their housing search while transitioning from an institution into the community.

Federal Transition Funding through the CA Department of Rehabilitation may assist qualified institutionalized participants with one-time transition funding to cover first month's rent and utilities; moving expenses; household and personal items; short-term personal care services; and assistive technology devices.

Long-term Services and Supports (LTSS) through Cal Medi-Connect: Santa Clara Family Health Plan and Anthem Blue Cross provide Medi-Cal/Medicare enrollees with a range of home and community-based services that support people living independently in the community.

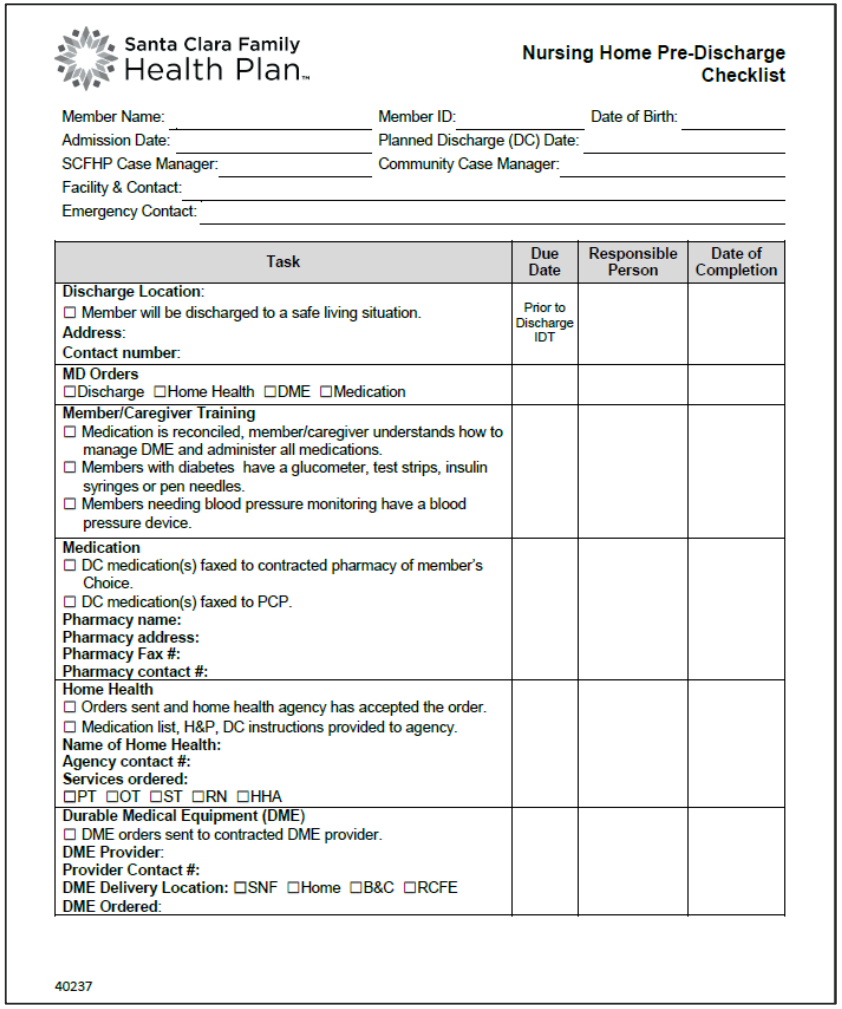
How do I Qualify and Apply?

Eligibility requirements depend upon individual's income level, the contracting health plans, and available CTP support funding. SVILC's Transition Services are also available on a private pay basis.

For more information, please call SVILC at 408-894-9041, ext. 201.

Click on the flyers to open them

SCFHP pre-discharge checklist



Santa Clara Family Health Plan

Nursing Home Pre-Discharge Checklist

Member Name: _____ Member ID: _____ Date of Birth: _____
Admission Date: _____ Planned Discharge (DC) Date: _____
SCFHP Case Manager: _____ Community Case Manager: _____
Facility & Contact: _____
Emergency Contact: _____

Task	Due Date	Responsible Person	Date of Completion
Discharge Location: ☐ Member will be discharged to a safe living situation. **Address**: **Contact number**:	Prior to Discharge IDT		
MD Orders ☐Discharge ☐Home Health ☐DME ☐Medication			
Member/Caregiver Training ☐ Medication is reconciled, member/caregiver understands how to manage DME and administer all medications. ☐ Members with diabetes have a glucometer, test strips, insulin syringes or pen needles. ☐ Members needing blood pressure monitoring have a blood pressure device.			
Medication ☐ DC medication(s) faxed to contracted pharmacy of member's Choice. ☐ DC medication(s) faxed to PCP. **Pharmacy name:** **Pharmacy address:** **Pharmacy Fax #:** **Pharmacy contact #:**			
Home Health ☐ Orders sent and home health agency has accepted the order. ☐ Medication list, H&P, DC instructions provided to agency. **Name of Home Health:** **Agency contact #:** **Services ordered:** ☐PT ☐OT ☐ST ☐RN ☐HHA			
Durable Medical Equipment (DME) ☐ DME orders sent to contracted DME provider. **DME Provider**: **Provider Contact #:** **DME Delivery Location:** ☐SNF ☐Home ☐B&C ☐RCFE **DME Ordered**:			

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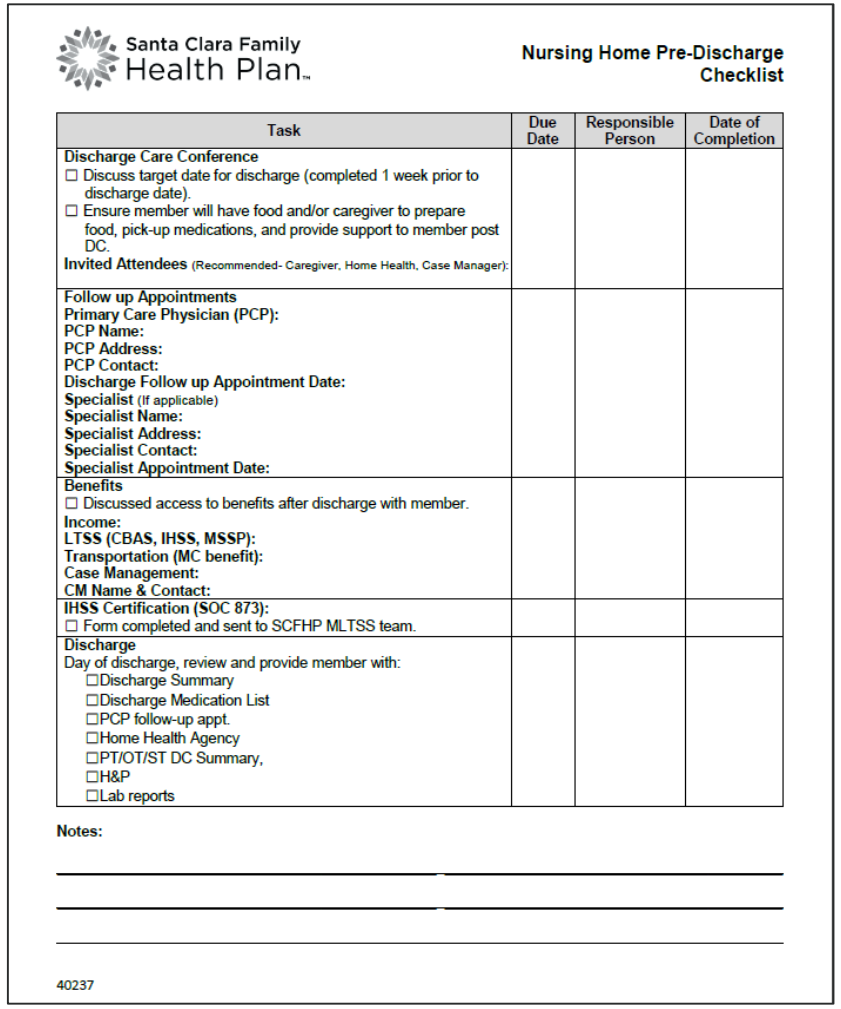

Santa Clara Family Health Plan

Nursing Home Pre-Discharge Checklist

Task	Due Date	Responsible Person	Date of Completion
Discharge Care Conference ☐ Discuss target date for discharge (completed 1 week prior to discharge date). ☐ Ensure member will have food and/or caregiver to prepare food, pick-up medications, and provide support to member post DC. **Invited Attendees** (Recommended- Caregiver, Home Health, Case Manager):			
Follow up Appointments **Primary Care Physician (PCP):** **PCP Name:** **PCP Address:** **PCP Contact:** **Discharge Follow up Appointment Date:** **Specialist** (If applicable) **Specialist Name:** **Specialist Address:** **Specialist Contact:** **Specialist Appointment Date:**			
Benefits ☐ Discussed access to benefits after discharge with member. **Income:** **LTSS (CBAS, IHSS, MSSP):** **Transportation (MC benefit):** **Case Management:** **CM Name & Contact:**			
IHSS Certification (SOC 873): ☐ Form completed and sent to SCFHP MLTSS team.			
Discharge Day of discharge, review and provide member with: ☐Discharge Summary ☐Discharge Medication List ☐PCP follow-up appt. ☐Home Health Agency ☐PT/OT/ST DC Summary, ☐H&P ☐Lab reports			

Notes:

_____

_____

_____

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Click on the form to open it

Special circumstances

- IHSS access: Timing and SCFHP support
- Out of area (OOA) placements
- Homelessness
  - Requirements for safe discharge
  - Housing resources and community placement agencies
  - Unsafe practices
  - Obtaining benefits to support housing costs – Supplemental Security Income (SSI)

Homelessness and homes/shelter

Resources and sustainable options

- Talk about possible **red-flags**
- Be aware that *bad* vendors or agencies exist in our community
- Discharge to shelter
- Safe discharge
- Working with placement agencies
- SSI increase – community referrals to SLVIC and IOA

SCFHP is committed to quality

SCFHP's quality, training, and outreach includes:

- Quality measures
- Medication reconciliation
- Training
- Provider outreach
- Potential quality issues (PQI)
- Site visits
- Preventing re-admissions
- Sharing best practices (INTERACT)

Quality improvement

About PQI

- A potential quality issue (PQI) is found when the care given to a member is suspected to be different from professionally recognized standards of performance.
- The PQI may be observed and reported, or a documented clinical event or trend found by a member, physician or SCFHP staff member.
- SCFHP reviews medical records, interviews staff, and investigates as needed to address potential PQI. Documentation of findings is submitted to SCFHP's Quality Improvement Department for review.
- Please reply promptly if SCFHP requests additional information on a PQI. Not every PQI is found to be substantiated as an actual quality of care issue.

Case Study #1 - PQI investigation

(Satisfactory outcome)

Situation: During a transition of care (TOC) call, the member stated he **was forced to discharge** because he did not pay his required share of cost (SOC).

Background: The member was advised by SNF staff (in English and Spanish) that he could stay at the facility, but had to pay SOC.

Assessment: The member wanted to discharge against medical advice (AMA). Social Services encouraged the member to remain at SNF until a discharge order could be obtained. Social Services explained the risks of AMA.

Recommendation: A discharge order was obtained, and the remaining supply of medications were given. An order for HH, physical therapy (PT)/occupational therapy (OT)/RN was also obtained. Member was discharged to their home.

Case Study #2 – PQI investigation

(Unsatisfactory outcome)

S: Face to face visit with member who was discharged to an unlicensed Board and Care. Member readmitted to acute setting one (1) day post discharge. Admitting Diagnosis (DX) to acute setting and reason for PQI: **status post fall** with inability to ambulate, right knee pain 8/10, **urinary tract infection, sepsis**.

B: Members baseline DX: bradycardia, muscle weakness, major depressive disorder, obstructive sleep apnea, shortness of breath, morbid obesity, hypothyroidism, hyperlipidemia, other specified bacterial agents as the cause of diseases classified elsewhere, personal history of mental health and behavioral disorders, bipolar disorder, current episode depressed, psychotic disorder, systolic congestive heart failure, borderline personality disorder, PTSD, anxiety disorder, unspecified heart failure, suicidal ideations.

Case study #2 continues on the next slide →

Case Study #2 – PQI investigation *continued*

(Unsatisfactory outcome)

A: Member is currently discharged from acute setting and readmitted to another SNF. Member is 39 year old female, alert and oriented x 4 (person, place, time, and situation). Prior level of functioning is ambulatory with front wheel walker. Supervision needed for activities of daily living (ADL). Review of discharge summary, nurse's notes, PT/OT discharge recommendations: No front wheel walker was provided or ordered. The member states that she did not have a front wheel walker at the board and care. A Home Health (HH) referral is recommended, no HH referral made, no follow-up primary care provider (PCP) appt. was made, no follow-up behavioral health (BH) appt. was made with mental health provider. Review of DC summary and pharmacy claims data an adequate supply (14 day) of psychotropic medication (Latuda) was provided to the member. A transition prescription for Latuda was not provided to member. Discharge summary does not indicate that member has or was provided with a CPAP. Review of laboratory data collected 5/20/19 indicated member had episode of **elevated white blood cells (WBC) 13.2**, nurses note on 5/21/19 at 09:50 indicate the "labs were reported to the attending MD via phone call, no answer, left message and faxed. Will follow up for any new order". There is **no further indication of follow up or new MD order for elevated WBC lab data. No "change of condition**" was completed for altered lab values. **Nurse's notes do not reflect there are no signs and symptoms of infection.**

Case study #2 continues on the next slide →

Case Study #2 – PQI investigation *continued*

(Unsatisfactory outcome)

R: Reassured member that SCFHP wants to ensure she gets the care she needs. **Referred to PQI for evaluation**. SCFHP's LTSS team to follow for transition back to community when able. **Member is followed by community partners IOA and SVILC**.

What contributes to a PQI?

- Preventable re-admission
- No Home Health
- No durable medical equipment (DME)
- No medications or not enough medications
- No family or caregiver involvement
- No discharge interdisciplinary team (IDT) meeting held
- No follow-up appointment scheduled with PCP or specialist
- No medication reconciliation
- Inadequate member education

Reflection and discussion

- Can a member leave the SNF against medical advice (AMA)?
  - **What is your AMA procedure**?
- How do SNFs ensure **member's understanding** of what was explained?
- How did **Social Services** advocate for this member?
- What type of **documentation** will SCFHP look at when evaluating a PQI?
- How important is the SNF **documentation** of events or situations?
- What are the patient rights?

Wrap up, next steps, question and answers

Reflections

- What did you learn or were reminded of?
- Any new opportunities?
- How can we improve partnerships for safe discharges?
- What can we do to improve the discharge process?
  - SCFHP and SNFs

Questions?

- https://www.scfhp.com/for-providers/ltss/
- mltsshelpdesk@scfhp.com

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