

Nursing Home to Community Program: A Discharge Planning Manual

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Broome County Community Alternative Systems Agency*

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Manual's Purpose

The purpose of the Manual is to orient the long term care providers in Broome County to the nursing home discharge process by defining the roles of the key partners who are involved in returning residents to community living and to document a standard protocol for accessing and maximizing partner resources. Veteran Broome County skilled nursing facility staff may also find the Manual a useful reference tool for assisting residents with navigating the county's long term care system.

How the Manual is Organized

- The first section titled, Discharge Planning, is the work of the Discharge Planning Workgroup convened by the NYS DOH and OFA in 2004. The workgroup developed the guidelines as a “best practice” model targeted at hospital discharge planners; however, the information lends itself to any institutional setting and is provided here as a general reference to what people seeking discharge and those assisting them should consider when developing post discharge care plans. This information can also be accessed on the web at:
http://www.health.state.ny.us/professionals/patients/discharge_planning/index.htm
- Sections two and three describe the Nursing Home to Community Program in Broome County, N.Y. This program started in 1996. The Manual outlines the policies and procedures of the primary partners in the Nursing Home to Community Program: the skilled nursing facility resident (and their family), the staff of the skilled nursing facility, Broome County Community Alternative Systems Agency (CASA) and the Southern Tier Independence Center (STIC).
- Sections four and five outline programs and services available in the community as well as sources of payment for residents and care planners to consider.
- Section six includes frequently asked questions.
- Appendixes A and B describe in more detail the work of CASA and STIC.
- This Manual is in a three-ring binder so that each skilled nursing facility can customize the Manual to reflect their facility mission statement and other policies and procedures unique to the facility. The last section has a cover sheet with a checklist that reflects the type of information you might want to add to this section.
- In time, should other partners join the process, community resources are updated, or a partner has an addition to the current policies and procedures, these changes can easily be inserted into the Manual.
- This Manual was developed specifically as a tool for skilled nursing discharge planners and other community partners involved in the Nursing Home to Community Program.
- Where it made sense to do so, we refer to the people being served by the program as “residents” as that is how they are referred to in the aggregate by the skilled nursing facility staff. Terminology in regard to the people served in the Discharge Planning (NYS DOH) section and the material in the appendix provided by STIC are at the discretion of those who originated the materials.

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Discharge Planning Tools

Introduction

In June of 2004, the State Department of Health and Office for the Aging convened a Discharge Planning Workgroup as a result of recommendations from the Most Integrated Setting Coordinating Council. Representatives from providers, professional associations, local government and consumer advocates met in Albany on five occasions to develop, from their perspective, tools for discharge planners and consumers addressing three issues:

- ▶ Safety
- ▶ Discharge Planner Education
- ▶ Consumer Education.

The tools developed reflect the expertise and “best practice” experience of Workgroup participants and are being shared to assist with discharge planner and consumer education. They should not be considered exhaustive since it is recognized that many in the community will have additional ideas which can contribute to facilitating an individual’s return to the community.

Workgroup participants developed the following tools which we hope will be helpful to discharge planners and consumers:

1. Consumer Guide to Discharge Planning, including “What Consumers and their Families Need to Know Before Being Discharged to Home Care” and “What Consumers Need to Know about their Abilities and Responsibilities”
2. What the Discharge Planner Needs to Know to Effect a Safe and Efficient Transition
3. Safety Considerations, including “Safety Concerns that Impact an Individual Wishing to Live in the Community” and “Key Elements For Effective and Safe Discharge Planning to Facilitate an Individual’s Right to Chose”
4. One model for Transitional Care Planning (including Initial Discharge Screen, High-Risk Screening Criteria, Comprehensive Assessment and Screening Assessment Flow Chart).”

The exact text for pages 2 - 11 can be found on the New York State Department of Health Website at: http://www.health.state.ny.us/professionals/patients/discharge_planning/index.htm

Consumer Information Guide to Discharge Planning

What Consumers and Their Families Need to Know Before Being Discharged to Home Care

You have the right and responsibility to be involved in your plan of care. To the greatest extent possible, consumers should be active participants in developing that plan. Below are questions to help you and your family with your discharge and future health needs.

- Do you have your insurance cards or other documents?
- Do you and your family feel that your current medical and mental health status is stable enough to be discharged to home care?
- Do you have family or other people at home to assist you at home?
- If not, are you comfortable taking care of yourself as needed?
- Do you need people to take care of you?
- Do you know how you and your family will be paying for your care? Do you think you are eligible for Medicare and/or Medicaid? Do you have private insurance or will you and/or your family be paying for your care?
- Are you and/or your family comfortable that you and/or they can make important decisions about your health care needs? Do you and/or your family feel it is necessary to consult a professional about your decision making status?
- Do you feel comfortable that you and/or your family understand your physician's expectations about your health status and decision to be cared for at home?
- What are your expectations/goals for your immediate and short term health care needs?
- What are your expectations for your long term care?
- What are the expectations/goals of your family and/or other informal supports assisting you in your care?
- What services did you have prior to admission?
- Do you know the name of the agency or facility that provided those services?
- Do you expect that those services will be provided at the same level of service? Will that be sufficient or is an increase in hours needed? Is your provider willing to reinstate services? If not, why?
- Do you know how to access services?
- Does your primary care physician or person on your medical team need to be contacted? Do you know which physician will be responsible for overseeing your care at home?
- Do you and/or your family feel that your home is adequately equipped for you to be cared for at home?

What Consumers Need to Know About Their Abilities and Responsibilities

- For consumers with newly acquired disabilities, the consumer needs to understand his/her condition from both a medical perspective and what it will mean to live with a disability. Physicians should discuss with the consumer physical changes, probable care needs, possible complications and other things to watch for related to the disability. Peer support should be offered to each consumer. Peer support is available through the local Independent Living Center, as well as various disability specific support groups.
- Consumers should know their right to receive services in the most integrated setting and who to contact if they feel that right is not being fulfilled.
- The consumer needs to have a firm understanding of what assistance he/she will need or want and how to best benefit from the available assistance.
- The consumer needs to understand what services and supports are available to meet his/her needs and desires. The discharge planner needs to know what services are available to meet the needs and desires of the consumer and the eligibility requirements of available services and supports.
- At long-term planning, consumers should be given information on what services or supports are available, and contact information for assistance and advocacy, should their needs change.
- The consumer and discharge planner must have a clear understanding of the role of any informal supports. The consumer and discharge planner should candidly explain this role to the informal supports in order to ensure that they understand their role. If informal supports have agreed to be part of the Discharge Plan, the consumer and discharge planner must ensure that the informal supports understand what will happen if they do not fulfill their role.
- Consumers need to understand what types of services and supports their medical insurance will cover and for what public benefits they may be eligible. Discharge planners should be familiar with basic guidelines for Medicare and Medicaid coverage, and refer consumers to the appropriate person or entity that can explain specific coverage benefits and limitations.
- Consumers should have a firm understanding of their rights to appeal adverse decisions.

What the Discharge Planner Needs to Know in Order to Effect a Safe and Efficient Transition

- ☑ Baseline information about the individual¹ such as their: current medical, psychological and mental health status, family and community support systems, payor source, financial status, decision making capacity (proxies, Do Not Resuscitate, Power of Attorney, Guardianship), religious preference, legal issues, Adult Protective Services involvement, environmental limitations, etc.
- ☑ Does the individual have a community medical provider?
- ☑ Would they like assistance in finding one?
- ☑ What are the medical team's expectations regarding length of stay?
- ☑ What are the individual's expectations/goals in terms of their long term plan and short term or immediate plan?
- ☑ What are the expectations/goals of the informal supports assisting the individual?
- ☑ What services did the patient have prior to admission/will same level of service be sufficient or is an increase in hours needed? Is provider willing to reinstate services? If not, why?
- ☑ Are there any reimbursement restrictions or limitations of service providers involved with delivering services to the individual?
- ☑ Who will be the medical provider responsible at home and what is the means of communication between providers from the hospital to the home setting? (In certain situations a medical provider other than a physician will be responsible. Please note that the rules vary regarding whether a non-physician such as a nurse practitioner who is able to sign orders for clinical purposes may do so for payment purposes).
- ☑ Who or what entity has overall responsibility for checking the facts?
- ☑ Are there any parameters or limitations affecting the patient's right to choose?
- ☑ What constitutes "non-compliance" by the individual living at home, and how is that communicated to the home care provider (which may be a home care agency or a community services provider).
- ☑ Can the non-compliance be addressed:
 1. Can it be fixed?
 2. Is there history of behavior that affects the individual's health and puts them at risk of imminent danger?
 3. Does patient have capacity?
 4. How serious is the risk?
 5. Are staff at risk/threatened?
 6. Is caregiver non-compliance/abandonment a factor?
 7. Is the back up plan realistic?
 8. Is there adequate care being provided?
 9. Is compliance linked to reimbursement?

¹ We have chosen to use the term "individual" to refer to the user of healthcare services. This includes the individual in the community, the patient in the hospital or the resident in a skilled nursing facility.

- Who or what entity should be notified should the home care entity determine that services cannot be delivered safely?
- What is the range of available resources to the discharge planner to meet an individual's need?
- Does the discharge planner know how to research the requirements for the various programs in their community?
- What are the environmental limitations of the individual's residence and can the residence support the plan?

For example:

1. Is there 220 wiring to support any special equipment needs?
2. Is there clean adequate water?
3. Is the home clean and free from germs?
4. Is the home debris free sufficient to prevent accident hazards in elderly and individuals with disabilities (for example a throw rug may not pose an accident risk for most people, but may for someone with an unsteady gait)?
5. Does the home provide adequate access for an individual with disabilities or does the home require modifications?

Discharge Planning Safety Considerations

Safety Concerns that Impact an Individual Wishing to Live in the Community

Individual Capacity Issues

- Competence and decision making capacity of the person
- Ability of the person to self-direct
- Non-compliance
- Balance – frequent falling
- Memory impairment
- Self-medication
- Sensory deficits
- Unstable clinical condition
- Mental health concerns
- Lack of education e.g. affecting ability to read instructions

Environmental Issues

- Unsafe housing
- Lives alone
- Lack of support
- Lack of understanding of individual's situation
- Homelessness, housing availability and accessibility

Provision of Service Issues

- Geographic location
- Availability of services as a factor in determining discharge potential
- Lack of transportation
- Lack of equipment and supplies at home
- Drug and alcohol abuse
- Criminal activity
- Costs of services and perceptions of costs
- Funding constraints and inadequate financial resources.
- Insurance coverage (individual's assumption of risk may affect scope of coverage)
- Potential abuse in home
- Inappropriate use of resources
- Fear of raising issues/concerns earlier
- Language/cultural barriers
- Refusal to accept services
- Definition of safety
- Medical perspective of safety needs
- Perception - actual liability concerns
- Interpretation of standards/regulations
- Fear of litigation
- Safety of aides – have aides been exposed to criminal behavior or sexual harassment while on the job in this person's home in the past?
- Lack of coordination between discharge planner and home care agency concerning acceptance/capacity
- Consideration of the facts of a “difficult patient's” care before determining Home Care Agency's compliance with regulation

Key Elements for Effective and Safe Discharge Planning to Facilitate An Individual's Right to Choose

Policy Elements

- Clear policies and protocols for managing and directing the practice of discharge planning
- High risk identification process that functions as a problem solving forum and resource coordination manager supported by the highest level of administration that engages all the players (e.g. Case Management, Social Worker, Administration, Legal, Risk Management, ethics, business, Chaplain, financial, external agencies)
- Early planning and intervention to identify/discuss safety issues in order to make the necessary linkages with community services
- Ability of the home care agency to implement accessible flexible staffing
- Electronic HIPAA compliant uniform record sharing among stakeholders with standardized policies and protocols to guide the exchange of information
- Shared knowledge base that informs discharge planners concerning safety issues and solutions
- Established standards for discharge planning throughout a continuum of care at home based on: education; accountability; individual choice and peer support
- Consolidated/accessible/current database of resource information designed to educate and inform professionals about available resources
- Standards to establish uniform practices for the exchange of discharge information
- Establish relationships with local resources including adult/child protective service agencies
- Discharge and service plans that are realistic and attainable in a reasonable time frame with available resources
- The availability of a 24/7 care management safety net
- Recognition/acknowledgement of individual's rights and informs persons of their rights applied to the discharge planning process and educates persons about service options, financial options, etc.

Process Elements

- A person centered assessment process that is proactive and careful in assessing problems/concerns
- A person centered assessment process that focuses on the person's strengths vs. deficits to ensure consumer directed care and control
- Communication and coordination among formal and informal caregivers and stakeholders that is designed to mobilize resources and identify potential solutions
- Engagement and support from the multi-interdisciplinary team including physicians
- Collaboration with community advocates concerning safety issues and solutions as needed
- Utilization of peer support to prepare persons for transition between levels of care and to help sustain persons in the least restrictive setting

Suggested Model for Transitional Care Planning

Transitional Care Planning is a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Ongoing consultation with the patient care team and reassessment of the patient's changing medical functional, social and cognitive capabilities assures that the comprehensive needs of the patient are addressed. Patients and families are apprised of the appropriate community resources available and encouraged to participate in all phases of the transitional care planning process. Referral mechanisms with community providers occur in a timely, systematic fashion in order for the patient to gain access to identified resources. The process concludes with the coordination and implementation of services and transition to the least restrictive level of care in keeping with the individual's wishes.

- Transitional Care Planning considers the patient's medical, physical, cognitive, economic and emotional strengths and abilities as well as their available support system
- Assessment of the patient's level of functioning prior to admission provides insight into resources available post discharge
- Ongoing collaboration between the patient, family and the interdisciplinary team provides an invaluable link, which facilitates the process of informed decision making
- Patients and families will receive verbal and written information of the range of services and available options available in the patient's community
- Patients and families will be given the opportunity to select the providers of services whenever possible

Initial Discharge Screen

These questions should allow the discharge planner to determine whether the patient is likely to need a more comprehensive assessment.

- Was the patient independent prior to admission?
- Will this current episode of illness impact the patients independence?
- Short term or long term?
- Does the patient have adequate informal supports to manage any loss of independence?
- Does the patient have adequate resources to provide for post discharge (Hospital, Skilled nursing facility, Certified Home Health Agency) needs, such as meds, equipment, rehab, or follow up treatment? (Insurance, Private funds, Medicare, Medicaid).
- If the patient had prior home care services, were they adequate? Are they likely to be adequate after discharge?
- Are there any special requirements to access? Is there a different level of care needed and is there a different payor because of hospital/skilled nursing facility stay?
- Has this patient had multiple hospital admissions?

High Risk Screening Criteria

Patients who fall into any of these categories should be targeted for a comprehensive assessment

- Over the age of 70
- Multiple diagnosis and co-morbidities
- Impaired Mobility
- Impaired self care skills
- Poor cognitive status
- Catastrophic injury or illness
- Homelessness
- Poor social supports
- Chronic illness
- Anticipated long term health care needs (e.g. new diabetic)
- Substance abuse
- History of multiple hospital admissions
- History of multiple emergent care use

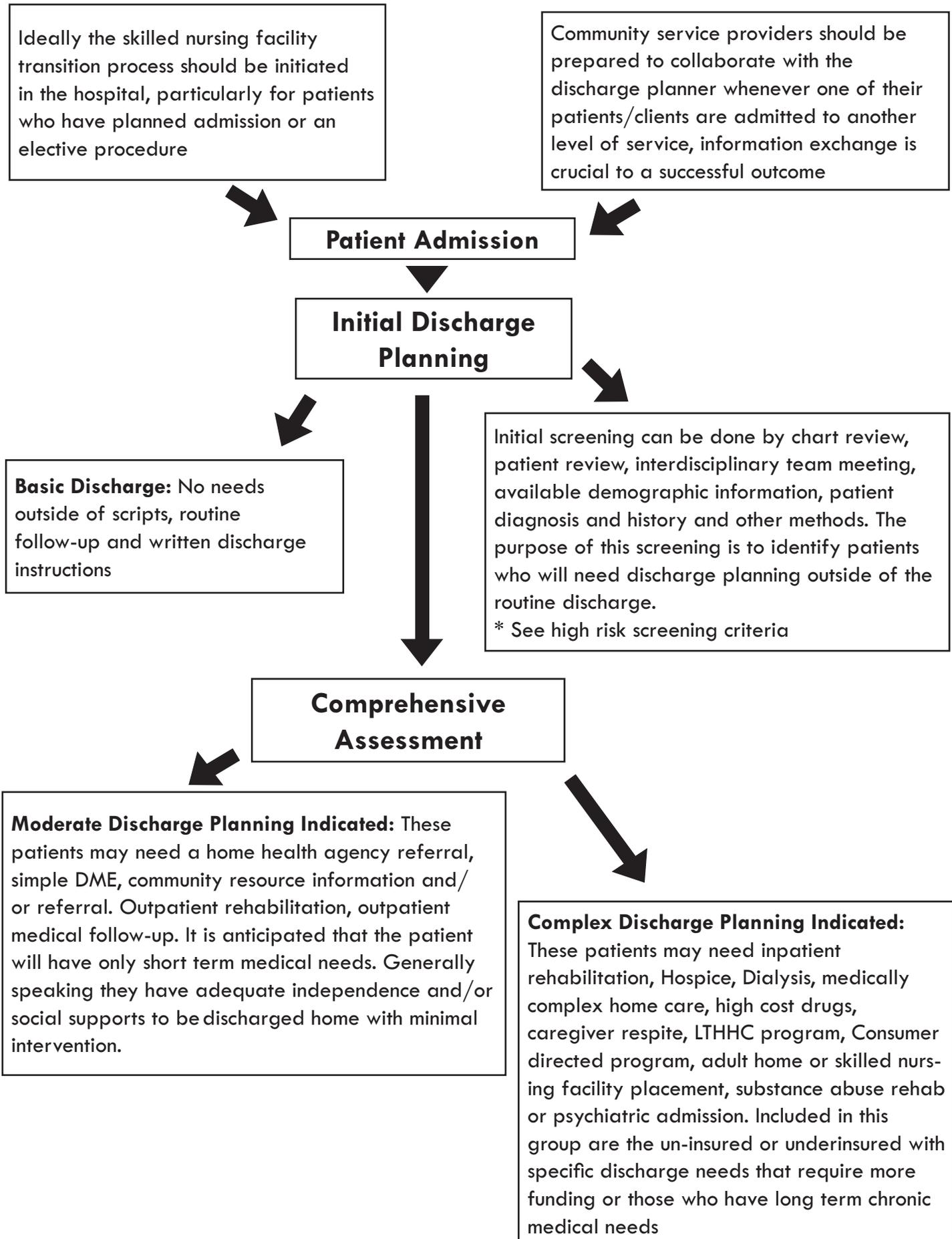
Comprehensive Assessment

Patients who are identified as High Risk or those for whom a more comprehensive assessment is indicated should be evaluated using the following criteria. *The screening process is dynamic and may include other information not listed below.*

- Functional assessment (the patients ability to perform ADL's and IADL's)
- Cognitive assessment if indicated
- Who are the patient's informal supports?
- What are the abilities of the informal supports?
- What is the availability of the informal supports?
- What is the patient's living arrangement? (home, apartment, with family, congregate living, homeless)
- This should include a description of the setting, such as stairs to enter, wheelchair accessibility, functional plumbing, heat, cooking facilities
- What is the patient's understanding of their illness?
- Is the patient capable of participating in his or her own discharge planning, if not, do they have someone who can represent them in the process?
- What are the patient's goals for discharge?
- What does the patient need to achieve functionally to achieve these goals?
- What services might be available to the patient to achieve these goals?
- What services did the patient have prior to admission?
- Does the patient have a preference for service provider?
- Does the patient's insurance have a preferred provider network?
- Does this patient have insurance or funds to pay for necessary care, if not what resources are available to them?
- Is the patient understanding of risks/benefits associated with their choices?
- Is there a history of non-compliance, which impacts the ability to be managed at home?

NOTE: This document refers to patient rather than individual/consumer because it is intended to be used by Hospitals for their patients.

Screening and Assessment Flow Chart



“Nursing Home to Community” Overview

Nursing Home to Community

- There are nine skilled nursing facilities in Broome County. Four of them are free standing and the other five are multi-level facilities with a mix of residential or home care services.
- All nine skilled nursing facilities work in partnership with Community Alternative Systems Agency (CASA) and Southern Tier Independence Center (STIC) on discharge/transition planning.
- There is a CASA nurse assigned to each facility and they visit each facility on a routine basis. Two nurses are assigned to cover nine nursing homes with approximately 1,700 skilled nursing beds. These nurses assess a combined average total of 650 nursing home residents a year for discharge.
- STIC works on referral and visits the facilities on an as needed basis.

Referrals

- There are many ways for consumers to make referrals for a nursing home to community assessment. CASA hospital liaisons may be made aware of the need for skilled nursing facility follow-up when a patient is transferred from the hospital to the skilled nursing facility.
- Referrals can come from family members or the resident.
- But most referrals come from the skilled nursing facilities themselves. Referrals are called in to CASA or given to the CASA nurse when she makes rounds at the facility.

Assessment Process

- The facility staff will meet with the resident and/or the resident’s family to discuss discharge plans. A release is obtained to involve other agencies in the review of the medical record. Residents are triaged for their level of need post discharge.
 - **Post Hospital Short Term Medicare Admissions:** CASA staff is available to consult on these short term admissions; however, many of the people in this category will return to highly functional lives and need little beyond what the skilled nursing facility offers in rehabilitation.
 - **Frail Elder Short Term Post Hospital Medicare Admissions:** These admissions often need the assistance of the CASA staff. For frail elders² admitted under Medicare with no Medicaid back-up, these admissions often become a “race against the clock”. Medicare only pays 100% of the skilled nursing facility stay for the first 20 days. After that the next 80 days require a co-pay. Frail elders are often anxious to return home within the first 20 days of admission.
 - **Frail Elders and Disabled Adults:** Most referrals to CASA and STIC come from this category of care. It is not unusual to work with people over a matter of months while they regain their strength and obtain adequate home care.
- Once the skilled nursing facility determines who needs to be involved, a referral is made to the appropriate community agency.

² Definition of frail elders: Elders who need assistance due to deficiencies in one ADL and two IADLs OR who identify themselves as frail.

- If complex discharge planning is required, a referral to CASA is generally made. The CASA nurse consults with the resident and skilled nursing facility staff and begins to build the community care plan with the resident. All areas of community living are explored. Does the person have a place to live? What is their informal support network? What can they do for themselves? Did they receive formal or informal assistance prior to this admission? What are their medical care plan needs?
- STIC is often referred to when residents need assistance in finding a place to live or are anxious and concerned about their ability to live independently in the community. They are expert in assisting residents build independent living skills.

Care Plan Development

- Skilled Nursing Facilities make a variety of home care referrals. They may refer post rehab residents to a Medicare Certified Home Care Agency, Meals on Wheels, Social Day Care or Medical Day Care to name a few.
- Residents who are not going to be receiving Medicaid home care services, but were assessed by CASA, are given a copy of the CASA Care Plan with recommendations for home care.
- Those who are Medicaid eligible receive a CASA care plan that outlines the services they will receive post discharge.
- Residents assessed by STIC are given a copy of the goal sheet STIC develops with the resident.
- Residents and families are also given a *Broome County Elder Services Guide* that outlines all long term care services available in the community.

Other Community Agencies

- Once a thorough assessment has been completed, all parties will work with the resident to identify the other agencies that could possibly provide assistance. For elders in need of home care there are a variety of care options available. The need for a Medicare CHHA would be a prime consideration. Services such as Meals on Wheels and social and medical day care may also be recommended. Residents may look to privately hired assistance or if they are eligible for Medicaid, a number of care options can be considered.
- For adults with disabilities under the age of 60 CASA frequently partners with the Southern Tier Independence Center (STIC). STIC staff can work on a variety of post discharge concerns such as assisting the resident obtain housing or making the appropriate contacts for benefits.
- CASA, skilled nursing facility and community agency staff will often coordinate a care conference with the resident (and their family if they so chose) to develop the post discharge plan. At this conference everyone is assigned a role, including the resident, in achieving the goal of discharge.

Length of Stay

Since CASA staff routinely visit the skilled nursing facilities, they make frequent visits to the residents who are working on discharge plans. As described above, length of stay varies depending on the complexity of the discharge plan and is an important factor in triaging the need for outside assistance in discharge planning.

Obtaining Equipment

If the resident is capable of obtaining the needed equipment for home care, they are encouraged to do so. Anything residents can do for themselves is encouraged as that will demonstrate their ability to live independently in the community. However, it is often the case that these arrangements are done by professionals, whether it is the skilled nursing facility staff, CASA staff or STIC staff.

Returning Home Successfully

- As noted in the Length of Stay description, people have differing abilities and need for assistance in successfully achieving discharge. While some people can return home with minimal assistance, others take a great deal of planning and coordination with community agencies, and these are the people that we spend the majority of our time assisting.
- Young adults with disabilities can present a myriad of complex needs, both physical and mental. When we first began this effort in 1996, we expected to act more as coaches than case managers. However, due to the severity of need among the population we serve, we often find ourselves doing more for the residents than originally expected.
- Our community's experience in skilled nursing facility transitions has also taught us that there are different definitions of independence. The initial stage of transition, when a person first returns home, can be very chaotic. But once a home care routine is established things often work out, even for people with the most extreme disabilities. The following case is a good illustration.

Nursing Home to Community: A Resident's Story

Lauren is a 30-year-old female with multiple sclerosis (MS). She is bipolar, has borderline personality disorder, a history of alcohol abuse, is paralyzed on one side and is obese. She requires wound care for persistent skin breakdown and has a catheter.

Lauren came to CASA in 1998 and received 10 hours of Personal Care Services Program (PCSP) home care per week. Over time her MS has advanced and her remissions are shorter. In 2000 her CASA nurse case manager recognized that she needed a higher level of care and authorized services from the Long Term Home Health Care Program (LTHHCP). By 2003 Lauren's care needs were so great that she exceeded the budget for the LTHHCP. After a hospital stay she entered a skilled nursing facility for rehab. The CASA nursing home liaison worked with her to develop a home care plan that would address her growing needs.

The nurse enlisted the assistance of the local Independent Living Center (ILC) to find Lauren a more accessible apartment. Once an apartment was found a care plan of 56 hours per week was established and Lauren now receives the bulk of her care from the Consumer Directed Personal Assistance Program (CDPAP). She also receives the support of a Certified Home Health Agency (CHHA) nurse and her family has agreed to provide the back-up care necessary when the Consumer Directed Aides might not be available. Lauren has a Personal Emergency Response System (PERS) Unit, takes 18 medications per day, uses a hooyer lift and electric wheelchair, meets with a counselor from Catholic Charities and has an adult protective worker.

All of these services are noted in the CASA care plan. Lauren is only 30 years old and will continue to be in and out of the hospital, skilled nursing facility and home care for the rest of her life, with CASA acting as the coordinating agency.

Roles in Discharge/Transition Planning

What is the Role of the Resident?

When planning for discharge to home care or a lower level of care, the resident (and/or family) will be responsible for initiating and agreeing to the ultimate plan for discharge. Working with the interdisciplinary team consisting of skilled nursing facility staff, identified community agencies, and informal supports, the resident, to the extent that he/she is capable of doing, is expected to make decisions and participate fully in the transition process.

The first step toward full community integration for residents is to participate in the planning of their own discharge. By demonstrating their ability to plan and/or participating in the planning of their own discharge, residents gain the confidence and make the connections they need to live successfully outside the skilled nursing facility.

What is the Role of the Skilled Nursing Facility?

To ensure that every resident receives appropriate, quality care that is tailored individually to his or her needs, every resident shall be evaluated upon admission to the skilled nursing facility for his/her potential to return to home or to a lower level of care. Current residents in the skilled nursing facility will be routinely evaluated for their potential to be transferred to a lower level of care or return to the community. If the resident demonstrates the potential to be discharged, this objective shall be clearly stated in the resident's plan of care, thereby ensuring ongoing evaluation of the resident's progress towards meeting his/her goals and those goals identified by the interdisciplinary team.

What is the Role of CASA?

With the knowledge and cooperation of the nursing home discharge planner, the liaison reviews the medical records of the residents referred and confers with the residents and their families about discharge plans. The nursing home discharge planner may consult with the liaison on short term rehab residents, or may need the assistance of the liaison in developing more complex discharge plans. CASA staff assigned to the facilities are nurses and they conduct reviews of medical need and how these needs can be met in the community.

What is the Role of STIC?

STIC staff works with the residents on developing independent living skills. If long term residents are leery of leaving the security of the 24 hour care of the skilled nursing facility, STIC can work with them to relieve their anxiety prior to returning to the community. Care plans are developed to address the medical needs of the residents once they return home. STIC is also very helpful in assisting people who don't have housing in the community, in finding a place to live. STIC staff assigned to this duty are caseworkers and they handle social issues such as integrating into community life.

These four partners work closely with one another throughout the discharge process, both formally conferencing and keeping in touch by phone when necessary.

Procedures of Key Partners

Resident Procedures

Residents will be made aware of the number of services available to assist them in living outside of the skilled nursing facility via the following procedures:

- The resident begins the discharge process simply by voicing a desire to explore living elsewhere.
- The resident may contact the skilled nursing facility discharge planner, CASA or STIC to discuss the resident's options and goals. (Refer to Manual's CASA section.)
- Once the resident's goals are established, the resident will explore housing and post-discharge care options with appropriate community agencies.
- The resident will work toward obtaining the financial assistance necessary to pay rent, utilities, food, etc.
- For residents with complex discharge plans, a care coordination meeting will take place with the resident and the interdisciplinary team.

Skilled Nursing Facility (SNF) Procedures

- Alternate care options are discussed with the resident and his/her family.
- Residents are given goals/criteria for discharge such as ability to test own blood sugar, transfer from bed to chair, walk 50 feet. (These goals are examples; it is understood that some people leave the facility without these abilities).
- SNF nursing and therapy staff discuss residents' goals for discharge at routine care planning meetings.
- SNF triages residents need for referral to community programs. A referral to CASA may happen at any stage of the following:
 - **Short Term Medicare Stays (20 days or less) requiring Minimal Assistance:** These cases can easily be handled by the skilled nursing facility staff and generally don't require CASA referral. However, CASA staff is available to consult on any case, regardless of length of stay or client ability.
 - **Short Term Medicare Stays (within 100 MC days) requiring Higher Intervention:** These residents may need to stay in the skilled nursing facility for one to three months, and may lose Medicare benefits in the process. Upon discharge they may need to access a variety of community services such as Meals on Wheels (MOW), Long Term Home Health Care, and Medical Day Care.
 - **Frequent Readmissions:** These residents often have complex care plans and may receive services from Adult Protective, Mental Health, and home care when living in the community. They usually require intense coordinated planning efforts to be successful at staying home.
 - **People with Disabilities with Complex Discharge Care Plans:** CASA and the skilled nursing facilities have found that discharge planning for a resident with complex care needs can take a significant amount of time. These residents may live in the skilled nursing facility for one or two years while securing a place to live post discharge and a home care plan is being developed.

- Once skilled nursing facility staff has made their assessment of the resident’s ability to return to the community, a referral may be made to Broome County CASA with the resident’s consent. Referral information shall include: Name, address, date of birth, diagnosis, significant other and unit of the SNF where the person can be found. This information is useful in checking CASA’s database to see if the resident was previously known to the agency. CASA shall then begin their assessment as outlined in the CASA section of this Manual.
- SNF case manager coordinates care with the physician and assists the resident and family in obtaining equipment prescriptions, and home care services.
- SNF staff confers with CASA and STIC on a regular basis as to resident’s progress.
- Any member of the team (Resident, CASA, STIC, SNF) can call for a case conference at any time.
- For residents who are placed in the facility for stays of less than two weeks (i.e. post hip or knee replacement) and are expected to return to previous, high levels of functioning, the skilled nursing facility staff will consider making the following referrals:
 - Certified Home Health Care Agency (CHHA)
 - EISEP, Meals on Wheels³
 - Resources listed in the Broome County Elder Services Guide⁴

CASA Procedures

1. Referral and Initial Contact:

- CASA works on *referral*. Referrals come from a variety of sources including self-referral, family, community agencies, skilled nursing facilities and hospitals. CASA nurses are available to consult on any case referred, with preference given to residents of Broome County.
 - **Short Term Medicare Stays (20 days or less) requiring Minimal Assistance:** Many people in our community are admitted to skilled nursing facilities for rehab after scheduled post hip or knee replacements. Oftentimes, these residents are very functional prior to their surgery. They may require some post discharge referrals to a Certified Medicare Home Care Provider or outpatient therapy.
 - **Short Term Medicare Stays (within 100 MC days) requiring Higher Intervention:** Frail elders⁴ who are admitted for anticipated short-term stays, will most likely require some CASA intervention. Frail elders respond to therapy at very different rates, usually taking a longer time to regain strength after an acute episode.
 - **Frequent Readmissions:** Because CASA nurses serve all skilled nursing facilities in Broome County, we can provide information and follow up to skilled nursing facility staff on residents who may be readmitted frequently due to the instability of their health conditions and/or community living environments.

³ If these referrals are made prior to the day of discharge, CASA staff can perform the initial assessments so that services can begin upon discharge.

⁴ Visit the online Broome County Elder Services Guide at www.broomeelderservices.org.

- **People with Disabilities with Complex Discharge Care Plans:** At times, the resident's (or family's) confidence in his/her ability to live in the community comes into question. For this reason, it's important that goals are established clearly and that skilled nursing facility staff and community agencies work together with the resident to build confidence and actively engage the resident in accessing services. It has been CASA's experience that taking the time to develop a good care plan is well worth the effort, rather than rushing to discharge.
- Upon receiving a referral, CASA makes an ***initial contact*** with the resident and/or family members and skilled nursing facility staff within two (2) business days to schedule an assessment visit. This visit usually takes place within five (5) business days or before discharge date.

2. Discharge/Transition Planning:

- During the initial assessment visit, a CASA nurse will review the resident's chart and gather information (all therapies provided, nursing notes, history and physical, activities of daily living (ADLs) and any other sources of information) pertinent to the resident's case.
 - ✓ The resident will be evaluated with input from family and skilled nursing facility staff.
 - ✓ A CASA Assessment Tool and care plan will be completed during this evaluation.
 - ✓ Skilled nursing facility staff will be given a copy of the care plan that is developed.
 - ✓ A discharge planning meeting involving the resident, family, SNF staff, and community agencies may be held if necessary.
- With the resident's consent, CASA staff will contact community agencies that will act as referral sources: STIC, LTHHCP, CHHA.

FOR MEDICAID RESIDENTS WHO WILL RECEIVE PCSP OR CDPAP SERVICES UPON DISCHARGE:

- ✓ Validate whether the resident's Medicaid is active by calling the Department of Social Services (DSS).
- ✓ Request MD orders and broker services with a PCSP agency. A home visit is recommended prior to PCSP services being brokered.
- ✓ Complete the Long-Term Care Assessment Form.
- ✓ Complete an Activities of Daily Living Task Sheet.
- ✓ Initiate/update the resident's Care Plan if needed.
- ✓ Request that the resident sign the Patient Bill of Rights.
- ✓ Provide the resident with a Fair Hearing letter.
- ✓ Provide the resident with a copy of the Care Plan and Task Sheet.
- ✓ Coordinate with skilled nursing facility staff other services that may be needed, such as Meals on Wheels, Durable Medical Equipment, Certified Home Health Agency, Family Homes for the Elderly, Long Term Home Health Care Program, Assisted Living Program, In-Home Mental Health Program.
- ✓ Transfer the resident's case to a geographic case manager when the resident is an open Medicaid CASA client⁵.

⁵ When there is a delay of more than four (4) weeks between Initial Assessment Visit and Medicaid being activated, the geographic case manager nurse will visit client in his/her home to update Care Plan and Task Sheet reflecting current client needs.

- The day before discharge (For MA Residents Only), skilled nursing facility staff shall contact the appropriate DSS Examiner to arrange a time to pick up a Temporary Medicaid card, or to set up other arrangements when necessary. The DSS Examiner shall determine the resident's continuing eligibility and prepare the Temporary Medicaid card if continued eligibility is warranted.
- The day of discharge (For MA Residents Only), the nursing facility will fax the Discharge Form (DSS-3559) to DSS at 778-2779. To direct the delivery of the Temporary Medicaid card, the Form must include a PICK-UP BY (name) or FAX TO (Fax #), along with the resident's post discharge address. The DSS Examiner will have the Temporary Medicaid card ready for pick-up at the pre-arranged time; or when necessary, will fax a copy of the card to the skilled nursing facility. The resident's file will be transferred from the DSS Medicaid Chronic Care Unit to the appropriate Medicaid Unit (Medicaid-SSI Unit in Endicott, or one of two Community Medicaid Units).

3. Post Discharge Follow-Up:

- The CASA nurse will follow-up with the resident by telephone within one-two weeks after discharge from the skilled nursing facility. The resident's case will be closed at this time if the resident is private pay. If the resident is eligible for community Medicaid or spousal Medicaid the case will be transferred to the appropriate community health nurse.

STIC Procedures

1. Referral and Initial Contact:

- STIC works on referral. Referrals come from a variety of sources including self referral, hospital discharge planners, skilled nursing facility social workers, Broome County CASA, DSS/Adult Protective Services, other agencies, family members/friends, etc.
- In all cases, the individual must be aware of and in agreement with the referral to STIC's Community Integration program.
- All referrals made to STIC's Community Integration Program for individuals who wish to transition from skilled nursing facilities to the community are taken by the Community Integration Director (CID).
- Within two working days, the CID will respond to the referral source and document appropriate information, contact the consumer by phone to complete an initial contact information sheet, and let the person know that a Community Integration Advocate will call to schedule a visit.
- A Community Integration Advocate will call the consumer and schedule a visit within one week of receiving the referral.

2. Transition Planning:

- The first visit will take place within 10 working days of the initial phone contact unless circumstances dictate otherwise (i.e. the consumer is hospitalized; a family member whom the consumer wants to attend the meeting cannot come within the typical time frame).
- The consumer may have as many people at the meeting as he/she wishes.

- At the first visit:
 - ✓ The Community Integration program and services are described.
 - ✓ Consumer role, rights and responsibilities explained; consumer contract and HIPAA form signed; intake paperwork completed.
 - ✓ Consumer is interviewed and an in-depth assessment of the person's needs, supports, finances, etc. is begun. Because this assessment is very involved, it may take several visits to obtain all of the information necessary to assist the person.
 - ✓ Family members, friends and other supportive persons are identified by the consumer.
 - ✓ Advocates identify and explain any programs and/or services that can assist the consumer with the transition and in the community.
 - ✓ Consumer is asked if we may communicate with other agencies, family members and/or any relevant parties. When agreed, releases are signed.

- With consumer consent, STIC advocates will maintain communications with all supporters and service providers throughout the transition process.

- With consumer consent, appropriate referrals are made to agencies and programs that can assist the person: CASA, Office for Aging, TBI Waiver, OMRDD, etc.

- A preliminary discharge planning meeting typically takes place early in the process to allow the consumer and key supporters to collaborate. At this meeting:
 - ✓ Consumer is given an opportunity to express wishes, goals, dreams, fears, concerns, etc.
 - ✓ Each member of the person's support team explains progress, needs as they see them, strengths, deficits, concerns, etc.
 - ✓ Each team member explains the types of supports and services he/she can provide to assist the person both pre- and post-discharge.
 - ✓ CASA nurse puts a care plan in place outlining the steps that must be completed prior to the person's discharge and identifying the role of each team member.

- Information obtained from the preliminary discharge meeting will be used to develop a comprehensive transition plan in accordance with the consumer's goals and wishes.

- STIC advocates will work closely with the consumer on a weekly basis (either by phone or in person as need dictates) to achieve the goals and objectives outlined in the transition plan. During this phase:
 - ✓ Larger, long-term goals are broken down into smaller, more manageable tasks.
 - ✓ The consumer and advocates will determine the responsibilities of each party in accomplishing the necessary tasks to move the transition forward. Deadlines will be established for completing each task and progress will be tracked on goal sheets.

- As the consumer progresses in accomplishing the tasks necessary for discharge, STIC staff will communicate regularly, as need dictates, with CASA, Skilled Nursing Facility social worker, family members and other supporters both in person and via phone.

3. Post-Discharge Follow-Up Support:

- Experience has proven that the need for supportive services to the consumer must intensify dramatically once the person has transitioned into the community. The first few months are a time of adjustment for most people, especially for those who have spent many years living in a skilled nursing facility. During the adjustment period, STIC advocates make themselves available to the consumer at any time of the workday. Services offered are problem-solving, trouble-shooting and peer counseling. Typical barriers encountered are Medicaid eligibility, problems with a PCSP or agency, strained relations developing with friends or family members who are key supporters, etc.

Isolation and loneliness are perhaps the biggest obstacle to a person successfully living in the community. In accordance with each person's wishes, STIC advocates will work with the consumer to develop connections in the community to which he/she is moving. Ideally STIC helps the person make new connections in the community, prior to leaving the skilled nursing facility.

As each person becomes more comfortable with day-to-day life in the community, STIC's role becomes smaller. Our goal is to gradually fade from providing intensive support to being a resource the person can contact when needed or just for a friendly chat.

Shared Procedures

As a community we recognize that not every person who transitions from a skilled nursing facility into the community will be successful. We believe, however, that every person deserves a chance to try. Failure to stay out of the skilled nursing facility does not necessarily mean that the Community Integration Advocates who were working with the person will terminate contact or decline services. For complex care planning a case conference is usually held with all team members.

Conducting a Discharge Care Planning Meeting:

- ☑ Identify the problem and decide on a conference leader who shall be responsible for coordinating the conference. (Ideally the conference leader should be the resident.)
- ☑ Set three to four objectives.
- ☑ Decide on the number of participants and designate a time and place for meeting. (Try to limit number of participants to eight.)
- ☑ Choose a recorder.
- ☑ Focus the conference on:
 - Presenting an overview of the client case
 - Reviewing current plan of care - allow each participant to summarize their involvement in assisting with the client in obtaining their goals.
 - Discussing objectives sequentially
 - Summarizing important issues.
- ☑ Discuss outcomes/decisions based on actions with client and family or significant others.
- ☑ Decide on a date for an evaluation conference.
- ☑ Send copies of recorded minutes if applicable.
- ☑ Develop a client-centered action plan utilizing conference objectives.
- ☑ Share conference outcomes with resident/informal caregivers and document in the resident's record.

Community Agency Referral Sources

How Can Other Community Agencies Be of Assistance?

- Broome County Office for Aging (OFA) acts as a clearinghouse and provides assistance in locating needed services for elderly residents and their caregivers through its Information and Resource Assistance Unit, Senior Resource Line, Caregiver Services Unit, and other services that assist frail and homebound elderly.
- Action for Older Persons, Inc. (AOP) offers additional information and referral services as it receives more than 5,000 telephone inquiries per year from elderly residents and their caregivers in search of services.
- Broome County CASA complements these roles by serving as the central access agency for Broome County residents in need of information about long-term care alternatives.
- As Broome County's Independent Living Center, STIC further enhances the information and referral capabilities of these agencies by serving people of all ages who have disabilities.

Each of these agencies relies heavily on the Broome County Elder Services Guide – in both hardcopy and online versions - as a handy resource that enables the quick and efficient location of available services and providers. A fourth edition was released in March 2006. The Guide is a well-established means of locating supportive services for older and/or disabled residents of Broome County. Used by consumers, informal caregivers, and professional service providers alike, the Guide pulls together the entire array of local programs and services available for mid-life and older adults into one comprehensive package. Since 1996, the Guide has played a significant role as part of Broome County's integrated aging services information system.

The more recent addition of an on-line version of the Broome County Elder Services Guide is a creative use of technology aimed at improving accessibility to services that meet the growing needs of our most at-risk residents and their caregivers. This approach is especially warranted since use of the Internet by aging and disability service providers both as an information source and as a means to access up-to-the-minute data has become commonplace. Consumers are also increasingly exposed to technology. The on-line Guide further serves as a resource for out-of-town family caregivers who are responsible for arranging services for elderly/disabled loved ones living in Broome County.

Senior Resource Line	778-2411
Action for Older Persons	722-1251
Broome County CASA	778-2420
Broome County STIC	724-2111

Community Agency Referral Sources

1. Brokering and Approval of Services

- CASA brokers, approves or initiates a referral for services for the following programs:

➤ Personal Care Services Program (PCSP) & Consumer Directed Personal Assistance Program (CDPAP)	➤ Personal Emergency Response System (PERS) ⁸ <ul style="list-style-type: none">• Project HEAR• Link To Life
➤ Certified Home Health Care (CHHA) ⁶ <ul style="list-style-type: none">• Gentiva• Lourdes• Twin Tier	➤ Assisted Living Program (ALP) <ul style="list-style-type: none">• Elizabeth Church Manor ACF• Hilltop ACF• Ideal ACF
➤ Long Term Home Health Care Program (LTHHCP) ⁷ <ul style="list-style-type: none">• Ideal Long Term Home Health Care Program• Lourdes Long Term Home Health Care Program	➤ Private Duty Nursing (PDN) ⁹ <ul style="list-style-type: none">➤ Family Homes for the Elderly (FHE)

- On occasion an agency or all agencies will refuse to serve a resident due to past history with the resident. In the event that all Broome County PCSP agencies refuse to service a resident, CASA and STIC will continue to work toward the residents' goal of discharge. Alternatives such as Consumer Directed Personal Assistance Program will be pursued.
- For residents who need to obtain housing, a referral is made to Southern Tier Independence Center at 724-2111. Representatives from STIC will meet with the resident to discuss living preferences and complete the Community Transition Planning Assessment. Residents will be expected to follow through on making contacts and applications to local housing authorities.
- For residents with questions and concerns about their prescription drug coverage and/or other Medicare/health insurance issues, a referral should be made to Action for Older Persons, Inc.'s (AOP) Health Insurance Information, Counseling & Assistance Program.
 - An appointment will be made for the resident and/or family member to meet with a health insurance counselor at AOP. A Client Intake Form will be filled out.
 - The health insurance counselor will inform the resident of the choices available to him/her. The decision to follow through on any selections, plan enrollments, etc. is the responsibility of the resident and his/her family. Health Insurance counselors cannot make subjective recommendations.
- For residents who will be unable to prepare meals for themselves (even if only for a short-term transition period) and have no informal supports for meal preparation, a referral should be made to Meals on Wheels.
 - For residents whose post-discharge addresses will be in Johnson City or Western Broome, call Meals on Wheels of Western Broome at 754-7856.
 - For residents whose post-discharge addresses will be in Binghamton, Northern or Eastern Broome, call Office for Aging's Meals on Wheels at 778-6205.

⁶ CHHA care includes nursing visits, physiotherapy, occupational therapy (OT), social worker, dietician, home health aide (HHA) services.

⁷ LTHHCP services include nursing visits, physiotherapy, occupational therapy, social worker, dietician, etc.

⁸ PERS is a device used by a client to get emergency services.

⁹ PDN is a service provided by provider agency registered nurses and licensed practical nurses.

2. Self Referrals

- The *Broome County Elder Services Guide* provides a comprehensive listing of services available specific to Broome County.
 - Information can be looked up using a Needs Index at the beginning the Guide, or an Index and Telephone Directory at the end of the Guide.
 - Providers may obtain copies of the Guide for use with residents by requesting, completing and returning to AOP an Elder Services Guide Request Form.
 - Residents may obtain single copies of the Guide by picking one up at AOP, Broome County Office for Aging, or any local senior community center.
 - The online Guide may be visited at www.broomeelderservices.org

Community Agency Websites:

Action for Older Persons, Inc.	www.tier.net/aop
CASA	www.gobroomecounty.com/departments/casa.php
Elder Services Guide Online	www.broomeelderservices.org
Office for Aging	www.gobroomecounty.com/community/senior.php
STIC	www.stic-cil.org

Long-Term Care Payment Options

How Much Does Long-Term Care Cost?

- In 2006, the average annual cost of skilled nursing facility care in upstate New York was \$83,000. That's about \$228 a day.
- In 2006, the average daily cost of Adult Care and Assisted Living was more than \$100 a day.
- Even long-term care in your own home can be quite costly. Home health aide services may cost \$20 per hour or more, and a nursing visit can be \$90 per hour or more.

The long-term care choices available to consumers are largely based on their personal financial situation. Because different types of long term care accept different forms of payment, a consumer's choices for care are directly linked to his/her ability to pay for those choices.

This section describes the most common ways to pay for long term care in Broome County.

Private Pay Using Income and Assets

All long-term care service providers accept private payment; some give preference to, or only accept private payment. Consumers typically have more options to choose from if they're able to pay privately for their care, even if for a limited period of time.

When assessing a person's ability to pay privately for long-term care, reverse mortgages and life insurance accelerated death benefit riders should be considered as well as long-term care insurance. This type of insurance policy pays for long-term care expenses, and is purchased by people who want to protect their assets and/or avoid a spend-down situation. When exploring long-term care insurance options, be sure to look into the New York State Partnership for Long-Term Care. For more tips on how to choose a long-term care insurance policy, contact:

- Action for Older Persons' HIICAP
30 West State Street, Binghamton, NY 13901
Phone: (607) 722-1251

For people living on fixed and limited incomes, expenses may become a challenge. Community-based residents who are having difficulty paying their bills should explore whether they are eligible for financial assistance to cover transportation, rent, utilities, and/or food costs.

Government programs for adults age 60 and over are mainly coordinated by the Broome County Office for Aging who offer a variety of non-medical community services for minimal or no cost. These include:

- Expanded In-Home Services for the Elderly (EISEP)
- Supportive Services (Title III-B)
 - Transportation
 - Caregiver Resource Services
 - Legal services
 - Home repair
 - Information and assistance
 - Nutrition Services (Title III-C)
 - Senior centers
 - Meals on Wheels & other meal programs

- Community Services for the Elderly (CSE)
 - Social adult day care
 - In-home mental health counseling
 - Case management

Nonprofit and volunteer groups also offer assistance with shopping, transportation, home maintenance, etc. To obtain more comprehensive information on these services and/or other cost-saving ideas, consumers should be directed to call:

- The Senior Resource Line, Broome County Office for Aging
Phone: (607) 778-2411

Medicare (Title XVIII)

Medicare is a government insurance program available to people age 65 and older and to some people with long-term disabilities regardless of age. Medicare is not a solution to paying for long-term care. At most, Medicare may pay for limited, short-term care for rehabilitation purposes in a skilled nursing facility or in a community-based home if certain conditions are met. Also, Medicare supplemental insurance policies, or “Medigap” policies, will not cover any care that is not a Medicare eligible service.

When will Medicare cover skilled care?

1. All of the following must be true for a person to be covered by Medicare for skilled care:
 - He/she must have Medicare Part A and days left to use in his/her benefit period.
 - He/she must have a qualifying hospital stay. This is an inpatient hospital stay of three consecutive days or more, not including the day he/she leaves the hospital. (Important note: The time a person is being observed in a hospital before being admitted does not count toward this three-day qualifying inpatient hospital stay.)
 - His/her doctor has ordered the services needed for skilled nursing facility (SNF) care that requires the skills of professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists or audiologists, and are furnished by, or under the supervision of these skilled personnel.
 - He/she must require skilled care on a daily basis, and the services must be ones that can only be provided in a SNF on an inpatient basis.
 - He/she needs these skilled services for a medical condition that was treated during a qualifying three-day hospital stay, or started while receiving SNF care for a medical condition that was treated during a three-day qualifying hospital stay.
 - The skilled services must be reasonable and necessary for the diagnosis or treatment of his/her condition.
 - He/she gets these skilled services in a SNF that is certified by Medicare.

How long does Medicare cover care in a skilled nursing facility?

Medicare uses a period of time called a benefit period to keep track of how many days of skilled nursing facility (SNF) benefits a person uses, and how many are still available. A benefit period begins on the day a person starts using hospital or SNF benefits under Part A of Medicare. A person may receive up to 100 days of SNF coverage in a SNF benefit period. Once those 100 days are used, the current benefit period must end before SNF benefits may be renewed. A person's benefit period ends: (1) when he/she has not been in a SNF or hospital for at least 60 days in a row; or (2) if he/she remains in a SNF when he/she hasn't received skilled care there for at least 60 days in a row.

There is no limit to the number of benefit periods a person may have. However, once a benefit period ends, another 3-day qualifying hospital stay and other Medicare requirements listed above must be met.

When a person is in a skilled nursing home getting Medicare-covered skilled nursing care, his/her prescriptions generally will be covered by Medicare Part A. Since January 1, 2006, Medicare has also been offering prescription drug coverage for everyone with Medicare.

In order to get the Medicare Part D drug coverage, a person must enroll in a Medicare prescription drug plan. The initial enrollment period extended from November 15, 2005 –May 15, 2006. In most cases, if a person didn't enroll during this period his/her next chance to enroll will be November 15, 2006–December 31, 2006, and he/she may have to pay a higher premium. (A person won't have to pay a higher premium if he/she had continuous drug coverage from another source that was, on average, at least as good as standard Medicare drug coverage.)

How does Medicare's New Prescription Drug Benefit affect nursing home residents or persons living in certain types of long-term care facilities?

Drug plans must contract with pharmacies in local areas. Nursing homes and other long-term care facilities usually work with specific pharmacies or they may have their own pharmacies. A person moving into a nursing home or other long-term care facility who is already enrolled in a Medicare prescription drug plan can switch to a different plan at that time if he/she chooses to do so. Likewise, when a nursing home resident is returning to live in the community, it is important to check with the plan he/she is currently enrolled in to make sure a particular pharmacy or a pharmacy in the plan is in a convenient location. Transitioning into the community allows the former resident to switch plans for two months following nursing home discharge. Also, some plans may offer a mail-order program that will allow drugs to be sent directly to a person's home.

In addition, there is extra help for people with limited income and resources, including people who have Medicaid health coverage and people who receive Supplemental Security Income.

- If a person has full coverage from Medicaid, his/her prescription drugs stopped being covered by Medicaid, and start being covered by Medicare on January 1, 2006. A person with full Medicaid coverage who lives in a nursing home will pay nothing out of his/her own pocket. A person with full Medicaid coverage who lives in an Assisted Living or Adult Living Facility, or a Residential Home will pay a small co-payment for each covered prescription drug.
- If a person is a private pay nursing home resident, the cost sharing Part D rules for community seniors apply. When a resident's income level is at or below 150% of Federal poverty level, he/she should determine ASAP if he/she is eligible for 'extra help' (also called the low income subsidy, 'LIS') provided by the government in paying for the costs of the Part D plan coverage. (For more information, contact the local Social Security Administration office).

- If a person doesn't meet the income and asset level for extra help, he/she may be eligible for New York State's Elderly Pharmaceutical Insurance Coverage (EPIC) to fill gaps in coverage. EPIC is a New York State sponsored prescription plan for senior citizens who need help paying for their prescriptions. State residents who can join EPIC are those who are 65 or older, and have an annual income of \$35,000 or less if single, or \$50,000 or less if married. Seniors who receive full Medicaid benefits are not eligible for EPIC benefits. Seniors with prescription coverage through Medicare or other plans can join EPIC to cover drug costs not covered by the other plans. EPIC operates a toll-free Helpline which is available from 8:30AM to 5:00PM, Monday through Friday. Call 1-800-332-3742 (TTY 1-800-290-9138) for more information or to request an application. Email EPIC at: epic@health.state.ny.us. Or write to EPIC at:
 - EPIC
P.O. Box 15018
Albany, NY 12212-5018

How can a nursing home resident returning to the community get more information on his/her options for enrolling/disenrolling in Medicare drug plans?

- Read the "Medicare & You 2006" handbook that he/she got in the mail in October 2005.
- Visit www.medicare.gov on the web. Select "search tools" to get personalized information.
- Call the local Health Insurance Information, Counseling & Assistance Program. In Broome County that phone number is 722-1251 (Action for Older Persons, Inc.)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Look for local Medicare-related events.

Medicaid (Title XIX)

Medicaid is a government health insurance program that acts as a safety net to ensure that anyone who needs care will receive it regardless of ability to pay. It is the most frequent, or "primary" payer of long-term, skilled nursing costs since few individuals can afford to pay for this type of care over an extended period of time.

A person may qualify for Medicaid coverage in either of two ways: (1) He/she may be eligible based on income and assets; or (2) He/she may qualify for a monthly spend-down of income and assets to pay for medical expenses until income eligible. Currently, asset limits do not include a person's house, car, limited burial fund, and unlimited money in an irrevocable funeral trust.

If Medicaid is paying for a married person's long-term care in a skilled nursing facility, his/her spouse is protected by the *Medicaid Spousal Impoverishment Protection Act*. This law allows the community spouse to retain a certain amount of income and assets, a house, a car and personal possessions before being required to contribute financially towards skilled nursing facility costs.

There are two types of Medicaid coverage:

1. Community Medicaid pays for medical care and a wide range of related health care services in the community, including the home care portion of Assisted Living Programs, the Long-Term Home Health Care Program, and hospice.

2. Chronic Care Medicaid pays for skilled nursing care in a facility (nursing home). However, a person could be eligible for Medicaid in the skilled nursing facility but not in the community.

To determine eligibility and/or to apply for Medicaid, contact:

- Department of Social Services, Broome County
36-42 Main St., Binghamton, NY 13905
Phone: (607) 778-2604

In addition to the two types of Medicaid coverage described above, residents might benefit from non-traditional Medicaid programs such as:

Medicaid Buy-In Program

This program is available to working people with disabilities. To be eligible, a person's disability must fit the definition as defined by the Social Security Administration. Through this program, the consumer may retain a higher income and more financial resources than allowed under traditional Medicaid. Payment of a premium may be required.

Consumer Directed Personal Assistance & Traumatic Brain Injury Waiver Programs

These programs are designed to give people more control over the services they receive in their home as well as who provides those services. To determine if a Medicaid qualified person is eligible for either of these programs, contact:

- CASA (Community Alternative Systems Agency), Broome County
Broome County Office Building, 4th Floor
Binghamton, NY 13902-1766
Phone: (607) 778-2420

Frequently Asked Questions

What is the role of CASA hospital liaisons in Nursing Home to Community?

The CASA hospital liaisons act as referral sources for the CASA nursing home to community program. They begin the paperwork in the hospital and discuss the short term stay with the patient and their family prior to leaving the hospital. Patients and families are given the name of the CASA liaison that they will see in the skilled nursing facility. The hospital liaison then transfers the case to the nursing home liaison.

Do any of the partners assess the residents' home environment in the community prior to discharge?

This can happen in a number of ways. Depending on the facility, some physical therapists make home visits prior to the resident returning home. Depending on the complexity of the case, CASA or STIC staff may make a home visit prior to the resident returning home. Sometimes the people are previously known to CASA so they are familiar with the home setting.

Do any of the partners see the resident after they return home?

STIC operates the community integration program which is primarily addressed after discharge. If the resident is going to be open and active to personal care or Long Term Home Health Care (LTHHC), he/she will be assigned to a caseworker from one of those programs. Other residents may receive Certified Home Health Agency (CHHA) referrals or Meals on Wheels (MOW).

If the transition plan fails, will the skilled nursing facility readmit the person?

Our partners believe if someone wants to return home, and there is no history of not being successful with home care in the past, we do everything possible to give that person a chance at community living. However, as Lauren's case outlines (see pg. 16), the complexity of care can be such that either the consumer cannot manage it or the plan may fall apart for a variety of reasons. In Lauren's case, the skilled nursing facility she was discharged from made a commitment to readmitting her if need be. That gave her the confidence she needed to try to be successful at home and she has been very successful. However, others have not been so successful. If a plan is complex and challenging, most skilled nursing facilities are agreeable to taking the resident back if community care fails.

Who should be referred to the Nursing Home Transition Program?

Any resident who expresses a desire to leave the facility.

To which community agency should the skilled nursing facility make initial referrals?

All referrals for initial assessment should be referred to Broome County CASA by contacting your liaison or calling 778-2420.

What is a level of care assessment?

One of CASA's main charges is to conduct level of care assessments. We must consider all levels of care and combinations thereof when determining how to best serve people in need of long term care. The assessment may indicate that a person could qualify for Family Homes for the Elderly or Assisted Living. Or, people in need of ongoing nursing intervention and evaluation may be eligible for LTHHCP. Persons in need of assistance with ADLs/IADLs may be best suited for personal care, with short term nursing needs met by a Certified Home Health Care Agency.

The CASA assessment may indicate that a person is well served by staying in the skilled nursing facility. Perhaps they have had several admissions over time and have not been successful in managing their own care at home. While we would suggest this as an option, we would not discourage anyone from continuing to pursue a return to home.

What does an assessment consist of?

CASA conducts a complete medical, psycho-social assessment by reviewing the resident's chart, interviewing staff and speaking with the resident. The history of any care the resident was receiving prior to admission is reviewed and options for post discharge care are discussed with the resident. From this review, discharge goals are established and community agencies are identified that can provide the services. For instance, CASA refers people to STIC, particularly when housing is needed or residents are insecure about their ability to function outside of the skilled nursing facility.

What is a care plan/assessment form?

The Care Plan is a structured overview of an individual's problems, goals and the interventions that have been jointly agreed upon by the resident (or caregivers) and CASA evaluator(s). A CASA Assessment Form takes the place of the Care Plan during "information only" visits. It clearly lists the information given at the visit and the recommendations made to the resident/family/caregiver. The purpose of the CASA Assessment Form is to provide written communication and direction for the resident and all involved formal and/or informal supports. The signature of the resident, family and/or informal supports on the Care Plan/CASA Assessment Form/Consent to Use or Disclose Protected Health Information Form grants CASA permission to release information regarding the resident to community agencies and professionals.

Who is in charge of securing discharge plans?

Ideally, the resident or a designated family/community support person should be in charge of securing discharge goals. Of course, the assistance of a well coordinated team effort on the part of the skilled nursing facility staff and community agencies is always essential.

Who develops the home care plan?

CASA, in partnership with the resident and community agencies, will develop the care plan. If the person is Medicaid eligible, CASA will also authorize the home care services.

What does Medicare pay for post discharge?

Medicare will cover care delivered by a Certified Home Health Care Agency if a skilled nursing or restorative therapy is still required after a person goes home. It is always good to err on the side of caution and make the referral to the CHHA and let them complete an assessment to determine whether or not the resident will be covered under Medicare.

What does Medicaid pay for post discharge?

If a person is Medicaid eligible, Medicaid could be the primary payer of services post discharge depending on a person's care needs and ability to manage his/her own care. CASA will conduct a level of care assessment to determine what level of care is most appropriate of the resident post discharge.

What is a Medicaid waiver?

States can apply to the federal government to expand services and create new programs under Medicaid that are not traditionally covered by established Medicaid programs. When a state applies to the federal government to expand services, they generally put a service package together under a waiver application. This allows states to tailor programs to meet specific state needs. For instance, NYS created the first LTHHCP in the nation to address the need to keep people at home rather than skilled nursing facilities for as long as possible. Waiver programs typically bundle services under one program, rather than having to piecemeal services together from a variety of programs. If a client is served in the LTHHCP, they can receive their nurse service, aide service, dietician, therapist and social work all from one agency.

What is CASA's role in Medicaid waiver programs?

CASA determines a resident's level-of-care eligibility for Medicaid Waiver programs; however, the acting Medicaid Waiver agency serves as coordinator or case manager providing the overall case management. Programs include:

- Care-at-Home (CAH), Home and Community Based Waiver (HCBW), Traumatic Brain Injury¹⁰
- Long-term Home Health Care Program (LTHHCP)¹¹

What is the definition of case management?

Case management is an activity that promotes continuity of care and involves the process of planning, organizing, coordinating and monitoring services and resources needed to respond to an individual's health care needs. It supports the effective use of health care, social services and good stewardship of financial resources. Case management offers a holistic resident/family approach to meet mutually identified resident needs in a cost-effective and care-efficient manner. This "Systems" approach is utilized to coordinate the assessment, delivery, re-assessment and monitoring of all services to ensure quality of care. A CASA Community Health Nurse (CHN) or Case Manager (CM) provides the coordination of services. CASA staff authorizes Medicaid payments for and/or case manages the following programs:

- Assisted Living Program (ALP)
- Consumer Directed Personal Assistant Program (CDPAP)
- Family Homes for the Elderly (FHE)
- Medical Day Care (Golden Days)
- Personal Care Services Program (PCSP)
- Private Duty Nursing (PDN)
- Shared Aide (SA)

CASA staff also provides case management for people (both Medicaid and non-Medicaid) who are referred to the following programs:

- In-Home Mental Health Program (IHMHP)
- Nursing Home to Community
- Nursing Home Placement (NHP)

¹⁰ CASA only manages the PCSP, CDPA and PDN portion of services that may be provided with these programs.

¹¹ CASA oversees the budget and manages the CDPA portion of services that may be provided with this program.

Does CASA assist consumers going *into* a skilled nursing facility?

As part of CASA's role in coordinating long term care services in Broome County, the agency evaluates people residing in the community in need of skilled nursing facility placement (including residents in their own homes, boarding homes, Family Homes for the Elderly, and Adult Care Facilities.). CASA will assess clients and determine the appropriate level of care. A PRI/Screen-certified, CASA CHN will facilitate the skilled nursing facility placement process if the client and/or representative(s) is agreeable to placement.

What can be done to ensure an accessible community placement for those residents in wheelchairs?

Accessibility and usability are two different concepts. Many senior/disabled housing complexes in Broome County are accessible to wheelchairs, yet most apartment units and private homes are not designed to be wheelchair friendly.

While ramps and elevators provide access to homes and apartments for people who use wheelchairs, once inside navigation can still be difficult.

Therefore, residents who use wheelchairs and are planning discharge should tour the housing unit they will be moving to. If they cannot personally tour, they should instruct a friend or loved one to look at the unit and ask the following questions:

- Is there a ramp or elevator into the home?
- Are the doorways wide enough for a wheelchair to pass through?
- Is there a bathroom on the first floor?
- Is the bathroom big enough to fit a wheelchair?
- Can a wheelchair fit under the bathroom sink?
- Is the shower a roll in verses a walk in?
- Is the kitchen designed for wheelchair use?
- Is there at least one counter that a wheelchair can fit under?
- Can a person in a wheelchair access the storage spaces in the kitchen?

Most homes and apartment units are not designed to accommodate people who use wheelchairs. However, size does matter. Large bathrooms and kitchen space at least enable a person in a wheelchair to make personal accommodations in how they might access the space most effectively.

For advice on retrofitting a home for other conditions or disabilities such as sight impairment or limited mobility contact STIC at 724-2111.

Is there any agency we can refer to when a resident decides to leave against medical advice?

Adult Protective at Broome County Social Services (778-2635) should be notified when a person leaves against medical advice. CASA will also assess the situation and on a case-by-case basis determine if services can be provided. If possible a home care assessment may be conducted by CASA to determine level of care.

Broome County Community Alternative Systems Agency (CASA)

Broome County CASA's *mission* is to serve as a central access point for assessing long term care needs of individuals and families to promote maximum independence and optimal use of available community resources.

The agency provides comprehensive assessment, care planning and case management services based on individual need, regardless of age or income, and with consideration for the personal wishes of people and their families. CASA seeks to assure that all services are designed to assist individuals to live as independently as possible. CASA, in partnership with the recipient of services, family and provider community, will assist individuals in determining how best to use available resources in coordinating care that meets their needs in a dignified, individualized manner.

The three *principle outcomes* to be achieved through CASA's central access point:

- Improved quality of life for the chronically impaired and their informal supports based on informed choices.
- Efficient, cost-effective long term care system which recognizes constraints and avoids unjustified expenditures.
- Effective coordination among service providers to meet the challenges of serving people with chronic conditions and disabilities by recognizing the value and worth of each type of service and their contribution to the overall quality of consumer care.

Broome County CASA addresses concerns associated with the long-term care needs of the elderly and the chronically ill of all age groups by providing free level of care (LOC) assessments. The *primary goal* of CASA is to maintain a client in the home whenever possible, in the least restrictive setting appropriate to their needs with help provided by family, friends and community resources.

While the intention of the program is to foster community based alternatives as opposed to institutional care, CASA recognizes the valuable service provided by institutional long term care providers and is pleased to work in partnership with the institutions that serve our community.

CASA was designed to assist individuals and providers in coordinating services across the long-term care system from institutional services (hospitals and skilled nursing facilities) to community-based alternatives (home care). Within that framework, CASA is charged with meeting *specific objectives*:

1. Providing level of care recommendations for long term care services through effective coordination at the entry points, with a focus on the use of community-based care.
2. Meeting the growing demand for long-term care services by selective expansion of non-institutional community-based alternatives.
3. Recognizing and supplementing the informal support system in order to effectively contain expenditures and enhance the quality of care.
4. Identifying individuals with unmet needs and developing mechanisms to resolve those needs on a priority basis.

CASA's Programs & Partnerships

- ▶ **Personal Care Services (PCSP) Program:** The personal care services program operates under three models: traditional Personal Care, Shared Aide (SA), and Consumer Directed Personal Assistant Program (CDPAP). This program represents the largest Medicaid home care program in the state as well as the United States.
- ▶ **Long Term Home Health Care Program (LTHHCP):** This program is referred to as the “Nursing Home Without Walls” program. LTHHCP provides a higher level of nursing case management and assessment than the personal care program.
- ▶ **Assisted Living Program (ALP):** There are three providers of these residential care programs in Broome county with a total of 70 beds and 26 Medicaid clients. CASA assesses all clients, (private pay or Medicaid, who want to access the program) and authorizes payment for Medicaid residents.
- ▶ **Medical Day Care:** Susquehanna Nursing Center (SNH) operates the only Medical Adult Day Care (ADC) Program in Broome County. CASA assesses and authorizes the care for all Medicaid clients served by the program.
- ▶ **Private Duty Nursing (PDN):** CASA assesses, authorizes and case manages all Medicaid private duty nursing cases in Broome County, with an average of 30 clients through five providers. People in receipt of this care are mainly children with high-tech nursing and intense nursing management needs.
- ▶ **Care-at-Home (CAH):** CASA provides assessment and Medicaid payment authorization to this program designed to serve medically fragile children.
- ▶ **Nursing Home to Community:** This effort is a model program for the state and the nation. Since 1996, Broome County CASA has assisted over 3,000 people achieve skilled nursing facility discharge.
- ▶ **Skilled Nursing Facility Placement:** CASA conducts level of care assessments in the community (not the hospital) to determine if someone is eligible for skilled nursing facility placement. A CASA nurse meets with the client and their support person and completes an initial assessment visit.
- ▶ **Family Homes for the Elderly (FHE):** One provider coordinates approximately 20 private homes and serves 40 clients on a monthly basis. CASA determines eligibility and authorizes the Medicaid payment for clients served in this program. The program is operated by Family & Children’s Society (F&C) and is the most successful program of its kind in New York State.
- ▶ **In-Home Mental Health Program (IHMHP):** CASA recognized the need for greater management of psychotropic drugs in home care. Community Mental Health Reinvestment money was obtained by Family & Children’s Society to assist people in their homes stay on their medication regime. There are no Medicaid dollars involved in the delivery of this service, yet it has the potential to save Medicaid dollars by assisting clients in managing their care and increasing their independence.
- ▶ **Home Community Based Waiver (HCBW):** CASA determines level of care (PDN, PCSP, or Home Health Aide) for recipients of this program when they are in need of home care.
- ▶ **Personal Emergency Response Systems (PERS):** CASA assesses and approves the Medicaid payment for personal care recipients in need of a personal emergency response unit.

Southern Tier Independence Center (STIC)

STIC's *mission* has three parts. The Center provides assistance and services to people with all disabilities of all ages to increase their independence in all aspects of integrated community life. STIC also serves their families and friends, and businesses, agencies, and governments to enable them to better meet the needs of people with disabilities. Finally, STIC educates and influences our community in pursuit of full inclusion of people with disabilities.

STIC embraces the Independent Living Philosophy which states that people with disabilities should be empowered to control the direction of their own lives. This means choosing their goals, plotting their course and taking responsibility for their actions and the results. People with disabilities have the right to make their own choices and decisions and the right to make mistakes and learn/benefit from those mistakes. Independent living centers (ILCs) foster independence, help disabled people to develop networks/supports and promote self-reliance. ILCs advocate for the inclusion and integration of people with disabilities in all aspects of community life.

STIC further defines its *philosophy and approach* to include the following:

- The consumer is *ALWAYS IN CHARGE*. To the extent that he/she is capable of doing so, the consumer is expected to make decisions and participate fully in the transition process. We will not do for the consumer what he/she is capable of doing for him/herself.
- STIC's assistance and services are customized to each individual's needs, goals and wishes. No service is provided that is not wanted, agreed to or needed by the consumer.
- STIC *will not* take responsibility for making decisions for the consumer's medical care and/or services.
- STIC will not release any consumer information that is not essential for the delivery of services.
- STIC reserves the right to terminate services and/or contact under extenuating circumstances such as a lack of cooperation or participation by the consumer in the transition process.

STIC's website¹² lists the following agency *values*:

- We value the ability of every human being to reach for their dream.
- We hold that each individual has strengths and weaknesses that must be taken into account in their journey toward their dreams. Each individual must accept the responsibility for the dream, the journey, as well as the work to get there.
- We offer support, ideas, tools, training, respect and concern.
- We will not do for, when it can be done by the person.
- We will not patronize for the sake of efficiency, or in the guise of caring. We will try to understand when this causes fear, anger and frustration.
- As we develop programs and policies, we will be guided by the dreams and abilities of the people we serve.
- No matter how difficult the road, we will always choose the path of inclusion and integration.
- We will not sacrifice our principles or values for money, convenience or expediency.
- We will not shy away from controversy if that controversy will further our mission.
- We offer hope and continue to look at each person as a unique and joyful experience that will teach and take us on a journey where we have never been.

¹² <http://www.stic-cil.org/>

STIC's Programs and Services

- ▶ **Accessibility Advice**: Help with finding the cheapest and easiest way to make a home barrier-free. For some eligible people, the program can also find funding for modifications for homes or vehicles.
- ▶ **Assistive Technology**: The TRAIID (Technology Related Assistance for Individuals with Disabilities) Center shows how technology--from simple homemade gadgets to computer systems--can foster independence. Items are on display.
- ▶ **Loan Closet**: All kinds of equipment (i.e. wheelchair, TTY, telecaptioner, walker) are available for short term loan. Some items require a refundable deposit.
- ▶ **Wingspan Technology Center**: The Wingspan Center provides communication technology assessments, product demonstrations, advice and assistance to people with disabilities of all ages, but especially to children.
- ▶ **Americans with Disabilities Act Services**: Training and consultation on all areas of ADA access and employment provisions for businesses, agencies, and government, for a fee.
- ▶ **Benefits Assistance**: Information and help in applying for and receiving benefits from Social Security--including the Medicaid Buy-In, Social Services, medical programs, utilities, etc.
- ▶ **Housing Assistance**: Information and help on finding suitable, affordable housing.
- ▶ **Information & Referral**: Information on disability issues.
- ▶ **Resource Library**: Loans books (print/braille), tapes (audio/video), magazines, on disability issues.
- ▶ **Advocacy**: Works with consumer to make sure his/her rights are protected, such as right to a sign language interpreter at public meetings, right to a barrier-free community, right to attendant care with dignity, and a child's right to a free appropriate education.
- ▶ **SAIL**: The System Advocates for Independent Living group works to make the world a better place for people with disabilities.
- ▶ **Consumer Directed Personal Assistance**: Shows consumers how to hire, train and supervise own attendants to assist with bathing, dressing, eating and other daily tasks.
- ▶ **Community Integration**: Community Integration Advocates (CIAs) help consumers get out of a skilled nursing facility, group home, hospital, or other institutional setting and move into own home in the community. Offers a full range of services including peer counseling, advocacy, housing and benefits advice and assistance, and assistance with loan or give-away household items--everything needed to find an accessible place to live and set up housekeeping.
- ▶ **Peer Counseling**: A chance to talk to someone with a similar disability or to be part of a support group.
- ▶ **Professional Counseling**: Centered around consumer and/or consumer's family, working together to find the best ways to cope with stress, family, emotional, disability and other personal concerns. This includes "Community Integration Counseling" funded by the NYS Head Injury Waiver.

- ▶ **Deaf Services:** All of the services listed here are available to people with hearing loss, including those who are culturally Deaf. Our Deaf Services Coordinator is a native American Sign Language (ASL) user, and most of our staff know some basic sign language.
- ▶ **One-Stop Center Disability Navigator:** Looking for some help to find a job or to advance your career at Department of Labor One-Stop Centers? Our Disability Navigator is there to assist you to make your way through the thicket of specialized disability-related employment programs in Broome and Tioga Counties.
- ▶ **Supported Employment:** If eligible, the Job Connections program can help find a job and provide a “coach” to assist with learning duties and be a part of the workplace.
- ▶ **Independent Living Skills:** There are as many different ways of doing household chores, budgeting, shopping, etc., as there are disabilities. If eligible for the New York State Department of Health’s Traumatic Brain Injury Home and Community-Based Services waiver, STIC can provide a more structured form of Independent Living Skills Training.
- ▶ **Interpreter Services:** Arranges for qualified sign language interpreters, or readers, scribes, for a fee.
- ▶ **Service Coordination:** Assistance with hooking up with a variety of service providers to meet specified needs. STIC is approved to provide this service under the:
 - ▶ OMRDD Home and Community-Based Services (HCBS) waiver
 - ▶ DOH TBI (head injury) HCBS waiver
 - ▶ DOH Early Intervention program
- ▶ **“Parents Empowering Parents” (PEP):** A support group for parents of children with disabilities.
- ▶ **Transition Services:** A range of services to assist high school students with disabilities to plan for and achieve the changeover from school to living and working in the real world, in integrated settings and real jobs that they choose. Services are available to students in Broome-Tioga BOCES, and in the Binghamton, Johnson City, and Union-Endicott school districts.
- ▶ **Professional Training:** Because STIC is controlled by people with disabilities, it’s the only local agency with a true disability perspective on issues such as law, services and education. Our expertise can aid your professional growth and help you understand legal issues regarding disability. Our Americans with Disabilities Act (ADA) and Disabilities Awareness (for children, teachers and others) training programs are available for a fee. We also design customized training on deafness, medical services and other issues.

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The work on this manual is a reflection of the community effort that the manual represents. Nursing Home to Community has been successful in Broome County because of the partnerships and trust that we have developed among the numerous providers who worked so hard to make this program a success.

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INSERT YOUR OWN FACILITY'S POLICIES & PROCEDURES HERE

- Mission Statement**
- Values/Philosophy Statements**
- Residents' (Clients') Bill of Rights**
- Transition (Discharge) Policy**
- Transition (Discharge) Procedures**
- Partner List & Contact Information
(i.e. important phone/fax numbers)**
- Other Important Forms**