Virginia Department of Behavioral Health & Developmental Services

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Office of Integrated Health
Long-Term Care- Community Transition Team

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Children Nursing Facility Transition Protocol/Process

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I. <u>Purpose</u>

To develop and implement systematic processes/protocols that facilitates successful transitions of children with developmental disabilities from nursing facilities into community settings with appropriate services and supports.

II. Entry Point (For identifying children in nursing facilities): PASRR; this is how the Long-Term Care Division within Office of Integrated Health (OIH) is informed of a child admission to a nursing facility. All efforts are made so that children are pre-screened; however, if a child who is receiving services in a nursing facility is identified as potentially having a DD diagnosis, then a resident review is conducted.

III. Definitions

a. **Children**: This means individuals under 22 years of age.
b. **Community Services Board (CSB):** This means the public body established pursuant to §37.2-501 or §37.2-602 of the Code of Virginia that serves the area in which a minor's parent or guardian resides, and that may provide support coordination and discharge planning support to a child living in a Nursing Facility
c. **Registered Nurse Community Integration Consultant (RNCIC):** Responsible for the oversight of the PASRR II process, reviews and approves all PASRR II summaries of findings prior to admission or diversion from a nursing facility
d. **Community Transition Nurse (CTN):** Works with RNCIC, nursing facilities, CSBs, and other entities involved in transitioning a child to a placement of lesser intensity, to ensure the best possible outcomes for the child. Notifies CSB when a child from their catchment area is hospitalized.
e. **Preadmission Screening Resident Review (PASRR): -** The Preadmission Screening and Resident Review (PASRR) process is a federal mandated process to ensure that individuals with a Serious Mental Illness (SMI), Intellectual Disability (ID), and/or a Related Condition (RC) are not inappropriately placed in nursing facilities. The PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they have a SMI, ID, or a Related Condition that meets the criteria to be included in the PASRR process. This is called a "Level I screen". Those individuals who are identified with a SMI, ID, or RC are then evaluated through the "Level II" PASRR process to ensure that the Individual meets the criteria for Nursing Facility admission and to make recommendations for rehabilitative and Specialized Services.
f. **Active Discharge:** Transition process where discharge from the nursing facility is actively being planned within the next 3-6 months; discharge planning begins at admission.

IV. Process

a. Preadmission Screenings (PAS) and Resident Review (RR) process is overseen by the Nurse Community Integration Consultant (RNCIC).

- **i.** The RNCIC notifies the CTN that a PAS or RR has been completed on a child (ages: 0-21) via secure email and provides a summary of findings, Level I screening, and Level II information
- **ii.** RNCIC conducts a quarterly comparison of NF billing data provided by DMAS and the list of children identified through the PASRR process to ensure that all children are identified ongoing.

b. CTN Case Review/Identification

- **i.** Review case file
- **ii.** Determine Community Services Board (CSB) affiliation
- **iii.** Identify and connect with appropriate CSBs

c. CSB Connection Process

- **i.** DBHDS distributes an introduction letter to the CSBs outlining the Children Nursing Facility Transition Protocol/Process
- **ii.** Via an Awareness Letter (through a secure email), CTN notifies the appropriate CSB that a child from their catchment area is being admitted or residing in a Nursing Facility (NF) and may benefit from a less restrictive setting with the proper services and supports in place.
- **iii.** CSB is advised to initiate a Regional Support Team (RST) referral if needed.
- **iv.** As appropriate, CTN will collaborate with the CSB to ensure the submissions of an RST referral is made within accordance to established guidelines when:
  1. The nursing facility is having difficulty finding medical/nursing support in the community prior to discharge
  2. The nursing facility team is having difficulty finding services in the community within three months of receiving a slot
  3. When the individual/guardian is choosing to move to a group home of five or more individuals
  4. When the individual/guardian is choosing to move into a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
  5. The individual has a pattern of repeatedly being removed from the home

V. Facility Work

a. Community Connections Schedule

- **i.** CTN will attend discharge coordination meetings based on the nursing facility schedule and mutually agreed upon attendance
- **ii.** CTN will work with facility to prioritize children and identify ways to remove/reduce barriers to discharge

VI. Family/Guardian Outreach Protocol/Process

a. **Initial Outreach to Families/Guardian of Individuals <22 years of age residing in Long-Term Care**
    i. CTN will send an initial contact letter to family/guardian/authorized representative of those children receiving long-term care services via US mail with a copy of the Community Transition Guide as an informational resource not less than semi-annually
    ii. RNCC will make follow-up contact via phone with families/guardians/AR documenting attempts (at least three phone attempts) and responses on tracking log (created by CTN)
    iii. CTN will provide families/guardians/AR more information about community resources and supports (example: connection to the Family to Family Support Network) if interest is expressed during initial contact
    iv. For those families/guardians/AR identified as open to discussing transition to community services, DBHDS will facilitate a discussion with NF Social Worker, CSB, and family/guardian/AR to determine next steps

b. **Ongoing Outreach to Families/Guardians of Individuals <22 years of age residing in Long-Term Care**
    i. CTN will ensure all newly identified children <22 years of age identified as receiving long-term care services in NFs are added to the tracking log and family/guardian/AR contact attempts and responses are documented at least annually
    ii. CTN and Family Resource Consultants will offer training/education sessions semi-annually to NFs to increase awareness of community services that are open to staff and families
    iii. CTN, RNCCs, and Family Resource Consultants will explore ways to highlight transition successes from institutional settings to community settings to families and NF staff

VII. Transitional Individual Specific

a. **Transition Procedure**
    i. CTN will liaise between the facility Case Manager and the CSB Support Coordinator
        1. Within 90 days of being notified that a child is identified as being in active discharge status, the CTN will send an action letter to the appropriate CSB. This letter will inform the CSB that a child in their catchment area is currently in active discharge status and there is available funding to assist with Case Management services to assist with discharge planning and facilitate discharge.
    ii. CTN, CSB, and other stakeholders work together as indicated to reduce barriers to discharge
    iii. If unable to resolve barriers, refer to RST (see IV.C.iv above)
    iv. Implement recommendations of the RST as appropriate

VIII. Post Move

a. **Post Move Monitoring Plan**

   i. DBHDS will develop and implement a post-move monitoring process for children being discharged from a nursing facility to ensure that services and supports are in place and there are no gaps in care. The process will include the frequency and intensity of monitoring as appropriate to individual circumstances and a monitoring checklist.

b. Post-Placement Consultation

   i. Post NF discharge, individuals will be referred to the Health Support Network team as needed/directed by the agency providing care
   ii. Consult with the Community Integration Team as needed (i.e. Community Resource Consultants, CSB)

c. Reporting

   i. A Tracking Log is currently in place with the RNCIC. The CTN will report to the RNCIC on active transition plans (i.e., discharges, deaths, etc.)