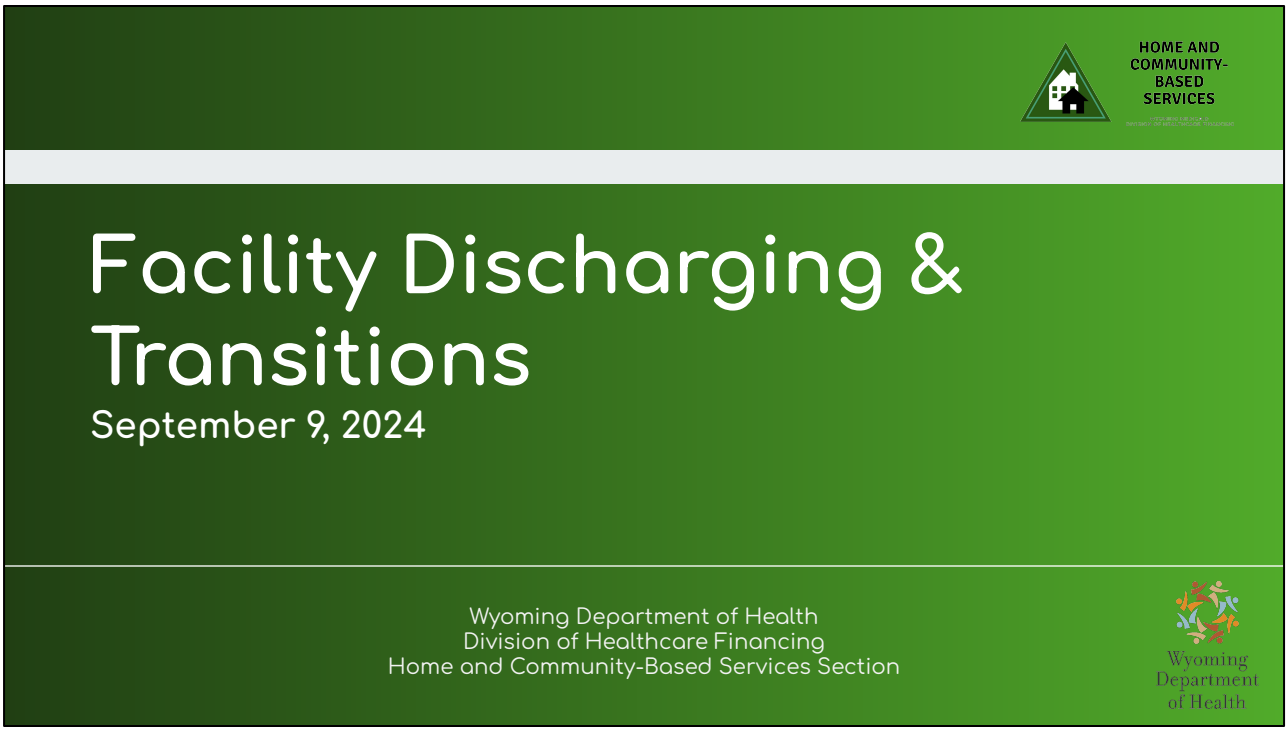


Welcome to the Home and Community-Based Services case manager support call training on discharging and transitioning from state facilities. My name is Patrice Chesmore, a Benefits and Eligibility Specialist with the Home and Community-Based Services Section. Thank you for joining us today.

The purpose of this training is three-fold. First, we want to familiarize case managers with the state facilities. More specifically, we will discuss the mission and services available at Wyoming's two State operated institutional level-of-care facilities: the Wyoming State Hospital and the Wyoming Life Resource Center. Both state facilities are part of the Department of Health under the Behavioral Health Division

Secondly, we will review the the discharge processes for individuals transitioning out of those facilities and look at the specific steps necessary for case managers to understand to support participants as they transition back into the community.

Finally, we'll cover the roles and responsibilities of case managers and other team members and how their coordinated effort and engagement is essential for smooth participant transitions after discharge.

Before we get started, we'd like to review some of the acronyms and abbreviations we will be using in today's training. The Medicaid system in general, and the home and community-based services section in particular, uses a lot of acronyms. Although you may already know these, for anyone that does not, things can quickly become confusing.

First, the Wyoming Life Resource Center may be referred to as WLRC, and the Wyoming State Hospital is often shortened to WSH. ICF means Intermediate Care Facility. SSI refers to Supplemental Security Income; LOS is Level of Service.

When we speak of *your* BES, we're referring to the HCBS, Home and Community-Based Services Section, Benefits and Eligibility Specialist that is assigned to *your* county. Additionally, within our BES Team, there is a **BES Liaison** who is the designated contact for each state facility. LTC are our partners in the Long Term Care Unit. You will also hear us refer to the participant's LAR, or Legally Authorized Representative.

HOME AND COMMUNITY-BASED SERVICES

Wyoming's State Facilities

Now let's look at Wyoming's State Facilities

Wyoming Life Resource Center

Mission:
Provide intermediate, long-term and/or skilled nursing care to individuals who no longer have access to services in their communities.

Services:
The Canyons Intermediate Care Facility for individuals with intellectual disabilities

Mountain View Skilled Nursing Community

Rules:
WY Administrative Rules, Dept. of Health, Medicaid & WLRC Chapters

The Wyoming Life Resource Center or WLRC is located in Lander, Wyoming. Prior to 2016, the entire WLRC campus was dedicated to serving individuals with an intellectual disability needing ICF (intermediate care facility) level-of-care. In 2016, the Wyoming legislature enacted law updating WLRC's mission and vision to include a second, skilled-nursing facility within its campus.

Today, the WLRC is comprised of two programs: The Canyons Intermediate Care Facility, for individuals with intellectual disabilities, and the Mountain View Skilled Nursing Community. The mission of WLRC is to provide intermediate, long-term and/or skilled nursing care to individuals who no longer have access to services in their communities. Participants must already be on, or eligible for, an HCBS waiver.

The vision of the Wyoming Life Resource Center is to:

1. Ensure residents' strengths and needs are recognized, supported, and met;
2. Provide a safe environment, respect, independence, and ensure the rights of each resident are always protected;
3. Create opportunities for the most medically and behaviorally vulnerable people in the State to live more independently in their respective communities by providing compassionate care, a sense of community, and an opportunity to enjoy life in a resident-centered environment;
4. Maintain a center of excellence that helps restore individuals in need of short-term assistance to live in less restrictive environments.

Temporary admission to WLRC may be allowed for up to 75 days and individuals may enter

and exit with the same level-of-service requirements.

Wyoming Sate Hospital

Mission: To improve the lives of those in Wyoming affected by severe mental illness.

Services:
Adult Psychiatric Services (acute & intermediate)

Criminal Justice Services (evaluation & treatment services)

Rules:
Title 25 for civilly ordered involuntary hospitalizations

Title 7 for court ordered evaluations and restorations

In March of 1886, the Wyoming Territorial Legislature appropriated $30,000 for the construction of a “State Mental Hospital”. The Wyoming State Hospital started with a 20 bed capacity, grew to a capacity of 750 beds in 1968, and is currently operating 103 beds today.

The mission of the Wyoming State Hospital is to improve the lives of those in Wyoming affected by severe mental illness. The State Hospital is the only state-operated psychiatric facility licensed in Wyoming. It provides both Adult Psychiatric Services (including Medical Geriatric Psychiatric Services) and Criminal Justice Services.

Adult Psychiatric Services provide acute crisis and intermediate care for persons requiring psychiatric intervention. Criminal Justice Services serve the Wyoming court system by providing forensic evaluations and a range of other treatment services under the direction of the courts. This includes individuals who are admitted by court order and who may, or may not be, already on or eligible for medicaid waiver services.

The hospital operates under Wyoming Statute Title 25 for civilly ordered, involuntary commitments (medically ordered psych holds), and Wyoming Statute Title 7 for forensic court ordered psychiatric evaluations and restorations.

HOME AND COMMUNITY-BASED SERVICES

The Discharge Process

Let's move on and discuss the discharge process and the Case Manager's responsibilities for institutional placements.

It is important for the case manager to maintain engagement and follow cases when a participant is admitted to one of these facilities. The case manager will be responsible for coordinating with the participant's facility team when they prepare for discharge and transition out of the facility. **By following participant's case, the case manager helps facilitate a person-centered continuum of care.**

In order to support a participant who is placed in the Wyoming Life Resource Center or Wyoming State Hospital, the case manager must work with the BES Liaison to understand their role in supporting the participant. The case manager is expected to continue to follow and monitor the participant while they are in the facility, as well as maintain required documentation in order to bill for services during the participant's stay.

The BES Liaison will provide the case manager with a transition workbook to assist them through the discharge process, and to track time spent performing case management duties during the participant's facility placement – similar to how they would for a participant who receives Targeted Case Management services. At the time of discharge, the case manager may submit their time and documentation to the BES Unit Manager (BESM).

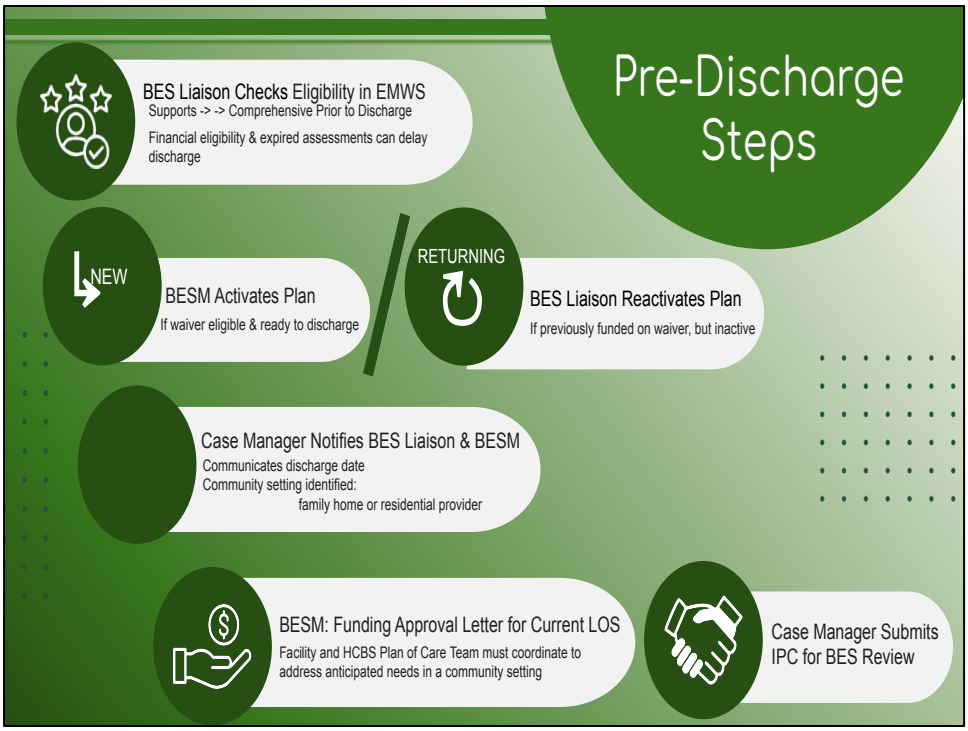
Before HCBS staff can open or reopen a case, it is critical for the case manager to communicate ***in writing*** that the participant (or LAR) would like to receive waiver services upon discharge. Remember, the waiver is a program of choice.

Before we go any further, let's pause to focus on that fact. The waiver program is an optional choice, and is *not required* for discharge.

Remember, participant choice is a basic tenet of home and community-based waiver services and that is true no matter the circumstances. You hear us say it often, and we say it because we want it to be in the forefront of everyone's mind. **All participants must have the freedom to choose the services they receive, who provides those services, where they live, with whom they spend time, and what they want for their future.**

Having choice is paramount to human dignity. Restricting a participant's basic human rights is a really big deal, should never be taken lightly, and should never be the only response to a challenging situation.

Please note, if a participant discharges from a facility without being waiver eligible, and without an approved Individualized Plan of Care, they will need to complete the eligibility process to be placed on the Supports Waiver waitlist. If they are on an active waiver program but on-hold during their stay, they will return to that waiver after discharging and must utilize the existing funding already in place.



Let's continue by reviewing the discharge process in more detail from a Home and Community-Based Services lens.

Once a participant is admitted, the BES Liaison checks waiver eligibility status in EMWS. Applicants may admit to the facility on the Supports Waiver, but will transfer to the Comprehensive Waiver prior to discharge.

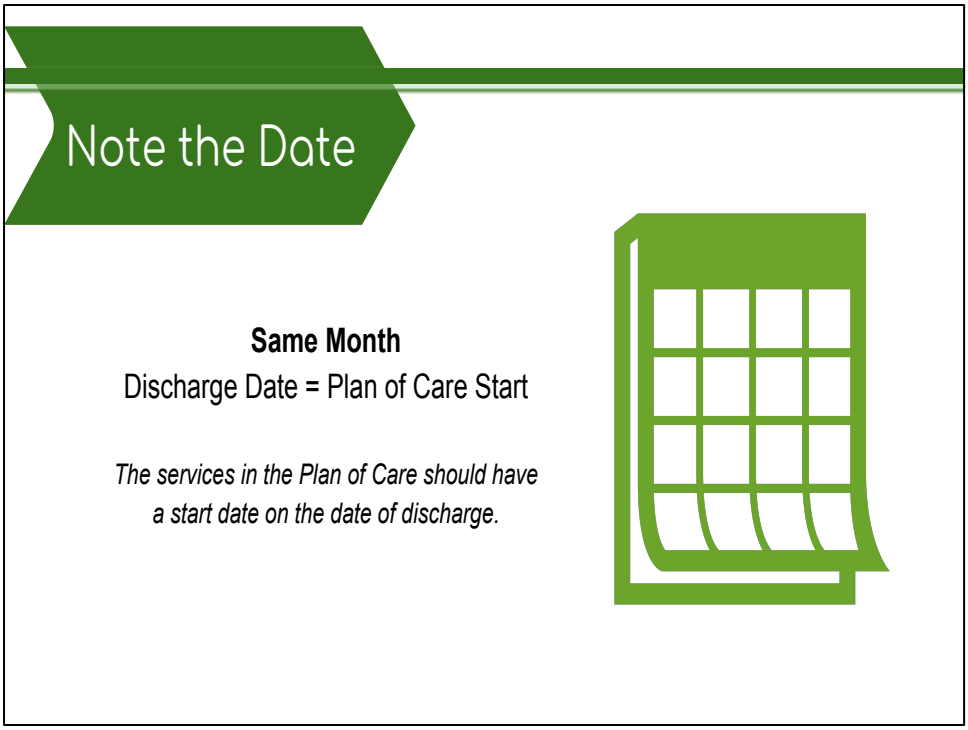
At this point, confirming the participant's financial eligibility is out of the BES control. It is important for case managers to monitor financial eligibility as well as assessment expirations, as an issue with either requirement can delay the discharge process, and ultimately interfere with the individual's ability to discharge with waiver services.

When a participant has been identified for discharge, the case manager should give the BES Liaison a *minimum* of 60-days notice prior to the discharge date. Participants new to waiver services must complete the eligibility process. The Benefits and Eligibility Unit Manager (BESM) will activate the waiver Plan of Care in EMWS when the individual is ready to discharge. If the participant has previously had an active waiver case, the BES Liaison will reactivate the case as appropriate.

Once decided, the case manager or facility representative will notify the BES Liaison of an individual's discharge plan. This includes sharing information on the community living setting (like family home, CLS Basic, or CLS levels 3-6), and the rationale for the decision. For example, upon discharge, Joe will likely go to a family home because…..

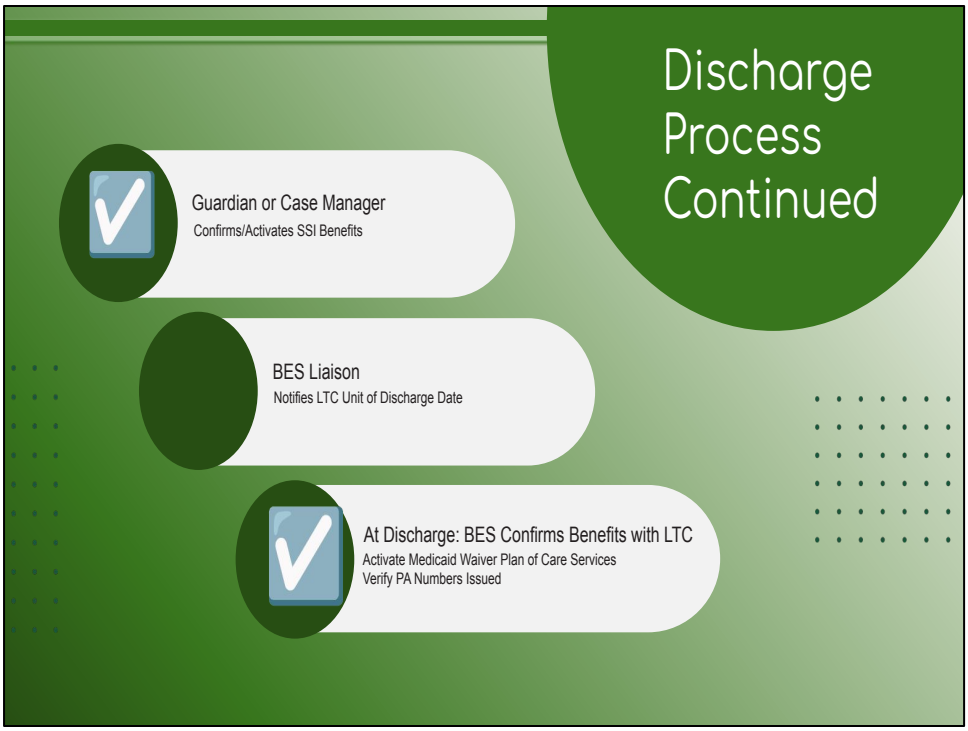
This information is then shared with the Benefits and Eligibility Unit Manager (BESM).

The BESM (or designee) will then generate a letter approving the participant's funding at their **current** level-of-service (LOS). This letter will indicate the funding available to them based on their current support need as well as any other needed information. The facility team and HCBS plan of care team must coordinate to address anticipated needs in a community setting. The case manager then submits the individualized Plan of Care to the Benefits and Eligibility Specialist for review and provision of waiver services upon discharge.



Note that when discharging, it is imperative that the discharge date and the Plan of Care date occur within the same month. The services in the Plan of Care must have a start date that begins on the date of discharge. This is one of a few times that this is allowed.

For example, if Joe discharges on August 15th, his Plan of Care would have a start date of August 1st. Joe's service line effective dates would begin on August 15th - the day he discharges to his community setting.



The guardian or case manager must confirm social security income (SSI) benefits ***prior*** to discharge. The BES liaison sets a calendar reminder to confirm date of discharge with the Long Term Care unit for activation of Medicaid waiver benefits.

The case manager and the community plan of care team must coordinate with the facility team to accurately assess the participant's needs and, over time, step down supports that are required post-discharge. Although not always the case, as a participant adjusts to being back in their community setting, their level-of-service score may decrease.

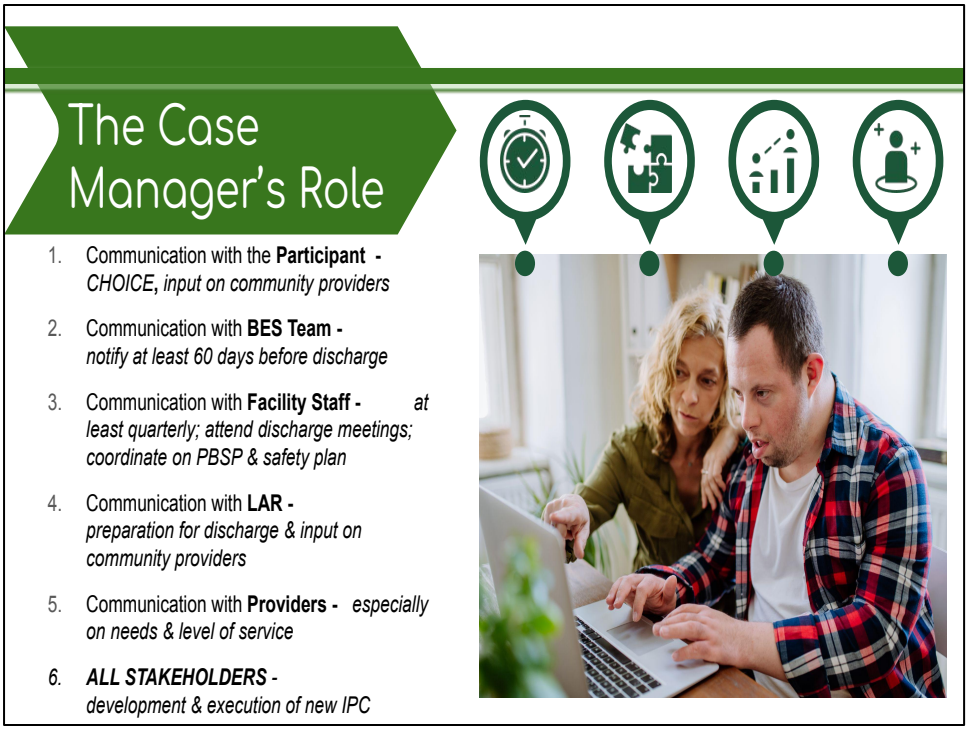
Understanding the Reserve Capacity Funding methodology is critical for case managers during the discharge and transition process. Because of their needs at discharge, participants will likely transition with this temporary budget. The budget is set in EMWS and only lasts for a six month period post discharge.

At the end of that time, a new ICAP will be requested by the BES Liaison, and a new level of service will be determined with a corresponding individualized budget amount (IBA). The new IBA may be lower than the post-discharge IBA, and it's important that case managers anticipate this decrease and reflect it in the services they include as they develop the participant's annual Plan of Care.

HOME AND COMMUNITY-BASED SERVICES

Roles & Responsibilities

Roles & Responsibilities



Now that we've reviewed the discharge steps, let's consider the case manager's role in supporting the participant throughout the process. In addition to knowing what documentation is required in order to bill for case management services during the participant's institutional placement, the biggest role of the case manager is to maintain **communication** with all stakeholders.

First, as obvious as it may seem, case managers must maintain communication with **participants** regarding the discharge process. Case managers should understand that they cannot force a participant to maintain HCBS program eligibility or enroll for waiver services. The HCBS Waivers are waivers of choice and it's paramount that case managers respect the participant's choice. Knowing this, it is important to understand that if the team would like HCBS funding upon discharge, the waiver eligibility process must be followed.

Timely communication with the BES team, facility staff, and the Legally Authorized Representative (LAR) is also important. The case manager must inform **BES Staff** of anticipated discharge dates at least 60-days beforehand, as well as communicate the rationale and plan for services upon discharge.

The case manager must work alongside the **facility team**, attend discharge meetings, and coordinate with facility staff on the development of the participant's positive behavior support plan (PBSP) and safety plan.

The case manager should also collaborate to the fullest extent possible with the participant's **legally authorized representative** in securing community service providers in preparation for discharge. Case managers need to be prepared for providers that may be unable to support the participant and know that it is ultimately the provider's choice as to whether or not they agree to resume services for a participant after discharge. The case manager must communicate the participant's level-of-service and support needs to **providers** so they have a clear understanding of the level-of-care that will be required to keep the participant safe, healthy, and successful.

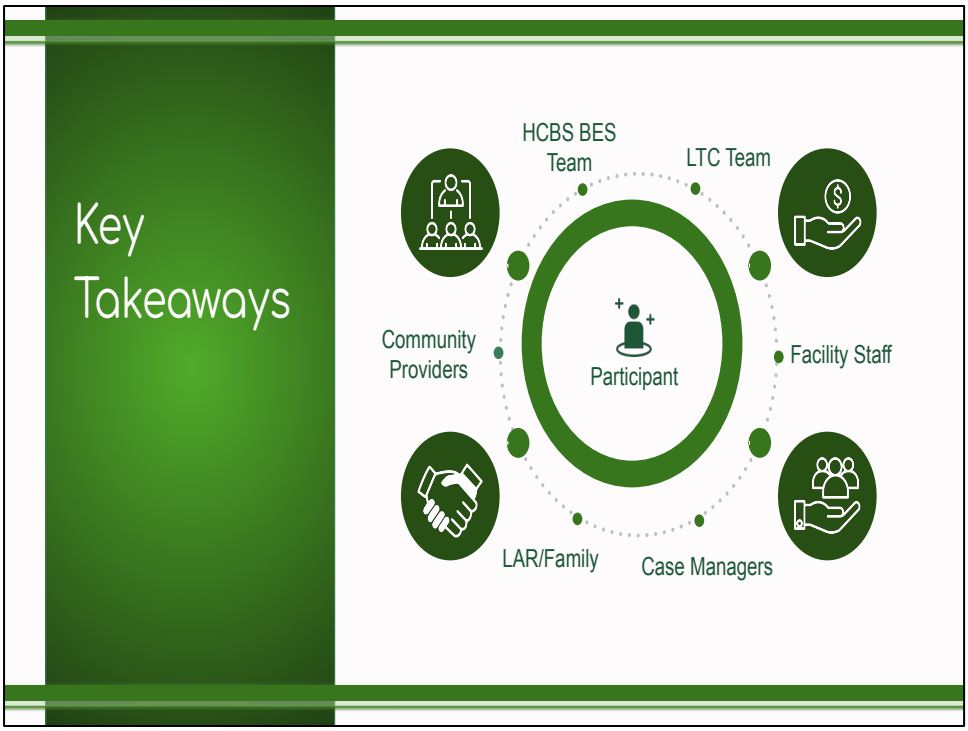
And finally, the case manager must also coordinate with the same stakeholders - the participant, facility staff, BES team, LAR and community providers - to develop a new individualized Plan of Care.

The case manager can bill for Targeted Case Management for services they provided while the participant was in the state facility. Once the participant discharges, the case manager should submit a summary of all services provided – including dates and times – along with an invoice to the BESM. The BESM will process and submit it for payment to allow the case manager to be paid using state funds.

There are several resources available on the HCBS website that case managers may find useful when assisting with transitions:

> The Positive Behavior Support Plan (PBSP) Manual, the PBSP itself, and the Rights Restriction Review Tool. There are also trainings on the Rights Restriction Review Tool, step-by-step instructions for the EMWS Rights Screens and Positive Behavior Supports and Restraint Standards.

For questions regarding the Wyoming Life Resource Center, we've included Tammy Edmondson's contact information. She is the WLRC Admission & Discharge Coordinator. Contact information has not been provided for the Wyoming State Hospital because participants are typically admitted through the judicial or mental health system.



Today we've discussed Wyoming's two institutional level-of-care facilities - the WLRC and WSH. We've also covered the discharge process and how you, as a case manager, can help make transitions go smoothly by knowing your role and responsibilities, as well what you can expect from other stakeholders.

Key Takeaways Include:

1. The Wyoming Life Resource Center is designed for intermediate and long term care of waiver eligible participants.
2. The Wyoming State Hospital is for acute treatment and stabilization.
3. The discharge process involves stakeholders from several different agencies all working toward a common goal to serve the participant.
4. The key to a smooth transition is understanding the process, the players, and maintaining communication throughout. There are resources available to assist case managers as their role is crucial to the process.

Thank you for joining us today for our training on Facility Discharging & Transitions. We're happy to answer any questions may you have at this time.