2017 Discharge Planning Manual

for Community Professionals Assisting DC Residents with Multiple or Complex Needs

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Introduction

The District of Columbia government has created this discharge planning manual as a resource for Discharge Planning professionals assisting DC residents with multiple or complex needs to experience smooth, successful discharges from institutional to community settings. The goals of the manual are to streamline District-wide discharge planning practices, and make community long term services and supports as accessible and transparent as possible. Additionally, this manual is intended to improve discharge planning processes by enhancing collaboration among responsible agencies and facilities; and to hold each agency accountable for their designated role in discharges.

In 2006, the District of Columbia government passed the Disability Rights Protection Act, which created the Office of Disability Rights (ODR). Among other things, ODR takes the lead in developing and submitting an Olmstead Compliance Plan. ODR published the District's first Olmstead Plan in 2011, and the city has since made a number of updates based on the input of those involved in the discharge planning process. The most recent Olmstead Plan can be found on ODR's website. ODR has also created a practical tool for facilitating self-directed discharge planning which is located here.

The District's Olmstead Plan assists people with disabilities, that are living in settings like hospitals or nursing homes, move back into the community if they express interest in living outside of an institutional setting and there are available

supports in place to make that possible. This transition from one level of care to another should be smooth for the individual.

Transitions from one care setting to another can be complex and require significant coordination between an individual, providers, and several systems. The individual and their goals are at the center of this process and are what drive the overall transition plan. Transition plans need to begin at admission, be updated throughout an individual's stay, and the discharge should be timed appropriately, with needed supports in place. For a successful transition, there must be clear communication between individual, family and caregiver(s), facility, and community-based providers outlining roles, responsibilities, timelines, care needs and up to date contact information.

The District recognizes that all people with past, current or future disabilities can and should be a part of the community if they choose, and have lives that are full of opportunities:

Local and Federal Regulations for Nursing Homes and Hospitals

When discharge planning, **nursing homes** must adhere to the following local and federal regulatory standards:

Summary of Title 22B District of Columbia Municipal Regulations

The following information is only a summary; please see the tables in Appendix 1 for the full regulations that must be followed during the discharge process.

The checklist below is only an outline and general framework of the regulations and the rules for discharge practices which include but are not limited to:

Nursing Home Discharge Planning Responsibilities Checklist

Discharge Assessment

- Within 14 days after admission, a facility is required to conduct a discharge assessment which includes confirming whether the resident wants to return to the community. If the answer is yes, goals toward discharge must be established.
- If the resident is uncertain, the facility should revisit this question with the resident on a quarterly basis.
- If the resident wants to transfer to another facility, steps should be taken to facilitate this request.

Discharge Plan

The Social Services staff, with the resident, coordinates the discharge planning with an interdisciplinary team that includes the nursing facility resident, members of their informal support network as selected by the

resident, and any other appropriate agencies or organizations. A physician prescribes the plan for continuing care in the community.
The Discharge Plan should include the following:

1. Overview of the transition from facility to the community including housing, and any needed home and community based supports

2. Medication Needs: released to resident upon discharge with their physician's authorization

3. Patient Record:
   - Completed within 30 days from date of discharge
   - Patient Record must include
     - Date of Discharge
     - Condition Upon Discharge
     - Location to which resident was discharged
     - Medications on discharge
     - Summary by physician of resident's medical experiences upon discharge
     - Hospital discharge summaries
     - Government-issued identification including driver's license, birth certificate and Social Security card
     - As applicable, previous applications to the DC Housing Authority filed before admission to the nursing facility
     - Documentation of income, including but not limited to SSI
     - Documentation of legal guardianship or power of attorney

4. Final location of the transition and dates when supports will be put into place

Resident Rights

- Resident has the right to provide written or oral notice to the facility of desire to be discharged

- Resident has the right to receive a consultation from the physician to confirm needed medical supports in the community
- Upon receiving notification, the facility must provide resident and their representative with a current assessment, counseling rights and discharge plan
- Resident is linked to community resources and supports such as the District's Local Contact Agency, the DCOA Aging and Disability Resource Center **(202-724-5626)**
- Resident can be connected to DC LTC Ombudsman: **(202-434-2190)**, DCOmbuds@aarp.org
- If the discharge is initiated by the facility, the resident is required to receive formal notice with appeal rights in compliance with both DC and federal law. Review the law referenced below regarding facility initiated or involuntary discharges.

*A transfer or discharge of a resident from a nursing facility shall be done in accordance with the **Nursing Home and Community Residence Facility Residents' Protection Act of 1985**.(D.C. Law 6-108; D.C. Official Code §§44-1003.01, et seq.)*

The **nursing home** must also follow the federal regulations: **42 CFR (Code of Federal Regulations) §483.10-§483.75**. See **Appendix 1** for the full regulations.

When discharge planning, **hospitals** must adhere to the following federal regulatory standards:

Summary of Centers for Medicare and Medicaid- State Operations Manual

The following information is only a summary; please see the tables in Appendix 1 for the full regulations that must be followed during the discharge process.

The checklist below is only an outline and general framework of the regulations and the rules for discharge practices include but are not limited to:

Hospital Discharge Planning Responsibilities Checklist

Discharge Planning Process

- Hospital must have discharge process that applies to all patients
- Policies and procedures must be in writing
- Process must be supervised by qualified personnel
- Planning must be person-centered

Discharge Planning Evaluation

- Hospital must identify any patients at risk for adverse health consequences if discharged without planning
- Evaluation must be completed on a timely basis by qualified personnel (nurse, social worker etc.)
- Evaluation must include likelihood of patient needing post-hospital services and their availability and patient's capacity for self-care
- Evaluation results must be discussed with the patient, family and/or guardian
- Evaluation must be included in medical record

Discharge Plan Implementation

- Hospital must arrange for initial implementation of discharge plan
- Those assisting with post-hospital care for the patient must be counseled in preparation
- Hospital must transfer or refer patients to appropriate settings
- Patient has the right to choose among participating Medicare providers of post-hospital care services
- Hospitals must include in the Discharge Plan a list of HHAs or SNFs that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides, or in the case of SNF, where the patient requested.

Reassessment

- Hospital must reassess on an ongoing basis in case factors affect continuing care needs or appropriateness of the discharge plan

The **hospital** must also follow the local regulations: **Title 22 District of Columbia Municipal Regulations, Chapter 20**. See **Appendix 1** for the full regulations. The checklist below is only an outline and general framework of the regulations and the rules for discharge practices include but are not limited to:

Each Hospital Shall Provide Discharge Planning to Patients.

The Hospital Discharge Planning Program Includes but is not Limited to:

- A system for timely evaluation of any discharge planning needs of patients
- Identification of staff responsible for the program
- Development of a discharge plan, including medication review, with the patient or representative when need is identified
- Medication review with the patient or representative
- Maintenance of a complete and accurate list of community-based services, resources and facilities to which patients can be referred
- Arrangement for the initial implementation of a discharge plan including transfer of necessary medical information

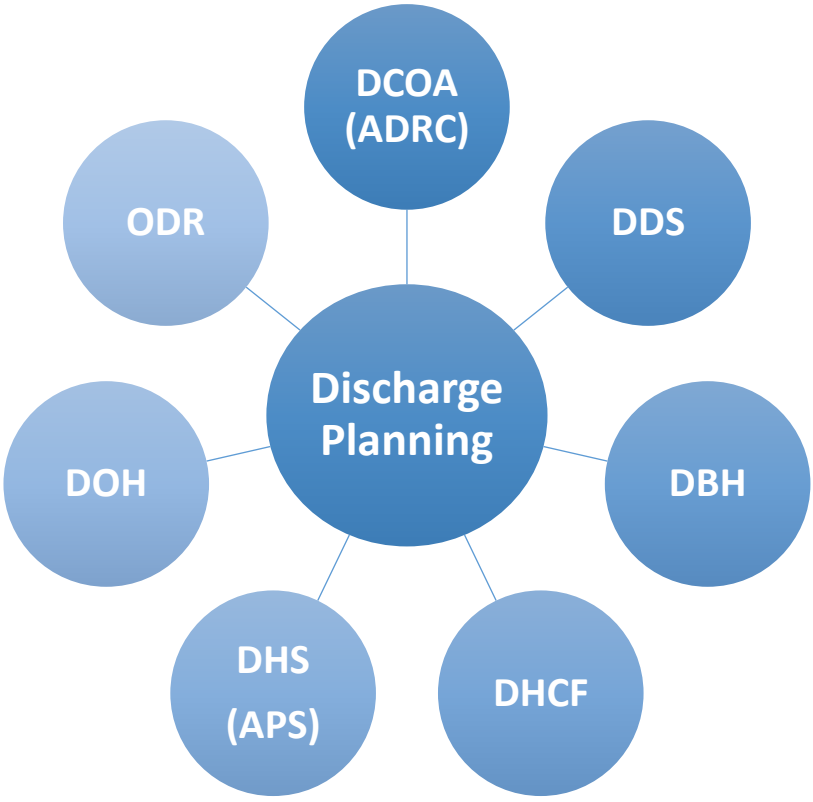
Allowable Reasons for Involuntary Discharge under federal Nursing Home Reform Law include:

- Necessary to meet resident's welfare
- Resident's health has improved and they no longer need facility services
- Safety of other residents is endangered
- Health of other residents is endangered
- Nonpayment after reasonable notice
- Facility ceases to operate

The resident must receive a written involuntary discharge notice from the facility. The Involuntary Discharge notice is required to contain specific and detailed legal requirements including a reason for discharge a location of discharge. This notice must provide 30 day timeframe for appeal.

District Agency Leads for Discharge Planning

In order for the District's discharge planning process to be successful, a number of government agencies work together. These organizations are listed in the chart below and a description of each organization and its website can be found in **Appendix 2**.



Discharge Planning by Population Type

People receiving discharge planning services in the District are generally a member of at least one of the following four population types with multiple or complex needs:

People with Intellectual and Developmental Disabilities

For people with intellectual and developmental disabilities, the Department of Disability Services (DDS) generally coordinates the discharge planning process. **Appendix 5** of this manual provides the Transition of Care Guide from DDS.
If a person has already been served by DDS, admission to a nursing home would lead to enhanced monitoring to make sure the setting stays the least restrictive to meet that person's needs.
People who live in institutional settings are given on at least a yearly basis the opportunity to receive services under the Intellectual and Developmentally Disabled (IDD) Home and Community-Based Services (HCBS) Waiver as an option other than institutional services during their person-centered care planning meeting. People wanting to enroll in The Developmental Disabilities Administration (DDA) services, must have an intellectual disability that was diagnosed before age 18. The disability must reflect significant limitation in intellectual functioning and in adaptive behaviors. More details can be found here.

Primary Contact: Shirley Quarles-Owens (Shirley.quarles-owens@dc.gov)

People over the age of 60 or Adults with Physical Disabilities

For people over the age of 60 or adults with physical disabilities, the Aging and Disability Resource Center (ADRC) of the D.C. Office on Aging (DCOA), generally will assist with the discharge planning process (full diagram in **Appendix 12**) in collaboration with local hospitals and nursing homes. Resources used by the ADRC for the discharge planning process can be found in **Appendix 3.** The ADRC team uses a preference interview tool and transition service checklist and the decision to move back into the community is made by the resident, their legally authorized representative, social worker, medical professional, and other members of the care team. Once a successful transition to the community takes place, ongoing case management services are provided through:

- Elderly and Persons with Disabilities (EPD) Waiver Program
- Community Transition Program
- DCOA's Senior Service Network

Note: Transition coordination assistance through the ADRC's Community Transition Team and its Money Follows the Person Demonstration program can be used by people with intellectual disabilities only if they are being discharged from an Intermediate Care Facility (ICF) setting. This is effective through the demonstration program's lifetime, or December 31, 2018.

Primary Contact: Sara Tribe Clark (sara.tribe@dc.gov)

Youth with Mental Health Issues Being Discharged from Psychiatric Residential Treatment Facilities (PRTFs)

For youth with psychiatric disorders being discharged from Psychiatric Residential Treatment Facilities (PRTFs) the Department of Behavioral Health (DBH) generally supports other DC child-serving agencies as they lead the discharge planning process. More information on their discharge planning materials can be found in **Appendix 4**. DBH has staff assigned to the majority of youth in a PRTF, visiting the youth and participating in all treatment team and discharge planning meetings. Before the discharge occurs, a Core Service Agency (CSA) is identified if no relationship previously existed. The PRTF staff, DBH Monitor and CSA work with the youth, and any other involved District agencies, to develop a discharge plan that includes mental health services, housing, education and other support systems. Service provisions include:

- Access HelpLine (Behavioral Health)(**1-888-7WE-HELP**)
- Certified Community Behavioral Health Providers
- Assessment and Referral Center (Substance Use Disorders) (**202-727-8473**)
- Mobile Crises Services (18yo+) (**202-673-9300**)

Primary Contact: James M. Ballard III, Ph.D. (James.Ballard2@dc.gov)

People with Behavioral Health Needs

The Department of Behavioral Health (DBH) contracts with several Core Service Agencies (CSAs) to provide outpatient behavioral health care to District residents with DC Medicaid or with no insurance. For individuals with a CSA relationship, the discharge planner should work directly with that agency to coordinate discharge planning. If there isn't an existing CSA relationship, then the individual should be assisted in contacting DBH's Access HelpLine to choose an agency for outpatient care. If an individual has private insurance, then the discharge planner should work with the insurer to arrange discharge behavioral health services. DBH also contracts with several agencies to provide treatment for substance use disorders, with the Assessment and Referral Center (ARC) being the primary access point for services. The ARC provides same day assessment and referral for District residents 21 years of age and older seeking treatment for substance use disorders. The Pre-Admission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

- Access HelpLine (**1-888-7WE-HELP**)
- Certified Community Behavioral Health Providers
- Assessment and Referral Center (**202-727-8473**)
- Mobile Crises Services (**202-673-9300**)

Primary Contact: Alvin Hinkle, MSW, CPM (Alvin.hinkle@dc.gov)

Discharge Resources for DC Residents with Multiple or Complex Needs

ADRC Resources for Accessing Community Services and Supports

The Aging and Disability Resource Center (ADRC) connects seniors and DC residents with a disability, professionals, and caregivers seeking community based resources, to the following programs, agencies or organizations when they are transitioning into the community:

Federal Programs and Agencies for Income Resources

1) **Medicare:** Federal health insurance program intended for people who are 65 years old or older, or for younger individuals living with a disability, and supports individuals with End-Stage Renal Disease. Medicare helps cover specific services:
    a. *Medicare Part A*: Hospital Insurance that covers inpatient hospitals stays, care in a skilled nursing home, hospice care, and some home health care.
    b. *Medicare Part B*: Cover community, outpatient care, doctor services, medical supplies, and preventative services.
    c. *Medicare Part C*: Part C is a type of health plan offered by private companies that contracts with Medicare to provide all Part A and B benefits, commonly known as Medicare Advantage Plans. Not commonly used when assisting low or no-income nursing home residents.

d. *Medicare Part D:* Part D adds prescription drug coverage to original Medicare and some health plans, plans are offered by insurance companies or other private companies.

For more information contact Medicare by calling: **1-800-633-4227** or visiting their website.

2) **Qualified Medicare Beneficiary (QMB) Program:** The QMB program helps District residents who are eligible for Medicare pay for their Medicare costs. Medicaid will pay for the Medicare premiums, co-insurance and deductibles for Medicare covered services. QMB is NOT Medicaid. A person is eligible for QMB if they are:
   - Medicare eligible; entitled to Medicare Part A or Part B (or both)
   - A District Resident
   - A US citizen or have eligible immigration status
   - Have income up to 300% of the Federal Poverty Level (FPL)

3) **Supplemental Security Income (SSI)**: Designed to help seniors, those who are blind and/or have a disability, who have little or no income, and provides cash to meet basic needs for food, clothing, and shelter. More information can be found here or by calling: **1-800-772-1213**.

4) **U.S. Department of Veterans Affairs:** Veterans have many application options when applying for community benefits, to review eligibility and seek assistance visit this website or call: **1-800-273-8255 (press #1)**.

5) **Department of Housing and Urban Development Programs for Seniors Citizens:** Section 8 Housing Vouchers: a federal program that helps eligible low-income households, seniors and residents with disabilities, by assisting with rental payments. To apply or seek additional information, visit this website or visit the DC Housing Authority website for a local application and updated resources on this website.

Insurance Programs

1) **Health Insurance Counseling Project:** This is the Washington, DC State Health Insurance Counseling Program (SHIP). Contact the SHIP program for help in making decisions about Medicare Health Plans, Medigap Insurance, Medicare Drug Plans, and Long Term Care Insurance. The SHIP program can also help consumers understand their Medicare rights and protections, the DC Medicaid spend-down process for people who are over-income, and help filing appeals.

2) **DC Healthcare Alliance:** A locally-funded program designed to provide medical assistance to DC residents who are not eligible for Medicaid. DC Healthcare Alliance will cover: doctor appointments, prescription drugs, preventive care (nutrition, diet, checkups), and more. For a complete eligibility list and additional service coverage, visit the Department of Health Care Finance's website or call: **202-442-5988**.

Local Supports

1) **Washington DC VA Medical Center:** the Community Resource and Referral Center (CRRC) will serve as a 24/7 hub to combat homelessness among Veterans. Although not a shelter, the CRRC provides services and benefit assistance for Veterans and family members. For eligibility requirements and information, visit this website or call: **202-636-7660, press 5 for an operator.**

2) **DC Court Guardianship Program Support:** If the DC Court finds that an adult cannot manage affairs, adult guardianship laws provide legal process to appoint a guardian and a guardian of the estate (conservator). Types of guardians: Temporary, Limited, General, Family, and/or Attorney. To learn more about the DC Court's Guardianship program contact:

   Sonya Roundtree-McClain, LICSW (Sonya.Roundtree@dcsc.gov)
   Deputy Program Manager, Guardianship Assistance Program
   District of Columbia Superior Court, Probate Division
   Call: **202-879-9452**

3) **Immigration Program Support:** When facing citizenship challenges, the best course of action is to seek a pro-bono attorney or advocate. Legal Counsel for the Elderly's (LCE) DC Long-Term Care Ombudsman

Program can interview the resident to learn additional details regarding the situation and request an attorney from LCE to assist.
Long-Term Care Hotline Number: **202-434-2190**
Home and Community-Based Services Hotline Number: **202-434-2160** Email: DCOmbuds@aarp.org
If a resident needs to apply or seek an update of his/her naturalization process, visit U.S. Citizenship and Immigration Services website or call: **1-800-375-5283**.

Housing Support

1) **Department of Human Services:** Emergency Rental Assistance Program (ERAP) helps District residents with low-income facing housing emergencies. The program provides funding for overdue rent if a qualified household is facing eviction (including late costs and court fees). The program also supports security deposits and first month's rent for residents moving to new apartments. Call: **202-671-4200** or visit this website to seek local organizations who will schedule appointments per resident in need.

As mentioned above, the Department of Human Services may be able to assist with security deposits and first month's rent, however locating housing support can be a long process. Upon admission to a nursing home, ensure that housing programs and processes be identified and applied for immediately. The following agencies and organizations can assist in locating affordable and accessible housing units:

2) **DC Housing Authority:** contact the DC Housing Authority to apply for Section 8, Housing Choice, Local Rental Supplemental Program, Tax Credit Program, and a host of voucher programs. Contact Diane Oliver (doliver@dchousing.org), **202-435-3302**

3) **DC Housing Counseling's Services, Inc.**: Offers supports for residents seeking tenant counseling services, call **202-667-7006** or the Rental Assistance Hotline: **202-667-7339**
   Email: info@housingetc.org

4) **DC Housing Search:** DC's free affordable housing listing and search engine where you can find accessible, affordable, and for-sale homes by providing financial information in your search.

5) **Safe at Home**: The DCOA program that provides preventative adaptations to reduce the risk of falls in the homes of qualifying seniors and adults with disabilities. Call **202-638-0050** for more information.

Level of Care

Medicaid beneficiaries must meet a nursing facility Level of Care (LOC) in order to receive long-term care services in a nursing facility or through the Elderly and Persons with Disabilities (EPD) Medicaid Waiver program. A face-to-face assessment is conducted by a registered nurse using a standardized needs-based assessment tool to determine a person's support needs for long term care services and supports. A physician or advanced practice registered nurse must complete and submit a prescription order form (POF) to order the face-to-face assessment. The assessment shall confirm and document the person's functional limitations, cognitive/behavioral needs, and skilled care needs. To satisfy the LOC requirement, beneficiaries must have a score of nine (9) or higher. Please see **Appendix 8** for more information on the LTC assessment process.

PASRR Referral

1.) Approval for nursing home admission to a DC facility requires a completed Level of Care (LOC), Department of Health Care Finance (DHCF) form 1728 and a Level 1 Pre-admission Screen. The completed LOC must be submitted to the Quality Improvement Organization (QIO) via the web portal at www.qualishealth.org. The QIO will render a decision within 3 business days of receiving the request. Please note that the authorization is only valid for 30 days. If the consumer is not admitted during the 30 days of approval, the referring agency must submit a request for a new LOC.

2.) Obtain a PASRR determination from the Behavioral Health Authority. The completed PASRR referral must be submitted to the Department of Behavioral Health (DBH) for a determination and the determination must be signed by the DBH Chief Clinical Officer. Please forward PASRR referrals to Chaka Curtis, DBH PASRR Coordinator at chaka.curtis@dc.gov Fax number: **202-671-2972**

3.) A complete PASRR referral must include:

- Pre-Admission Screen (Level 1 Screen)
- PASRR Level II Psychiatric Evaluation (Must be completed and signed by a psychiatrist)
- Form 1728 LOC
- Psycho-Social Assessment
- History and Physical
- Supporting Documentation, such as lab work, OT/PT assessments, medications, etc. can be included in the submission packet if it is pertinent to supporting medical necessity.

4.) The completed PASRR Level 1 Screening referral for people with an intellectual disability must be submitted to the Department on Disability Services (DDS) for a determination review. Please forward referrals to Shirley Quarles-Owens, DDS Health and Wellness Nurse Manager at Shirley.quarles-owens@dc.gov or for questions you can call: **202-730-1708**

After obtaining the LOC and PASRR determination, the referring agency can proceed with submitting the referral to nursing homes of choice.

Regulations on Level of Care

A Prescription Order Form (POF) is required to request an assessment for Long Term Care Services and Supports (LTCSS). The request shall include any supporting documentation established by the respective long term care program's regulations. An initial request for an assessment or a subsequent request for re-assessment based upon a change in the individual's condition or acuity level may be made by the person seeking services, the person's representative, family member or health care professional. A request is considered complete if it consists of a POF with all fields complete and signed by a DC Medicaid physician or advanced practicing nurse (APRN). The POF is submitted to Delmarva Foundation, DHCF's LTCSS contractor.

Delmarva Timeline for PCA Services

Effective April 2017, Delmarva Foundation will conduct a face-to-face assessment utilizing the standardized needs-based assessment tool to determine an individual's level of need for LTCSS. Based upon the results of the face-to-face assessment, Delmarva will issue an assessment determination that specifies the level of need for a range of LTCSS for which the individual is eligible. For hospital discharges, the assessment will be completed and determination issued within forty-eight (48) hours from the receipt of a request for an assessment. For nursing home discharges, the timeline for completing the LTCSS assessment shall be five calendar days of the receipt of a

request for an assessment and the determination will be issued within 48 hours after the assessment is completed.

During the assessment process, the person is given a list of Home Care Agencies (HCAs) to select their 1st-6th choice of service providers. Delmarva issues a Prior Authorization (PA) to the 1st HCA when the case is initially sent for acceptance, and the PA is transferred to the subsequent choice of provider if the first provider does not accept the case within 48 hours of receiving the referral from Delmarva. Delmarva will refer to the subsequent choices until a provider accepts the case.

Reporting Action if Delmarva Exceeds Timelines

If you need to submit a complaint to Delmarva related to exceeding established timelines, you can visit the contact on their website: http://dhcf.dfmc.org/personalCareAide/delmarva-contact-information.html or send an email directly to Delmarva at: DCLongTermCare@dfmc.org

Applying for EPD Waiver or State Plan Medicaid

The Elderly and Persons with Disabilities (EPD) Waiver program provides services in the homes of individuals who would otherwise need to live in a nursing home. The goal of the program is to help the person live independently in their own home and community. If your client qualifies for the program, they will work with a case manager to decide what type of services they need to assist with their daily life. The EPD Waiver contains an

option called "Services *My* Way." This program allows beneficiaries to have the option to choose what care providers they receive their care services from. Family members, including adult children, can be hired and paid to provide services.

To apply for the EPD Waiver, an applicant must contact the Information and Referral/Assistance (I&R/A) Department at DCOA by calling **202-724-5626** or emailing: Ask.ADRC@dc.gov.

- The applicant and/or authorized representative should state they are interested in applying for the EPD Waiver Program.
- A Universal Intake will be completed and demographic information will be gathered.
- Once an intake is completed, a self-service application packet is mailed to the applicant. The applicant is encouraged to complete the application and drop it off at the ADRC, or return it via email, certified mail, or fax. Follow-up calls are provided to all applicants within 7-10 business days. If additional application coordination assistance is required, applicants are offered a phone consultation, or scheduled for an office, or home visit with a Medicaid Enrollment Specialist (MES).
- The District licenses 13 Assisted Living Facilities, three of which are used by Medicaid recipients via the EPD Waiver.

Maintaining EPD Waiver Eligibility in Institutions

A beneficiary who is residing in a nursing facility can maintain their EPD eligibility up to 120 days. The EPD Waiver case manager is responsible for providing transitional case management services during an institutional stay to facilitate a beneficiary's transition back to the community. *The commonly referred to "30-day rule" is no longer a policy*.

Transmittal #15-33
Supporting Community Re-Integration and Continuity of Care

This transmittal from September 18, 2015, is to notify Elderly and Persons with Disabilities (EPD) waiver providers, case managers, hospitals and nursing facilities that effective October 1, 2015, individuals enrolled in the EPD waiver who have been admitted to a hospital or long term care facility will be able to remain enrolled in the EPD Waiver for a period of up to 120 days. DHCF is instituting this policy to promote continuity of care and community re-integration for an EPD Waiver beneficiary who may require hospitalization or admission to an institutional setting due to a medical condition. The full transmittal can be read **here**.

Resident Rights and Appeals Process

A DC nursing home resident admitted into a nursing home has both local and federal rights regarding discharging into the community or relocating within a facility. Governing the grounds for involuntary discharges, transfers or relocations and appealing procedures is DC's legislation entitled: Title 44: Charitable and Curative Institutions, Chapter 10: Nursing Home and Community Residence Facility Protections, Subchapter III: Discharge, Transfer, and Relocation of Residents (§44-1003.01 - §44-1003.13). Residents, family members, and professionals are able to seek counseling and technical assistance when developing a discharge plan, prior to a discharge, through the Legal Counsel for the Elderly's DC Long-Term Care Ombudsman Program. To review the law, click here.

Contact List for Troubleshooting

If you are unable to get the answers you need from the above section on Discharge Resources for DC Residents with Multiple or Complex Needs, please use the contact information outlined below:

Reason to Contact	Agency/Contact	Email/Phone
Receive additional help in locating and accessing appropriate services in your area	DCOA Aging and Disability Resource Center (ADRC)/ Sara Tribe Clark	adrc.managers@dc.gov 202-724-5626
Post-discharge questions regarding transfer to assisted living, residential placement or home care services	DOH/Sharon Mebane	sharon.mebane@dc.gov 202-442-4751
Hospital and Nursing Home discharge questions	DOH/Veronica Longstreth	Veronica.longstreth@dc.gov 2202-727-9861
Get connected to services provided by DBH	DBH Access Helpline	1-888-793-4357
Problems accessing Medicaid-funded LTCSS	Department of Healthcare Finance Long Term Care Administration/Jenna Crawley	dhcfltcacomplaints@dc.gov LTCA Hotline: 442-9533
For Delmarva concerns, put *"Request Exceeds Timeline"* in the email subject line	Delmarva	DClongtermcare@dfmc.org

Appendix

Appendix 1: Department of Health (DOH) Regulations and Discharge Materials

Nursing Home Federal Regulations- 42 CFR (Code of Federal Regulations) §483.10-§483.75

§483.12 Admission, Transfer and Discharge Rights (F201-208)
§483.15 Social Services- discharge planning services (F-250)
§483.20 Post-discharge plan of care (F284)
§483.20 Preadmission Screening and Resident Review (PASRR) (F285)

Note: CMS is in the process of updating the federal regulations, a draft version of those changes and the phases that will be rolled out can be found here:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf

§483.12 Admission, Transfer, and Discharge Rights

§483.12(a) Transfer, and Discharge
(1) Definition
Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
Guidelines §483.12

This requirement applies to transfers or discharges that are initiated by the facility, not by the resident. Whether or not a resident agrees to the facility's decision, these requirements apply whenever a facility initiates the transfer or discharge. "Transfer" is moving the resident from the facility to another legally responsible institutional setting, while "discharge" is moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident's care.
If a resident is living in an institution participating in both Medicare and Medicaid (SNF/NF) under separate provider agreements, a move from either the SNF or NF would constitute a transfer.
Transfer and discharge provisions significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility. The facility may not transfer or discharge the resident unless:

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;
5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or
6. The facility ceases to operate.

To demonstrate that any of the events specified in 1-5 have occurred, the law requires documentation in the resident's clinical record. To demonstrate situations 1 and 2, the resident's physician must provide the documentation. In situation 4, the documentation must be provided by any physician. (See §483.12(a) (2).) Moreover, before the transfer or discharge occurs, the law requires that the facility notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in the clinical record. The facility's notice must include an explanation of the right to appeal the transfer to the State as well as the name, address, and phone number of the State long-term care ombudsman. In the case of a developmentally disabled individual, the notice must include the name, address and phone number of the agency responsible for advocating for the developmentally disabled, and in the case of a mentally ill individual, the name, address and phone number of the agency responsible for advocating for mentally ill individuals. (See §483.12(a) (3) and (5).)

Generally, this notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of:

- Endangerment to the health or safety of others in the facility;
- When a resident's health has improved to allow a more immediate transfer or discharge;
- When a resident's urgent medical needs require more immediate transfer; and
- When a resident has not resided in the facility for 30 days.

In these cases, the notice must be provided as soon as practicable before the discharge. (See §483.12(a) (4).)

Finally, the facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. (See §483.12(a) (6).)

Under Medicaid, a participating facility is also required to provide notice to its residents of the facility's bed-hold policies and readmission policies prior to transfer of a resident for hospitalization or therapeutic leave. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative of the duration of any bed-hold. With respect to readmission in a Medicaid participating facility, the facility must develop policies that permit residents eligible for Medicaid, who were transferred for hospitalization or therapeutic leave, and whose absence exceeds the bed-hold period as defined by the State plan, to return to the facility in the first available bed. (See §483.12(b).)
A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third

party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

§483.10(o), Tag F177, addresses the right of residents to refuse certain transfers within an institution on the basis of payment status.

F201

§483.12(a) (2) Transfer and Discharge Requirements

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

SEE GUIDANCE UNDER TAG 202

F202

(Rev. 127, Issued: 11-26-14, Effective: 11-26-14, Implementation: 11-26-14)

§483.12(a) (3) Documentation

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a) (2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a) (2) (i) or paragraph (a) (2) (ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a) (2) (iv) of this section.

Interpretive Guidelines: §483.12(a) (2) and (3)

If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. (See §483.20(b) (4) (iv), F274, for information concerning assessment upon significant change.) Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment. Refusal of treatment would not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety

of others. Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy. If a nursing home discharges a resident or retaliates due to an existing resident's failure to sign or comply with a binding arbitration agreement, the State and Region may initiate an enforcement action based on a violation of the rules governing resident discharge and transfer. A current resident is not obligated to sign a new admission agreement that contains binding arbitration.

Procedures: §483.12(a) (2) and (3)
During closed record review, determine the reasons for transfer/discharge.
If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident's physician justify why the facility could not meet the needs of this resident.

Probes: §483.12(a) (2) and (3)

- Do records document accurate assessments and attempts through care planning to address resident's needs through multi-disciplinary interventions, accommodation of individual needs and attention to the resident's customary routines?

- Did the resident's physician document the record if:
  - The resident was transferred/discharged for the sake of the resident's welfare and the resident's needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization)? or

  - The resident's health improved to the extent that the transferred/discharged resident no longer needed the services of the facility.

- Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered?

- Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary?

- Did the survey team observe residents with similar safety concerns in the facility? If so, determine differences between these residents and those who were transferred or discharged. Look for changes in source of payment coinciding with transfer. If you find such transfer, determine if the transfers were triggered by one of the criteria specified in §483.12(a) (2).

- Ask the ombudsman if there were any complaints regarding transfer and/or discharge. If there were, what was the result of the ombudsman's investigation?

F203

(Rev. 107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)
§483.12(a) (4) Notice Before Transfer
Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
(ii) Record the reasons in the resident's clinical record; and
(iii) Include in the notice the items described in paragraph (a) (6) of this section.

§483.12(a) (5) Timing of the notice.

(i) Except when specified in paragraph (a) (5) (ii) of this section, the notice of transfer or discharge required under paragraph (a) (4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) The safety of the individuals in the facility would be endangered under paragraph (a) (2) (iii) of this section;
(B) The health of individuals in the facility would be endangered, under (a) (2) (iv) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a) (2) (ii) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a) (2) (i) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.12(a) (6) Contents of the notice
The written notice specified in paragraph (a) (4) of this section must include the following:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term care ombudsman;
(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

Procedures §483.12(a) (4)-(6)

If the team determines that there are concerns about the facility's transfer and discharge actions, during closed record review, look at notices to determine if the notice requirements are met, including:

- Advance notice (either 30 days or, as soon as practicable, depending on the reason for transfer/discharge);
- Reason for transfer/discharge;
- The effective date of the transfer or discharge;
- The location to which the resident was transferred or discharged;
- Right of appeal;
- How to notify the ombudsman (name, address, and telephone number); and
- How to notify the appropriate protection and advocacy agency for residents with mental illness or intellectual disabilities (mailing address and telephone numbers).
- Determine whether the facility notified a family member or legal representative of the proposed transfer or discharge.

F204

§483.12(a) (7) Orientation for Transfer or Discharge
A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Interpretive Guidelines §483.12(a) (7)
"Sufficient preparation" means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence. Some examples of orientation may include trial visits, if possible, by the resident to a new location; working with family to ask their assistance in assuring the resident that valued possessions are not left behind or lost; orienting staff in the receiving facility to resident's daily patterns; and reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan.

Procedures §483.12(a) (7)
During Resident Review, check social service notes to see if appropriate referrals have been made and, if necessary, if resident counseling has occurred.

F205

§483.12(b) Notice of Bed-Hold Policy and Readmission
§483.12(b) (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies--
(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and
(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b) (3) of this section, permitting a resident to return

§483.12(b) (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.
Interpretive Guidelines §483.12(b) (1) and (2)
The nursing facility's bed-hold policies apply to all residents.
These sections require two notices related to the facility's bed-hold policies to be issued. The first notice of bed-hold policies could be given well in advance of any transfer. However, reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice, which specifies the duration of the bed-hold policy, must be issued at the time of transfer

In cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. Bed-hold for days of absence in excess of the State's bed-hold limit are considered non-covered services which means that the resident could use his/her own income to pay for the bed-hold. However, if such a resident does not elect to pay to hold the bed, readmission rights to the next available bed are specified at §483.12(b) (3). Non-Medicaid residents may be requested to pay for all days of bed-hold.

If residents (or their representatives in the case of residents who are unable to understand their rights) are unsure or unclear about their bed-hold rights, review facility bed-hold policies.

- Do policies specify the duration of the bed-hold?

- Is this time period consistent with that specified in the State plan?

- During closed record review, look at records of residents transferred to a hospital or on therapeutic leave to determine if bed-hold requirements were followed. Was notice given before and at the time of transfer?

- During closed record review, look at records of residents transferred to a hospital or on therapeutic leave to determine if bed-hold requirements were followed. Was notice given before and at the time of transfer?

F206

(Rev. 70, 01-07-11, Effective: 10-01-10 Implementation: 10-01-10)
§483.12(b) (3) Permitting Resident to Return to Facility
A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident--

(i) Requires the services provided by the facility; and
(ii) Is eligible for Medicaid nursing facility services.

Interpretive Guidelines §483.12(b) (3)
"First available bed in a semi-private room" means a bed in a room shared with another resident of the same sex. (see §483.10(m) for the right of spouses to share a room.) Medicaid-eligible residents who are on therapeutic leave or are hospitalized beyond the State's bed-hold policy must be readmitted to the first available bed even if the residents have outstanding Medicaid balances. Once readmitted, however, these residents may be transferred if the facility can demonstrate that non-payment of charges exists and documentation and notice requirements are followed. The right to readmission is applicable to individuals seeking to return from a transfer or discharge as long as all of the specific qualifications set out in §483.12(b)(3) are met.

Procedures §483.12(b) (3)
For Medicaid recipients whose hospitalization or therapeutic leave exceeds the bed-hold period, do facility policies specify readmission rights?
Refer to the current MDS for discharge information.
Review the facility's written bed-hold policy to determine if it specifies legal readmission rights. Ask the local ombudsman if there are any problems with residents being readmitted to the facility following hospitalization. In closed record review, determine why the resident did not return to the facility. Ask the social worker or other appropriate staff what he/she tells Medicaid-eligible residents about the facility's bed-hold policies and the right to return and how Medicaid-eligible residents are assisted in returning to the facility. If potential problems are identified, talk to discharge planners at the hospital to which residents are transferred to determine their experience with residents returning to the facility.

F207

§483.12(c) Equal Access to Quality Care

§483.12(c)(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;
§483.12(c)(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and
§483.12(c) (3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.
Interpretive Guidelines §483.12(c)
Facilities must treat all residents alike when making transfer and discharge decisions. "Identical policies and practices" concerning services means that facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law. All nursing services, specialized rehabilitative services, social services, dietary services, pharmaceutical services, or activities that are mandated by the law must be provided to residents according to residents' individual needs, as determined by assessments and care plans.
Procedures §483.12(c)
Determine if residents are grouped in separate wings or floors for reasons other than care needs.

F208

(Rev. 127, Issued: 11-26-14, Effective: 11-26-14, Implementation: 11-26-14)
§483.12(d) Admissions Policy
(1) The facility must--
(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and
(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Interpretive Guidelines §483.12(d) (1)
This provision prohibits both direct and indirect request for waiver of rights to Medicare or Medicaid. A direct request for waiver, for example, requires residents to sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid. An indirect request for waiver includes requiring the resident to pay private rates for a specified period of time, such as two years ("private pay duration of stay contract") before Medicaid will be accepted as a payment source for the resident. Facilities must not seek or receive any kind of assurances that residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Procedures §483.12(d) (1)

If concerns regarding admissions procedures arise during interviews, review admissions packages and contracts to determine if they contain prohibited requirements (e.g., "side agreements" for the resident to be private pay or to supplement the Medicaid rate).
Ask staff what factors lead to decisions to place residents in different wings or floors. Note if factors other than medical and nursing needs affect these decisions. Do staff know the source of payment for the residents they take care of?
Ask the ombudsman if the facility treats residents differently in transfer, discharge and covered services based on source of payment.
With respect to transfer and discharge, if the facility appears to be sending residents to hospitals at the time (or shortly before) their payment source changes from private-pay or Medicare to Medicaid, call the hospitals and ask their discharge planners if they have detected any pattern of dumping. Also, ask discharge planners if the facility readmits Medicaid recipients who are ready to return to the facility. During the tour, observe possible differences in services

- Observe if there are separate dining rooms. If so, are different foods served in these dining rooms? For what reasons? Are residents excluded from some dining rooms because of source of payment?

- Observe the placement of residents in rooms in the facility. If residents are segregated on floors or wings by source of payment, determine if the facility is providing different services based on source of payment. Be particularly alert to differences in treatment and services. For example, determine whether less experienced aides and nursing staff are assigned to Medicaid portions of the facility. Notice the condition of the rooms (e.g., carpeted in private-pay wings, tile in Medicaid wings, proximity to the nurses' station, quality of food served as evening snacks).

As part of closed record review, determine if residents have been treated differently in transfers or discharges because of payment status. For example, determine if the facility is sending residents to acute care hospitals shortly before they become eligible for Medicaid as a way of getting rid of Medicaid recipients.

Ask social services staff to describe the facility's policy and practice on providing services, such as rehabilitative services. Determine if services are provided based on source of payment, rather than on need for services to attain or maintain functioning.

§483.12(d)(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.
Interpretive Guidelines §483.12(d) (2)
The facility may not require a third person to accept personal responsibility for paying the facility bill out of his or her own funds. However, he or she may use the resident's money to pay for care. A third party guarantee is not the same as a third party payor, e.g., an insurance

company; and this provision does not preclude the facility from obtaining information about Medicare or Medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all residents and prospective residents in all certified long term care facilities, regardless of payment source.

§483.12(d)(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,--

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

Interpretive Guidelines §483.12(d) (3)

This requirement applies only to Medicaid certified nursing facilities.

Facilities may not charge for any service that is included in the definition of "nursing facility services" and, therefore, required to be provided as part of the daily rate. Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes deposits from Medicaid-eligible residents or their families, or any promise to pay private rates for a specified period of time.

NOTE: This regulation does not preclude a facility from charging a deposit fee to, or requiring a promissory note from, an individual whose stay is not covered by Medicaid. In instances where the deposit fee is refundable and remains as funds of the resident, the facility must have a surety bond that covers the deposit amount (§483.10(c)(7)).

Permitted Charges for Medicaid Eligible Residents §483.12(d) (3)

A nursing facility is permitted to charge an applicant or resident whose Medicaid eligibility is pending, typically in the form of a deposit prior to admission and/or payment for services after admission. Medicaid eligibility will be made retroactive up to 3 months before the month of application if the applicant would have been eligible had he or she applied in any of the retroactive months.

In addition, the nursing facility must accept as payment in full the amounts determined by the state for all dates the resident was both Medicaid eligible and a nursing facility resident. Therefore, a nursing facility that charged a recipient for services between the first month of eligibility established by the state and the date notice of eligibility was received is obligated to

refund any payments received for that period less the state's determination of any resident's share of the nursing facility's costs for that same period. A nursing facility must prominently display written information in the facility and provide oral and written explanation to applicants or residents about applying for Medicaid, including how to use Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
Under the post-eligibility process, if the Medicaid-eligible resident has income and is required to make a monthly payment to the nursing facility (which is a portion of the Medicaid payment amount), then the nursing facility is permitted to retain the amount it is legally owed. However, the nursing facility must not charge any administrative fees.
A nursing facility may charge a Medicaid beneficiary for a service the beneficiary has requested and received, only if:

- That service is not defined in the State plan as a "nursing facility" service;
- The facility informs the resident and the resident's representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and
- The resident's admission or continued stay is not conditioned on the resident's requesting and receiving that service.

Procedures §483.12(d) (3)

Review State covered services. Compare with the list of items for which the facility charges to determine if the facility is charging for covered services. Determine if the facility requires deposits from residents. If you identify potential problems with discrimination, review the files of one or more residents selected for a focused or comprehensive review to determine if the facility requires residents to submit deposits as a precondition of admission besides what may be paid under the State plan.
If interviews with residents suggest that the facility may have required deposits from Medicaid recipients at admission, except those admitted when Medicaid eligibility is pending, corroborate by, for example, reviewing the facility's admissions documents or interviewing family members.

§483.12(d) (4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§483.15 Quality of Life
A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.
Interpretive Guidelines §483.15
The intention of the quality of life requirements is to specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident. Compliance decisions here are driven by the quality of life each resident experiences.

F250
***(Rev. 157, Issued: 06-10-16, Effective: 06-10-16, Implementation: 06-10-16*)**
§483.15(g) Social Services
§483.15(g)(1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
Intent §483.15(g)
To assure that sufficient and appropriate social service are provided to meet the resident's needs.

Interpretive Guidelines §483.15(g) (1)
Regardless of size, all facilities are required to provide for the medically related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. It is not required that a qualified social worker necessarily provide all of these services. Rather, it is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate disciplines.

"Medically-related social services" means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example:

- Making arrangements for obtaining needed adaptive equipment, clothing, and personal items;

- Maintaining contact with facility (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;

- Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications;

- Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);

- Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);

- Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);

- Providing or arranging provision of needed counseling services;

- Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs;

- Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality;

- Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;

- Finding options that most meet the physical and emotional needs of each resident;

- Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet;

- Meeting the needs of residents who are grieving; and

- Finding options which most meet their physical and emotional needs

Factors with a potentially negative effect on physical, mental, and psychosocial well-being include an unmet need for:

- Dental /denture care;

- Podiatric care;

- Eye Care;

- Hearing services

- Equipment for mobility or assistive eating devices; and

- Need for home-like environment, control, dignity, privacy

Where needed services are not covered by the Medicaid State plan, nursing facilities are still required to attempt to obtain these services. For example, if a resident requires transportation services that are not covered under a Medicaid state plan, the facility is required to arrange these services. This could be achieved, for example, through obtaining volunteer assistance. Types of conditions to which the facility should respond with social services by staff or referral include:

- Lack of an effective family/support system;

- Behavioral symptoms;

- If a resident with dementia strikes out at another resident, the facility should evaluate the resident's behavior. For example, a resident may be re-enacting an activity he or she used to perform at the same time every day. If that resident senses that another is in the way of his re-enactment, the resident may strike out at the resident impeding his or her progress. The facility is responsible for the safety of any potential resident victims while it assesses the circumstances of the residents behavior);

- Presence of a chronic disabling medical or psychological condition (e.g., multiple sclerosis, chronic obstructive pulmonary disease, Alzheimer's disease, schizophrenia);

- Depression

- Chronic or acute pain;

- Difficulty with personal interaction and socialization skills;

- Presence of legal or financial problems

- Abuse of Alcohol and other drugs

- Inability to cope with loss of function;

- Need for emotional support;

- Changes in family relationships, living arrangements, and/or resident's condition or functioning; and

- A physical or chemical restraint.

- For residents with or who develop mental disorders as defined by the "Diagnostic and Statistical Manual for Mental Disorders (DSM-IV)," see §483.45, F406.

Probes: §483.15(g) (1)
For residents selected for a comprehensive or focused review as appropriate:

- How do facility staff implement social services interventions to assist the resident in meeting treatment goals?

- How do staff responsible for social work monitor the resident's progress in improving physical, mental and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly?

- How does the care plan link goals to psychosocial functioning/well-being?

- Have the staff responsible for social work established and maintained relationships with the resident's family or legal representative?

- [NFs] What attempts does the facility make to access services for Medicaid recipients when those services are not covered by a Medicaid State Plan?

Look for evidence that social services interventions successfully address residents' needs and link social supports, physical care, and physical environment with residents' needs and individuality.
For sampled residents, review the appropriate sections of the current MDS.

DEFICIENCY CATEGORIZATION (See SOM Appendix P, Part IV)
Surveyors should be mindful of the elevated risk of psychosocial harm associated with the regulation at tag F250 that may lead to noncompliance, and consider this during their investigation.
Once the team has completed their investigation, analyzed the data, reviewed the regulatory requirements, and identified any deficient practice(s) that demonstrate that noncompliance with the regulation at F250 exists, the team must determine the scope and severity of each deficiency, based on the resultant harm or potential for harm to the resident.
The survey team must consider the potential for both physical and psychosocial harm when determining the scope and severity of deficiencies related to social services.
See also the Psychosocial Outcome Severity Guide and Investigative Protocol in Appendix P, Part IV, Section E for additional information on evaluating the severity of psychosocial outcomes.

F284

(Rev. 107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)
§483.20(l)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

Interpretive Guidelines §483.20(l) (3):
A post-discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for individuals with intellectual disabilities. Resident protection concerning transfer and discharge are found at §483.12. A "post-discharge plan of care" means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community.

Probes §483.20(l):

- Does the discharge summary have information pertinent to continuing care for the resident?

- Is there evidence of a discharge assessment that identifies the resident's needs and is used to develop the discharge plan?

- Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)?

- Do discharge plans address necessary post-discharge care?

- Has the facility aided the resident and his/her family in locating and coordinating post-discharge services?

- What types of pre-discharge preparation and education has the facility provided the resident and his/her family?

- Does the discharge summary have information identifying if the resident triggered the CAA for return to community referral?

F285

(Rev. 107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)
§483.20(e) Coordination
A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

Interpretive Guidelines §483.20(e)
With respect to the responsibilities under the Pre-Admission Screening and Resident Review (PASRR) program, the State is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. The State is required to provide a copy of the PASRR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide.

§483.20(m) Preadmission Screening for Mentally Ill Individuals and Individuals with Intellectual Disabilities.

§483.20(m) (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disabilities.

(ii) Intellectual Disability, as defined in paragraph (m) (2) (ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission--

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disabilities.

§483.20(m)(2) Definitions. For purposes of this section:

(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at 483.102(b) (1).

(ii) An individual is considered to be "intellectually disabled" if the individual is intellectually disabled as defined in 483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

Intent §483.20(m):

To ensure that individuals with mental illness and intellectual disabilities receive the care and services they need in the most appropriate setting.

"Specialized services" are those services the State is required to provide or arrange for that raise the intensity of services to the level needed by the resident. That is, specialized services are an "add-on" to NF services--they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the NF.

The statute mandates preadmission screening for all individuals with mental illness (MI) or intellectual disabilities (ID) who apply to NFs, regardless of the applicant's source of payment, except as provided below. (See §1919(b) (3) (F).) Residents readmitted and individuals who initially apply to a nursing facility directly following a discharge from an acute care stay are exempt if:

- They are certified by a physician prior to admission to require a nursing facility stay of less than 30 days; and

- They require care at the nursing facility for the same condition for which they were hospitalized.

The State is responsible for providing specialized services to residents with MI/ID residing in Medicaid-certified facilities. The facility is required to provide all other care and services appropriate to the resident's condition. Therefore, if a facility has residents with MI/ID, do not survey for specialized services, but survey for all other requirements, including resident rights, quality of life, and quality of care.

If the resident's PAS report indicates that he or she needs specialized services but the resident is not receiving them, notify the Medicaid agency. NF services ordinarily are not of the intensity to meet the needs of residents with MI or ID.

Probes §483.20(m):
If sampled residents have MI or ID, did the State Mental Health or Intellectual Disabilities Authority determine:

- Whether the residents needed the services of a NF?

- Whether the residents need specialized services for their ID or MI?

Chapter 32 of Title 22B District of Columbia Municipal Regulations (DCMR)
(Title 22B District of Columbia Municipal Regulations)

Section	Rule
3207.6	The physician shall prescribe a planned regimen of medical care which includes the following: (a) Medications and treatment; (b) Rehabilitative services (c) Diet; (d) Special procedures and contraindications for the health and safety of the resident (e) Resident therapeutic activities; and (f) Plans for continuing care and discharge in accordance with section 3270
3226.6	Medication shall be released to a resident upon discharge only on the authorization of his or her physician.
3229.4	In conjunction with the resident's admission, stay, and discharge, the functions of the social services program shall include the following: (a) Direct service, including therapeutic interventions, casework and group work services to residents, families and other persons considered necessary by the social worker; (b) Advocacy on behalf of residents; (c) Discharge planning; (d) Community liaison and services; (e) Consultation with other members of the facility's Interdisciplinary Care Team; (f) Safeguarding the confidentiality of social service records; and (g) Annual in-service training to other staff of the facility on subjects including, but not limited to, resident's rights, psychosocial aspects of aging and confidentiality
3231.5	The medical records shall be completed within thirty (30) days from the date of discharge.

Section	Rule
3231.12	Each facility shall ensure that each medical record shall include the following information: (a) The resident's name, age, height, weight, sex, date of birth, race, marital status, home address, telephone number, and religion; (b) Full names, addresses, and telephone numbers of the personal physician, dentist, and interested family member, including the designated family representative, or sponsor; (c) Medicaid, Medicare, and health insurance numbers; (d) Social security and other entitlement numbers; (e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f) Date of discharge and condition on discharge; (g) Hospital discharge summaries or a transfer form from the attending physician; (h) Medical history and allergies; (i) Descriptions of physical examinations, diagnoses, and prognoses; (j) Rehabilitation potential; (k) Vaccine history, if available, and other pertinent information about immune status in relation to vaccine-preventable disease; (l) The current status of the resident's physical and mental condition; (m) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable; (n) The resident's medical experiences upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;

Section	Rule
	(o) Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q) The plan of care; (r) Consent forms and advance directives; and (s) A quarterly inventory of the resident's personal clothing, belongings, and valuables.
3268.2	Except as provided in subsection 3266.4, the tenure of the temporary manager or monitor shall be concurrent with the provisional or restricted license, except that the temporary manager or monitor may be terminated when: (a) A court determines the temporary manager or monitor is no longer necessary because the grounds on which the appointment was made no longer exist; or (b) The facility is closing and all of its residents have been transferred or discharged.
3269.1	Each resident in a nursing facility shall have the right to the following: (a) Freedom from discrimination in treatment or access to services based on reasons prohibited by the Human Rights Act of 1977, effective December 13, 1977 (D.C. Law 2-38; D.C. Official Code §§ 2- 1401.01, et seq. (2007 Repl. & 2011 Supp.)); (b) To be fully informed by the nursing facility of all resident rights and all facility rules governing resident conduct and responsibilities upon admission and annually thereafter; (c) To either manage his or her own personal finances, or be given a quarterly report of the his or her finances if this responsibility has been delegated in writing to the nursing facility; (d) To be treated with respect and dignity and assured privacy during

Section	Rule
	treatment and when receiving personal care; (e) To not be required to perform services for the nursing facility that are not for therapeutic purposes, as identified in the plan of care for the resident; (f) To associate and communicate privately with persons of the resident's choice, unless medically contraindicated; (g) To send and receive personal mail, unopened by personnel at the nursing facility; (h) To participate in activities of social, family, resident, religious, and community groups at the discretion of the resident, unless medically contraindicated; (i) To keep and use personal clothing and possessions, as space permits, unless to do so would infringe on other residents' rights or is medically contraindicated; (j) To maintain, at the nursing facility, a private locker, chest, or chest drawer that is large enough to accommodate jewelry and small personal property and that can be locked by the resident; (k) To be provided with privacy for visits by the resident's spouse or domestic partner, or, if spouses or domestic partners are both residents in the nursing facility, be permitted to share a room, unless medically or psychosocially contraindicated; (l) To be free from mental or physical abuse; (m) To be free from chemical and physical restraints except as authorized pursuant to federal or District law and regulation; (n) To be discharged from the nursing facility after receiving a consultation from a physician of the medical consequences of discharge; and (o) Providing the administrator, physician, or a nurse of the nursing facility with written notice of the desire to be discharged; provided, that if the resident is a minor or a guardian has been appointed for a resident, the written request for discharge shall be signed by the resident's guardian, unless there is a court order to the contrary.

Section	Rule
3270.1	A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)).
3270.2	The facility shall conduct a discharge assessment of each resident within fourteen (14) days after admission and twice annually thereafter. The discharge assessment shall include: (a) A timeframe for discharging the resident to return home or to another facility; and (b) If the resident is likely to be discharged within six (6) months after the discharge assessment, a discharge plan.
3270.3	Upon oral and written notification of discharge, the nursing facility shall provide to the resident and his or her representative: (a) A current assessment of the resident's care needs and the kind of services and supports the resident will need upon discharge; (b) Information about the resident's right to receive counseling that explains the resident's options of community-based care and care in the home, including the right to request that the facility arrange a visit to at least one (1) alternative community-based care facility; and (c) A discharge plan that: (1) Links the resident with community resources, including the District of Columbia Aging and Disability Resource Center; (2) Explains the resident's options of community-based care and care in the home, including the right to request that the facility arrange a visit to at least one (1) alternative community-based care facility; and (3) Sets forth an arrangement for the resident and an immediate family member or legal representative, if any, to visit at least one (1) alternative community-based care facility, at the resident's request.

Title 22 District of Columbia Municipal Regulations, Title 22, Chapter 20

Section	Rule
2029 Discharge Planning	Each hospital shall provide discharge planning to patients. The discharge planning program includes, but is not limited to: (a) A system for timely evaluation of any discharge planning needs of patients; (b) Identification of staff responsible for the program; (c) Development of a discharge plan, including medication review, with the patient or representative when need is identified; (d) Medication review with the patient or representative; (e) Maintenance of a complete and accurate list of community-based services, resources and facilities to which patients can be referred; and (f) Arrangement for the initial implementation of a discharge plan including transfer of necessary medical information

Centers for Medicare and Medicaid Services- State Operations Manual- Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Section	Rule
A-0799 §482.43 Condition of Participation: Discharge Planning	The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.
A-0800 §482.43 (a) Standard: Identification of Patients in Need of Discharge Planning	The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.
A-0806 §482.43 (b) Standard: Discharge Planning Evaluation	(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician

Section	Rule
	(2) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services (3) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital
A-0807 §482.43(b)(2)	A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.
A-0810 §482.43(b)(5)	The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.
A-0811 §482.43(b)(6)	The hospital … must discuss the results of the evaluation with the patient or individual acting on his or her behalf.
A-0812 §482.43(b)(6)	[The hospital must] include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan….
A-0818 §482.43(c) Standard: Discharge Plan	A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.
A-0819§482.43(c)(2)	In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.
A-0820 §482.43(c)(3	The hospital must arrange for the initial implementation of the patient's discharge plan….
A-0820 §482.43(c)(5)	As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.
A-0821 §482.43(c)(4)	The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.
A-0823 §482.43(c)(6)	The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area

Section	Rule
	requested by the patient. HHAs must request to be listed by the hospital as available. (i) - This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation. (ii) - For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations. (iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.
A-0823 §482.43(c)(7)	The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.
A-0823 §482.43(c)(8)	The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.
A-0837 §482.43(d) Standard: Transfer or Referral	The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.
A-0843 §432.43(e) Standard: Reassessment	The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

Appendix 2: District Agency Descriptions

D.C. Office on Aging (DCOA)

DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network, which together consist of more than 20 community-based organizations, operating 37 programs for District residents age 60 and older, people living with disabilities (age 18-59), and their caregivers. In addition, the ADRC provides information, coordinates service access, and provides direct social work services to help people move to the community and/or stay in the community for as long as possible. In fiscal year 2016, ADRC served 11,290 people, 9.38% of whom were 18 to 59 years old, with a disability. The remaining individuals served by the ADRC are people age 60 and older who may also have a disability.

Primary Point of Contact: Sara Tribe Clark, ADRC Associate Director (sara.tribe@dc.gov)
Phone: 202-535-1367

Department of Behavioral Health (DBH)

The Department of Behavioral Health (DBH) contracts with several Core Service Agencies (CSAs) to provide outpatient behavioral health care to District residents with DC Medicaid or with no insurance. For individuals with an existing relationship with a CSA, the discharge planner should work directly with that agency to coordinate discharge planning. If an individual does not have an existing relationship with a CSA, then the individual should be assisted in contacting DBH's Access HelpLine to choose an agency for outpatient care. If an individual has private insurance, then the discharge planner should work with the insurer arrange discharge behavioral health services. DBH also operates Saint Elizabeths Hospital, the only inpatient psychiatric facility operated by the District of Columbia. This 292-bed facility provides in-patient psychiatric treatment to individuals with serious mental health diagnoses.

Primary Point of Contact: Alvin Hinkle, MSW, CPM (Alvin.hinkle@dc.gov)

Additional DBH Team Contacts:

Eugene R. Wooden, APRN, BC
Coordinator of Assertive Community Treatment/Co-occurring Disorder
202-673-2061 Desk
Eugene.wooden@dc.gov

Chaka A. Curtis, RN
Psychiatric Nurse / PASRR Coordinator
202-673-6450 (office)
Chaka.curtis@dc.gov

Randall Raybon, MA, LPC
Clinical Supervisor, Adult Services
Department of Behavioral Health
Tel. 202-673-7013
Randall.raybon@dc.gov

Department on Disability Services (DDS)

DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choosing. DDA promotes health, wellness and a high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program. In fiscal year 2016, DDA served 2,363 people.

DDS' Rehabilitation Services Administration (RSA) provides comprehensive, person-centered employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments. In fiscal year 2016 RSA served 7,309 people.

Primary Point of Contact: Shirley Quarles-Owens, Supervisory Community Health Nurse (Shirley.quarles-owens@dc.gov)

Phone: 202-730-1708

Department of Health Care Finance (DHCF)

DHCF is the District's Medicaid agency and the primary payer for all long term services and supports the city provides. In fiscal year 2016, the District spent a total of $796 million in Medicaid funds on these services; $241 million (or 30%) were local dollars. These funds pay for care in institutional settings including nursing facilities and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS), described below. Approximately 44% of total Medicaid funds spent on LTSS were spent on institutional care while 56% were spent on home and community-based services.

Primary Point of Contact: Jennifer Crawley, MSW, LICSW Program Manager (Jennifer.crawley@dc.gov)
Phone: 202-442-9533

LTCA Intake and Assessment:
Sheverly Nail, Program Manager (Sheverly.nail@dc.gov)
Phone: 202-478-9304

Department of Human Services (DHS)

Across its extensive range of programming, DHS routinely serves people with disabilities. For example, in fiscal year 2014, approximately 17% of applicants were assessed as likely to have a mental disorder of some magnitude, and 4% to have a learning disability in income-based programs such as TANF, SNAP, and Medicaid. In the homeless services program, 40% of singles and 16% of adult head of families entering shelters were assessed by DHS to have a disability in at least one of eight categories. In the Adult Protective Services program -- which investigates reports of abuse, neglect, exploitation and self-neglect, and provides temporary services and supports in some founded cases -- an estimated 45% of those served were assessed to have a disability.

Adult-Protective Services Contact: Toya Fisher (Toya.Fisher@dc.gov)

Hotline Phone: 202-541-3950

Homeless Outreach Contacts: Cornelia Obeng (Cornelia.Obeng@dc.gov) and Dallas Williams (Dallas.Williams@dc.gov)

Department of Health (DOH)

The DOH Health Care Facilities Division and Intermediate Care Facilities Divisions administer all District and federal laws and regulations governing the licensure, certification and regulation of all health care facilities in the District of Columbia. In this role, Health Regulation and Licensing Administration (HRLA) staff inspect health care facilities and providers who participate in the Medicare and Medicaid programs, certified per District and federal laws, respond to consumer and self-reported facility incidents and/or complaints, and conduct investigations, if indicated. When necessary, HRLA takes enforcement actions to compel facilities, providers and suppliers to come into compliance with District and Federal Law.

Primary Point of Contact for Hospitals: Veronica Longstreth, RN, MSN, Interim Program Manager (veronica.longstreth@dc.gov)

Phone: 202-727-9861

Primary Point of Contact for Nursing Homes: Cassandra Kingsberry, RN, Supervisory Nurse Consultant (Cassandra.kingsberry@dc.gov)

Phone: 202-724-7487

Economic Security Administration

The Economic Security Administration (ESA) (formerly known as IMA) determines eligibility for benefits under the Temporary Cash Assistance for Needy Families (TANF), Medical Assistance, Supplemental Nutrition Assistance Program (SNAP), Child Care Subsidy, Burial Assistance, Interim Disability Assistance, Parent and Adolescent Support Services (PASS) and Refugee Cash Assistance programs.

Primary Point of Contact: Rebecca Shields, Program Manager

Phone: 202-698-4338

Office of Disability Rights (ODR)

ODR assesses and evaluates all District agencies' compliance with the Americans with Disabilities Act (ADA) and other disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training and technical assistance regarding ADA compliance and disability sensitivity and rights training to all DC agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites and community spaces; leading monthly disability-wellness seminars and managing the District's Mentoring Program for students with disabilities.

Primary Point of Contact: Jessica L. Hunt, Esq., M.Ed. (Jessica.hunt@dc.gov)

Phone: 202-727-3363

Appendix 3: D.C. Office on Aging (DCOA) ADRC Discharge Materials

CMS Section Q Know Your Rights Brochure 2016

-A pamphlet that explains a person's right to know if they can live in the community and get the services and supports they need to remain there

Community Transition Guide

- The Aging and Disability Resource Center (ADRC) Community Home Transition Program can help you regain your independence and return to your home or community after a nursing home stay. Email ADRC.Managers@dc.gov for a copy of this guide

Nursing Home Transition Referral Form

- In order to expedite the intake process, fill out this form completely and email to Aweke Wudineh at transition.adrc@dc.gov

Preference Interview Tool

- The Preference Interview Tool is designed to educate residents and family members about available services and housing options and whether they are eligible for some services. Residents who are not eligible but who request to live in the community will be referred to existing service providers

Safe at Home Program

- This DC Office on Aging program provides preventative adaptations to reduce the risk of falls in the homes of qualifying seniors and adults with disabilities. Call **202-638-0050** for more information

Appendix 4: Department of Behavioral Health (DBH) Discharge Materials

Policy 511 3A Preadmission Screening and Resident Review (PASRR) June 7, 2016

- Purpose: To establish a policy and procedures for conducting Preadmission Screening and Resident Review (PASRR) for individuals referred for nursing facility (NF) placement and those who experience a change in condition. This revision incorporates the new Level 1 Pre-Admission Screen/Resident Review for Serious Mental Illness (SMI) and/or Related Conditions form (Exhibit 1) and the new Nursing Facility Level of Care Form 1728 (Exhibit 3).

22 DCMR A34 Excerpt

- (Mental Health Rehabilitation Services) A person needs to be Medicaid eligible or below a certain income level and have a mental illness; the provider has 30 days to do a full diagnostic assessment for the diagnosis and 90 days to establish Medicaid or income eligibility through ESA.

Preadmission Screen and Resident Review (PASRR) Referral

1.) Approval for nursing home admission to a DC facility requires a completed Level of Care (LOC), Department of Health Care Finance (DHCF) form 1728 and a Level 1 Pre-admission Screen. The completed LOC must be submitted to the Quality Improvement Organization (QIO) via the web portal at www.qualishealth.org. The QIO will render a decision within 3 business days of receiving the request. Please note that the authorization is only valid for 30 days. If the consumer is not admitted during the 30 days of approval, the referring agency must submit a request for a new LOC.

2.) Obtain a PASRR determination from the Behavioral Health Authority. The completed PASRR referral must be submitted to the Department of Behavioral Health (DBH) for a

determination and the determination must be signed by the DBH Chief Clinical Officer. Please forward PASRR referrals to Chaka Curtis, DBH PASRR Coordinator at chaka.curtis@dc.gov Fax number: 202-671-2972

3.) A complete PASRR referral must include:

- Pre-Admission Screen (Level 1 Screen)
- PASRR Level II Psychiatric Evaluation (Must be completed and signed by a psychiatrist)
- Form 1728 LOC
- Psycho-Social Assessment
- History and Physical
- Supporting Documentation, such as lab work, OT/PT assessments, medications, etc. can be included in the submission packet if it is pertinent to supporting medical necessity.

After obtaining the LOC and PASRR determination, the referring agency can proceed with submitting the referral to nursing homes of choice.

Appendix 5: Department of Disability Services (DDS) Discharge Materials

Transition of Care Guide

- A guide for community support providers to facilitate safe transitions from the hospital or long term care facility to home

DDS Preadmission Screening and Resident Review (PASRR) Level II Screening Tool

- This is the Preadmission Screening Resident Review PASRR Level II from the DC Department on Disability Services Health and Wellness Unit. The PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that all applicants to a Medicaid-certified nursing facility:
    - Be evaluated for serious mental illness (SMI) and/or intellectual disability
    - Be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings
    - Receive the services they need in those settings. For more information visit this website: http://bit.ly/2diX3sW

Appendix 6: Helpful Online Resources for Discharge Planning

1. **D.C. Long-Term Care Ombudsman Program**

   The D.C. Long-Term Care Ombudsman Program is administratively housed within Legal Counsel for the Elderly which advocates for residents of nursing homes, assisted living facilities, community residence facilities and residents in their private homes. **(202-434-2190)**

2. **District of Columbia Health Care Association**

   The District of Columbia Health Care Association represents 100% of all of the licensed non-federal nursing facilities and many of the Assisted Living facilities in the District of Columbia. **(410-798-4925)**

3. **District of Columbia Hospital Association**

   The District of Columbia Hospital Association is a non-profit organization with 14 member hospitals and approximately 30 Associate Members whose mission is to provide leadership in improving the health care system in the District of Columbia. **(202-682-1581)**

4. **Eldercare Locator**

   The Eldercare Locator is a public service of the U.S. Administration on Aging connecting you to services for older adults and their families. **(1-800-677-1116)**

5. **Family Care Navigator**

   The Family Care Navigator helps family caregivers locate public, nonprofit, and private programs and services nearest their loved one-living at home or in a residential facility. Resources: Government Health and Disability Programs, Legal Resources, Disease-Specific Organizations and more. **(1-800-445-8106)**

6. **InterFaith Conference of Metropolitan Washington**

The InterFaith Conference of Metropolitan Washington is an online database of over 400 service providers. **(202-234-6301)**

7. **LeadingAge DC**

   LeadingAge DC is an advocacy and education leader for not-for-profit aging services organizations through the continuum of care: continuing care retirement communities, senior housing, assisted living, nursing homes and home and community based services. **(202-508-9446)**

8. **Medicare Discharge Planning List**

   The Medicare Discharge Planning List from the Department of Health and Human Services is for patients and their caregivers preparing to leave a hospital, nursing home or other care setting.

9. **Medicare Rights Center**

   The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives. **(202-637-0961)**

10. **National Council on Aging Benefits CheckUp**

    The National Council on Aging Benefits CheckUp is a tool that allows you to quickly find benefit programs that could help you pay for medications, health care, food, and more all from a reliable and trusted source.

11. **The Network of Care**

    The Network of Care for behavioral health is an online resource directory of mental health and substance use services and resources. **(202-673-7440)**

Appendix 7: Discharge Planners Capabilities Grid (DC Health Care Association)

DC Nursing Facility Care capabilities, including bed capacities, as of May 2011 can be viewed here.

DISTRICT OF COLUMBIA HEALTH CARE ASSOCIATION (www.dchca.org)
DC NURSING FACILITY CARE CAPABILITIES AS OF MAY 2011
FACILITY IDENTIFYING INFORMATION ON PAGE 3

FACILITY CAPABILITIES	Transitions Healthcare Capitol City	Deanwood Health & Rehabilitation Center	Stoddard Global Care at WCAS	Carrol Manor	Unique Residential Care Center	Washington Home	Brinton Woods of DC	Brinton Woods at Dupont Circle	Stoddard Baptist	United Medical Nursing Center	Bridgepoint-Capitol Hill	Ingleside Presbyterian Retirement	Bridgepoint-Hadley	Lisner Home	Army Distaff Foundation and Knollwood	Forest Hill of DC	Sibley Renaissance Unit	Jeanne Jugan	Residences at Thomas Circle	FACILITY CAPABILITIES
Bed Size	360	296	262	252	244	192	183	180	164	120	117	60	62	60	73	50	45	40	27	Bed Size
Admission 24hours/day	YES	YES	YES	YES	YES	NO	NO	YES	YES	YES	YES	NO	YES	NO	NO	NO	NO	NO	YES	Admission 24hours/day
Alzheimer's Locked Unit	NO	NO	YES	YES	YES	YES	NO	NO	NO	NO	NO	NO	NO	NO	YES	NO	NO	NO	NO	Alzheimer's Locked Unit
Bariatric Care	YES	NO	NO	NO	YES	NO	NO	YES	NO	YES	YES	NO	YES	NO	NO	NO	NO	NO	NO	Bariatric Care
Blood Transfusions	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	NO	NO	Blood Transfusions
Dialysis, On site	YES	YES	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	Dialysis, On site
Dialysis, w/community chair	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	NO	Dialysis, w/community chair
Enteral Nutrition	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES	Enteral Nutrition
HIV/Aids Care	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	HIV/Aids Care
Hospice Care	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	Hospice Care
Isolation: MRSA/VRE, Cdiff	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES	NO	YES	NO	YES	Isolation: MRSA/VRE, Cdiff
IV Meds	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	NO	YES	YES	YES	NO	YES	NO	YES	IV Meds
Pain Management	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	Pain Management
Parenteral Nutrition	YES	NO	YES	NO	NO	NO	NO	NO	NO	YES	YES	NO	YES	YES	NO	NO	NO	NO	NO	Parenteral Nutrition
Psychiatry, contract on site	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES	NO	YES	Psychiatry, contract on site
Rehab (PT,OT,SLP)	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	Rehab (PT,OT,SLP)
Respite Care	YES	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES	YES	YES	NO	YES	NO	NO	YES	YES	Respite Care
Specialty bed/mattress	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	Specialty bed/mattress
Tracheostomy Care	YES	YES	NO	NO	YES	YES	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	YES	NO	YES	Tracheostomy Care
Ventilator Care (special rate)	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	NO	Ventilator Care (special rate)
Wound Care	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	Wound Care

Appendix 8: Department of Healthcare Finance (DHCF) 2017 LTC Assessment Process

LTC Assessment Rule (March 24, 2017)

Transmittal #17-01: Revised Prescription Order Form (POF) for Long Term Care Services and Supports (LTCSS) (January 12, 2017)

Transmittal #17-01: Revised Prescription Order Form (POF) for Long Term Care Services and Supports (LTCSS) (December 2, 2016)

The most up to date Prescription Order Form (POF) can be found here.

The POF is utilized to request a face to face assessment for state plan services and ADHP and in July 2017 will be utilized to request assessment for all LTCSS.

The summary of the scoring that will be used to establish eligibility for LTCSS rather than the 1728 form: Pending approval of the LTCSS assessment rule, in July 2017 DHCF will be changing the assessment process to assess the need for **all** long term care services, beyond just Personal Care Aid (PCA). This includes nursing home services, services and supports under EPD Waiver, PCA services, Adult Day Health Program (ADHP) services under the home and community-based state plan benefit, and other LTCSS not intended to serve individuals with IDD.

The total numerical score consists of a value between zero to thirty-one (0-31); which may include a score of up to twenty-three (23) on the functional assessment, a score of up to three (3) on the cognitive/behavioral assessment, and a score of up to five (5) on the skilled care needs assessment.

The total numerical scores reflect a person's needed level of assistance with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs), thereby establishing eligibility for LTCSS as follows:

a) A score of four or higher for personal care aide services;

b) A score of four or five for adult day health acuity level 1 services;

c) A score of six or higher for adult day health acuity level 2 services; and

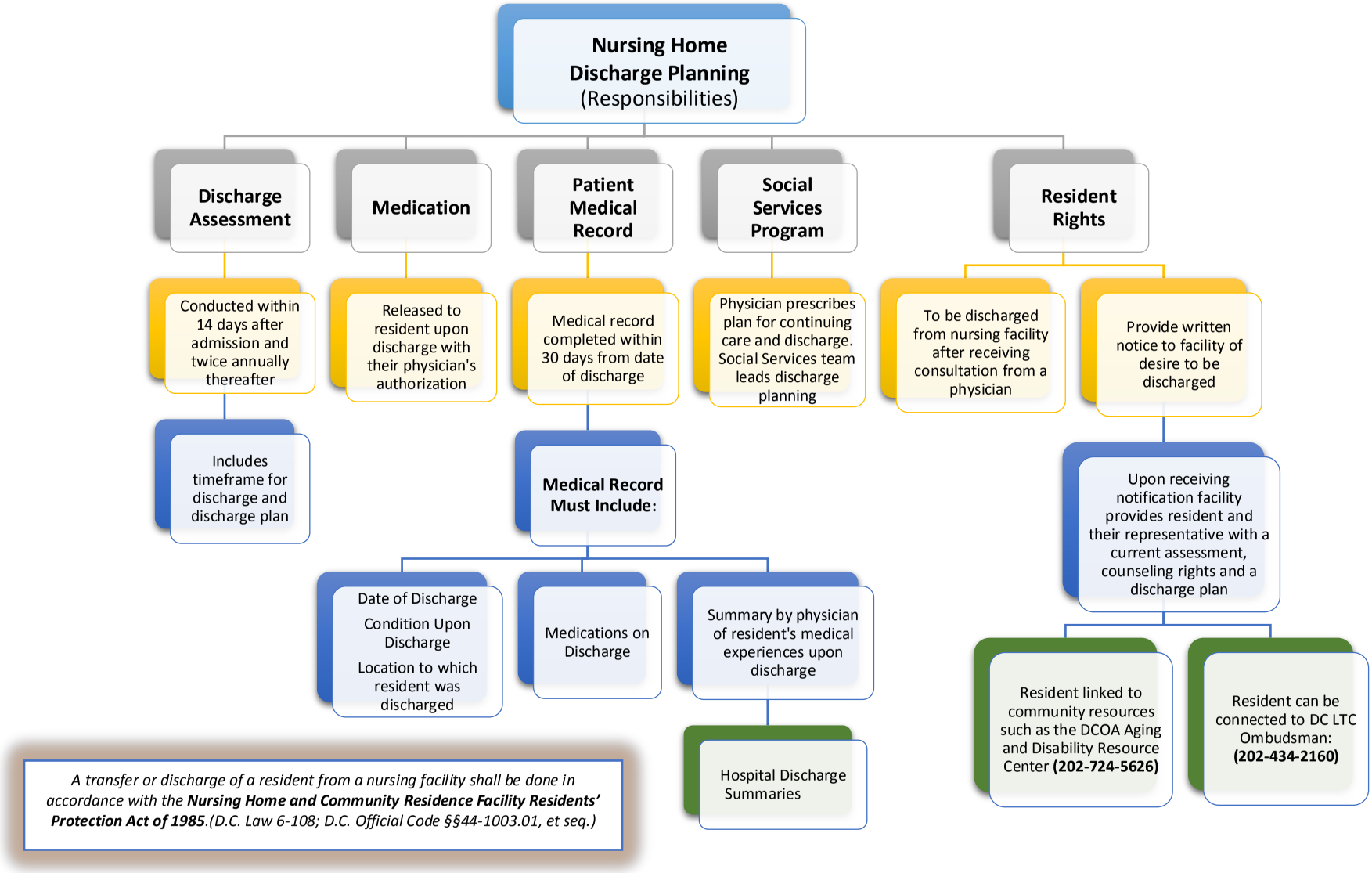
d) A score of nine or higher for nursing home, EPD Waiver or other programs/services that require a nursing home level of care.

Please note, a person will only be deemed to have a level of need for PCA services if his/her functional score without medication management is four or higher.

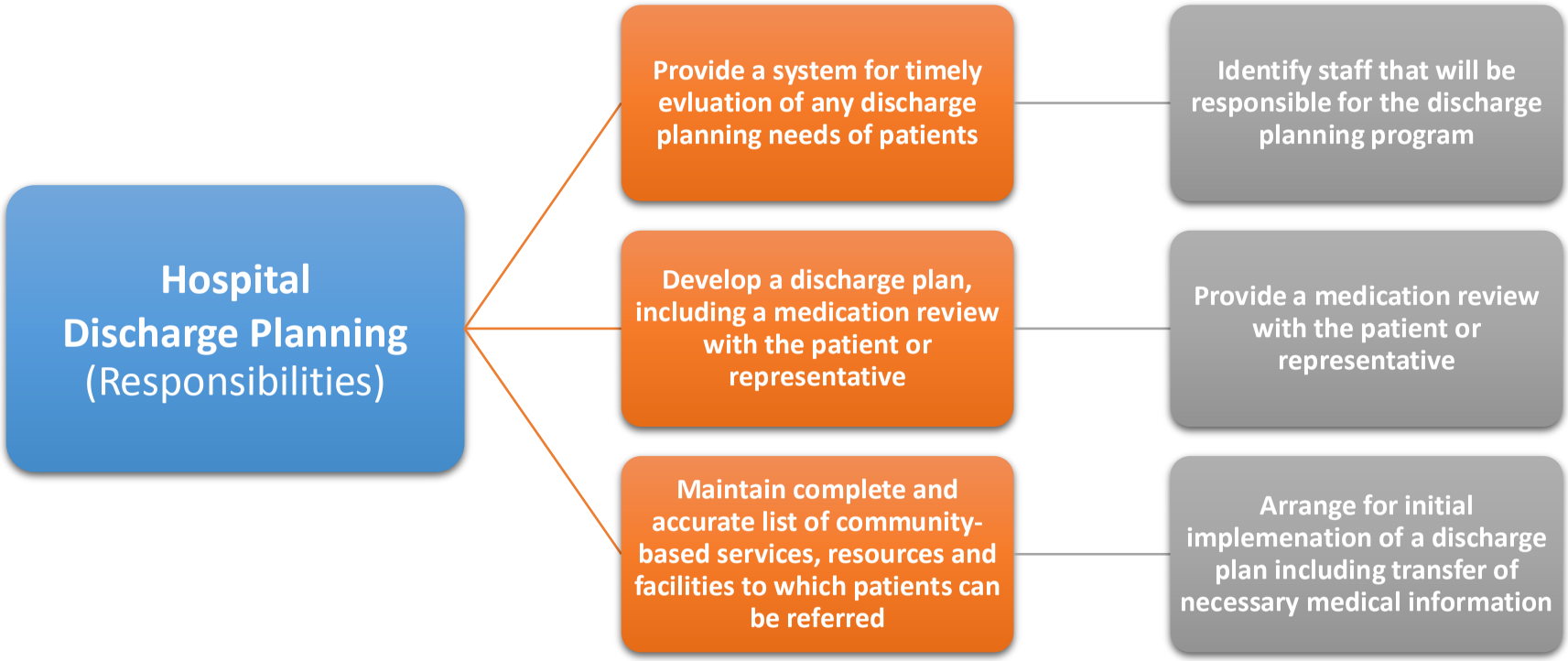
Based upon the results of the face-to-face assessment, DHCF or its authorized agent (i.e., Delmarva Institute) will issue to the person an assessment determination that specifies his/her level of need for a range of LTCSS for which the person is eligible. The assessment determination will include the types of LTCSS available to the person based on the scores received and will be issued to the person no later than forty-eight (48) hours after the assessment is completed, unless the person's condition necessitates that services be authorized and provided earlier.

For hospital discharges, the timeline for completing the LTCSS assessment, including an assessment determination, is forty-eight (48) hours from the receipt of a request for an assessment.

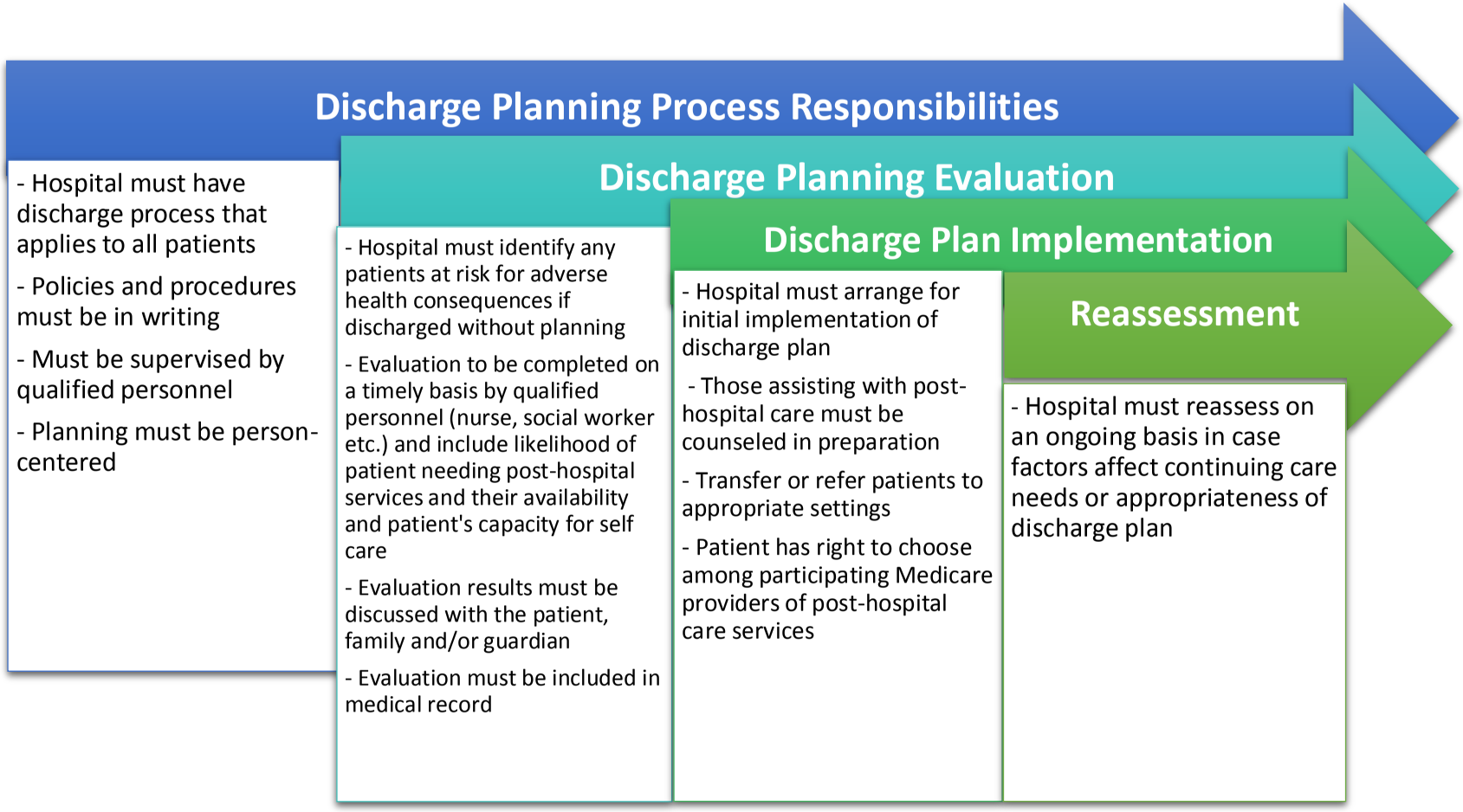
Appendix 9: Title 22B DCMR Chapter 32 Nursing Homes §3270 Discharge Planning



Appendix 10: Title 22 District of Columbia Municipal Regulations, Chapter 20



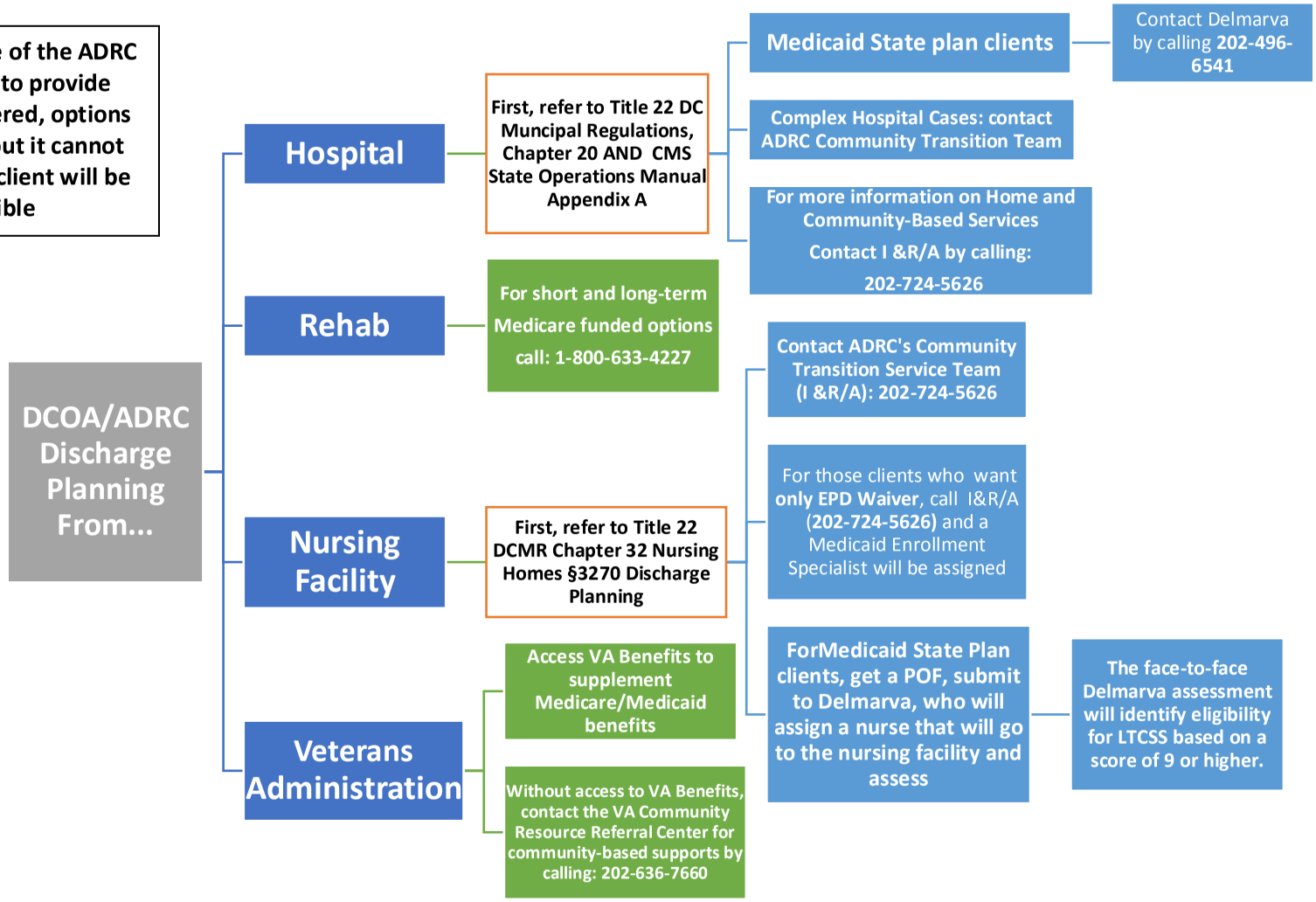
Appendix 11: CMS State Operations Manual- Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals



Hospitals must include in the Discharge Plan a list of HHAs or SNFs that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides, or in the case of SNF, where the patient requested.

Appendix 12: DC Office on Aging, Aging and Disability Resource Center

The main role of the ADRC at DCOA is to provide person-centered, options counseling but it cannot guarantee a client will be eligible



Appendix 13: Providence Hospital Sample Initial Care Management Discharge Planning Assessment

PATIENT:_____ ROOM#:_____ DATE:_____

INITIAL CARE MANAGEMENT DISCHARGE PLANNING ASSESSMENT

Patient Orientation	○ Person	○ Place	○ Time	○ Circumstances
Name of Person Providing History:				
Primary Contact Name/Relationship:		**Primary Contact Phone:**		
Secondary Contact Name/Relationship:		**Secondary Contact Phone:**		
Do you have a POA?		**Do you have a Legal guardian?**		

Language & Communication			
Preferred Language	○ English	○ Spanish	○ Other:
Do you have any communication needs or preferences that you would like to share?			

Where do you currently live?			
○ House	○ Nursing Home / LTC	○ Group Home	○ Homeless in Shelter
○ Apartment	○ Assisted Living Facility	○ Psych Residential Home	○ Homeless on Street
○ Other:			
Lives with (specify all):			

Home Physical Environment	○ Stairs	○ Rails	○ Stair Lift	○ Elevator	○ Ramp(s)	○ Other:

Dispositions	**Admitted to Hospital From**	**Patient Preferred Discharge Plan**
Home w/MD-RX f/u	○	○
Home w/Homecare Svc	○	○
***SAR/SNF**	○	○
***Nursing Home/LTC**	○	○
LTACH	○	○
Acute Rehab	○	○
Group Home	○	○
Shelter	○	○
Hospital Transfer	○	○
Other: _____	○	○
Facility		
If returning to LTC, does PT have Bed Hold days? _____	○	○
Issues with returning to facility?	○	○

Anticipated Discharge Transportation	
Private Vehicle	○
Ambulance	○
Cab	○
Bus/Metro	○
Metro Access/MTM	○
Drive-self	○
Walk Home	○
Other:_____	○
Enter contact name and details for planned transportation:	

Care Management Comments:
*Note Patient's Primary Caregiver(s) and ability to provide needed support; details and obstacles for discharge; name of entities/services utilized; home modifications needed.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Medical Equipment	Patient Has	Info Requested
Cane	○	○
Walker	○	○
Wheelchair	○	○
Oxygen	○	○
CPAP/BiPAP	○	○
Diabetic Supplies	○	○
Hospital Bed	○	○
Shower Chair	○	○
Bedside Commode	○	○
Wound Care Supplies / Ostomy	○	○
Adult Diapers	○	○
Other:	○	○
None	○	○

Prior Level Functioning (ADLs / *IADLs*)	Independent	Require Assistance	Dependent
Ambulating	○	○	○
Bathing	○	○	○
Dressing	○	○	○
Eating	○	○	○
Transferring	○	○	○
Toileting	○	○	○
Medications	○	○	○
Grocery Shopping	○	○	○
Preparing Meals	○	○	○
Driving / Transportation	○	○	○
Telephone Use	○	○	○
Do you have any goals for your discharge that you would like to share?			

Community Health Services/Programs	Currently Connected	Info Requested
Home Health Skilled Services (PT/OT/SN/SP)	○	○
PCA (Personal Care Aid)	○	○
Outpatient rehab	○	○
Dialysis	○	○
Mental Health	○	○
Substance Abuse	○	○
Hospice Inpatient	○	○
Home Hospice	○	○
Diabetes & Nutrition Center	○	○
Pulmonary Rehab	○	○
Adult Day Program	○	○
Other:	○	○
None	○	○

Non-Health Community Services/Programs	Currently Connected	Info Requested
Insurance/Financial Counseling (Accretive)	○	○
Transportation	○	○
POA Paperwork	○	○
SSI / SSDI	○	○
TANF	○	○
Food Stamps	○	○
Employment Services	○	○
APS	○	○
Aging & Disability Resource Center	○	○
Housing Services	○	○
Homeless Shelter / Services	○	○
Other:	○	○
None	○	○

To help reduce readmissions, consider risk factors in developing discharge plan: 1. Problems with Medications, 2. Psychological Issues, 3. Principle Diagnosis (Related to cancer, stroke, diabetic complications, COPD, CHF), 4. Physical Limitations, 5. Poor Health Literacy, 6. Poor Social Support, 7. Prior Hospitalizations, 8. Palliative care needs

Appendix 14: Community Transition Referral Form

COMMUNITY TRANSITION REFERRAL
Attach the resident's admission record to expedite intake
E-mail referral form (**PDF only**) to transition.adrc@dc.gov
General Questions? Please call: (202) 727-1871
INCOMPLETE REFERRALS WILL DELAY THE INTAKE PROCESS
For information about EPD Waiver call: (202) 724-5626

RESIDENT'S INFORMATION							
Name				**Date of Birth**			
Address				**Ward**			
Primary Phone				**Secondary Phone**			
MDS Section Q Referral?	☐	Yes	☐	No	**Admission Date**		
Sexual Orientation*	☐	Bisexual	☐	Lesbian	**Ethnicity***	☐	Hispanic or Latino
						☐	Non-Hispanic or Latino
	☐	Gay	☐	Transgender		☐	Other _____
	☐	Heterosexual	☐	Refused		☐	Refused
Legal Guardian/POA Name					**Phone**		
Source of Income					**Amount Per Month**		
(Example, TANF, SSI, SSDI, IDA, Pension/Social Security, VA benefit, Unemployment benefits, employment, etc.)							
Health Insurance Information	☐	Medicare #	☐	Medicaid #	**Primary Care Doctor/Clinic Phone**		

REASON(S) FOR REFERRAL					
☐	**Community Transition Service** • Resident must have been institutionalized for 90 consecutive days, not necessarily in one facility.	☐	**Medicaid Waiver** • Elderly and Persons with Physical Disabilities, and Persons with Intellectual and Developmental Disabilities (EPD and ID/D waivers)	☐	**Home Modification** • i.e. wheelchair ramps, guard rails, stair treads, grab bars, widen interior doors, etc.
☐	**Specialized Care** • i.e. adult day health centers, assisted living, emergency shelter for older adults experiencing abuse/neglect	☐	**Recreation/Socialization/Fitness** • i.e. senior centers, senior wellness programs, DC Parks and Recreation-Senior Services	☐	**Food** • i.e. home delivered meals, commodity, supplemental food, congregate meals site, etc.

			Division		
	Respite Care/ Caregiver Support		**Medical Equipment**		**Legal Assistance/Advocacy**
	Rental Assistance		**Housing Counseling Service**		**Utility Assistance**
	Job Training/Employment • i.e. RSA, OWETP, DOES		**Transportation** • i.e. MTM, Metro Access, CREST, WEHTS, Call-N-Ride, other		Other _____ ___ _____ _____ _____

REFERRAL ORGANIZATION/AGENCY'S NAME			
Referred by:		**Title:**	
Organization/Agency		**Phone:**	
Fax:		**Email:**	
Date of Referral:		**Received Date:**	

***NOTE: Providing gender identity, sexual orientation, and ethnicity data is voluntary and as required by law, will not impact eligibility decisions. (Revised: 4/19/17)**

Appendix 15: Caregiver Advise, Record, and Enable Amendment Act of 2016

ENROLLED ORIGINAL

AN ACT

D.C. ACT 21-385

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

MAY 4, 2016

To amend Chapter 22 of Title 21 of the District of Columbia Official Code to require hospitals to allow a patient the opportunity to designate, upon inpatient admission, a lay caregiver in the patient's medical record, to require a hospital to notify and meet with the designated lay caregiver along with the patient to discuss the patient's plan of care before the patient's discharge, and to require a hospital to instruct the designated lay caregiver in certain after-care tasks upon a patient's discharge to the patient's current residence.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Caregiver Advise, Record, and Enable Amendment Act of 2016".

Sec. 2. Chapter 22 of Title 21 of the District of Columbia Official Code is amended as follows:

(a) The table of contents is amended by adding a new Subchapter III to read as follows:

"Subchapter III. Hospital Discharge Planning.

"21-2231.01. Definitions.

"21-2231.02. Lay caregiver designation.

"21-2231.03. Hospital discharge plan.

"21-2231.04. Construction.

"21-2231.05. Rules.".

(b) A new Subchapter III is added to read as follows:

"Subchapter III. Hospital Discharge Planning.

"§ 21-2231.01. Definitions.

"For the purposes of this subchapter, the term:

"(1) "After-care" means any type of assistance that is not regulated under Chapter 12 of Title 3, or similar law, and that is provided by a lay caregiver to a patient after the patient's discharge and is limited to the patient's condition at the time of discharge.

"(2) "Authorized representative" means a person who is authorized to make a health-care decision on behalf of an incapacitated individual or minor in accordance with §§ 21-2205 and 21-2210.

"(3) "Discharge" means a patient's exit and release from a hospital to the patient's residence following an inpatient admission.

ENROLLED ORIGINAL

"(4) "Hospital" shall have the same meaning as provided in § 44-501(a)(1).

"(5) "Lay caregiver" means an individual who is designated by the patient or authorized representative to provide after-care to the patient at the patient's residence and accepts the role as the patient's lay caregiver.

"(6) "Residence" means a dwelling that the patient considers to be the patient's home and does not include a rehabilitation facility, hospital, nursing home, assisted living facility, or group home licensed by the Department of Health.

"§ 21-2231.02. Lay caregiver designation.

"(a) A hospital shall provide each patient or authorized representative an opportunity to designate a lay caregiver as soon as practicable following the patient's inpatient admission into a hospital and before the patient's discharge.

"(b)(1) If the patient or authorized representative designates an individual as a lay caregiver, the hospital shall:

"(A) Provide notice to the lay caregiver as soon as practicable following the designation and before the patient's discharge;

"(B) Promptly request the written consent of the patient or authorized representative to release medical information to the patient's lay caregiver in accordance with the hospital's procedures for releasing personal health information and in compliance with all federal and District laws, including the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub. L. No. 104-191; 110 Stat. 1936);

"(C) Record the patient's or authorized representative's designation of the lay caregiver, the relationship of the lay caregiver to the patient, and the name, telephone number, and address of the lay caregiver in the patient's medical record; and

"(D) Notify the lay caregiver of the patient's discharge to the patient's residence as soon as practicable; provided, that if the hospital is unable to contact the lay caregiver, the hospital shall document that in the patient's medical record as soon as practicable.

"(2) If a patient or authorized representative fails to authorize the release of medical information to the lay caregiver under paragraph (1)(B) of this subsection, the hospital is deemed to have met the requirements of the subchapter and no further action is needed.

"(3) A patient or authorized representative may elect to change the designation of a lay caregiver at any time before the patient's discharge; provided, that if a change is made, the hospital shall record that change in the patient's medical record as soon as practicable.

"(4) The designation of a lay caregiver by the patient or authorized representative does not obligate the lay caregiver to accept the designation or provide after-care.

"(5) A hospital is not obligated to determine the ability of a lay caregiver to understand or perform after-care tasks.

"§ 21-2231.03. Hospital discharge plan.

"(a) As soon as practicable before the patient's discharge, the hospital shall:

"(1) Consult with the lay caregiver and the patient or authorized representative regarding the lay caregiver's capabilities and limitations;

"(2) Provide a copy of the discharge plan to the lay caregiver;

ENROLLED ORIGINAL

"(3) Consult with, and provide instruction to, the lay caregiver regarding the patient's discharge plan; and

"(4) Provide contact information for any health care, community resources, and long-term care services and supports necessary to carry out the patient's discharge plan.

"(b) At a minimum, the discharge plan described in subsection (a) of this section shall include:

"(1) The name and contact information of the lay caregiver;

"(2) A description of all after-care tasks necessary to maintain the patient's ability to reside in the patient's residence; and

"(3) Contact information for any health care, community resources, and long-term care services and supports necessary to carry out the patient's discharge plan.

"(c)(1) At a minimum, the instruction to the lay caregiver described in subsection (a) of this section shall include:

"(A) An opportunity for a demonstration at the hospital of the after-care tasks; and

"(B) An opportunity for the lay caregiver and the patient to ask questions and receive answers to questions about the after-care tasks; and

"(2) The instruction provided shall be documented in the patient's medical record and shall include, at minimum, the date, time, and contents of the instruction.

"§ 21-2231.04. Construction.

"(a) Nothing in this subchapter shall be construed to delay the discharge of a patient or the transfer of a patient from a hospital to another facility, including the inability of the hospital to contact a designated lay caregiver;

"(b) Nothing in this subchapter shall be construed to create a private right of action not otherwise existing in the law for compliance or non-compliance with this subchapter.

"§ 21-2231.05. Rules.

"The Mayor, pursuant to subchapter 1 of Chapter 5 of Title 2, may issue rules to implement the provisions of this subchapter.".

Sec. 3. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 4. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December

24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

Chairman
Council of the District of Columbia

Mayor
District of Columbia
APPROVED
May 4, 2016

COUNCIL OF THE DISTRICT OF COLUMBIA
WASHINGTON, D.C. 20004

Docket No. **B21-230**

[X] ITEM ON CONSENT CALENDAR
[X] ACTION & DATE — **ADOPTED FIRST READING, 04/05/2016**
[X] VOICE VOTE
RECORDED VOTE ON REQUEST — **APPROVED**
ABSENT
[ ] ROLL CALL VOTE – Result (

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Mendelson	X				Evans	X				Orange	X			
Alexander	X				Grosso	X				Silverman	X			
Allen	X				May	X				Todd	X			
Bonds	X				McDuffie	X								
Cheh	X				Nadeau	X								
X – Indicate Vote					AB – Absent					NV – Present, Not Voting				

CERTIFICATION RECORD

Secretary to the Council — 4-21-16 Date

[X] ITEM ON CONSENT CALENDAR
[X] ACTION & DATE — **ADOPTED FINAL READING, 04/19/2016**
[X] VOICE VOTE
RECORDED VOTE ON REQUEST — **APPROVED**
ABSENT
[ ] ROLL CALL VOTE – Result (

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Mendelson	X				Evans	X				Orange	X			
Alexander	X				Grosso	X				Silverman	X			
Allen	X				May	X				Todd	X			
Bonds	X				McDuffie	X								
Cheh	X				Nadeau	X								
X – Indicate Vote					AB – Absent					NV – Present, Not Voting				

CERTIFICATION RECORD

Secretary to the Council — 4-21-16 Date

[ ] ITEM ON CONSENT CALENDAR
[ ] ACTION & DATE
[ ] VOICE VOTE
RECORDED VOTE ON REQUEST
ABSENT
[ ] ROLL CALL VOTE – Result (

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Mendelson					Evans					Orange				
Alexander					Grosso					Silverman				
Allen					May					Todd				
Bonds					McDuffie									
Cheh					Nadeau									
X – Indicate Vote					AB – Absent					NV – Present, Not Voting				

CERTIFICATION RECORD

Secretary to the Council — Date

Click here to return to Table of Contents