

Discharge Planning Guide Book





TABLE OF CONTENTS

Topic	Page
Preface	4
Learning About Options	7
Assessment of Needs and Preferences	8
Exchanging Information about the Resident and about What He or She Wants and Will Be Needing	9
Touring New Places	10
Planning for the Move	11
Belongings and Property	13
On the Day of the Move	15
Settling In	16
Post Discharge	17
Problems in the Resident's New Home	18
When a Facility Closes	20
In the Meanwhile	23
Questions to Ask Staff While Making Plans to Move	25
Questions to Ask While Reviewing the Discharge Plan	27
List of Documents to be Sent to the New Care Provider	31

PREFACE

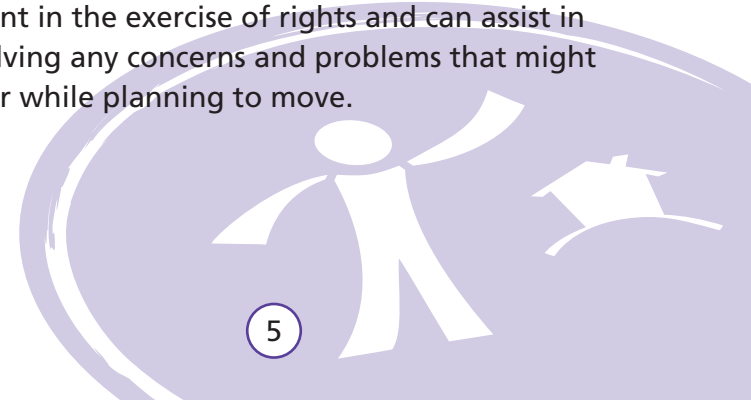
For the resident or tenant of a long term care facility, moving, whether back home or to another facility, can be both exciting and stressful. Careful consideration of options and thorough planning are the best ways to minimize any negative impact of having to relocate. The Wisconsin Board on Aging and Long Term Care is a state agency that works to resolve problems and improve conditions in long term care for persons aged 60 and older. A long term care ombudsman encourages the resident/tenant and other interested parties to become well-informed and actively involved in discharge planning activities with staff at the facility in order to maintain as much control as possible in the upcoming decisions about where he or she will live. It is beneficial to attend all discharge planning meetings and care conferences that may be held on the resident's or tenant's behalf. This is an opportunity to express thoughts and preferences for the kinds of care and services the resident/tenant will need and want to receive and in what kinds of settings. At these meetings there should be a discussion of the resident's/tenant's current needs for care and support as well as all available options to meet those needs.

Either returning home or moving to an assisted living facility in the community might be a possible option. Discussions should include the county human services department or Aging and Disability Resource Center (ADRC) in order to explore eligibility for funds and supports.

It is important that the resident/tenant be encouraged and allowed to take advantage of opportunities to visit several different locations to aid in better choosing where the resident/tenant will live. This facility can assist with arranging transportation for the Resident/tenant to revisit his or her home or to tour new facilities under consideration.



An ombudsman with the Wisconsin Board on Aging and Long Term Care is available to answer questions and to lend support throughout this transition. We can provide information about options, about differences between residential services and settings, about specific care facilities and service providers, and about possible funding sources to help pay for them. We can advise the resident or tenant in the exercise of rights and can assist in resolving any concerns and problems that might occur while planning to move.



Some of the **potential issues** could be:

- Inadequate care and treatment or services to meet needs throughout the relocation process
- Objections to being told to leave or to a particular proposed future placement setting
- Lack of information or involvement in discharge planning
- Objections to any part of a discharge plan
- Any abuses or rights violations, real or perceived

Residents and tenants of long term care facilities have rights under state and federal law. A list of those rights should have been provided upon admission to this facility and shared again upon entering another care setting. These rights should be made available in writing and in a language and format that is easily understood. The Board on Aging and Long Term Care has a booklet available that is intended to inform the reader of those rights and to assist in exercising them. A copy of that booklet can be provided, at no cost, by contacting an ombudsman, or by going to the website of the Board on Aging and Long Term Care and clicking on the Publications button. That website address is: www.longtermcare.wi.gov.

Keep in mind that residents/tenants do not forfeit any of their constitutional rights by living in a nursing home or an assisted living facility.

Board on Aging and Long Term Care Ombudsmen advocate for long term care consumers aged sixty or over. Please call the Ombudsman program, at (800) 815-0015, if there's anything we can do to help make the transition go as smoothly as possible.

LEARNING ABOUT OPTIONS



The resident or tenant should expect that staff from the facility is available to begin discussions about where it is that he or she might want to live. The social worker or facility manager/administrator may be approached to answer questions or to hear about preferences for alternate living arrangements. Depending on the type of facility, the resident or tenant may be entitled to relocation assistance and may also be entitled to designate anyone to accompany him or her to discharge planning meetings.

At the request of the resident, tenant or authorized decision-maker, an ombudsman can be contacted to attend and advise the resident or tenant at a discharge planning meeting. Independent arrangements for moving can be made, but the resident/tenant is entitled and encouraged to take full advantage of the planning and assistance to be offered by the facility.

The county ADRC should be contacted to consult with the resident/tenant about residential and other services options. The ADRC will also provide written information about programs and funding sources to help pay for community-based services, and will assist in the enrollment process for funding, should it be necessary.

ASSESSMENT OF NEEDS AND PREFERENCES

The resident or tenant may request an assessment by the county ADRC to determine eligibility for receiving public funding and support to safely return home or to move to another living facility. The resident or tenant may be approached by someone from the county offering this assessment. A social worker, facility manager/administrator or an ombudsman can be asked to arrange for someone to visit.

Should the resident or tenant prefer to move to a nursing home, the staff can be asked to call a particular facility to begin the assessment process and to see whether they have an acceptable room available, and can meet his or her needs. At any time, the assistance of representatives from various state and county agencies can be requested to advise the resident or tenant about his or her options.



EXCHANGING INFORMATION ABOUT THE RESIDENT AND ABOUT WHAT HE OR SHE WANTS AND WILL BE NEEDING

When being referred to another facility or care provider, information about the resident's/tenant's preferences and any needs for assistance should be provided. There should be notification including a request for authorization, in writing, to release and exchange information. This is done so that the new care provider can prepare to adequately and immediately meet the resident's/tenant's needs. Exchanging information, early on between service providers is critical in promoting a smoother transition and better continuity of care. This information should be shared only when the written release form has been signed by the resident/tenant or legal representative, and the authorization can be limited or withdrawn at any time.

Documentation sometimes called a discharge summary should be made available at the time of relocation. This should be sent on to any new providers. It should include contact and other information about the resident's/tenant's current medical providers and condition as well as instructions for his or her care. It should include or summarize an assessment and individualized care or service plan that is meant to help him or her adjust to a new living environment. This should include any instructions and referrals for community services when moving home or to a community based setting.

TOURING NEW PLACES



It's a good idea to tour and to see a proposed new place to live, first hand. The facility should arrange transportation so that the resident or tenant is provided with opportunities to visit potential alternate living arrangements. A request can be made that staff accompany the resident or tenant on a tour that is arranged at a time that's convenient for the resident/tenant and a friend or family member. He or she has the right to meet with any potential roommate(s) and other residents to ask questions about the place and to see State inspection reports.

He or she has the right to meet with any potential roommate(s).

Advocates can help locate and review inspection reports of licensed facilities. Checklists are available that can help to focus on things to look for or questions to ask when visiting a possible new home.

The Board on Aging and

Long Term Care offers such a checklist, entitled, "Making the Right Choice: Choosing a Residential Facility." This checklist can be viewed on the internet or obtained by asking an Ombudsman.

When returning home or moving to an apartment, the resident or tenant is entitled and encouraged to first visit with qualified staff to see that he or she can get around and safely manage.

PLANNING FOR THE MOVE



The resident or tenant has right to be involved in the planning of a move and to determine where he or she is to live by choosing from among the available alternatives. After having toured, applied for and been accepted, and the resident or tenant has approved the placement, the opportunity to select the date for moving should be offered. The resident or tenant may move as soon as he or she, and the new care providers are ready, and plans have been finalized. This may include needing to have a service plan approved by state and county agencies if using public funds to return home or to move into an assisted living facility. The move should be on a date that is convenient for the resident or tenant and for any persons assisting with the move. Depending on the facility's licensure, the resident/tenant is entitled to at least thirty days written notice prior to the relocation. The notice should confirm when and to where he or she will move. This written notice should provide information about how to seek a review of the discharge decision or any part of the discharge plan and how to contact an advocate for assistance in doing so. He or she may waive this thirty day waiting period or might want to contact an advocate if feeling pressured into moving before being ready.

The resident or tenant would also benefit from participating in a planning session to confirm the details of the move. Once a decision has been made and alternate living arrangements have been secured, a meeting should be held to develop and discuss a discharge plan that includes counseling on how the resident/tenant, and his or her records and belongings will be moved. Written notice of this meeting should be provided well in advance of the planning conference. The resident may ask any other person to join him or her at this meeting or can forego it altogether. He or she may choose to move sooner than the planning process allows, and can waive any applicable timelines as well. It's important, however, that the resident or tenant feel well prepared and comfortable about the move, and that all interested parties be informed about and know what to expect of the discharge plan. Please note the addendums in the back of this booklet that include lists of questions to

assist in developing and evaluating the quality of the discharge plan.



BELONGINGS AND PROPERTY

The resident or tenant has a right to have and to use his or her clothing and other possessions, and to expect that they be safely transported to the new location. It's recommended that the resident or tenant directly supervise the packing of belongings, if able, and that they be inventoried and recorded in writing. This written inventory should accompany the resident/tenant to his or her new home. The resident or tenant may choose to pack his or her own things or to ask a friend or family to assist, but can also expect help from facility staff, if preferred. While still limited, adequate space for things ought to be provided in the room at the new facility as well as there being some secure storage space for extra possessions. If returning home or moving into a new apartment, the resident or tenant should inquire into any available funding to assist with the cost of equipping the new place.

Upon discharge, the resident/tenant is entitled to a statement of any funds being held by the closing facility. This statement should show all expenditures, disbursements and deposits made to any account managed by the facility. The resident or tenant should decide and dictate how those funds will be transferred at the time of his or her relocation (whether by check given to the resident or a responsible party, or sent directly to

the new facility.) Arrangements will need to be made to see that funds and all other business, are routed to the new home. Each agency may need to be contacted separately to let them know that the resident/tenant is moving and what his or her new address will be. Some sources of payment or income to consider include a Social Security check, Supplemental Security income (SSI,) Pension funds, Insurance policies, Bank/Credit Union information on certificates of deposit, checking and savings accounts, Trust funds, Stocks, etc. A change of address form should be completed and submitted to the post office, as well as arrangements made for any business to be transferred to the new location. The nursing home social worker or facility manager/administrator can assist with all of this.

The resident is entitled to a statement of any funds being held by the closing facility.

ON THE DAY OF THE MOVE

The resident/tenant and interested parties should have already been informed of the specifics of the plan for moving, as to when and how, at the planning session. Belongings should have been packed and inventoried, and should accompany the resident or tenant on the move. His or her address should have been changed and instructions should have been submitted for redirecting any business expenses like the telephone or cable bill, etc. A summary of care needs should have been sent ahead to the new care providers. Family and friends, with the resident's/tenant's permission, should have been notified as well as the physician as to the new location.

The resident or tenant may want to inform staff that he or she would like to take some time to say goodbye to other residents and staff before leaving. It's important that everyone involved be mindful of how the resident or tenant may be feeling, and any signs or symptoms of illness or change in condition should be promptly reported to current and new staff.



SETTLING IN

Upon arrival at a new facility, the resident or tenant should be shown to and around the new room, introduced to any roommate and offered a tour of the facility. Everyone involved should be alert to potential hazards in a new location and increased lighting should be offered to the resident or tenant while acclimating to the unfamiliar environment. At a minimum, he or she should be informed of the location of the bathroom, how to call for an emergency, and where meals are to be taken. It may be helpful to ask about the availability of any programs or activities that might be of interest to the resident or tenant and that might provide opportunities for him or her to meet new people. The resident or tenant should be given an opportunity to discuss preferences for certain routines such as when he or she likes to rise in the morning and go to bed at night, and for bathing, food preferences, etc. He or she should ask, if not already instructed, about how to alert staff when assistance is needed.

As belongings are being unpacked, items should be checked against the written inventory to see whether anything is missing. The inventory should have been completed as things were packed and should have accompanied the resident/tenant. It's recommended that any lost or damaged belongings be promptly reported to either the social worker or manager at the new facility, or case-manager if the resident or tenant is receiving assistance from the county. An ombudsman can be called to help in trying to locate or get missing things replaced.

POST DISCHARGE

All facilities are required to make information about the needs of the resident or tenant available to the resident/tenant and subsequent care providers at the time of discharge. At a minimum this should include a current assessment or service plan as well as other information about the resident's medical needs. A nursing home is required to develop, with the participation of the resident and his or her family, a post-discharge plan of care that is meant to help him or her adjust to the new living arrangement. It's to be designed to ensure that needs are met, and should be done regardless of whether the resident is returning home, or moving to an assisted living facility or to another nursing home.

All receiving facilities, upon the resident's or tenant's admission, are required to develop and implement an initial care or service plan that is designed to meet the immediate needs of the new resident or tenant. It should also include approaches to address any new problems identified in the facility's pre-admission assessment. It's critical that this plan be thorough and specific enough to meet the needs of the resident or tenant immediately upon her or his arrival at the new home.



PROBLEMS IN THE RESIDENT'S NEW HOME

The resident or tenant should feel comfortable asking any question or reporting any problems at the new location. He or she has a right to be listened to and to have concerns responded to in a timely and respectful manner. He or she also has a right to have any complaints addressed without fear of retaliation.

In the new home, the resident or tenant should know who to contact to report a problem or concern. He or she may want to ask about the name of the social worker or manager/administrator at the facility and how that person can be reached.

Within weeks of admission, the resident or tenant should be offered a care-planning session, but may request that one be scheduled at anytime to address

a specific care concern or issue. A formal grievance may be filed with any facility or provider, and the agency is required to provide the complainant with their determination. The written findings of their inquiry or

He or she also has a right to have any complaints addressed without fear of retaliation.

investigation may be requested, and a decision can usually be appealed. A formal complaint with the regulatory agency having oversight of any licensed program can be filed as well. An ombudsman can be contacted to discuss options for and provide assistance with redressing concerns, filing complaints and seeking appeals.

In a private residence, the names and phone numbers of care providers, the physician, emergency services and for a case or care-manager (where assigned) should be made readily available.



WHEN A FACILITY CLOSES

Wisconsin has seen an increase in the numbers of closing or down-sizing long term care facilities. These situations can be very stressful as the resident or tenant may not have much control over the decision to move. When it's been decided that a facility is to close, the facility's management may be required by law to inform the State and to submit a plan to the Department of Health Services that describes how it will assist the residents or tenants to move safely and with as little stress as possible.

The State will approve the plan or, if unacceptable, ask the facility to revise it. The residents/tenants and their families should, then, be invited to an informational meeting with staff from the facility and representatives from state and county agencies as well as from advocacy organizations. The purpose of this meeting would be to formally announce the facility's plans, and to inform the participants about options and about what kinds of help one can expect. We encourage attendance at this meeting to ask any questions about the closure. This is an opportunity to meet with professionals who can advise and assist the resident or tenant in finding another nursing home, or in exploring whether he or she can relocate to an assisted living facility or return to live at home with support. Questions about

options can be asked of advocates who can offer their help and support.

Arrangements can be made to meet with the social worker at the home to begin making plans to move. There should be much written information at this meeting as well.

An anticipated date for closure should be announced, but the facility has a responsibility to see that each resident or tenant moves to a place that can adequately meet his or her care needs. There should be time to learn about options, to have the residents'/tenant's needs and preferences assessed, to visit potential alternate living arrangements, and to plan the move. A



resident or tenant has rights in choosing his or her final destination and may not be forced to remain in any place without a court order. No one should be required to move without first having suitable alternate living arrangements made. There should be a place at the closing facility designated as a Resource Room where written information including lists of other facilities and local directories of care providers can be obtained. Contact information for people and places that can assist the resident in deciding

where to live should also be made available. There are descriptions of a variety of different kinds of long term care facilities and information about public funding to help pay for them that can be made available.

A team of state and county representatives, along with advocates, will regularly meet with the facility to monitor the closure and to discuss the relocation plans of each resident or tenant. The resident/tenant or authorized decision-maker can contact an ombudsman to represent his or her interest at these meetings. The ombudsman can advise the resident or tenant about options and make the facility aware of his or her preferences, and can participate (with the resident's/tenant's permission) in any discharge planning activities. An ombudsman can also discuss options for addressing care concerns or complaints about the facility.

In the event of a room change while still at the closing facility, to bring residents or tenants closer together for safety reasons, he or she has the right to receive reasonable advanced notice and some accommodation of preferences. He or she also has a right to have personal possessions promptly unpacked and accessible throughout the closure.

IN THE MEANWHILE



All persons involved with a resident or tenant who is relocating should be conscious of the potential impact of the changes in his or her life and allow that person a period of time to adjust, but to also recognize and promote some of the possible positive aspects of moving. The resident/tenant should be included in discussions and listened to at every phase of the relocation process. It should be understood that as options are presented and become clearer that that person may need time to decide and may change his or her mind. Plans must be sufficiently flexible to accommodate the resident or tenant. He or she should be made to feel comfortable about asking questions and actively encouraged to voice any opinions and concerns before, during and after move. He or she should be consulted, and asked to consider and share thoughts on what might be done to make the transition easier and to help him or her feel more at home in the new living environment. Everyone involved with the relocating resident or tenant should be aware of and watch for any indications of stress as a result of this transfer.

The Board on Aging and Long Term Care realizes the complexity of all that's involved in the relocating of persons living in a long term care facility, and has created this booklet in hopes

of improving care and enhancing the quality of life for residents and tenants. *We appreciate that you have taken the time to read it to better understand ways to help residents and tenants through this time of change in a way that minimizes stress and promotes satisfaction with having been involved in a well-planned move.*

Please know that our ombudsmen remain available to help in any way that they can.

PLEASE CALL

1-800-815-0015

to ask any questions or to seek direct assistance in making the best possible discharge plans for residents and tenants.

ADDENDUMS

QUESTIONS TO ASK STAFF WHILE MAKING PLANS TO MOVE

- How much time do I have to make my moving plans?
- What kinds of help with planning can I expect and from whom?
- What exactly do I have to do? What happens next?
- What are my current needs for care or support?
- Will I need any special equipment or adaptive aids in my new home?
- Who will help me get this equipment or these aids?
- What services are available to help me get these needs met?
- In what kinds of places can these care needs be best met?
- If I want to live in my own home or apartment, what are my options?
- If I want to live in an assisted living facility, what are my options?
- If I want to live in another nursing home, what are my options?
- What government programs might help me pay for these services?

- How do I get into these programs and who'll help me apply?
- When can I visit some possible new places to live?
- How can I get to see these places and who will accompany me on a tour?
- Once I decide on where I'd like to live, what do I need to do?
- How long until I'm able to move?
- Will I be able to stay in my current room until I move?
- Who will help me pack and move my belongings?
- Do I have money in any account and how soon will it be made available?
- How will people be notified of my move to a new location?
- Will I be able to keep my current doctor?
- Will my doctor come to see me at my new home?
- What arrangements will be made for my care in a different setting?
- What records, equipment and supplies will be sent to my new care providers?
- What chance will I have to work out the final details my plans?
- What if I change my mind and don't want to move there?

QUESTIONS TO ASK WHILE REVIEWING THE DISCHARGE PLAN

Knowing your rights as a resident or tenant in a long term care facility can help you make informed decisions about where you will live and who will provide the care you may need. You have the right to be kept informed about options throughout the period of time it takes for you to make plans to relocate from this facility. This should involve several discussions with the staff at the facility that ends in your being invited to participate in a discharge/relocation meeting where your plan is finalized and reviewed with you. It's another opportunity to ask questions and to be sure that the details of your move have been addressed. You also have the right to ask an ombudsman, your guardian, your family and/or friends to join you at this or any other meeting for support in making sure your preferences are heard and considered. The following list of questions might help you to make sure you get all of the information and assistance that you have a right to receive.

- 1) Was I given an opportunity to discuss my options and to tell the facility staff about where it is I'd like to live?
- 2) Did I receive enough information about services and supports available to me? Was this information clear and easy to understand?
- 3) Was I offered an opportunity to meet with my county agency to discuss community living options?

- 4) Did anyone offer me an assessment for funding to return home or to move to an assisted living facility?
- 5) Was I informed of the outcome of that assessment and do I feel that it accurately described my condition? If not, was I advised on any appeal rights?
- 6) Has the facility made arrangements for me to visit possible places to live? Has anyone followed up with me on the results of that visit? Was I given an opportunity to ask questions about any of these places?
- 7) Was I given an opportunity to decide whether I'd like to move to one of these places?
- 8) Once I had decided on a location and my arrangements were made, was I offered a discharge planning meeting?
- 9) Did I receive a written notice informing me about the date, time, location and agenda of the discharge / relocation meeting?
- 10) Was I given the chance to change the date and/ or time of the meeting if it wasn't convenient for me or my representative?



- 11) Was sufficient notice of my discharge / relocation planning meeting provided?
- 12) Did the facility inform me that I have the right to have an ombudsman or another person present to help me voice my preferences at this meeting?
- 13) Was there enough time scheduled at this meeting for me to discuss all of the things that are important to me?
- 14) Did I receive a written summary about what was discussed at my discharge/ relocation meeting?
- 15) Was I given a written notice at least thirty days before the date I anticipate moving? Did it identify when and to where I'm expected to move?
- 16) Do I know how my belongings will be taken to my new home?
- 17) Do I know who to talk to at the facility if I have questions or concerns about my discharge / relocation plan?

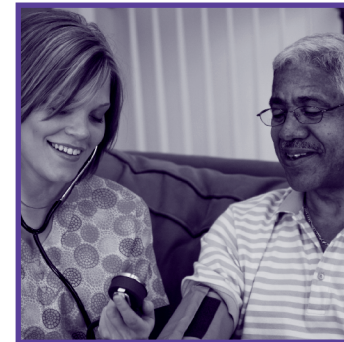
If you'd like help in developing or do not agree with the discharge plan already developed by the facility, you have the right to appeal the decision. You may seek assistance in making your plan or with an appeal by contacting an ombudsman at:

1-800-815-0015

**AN OMBUDSMAN CAN
ADVISE AND ASSIST YOU.**

LIST OF DOCUMENTS TO BE SENT TO THE NEW CARE PROVIDER

- Medical Records including a face sheet, physician's orders for medication and treatment, current history and physical examination reports, assessments, plans of care, relevant progress notes and any other information needed by subsequent care and service provider.
- Discharge Summary that includes current medical condition and findings, final diagnoses, rehabilitation potential, a summary of the course of treatment, nursing and dietary information, ambulation status, administrative and social information and any other instructions for needed continued care.
- Post Discharge Plan of Care that provides pertinent information for continuing care that's based on assessed needs and includes strategies for ensuring those can be met after discharge.



- Legal papers that include any Power of Attorney Instruments and Statements of Incapacity, Letters of Guardianship and Determination and Orders (Protective Placement,) Social Security Cards, Medicaid Cards, documentation of citizenship or visitor status, etc.
- Financial Records including bank and facility trust account statements, documentation of any pension funds, insurance policies, other bank/credit union information on CD's, checking and savings accounts, trust funds, stocks, and documentation of public benefits.
- Inventory of Personal Property including a written checklist of clothing and personal effects, furniture, equipment and supplies on hand, deeds and titles to vehicles, homes and property.
- Family and other personal information including names, addresses and phone numbers of friends and relatives. Correspondence and photographs.
- Burial Information including documentation of pre-paid arrangements and trust fund accounts, preferences for funeral directors, cemetery plots and markers. Obituary information.

NOTES



NOTES

NOTES



What is an OMBUDSMAN?

The word Ombudsman (Om-budz-man) is Scandinavian. In this country the word has come to mean an advocate or helper. Recognizing the importance of quality of life and quality of care, an Ombudsman works with individuals and their families to protect and promote the rights of long term care consumers, while also working with facilities to define and achieve the highest standards possible.

The Ombudsman Program is required by law. In Wisconsin the Board on Aging and Long Term Care provides ombudsman services to long term care consumers over 60 years of age statewide.



**State of Wisconsin
Board on Aging and Long Term Care
Ombudsman Program**

1402 Pankratz St., Suite 111
Madison, WI 53704-4001
1.800.815.0015

website longtermcare.wi.gov
email boaltc@wisconsin.gov