

Local Contact Agency Referral Process

Local Contact Agency Referral Process

Overview

MDS 3.0 Section Q is designed to engage nursing facility residents in their discharge planning goals by directly asking the resident if they want information about long-term care community options. The primary goal is to support the nursing facility resident's ability to achieve his or her highest level of functioning.

Section Q is also intended to promote information exchange between nursing homes, local contact agencies, and community-based long-term care providers as well as to promote discharge planning collaboration between nursing homes and local contact agencies for residents who may require medical and supportive services to return to the community.

Enriched transition resources are now available and will grow over time. Resource availability varies across local communities and may present barriers to allowing some resident's return to their community. Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.

Nursing Facility Role

Nursing home staff will be responsible to contact the Local Contact Agency for those residents who express a desire to learn about possible transition back to the community and/or for consultation on care options and supports that may be available to the resident in the community.

The nursing facility and Local Contact agency staff should guard against raising the resident and their family members' expectations of what can occur until more information is obtained. The nursing facility and local contact agency/transition agency teams must explore community care options and or supports and conduct appropriate care planning to determine if transition back to the community is possible.

Local Contact Agency Role

The Local Contact Agencies will be responsible to respond to nursing facility staff referrals and requests for information by providing information about community-based long-term care supports and services to residents and/or to nursing facility staff through a process called "Options Counseling". This "Options Counseling" will involve one or more visits with the resident and those persons the resident would like to be involved with the process and the provision of an "Options Plan" outlining what services and supports may be available in the community. The Options Plan will also provide information about the agency choices that may be able to assist with discharge or transition activities.

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Transition Agencies and Discharge Planning Responsibilities

Once the community services options plan has been outlined by the Local Contact Agency, nursing facility staff will work jointly with community agencies that can assist with discharge/transition to the community for nursing facility residents that wish to pursue transition.

The community agencies available to assist with transition include but are not limited to the Centers for Independent Living; Money Follows the Person Grant Transition Coordination Services; County Home and Community Based Services Case Management; and private home health services. The nursing facility and the community transition agencies are jointly responsible to meaningfully engage the resident in their discharge and transition planning process and collaboratively work to arrange for all of the necessary community-based long-term care service

Local Contact Agency Designation:

North Dakota has designated the eight Regional Human Service Center Aging Service Units as the Local Contact Agencies. The Human Service Centers serve designated counties in their region. Nursing facilities will be served by the Human Service Center designated to provide services in the county where the nursing facility is physically located. See Attachment (F) for specific designation and Local Contact Agency information

Information on Community Resources

Aging and Disability Resource LINK

North Dakota Aging and Disability Resource **LINK** – Provides help locating long-term services and providers-Nationwide Toll Free: **1-800-451-8693**

Web site: www.carechoice.nd.gov, E-mail: carechoice@nd.gov

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MDS 3.0 Section Q Guidance and Applications for North Dakota

In most nursing facilities in North Dakota the Social Services Department staff is responsible for discharge planning related activities. This generally will include the completion of MDS 3.0 Sections: Q0400 Discharge Plan, Q0500 Return to the Community, and Q0600 Referral, as well as the care area assessment, care planning, and any discharge specific activities that may be required.

Contact with the Local Contact Agency can be initiated by the Social Services Staff or other facility professionals responsible for discharge planning as the result of any one of the activities listed above. The nursing facility can contact the Local Contact Agency for consultation about service availability (Q0400), to make a referral on behalf of a resident's request to talk to someone about the possibility of returning to the community (Q0500), or to inquire about community service or transition agency options and/or to make a formal referral to the LCA (Q0600).

Q0400 Discharge

Q0400. Discharge Plan	
Enter Code <input type="checkbox"/>	A. Is there an active discharge plan in place for the resident to return to the community? 0. No 1. Yes → Skip to Q0600, Referral
Enter Code <input type="checkbox"/>	B. What determination was made by the resident and the care planning team regarding discharge to the community? 0. Determination not made 1. Discharge to community determined to be feasible → Skip to Q0600, Referral 2. Discharge to community determined to be not feasible → Skip to next active section (V or X)

Active Discharge Planning:

Active discharge planning is defined as the formal care planning activities of a nursing facility resident and their care team specifically addressing the residents' goal of returning to live in the community.

Feasibility of Discharge

Interdisciplinary teams should not assume that any particular resident is unable to be discharged. The nursing facility interdisciplinary team must interview residents and/or their family members, whenever possible, and determine their preferences and agreement about the feasibility of discharge. The nursing home should fully explore the resident's preferences and possible home and community based services/options available to the resident. In many situations this would require consultation with community resource experts at the Local Contact Agency. This may at times require a referral to the Local Contact Agency so that information can be reviewed with the resident to insure they fully understand their options and make a sound decision about discharge.

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Q0500 Return to the Community

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	A. Has the resident been asked about returning to the community? 0. No 1. Yes - previous response was "no" 2. Yes - previous response was "yes" → Skip to Q0600, Referral 3. Yes - previous response was "unknown"
Enter Code <input type="checkbox"/>	B. Ask the resident (or family or significant other if resident is unable to respond): " Do you want to talk to someone about the possibility of returning to the community? " 0. No 1. Yes 9. Unknown or uncertain

Returning home or to other non-institutional settings can be very important to a nursing facility resident's health and quality of life. For residents that have been in a facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There may be improved community resources and supports that might benefit these residents and allow them to return to a community setting. However being discharged from the nursing home without an adequate discharge plan could result in the resident's decline and increase the chances for re-hospitalization and aftercare. A thorough examination of the options with the resident and Local Contact Agency is imperative.

Q0600 Referral

Q0600. Referral	
Enter Code <input type="checkbox"/>	Has a referral been made to the local contact agency? 0. No - determination has been made by the resident and the care planning team that contact is not required 1. No - referral not made 2. Yes

Some nursing facility residents may be able to return to the community if they are provided appropriate assistance and referral to appropriate community resources to facilitate care in a non-institutional setting. Nursing facility residents/family/legal decision makers in cooperation with their nursing facility care planning team will need to determine if a referral is needed to the Local Contact Agency to assist in the discharge to the community planning process or if discharge can proceed without additional assistance from the Local Contact Agency or a transition agency.

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Formal and Informal Referral Process:

The goal of the North Dakota MDS 3.0 Section Q referral process is to initiate and maintain collaboration between the nursing facility and the local contact agency and/or a transition agency to support the resident's expressed interest in being transitioned to community living.

Nursing Facility Role

Referral to Local Contact Agency

- **Q0500**-When a resident (or family or significant other or guardian/legally authorized representative, if the resident is unable to respond) answers yes to the question; "Do you want to talk to someone about the possibility of returning to the community?" a Local Contact Agency (LCA) Referral Form will be completed and faxed or mailed to the designated contact agency within 10 business days of the completion date of the MDS. This will typically be completed by the facility social services staff or other designated discharge planner. See Attachment (A)
- **Q0400**-The Local Contact Agency is available for consultation to assist nursing facility residents and care teams in identifying support services available in the community. The Interdisciplinary Care Team will consider whether a discharge to the community is feasible or not feasible.
- **Q0400**-A written referral will occur to the Local Contact Agency if a resident expresses an interest in talking to someone about returning to the community and the care team has concerns about the availability of community resources to meet the resident's needs. The written referral will be made to the Local Contact Agency representative to help address the interdisciplinary team's concerns about feasibility of return to the community. See Attachment (A)
- **Q0600**- A Local Contact Agency (LCA) Referral Form will be completed and sent to the designated contact agency within 10 business days when the assessment process identifies a resident's desire to speak with someone about returning to community living. See Attachment (A)

Release of Information:

Nursing facilities will manage the release of information to the Local Contact Agency per their facility HIPPA Policy and Procedure.

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Care Planning

- Follow-up care planning will need to be initiated by the interdisciplinary care team to assess the resident's preferences and needs for possible transition to the community. Facilities are encouraged to utilize the "Discharge Plan of Care" developed by the MDS 3.0 Section Q Planning Committee to assure that all minimum planning requirements are addressed by the Care Team. See Attachment (C)
- The Local Contact Agency will be responsible to respond to all LCA referrals received from the nursing facility within 3 business days by phone and will complete an in person visit within 15 business days.
- If the Local Contact Agency does not contact the facility discharge planner by telephone or in person within 3 business days, the nursing facility is encouraged to make a follow-up call to the designated Local Contact Agency.

Local Contact Agency

- Once a Local Contact Agency Referral Form has been received, the LCA staff member will follow-up within 3 business days with a phone call to the designated discharge planner to review the referral. This may include establishing an in person visit date.
- Within 15 business days the LCA will meet in person with the resident and anyone else that the resident would like to have present. The purpose of this meeting is to gather information about the goals of the resident, identification of their support needs, and to provide information about community living options that may or may not be available in the community.
- The LCA will prepare and present an LCA Options Counseling Plan in cooperation with the individual nursing facility resident. The Options Counseling Plan Visit Summary will outline the community living options, the long-term care supports and services that may or may not be available in the community, and will identify agencies available to assist with transition if the resident's support needs can be met in the community. This information will include contact information. The LCA will provide a copy of the completed LCA Referral Document to the resident and facility discharge planner at the time of the in person visit. See Attachments (A and B)

A final copy of the LCA Options Plan Visit Summary will be provided to the discharge planner within 3 business days. The Discharge Planner will provide a copy to the resident upon receipt. The LCA will also provide a copy of the Summary to the MFP Program Administrator for all MFP eligible residents. See Attachment (B)

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Transition Agency and/or Nursing Facility Discharge Responsibilities:

- The nursing facility, the LCA and/or a transition agency will jointly explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- If the resident wishes to move forward with discharge/transition, the facility interdisciplinary care team will assist with the discharge care planning process which will be reflected on the “Discharge Plan of Care”. This assistance could include a referral to one of the agencies available to assist with the resident’s transition planning needs. See Attachment (C)
- If the resident wishes, the facility social services staff member/discharge planner will assist the resident with referral to a transition agency to work toward the resident’s goal of returning to the community.
- The nursing facility and the transition agency will work collaboratively to support the resident’s expressed interest in being transitioned to community living.
- The resident, interdisciplinary team, and the transition agency (when a referral has been made to a transition agency) will determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance, etc.) and make appropriate referrals.
- Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be assessed prior to discharge. This may determine what the resident’s options for discharge include (e.g., home, assisted living, basic care, group living, etc.).
- If the resident is being discharged, an evaluation of the site should be conducted by the nursing facility to determine the safety of the resident’s surroundings and the need for assistive/adaptive devices, medical supplies, and equipment.
- The care planning team will assess the level of the resident’s family involvement and support after discharge.
- At the time discharge/transition occurs the nursing facility will provide the resident the information necessary to successfully discharge from the facility. Facilities may use the recommended “Discharge Instruction Document” or similar tools for this purpose. See Attachment (D)

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MDS Triggers LCA Contact

1

Discharge Planner:
LCA Referral form faxed to LCA within 10 business days by facility discharge planner
Discharge Care Planning added or adjusted to address resident's transition goal

2

LCA Response to Referral:
By phone to discharge planner within 3 business days
In person with resident and any other persons that the resident would like to have present within 15 business days

3

LCA Role:
LCA completes Options Counseling with the resident
Provides a copy of the completed referral form
Provides LCA Options Counseling Visit Summary to resident and the discharge planner within 3 business days and to the MFP PA for all MFP eligible residents

4

LCA Options Counseling Visit Summary :
Outlines support service options discussed and discussion outcomes
Identifies agencies that could assist with transition

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Transition Process:

Resident and NF Care Team determine if transition to the community is going to be pursued

1

Discharge Planner:

Contacts agency to assist with transition planning process (Centers for Independent Living, Home and Community Based Services Case Management, Money Follows the Person Transition Coordination, Home Health Agency etc.)

2

Transition Agency:

Works in cooperation with resident, family, nursing facility, and community support services agencies toward goal of transition to the community

3

Planning Process:

Resident, family, and the discharge/transition planning team determine if transition to community can be accomplished

Discharge activities are completed by the resident/family, nursing facility, transition agency, and community support providers

4

Transition:

Resident transitions to the community with needed support services