

Local Contact Agency Referral Process

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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 give the resident a direct voice in expressing preference and to provide the facility means to assist residents in locating and transitioning to the most integrated setting.

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 facility 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 services 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 service and support options 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 services and supports to residents and/or to nursing facility staff. This will involve one or more visits with the resident and those persons the resident would like to be involved with the process. The LCA will prepare a Transition Plan of the services and supports that may be available in the community. The Transition 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 have 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 Local Contact Agent staff, the Centers for Independent Living; 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:

The ND Department of Human Services has designated the eight regional Aging Services Units to act as the Local Contact Agency. Nursing facilities will be served by the regional unit designated to provide services in the county where the nursing facility is physically located. Information on the Aging Services Unit assigned to each facility will be provided by the Aging Services Division.

Information on Community Resources

North Dakota Aging and Disability Resource-**LINK (ADRL)**: Provides help locating long-term services and providers

All LCA related forms and sample policy and forms can be found at <http://www.nd.gov/dhs/services/adultsaging/>

Nationwide Toll Free: **1-855-462-5465**

Web site: www.carechoice.nd.gov

E-mail: carechoice@nd.gov

Fax number: 701.328.8744

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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 at any time. 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 active discharge planning already occurring for the resident to return to the community? 0. No 1. Yes → Skip to Q0600, Referral

Active Discharge Planning:

An active discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff is taking active steps to accomplish discharge, and there is a target discharge date for the near future. If there is not an active discharge plan, residents should be asked if they want to talk to someone about community living and then referred to the Local Contact Agency accordingly.

Q0500 Return to the Community

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in 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

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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? (Document reasons in resident's clinical record) 0. No - referral not needed 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 2. Yes - referral made

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.

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 or legally authorized representative) states that he or she **wants to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community** a Local Contact Agency (LCA) Referral Form will be completed and emailed or faxed to the Aging Services Office in Bismarck 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**-MDS Question Q0400 should only be answered "yes" for permitted reasons, such as:
 - a) The resident is currently being assessed for transition by the Local Contact Agency
 - b) The resident has a Transition Plan in place, which has all of the required elements and has been incorporated into the resident's Discharge Plan

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- c) The resident has an expected discharge date of three months or less, has a discharge plan in place with all the required elements, and the discharge plan could not be improved upon with a referral to the Local Contact Agency

The Local Contact Agency is available for consultation to assist nursing facility residents and care teams in identifying support services available in the community.

Q0600-The Local Contact Agency (LCA) Referral Form (SF 584) will be completed and emailed or faxed to the Aging Services Office in Bismarck 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.

Care Planning

- a) 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)
- b) The Local Contact Agency will be responsible to respond to all LCA referrals received from the nursing facility within three business days by phone and will complete an in person visit within 15 business days.
- c) If the Local Contact Agency does not contact the facility discharge planner by telephone or in person within three 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 three 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

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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 Transition Plan (SF 585) in cooperation with the individual nursing facility resident. The LCA Transition Plan 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 form to the resident and facility discharge planner at the time of the in person visit. See Attachments A.

A final copy of the LCA Transition Plan will be provided to the discharge planner within three business days of the visit. The Discharge Planner will provide a copy to the resident upon receipt. The LCA will also provide a copy of the LCA Referral and Transition Plan to the LCA Coordinator. See Attachment (B)

Transition Agency and/or Nursing Facility Discharge Responsibilities:

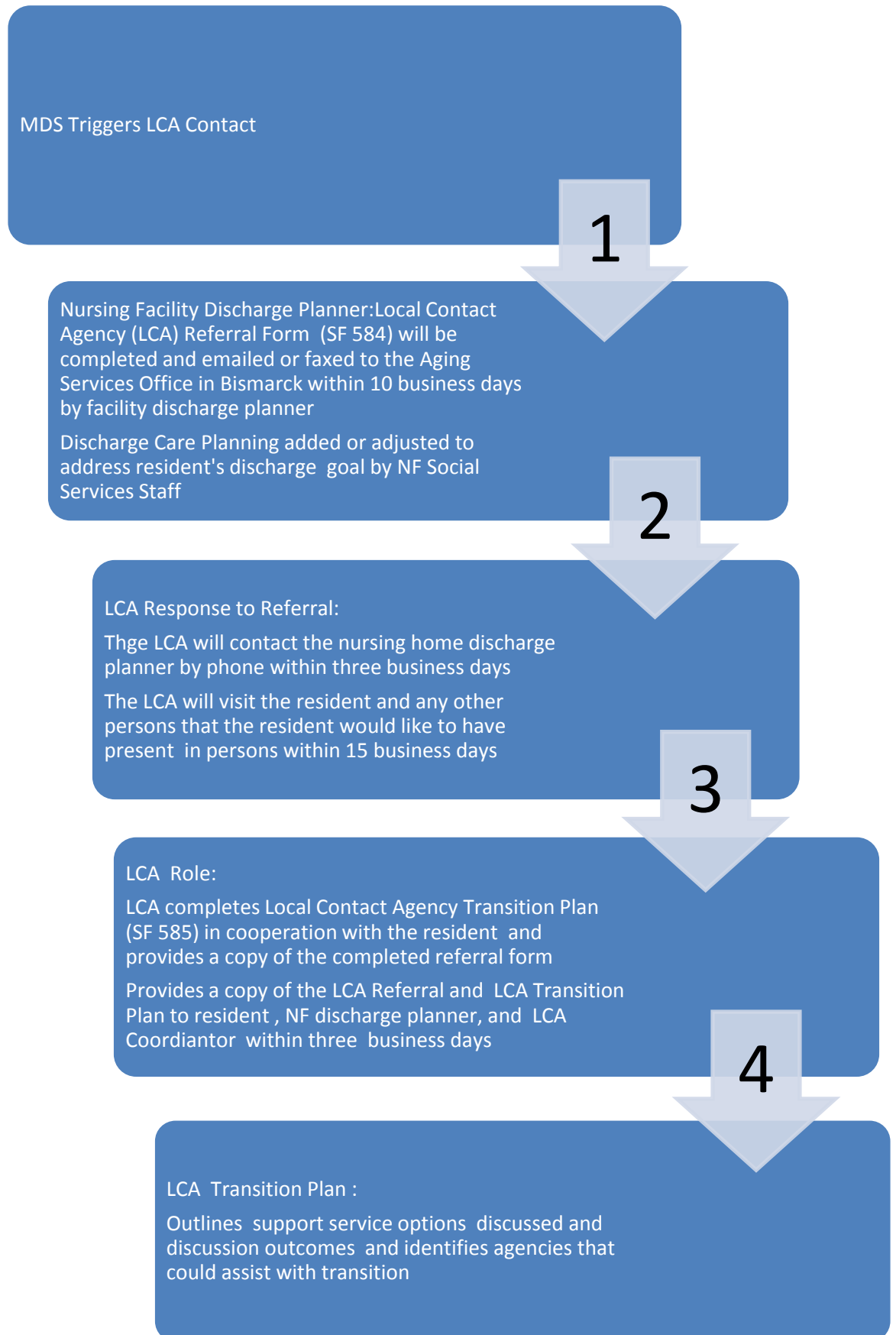
- The nursing facility, the LCA and/or a transition agency will jointly explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- If the resident wishes to move forward with discharge/transition, the facility interdisciplinary 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

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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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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 (Local Contact Agency, Centers for Independent Living, Home and Community Bases Services Case Management, 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