N.C. Department of Health and Human Services

Direction, Linking and Learning

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MDS 3.0 RAI Manual V1.13

The updated RAI Manual was posted to the CMS website in late September 2015

Go to www.qtso.com and click on MDS 3.0 and then click on MDS 3.0 RAI Manual. Scroll to the Downloads

Section Q of the MDS

- To provide residents, who do not have current active plans for discharge, an opportunity to speak with an outside resource (Local Contact Agency)
- Nursing Home staff and Local Contact Agencies are expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all necessary community-based, long-term care services

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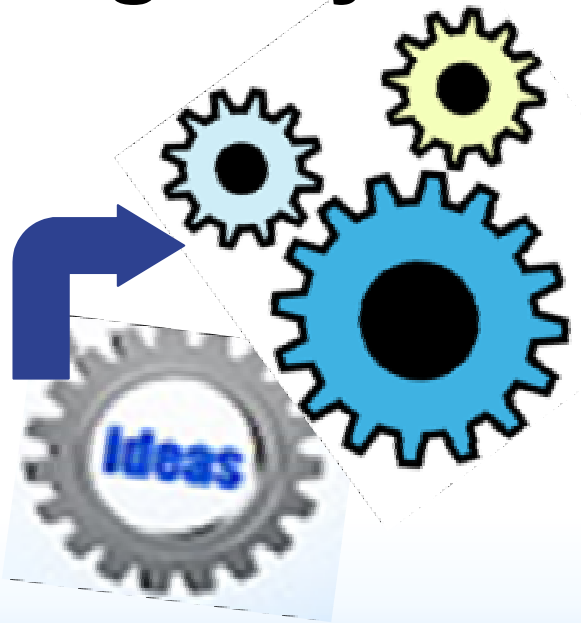
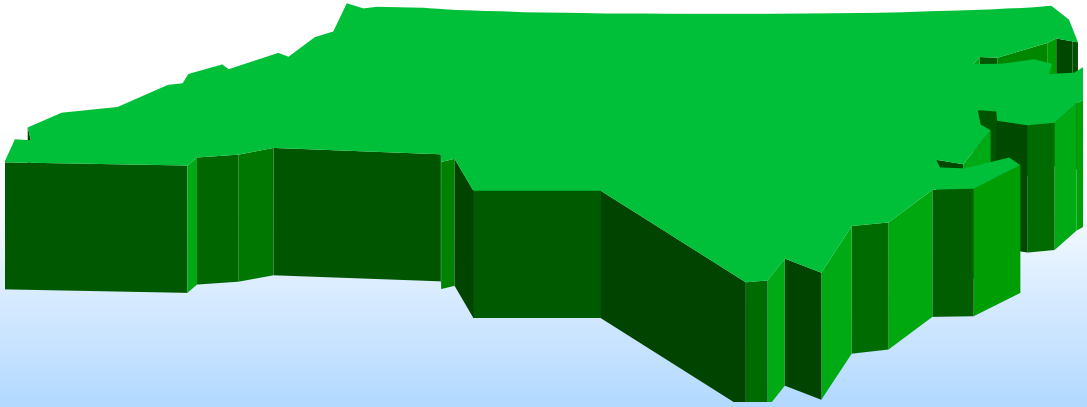
What is the Local Contact Agency?

- The Local Contact Agency (LCA) is responsible for providing facility-based options counseling in response to MDS-Section Q referral



Who is my LCA?

- Trained Options Counselors are provided by:
  - Area Agency on Aging – Regional Connector
  - A partner within a Community Resource Connection



Q0100 Participation?

A. Resident

B. Family or Significant other

C. Guardian or Legal Representative

Q0300 Resident's Expectation?

A. Select a Goal

B. Source of Information

Q0400 Discharge Plan?

If there is a viable plan, Skip to Q600

Q0490 Documentation to Avoid Q500B?

A. Resident

B. Family or Significant other

C. Guardian or Legal Representative

Q0500 Return to Community

A. Select a Goal

B. Source of Information

Q0550 Discharge Plan?

If there is a viable plan, Skip to Q600

Q0600 Referral

Has a referral been made to the Local Contact Agency? (Document reasons in the resident's record)

0. No = referral not needed
1. **No = a referral is or may be needed**
2. Yes – referral made

Return to Community Referral

- Consider each resident's strengths and concerns that affect his or her capacity to function;
- Identify areas of concern needing interventions;
- Develop, interventions in the context of the resident's condition, choices, and preferences
- Discuss goals so the resident knows what must be achieved to move toward discharge

CAA Summary

- Document the resident's desire to talk about discharge and that the IDT is aware of the resident's choice

- Document discussion with the resident and family that identifies potential barriers. Document care plan considerations that would support a successful transition

CAA Summary continued

- Review cognitive skills, functional mobility, need for assistive devices or home modifications
- Review overall goals like rehab at home, palliative or hospice care
- Document contact was made with the LCA within 10 days

Referral Process

- Once a referral is made to the toll-free line, **1-866-271-4894**, the MDS call center will forward the referral information to the Local Contact Agency for your county

- Upon receiving the referral from the MDS call center, the LCA options counselor will make contact within 10 days to discuss possible transition options

What does the LCA do?

- Uses a team approach to transition planning by working with the resident, the Nursing Home Staff and those who support the individual (family or friends)

- Meets with the individual to provide options counseling and to support decisions leading to the possibility of transition

What does the LCA do?

- Collaborates with the resident and Nursing Home Staff to incorporate independent living skills into the resident's care plan
- Shares information and assists with identifying community-based resources needed for a safe and successful transition
- Provides follow-up with the resident and staff on the resident's progress leading up to the transition process
- Facilitates the interested resident to transition from the Nursing Home to a community-based setting

Resident LCA Packets

- LCA Options Counselor Contact Information
- Community-based Resource Materials for Individual
- PASSPORT Tools
- Money Follows the Person Brochure

PASSPORT

- The PASSPORT is a tool for individuals to help them advocate for themselves and be more prepared when facing a transition

- This material was developed for people transitioning from Hospital to Home, but can be used as a “Best Practice”

What's the Plan?

The discharge plan should include at a minimum:

- Individual's preferences/needs for care & supports

  (Contact information for MD, Pharmacy and Care services, Health Hx, Advance Dir/Meds/Tx/ Allergies, Equipment, Housing, Transport)
- Follow-up appts with community MD & Specialists
- Medication education & When to call the doctor
- Who to call in case of emergency
- NH discharge procedures
- Mental health support as needed

Closing

- The Local Contact Agency is a resource for the resident and the skilled nursing facility staff
  - Common Goals
  - Strengthen the partnership
  - Identify challenges and opportunities for improvement

Contacts

Toll-free MDS Section Q Referral call center

- **1-866-271-4894**
- Monday – Friday 9:00am – 5:00 pm

- **MDS questions**:

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N.C. Department of Health and Human Services

LCA Contacts

For NC statewide LCA questions:

contact Lorrie Roth

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- http://www2.ncdhhs.gov/aging/lca.htm
- http://www2.ncdhhs.gov/aging/LCA_StepbyStep_Referral_Guide.pdf