## Money Follows the Person Transition Timeline

# SNF >>> LCA >>> MFP(?) Social Worker/Staff Calls LCA Referral Line: When client answer "yes" on MDS-Q Whenever client says "I want to go home."

LCA Visits and Discusses Options:
What is the best route home?
What does client want?
Reality check

## SNF >>> MFP >>> LCA(?)

Referral Comes Direct to MFP
Client word of mouth
MFP TC outreach
"Success referrals"
Habit/Convenience
Partner agencies

\*\*\*\*THE ONLY INAPPROPRIATE REFERRAL IS THE ONE NEVER MADE!\*\*\*\*

#### **First Things First**

Brief assessment CAP eligible? Needs? Income? Support? Referrals? Feasible/Still interested? No? – Refer out (back to LCA?) Yes? – Set up Initial Planning Meeting

#### Building the Team (Initial Planning Meeting)

Client! CAP LCA Independent Living Family/support people Relevant facility staff Social Worker PT/OT? Director of Nursing?

### Hurry Up and Wait

Housing
Modifications
Caregiver issues
Physical Therapy
Physical/Mental Readiness
Other!

#### "The Scramble"

DME? Furniture? Deposits? Transportation Home? SS Check? What bank/pharmacy/doctor? Other!

#### Calling in CAP

Prep Client

- Start SRF >> send to CAP
- Communicate! (SRF approved?/Clock ticking?)
  - No? >> Troubleshoot?

Communicate! (Assessments Scheduled?)

- Communicate! (Client approved?)
  - No? >> Troubleshoot?
  - Yes? >> Set up Final Planning Meeting

### **Final Planning Meeting**

- Client!
- CAP and Discharge Planner MANDATORY!
- Caregivers/Support People
- PT/OT
- Independent Living
- Other!

\*SET DISCHARGE DATE\*
 \*Complete Quality of Life Survey\*

#### Moving Day

TC Must Be Available for:

Glitches
Questions
Hands-on help
Emotional support
Other!

#### **Follow Along Visits**

#### Medications?

- CAP Aide/Home Health Showing Up?
- Referrals Needed?
- Caregiver Issues?
- Need More Mods/DME?
- PCP Appointment Kept?
- Other?!

#### Hand-Off

Final Visit (with CAP)
List of "Who To Call for..."
More Referrals?
QoL Reminder
Hugs!

