N.C. Department of Health and Human Services

MDS & LCA

Direction, Linking and Learning

Mary Maas, MDS/OASIS Edu.Coordinator
Lorrie Z. Roth, Community Living Coordinator

MDS 3.0 RAI Manual V1.11

The updated RAI Manual was posted to the CMS website in late September 2013

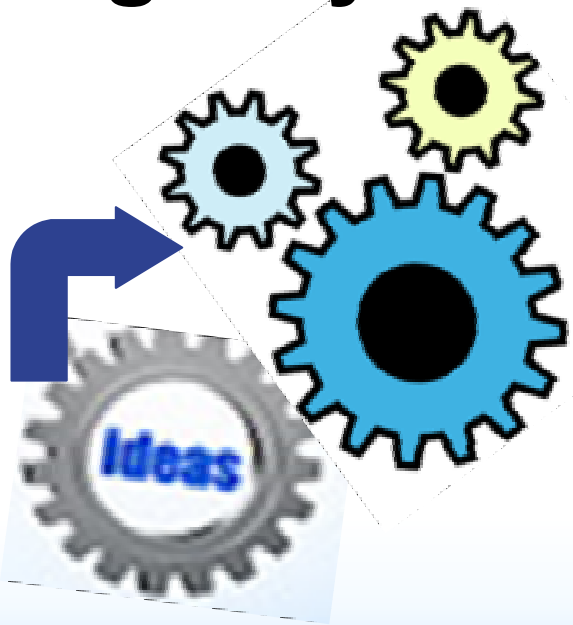
Go to www.qtso.com and click on MDS 3.0 and then click on MDS 3.0 RAI Manual. Scroll to the Downloads

- ✓ This section is designed to provide residents who do not have current active plans for discharge, with an opportunity to speak with an outside resource (Local Contact Agency/LCA).

- ✓ Nursing Home staff and Local Contact Agencies expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all of the necessary community-based, long-term care services

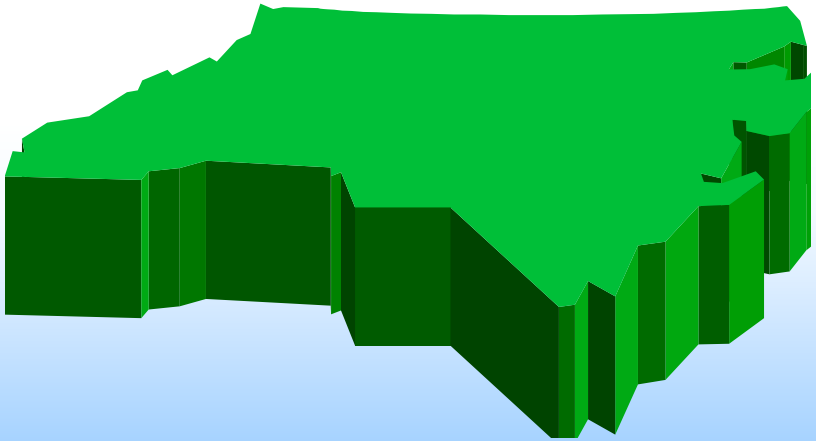
What is the Local Contact Agency?

- 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



***Please Note the Changes ***

Q0100. Participation in Assessment	
Enter Code	A. Resident participated in assessment 0. No 1. Yes
Enter Code	B. Family or significant other participated in assessment 0. No 1. Yes 9. Resident has no family or significant other
Enter Code	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. Resident has no guardian or legally authorized representative

Q0300. Resident's Overall Expectation Complete only if A0310E = 1	
Enter Code	**A. Select one for resident's overall goal established during assessment process** 1. Expects to be **discharged to the community** 2. Expects to **remain in this facility** 3. Expects to be **discharged to another facility/institution** 9. **Unknown or uncertain**
Enter Code	**B. Indicate information source for Q0300A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family, or significant other, then **guardian or legally authorized representative** 9. **Unknown or uncertain**
Q0400. Discharge Plan	
Enter Code	**A. Is active discharge planning already occurring for the resident to return to the community?** 0. **No** 1. **Yes** → Skip to Q0600, Referral

Q 0300 Expectation ***Steps for Assessment***

1. Ask the resident about overall expectations to be sure there is a current understanding of his/her situation.
2. Ask the resident to consider his/her health status, expectations for improvement/worsening, as well as community supports and opportunities
3. If not already stated, ask the resident about his/her expectation regarding the outcome of the nursing home stay and expectations about returning to the community
4. The resident's goals are recorded here. The family or legal representative's goals for the resident may also be recorded in the record

Q 0300 Expectation ***Steps continued***

5. Because of temporary (delirium) or permanent (dementia) condition a resident may not be able to provide a clear response so then the information can be obtained from family, significant other or legal representative

6. If the resident consents, encourage the involvement of family or significant others

7. Even if the decision-making authority is vested in the individual's guardian, the resident's wishes should be recorded here if he/she is able to comprehend and communicate

Q0400 Discharge Plan ***Steps for Assessment***

1. Review the care plan, the medical record, and all clinician progress notes for discharge – *needs, therapy, appointments, care, assistance required, etc*
2. If the resident is unable to communicate preferences, involve family or significant other or guardian – *but be sure they understand that they are speaking on behalf of resident*
3. If a nursing facility has a referral/resource process and residents have supports already in place, a referral to the LCA may not be necessary
4. Record the resident's expectations whether you believe they are realistic or unrealistic

Q0400 Discharge Plan *Steps continued*

5. If discharge needs cannot be met by the NH, an evaluation should be conducted by the LCA
6. The resident, IDT, and LCA should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance)
7. Review financial eligibility to identify the options (e.g., home, assisted living, or group homes, etc.)
8. A determination of family involvement, capability and support after discharge should also be made

Q0490- Resident's Preference to Avoid Being Asked Question Q0500 B

- Complete only if A0310 A = 02, 06, or 99

Does the resident's clinical record have a documented request that this question be asked only on comprehensive assessments?

0. No = nothing in the chart about Q0500 preference
1. Yes = there is documentation in the record so don't ask again about Return to Community until the next comprehensive > skip to Q0600, Referral
8. Information not available

Q0500 Return to Community

"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

Do not assume that the resident cannot transition out of the SNF/NF due to level of care needs. The SNF/NF can talk with the LCA to see what is available that does not require family support

Return to community questions may upset residents who cannot understand what the question means and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other guardian and/or legally appointed decision-maker for that individual could be asked the question.

Q0550- Resident's Preference to Avoid Being Asked Question Q0500 B again

A. Does the resident (or family/significant/guardian/ or legal representative) want to be asked about returning to the community on all assessments? clinical record have a documented request that this question be asked only on comprehensive assessments?

B. Indicate the source for Q0550 A

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. Yes = a referral is or may be needed (For more information see Appendix C, Care Area Assessment resource)
2. Yes – referral made

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

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

MDS questions:

Mary Maas 919-855-4554
mary.maas@dhhs.nc.gov

LCA Contacts

For NC statewide LCA questions:

contact Lorrie Roth

NC Community Living Coordinator at

919-855-4986

lorrie.roth@dhhs.nc.gov