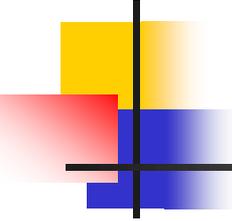


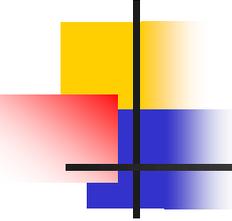
The Role of the Local Contact Agency in MDS Section Q

Brenda Gallant, RN
The Maine Long Term Care
Ombudsman Program



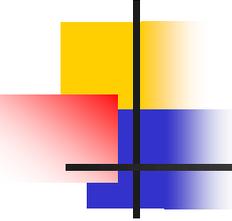
The Maine Long Term Care Ombudsman Program (MLTCOP) Older Americans Act Section 712

- Federally mandated advocate for long term care consumers
- MLTCOP serves consumers in all settings including: Nursing Homes, Residential Care, Assisted Living and Home Care
- Resolves complaints on behalf of consumers
- Provides information, consultation, education to residents, families and facility staff
- Works to ensure that residents receive information about care, services and available community resources
- Provides residents rights in-service for facility staff
- Provides systems advocacy to improve care and services



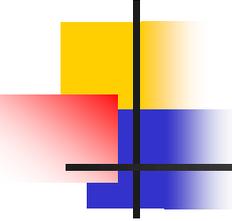
Context of MDS 3.0 Section Q

- The Americans with Disabilities Act (1990) and the Olmstead Supreme Court Decision (1999)
- Individuals have the right to receive care in the least restrictive setting and government has the responsibility to enforce and support these choices
- Nursing Home residents have the right to information about discharge
- Residents may not be aware of the option of returning to the community and that services and supports may be available in the community to meet their needs
- Provides an opportunity to discuss the residents expectations regarding a return to the community and his/her goals for care



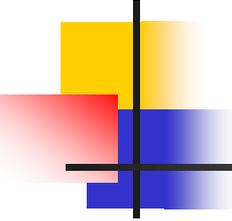
Goals of the MDS 3.0 Section Q

- Assures that residents have a voice regarding discharge
- Supports Person Centered Planning
- Promotes Transition Planning
- Fosters greater collaboration among nursing home providers and community care providers



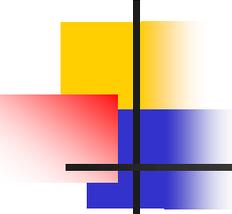
Local Contact Agency (LCA)

- The Maine Long Term care Ombudsman Program serves as Maine's LCA
- Nursing Home staff must contact the LCA for those residents who express a desire through Section Q, to learn about possible transition back to the community and the care options that are available
- A referral to the LCA is not necessary if an active discharge plan is in place
- Consent must be obtained from the resident or legal guardian for the referral
- Referrals from the Nursing Home to the LCA should be made within 2 business days



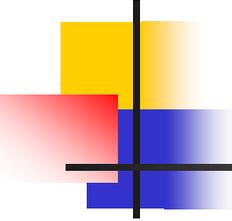
LCA continued

- The LCA responds to referrals by providing information to residents about available community based long term care services and supports
- The LCA is expected to engage the resident in their discharge and transition plan and collaboratively work to ensure that all the necessary and available community based long term care services are accessed
- The LCA will visit the resident within 5 business days after the referral is received from the Nursing Home



Nursing Home Role in Discharge Planning

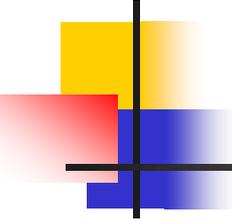
- MDS Section Q **DOES NOT** diminish or change the Nursing Home's role in discharge planning
- Discharge planning responsibility under 10-144 Chapter 110 Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 14
- 14 A. 4 **Responsibilities for Social Services Staff**
 - c. Planning and coordinating discharge planning as directed by the MDT
 - d. Assisting the resident and family with discharge plans, including an evaluation of the environment to which the resident will transfer and referring to appropriate supportive services.



Resident Interview conducted by MLTCOP

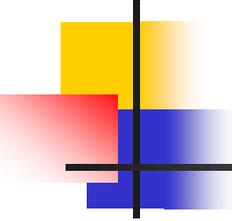
*When residents have responded affirmatively to MDS
Section Q*

- What brought them to the Nursing Home
- What do they see as their needs
- What kinds of family/informal support do they have
- What is their payment source
- What is the status of their housing
- What are their perceptions regarding their need for care if discharged back to the community
- Provide information about potential long term care services and supports in the community
- Initial Screening for and referral to Money Follows the Person (Homeward Bound) for those who may be eligible.



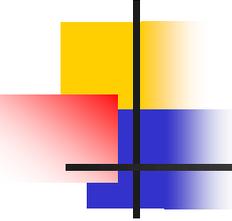
Planning for Resident Discharges

- MLTCOP as the LCA works with the resident, their family, the Nursing Home Discharge Planner, Physician, Nursing Staff, Home Health, Aging and Disability Resource Centers (ADRC), Center for Independent Living (Alpha One) to facilitate the discharge
- MLTCOP works to resolve barriers to the discharge
- Identifies resources needed for care in the community



Special Considerations

- If the resident states a preference not to be asked about discharge, it is acceptable for the resident to opt out of being asked about discharge on quarterly non-comprehensive assessments
- This preference should be noted in the clinical record
- The resident should be asked annually about return to the community at the comprehensive assessment
- If the level of cognitive impairment is such that the resident does not understand, a family member, significant other or legally appointed decision maker for the resident can be asked about return to the community



Special Considerations, cont.

- When a resident wants to return to the community and their family does not support this decision, the wishes of the resident supersede those of the family
- Do not hesitate to call with questions. Every resident is unique as are their circumstances

MLTCOP : 1-800-499-0229

Fax: 621-0509

Section Q Survey Results

Thank you for your responses!

Common concerns:

- Inadequate resources for residents to return to the community
- There is no 24 hour care in the community
- Waiting lists for state funded home care services
- Direct care staffing shortages
- Raising false hopes for residents
- Families upset