SECTION Q - DISCHARGE TO COMMUNITY

KEY INFORMATION

Section Q has been broadened beyond the traditional definition of discharge planning for sub-acute residents to encompass discharge planning with expanded resources for long stay residents and individuals who previously may not have been able to transition back to the community.

Through the ongoing expansion of Medicaid waiver and State plan services, and Federal and State programs, many more individuals can receive long-term care (LTC) services and supports in the community to support an optimum quality of life and function.

Local Contact Agencies (LCAs), such as Aging and Disability Resource Centers, Centers for Independent Living, and Area Agencies on Aging, provide community care information and transition services to the resident.

Nursing Homes (NHs) will continue to do discharge planning and meet those regulatory requirements. Local contact agencies can assist the resident and the NH in transition planning to secure/locate housing, home modifications, personal care, and community integration.

Section Q has been revised to be person-centered, provide the resident the opportunity to express their expectations for care, engage the resident in their discharge planning goals, and initiate a referral to a LCA to provide information and explore the potential for returning to the community.

Residents are asked directly what their expectations are for discharge from the NH and if they want to talk to someone about community care options and supports.

If a resident wants to talk to someone about available LTC community options and supports and the possibility of transitioning back to the community, a referral is made to the LCA.

The LCA comes to the NH, talks with resident and NH staff. NH staff and LCA work collaboratively to implement discharge and transition planning.

Skip patterns are built into Section Q so that if the resident has already been asked the question and it has been acted upon (active discharge plan in place and/or referral made to LCA), or a determination has been made that the resident is unable to transition back to the community, the question is not repeated with each subsequent assessment.

Discharge and transition planning collaboration between nursing homes and local contact agencies is important for residents who express a desire to return to the community and require services such as securing/locating housing, home modifications, and personal care.