

Department of Social Services
Informed Choice Process for Nursing Facilities

The goals of this informed choice protocol:

- find out clients individual preference for where they wish to receive LTSS
- provide access to information about community options
- have the Universal Assessment completed and explore an individualized community care plan option for each individual
- opportunity to move to the desired and most integrated setting appropriate to their needs
- consistent documentation regarding the **Residents** preferences

Procedures for the informed choice protocol are as follows:

The Department of Social Services, Money Follows the Person Demonstration shall:

- a. Establish project team to assure implementation of informed choice protocol
 - Identify team lead for facility responsible on behalf of DSS for implementation of the protocol at the facility
 - Identify care planning leads representing respective home and community based service packages who report to team lead;
 - Additional care planning staff may be added to the facility as identified by the care planning lead
 - Identify transition coordination and housing coordination staff who report to team lead

Responsibilities of staff:

- Team Lead is responsible for
 - Status updates biweekly;
 - Coordinating all activities of care planning staff, transition coordinators and housing coordinators;
 - Serving as contact with NF administrator with respect to community transition process;
 - Assuring all timelines are met on schedule;
 - Assuring coordination with facility staff;
 - Assuring communication of discharge planning meetings to care planning staff and others as appropriate;
 - Attending all discharge planning meetings and other meetings as required at the facility;
 - Assuring standardization of process across all care planning systems;
 - Assuring all protocol paperwork required as part of the informed choice protocol is completed;
 - Meeting biweekly with care planning leads (one individual from each of the agencies or organizations representing community target service plans. (Access agency, DSS social worker, DDS, DMHAS) to assure compliance with protocol timelines;

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- Drafting meeting summaries;
 - Producing written monthly status updates.
- Care planning staff is responsible for
 - Reviewing all charts in preparation for assessment of all residents;
 - Completion of MFP paperwork;
 - 1:1 needs assessment and level of care;
 - Preparing community plan;
 - Attending discharge planning meeting;
 - Follow up with implementation of community care plan
- Transition Coordinators are responsible for
 - Collection of resident identification documentation
 - Locating housing and assisting with apartment set-up and move;
 - Arranging transportation to visit apartments;
 - Completion of MFP paperwork;
 - Assisting with hiring personal care assistants;
 - Arranging for PT assessment of home prior to discharge either through coordination with the nursing home staff or through independent contractor if nursing home staff is not available (prior approval MFP)
 - Determining need for accessibility modifications and coordinating process according to MFP protocol.
 - Assisting lead coordinator with implementation of the protocols as requested
- Housing Coordinators are responsible for
 - Locating at least 2 community housing options
 - Photographing community options
 - Initial measurements for accessibility
 - Completing all housing paperwork
 - Coordinating and communicating with landlord
- Nursing Facility Staff are responsible for
 - Providing input into community care plan
 - Arranging discharge planning meetings and communicating with facility community lead
 - Arranging for 30 day supply of medication upon discharge
 - Arranging for DME and other state plan services upon discharge
 - Arrange facility wide outreach and education
- Ombudsman are responsible for
 - Advocating for the resident
 - Attending education and outreach meetings
 - Participation in care planning meetings as requested by the resident

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- b. Attend facility wide outreach and education
 - Presentation of community options to facility staff, including physicians, regarding community options
 - Attend residents meeting/family meeting to discuss new community options and encourage participation in needs assessment
 - 1:1 outreach with all residents
 - Discuss that all persons will be assessed for options as part of the planning process including community options
 - For conserved residents where conservator does not participate in the meeting, place telephone call to conservator to inform about process
 - If there is an objection to the assessment process designed to inform the resident and family about options, obtain appropriate signatures indicating that the resident or the conservator chooses to remain institutionalized and chooses to forgo opportunity for needs assessment and opportunity to explore community options
 - If conservator disagrees with resident (ward) regarding interest in exploring community options, consider recommending a request to Probate Court for a hearing in order to have the Judge decide or for a new COP/COE named
- c. Complete universal assessment and care plan development
 - 1:1 assessment of all residents by care planning staff of home and community based service package unless resident signs refusal for assessment
 - Complete assessment process and if alternative target home and community based menu of services is more appropriate, coordinate with appropriate key staff
 - Develop care plan
- d. Attend facility discharge meeting with resident (family members and conservator, if appropriate) and care planning staff to present and as client what they think is the most integrated setting appropriate to their individual needs
 - Discuss care plan and community options with resident and, if appropriate, conservator and family
 - Assure that resident, family members and conservator are educated about options, including community options so that they may make an informed choice
 - Outcome assuming community is chosen as most integrated setting, meets residents desired setting and meets their needs:
 - If the resident agrees to pursue community placement obtain signed agreement with care plan, signed informed consent and signed informed risk agreement

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- If the resident disagrees with transition to the community and chooses an institutional placement obtain signed documentation indicating that the resident or the conservator chooses to stay institutionalized and chooses to forgo acceptance of community care plan – begin search for appropriate alternative institution
 - If ward (resident) chooses the community option but the conservator chooses continued institutionalization , request a Probate Hearing in order to have the Judge decide or for a new COP/COE named
- Outcome if after all options are explored team (to include the Client) feel continued institutional placement is least restrictive available
 - If the person agrees with the recommendation to continue institutionalization, facility staff begin search for appropriate alternative institutions;
 - If the person (or conservator) chooses community setting despite team recommendation obtain signed care plan, signed informed consent and signed informed risk agreement addressing risks that the team feels are not mitigated in the care plan – continue transition planning to the community
- Complete team meeting summary including most integrated setting check list, team recommendation, and outcome form.
- e. For those transitioning to the community, collect identification documentation, establish credit in community, establish bank account, and begin independent skills training
- f. Identify housing – assure choice, modify if necessary and coordinate community supports for those transitioning to community
- g. Transition to the community and provide on-going support with additional supports through MFP for the transitional year to ensure successful integration into community
- h. Collect and analyze data regarding service utilization and quality of life data for 2 years subsequent to community discharge
- i. Prepare and distribute semi-annual reports