

In support of the MDS 3.0 Section Q, the state of New Hampshire in partnership with The New Hampshire Institute for Health Policy & Practice at the University of New Hampshire convened a group of community stakeholders representative of nursing homes, ServicLink Aging & Disabilities Resource Center Network, and community providers and members to collectively develop the Section Q Referral Procedure for nursing home residents who answer “Yes” to Q500B.

This group of statewide stakeholders united, sharing their expertise and perspectives to develop procedures for nursing home resident referrals and transitions to the community. The Section Q referral procedure documents include the “Statement of Understanding” and the Referral Notification form standardized for use by nursing homes for MDS 3.0 Section Q referrals. The Statement of Understanding provides the workflow on how the referral is processed and includes roles and responsibilities of involved stakeholders.

The Referral Notification Form serves as a tracking and documentation tool.

The referral notification form is initiated by the nursing home for residents who answer “yes” to Q500B “Return to Community” question. It is important to complete the entire form (leave no blanks). If not applicable note N/A.

Starting at the upper right note the date the resident answered “yes” to Q500B .

Just beneath note the date referral is sent to ServiceLink Resource Center. This is critical as the each step in the process has established timeline for completion.

Note mode of referral: fax, email, or us mail . Sending referal via us mail note reason . This is due to the established timelines.

Complete section I. Nursing Home information

Complete section II. Individual being referred information

Complete section III. Individual’s Designated Contact Person (if applicable)

Additional information: note information pertinent to the referral

This form is double sided. Side 2 is guideline for nursing homes provided by NH Department of Health & Human Services.

"The Statement of Understanding is between nursing homes and ServiceLink Aging & Disabilities Resource Center Network concerning the roles and responsibilities when generating and processing a MDS 3.0 Section Q referral. In addition to providing guide, it promotes accountability between parties.

The first document within the statement of understanding is the workflow action steps.

Timelines established are described as best practice. The intention is to capture the best operating practice for nursing homes and ServiceLink Resource Centers in their response to nursing home residents wishing to learn of their community living options. If timeline is not met document reason.

Step one

The nursing home asks the resident section Q500B "Return to Community" question of the MDS 3.0. The resident answers, "Yes, I want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community".

Step two

Within three business days of individual's "yes" to Q500B, the nursing home will generate referral to Service Link Resource Center using the standardized referral notification form. "

Step three

Within the same three business days of the resident answering "Yes" to Q500B, the nursing home will give the resident the ServiceLink Aging & Disabilities Resource Center brochure to inform him or her who will be coming to visit to talk about community living options. The nursing home will document the date the brochure was given to the resident."

Step four

Within three business days of receiving the referral, ServiceLink Resource Center will confirm with the nursing home receipt of the referral and verbally confirm the resident's interest in speaking to a third party about available community living supports, and schedule a face-to-face visit. "

Step five

Within ten business days of receiving the referral, ServiceLink Resource Center will visit the resident. This first face-to-face will be a meet and greet. This visit will be a time to gather information about the resident's desires and community support needs. "

Step six

ServiceLink Resource Center will inform the nursing home that the first face-to-face with the resident has occurred and that an overview of available community living supports was shared. If not already determined, ServiceLink Resource Center will confirm if the resident would like to meet again to discuss community options specific to the resident's desires and needs. "

Step seven

If the resident wants a second face-to-face with ServiceLink Resource Center to learn additional information about community living options, ServiceLink Resource Center will gather the needed information from the resident's family, circle of support and nursing home.

Step eight

The nursing home and ServiceLink Resource Center will participate in conversations with the resident, family members, and the resident's circle of support to learn if the resident wants to pursue community living options or end the referral process.

Step nine

Within ten business days of the first face-to-face with the resident, ServiceLink Resource Center will conduct the second face-to-face meeting with the resident to discuss community living options available specific to the resident's desires and needs.

Step ten

If the resident decides to end the process, both ServiceLink Resource Center and the nursing home will document the date and reason (if provided) why the process ended.

Step eleven

If the resident decides to pursue community living, the nursing home makes the referral to the applicable provider agency chosen by the individual.

For Detail description or roles and responsibilities, see Roles & Responsibilities document listed on this website. For status form information, see # 8 of Nursing Facility Roles & Responsibilities .