



July 7, 2010

Dear Admissions Coordinator/Social Services Director,

This letter is intended to provide you with additional information regarding the Minnesota Return to Community initiative. A letter was mailed to each Minnesota nursing home administrator on March 18<sup>th</sup>, 2010 to provide an overview of Return to Community and what it means for nursing home residents and staff. This letter will provide information about the enclosed brochures and the protocol for providing the brochure to people entering a nursing home.

The Minnesota Return to Community initiative passed during the 2009 legislative session. Minnesota Statutes section 256.975, subdivision 7, paragraph (b), requires the Minnesota Board on Aging and its designated Area Agencies on Aging to provide long-term care options counseling to current residents of nursing homes who express a desire to return to the community. In addition to providing long-term care options counseling, each nursing home resident must also receive written information about their options for returning to the community of their choice.

The enclosed brochures have been developed and printed by the Minnesota Board on Aging which operates the Senior LinkAge Line®. The brochure should be made available to each person upon admission to the nursing home. This can be provided to the person along with a discussion about options in order to provide the Senior LinkAge Line® as a resource for residents who wish to learn about returning to the community or home of their choice. At a minimum, this brochure should be given upon discharge from the nursing home. The brochure is not intended to replace the work of the nursing home discharge planner but simply as an additional resource for nursing home residents and families. To reorder brochures, please contact the Senior LinkAge Line® at 1-800-333-2433. Additional copies are available at no expense to the nursing home.

The Return to Community initiative was based on research done by the Centers on Aging at the Universities of Indiana and Minnesota. The research shows a cohort of individuals who have low to moderate needs, have been in the nursing home less than 90 days, and have expressed a desire to return to the community and/or have a supportive caregiver. The intervention involves assessment, care planning, service coordination, placement and ongoing monitoring of care in the community. This is a person centered approach and engages the nursing home staff as key to an effective transition. By implementing this initiative, Minnesota is well on its way to being compliant with changes to MDS 3.0, section Q that will be implemented this coming October.

The Senior LinkAge Line® staff designated as “MinnesotaHelp Network™ Community Living Specialists,” are provided with a list of nursing home residents compiled by staff at the Department of Human Services utilizing Minimum Data Set (MDS) admission assessments. Residents targeted for this intervention are early in their nursing home stay (60 – 90 days after admission); have the desire and support to return to the community; fit a community discharge profile that indicates a high probability of community discharge; and are at risk of becoming a long stay resident. The Community Living Specialists provide the resident with long-term care options counseling including initial assessment, review of risk factors, independent living support and consultation.

The Community Living Specialists are highly trained nurses and social workers who work with discharge planning staff and nursing home social workers in facilities. These staff should be viewed as partners and resources for your discharge planning team. These staff only work with those residents who are requesting the assistance to relocate back to the community. This intervention is intended to support current discharge planning efforts already occurring in nursing homes and should not be viewed as a replacement to those services. Community Living Specialists will provide follow up services which are critical to sustaining the individual's choice to transition back to the community.

**Additional Information about this new service:**

- The Minnesota Return to Community initiative primarily serves private pay individuals. Those individuals who are on a public program or who have a managed care coordinator will be connected to their county of residence or managed health care organization for assistance.
- The effort is coordinated with the MinnesotaHelp Network™ (Minnesota's federally designated Aging and Disability Resource Center) through the Senior LinkAge Line®, Disability Linkage Line® and through the Web at [www.MinnesotaHelp.Info](http://www.MinnesotaHelp.Info).
- In October 2010 a new version of the MDS will be implemented. The new version 3.0 will contain many new changes including changes to Section Q. The new Section Q will require the nursing home to ask each resident, upon admission, "*Do you want to talk to someone about the possibility of returning to the community?*" A response of yes should trigger follow-up care planning and referral to the designated local contact agency about the resident's request. In Minnesota, the referral will be made to the Senior LinkAge Line® (1-800-333-2433).

More information about MDS 3.0 changes will be forthcoming in the future months from the Centers for Medicare & Medicaid Services and the Minnesota Department of Health. The Return to Community initiative and the timing of the new MDS 3.0 gives Minnesota nursing homes and providers an advantage to prepare for federal changes when helping residents transition from the nursing home back to the community.

If you have any questions about the initiative please feel free to contact Darci Buttke, the Return to Community Program Coordinator at [Darci.Buttke@state.mn.us](mailto:Darci.Buttke@state.mn.us) or (651) 431-2580.

Sincerely,

Robert Held, Director  
Nursing Facility Rates and Policy Division

Jean K. Wood, Executive Director  
Minnesota Board on Aging