MDS 3.0 Section Q Implementation
Questions and Answers from Informing LTC Choice conference and emails
September 22, 2010

DATA USE AGREEMENTS (DUA)

1. Do state agencies need a Data Use Agreement to implement Section Q? What circumstances require a Data Use Agreement?

No DUA is needed for individual nursing facilities to refer the names of individuals requesting to talk to someone about the possibility of returning to the community to the local contact agency. The nursing facilities will need to obtain agreement and permission from each individual resident, through their usual signed release of information form, in order to refer that individual's name to the local contact agency.

In order for the local contact agencies to receive Minimum Data Set (MDS) data (i.e. a list of names of individuals from the MDS data set who answered, "Yes, I would like to speak to someone about the possibility of returning to the community" for each nursing facility), States will need a revised Data Use Agreement. CMS is asking State Medicaid agencies to amend their Medicaid MDS Data Use Agreements to include designated local contact/referral agencies if this is the case. The Medicaid Data Use Agreement must be amended to include those local contact agency entities to be authorized to obtain individual named referrals from the MDS data base in order to comply with the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) rule. This relationship must be included in the contract or memorandum of understanding between the Medicaid agency and the local contract agency (LCAs). Using this approach, the LCAs s is in compliance with privacy protection requirements under HIPAA.

2. Is the Data Use Agreement (DUA) specific to only Medicaid population?

The Medicaid Agency's Data Use Agreement applies to all nursing facility residents included in the MDS data base.

LOCAL CONTACT AGENCIES (LCAs)

3. Have the roles and responsibilities of the LCAs been defined?
   a. What is the appropriate level of contact by the local contact agency – face-to-face, phone, written?
   b. Do they provide information and assistance, or is transition assistance expected?

The roles and responsibilities for LCAs are defined generally by the Section Q process, but states are given great flexibility in defining their particular activities and responsibilities. In general, the LCA's role is to contact individuals referred to them by nursing facilities through the Section Q processes in a timely manner, provide information about choices of services and supports in the community that are appropriate to that individual's needs, and collaborate with the nursing facility to organize the transition to community living if possible. The exact mode and content of that contact with the nursing facility resident is to be determined by each state in response to

their goals for providing choices of services and settings to individuals, with substantial input from all stakeholders involved.

These resident contacts have been termed information and assistance[1] or options counseling[2] under various federal/state programs. In working with state officials to design the Section Q referral process, telephone contact (conversation) with the resident was considered the minimum contact requirement for an initial contact.

The Section Q pilot sites found that a face-to-face contact was needed to begin developing a rapport with the individual and to provide them with adequate information specific to their individual needs and circumstances. In addition, evidence from several States under the Nursing Facilities Transition Grant programs demonstrated that face-to-face contacts were the most effective approach for creating successful transitions and is recommended for Section Q as well.

4. Have all Local Contact Agencies been assigned by the State? If so, how do nursing facilities in each state find out which local contact agency has been assigned to them by their Medicaid State Agency? Is there a list available that we can distribute to our nursing home members so they can start the process of coordinating with their local contact agencies to prepare for implementation of MDS 3.0 Section Q?

CMS recognizes that each state must look at their current long term care services and resources before designating their local contact agencies and yet also recognizes that residents and nursing home staff will need immediate contacts after MDS 3.0 is implemented on October 1, 2010. As of the end of May 2010, most states have not yet designated their local contact agencies. Since it will take more time for some states to develop their process, CMS has requested State Medicaid Directors identity a lead entity, point of contact (POC) and provide contact information for that individual in each State. This list will be available @ http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage on 10/1/2010 and CMS has shared it with nursing home organizations, States, Ombudsmen, Aging and Disability Resource Centers, Centers for Independent Living, and other stakeholder organizations.

---

[1] Information and Assistance is a core service required for aging network providers (Area Agencies on Aging) by the Administration on Aging.

[2] Options counseling, for long term care services and supports, is an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long term care choices in the context of the consumer's needs, preferences, values, and individual circumstances. (National Association of State Units on Aging, *Long-Term Supports Options Counseling*, Independent Living Research Utilization, January 2007, p.4).

The goal for Options Counseling is ensuring that consumers make informed decisions concerning their long term care. The process assists the individual, their family and significant others to understand strengths, needs and preferences and translate this knowledge into support plans, strategies, and service choices available in their community. In the options counseling process, the counselor works with the individual consumer (and their family and/or significant other) so the consumer moves beyond obtaining information to gaining an understanding of how to apply it to their personal situation. The keys to options counseling are person-centered planning and decision support. (ADRC Technical Assistance Exchange, *The Art of Options Counseling*, ADRC-TAE, April 2009, p. 9).

After States have designated their local contact agencies, CMS will obtain that list and make it available in a central listing.

5. Are there time frames for responding to the referral and for contacting the resident?
   a. Will the response times be monitored?
   b. Will the outcomes of referrals be documented and reported?

There are instructions to nursing facilities in the MDS 3.0 Instructors Guide for a "Yes" response to item Q0500A to trigger follow-up care planning and make contact with the designated local contact agency about the resident's request within 10 business days of a yes response being given. This is a recommendation however, and not a requirement. Follow-up is expected in a "reasonable" amount of time. There are currently no regulatory or statutory requirements for MDS 3.0 that address the amount of time a skilled nursing facility/nursing facility (SNF/NF) has to make a referral to a local contact agency (LCA) or the amount of time a LCA has to respond to the referral from the SNF/NF. States may establish their own process to monitor performance.

The goal of follow-up action is to initiate and maintain collaboration between the nursing facility and the local contact agency to support the individual's expressed interest in the possibility of being transitioned to community living. This includes the facility supporting the individual in achieving their highest level of functioning, the local contact agency providing information about community living services and supports, and collaboration in assisting the individual in transition to community living.

CMS is communicating with State Medicaid Agencies and the Administration on Aging (AoA) about response times for local contact agencies. Each State's local contact agency will be different and for State's using Aging and Disability Resource Centers, ADRC penetration may vary. We would expect a reasonable contact response time on the part of the LCA of within 3 days by phone and within 10 days if an on-site visit is needed. Experiences in the Section Q pilot test showed that states were interested in establishing responsive time frames. For example, during pilot testing, Connecticut set 3 days to contact the person and two weeks to complete the initial face-to-face interview/screen. CMS and AoA will be collecting information about the Section Q implementation as part of the Money Follows the Person and Aging and Disability Resource Center Grant Program monitoring and evaluation activities.

Will nursing homes be cited by survey staff if the Local Contact Agency does not respond in a timely manner?

No.

6. Is the nursing facility required to follow up once a referral has been made?

Discharge planning follow-up is already a regulatory requirement, CFR 483.20(l)(3), and important for person-centered care. The optional Return to Community Referral Care Area Trigger checklist states that, "If the local contact agency does not contact the individual resident by telephone or in person within 10 business days, make a follow-up call to the designated local contact agency as necessary."

7. **What type of referral systems are states setting up – electronic, telephone, written?**

   States are in the process of investigating and developing the features of their referral processes and systems. The five States involved in the pilot testing all used telephone referrals because the two-month period to test the process did not allow time to develop an electronic system. For the ongoing operation of a statewide system, Connecticut is one of the States developing a web-based, electronic referral system.

8. **How will Medicaid certify that the Local Contact Agency's (LCAs) services meet Medicaid standards for residents who return to the community?**

   There are no specific federal standards for certifying a LCA ; LCAs are required to provide information and referral services . However, each Medicaid State Agency is held accountable to meet federal requirements for provider qualifications for those entities that provide Medicaid services and supports to the individual for transitioning and community care. Each State has the flexibility to develop their own (contract) standards based on their needs and circumstances and to monitor nursing home and local contact agency (LCA) coordination and performance. State Medicaid Agencies have designated a State point of contact (POC) for the Section Q implementation and are responsible to coordinate efforts to designate LCAs for their State's skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate.

   Experience with the pilot testing of Section Q has shown that building collaborative relationships between the LCAs s and the nursing facilities in their regions is critical. Training of local contact agency transition coordinators, if their responsibilities are new, is also important.

9. **When a nursing facility works with the Local Contact Agency to successfully transition a resident into the community, when does the liability for the nursing facility end?**

   CMS does not define legal liability because it must be evaluated on a case-by-case basis. Skilled nursing facilities and nursing facilities have always been required to provide discharge planning services and follow- up, CFR 483.20(l)(3) . The facility is responsible to provide support for the individual in achieving his or her highest level of functioning until the resident is discharged from the facility. This includes collaborating in a thorough assessment of the individual's needs and care planning to support the individual's choice to be transitioned to community living.
   The agency and/or entities providing care and services in the community are responsible for monitoring the delivery of care and assuring health and safety of the individual once he has returned to the community, and the State is responsible for monitoring these activities.

10. **Will the Local Contact Agency (LCA) be responsible for follow-up of residents who return to the community to ensure their discharge remains appropriate?**

The design of the information and assistance, choice counseling, transition, and follow-up programs and processes are organized differently in every State. Once an individual has been transitioned to the community, the agency and/or entity providing the care and services to the individual is responsible for monitoring the delivery and outcomes of care and the State is responsible for overseeing these entities. In most cases this will not be the responsibility of the Local Contact Agency (LCA). The responsibilities for care management and services provision embodied in the discharge plan, as developed by the skilled nursing facility/nursing facility interdisciplinary team and LCA will depend on the service plan and rules and contracts of the purchaser of services. Those responsibilities are not changed by Section Q. If the individual relocates into a Medicaid Home and Community Based Services waiver program, the responsibility for client monitoring is clearly defined in federal rules. If an individual is discharged with Medicare Home Health Agency services, the responsibility lies with the service provider coordinating with the individual's physician. States have the option of adding responsibilities for agencies and service providers as they deem appropriate.

11. If the Local Contact Agency does not evaluate a home's safety, will/can they subcontract this responsibility?

As written, this is not the responsibility of a LCA, but rather that of a transition coordination entity. In most instances, those agencies and/or entities responsible for conducting the needs assessment and service planning would include this assessment. In many States, such assessments are currently being done by, home health agency staff, or Medicaid Home and Community Based Services waiver case managers. Transitions are seen as collaborative efforts by multiple participants and should be designed to be flexible to accommodate a variety of needs over time.

a. Are there guidelines or information available on the home assessment criteria?

For individuals who are receiving Medicaid services, the community care level of care determination and service planning includes assessment of medical, personal care, and other supports including environmental modifications that the individual needs. Several states have established screening or assessment tools for transition candidates to identify Medicaid financial eligibility, level of medical need, and supports that may be needed. As best practices and tools are developed they will be posted on the CMS Community Living webpage at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage

12. How will the Local Contact Agency determine which residents will need a face-to-face visit versus a telephone call for those who indicate a desire to transfer into the community?

The level and type of response needed by an individual is determined on a resident-by-resident basis and is to be part of the State's design for Section Q implementation. In the Section Q pilot test, some States chose to make a face-to-face visit to each individual

requesting to talk to someone. In other instances a telephone contact may be used to screen candidates and determine their specific needs and to set appointments for visits.

SUPPORTS FOR TRANSITION

13. Have any states developed an assessment or interview tool?

Several states have developed client interview and assessment tools. Many of those are included in the Reference Manual CD distributed at the April Stakeholders conference.

a. California Preference Interview Tool
b. Connecticut Transition Challenges Tool
c. Indiana Post-Transition Checklist
d. Michigan Introduction Meeting Interview Guide
e. Michigan Initial Interview Guide

Others are available at: www.adrc-tae.org or www.hcbs.org or www.taformfp.com

14. Since the nursing community staff may not be aware of available programs and supports for seniors and persons with disabilities living in the greater community, will there be more partnerships and resources available to nursing homes?

State Medicaid Agencies have designated a State point of contact (POC) for the Section Q implementation and are responsible to coordinate efforts to designate local contact agencies (LCAs) for their State's skilled nursing facilities and nursing facilities. Formal and case-by-case education regarding community resources will be part of the partnership between nursing facilities and local contact agencies and occur mainly at the state and local level. The skilled nursing facilities and nursing facilities and LCAs must explore community care options and conduct appropriate care planning together to develop an array of supports for assisting the resident if transition back to the community is possible. There are now enriched transition resources including housing, in-home caretaker services and meals, home modifications, etc. available and these resources will grow over time. However, resource availability and eligibility coverage varies across local communities and States, which may be barriers to allowing some resident's return to the community.

15. Is there a logic model, action plan, or flow chart available for the states who piloted Section Q that outlines roles and responsibilities each partner fulfilled?

Although there is no logic model available, we would suggest reviewing "MDS 3.0 Section Q Pilot Test Interim Report" dated March 10, 2010 which provides helpful information about pilot test States' respective roles and responsibilities. The report was included on CD provided at the "Informing LTC Choice: MDS 3.0 Conference on April 16, 2010 or can be downloaded from the web at:
http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPageafter 10/1/2010.

16. How will Medicaid agencies address the gaps in services for residents who transfer into the community? For example, a resident who is receiving nursing home care, desires to

go to back to the community, but does not meet financial requirements to qualify for other services, such as low income housing, etc.?

Each state must determine how to address residents who do not meet financial requirements to be eligible for Medicaid services. Some State Medicaid Agencies are working with their Aging and Disability Resource Centers, Centers for Independent Living and/or Area Agencies on Aging to provide information and referral to these residents and to establish mechanisms to identify gaps in services and resolve those situations. The Money Follows the Person (MFP) Program also assists States in increasing the capacity of community services and supports.

Finding suitable housing options for community living has been expressed as a longstanding problem across all States. Most Medicaid HCBS waiver programs pay for some form of assisted living services, but creating housing options remains a substantial problem. Several States have made concerted efforts over time to address this issue. The State of Pennsylvania in particular has been highlighted for their success in using a multi-faceted approach to address this issue. CMS and HUD have been working closely and additional housing vouchers are being made available to States' local Public Housing Authorities (PHAs). In addition, CMS currently has a contract in place to assist MFP States to work with PHAs to build relationships and increase housing capacity at the local level.

GUARDIAN/LEGAL REPRESENTATIVE

17. Since the issue of family vs. guardian is confusing, can CMS clarify the differences? If there is a guardian or other legal representative (including someone with health care power of attorney), do they trump family members in terms of legal authority. In Q1, CMS refers to "family if applicable" and "guardian if applicable", which seems appropriate. But thereafter, the questions are, "or guardian if the family member is not available". Availability is not a criterion for decision-making.

If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative. A guardian is an individual appointed by the court to make decisions for the resident. This includes giving and withholding consent for medical treatment. A legally authorized representative is designated by the resident under State law to make decisions on individual's behalf when they are not able to do so themselves. This includes a medical power of attorney. Facilities should encourage the involvement of family or significant others in the discussion.. While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, if the resident is uncertain about his or her goals, the response selected must reflect the resident's perspective if he or she is able to express it.

18. Are there special considerations for individuals with a court appointed guardian?

Yes. Each State has its own guardianship law and these will not change as a result of MDS 3.0. Remember that Section Q does not make a decision about leaving the facility and returning to a community based setting. Section Q simply asks the resident if they … "want to talk to someone about the possibility of returning to the community?"

A guardian/legally authorized representative is defined in the MDS 3.0 Resident Assessment Instrument (RAI) manual as a person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.. If the resident has a court appointed guardian, the resident should still be asked the question (Q0500B) unless state law prohibits asking the resident. If the resident is unable to respond, then ask the family, significant other, or legal guardian. A guardian, family member or legally authorized individual should not be consulted to the exclusion of the resident.

In some guardianship situations, the decision-making authority regarding the individual's care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes.

As part of your assessment research, the letters of guardianship should be checked, because the guardian's powers may be limited and exclude the right to make healthcare decisions.

A referral to the local contact agency should be made if the resident wishes, even if they have a legal guardian, durable power of attorney for health care or a legally authorized representative, in accordance with state law.

EXPECTATIONS

19. Aren't nursing homes raising resident expectations if they know that the community system is fragmented and can't accommodate many more beneficiaries since Medicaid waivers are generally capped?

MDS 3.0 item Q0500B asks "do you want to talk to someone about the **possibility of returning to the community**." The nursing home and local agency staffs should guard against raising the resident and their family members' expectations of what can occur until more information is obtained. The nursing home and local contact agency team must explore community care options/supports and conduct appropriate care planning to determine *if* transition back to the community is possible. Enriched transition resources including housing, in-home caretaker services and meals, home modifications, etc. are now available and will grow over time. Resource availability and eligibility coverage varies across local communities and States and these may present barriers to allowing some resident's return to their community. Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.

20. It was stated at the Stakeholder conference that private pay patients would be looked at to monitor their spending down of personal assets. What is the intent of the focus and

the legal basis for granting access to self-pay patient information (medical and financial) and the potential for subsequent patient targeting?

A question was asked about whether or not it is the skilled nursing facility's/ nursing facility 's (SNF/NF) responsibility to monitor a resident's spending down of personal assets. For individual residents who have applied for Medicaid eligibility, the transition coordinator (or case manager), with permission of the resident, will monitor the progress of the eligibility determination process to determine if and when the individual may be eligible for Medicaid funded home and community-based services (HCBS). Sometimes the SNF/NF will monitor or assist the Medicaid case manager so that when the person becomes financially eligible for Medicaid they are enrolled and Medicaid funded HCBS can be utilized.

21. Will additional time frames be established for residents who have expressed a desire to return to the community and the time the discharge actually occurs, i.e., is there an expectation on how quickly a resident should be transitioned from a nursing home?

CMS is talking with State Medicaid agencies and the Administration on Aging about response times for local contact agencies (LCAs). Currently, there are no set expectations. States may choose to establish their own time frames for LCAs. We would expect a reasonable response time of within 3 days by phone and within 10 days if an on-site visit is needed. Experiences in the Section Q pilot test showed that states were interested in establishing responsive time frames. During the pilot test, Connecticut established a 3 day requirement to contact an individual and 2 weeks to complete a face-to-face interview/screen. This does not answer the question. The question asks how quickly a discharge should happen and is there an established timeline/expectation.

INDIVIDUALS WITH MENTAL HEALTH ISSUES

22. What is the facility's responsibility for notifying appropriate community-based authorities when a significant change assessment is completed on a patient indicating a change in care planning and for a patient with a known mental health condition?

This question appears to be getting at the distinction between who to notify for Section Q and who to notify for PASRR. Preadmission Screening and Resident Review (PASRR) requires the facility to notify the State mental health or mental retardation authority (your state agencies for those functions, or their delegated contacts) when certain kinds of changes trigger a Significant Change in Status Assessment. This applies to individuals who are already identified by PASRR Level II as having Severe Mental Illness or Mental Retardation (A1500 = Yes) and also applies to persons for whom Severe Mental Illness may be presenting as a new concern, (A1500 = No), and therefore require a PASRR Level II evaluation and determination.

Section Q requires contact with the designated local contact agency (defined by your state) about a resident's request to talk with someone about the possibility of returning to the community.. This would not likely be the same as the contacts for PASRR.

The two requirements may occur together when the Significant Change in Status Assessment is triggered by improvement in an individual with Severe Mental Illness such that the individual expresses a desire to consider discharge or other placement options. In that case both referrals should be made, and a new Level II assessment would be helpful in discussing community living options. Another possibility would be that an individual expresses interest in community living, triggering Section Q referral to the designated local contact agency, but upon responding the local contact agency finds the Level II PASRR documents on the chart reflect needs that cannot be met with available resources in the community. A referral for PASRR Level II should be made to the state mental health or mental retardation authority, discussing whether a Level II reevaluation may be needed to help clarify the current needs and to identify any alternative supports that may be recommended.

The simple answer is that the facility is always responsible to meet residents' needs with any necessary resources. When in doubt, the facility should contact all potentially helpful resources, whether or not there is a clear Federal regulatory requirement.

23. Have State laws been considered in the potential release of sensitive mental health information to community placement personnel? If so, have all state laws related to this issue been considered?

We take this question as applying to Section Q, not the Preadmission Screening and Resident Review (PASRR), since PASRR requirements have not changed. MDS 3.0 adds Question A1500, and clarifies the facility's responsibilities under PASRR when a Significant Change in Status Assessment occurs, to assist states and facilities in complying effectively with PASRR, but the PASRR requirements remain as they have been.

The new Section Q process of referral to a local contact agency may involve discussions of the mental health status of the individual resident. The HIPAA (Health Insurance and Portability and Accountability Act) privacy rule does not preempt State laws and rules about mental health information. Since MDS changes do not affect federal or State confidentiality rules, mental health information in discussions with local contact agency transition coordinators would be treated in the same manner that the facilities currently handle mental health information with outside health care providers.

If MDS 3.0 data is to be shared, it will only be shared if a Data Use Agreement (DUA) was in place naming the local contact agency on the DUA.

24. What is the role of the Department of Mental Health to ensure that residents with developmental disabilities and/or mental health issues are safe to return to the community?

The mental health needs of an individual are very important and they should be addressed in an individual's care plan designed by the NF and the LCA as well as other entities involved in the care planning and transition coordination process. States must also consider PASRR evaluations including question A1500 regarding PASRR level II evaluation and MR/DD Status (question A1550).

LAWS, FUNDING, MISC.

25. If a state participates in the Money Follows the Person (MFP) program, would that program be the local contact agency (LCA) for that State?

In some States the MFP program may be designated as the LCA however, this is not the case in all States. LCAs may be an Area Agency on Aging, Aging and Disability Resource Centers, Centers for Independent Living, or other agency designated by the State.

26. What are the federal laws around MDS Section Q?

It is required by Statute that all residents admitted to a nursing facility be assessed using the minimum data set (MDS) functional assessment tool, (beginning on October 1, 2010 the revised MDS 3.0 will be implemented). Also required by Federal regulation is that this information and other assessment information gathered by the nursing facility be used to develop and implement a comprehensive person-centered care plan for every resident.

27. The CMS Office of External Affairs has developed a general purpose, overview brochure describing and explaining Section Q. Is this brochure for people of all payer types?

Yes, the brochure gives a general overview and explanation of the Section Q process to all nursing facility residents and their families.

28. What federal funding is available for Local Contact Agencies (LCAs)?

Money Follows the Person (MFP) demonstration project and the Aging and Disability Resource Center (ADRC) grant funding can be utilized to support many LCAs functions. MFP and ADRC funding is available for outreach and education functions for all client types (i.e. non-Medicaid clients also). Administration on Aging funding for Information and assistance services and case management services may be used for individuals age 60 and over. Certain Home and Community-Based Services waiver program services such as case management or transition support services may also be devoted to support some local contact agency functions.

29. Is Money Follows the Person demonstration grant funding available only for Medicaid eligible clients?

Money Follows the Person (MFP) program outreach and education funding may be used for all clients, not just Medicaid eligible clients. However, only Medicaid eligible individuals may participate in MFP.

30. Can you provide more information on additional funding for Aging and Disability Resource Centers that may be used for implementing Section Q?

Aging and Disability Resource Center (ADRC) grant funding can be utilized to support many local contact agency functions. Specifically, funding for ADRC outreach and education functions that will cover all client (payer) types (not just Medicaid clients). In addition, Administration on Aging funding for Information and Assistance services and case management services may be used appropriately. Home and Community-Based Services as specified in a State waiver program may be devoted to support some local contact agency functions. In September 2010, supplemental grants awards were given to 24 ADRC Grantees to utilize the Section Q Return to Community opportunity to support receiving referrals and providing information to residents on available community services and supports.

31. Can the Ombudsman program be added to the CMS Planning for *Your Discharge Checklist*?

32. Yes. The issue has been addressed in the electronic version and print version as of May 25, 2010. There is also a new brochure designed specifically to support Section Q implementation entitled "Your Right to get Information about Returning to the Community". It can be downloaded at http://www.medicare.gov/publications/pubs/pdf/11477.pdf**re there any State rate setting examples for the Information and Assistance or Transition Coordinator functions?**

The scope of information and assistance varies across States. Information and assistance may include case management, locating housing, legal assistance, Medicaid eligibility determination, health care, home modifications, nutrition support, transportation, etc. In regards to transition coordinator functions, the State of Texas has recently conducted a procurement for a relocation contractor that includes the Section Q process functions. The State pays for the relocations on a cost reimbursement basis and require contractors to submit estimated costs per relocation and do have average cost figures. The

33. When a facility evaluates a resident and it is contraindicated to return to the community, do we treat this as an 'Against Medical Advice' case and continue to report this to DHR (Department of Human Resources)?

Leaving against medical advice must be evaluated on a case-by-case basis and it is the nursing home and State's responsibility to make this determination and report the event through their existing state processes. The resident should be provided information that allows him or her to make informed choices about his or her care and the setting in which it can be provided. The individual should also be supported in directing his or her care planning. The individual has the right to receive services in the least restrictive and most integrated setting and assume dignity of risk if that is their choice. This means that if the

individual is competent, has been provided all the information necessary to make informed decisions, is aware of the level of services and supports that are or are not available in the community, and decides to leave the facility, they are assuming responsibility for their choice**.** Many states have made substantial progress in moving the boundary of "contraindicated" and are able to provide services and supports to successfully assist individuals with complex medical needs to live in community based settings. If the individual is eligible for Medicaid and can receive services in the community, the State and/or its designee who will be providing services has the responsibility to ensure the individual's health and safety. This includes a full assessment prior to transition and mitigation strategies for identified risks.

34. If a resident is a court ordered or a protective placement individual, will the State respect the response of the facility not to address a discharge plan to return to the community?

The current care planning process for court ordered or protective placements does not change because of MDS 3.0 Section Q.

OMBUDSMAN PROGRAM

35. How should Medicaid and the Ombudsman program work together on transitions? What will be the Ombudsman's role be in the coordination of services for nursing home residents who return to the community?

The long-term care ombudsman is available to assist nursing home residents by resolving complaints related to the transitions process, as well as by providing information and education to consumers, facility staff, and the general public regarding the transitions process. However, the coordination of services is not a typical Ombudsman role.

CMS hosted a national MDS 3.0 Section Q Technical Assistance conference call on July 7, 2010 to discuss the Ombudsmen services in nursing homes related to MDS 3.0 Section Q. Representatives of the National Ombudsman Associations, most state Ombudsman programs and most State Medicaid Agencies joined the call. Ombudsmen from New Mexico (Sondra Everhart), Georgia (Phyllis Sadler) and Virginia (Joanie Latimer) discussed their experiences in assisting residents who are transitioning individuals from nursing facilities. The major activities described included: 1) investigation and resolution of resident complaints about transitions to the community, 2) supporting residents in their decision-making related to transitions, 3) providing information to consumers and providers (i.e. consultation to individuals) about residents rights and options, 4) providing educational sessions and materials to consumers and the general public about resident rights and options, and 5) Helping to identify candidates for transitioning to community living and making referrals as appropriate.

In a number of States, there is funding and/or authorization that permit the Long-Term Care Ombudsman Program to provide Ombudsman services to additional populations who receive long-term care in non-facility settings.