

MDS 3.0 Section Q Implementation Questions and Answers

(Q & As from December 22, 2010 and September 22, 2010)

ASKING THE SECTION Q QUESTIONS

1. **If the resident can appropriately answer questions, are they interviewable and should they be asked the Section Q questions?**

[Date Answered 12/22/10]

Background: *We would like your guidance for asking Q0500B, "Would you like to talk with someone about the possibility of returning to the community?" in these scenarios. We have residents in our memory care units (in an Indiana facility) who will answer the question with an "appropriate response" while in the next sentence say that they want to go home to be with their mother, who may have passed away 50 years ago. The RAI manual suggests that if the resident has been determined to be interviewable, then we need to ask the question. We feel that this puts undo stress on the resident because, of course, they want to go home. The RAI manual gives examples that aren't always clear with respect to the particular resident you are working with. Families are upset because they don't want us to ask this question. The Local Contact Agency (Area Agency on Aging) thinks we are making ridiculous referrals because they feel anyone with dementia should not have to answer this question (which is clearly not part of the CMS directives). Our approach, which has been validated by the trainers that did our MDS 3.0 training and were trained at the CMS training conference, is: If the resident can appropriately answer questions, then they are interviewable and should be asked the Section Q questions. We would like to know how to interpret the RAI manual with regard to section Q so that we can let the Area Agency know exactly what we are required to do. My fear is that different facilities and Area Agencies are interpreting section Q with a filter clouded by their own personal biases. We would love to not ask residents this question if not required to, because it is stressful to them to have the false hope of going home. However, we desire to be 100% compliant with the regulations as well.*

This scenario aptly describes the dilemma of balancing an individual resident's legal right to choice of services and settings and the concern for the feelings of certain individuals and their families. Section Q tries to address the issue through a series of skip patterns designed to avoid asking some individuals whether they want to talk to someone about returning to the community while maintaining the rights of others to be informed about their choices.

Item Q0400 asks if a determination was made by the resident and the care planning team that discharge to the community is feasible or not. Consistent with person-centered planning, the RAI Manual instructions stipulate that the resident and/or their family members must be consulted whenever possible to determine their preferences. If the determination is made that transition is not feasible, then subsequent items in Section Q are skipped and the assessor proceeds to Section V or Z.

Not asking the question directly to residents because of their diagnosis or condition (such as dementia) is not acceptable and should be avoided for obvious legal reasons. However, if the level of the cognitive impairment is such that the resident does not understand the question or cannot realistically answer etc. and a family member, significant other, or guardian is the spokesperson and/or legally appointed decision maker for that individual you would ask the resident's spokesperson the questions. Following your person-centered approach, using your judgment and the flexibility allowed in Section Q will serve you well. Based on the feedback we have received, we are in the process of developing and pilot testing new language and skip patterns to address this issue. We will be pilot testing the new language this February for possible implementation in the fall late 2011 or early 2012.

2. **What is CMS's definition of "adequate decision-making capacity" that is Stated on page 4-41 of the RAI manual? Would there be a possibility of somehow relating information from other portions of the MDS within the triggering conditions for Section Q to provide an avenue in which the staff along with the resident's physician are able to make the professional determination of whether it is necessary to ask this question?**

12/22/10]

[Date Answered

Background: *My Mom suffered a severe stroke and she has been residing in a nursing facility since May of 2009. In the past couple of months my family and I began to finally feel like Mom had begun to accept the nursing home as "home." Because of Mom's condition, she needs total assistance with dressing, bathing, toileting, and a mechanical lift for all transfers. She is able to speak but does not possess the ability to know that she cannot get out of her wheelchair and get herself into bed. After her admission to the nursing home Mom asked continuously about going back to the home that she and Dad had lived in. This had pretty much ended until now when the nursing home was required to ask her about returning to the community.*

The Centers for Medicare & Medicaid Services (CMS) understands your concerns that some nursing home residents, including some residents with a stroke or dementia desire to return home and are upset that they cannot. The items in Section Q are organized in such a manner that not everyone must be asked the

question (Q0500B), “Do you want to speak with someone about the possibility of returning to the community.” Skip patterns have been built into the questions contained in Section Q that can prevent this question being asked unnecessarily or repeatedly.

In addition, MDS 3.0 questions are designed to assess the resident’s cognitive status, to talk to the resident and their families or legal guardian, and to opt out of asking the resident the return to community question if the interdisciplinary team determines that the resident cannot answer the question, and/or if further assessment and care planning is necessary to explore the care options that are available. If the resident and care planning team, which includes families and significant others, have previously determined that discharge to the community is not feasible, the resident is not asked the question again.

The underlying intention behind the revisions to Section Q of MDS 3.0 is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible. CMS has found that in many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Section Q seeks only to provide those individuals interested in learning about community based services the opportunity to do so.

Because CMS is aware that the current return to community questions may upset residents that cannot go home and result in them being agitated or saddened by being asked the question, a workgroup made up of nursing home staff, advocates, consumers, and State Medicaid Agencies is again looking at the Section Q questions and is developing new language to address this concern. The work group that developed this revised language worked hard to achieve a balance between giving individual residents a voice and a choice about the services they receive while being sensitive to those individuals who may be unable to voice their preferences or be disturbed by the assessment process. The revised language will be tested in seven States this winter. We intend to follow this issue very closely, with the help of the work group, and expect to make corrections as needed over time.

- 3. How do we respond to family complaints that Section Q, item Q0500B, is widening wounds that are not yet healed for recently admitted nursing home residents?**

[Date Answered 12/22/10]

Background: *A provider reports that a number of resident family members are very upset by the suggestion and implications of Section Q. Many of them are just learning to overcome caregiver guilt and some family members are seeking somewhere and someone to direct formal complaints.*

If, after the facility has educated the family on the intent of the section and the skip patterns that are inherent in the MDS 3.0, the family still wishes to file a formal complaint, they should be directed to follow the state's established complaint process. The facility should make every effort to educate families on what the goals of Section Q are. CMS has developed a brochure that is available for downloading and printing for distribution by facilities to residents and families explaining why residents are being asked the questions in Section Q. Caregiver guilt is a serious issue and facilities need to be sensitive to that. However, that should not trump an individual resident's legal rights. The brochure is available at: <http://www.medicare.gov/publications/pubs/pdf/11477.pdf>. For providers to order the brochure, please visit <http://productordering.cms.hhs.gov> and set up an account to order. Once your account is approved you will be able to log on and place orders

Note that, if the resident and the care planning team determine that discharge to the community is not feasible (Item Q0400B = 2), the resident is not asked (Q0500) "Do you want to talk to someone about the possibility of returning to the community?"

4. **If a resident is in a facility on protective custody or a court order and, therefore, does not have the option of returning to the community, does the facility still have to ask Item Q0500B ("Do you want to talk to someone about the possibility of returning to the community?")? If they do not have to ask the resident, how should that Items Q0500A and Q0500B be coded?**

[Date Answered 12/22/10]

Individuals under court order are to be handled as they have in the past. The changes under MDS 3.0 Section Q will not affect them. An individual resident who is placed in a facility for protective custody or under court order has had their right to choose taken away by court order. That individual does not need to be asked items Q0500A and Q 0500B as part of their assessment. The court will make the determination about their return to the community.

In this instance, Section QA0400A should be coded: (= 0), No. Section Q0400B should be coded: (= 2), Discharge to community determined to be not feasible. With the current skip pattern, if Q0400B is coded = 2, then Section Q0500A and Q0500B do not have to be coded. Then the assessor should skip to the next active Section, V or X.

SKIP PATTERNS FOR SECTION Q

QUESTION Q0500B - Ask the resident, family or other “Do you want to talk with someone about the possibility of returning to the community?”

5. **Are there ways that the nursing home staff do not have to ask the resident again and again if they want to be discharged back to the community, after they and their families have made the difficult decision to stay in long term care?** [Date Answered 12/22/10]

Background: *A nursing facility staff member is concerned that it is hurtful to residents to ask Q0500 every 90 days and at significant change of condition and that it is especially confusing to residents with dementia. The staff member feels it is ethically wrong to do this to individuals who we know need stay in our nursing facility. Please look at this question closely and either change or eliminate the question or only ask it initially upon admission.*

There is an existing skip pattern in MDS Section Q that can be used to avoid inappropriate repetition. Item Q0400B asks, “What determination was made by the resident and the care planning team that discharge to the community is feasible?” If the resident (or family, or significant other, or guardian or legally authorized representative) and the care planning team had previously determined that discharge to the community is **not feasible**, then answer **B =2** should be coded and the remaining items in Section Q do not get asked. The assessor would skip to Section V or X.

Regarding Section Q and community discharge planning, we understand there may be a need to amend the skip pattern for asking the question so repetitively, especially for residents with a high acuity level of care and/or supports that may not be available or able to be provided in the community.. After hearing similar concerns, CMS is working with a group of States and facilities to pilot test new language that would reduce the repetitive questioning while maintaining a resident’s right of choice. The pilot test will evaluate whether the Q0500B return to community question can be asked on an annual basis and test some other clarifying language changes. CMS expects to complete the pilot test and based upon pilot study findings, may make needed changes in October 2011.

The impetus for MDS 3.0 Section Q changes including the Q0500B return to community question is to provide residents the opportunity to make known their choices and preferences, to get information about available community supports and services, and meet the requirements of the Americans with Disabilities Act and the Olmstead vs. LC Supreme Court ruling of 1999 “to provide community based services for person with disability” and to administer programs in the “most integrated setting appropriate to the needs of qualified individuals with disabilities.” Another issue supporting changes in Section Q is that States are trying to rebalance long term care spending by facilitating greater use of community services. While we understand your point that many residents cannot return to the community and asking them is upsetting, our experience is that the

Money Follows the Person and Home and Community Based Services waiver programs in many States have successfully been able to transition residents to community living that nursing home staff did not believe could be transitioned.

REFERRALS TO LOCAL CONTACT AGENCIES

QUESTIONS Q0400A&B - Discharge Plan and QUESTION Q0600 – Referral

6. **If it is determined by the resident and care planning team that a return to the community is not feasible (Item Q0400B = 2), do all subsequent assessments need to include asking this item again?** [Date

Answered 12/22/10]

Background: *A Virginia facility received feedback from families and are genuinely concerned about asking residents, on subsequent assessments, if they want to talk with someone about the possibility of returning to the community if it has previously been determined that such a transition is not feasible. Another facility wrote relaying concerns about the unrealistic expectations that Section Q is introducing for some residents. Many of them have taken years to adjust to the changing life course and the staff is concerned about creating genuine emotional strain by suggesting that they can reside in the community; these are cases in which the person either has no family, family that is not attentive, family that absolutely will not support them residing in the community because their needs are too extensive and community care services and supports are not available. Is it appropriate to disregard their well-being for a result that will likely remain the same? Our goal is to help our residents go home if it is a realistic alternative.*

This item is individualized and resident-driven, and the care planning team must interview residents and or their family, whenever possible, and determine their preferences and agreement. The interdisciplinary team should not assume that any particular resident could not be discharged. The assessor and care planning team should review the past record and consult with the resident and/or family about whether the resident's situation has changed in making the determination about the feasibility of discharge. The instructions are clear about the need to protect the individual's right to self-determination.

There is an existing skip pattern in MDS Section Q that can be used to avoid inappropriate repetition. Item Q0400B asks, "What determination was made by the resident and the care planning team regarding discharge to the community?" If the resident (or family, or significant other, or guardian or legally authorized representative) and the care planning team had previously determined that discharge to the community is not feasible, then answer B =2 should be coded and the remaining items in Section Q are not asked.

On page Q10 of the RAI User's Manual, question Q0400B asks, "What determination was made by the resident and the care planning team regarding discharge to the community?" The assessor can code B = 2, that discharge to the community was or is determined to be not feasible; then skip to the next active assessment section. The assessor would skip to Section V or X. The RAI User's Manual also cautions the interdisciplinary team to not assume that any particular resident is unable to be discharged. A successful transition will depend on the resident's preferences and choices and the services, settings, and sometimes family supports that are available.

The underlying intention behind the revisions to Section Q of MDS 3.0 is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible. CMS has found that in many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Section Q seeks only to provide those individuals interested in learning about community based services the opportunity to do so.

- 7. Do all nursing home residents with an active discharge plan have to be referred to the local contact agency (LCA)? Will the RAI Manual provide more guidance regarding this issue?**

[Date Answered 12/22/10]

Background: Several States had an unexpected response from nursing facilities that referred all residents who were coded, for Q0400A = Yes – 'Yes- An active discharge plan is in place,' because of fears that they are going to get in trouble with State surveyors or the nursing facility administrator if they do not make a referral for every single resident. One facility asked if a LCA referral is necessary if a plan is in place for a resident's discharge to home with home health nursing and therapy after a sub-acute stay. These examples are normally occurring discharges (e.g., for sub-acute care) that can be fully planned and arranged by the nursing facility with the resident and family.

No, the nursing facility does not have to refer all of its planned discharges (those with an active discharge plan in place) to the LCA. The Section Q items and skip patterns are designed to target only those individuals needing information about available community services and supports and the extra collaborative efforts of LCAs to facilitate a successful transition to the community. An example would be when a nursing facility has already developed a discharge planning referrals and resources for short stay residents and does not require a LCA. If a resident does not have a discharge plan already in place (Q0400 = No), then they will be asked if they want to speak with someone about the possibility of returning to the community. When Q0400A is marked Yes = 1 (an active discharge plan is in place for the resident to return to the community) and the nursing facility staff has

already developed a complete discharge plan, no referral to the LCA is needed. After answering Yes, assessors are instructed to skip to Q0600. At Q0600, there are two other options in addition to '2-Yes - a referral has been made to the LCA.'

The Resident Assessment Instrument User's Manual (page 16) has coding instructions, in addition to a referral to the LCA that could be used:

- a. Code "0, No" [determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted]. If the resident's discharge planning has been completely developed by the nursing home staff, there is no need for a LCA referral.
- b. Code "1, No" [referral not made]. This could be used if the nursing facility staff needs to assess and obtain more information from the resident (or family or significant other, or guardian or legally authorized representative) to determine the residential community options, needs, opportunities, feasibility, and family support regarding a discharge plan to determine whether the LCA is needed. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not necessary.

The RAI Manual will be changed to reflect this expanded Section Q coding guidance with CMS's first MDS 3.0 Resident Assessment Instrument User's (RAI) Manual update in 2011.

8. Will surveyors review Q0600 - LCA referral? What is Survey and Certification's role in the Section Q review process?

[Date Answered 12/22/10]

No, surveyors will not focus their review on item Q0600, resident referrals to the LCA. Surveyors are instructed, for F279¹ & F284¹ F-TAGs to evaluate whether comprehensive care planning is conducted appropriately using the information from the MDS, which would include Section Q & its Care Area Assessment (CAA), if triggered. These TAGs were relevant to the former Section Q and are relevant to the current Section Q. The items ask if the facility has used the results of the assessment to develop, review and revise the resident's comprehensive plan of care, whether the CAA was triggered and whether a referral was made (F279), and is there evidence of a discharge assessment that identifies the resident's needs and is used to develop the discharge plan (F484).

9. **If we have a resident at the ICF or SNF level of care on our Continuing Care Retirement Center campus who wishes to be screened for placement within our Assisted Living Facility (housed in the same building), is it necessary to involve the Local Contact Agency (Q0600) with a Section Q referral for community resources?**

[Date Answered

12/22/10]

Not necessarily, it depends on the individual's resources, eligibility for Medicaid and how your State has structured its programs. If the individual is not Medicaid eligible, then this situation would be a routinely planned discharge from a nursing facility to another residential setting, just as you have usually done no referral to a Local Contact Agency is required because you already have a complete discharge plan in place and additional community resources, services and/or supports are not needed.

Referral to the Medicaid Home and Community Based Services waiver program or the LCA may be necessary in order for Medicaid to pay for the support services in the new setting. If the resident is making a routine-discharge move, (i.e. not triggered by a Section Q item) and is paying for the services privately, then a referral to the local contact agency is not required.

10. **Since the State of Ohio plans to pull MDS 3.0 Section Q data from the database to make an electronic referral to the LCA, does the nursing facility need to make the referral to the local contact agency?**

[Date Answered 12/22/10]

Yes. States are planning to use the information obtained from Section Q in different ways. The proposed approach by the State of Ohio does not relieve the nursing facility from their responsibility of contacting the Local Contact Agency within approximately 10 business days of a resident saying Yes to Q0500. (See RAI User's Manual, page Q-14).

During the pilot test of Section Q, Connecticut found that having nursing facilities make referrals to a central State office that would then make referrals to a local transition agency added two weeks to the referral process. They changed this practice to speed up the referral for Statewide implementation on October 1, 2010.

11. **Does there have to be a HIPPA signature for the nursing facility to refer an individual to a Local Contact Agency? Shouldn't the facility have the resident sign a release of information, or, is it ok to release the information because the LCA has a DUA with the State Medicaid Agency?**

[Date Answered 12/22/10]

No, there does not have to be a HIPPA signature when the nursing home directly asks the resident if the facility can give their name to a LCA so that the LCA can contact the resident. This referral of the individual's name is covered because the resident has given permission. The facility should document in the care plan and/or resident progress notes that the resident has provided a verbal okay to make the referral, and keep current the facility's standard medical release form that is signed upon admission by the resident or designee. This would typically be done by a phone call or email exchange.

A DUA is required when the State Survey Agency is providing MDS electronic data to the State Medicaid Agency (SMA) and its agent. Any entity that the SMA is providing MDS data to must be listed on the CMS/SSA/SMA DUA that is in place. In this case MDS data-items and responses with identifiable information are being transmitted to the SMA and/or its agent.

ROLES & RESPONSIBILITIES

SNF/NF REQUIREMENTS

12. Is discharge planning the responsibility of the nursing facility and not the local contact agency?

[Date Answered 12/22/10]

Discharge planning continues to the responsibility of the nursing facility social worker. A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and a regulatory requirement at 42 CFR 483.20(1)(3).

The interpretive guidelines state that a post-discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for individuals with mental retardation. Resident protection concerning transfer and discharge are found at §483.12. A "post-discharge plan of care" means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community. The LCA can be a new partner to collaborate with, particularly on difficult to place clients and offer expanded resources. 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 when 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.

13. **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?**

[Date Answered

9/22/10]

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 (i) (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.

LCA RESPONSIBILITIES

14. **After the referral to the Local Contact Agency occurs, does the LCA work directly with the resident/family/legal representative or do they work directly with the nursing facility social worker to facilitate the return to the community? Is the LCA's only responsibility to provide the resident/family/social worker with community-living resource information and contact numbers to facilitate a placement at home or in the community?**

[Date Answered

12/22/10]

Background: *The assessors response to Section Q, Item Q0600 (Referral) could be different for everyone depending on their situation. In times past, for some individuals, the agency we contacted may have been a home health agency for*

them to go home with, or for other individuals, we may have contacted the Medicaid Home and Community Based Services Waiver Program staff, etc.

Local Contact Agencies and nursing facility staff should work collaboratively for effective discharge and transition planning to support the individual's choice to return to the community. The LCA should talk directly with the resident (and or family or guardian) and meet with the SNF/NF care planning team to address the resident's discharge, transition, and community services and supports needs. The Section Q assessment and potential referral process should not be considered a replacement to the facility's routine discharge planning process. It is a way of enlisting assistance and collaboration from an outside resource to work with the resident and facility to organize and implement a transition plan to return the resident to the community.

State Medicaid Agencies and all stakeholders (LCAs, transition providers, nursing home providers, LTC Ombudsman, and others) are collaborating and deciding on processes that can be organized at the State or at the local level. Many States have already issued letters to providers stating how the process will run in their State. The facility and the LCA along with the resident/family should all work together to make the transition as smooth as possible and it may require the expertise of many different clinicians, programs, and agencies.

In a more complex situation, such as when needing to locate or create a residential housing resource, the referral to the local contact agency would certainly be appropriate. Each State may handle this differently. Under certain Medicaid waivers, it may be necessary to go through the LCA for some residents, and for others who already have plans in place, it may not be necessary. During the Section Q training sessions that were held in the Spring and Summer of 2010, States were strongly encouraged to clearly define these protocols and convene meetings with nursing facilities, Aging and Disability Resource Centers, Centers for Independent Living, other local contact agencies and other stakeholders to discuss and train on these processes. Several resources are available at the Return to Community web site at:

http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#ToPOfPage which may be of help.

- a. MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues.
- b. The Section Q Pilot Test Results report describes the implementation activities of the States that pilot tested Section Q and the need to establish collaborative arrangements at the local level.
- c. The State-by-State Point of Contact (POC) list for MDS 3.0 Section Q including State's Local Contact Agencies and Section Q Coordinator Information.

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

[Date

Answered 9/22/10]

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

IMPLEMENTATION RESOURCES

16. Will the States Point of Contact list contain the list of State's local contact agencies?

[Date Answered

12/22/10]

The State Point of Contact (POC) and local contact agency (LCA) list is the responsibility of each state to develop and maintain. If the State has designated the LCA and POC and has made it available on their website, it has been added to the CMS Point of Contact/LCA list. The CMS webpage

contains the list of Section Q POCs for each state and provide a link to each state's list of Local Contact Agencies. The website is at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage. The document is available under Downloads and is called 'State-by-State point of contact (POC) List.' If there is no web link on the Point of Contact, the list provides either an 800#, or POC to help find the LCA in that State. CMS will post links from additional States as they are received.

The POC is the State point person, designated by the State Medicaid agency, responsible for coordinating Section Q implementation and the designation of the LCAs. Their contact information is being provided on the CMS website solely in the event that a nursing facility or other provider does not know who their LCA is, has other needs beyond that regarding Section Q, or an organization wants to be involved in the coordination process development and/or designation of LCAs.

17. Where will I find the latest version of the Section Q Questions and Answers document?

[Date

Answered 12/22/10]

The CMS webpage will contains Section Q Questions and Answers at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage. The document is available under Downloads and is called 'Section Q Implementation Solutions.'

18. 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?

[Date

Answered 9/22/10]

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

19. For States unable to view or download the Section Q interviews on YouTube.com website because of firewalls, can these States obtain DVD copies?

[Date Answered

12/22/10]

Yes. Send a request for DVD copies to mdsformedicaid@cms.hhs.gov

DATA USE AGREEMENTS (DUAs)

20. Do state agencies need a Data Use Agreement to implement Section Q?

What circumstances require a Data Use Agreement?

[Date

Answered 12/22/10]

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 is in compliance with privacy protection requirements under HIPAA.

Long Term Care Minimum Data Set (LTCMDS) for State Government Agencies DUA information can be found at:

http://www.cms.gov/PrivProtectedData/12_LTCMDSforStateGovAgencies.asp#TopOfPage. SMAs modifying existing DUAs to add a LCA(s) should download and complete the Medicaid Addendum available on this website.

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

[Date Answered 9/22/10]

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

LOCAL CONTACT AGENCIES (LCAs)

22. 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?**

[Date Answered]

12/22/10]

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 assistance² or options counseling³ 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.

23. 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?

[Date Answered]

9/22/10]

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 identify 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.

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

24. 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?** *[Date Answered 9/22/10]*

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.

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

Answered 9/22/10]

No.

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

Answered 9/22/10]

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 and the nursing facilities in their regions is critical. Training of local contact agency transition coordinators, if their responsibilities are new, is also important.

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

[Date Answered 9/22/10]

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.

28. 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?

[Date Answered 9/22/10]

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.

GUARDIAN/LEGAL REPRESENTATIVE

29. 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. [Date Answered 9/22/10]

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.

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

[Date Answered 9/22/10]

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

31. 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?

[Date Answered 9/22/10]

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.

32. 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? *[Date Answered 9/22/10]*

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.

33. 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?

[Date Answered 9/22/10]

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.

34. 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?

[Date Answered 9/22/10]

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.

35. 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?

[Date

Answered 9/22/10]

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).

36. **Do I make a referral to the local contact agency based on a resident with Alzheimer's disease answer (Q0500B) that he would like to talk to someone about the possibility of returning to the community? Or, due to the resident's cognitive impairment, do I consult with the family to see if they want contact made?** *[Date Answered 12/22/10]*

Background: *In interviewing a gentleman in our Alzheimer's care unit, he indicated Yes that he wants to go home. This is a common request from him. Many times he doesn't realize where he is or that he is here because of his dementia.*

The new Section Q items and instructions give an assessor certain latitude to use their judgment in situations such as this. The RAI Manual instructions require research and consultation with families, significant others or legal guardians as part of the assessment process. You certainly should consult with the individual's family about the individual's stated preference as part of your research for care planning. Item Q0400 asks whether discharge to the community is feasible and answering that question accurately will certainly require consultation with the family if they are available.

Each situation is unique to the resident, his family, and/or guardian. A referral to the Local Contact Agency may be appropriate for some individuals with Alzheimer's disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The RAI User's Manual cautions the interdisciplinary team to not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available.

OMBUDSMAN PROGRAM

37. **Can the Ombudsman program be added to the CMS Planning for *Your Discharge Checklist*?** *[Date Answered 9/22/10]*

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>

38. 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? *[Date Answered 9/22/10]*

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.

39. Have any states developed an assessment or interview tool? *[Date Answered 9/22/10]*

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.

40. **If a state participates in the Money Follows the Person (MFP) program, would that program be the local contact agency (LCA) for that State?** *[Date Answered 9/22/10]*

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.

41. **What are the federal laws around MDS Section Q?** *[Date Answered 9/22/10]*

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.

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

[Date Answered 9/22/10]

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.

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

[Date Answered 9/22/10]

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.

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

[Date Answered 9/22/10]

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.

45. Are there any State rate setting examples for the Information and Assistance or Transition Coordinator functions?

[Date

Answered 9/22/10]

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 requires contractors to submit estimated costs per relocation and do have average cost figures.

46. 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)?

[Date Answered 9/22/10]

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.

47. 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?

[Date Answered]

9/22/10]

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.

48. 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?

[Date Answered

9/22/10]

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 after 10/1/2010.

49. 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.?

[Date Answered 9/22/10]

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.

50. Which State is responsible when a resident is transferred from a nursing home in one State to the community in another bordering State?

[Date Answered 12/22/10]

The State which the individual transitions from is responsible for receiving the referral from the nursing facility and contacting the individual resident about the possibility of returning to the community. If the individual is wanting to transition to another State, the LCA's coordination with the receiving State is essential.

The discharging facility and the LCA or its designee would work with the resident, SNF/NF, and the receiving State's LCA/transition agency where the individual is going to live to identify transition and discharge planning activities and which entity is responsible for which activity. The State in which the individual is going to be living should arrange for plan the community-based services and supports that the individual will receive in the community. If the resident is Medicaid eligible in the receiving State and that State can provide care through their State plan and/or waiver, the cost for that individual's care.

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

[Date Answered]

9/22/10]

Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i) (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."

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

[Date Answered]

9/22/10]

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.

¹ **F279**, 42 CFR 483.20(k)(1), Comprehensive Care Plans (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that

are identified in the comprehensive assessment. The care plan must describe the following:

- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and
- (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

F284, 42 CFR§483.20(1)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment

² Information and Assistance is a core service required for aging network providers (Area Agencies on Aging) by the Administration on Aging.

³ 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).