



MDS 3.0 Section Q Training: Ohio's Implementation

**Collaborative training project by
ODJFS, ODA, ODH, CLS providers,
LTC Ombudsman**

Ohio

INTRODUCTION

GOALS FOR THIS TRAINING:

- Intent of Section Q
- Roles & responsibilities of Ohio – State Medicaid Agency, Nursing Facilities and Community Living Specialists
- Overview of Section Q (Patsy Strouse)
- Ohio's Implementation of Section Q
- FAQ's regarding Section Q
- Guardianship Issues (Bev Laubert)

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INTENT OF SECTION Q

- A tool to help meet Olmstead decision
- Increase person-centered care and discharge planning
- Increase communication and collaboration between providers
- Create new opportunities for transition collaboration

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LONG TERM CARE:

- “Enable seniors and people with disabilities to live with dignity in the setting they prefer”

Office of Health Transformation
Core Principle, 2011

HOME CHOICE:

- “Ohioans who need long term services and support get services and supports they need in a timely manner, in settings they want from who they want, and, if needs change, services and supports change accordingly”

Home Choice Planning & Advisory Committee
Vision Statement, 2008

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ROLES & RESPONSIBILITIES OF THE STATE MEDICAID AGENCY

State Contact (the policy developer, operations manager, facilitator, and monitor)

- Manage MDS data for dissemination to Community Living Specialists.
- Track disposition & timeliness of Community Living Specialist service provision.
- Reconcile number of CLS referrals with completed CLPA in accordance with provider agreement.
- Assure compliance with CLS provider agreement.
- Compile & analyze MDS data for patterns and trends for compliance purposes.

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ROLES & RESPONSIBILITIES OF THE NURSING FACILITY

The NF is the Lead Care Planner on the Discharge team

- Develops a comprehensive person-centered discharge plan for each resident. Discharge Planning responsibility under CFR 483.20(1)(3).
- Completes Care Area Assessment Tool titled “Return to Community Living”.
- Conducts follow-up assessments & care planning to support individuals choice to return to community.
- Nursing facilities may use the HOME Choice Transition Program as a tool in developing the person centered plan
Go to <http://jfs.ohio.gov/OHP/consumers/homechoice.stm> for information and application materials.

Be responsive to LCA/CLS follow up calls. Not a HIPAA violation

ROLES & RESPONSIBILITIES OF THE COMMUNITY LIVING SPECIALIST (CLS) PROVIDER

- To form effective working relationships with Nursing Facilities
- To accept MDS referrals as agreed upon through the CLS provider agreement with ODJFS
- To identify and provide timely information, resources and available services to NF residents
- Ohio's expectations of CLS provider:
 - Identify and explore options and resources such as Home Choice wraparound program, State Plan Medicaid benefits, Assisted Living waiver, support groups, etc.
 - Identify/report unique and/or recurring barriers
 - Create feedback loop with the nursing facility

Walk through Section Q with Patsy Strouse, RAI Coordinator, ODH

MINIMUM DATA SET (MDS) 3.0

Section Q		Participation in Assessment and Goal Setting	
Q0100. Participation in Assessment			
Enter <input type="checkbox"/> Code	A. Resident participated in assessment	0. No	1. Yes
Enter <input type="checkbox"/> Code	B. Family or significant other participated in assessment	0. No	1. Yes
Enter <input type="checkbox"/> Code	C. Guardian or legally authorized representative participated in assessment	0. No	1. Yes
		9. No guardian or legally authorized representative	
Q0300. Resident's Overall Expectation Complete only if A0310F = 1			
Enter <input type="checkbox"/> Code	A. Select one for resident's overall goal established during assessment process.	1. Expects to be discharged to the community	2. Expects to remain in this facility
		3. Expects to be discharged to another facility/institution	9. Unknown or uncertain
Enter <input type="checkbox"/> Code	B. Indicate information source for Q0300A	1. Resident	2. If not resident, then family or significant other
		3. If not resident, family or significant other, then guardian or legally authorized representative	9. None of the above
Q0400. Discharge Plan			
Enter <input type="checkbox"/> Code	A. Is there an active discharge plan in place for the resident to return to the community?	0. No	1. Yes → Skip to Q0600, Referral
Enter <input type="checkbox"/> Code	B. What determination was made by the resident and the care planning team that discharge to community is feasible?	0. Determination not made -	1. Discharge to community determined is feasible – Skip to Q0600
		2. Discharge to community determined is not feasible – Skip to next active section	
Q0500. Return to Community			
Enter <input type="checkbox"/> Code	A. Has the resident been asked if s/he wants to talk to someone about the possibility of returning to the community?	0. No	1. Yes – previous response was “no”
		2. Yes – previous response was “yes” → Skip to Q0600, Referral	3. Yes – previous response was “unknown”
Enter <input type="checkbox"/> Code	B. Ask the resident (or family or significant other if resident is unable to respond): “Do you want to talk to someone about the possibility of returning to the community?”	0. No	1. Yes
		2. Unknown or uncertain	
Q0600. Referral			
Enter <input type="checkbox"/> Code	Has a referral been made to the Local Contact Agency?	0. No – determination has been made by the resident and the care planning team that contact not required.	1. No – referral not made
		2. Yes	

Review—Opportunities

- MDS 3.0 formalizes long-standing requirements for nursing facilities and states to ensure individuals are appropriately assessed and reside in settings of their choice and appropriate to their needs
- MDS 3.0 assists in relationship-building between institutional and community care providers to implement care based on consumers' choices from the full array of LTC services and supports

Review—Section Q Discharge Planning

These were the original rules as stated by CMS:

- Nursing home staff expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available
- Local Contact Agencies expected to respond to nursing home staff referrals by providing information to residents about available community-based, long-term care supports and services
- Nursing home staff and Local Contact Agencies expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all of the necessary community-based, long-term care services
- **In Ohio, NHs do not have to contact the LCA; it will be done via the MDS 3.0 data that has been submitted for Section Q and the LCA will contact you.**

Review Section Q—Survey Process

The LTC NH survey process does not include a discrete task for Section Q follow-up or discharge planning.

- Prior to, or during the NH onsite survey, the NH's Ombudsman can be asked about Section Q results and their follow-up
- Does the Ombudsman have any information from residents, and/or others about whether or not residents saying that they want to talk to someone about community care results in referrals to a local contact agency (LCA) and the local contact agency coming to talk with them
- Any issues or findings that demonstrate that residents are not being referred, that LCAs are not coming to talk with them and/or that person-centered discharge planning is not being conducted should be further investigated
- If warranted, the deficiency and appropriate F Tag will depend on the information gathered as a result of the onsite investigation

Q0100: Participation in Assessment

Q0100. Participation in Assessment	
Enter Code <input type="checkbox"/>	A. Resident participated in assessment 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other
Enter Code <input type="checkbox"/>	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative

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.

Q0300: Resident's Overall Expectation

Q0300. Resident's Overall Expectation	
Complete only if A0310E = 1	
Enter Code <input type="checkbox"/>	A. Resident's overall goal established during assessment process 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain
Enter Code <input type="checkbox"/>	B. Indicate information source for Q0300A 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. None of the above

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. Families, significant others or legal guardians should be consulted as part of the assessment.

See the examples for coding Q0300 that are in the MDS 3.0 manual on pages Q-5 to Q-7.

Q0400: Discharge Plan

- Q0400A: Is there an active discharge plan in place for the resident to return to the community?
 - **Code 0** = no
 - **Code 1** = Yes, (skip to Q0600)
- Q0400B: What determination was made by the resident and the care planning team r/t discharge to community?
 - **Code 0** = determination not made by resident and care planning team regarding discharge to community
 - **Code 1** = discharge to community is feasible (skip to Q0600 - Referral)
 - **Code 2** = discharge to community is not feasible (skip to next active MDS section (Section V or X))

Q0500A;B Return to the Community

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	A. Has the resident been asked about returning to the community? 0. No 1. Yes - previous response was "no" 2. Yes - previous response was "yes" → Skip to Q0600, Referral 3. Yes - previous response was "unknown"
Enter Code <input type="checkbox"/>	B. Ask the resident (or family or significant other if resident is unable to respond): "Do you want to talk to someone about the possibility of returning to the community?" 0. No 1. Yes 9. Unknown or uncertain

0. **No**
1. **Yes**
9. **Unknown or uncertain**

- The underlying intention of the return to the community item 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 residents requiring long term care services and/or their families are unaware of community based services and supports that could adequately support them in community living situations.

Q0500: Return to Community

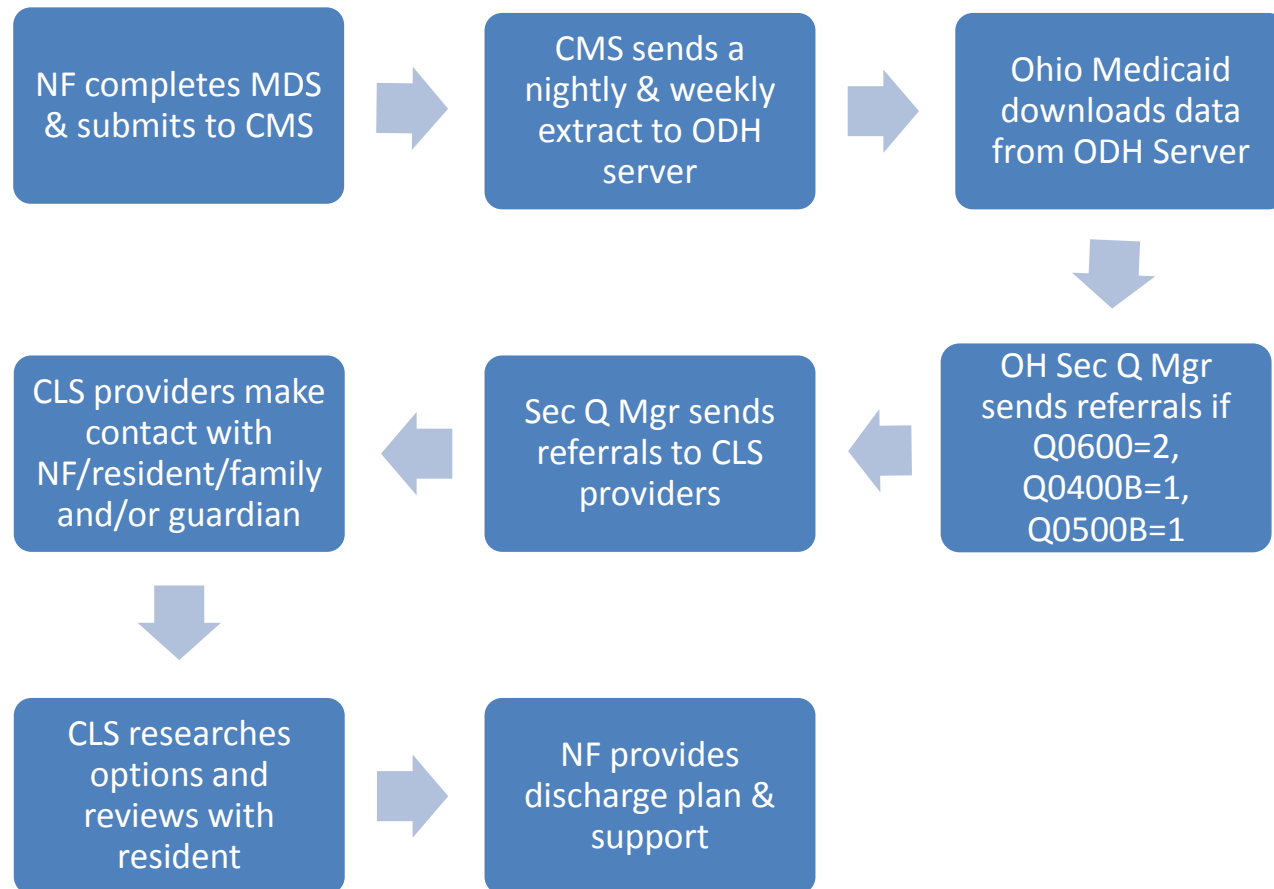
- Q0500B: First determine if the resident has been asked about returning to the community?
- Ask the resident, (or family or significant other if unable to respond)” **Do you want to talk to someone about the possibility of returning to live in the community?”** (p.Q-13)
- **NEW** coding tips on page Q-15 for Q0500

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Q0600: Referral

- Do you intend for a referral to be made to the local contact agency?
 - If Q0400 A = 0, No, complete CAA #20
 - If Q0400A = 1, yes, complete Q0600
 - If Q0400B = 1, yes, complete Q0600
 - If Q0500A = 2, yes, complete Q0600
 - If Q0500B = 1, yes, complete the CAA # 20
- Coding choices for Q0600
 - **Code 0** = No, determination has been made by the resident (or family et al) and care planning team that no contact needs to occur
 - **Code 1** = No, contact determined to be needed, but referral has not yet been made
 - **Code 2** = Yes, Referral to local contact agency has been made.
 - By coding this on the MDS it will result in a referral being made without the facility having to make a call.

Ohio's Implementation of Section Q: How it works



FAQ'S REGARDING SECTION Q

Q 1) When and under what circumstances does NF contact LCA/CLS?

A 1) NF providers contact with LCA on behalf of resident

- ODJFS will serve as a clearinghouse for Section Q information.
- ODJFS will use MDS data received in the ordinary course of business as the NF submits Section Q information. It is not necessary for the NF to notify the community living specialist directly.
- If NF provider has resident who is interested in talking with someone about moving to the community between MDS assessment dates, please contact your local AAA.

FAQ'S REGARDING SECTION Q –CONT.

Q 2) What to do when NF resident has dementia and it is not feasible for the person to move to community but the person states he or she wants to talk with someone about living in the community ?

A 2) It is important for Nursing Facility staff to be sensitive to the NF residents needs, wants and desires without causing unrealistic expectations. The purpose is to explore additional opportunities, not to create unreasonable expectations.

FAQ'S - CLS PROVIDER ROLE:

Q 1) What to do when face to face meeting is not possible due to NF resident's condition?

Q 2) What services will or will not be provided by the CLS provider?

Guardianship issues with Bev Laubert, State LTC Ombudsman

- 1 • How to identify guardians
- 2 • When contact with guardian should be made
- 3 • When guardian refuses CLS provider contact
- 4 • Other helpful advice re: guardians

UPCOMING REVISIONS TO SECTION Q

- Pilot test has been completed for Section Q in 9 facilities in 6 states.
- Changes for new language will be in keeping with the person centered approach while being more effective about identifying residents who are good candidates for moving.
- Question Q0400 and 0500 are being reviewed for clarification.
- Changes likely to occur in 2012

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RESOURCES:

Helpful web sites:

- <http://www.medicare.gov/publications/pubs/pdf/11376.pdf> - Your discharge planning checklist (a tool for patients and their caregivers preparing to leave a hospital, nursing home or other health care setting)
- http://jfs.ohio.gov/OHP/consumers/docs/relocation_handbook.pdf Home choice relocation workbook
- https://www.cms.gov/CommunityServices/20_MFP.asp CMS' website link to MFP
- <http://jfs.ohio.gov/OHP/consumers/HOMEChoice.stm> Home Choice web site

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Ohio Department of Health, Patsy Strouse

HOME Choice CLS Providers, AAA's & CareStar

State LTC Ombudsman, Beverley Laubert

THANK YOU FOR YOUR CONTRIBUTIONS

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HOME Choice web site:

http://jfs.ohio.gov/OHP/HC_CLS.stm

Ohio Department of Health:

<http://www.odh.ohio.gov/odhPrograms/io/mds/mds1.aspx>
ODH

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