

Section Q – Ohio Implementation Webinar

Notes for PowerPoint Presentation

Slide 1:

Good afternoon: my name is Terry Moore and I am the MDS Section Q Statewide Manager for ODJFS. Today's webinar is about Ohio's Implementation plan for the MDS Section Q referral process. This webinar is a collaborative training project that has been developed by ODJFS, ODA, ODH, State LTC Ombudsman and our CLS providers.

Slide 2:

The primary reason we are having this webinar is help refine the MDS Section Q referral process. In order to do that, we will provide you with an understanding of 1) the intent behind Section Q, 2) the roles and responsibilities of Ohio, 3) how to properly complete Section Q and how this aligns with Ohio's implementation plan, and 4) how Section Q completion triggers the MDS referral. We're also going to discuss some frequently asked questions about Section Q including Guardianship issues. Lastly, will finish up with the future revisions planned for Section Q.

Slide 3:

Deanna Clifford, ODA, will discuss intent of Section Q:

Bullet 1: 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." Resource: CMS - MDS 3.0 Section Q Implementation Q&A 12/22/10

Bullet 2: broadens the traditional definition of discharge planning by the nursing facility including a care plan that is individualized and person centered

Bullet #3: Effective partnerships between NF's and CLS providers

Bullet #4: To carefully identify persons who are capable of transitioning to community living and ensuring their success in community life.

Slide 4

It's important to note that the intent of Section Q is part of Ohio's overall vision for LTC and Home choice is a vehicle for implementing that vision

Slide 5

Manage MDS referral process = Track referrals, monitor provider compliance, analyze data, Authorize payment to CLS and process HC referrals/applications

Slide 6:

The purpose of this slide is to highlight a few key points:

1. While the CLS can help with options for discharge planning, the NF provider is responsible for determining feasibility for transition into community
2. We've received some very favorable feedback from some of our CLS providers about working with various NF's. We want to thank you for your efforts in locating residents and helping our CLS provider's make contact with your NF residents.
3. It's important to remember that this is a team approach between NF and CLS providers and this team approach will help build a comprehensive discharge plan for the resident.
4. We've had some feedback from NF's that they are concerned that CLS provider's visits are in violation of HIPAA. This is not a HIPAA violation: We have received approval from CMS via Data Use agreement to allow CLS provider to contact NF resident

Slide 7:

Deanna Clifford, ODA, will discuss roles & responsibilities of the CLS providers:

LCA's and Nursing Facility staff should form effective working relationships to develop comprehensive discharge and transition planning to support the individual's choice to return to the community. This is a way to enlist outside resources to ensure a successful transition to community living.

CLS service provision is a precursor to an assessment for program eligibility or LTC consultation that is provided by AAA's. It is about providing the individual with available options, not determining their eligibility for those options. If an individual expresses an interest in one or more of the choices the CLS presents, THEN, in cooperation with the nursing facility discharge planner, appropriate referrals are made, which may include an in-person assessment by the appropriate agency that determines eligibility.

Expectations bullets:

1. The options the CLS identifies should be in response to a preliminary conversation with the resident, to identify preferences of the resident and support systems in place. Can be wide ranging, exploring options at this point. Preliminary conversation may be over the phone. Information provided in a face-to-face meeting.
2. Community Living Plan Addendum- record of what options were presented, what barriers may be in place and the outcome of the discussion between the resident and the CLS provider

ODJFS is using the data collected in the Community Living Plan addendum to analyze trends, patterns, barriers and gaps in Ohio's service delivery system. That makes this work a key piece in our system reform issues, as well as aiding individuals in their transition to community living. CLS providers are

charged with challenging Ohio's system in new ways such as to find new resources, partnerships & collaborative opportunities

3. Share information with the NF, so the partners know what was discussed and what the outcome was from the meeting.

Share examples of community resources outside the scope of the usual and customary resources: caregiver support service

Slide 8 - 17

The next slides are excerpts from Section Q training provided by Patsy Strouse, RAI Coordinator, Ohio Dept. of Health. Patsy will review with you the next 9 slides about Section Q completion.

Slide 18

It's important to note that what triggers the MDS referral is Q0600 = 2, or Q0400B = 1 or Q0500B = 1

Slide 19

By entering 2 in Q0600, the NF has made the referral to the CLS according to Ohio's implementation plan. It is not necessary to contact the LCA directly.

The NF will not receive a citation from ODH for entering 2 in Q0600.

In Ohio, Q0600 should be marked yes (2) when determination has been made by the resident and the care planning team that contact IS required. The CLS provider will be contacted through the SMA and the MDS referral process approved by CMS.

- Doing so will create a statewide, cross-disability approach to information, referral and transition coordination and will assist the state in better understanding the needs of persons in nursing facilities who want to move back into home and community settings.

Slide 20

This occurs when Q0400B is answered something other than 2, not feasible. When this happens the assessor is obligated to ask Q0500 about whether the NF resident wants to talk with someone about moving into the community.

Ohio specifically asked CMS on 4/13/11 about what to do when person diagnosed with dementia and no family supports. CMS responded to Ohio in writing and will be posting this response to the CMS FAQ on their website:

CMS Response

The RAI manual indicates that the nursing home interdisciplinary team should not assume that any particular resident is unable to be discharged. The nursing home should code Q0400B as 2 after they

have fully explored the resident's preferences and possible home and community based services/options available to the resident. **If the nursing home interdisciplinary team determines that a resident with dementia cannot understand or answer the questions realistically, requires 24/7 care and does not have an informal support system, Q0400B would be coded as 2** [Discharge to community determined to be not feasible] and the assessor would skip to the next active section (V or X). For residents with dementia, Alzheimer's or related diagnoses that are cognitively unable to understand Section Q or MDS 3.0 questions and without family, an informal support system or designated guardian, the NF should pursue guardianship so that a guardian could make decisions for the resident, including giving and withholding consent for medical treatment.

Slide 21

A 1) Ohio's expectation for CLS service provision is to contact the NF, NF resident and/or family member/guardian to determine whether a face to face meeting is reasonable. If CLS contacts the resident and something about the resident's condition has changed, mark the CLPA "not feasible at this time." This person can be addressed during the next MDS assessment process.

A 2) The CLS service provision is about providing information about community support options, not about determining LOC or creating a discharge plan for the resident (i.e. make contact with resident & NF, determine preferences/needs in community living, research community based options, face to face meeting, coordinate with NF). It's also important to share this information with the NF as a communication tool to summarize the visit. Again, it's also important to document the resident's preferences, needs and barriers to community living on the Community Living Plan addendum to identify critical issues related to Ohio's LTC system.

Slide 22

Bev Laubert, State LTC Ombudsman will discuss guardianship issues

Answer to #2: the CLS provider should work with the NF to verify the scope of guardianship authority. The CLS provider and NF should then follow the guardianship authority since we must operate "in accordance with Ohio law." If there are problems, please call your Local LTC Ombudsman.

Important reminder: NF's must contact guardian to assist with questions in Sec Q

Slide 23

Training to be provided when CMS implements revised Section Q

Changes for new language are to provide residents with choice while being sensitive to those residents who cannot respond or might be disturbed by questions about moving into the community. The revised language will be in keeping with the person centered approach while being more effective about identifying residents that are good candidates for moving.