MDS
Section Q Training

This training is being brought to you by:

* SD Department of Human Services' Division of Long Term Services and Supports
* SD Department of Health - Office of Licensure and Certification
* SD Department of Social Services
* South Dakota Health Care Association
* South Dakota Association of Healthcare Organizations
* Great Plains Quality Innovation Network - South Dakota Foundation for Medical Care

Learning Objectives

The Learner will be able to:

1. Describe the purpose and intent of Section Q of the Minimum Data Set (MDS).
2. Translate the Section Q implications into operating practices.
3. Discern opportunities for long range planning for effective transitions of care.
4. Determine areas of improvement at the facility level to implement change.

Aging in Place

The U.S. Centers for Disease Control and Prevention defines

"Aging in Place": The ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level.

Aging Statistics

* People age 65 and older comprise 14.9% of the total population.
* By 2050 people age 65 and older are expected to comprise 22% of the total population.
* The average life expectancy in the U.S. is 79.9 years.

Source: U.S. Census Bureau

Goal of the MDS 3.0 Section Q

"Ensure that all individuals have the opportunity to learn about home and community-based services and supports and have an opportunity to receive long term services and supports in the least restrictive setting."

Section 504 of the Rehabilitation Act

Section 504 prohibits discrimination based on disability, including the unnecessary segregation of persons with disabilities. Unjustified segregation can include continued placement in an inpatient facility when the resident could live in a more integrated setting.

Americans with Disabilities Act

The unnecessary placement of an individual in a long-term care facility may constitute discrimination under Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act, as interpreted by the U.S. Supreme Court in Olmstead v. L.C.

Residents needing long term services and supports have the right to receive services in the least restrictive and most integrated setting.

Care Plan and Discharge Planning

In consultation with the resident and the resident's representative, the care plan must include the resident's goals, and the resident's preferences and potential for discharge.

The facility must document whether there has been an assessment of the resident's desire to move from the facility into the community, and must note any referrals made to appropriate agencies to facilitate such a move.

Q0100 Participation in Assessment

Q0100 Participation in assessment

* Who participated in the interview process?

To record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals.

Q0300
Resident's Overall Expectation

Q0300 Resident's Overall Expectation identifies the resident's general expectations and goals for the nursing home stay.

Response options:

* Discharged to the community
* Remain in this facility
* Discharged to another facility/institution
* Unknown or uncertain

Q0400 Discharge Plan

Q0400 Is active discharge planning already occurring for the resident to return to the community?

Important progress has been made in providing individuals with more community living choices, care options, and available services and supports to meet care preferences and needs in the least restrictive setting possible.

Q0400 Discharge Plan Continued

Care Plans should include:

* Name and contact information of a primary care provider chosen by the resident.
* Arrangements for durable medical equipment (DME) - if needed.
* Formal and informal supports that are available.
* Available providers in the community to meet the resident's needs.
* Where the resident is going to be living.

Definition of Active Discharge Plan

An Active Discharge Plan is a Discharge Plan that is currently being implemented.

* The resident's care plan has current goals to make specific arrangements for discharge;
* Staff are taking active steps to accomplish discharge; and
* There is a target discharge date.

Q0400 Discharge Plan Continued

Q0400 “Is Active Discharge Planning already occurring for the Resident to Return to the Community?” is answered “Yes” when:

* The services and assistance the resident may need post discharge is incorporated into the resident’s Discharge Plan.

OR

* The Local Contact Agency has discussed options for long term services and supports available in the community with the resident.

Q0400 Discharge Plan Continued

In addition, Q0400 is answered “Yes” when:

* The resident has an expected discharge date of three (3) months or less;
* Has an active discharge plan in place; and
* The discharge plan could not be improved upon with a referral to the Local Contact Agency.

Q0400 Discharge Plan Continued

When the answer is “No” to Q0400,
“Is Active Discharge Planning already occurring for the Resident to Return to the Community?”

Ask the follow-up question Q0500,
“Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”

Q0500 Return to Community

The goal is to initiate and maintain collaboration between the nursing facility and the Local Contact Agency (LCA) to support the resident's expressed interest in being transitioned to community living.

Q0500 Return to Community Continued

Q0500 “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”

If the resident’s answer is “Yes”:

* Make a “Section Q” referral to the Local Contact Agency (LCA) within 10 business days.

Q0500 Return to Community Continued

A Section Q Referral to the Local Contact Agency

* Does not commit the resident to leave the facility within a specific time period.

* Does not ensure the resident will move back into the community.

Q0550 Resident's Preference

Q0550 Resident's Preference to Avoid Being Asked
"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

If the resident's answer is "No" to Q0550:

* Document in the resident's clinical record that he/she only wants to be asked on the next comprehensive assessment.

* At the next comprehensive assessment ask the resident Q0500 again.

Q0600 Referral

Q0600 Has a referral been made to the Local Contact Agency?

* When a resident expresses to direct care facility staff an interest (outside of completing the MDS assessment), to live outside of the facility, the resident must be referred to the Local Contact Agency.

Q0600 Referral Continued

Facilities must not dissuade or deny residents a referral to the Local Contact Agency.

Facility staff cannot insert judgement:

* By believing discharge is not possible because the resident has complex care needs, no home or family support or a previous transition was not successful.
* When the family or caregiver does not want the resident to move from the facility.

Who is the Local Contact Agency?

The Department of Human Services' Division of Long Term Services and Supports (LTSS) is the designated Local Contact Agency (LCA) in South Dakota.

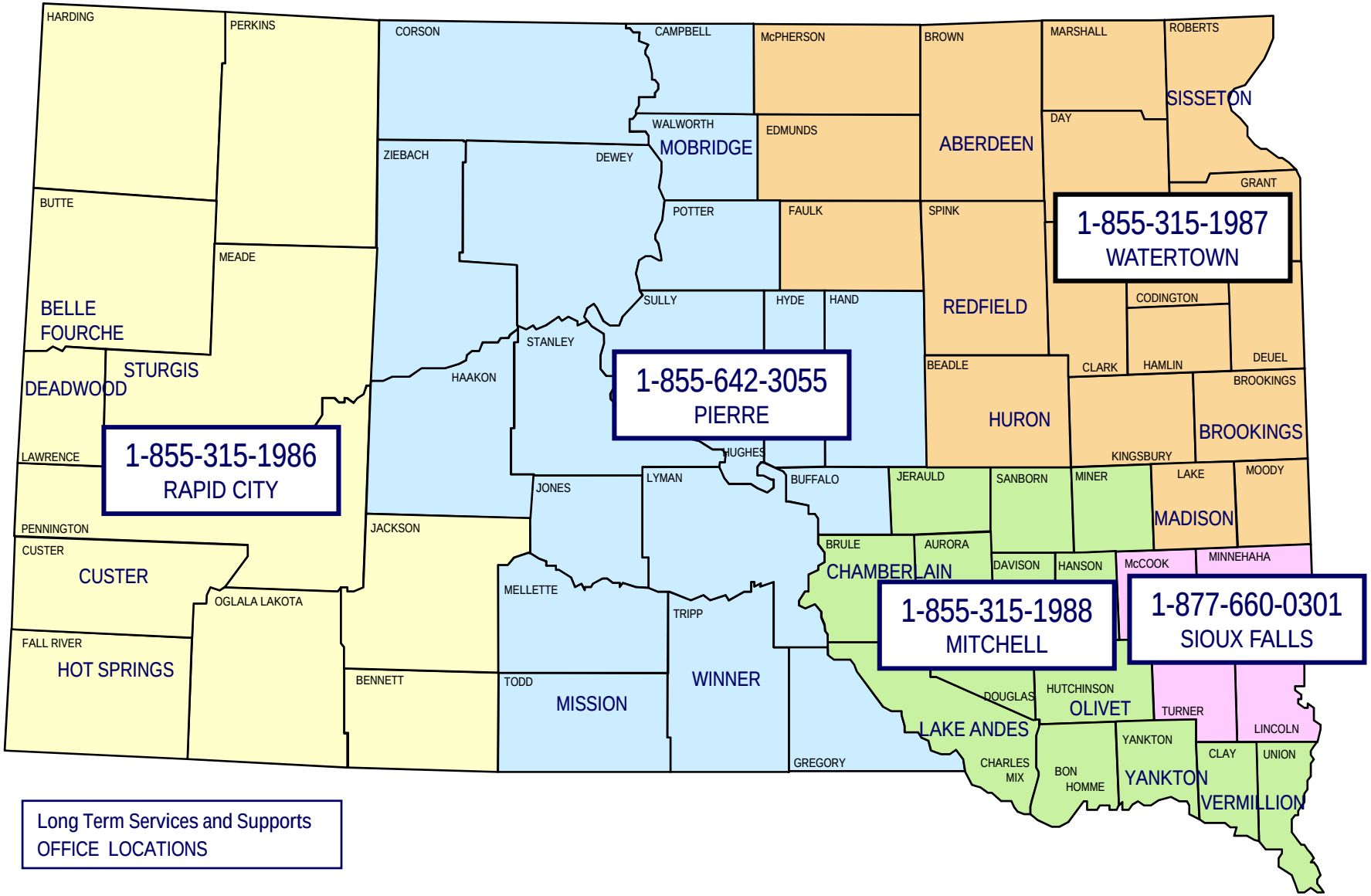
To make a "Section Q" referral, nursing facilities can contact a Long Term Services and Supports local office or the Aging and Disability Resource Connections (ADRC) Call Center.

Long Term Services and Supports Contact Information

Long Term Services and Supports (LTSS): http://dhs.sd.gov

Located in each local office are Specialists who provide information, referral, and assistance to access services and supports, options planning, needs assessments, care plan development, and case management to consumers receiving services through LTSS.

Aging and Disability Resource Connections Call Centers



Long Term Services and Supports
OFFICE LOCATIONS

Section Q Referral Protocol

When the nursing facility calls the Division of Long Term Services and Supports to make a “Section Q” referral, the referral is assigned to a Specialist for follow-up with the resident.

A Long Term Services and Supports (LTSS) Specialist will contact the resident at the nursing facility within 10 business days of receiving a Section Q referral from the nursing facility.

Facility Considerations

How are residents and family/guardians involved in the assessment process? How is their input obtained?

How are referrals to the local contact agency being documented?

How are community partners pulled into discharge planning discussions to collaborate on available options for residents?

Facility Considerations Continued

Do facility staff have access to information on options for community living, services and supports, and local, community and statewide resources?

Does facility staff training include how to talk with residents and family/guardians about the possibility of returning home and presenting all of the available options?

Frequently Asked Questions

Q. When I call the ADRC or a local LTSS office, who do I need to talk to?

A. Introduce yourself and tell the Specialist who answers the phone that you are calling to make a "Section Q Referral".

Q. What if I make a referral and nothing happens after 10 business days?

A. Contact the ADRC or local LTSS office and ask if the referral was received. If yes, ask when follow-up will occur. If no, make the referral again.

Frequently Asked Questions Continued

Q. Will the facility be cited by the Department of Health if the local LTSS office does not respond to the referral in a timely manner?

A. No.

Q. Is discharge planning the responsibility of the facility or LTSS as the Local Contact Agency?

A. Discharge planning of nursing facility residents is the responsibility of the nursing facility.

Frequently Asked Questions Continued

Q. Do I need to make a Section Q referral for a resident on a short term stay for rehabilitation?

A. A referral may not be necessary if there is an active discharge plan in place that includes home health services or home and community-based services including durable medical equipment, assistive devices, etc. or when a resident has informal supports and finances in place to discharge without services or assistance to return home following a short term stay.

Frequently Asked Questions Continued

Q. What if the resident has a court appointed guardian but the resident answers “Yes” on question Q0500?

A. When the court has given the guardian decision making authority over a resident’s care and placement and the guardian does not agree with the resident’s desires, a referral should be made even if the resident has a legal guardian or a durable power of attorney for healthcare. Information and education can be provided to the legally authorized representative and to the resident.

Frequently Asked Questions Continued

Q. Do I make a referral when a resident who has dementia wants to talk to someone about returning home? (even though he always answers yes to this question but has no idea that he can not stay home alone due to his memory loss).

A. A referral needs to be made because he responded “Yes”. A referral may be appropriate for a resident who has dementia. People with this diagnosis may be able to live at home with the right services and supports from in-home providers, and/or family members and other caregivers.

Frequently Asked Questions Continued

Q. Am I raising a resident's expectations only to see their hopes dashed by asking this question (Q0500)?

A. We should never promise more than what can be possible. A referral is the beginning of a process to determine if the possibility can become a reality for the resident.

Frequently Asked Questions Continued

Q. Who is responsible for follow-up after the resident discharges back into the community?

A. If the resident discharged from the nursing facility and is receiving services through Long Term Services and Supports, then a Specialist will provide case management follow-up with the individual.

Frequently Asked Questions Continued

Q. If the response is “No” to Q0550 “Does the resident want to be asked about returning to the community on all assessments?”, does the facility have to perform active discharge plans for that resident?

A. Each resident must have a discharge plan, which is included within the care plan. This resident will have a discharge plan but an active discharge plan may or may not be in place for a resident who responds “No” to Q0550.

Frequently Asked Questions Continued

Q. Do discharge plans need to be completed on all residents? Even the residents with Level II PASRR?

A. Discharge plans need to be completed on all residents, even residents who have Level II PASRRs.

Frequently Asked Questions Continued

Q. What if family is not around during the assessment completion?

A. You can plan ahead for when the assessment is due and pre-arrange a conference meeting/call with the resident, family members/guardian and discuss assessment items.

If family can not be present during the assessment, complete a follow-up later, at a time that is convenient to the resident, family members/guardian to discuss assessment items.

Section Q Guidance and Resources

* https://www.hhs.gov/sites/default/files/mds-guidance-2016.pdf

* http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/community-living-initiative.html

* RAI manual-https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf

Department of Health Contact Information

If you have questions on how to code Section Q

Contact: the State RAI/MDS Specialist
at the Department of Health:

Adeina Zeigler: 605-773-3674

CMS Products

http://productordering.cms.hhs.gov/ - order free products from CMS by setting up an account which includes providing an explanation of why you need access: To order products to provide to individuals and their family members…on discharge, choosing a nursing home, Medicare, etc.

* Your Right to get information about returning to the community (CMS Product No. 11477), English and Spanish versions.
* Your Discharge Planning Checklist (CMS Product No. 11376)

This concludes the training.

Thank you to the following entities:

* SD Department of Human Services' Division of Long Term Services and Supports
* SD Department of Health - Office of Licensure and Certification
* SD Department of Social Services
* South Dakota Health Care Association
* South Dakota Association of Healthcare Organizations
* Great Plains Quality Innovation Network - South Dakota Foundation for Medical Care