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CLIENT ADVISORY

Changes in MDS 3.0 Section Q and Implications for Nursing Facilities

The implementation of the Nursing Facility (NF) Minimum Data Set (MDS) version 3.0 occurred on October 1, 2010. Revised section Q in the MDS 3.0, termed "Participation in Assessment and Goal Setting," has been substantially changed and expanded, requiring an entirely different approach by nursing facility care providers in conducting the assessment. The new section imposes new requirements that will necessitate extensive collaboration between nursing homes, local contact agencies, and community-based long-term care providers for a small group of residents.

Overview of Prior MDS 2.0 Section Q

Through Section Q of MDS 2.0, CMS sought to improve the transition of individuals from nursing facilities to community living and to support individual choice. The stated goal of Section Q was to assist providers, upon a resident's admission to a facility and on other periodic occasions, in helping a resident return to their community if possible.

Section Q of MDS 2.0 thus contained a number of assessment items that sought to further these goals. In Section Q, nursing facility staff conducting an assessment were asked if the resident had expressed a preference to return to the community and whether the resident had a support person who was positive toward discharge. However, assessors were not instructed to ask the resident these questions directly and could answer the MDS questions based on their own observations. The MDS 2.0 only required that nursing home staff ask the questions upon admission to a facility and annually thereafter. Furthermore, under MDS 2.0 an assessor's findings were recorded in the MDS database but the nursing facility bore no obligation for follow-up action beyond traditional discharge planning requirements at 42 CFR 483(1)(3).

Overview of MDS 3.0 Section Q

The new Section Q arose from legal requirements to ensure that all individuals have the opportunity to receive long-term services and supports in the least restrictive and most integrated setting. This opportunity is now law under the Americans with Disabilities Act and the U.S. Supreme Court decision in *Olmstead v. L.C. and E.W.*¹

¹ In *Olmstead*, the Supreme Court indicated that a state may be able to fulfill its ADA obligations by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate. 527 U.S. 581 (1999)



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MDS 3.0 seeks to provide a more patient-centered assessment theoretically increasing the referral of, and transition of individuals to community living. Thus, the new Section Q now requires additional efforts by nursing facility care providers in conducting the assessment and generating and processing appropriate referrals.

A new item in Section Q requires the assessor to directly ask the resident if they are “interested in speaking with someone about the possibility of returning to the community.” If the resident responds “Yes”, then the facility must initiate care planning and must refer the resident to a state-designated local contact agency that will inform them of what care options and supports are available. Nursing home staff is additionally expected to engage the resident in their discharge and transition plan and collaboratively work to arrange for all the necessary community-based long-term care services.

Also in contrast to MDS 2.0, the MDS 3.0 Section Q includes a more extensive series of questions for assessment and investigation for care planning. Assessments are also now required to be more frequent. Under MDS 3.0, Section Q must be completed at admission, annually, quarterly, and upon a significant change in the resident’s status.

Implications of Section Q for Nursing Facilities

The new requirements of MDS 3.0 Section Q will require additional time resources of nursing facilities and coordination with outside agencies. Under the previous MDS, Section Q required little interaction with the resident, little of the resident’s participation in the assessment, and no mandatory referrals or coordination with other agencies. The new MDS 3.0 requires an assessor to ask residents a number of direct questions. Depending on the answers to those questions, the nursing home may be required to initiate a referral to a “Local Contact Agency” (LCA). In Virginia, the Department of Medical Assistance Services (DMAS) has designated the Area Agencies on Aging to serve as Local Contact Agencies for Section Q referrals. A spreadsheet of these agencies is available at: <http://www.vda.virginia.gov/localcontactagency.asp>.

After initiating a referral, the nursing home is then expected to coordinate and cooperate with outside agencies and the resident in forming a discharge and transition plan. The following list explains the responsibilities of nursing facilities:

- If directed by resident responses to MDS 3.0 Section Q, the nursing facility must contact a LCA within eight business days using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form (see attached)
- The nursing facility must confirm that the individual receives information on community services as provided by the LCA.



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- After the individual chooses a “Transition Coordination Provider” (TCP), the nursing facility must inform the LCA of the choice by using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form.
- The nursing facility must coordinate and assist the TCP in facilitating a transition to the community if appropriate. This could include arranging a face-to-face meeting between the individual or individual’s preferred contact, the TCP, and the nursing facility.
- The nursing facility must document all actions and the decisions of any individuals regarding their desire to transition to the community, participate in available training on community living options counseling, and adhere to HIPAA requirements.

A Statement of Understanding developed by DMAS further delineates the roles and responsibilities of the various parties involved when generating and processing MDS 3.0 Section Q referrals. The SOU also includes a helpful workflow chart visualizing the process for referrals and follow-up. A copy of the SOU is attached.

Enforcement of Section Q Responsibilities

CMS has clarified that the long term care survey process does not include a discrete task for Section Q follow-up or discharge planning. However, CMS has also noted that the local Ombudsman can be asked about Section Q results and required referrals. Any issues or findings that demonstrate residents are not being properly referred would be further investigated, and a survey deficiency levied when appropriate. Thus, failure to follow Section Q protocols, while not a separate survey item, could expose a facility to findings of deficiencies.

Conclusion

The new Section Q requires prompt attention by nursing facilities in order to comply with the October 1, 2010 implementation date. If our firm can be of assistance to you in interpreting the requirements of MDS 3.0 Section Q or with other long term care facility legal needs, please let Peter Mellette, Harrison Gibbs or Nathan Mortier know.

MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking Form

| | |
|-----------------------------|----------------------------------|
| Nursing Facility (NF) Name: | Local Contact Agency (LCA) Name: |
| NF Staff Contact(s): | LCA Staff Contact(s): |
| NF Fax number: | LCA fax number: |
| NF Phone Number: | LCA Phone number: |

MDS 3.0 Section Q Referral Tracking

| | | |
|---|---|---|
| <input type="checkbox"/> Original Referral Request from NF to LCA | Sender: | Date: |
| <input type="checkbox"/> LCA Notifies NF of Receipt of Referral | Sender: | Date: |
| <input type="checkbox"/> LCA Notifies NF that LCA has Spoken with Individual and Mailed Information | Sender: | Date: |
| <input type="checkbox"/> NF Notifies LCA of Individual's Decision | Sender: | Date: |
| Individual's Decision to Continue with Community Living Referral: | <input type="checkbox"/> No further services requested at this time | <input type="checkbox"/> Yes, Transition Coordination Provider (TCP) Name of chosen TCP: |
| <input type="checkbox"/> LCA Notifies TCP of Referral | Sender: | Date: |
| <input type="checkbox"/> TCP Notifies LCA of Receipt of Referral | Sender: | Date: |

MDS 3.0 Section Q Referral Information

| | | |
|---|---|--------------------|
| Individual's Name: | Individual's DOB: | Date of Admission: |
| Individual's Payer Source: (Check all that apply) | <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Pay <input type="checkbox"/> Other | |
| Does the individual have either of the following: | <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Enacted Durable Power of Attorney <input type="checkbox"/> No | |
| Individual's Preferred Contact: | <input type="checkbox"/> Self <input type="checkbox"/> Other Relationship: Name: | |
| Individual's Preferred Contact Mailing Address: | Phone Number: | Email: |

Statement of Understanding

Between the Virginia Department of Medical Assistance Services, Virginia's Nursing Facilities, Local Contact Agencies and Transition Coordination Providers

Purpose

This Statement of Understanding is between the Virginia Department of Medical Assistance Services (DMAS), Virginia Department for the Aging (VDA), Virginia's Nursing Facilities, Virginia's Area Agencies on Aging serving as the Local Contact Agencies and Transition Coordination Providers concerning the roles and responsibilities when generating and processing a MDS 3.0 Section Q referral.

Background

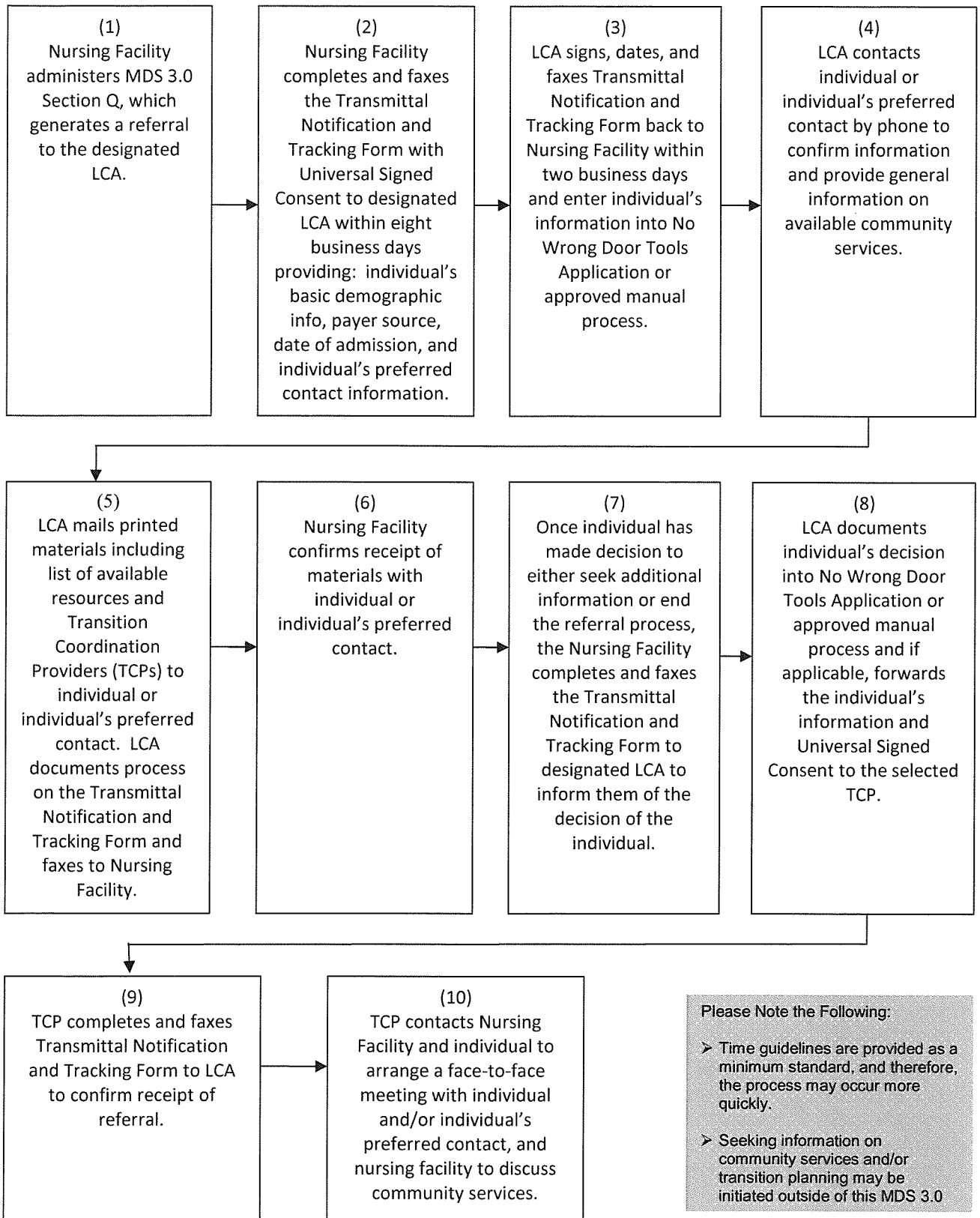
The Commonwealth of Virginia strives to ensure that all individuals have the right to receive long-term services and supports in the least restrictive and most integrated settings. This right became law under the American with Disabilities Act (1990) and in 1999 was further interpreted by the U.S. Supreme Court in the Olmstead vs. L.C. decision. The Governor, the Secretary of Health and Human Resources, the Virginia Department of Medical Assistance Services, the Virginia Department for the Aging, Virginia's Area Agencies on Aging, and Virginia's Centers for Independent Living are all committed to informing consumers about opportunities to exercise choice and self-direction. To that end, Virginia successfully applied and received approval for a Centers for Medicare and Medicaid Services' (CMS) Money Follows the Person Demonstration Project.

Virginia's Money Follows the Person (MFP) Demonstration Project has the following goals:

- Goal 1.** Rebalancing Virginia's long-term support system, giving individuals more informed choices and options about where they live and receive services;
- Goal 2.** Transitioning individuals from institutions (Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), nursing facilities (NF), and long stay hospitals (LSH)) who want to live in the community; and
- Goal 3.** Promoting quality care through long-term support services that are person centered, appropriate, and needs based, ensuring continual improvement is made through a quality management strategy for home and community-based services (HCBS) settings and institutions.

As of October 1, 2010, CMS launched the Minimum Data Set (MDS) 3.0, which includes an enhanced Section Q – Informing Long-Term Care Choice. This enhanced section seeks to broaden the traditional definition of "discharge planning" in nursing facilities by recognizing that an expansive range of community-based supports and services are necessary for successful community living. The implementation of Section Q encourages nursing facility interdisciplinary staff to assess both long stay residents who may not have been previously considered as candidates for community living and residents who have previously stated their desire to transition but who have not yet made the transition to facilitate resident and nursing facility connection and communication with Local Contact Agencies (LCAs). In their role as lead for Aging and Disability Resource Centers (ADRCs), DMAS has designated the Area Agencies on Aging (AAAs) in Virginia, to serve as LCAs for Section Q Referrals, providing community resource information for individuals interested in transitioning back to the community.

Workflow for the Generation and Processing of a MDS 3.0 Section Q Referral



Roles and Responsibilities

Nursing Facility:

1. Administers MDS 3.0 Section Q at the frequency and manner as directed by CMS.
2. Contacts designated Local Contact Agency (LCA) as directed by responses to MDS 3.0 Section Q within eight (8) business days using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form.
3. Confirms receipt of materials with the individual on community services provided by the LCA.
4. Contacts designated LCA on the decision of the individual and the Transition Coordination Provider (TCP) chosen by the individual using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form.
5. Coordinates and assists TCP as needed to facilitate a transition to the community.
6. Documents all actions taken by the Nursing Facility and subsequent decisions of individual on their decision to transition to the community.
7. Participates in available training on community living options counseling.
8. Adheres to Health Insurance Portability and Accountability Act requirements.

Local Contact Agency:

1. Responds to fax from Nursing Facility Section Q referral within two (2) business days using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form.
2. Calls and speaks with individual, or the individual's preferred contact, within two (2) business days of confirming receipt of referral from nursing facility.
3. Mails all relevant printed materials on community services including a list of geographically available TCPs to the individual, or the individual's preferred contact, within three (3) business days of speaking with the individual.
4. If applicable, forwards individual's information to the chosen TCP within two (2) business days of receiving notification of individual's decision from nursing facility.
5. Documents all actions taken by LCA in No Wrong Door Tools Application or approved manual process.
6. Participates in available training on community living options counseling.
7. Adheres to the confidentiality and exchange of protected health information guidelines as set forth in Code of Virginia.

Transition Coordination Provider:

1. Responds to fax notification from the LCA for a referral of an individual who is interested in transitioning to the community within three (3) business days.
2. Places call to the individual interested in transitioning to the community and/or the individual's preferred contact within three (3) business days of receiving fax notification from LCA for a referral.
3. Arranges face-to-face meeting with the individual and/or the individual's preferred contact, and nursing facility staff within ten (10) business days of speaking with the individual.
4. Coordinates and assists with Nursing Facility staff as needed to facilitate a transition to the community.
5. Documents all actions taken by TCP and subsequent decisions by individual to transition to the community.
6. Participates in available training on community living options counseling.
7. Adheres to Health Insurance Portability and Accountability Act requirements.