

# Minimum Data Set (MDS) Section Q Education

Helping People Return to the Community



# Overview of the Program

- In October 2010, CMS implemented a new version of the Minimum Data Set (MDS) 3.0 assessment, required to be used by all Medicaid certified nursing facilities.
- Thus began the implementation of the Section Q requirements.

# Overview of the Program

- The Section Q items identify nursing facility (NF) residents who wish to learn about available community supports and services along with the possibility of returning to the community.
- The goal of Section Q was to meaningfully engage the residents in their discharge planning goals. This also promotes information exchange between residents, nursing facilities, local contact agencies and community resources.

# Overview

- When any individual expresses a desire to discuss the possibility of returning to the community, facilities are required to contact the state Medicaid agency (In Iowa this is the Iowa Medicaid Enterprise [IME]).
- After receiving the referral, IME contacts the Local Contact Agency (LCA). The LCA is expected to respond to the individual's request for information about the possibility of returning to the community by providing information about choices.

# Overview

- The LCA (or agencies) are to provide options counseling and then transition planning for those residents identified as able to move to the community.
- The State Medicaid Agency is allowed to designate the LCA. The LifeLong Links Aging and Disability Resource Center\* within the local Area Agencies on Aging have been designated as the LCA's.

*\*The LifeLong Links Aging and Disability Resource Center will be referred to as LifeLong Links throughout the rest of the presentation.*

# Local Contact Agencies and Functions

LifeLong Links centers within the Area Agencies on Aging are responsible for these functions:

- **Referral Agency:** Entity that the nursing facility calls to refer the names of individuals requesting to talk to someone about the possibility of returning to the community.

# Local Contact Agencies and Functions

- **Options Counseling:** Entity(ies) that talks with the nursing facility resident, in person or by phone, to explain the options available.
- **Transition Planning:** Entity(ies) that will assist with the planning necessary for the resident to return to the community.

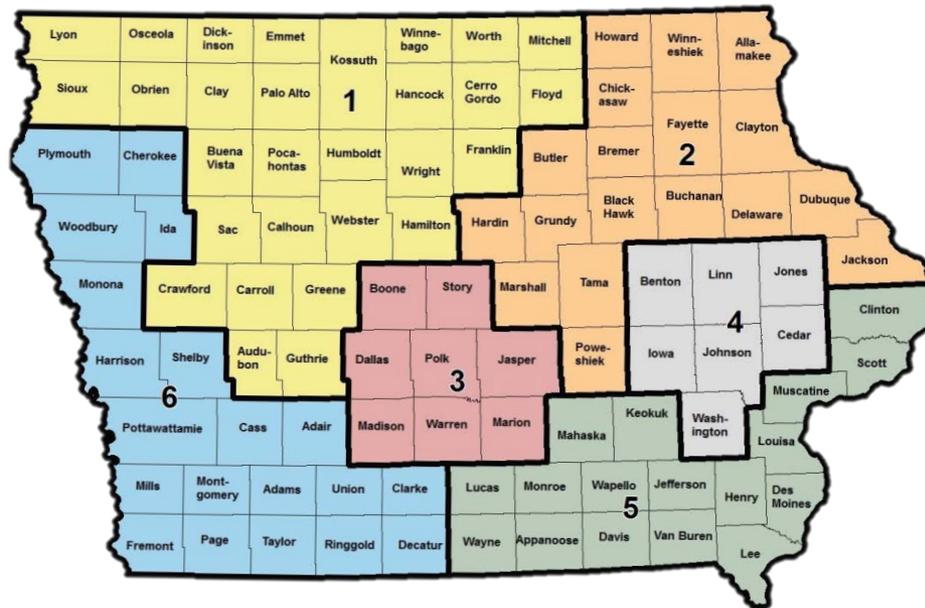
# Referral Agency

## Referral Agency:

The IME Medical Services Unit receives the calls from nursing facilities making referrals for all individuals who are requesting to talk to someone about the possibility of returning to the community. IME is the initial referral/contact point for all nursing facilities, in all counties. The nursing facility is instructed to call this number: **1-800-383-1173**.

# Options Counseling/Transition Planning

The Area Agency on Aging in your area handles these functions:



# Options Counseling/Transition Planning

Area Agency on Aging map key:

1. Elderbridge Agency on Aging: 1-800-243-0678
2. Northeast Iowa Area Agency on Aging (NEI3A): 1-866-468-7887
3. Aging Resources of Central Iowa: 1-800-747-5352
4. Heritage Area Agency on Aging: 1-800-332-5934
5. Milestones Area Agency on Aging: 1-641-682-2270,  
or 1-563-324-9085 x302
6. Connections Area Agency on Aging: 1-800-432-9209  
x1021

# Iowa Medicaid Enterprise (IME)'s Role

- Receive initial calls from facilities when a resident wants to learn more about discharging to the community.
- Initiate ISIS (Individualized Services Information System) from Section Q trigger.
- Make the referral to LifeLong Links within 4 days.
- Provide funding for the Section Q referral process.
- Provide oversight and quality assurance.

# LifeLong Links Aging and Disability Resource Center's Role

LifeLong Links is the Local Contact Agency.

- They receive the Section Q referral from IME.
- They initiate contact with the resident within two business days after receiving the referral from IME.
- If appropriate, they will meet with the resident, family and/or legal decision maker, and NF to discuss everyone's role and next steps (with the resident's permission).

# LifeLong Links Aging and Disability Resource Center's Role

- LifeLong Links will help to develop a transition plan.
- After discharge, LifeLong Links will follow up within 5 business days, and then 15 business days after the resident has been discharged into the community.

# Long-Term Care Ombudsman's Role

The **Office of the Long-Term Care Ombudsman** is in place to protect the health, safety, welfare and rights of individuals residing in long-term care by investigating complaints, seeking resolutions to problems, and providing advocacy with the goal of enhancing quality of life and care. Contact your Local Long-Term Care Ombudsman at: 1-866-236-1430.

# Section Q Assistance Provided by the LLTCO

The Local Long-Term Care Ombudsman (LLTCO) offers assistance with the Section Q process through:

Advocating for resident's rights by working with the facility to initiate the discharge planning piece through the Section Q process, per resident's request (this is possible even if the resident is not due for an MDS assessment).

# Section Q Assistance Provided by the LLTCO

Educating residents, families, and facility staff about the Section Q process through:

- Providing in-services
- Educating resident and family councils
- Circulating Section Q brochures

# Section Q Assistance Provided by the LLTCO

Educating residents, families, and facility staff about the Section Q process through:

- Providing information in monthly e-mail
- Posting information on the Iowa Department on Aging/Office of the State Long-Term Care Ombudsman website: [www.iowaaging.gov](http://www.iowaaging.gov).
- Intervening/advocating for residents if the discharge process is stalling.

# Resident and Family Caregiver's Role

- The resident must be actively engaged in the discharge planning process and must participate in making decisions. The family caregiver and/or legal representative should respect and support the resident's wishes during this process.

# Resident and Family Caregiver's Role

- The resident and family caregiver should work together to:
  - Identify goals and express preferences.
  - Follow through with the action plan to the best of their ability.
  - Allow the LifeLong Links Center to communicate with all applicable parties: i.e. the physician, nursing facility, psychiatrist, and family members, etc. in order to achieve discharge goals.

# Nursing Facility's Role and Expectations

- When a resident is admitted, immediately start discussing discharge planning goals.
- Begin the discharge planning process soon after admission if resident desires to return to the community.

# Nursing Facility's Role and Expectations

- Become informed about community resources or other living options:
  - For example, become informed about Medicaid waivers available in the community. This website offers some helpful overviews of the programs available:  
[http://www.ime.state.ia.us/HCBS/help\\_ownhome.html](http://www.ime.state.ia.us/HCBS/help_ownhome.html)
  - To identify local long-term services and supports, go to:  
<http://www.LifeLonglinks.org>

# Nursing Facility's Role and Expectations

Another program to be aware of is the Money Follows the Person (MFP) program through IME. The MFP program provides additional community transition funding for residents with a Brain Injury (BI) or ID (Intellectual Disability) diagnoses. This program has recently expanded to serve nursing facility residents with a BI or ID diagnosis.

# Nursing Facility's Role and Expectations

Benefits from the MFP program include:

- Extra services, supports and case management
- Assistance with paying a rental deposit.
- Assistance locating and paying for household set up items.

For more information, contact Brooke Lovelace, MFP Coordinator at: 515-256-4637, or [blovela@dhs.state.ia.us](mailto:blovela@dhs.state.ia.us)

# Nursing Facility's Role and Expectations

- If the goal is for the resident to move to another nursing facility or assisted living in another town, search DIA's website for facilities in that area. The facility staff should make these referrals. [https://dia-hfd.iowa.gov/DIA\\_HFD/Home.do](https://dia-hfd.iowa.gov/DIA_HFD/Home.do) Click on Entity Search, then enter the town into the "Entity City" box.

# Nursing Facility's Role and Expectations

- Initiate Section Q referral if discharge planning needs cannot be met by discharge planner/social worker. (These referrals **can** be made even when it is not time for an MDS assessment). Call IME with referrals: 1-800-383-1173.
- Facility may also contact the LifeLong Links by phone (refer to slides 9 and 10 for LifeLong Links areas) after IME has been contacted regarding a Section Q referral.

# Nursing Facility's Role and Expectations

- Actively participate in the process: continued involvement throughout discharge planning process. (The LifeLong Links Center's role is one of a third party consultant, who assists with facilitating a successful discharge plan).
  - The facility needs to communicate with LifeLong Links, resident, and other entities as appropriate.
  - Follow through on identified tasks (for example: sending faxes, sending applications, making referrals, following up on waiver waiting lists, etc.).

# When is a Section Q Referral Appropriate? (Non-Inclusive)

- If a resident needs an accessible apartment and the facility discharge planner has exhausted options in their area.
- If the resident has complicated multiple medical or mental health needs.

# When is a Section Q Referral Appropriate? (Non-Inclusive)

- If a resident wants to move to a different county and the facility discharge planner is not aware of options available in that area.
- If the resident wants to explore discharge options, but a guardian or legal representative is not supportive.

# When is a Section Q Referral **Not** Appropriate? (Non-Inclusive)

- If there is already a discharge plan in place.
- If the resident has already discharged.
- If the resident has entered the facility with the expectation of a short stay for rehab and already has a discharge plan in place.

# When is a Section Q Referral **Not** Appropriate? (Non-Inclusive)

- For residents whose discharge services and supports can easily be arranged to an established home.
- If there is a court committal: in which case, contact the mental health advocate. If needed, the Long-Term Care Ombudsman can be contacted to provide this number: 1-866-236-1430.

# Section Q Success Scenarios

*Below are some examples of successful discharges that have occurred through the Section Q process.*

## **Scenario 1:**

Male, 60, with mental health diagnosis and some medical issues. He became a resident at the NF after caregiver (mom) became unable to care for him anymore due to her medical conditions. Resident had been living with mom most of his adult life except when he had been at other facilities. When mom's needs increased he had to move back to a facility. During Section Q process a funding source (Habilitation) and Supported Community Living (SCL) provider were identified. He was assessed and found to be appropriate for a small Home and Community Based (HCBS) Waiver home in the community. He selected the HCBS site that fit his needs and was in close proximity to his aging mother. He transitioned from facility and for the past 6 months has been in the HCBS site successfully.

# Section Q Success Scenarios

## **Scenario 2:**

Female, 70, with physical health/mobility impairment and mental health diagnosis. She was court committed to the facility due to mental health issues. Through the Section Q process and work with the mental health advocate, an appropriate supportive community environment was found to meet her needs and court committal was moved to outpatient. No waivers were needed.

# Section Q Success Scenarios

## **Scenario 3:**

Male 64, stroke resulting in physical impairment and brain injury. Resident and wife wanted him to return home, but wife was still working and could not provide him the care needed. Through Section Q process he was able to apply for and obtain a Brain Injury (BI) reserved capacity waiver slot and was assigned a case manager with DHS to provide SCL services under the BI waiver to supplement wife's care. When male turns 65 the discussion of Elderly Waiver may be appropriate or he may remain on BI waiver.

# Steps after the Section Q has been Triggered

## After the Section Q is triggered:

1. Nursing facility makes the referral to IME: 1-800-383-1173 Monday through Friday 8:00 AM through 4:30 PM

IME will need the following information:

- a. Name, address and NPI (National Provider Identifier) number of the NF calling
- b. Full name of resident

# Steps after the Section Q has been Triggered

- c. SSN (Social Security Number) or SID (State Identification)
- d. Resident telephone number if appropriate
- e. Gender
- f. Date of Birth
- g. MDS date (ARD date)
- h. Medicaid eligible? (yes or no)

# Steps after the Section Q has been Triggered

- i. Original admission date to NF
- j. City of residence or intending to discharge if able to transition
- k. How long ago did the resident reside in the community including facility stay, acute hospitalization, or inpatient rehabilitation stay?
- l. Does the resident have a guardian, conservator or power of attorney?
- m. Can this person understand and make themselves understood on the phone?

# Steps after the Section Q has been Triggered

2. Nursing facility contacts the LifeLong Links Center as well to alert them that a referral is coming: (*Refer to the LifeLong Links county coverage areas on slides 9 & 10*).
3. The LifeLong Links Center contacts the “contact person” listed on the referral within two business days of receiving the ISIS referral.
4. A representative from the LifeLong Links Center connects with the resident in person or by phone to provide information regarding community-based options.

# Questions LifeLong Links will ask upon receiving a Section Q referral

1. Does the resident have a:
  - a. Guardian
  - b. Durable power of attorney for healthcare
  - c. Financial power of attorney
  - d. Conservator
2. Are there any family members and/or caregivers involved in the resident's discharge plan?

# Questions LifeLong Links will ask upon receiving a Section Q referral

3. Is the resident currently on Medicaid?
  - a. If not, has the resident applied?
  - b. Date of application:
4. What is the resident's current medical and mental health diagnosis?
5. Have there been any previous discharge attempts to the community?

# Questions LifeLong Links will ask upon receiving a Section Q referral

6. What has been the result of the discharge planning discussion?
7. What are the barriers to this resident discharging to the community setting?
8. Is the resident currently under court committal to this nursing facility?
  - a. If yes, when was the committal reviewed?
  - b. Has Mental Health Advocate/LLTCO been involved with the resident?

# Questions LifeLong Links will ask upon receiving a Section Q referral

9. What was the result of the most recent care conference?
10. Has there been an additional care assessment completed? (Have Physical/Occupational Therapies evaluated?)

# When does a Referral End?

- When a successful transition has occurred.
- If the resident changes his/her mind and does not want the service.
- When the services are not available.

# When does a Referral End?

- When the resident's needs exceed what home care services can provide.
- When the resident is unable to complete the transition due to a lack of supports.
- If funding is not available or there is a waiting list (waiting lists can take up to 18 months). **\*Nursing Facility is responsible for monitoring the waiting list through routine contact with DHS.**

# Nursing Facility Follow - Up

- If a referral has **not** been made, the NF is to gather additional information to determine why.
- The “Review of Return to Community Referral” is a checklist that assists the NF to do a further assessment. This checklist is located in the RAI (Resident Assessment Instrument) Manual Appendix C (C82-C83).

# Nursing Facility Follow - Up

- If the assessment shows that a referral should have been made and resident wants to talk to someone about community care, a referral should be initiated.

# Review of Return to Community Referral [RAI Manual Appendix C (C-82 to C-83)]

## Steps in the Process

1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not (Q0500B)

# Review of Return to Community Referral [RAI Manual Appendix C (C-82 to C-83)]

2. Interview the individual and his or her family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual's smooth transition to community living.

# Review of Return to Community Referral

[RAI Manual Appendix C (C-82 to C-83)]

3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include:
  - Cognitive skills for decision making and cognitive deficits
  - Functional/mobility or balance problems
4. Inform the discharge planning team and other facility staff of the individual's choice.

# Review of Return to Community Referral [RAI Manual Appendix C (C-82 to C-83)]

5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual's overall goals of care and discharge planning from previous items responses (Q0300& Q0400B). Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home?

# Frequently Asked Questions

- Q. What if a resident meets the criteria for a Section Q referral but it is not time for their MDS assessment?
- A. IME can be contacted anytime with a Section Q referral, even when it is not time for the MDS assessment: 1-800-383-1173. After contacting IME, contact the LifeLong Links Center to notify them that a Section Q referral has been made: (see slides on pages 9 & 10 for contact information).

# Frequently Asked Questions

Q. What if I make a referral to IME and nothing happens for weeks?

A. Contact LifeLong Links to see if they have received the IME referral. If LifeLong Links has not received the referral, the facility will need to contact IME once again. (LifeLong Links cannot initiate the Section Q process without a referral from IME).

# Frequently Asked Questions

Q. Do I make a referral to IME when a resident with dementia would like to talk to someone about the possibility of returning to the community? (Even if he always answers yes to this question and has no insight to realize his dementia is why he cannot stay at home?)

# Frequently Asked Questions

A. Each situation is unique. A referral to IME may be appropriate for some residents with dementia. There are many individuals with this diagnosis who live at home successfully, depending on the residential setting and support services available. The RAI User's Manual cautions the interdisciplinary team not to assume that any particular resident is unable to be discharged. A successful transition will depend on the setting, services, and sometimes family support services that are available.

# Frequently Asked Questions

- Q. Are nursing facilities unnecessarily raising resident expectations when asking about the possibility of a return to the community through Section Q?
- A. The nursing facility and LifeLong Links staff should guard against raising resident and family members' expectations of what can occur until more information is obtained. The NF and LifeLong Links team will explore appropriate community services and conduct care planning to determine whether a transition into the community is possible.

# Frequently Asked Questions

Q. What if question Q0500B “Do you want to talk to someone about the possibility of returning to the community”, is a hurtful or confusing question for residents? If the resident has already made the difficult decision to live in a nursing facility, do we have to keep asking this question every 90 days and upon significant changes?

# Frequently Asked Questions

- A. There is the option for the interdisciplinary team to skip this question if it had previously been determined that discharge to the community is not feasible. If the resident and care planning team (including families and significant others), have previously determined that discharge to the community is not feasible, the resident is not asked the question again.

# Frequently Asked Questions

Q. What if the resident has a court appointed guardian?

A. In some guardianship situations, the decision-making authority regarding the resident's care is given to the guardian. However, this should not lead the facility to presume the resident is unable to comprehend and communicate their wishes. A referral to LifeLong Links should be made if the resident wishes, even if they have a legal guardian, active durable power of attorney for healthcare, or other legally authorized representative, in accordance with state law.

# Frequently Asked Questions

Q. Who is responsible for follow up after discharge into the community?

A. LifeLong Links will follow up to ensure the delivery and outcome of community supports.

Q. Is discharge planning the responsibility of the NF or LifeLong Links?

A. Discharge planning continues to be the responsibility of the NF.

# Frequently Asked Questions

- Q. Which State is responsible when a resident is transferred from a nursing facility in one State to the community in a bordering State?
- A. The State which the individual transfers from is responsible for receiving the referral from the nursing facility and contacting the individual about a possible return to the community. If the individual is wanting to transition to another State, the LifeLong Links Center's coordination with the receiving State is essential.

# For Additional Questions

- Contact IME Provider Services Unit at 1-800-338-7909, or e-mail at [imeproviderservices@dhs.state.ia.us](mailto:imeproviderservices@dhs.state.ia.us)
- Information for the power point was adapted from:
  - IME Informational letter No. 954
  - IME informational letter No. 956
  - CMS MDS 3.0 Section Q Power Point
  - MDS 3.0 Section Q Implementation Questions and Answers document.

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Office of the State Long-Term Care

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*Established within the Iowa Department on Aging*

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