Section Q

Participation in Assessment and Goal Setting

Impetus for Section Q Changes

- Important progress has been made in the last 20 years so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible.
 - o Legislation such as the Americans with Disabilities Act (1990) and the Olmstead Supreme Court Decision (1999).
 - o Outcomes from various long-term care rebalancing initiatives, including grant and demonstration programs funded by CMS.



Minimum Data Set (MDS) 3.0 Section Q



Section Q: Expanding the Traditional **Definition of Discharge Planning**

- Broadened the traditional definition of "discharge planning" in nursing homes.
- Recognizes that an expansive range of community-based supports and services are necessary for successful community-living.
- Encourages nursing home interdisciplinary staff to assess long stay residents who may not have been previously considered as candidates for community living.
- Facilitates resident and nursing facility connection and communication with local contact agency experts to assess community resource availability and determine whether community discharge is possible.



Minimum Data Set (MDS) 3.0 Section Q

May 2010



Section Q: New Opportunities for **Discharge Planning Collaboration** Meaningfully engages residents in their discharge planning goals. ✓ Directly asks the resident if they want information about long-term care community options. ✓ Promotes linkages and information exchange between nursing homes, local contact agencies, and communitybased long-term care providers. ✓ Promotes discharge planning collaboration between nursing homes and local contact agencies for residents who may require medical and supportive services to return to the community. Minimum Data Set (MDS) 3.0



Section Q: New Requirements for **Discharge Planning Collaboration**

- ✓ 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
- ✓ Nursing home staff and Local Contact Agencies expected to meaningfully engage the resident in their discharge and transition plan and collaboratively work to arrange for all of the necessary community-based long-term care services.



Minimum Data Set (MDS) 3.0 Section Q

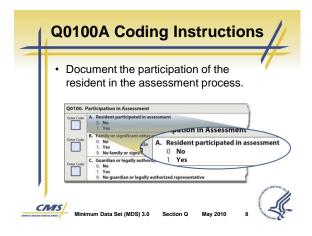
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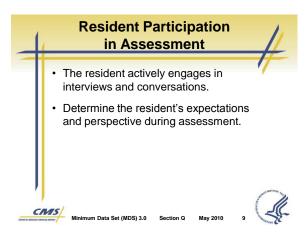
Item Q0100

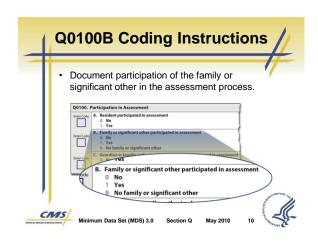
Participation in Assessment



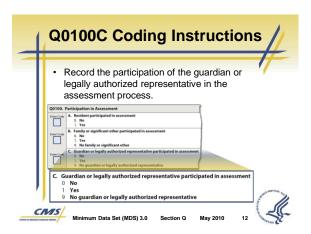


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Family or Significant Other Spousal, kinship (e.g., sibling, child, parent, nephew) or in-law relationship. Partner, housemate, primary community caregiver, or close friend. Does not include nursing home staff.



Legally Authorized Representative or Guardian

- Guardian
 - o Individual appointed by the court
 - o Authorized to make decisions instead of the resident.
 - o Includes giving and withholding consent for medical treatment
- · Legally authorized representative
 - o Designated by the resident under state law
 - o Makes decisions on the resident's behalf when resident is not able
 - o Includes a medical power of attorney

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Item Q0300

Resident's Overall Expectation

Q0300 Importance

- · Residents should be asked about expectations regarding return to the community and goals for care.
- · Residents may not be aware of longterm care options and choices that may be available in the community to meet their needs.





Q0300 Conduct the Assessment, · Ask the resident about his or her overall expectations. o Outcome of nursing home admission o Expectations about returning to the community · Ask the resident to consider:

o Current medical status

Social and other supports

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CNIS/



Q0300 Conduct the Assessment₂

- · Resident may be unable to provide a clear response.
- · Consult family, significant other(s).
- · Consult guardian or legally authorized representative if family or significant other(s) are not available.

CNIS/

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Q0300 Assessment Guidelines

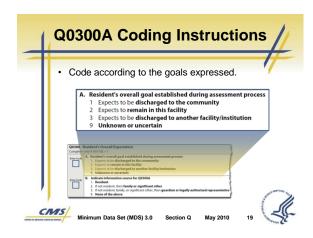
- Record family, significant other(s), or guardian or legally authorized representative perception of resident goals only if resident is unable to discuss or communicate goals.
- Encourage the involvement of family or significant others in the discussion if the resident consents.
- Code this item to reflect the resident's perspective if he or she is able to express/ communicate it.
- Record resident expectations as expressed/ communicated, whether or not they are realistic.

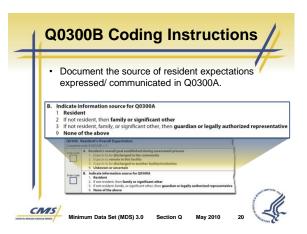


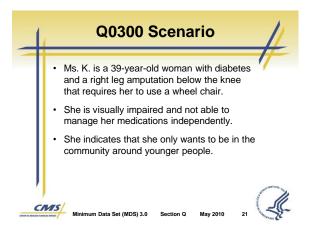
Minimum Data Set (MDS) 3.0 Section Q

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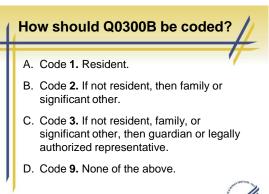
Q0300 Scenario Coding Code Q0300A as 1. Expects to be discharged to the community. Code Q0300B as 1. Resident. Q0300. Resident's Overall Expectation 1 CNIS

Minimum Data Set (MDS) 3.0

Minimum Data Set (MDS) 3.0

Minimum Data Set (MDS) 3.0 Section Q

How should Q0300A be coded? A. Code 1. Expects to be discharged to the community. B. Code 2. Expects to remain in this facility. C. Code 3. Expects to be discharged to another facility/ institution. D. Code 9. Unknown or uncertain.



How should Q0300A be coded? A. Code 1. Expects to be discharged to the community. B. Code 2. Expects to remain in this facility. C. Code 3. Expects to be discharged to another facility/ institution. D. Code 9. Unknown or uncertain. Minimum Data Set (MDS) 3.0

How should Q0300B be coded?

- A. Code 1. Resident.
- B. Code 2. If not resident, then family or significant other.
- C. Code 3. If not resident, family, or significant other, then guardian or legally authorized representative.
- D. Code 9. None of the above.

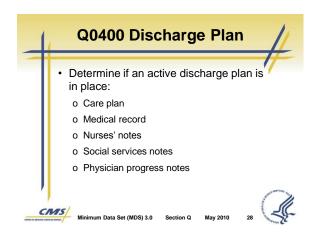
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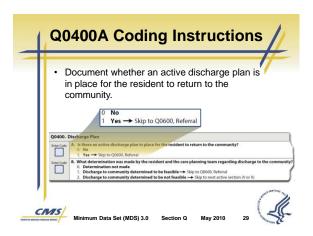


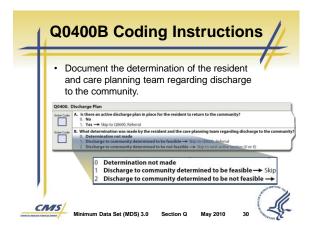
Item Q0400

Discharge Plan

9







Importance of Q0400B(2) -"Discharge Not Feasible"

- The interdisciplinary team must interview residents and/or their family members, whenever possible, and determine their preferences and agreement before concluding that a return to the community is not feasible.
- The LCA can help:
 - There are now more community resources and opportunities than ever before to enable residents, even long-stay, to return to community living.
 - The resident and interdisciplinary team will benefit from LCA involvement and knowledge of community support services.
- The U. S. Supreme Court Olmstead decision gives NH residents with disabilities civil rights and legal guarantees to services, programs and activities "in the most integrated setting appropriate to their needs."



Minimum Data Set (MDS) 3.0 Section Q



Item Q0500

Return to Community

Q0500 Conduct the Assessment

- · Ask the resident if he or she would like to speak to someone about the possibility of returning to the community.
- · Consult family or significant other or guardian or legally authorized representative if resident is unable to communicate preferences.
- · Explain that this item is meant to explore the possibility of different ways of receiving ongoing care.





Q0500 Conduct the Assessment₂

- · Ask the resident if he or she wants to talk to someone about the different care options and supports that may be available for community living.
- · Responding yes will be a way to talk to someone and obtain additional information about services and supports that would be available to support community living.



Minimum Data Set (MDS) 3.0



Q0500 Assessment Guidelines,

- · Make the resident comfortable that this a routine question asked of all residents.
- The intention is to allow a resident his or her right to explore all community options.
- · Answering "Yes" is a request for more information made by the resident.
- Answering "Yes" does not commit the resident to leave the nursing home at a specific time.





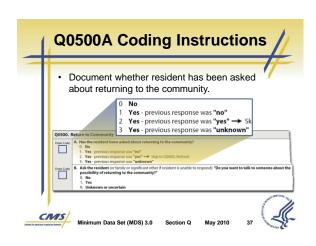
Q0500 Assessment Guidelines₂

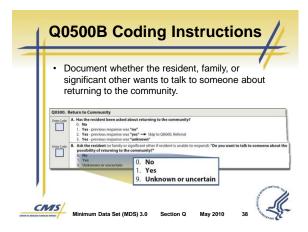
- · It also does not ensure the resident will be able to move back to the community.
- · Answering "No" is not a permanent commitment.
- · The resident can change his or her choice at any time.

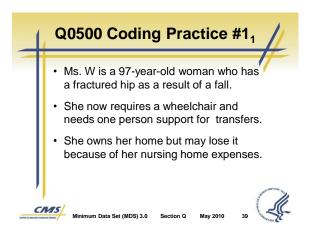






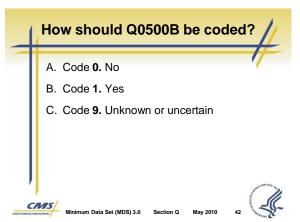


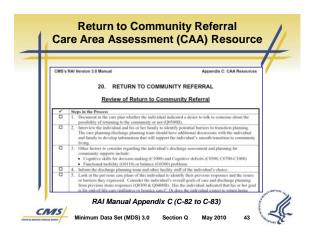




Output Output

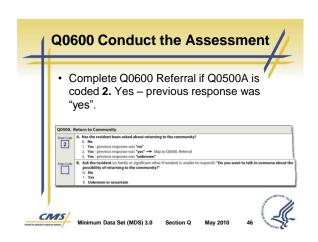
A. Code 0. No. B. Code 1. Yes - previous response was "no" C. Code 2. Yes - previous response was "yes" D. Code 3. Yes - previous response was "unknown"

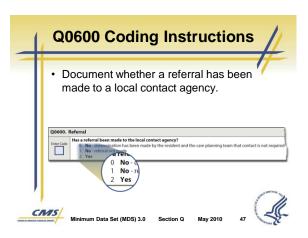


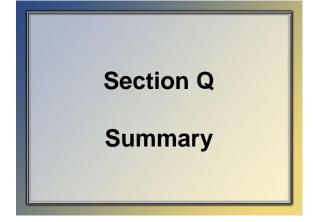


Item Q0600 Referral

Nursing Homes (NHs) will continue to do discharge planning and meet those regulatory requirements. Section Q provides the opportunity for residents to voice their choices and get information about available long term care (LTC) options and supports in the community. Local contact agencies can assist the resident and the NH in transition planning to secure/ locate housing, home modifications, personal care, and community integration. Minimum Data Set (MDS) 3.0 Section Q May 2010 45







Section Q Summary₁ · Section Q provides the opportunity and mechanism to: o Ask the resident what their expectations are about discharge from the nursing home (NH) and if they would like to talk to someone about the possibility of returning to the community; and Make a referral for the resident to a local contact transition agency when the individual says yes they would like to talk to someone about available long term care (LTC) community options and supports.

CMS/

Minimum Data Set (MDS) 3.0



Section Q Summary,

- Section Q provides the opportunity to expand and support NHs' usual discharge planning to include transition planning with the support of local contact agencies for individuals who previously may not have had the opportunity to explore LTC care options and supports and transition back to the community.
- Local Contact Agencies and NHs should work collaboratively for effective discharge and transition planning to support the individual's choice to return to the community.



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Section Q **Information and Comments**

- Section Q Return to Community Resource Information sheet can be found in the student packet.
 - o Provides referral, federal and state and community long-term care information.
- · E-mail questions or comments to:

mdsformedicaid@cms.hhs.gov



