ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-0454
TTY: (800) 526-5812

Informational Notice

Date: **Draft**

To: Nursing Facilities (ICF and SNF)

Re: Implementation of Section Q of MDS 3.0

The Resident Assessment Instrument (RAI) for Minimum Data Set (MDS) 3.0 makes important progress in assessing the resident's desires, through several formal interview processes, regarding discharge and return to the community. Section Q of the MDS 3.0 will record the participation and expectations of the resident, family members or significant other(s) in the assessment, and discuss the resident's overall goals regarding discharge and return to the community. In implementing Section Q, nursing facilities are required to actively engage the resident in an interview process to determine the resident's expectations and perspectives regarding discharge and return to the community. If the resident is unable to participate in the assessment process, a family member or significant other, and guardian/legally authorized representation can provide information about the resident's needs, goals, and priorities.

If the resident expresses a desire to return to the community, the nursing facility is required to contact a designated Local Contact Agency (LCA) within 10 business days of the assessment to apprise them of the resident's interest in receiving information about returning to the community. (The nursing facilities will need to obtain agreement and permission from each individual resident, through their usual signed release of information form, in order to refer that individual's name to the LCA.) The LCA's role is to contact individuals referred to them by nursing facilities in a timely manner, provide information about choices of services and supports in the community that are appropriate to that individual's needs, and collaborate with the nursing facility to organize the transition to community living, if possible. Although telephone contact (conversation) with the resident is considered the minimum contact requirement, face-to-face contact is recommended for Section Q implementation.

The following steps shall be followed regarding referral to the LCA:

1) Residents age 60 and over shall be referred to the local Case Coordination Unit.
2) Residents younger than 60 without serious mental illness (SMI) shall be referred to the local Center for Independent Living.
3) Residents of any age with an SMI diagnosis shall be referred to the appropriate mental health community agency.
4) Residents of any age with a development disability shall be referred to the appropriate developmental disability authority.

Information regarding each of the four classes of LCAs, as well as hyperlinks to the most current list of providers is included in Appendix One. Additional guidance to nursing facilities regarding implementation of Section Q requirement, developed by the Centers for Medicare and Medicaid Services, is included on subsequent pages.

1. **Is the nursing facility required to follow up once a referral has been made?**

   Discharge planning follow-up is already a regulatory requirement, CFR 483.20(l)(3), and important for person-centered care. The optional Return to Community Referral Care Area Trigger checklist states that, "If the local contact agency does not contact the individual resident by telephone or in person within 10 business days, make a follow-up call to the designated local contact agency as necessary."

2. **When a nursing facility works with the Local Contact Agency to successfully transition a resident into the community, when does the liability for the nursing facility end?**

   CMS does not define legal liability because it must be evaluated on a case-by-case basis. Skilled nursing facilities and nursing facilities have always been required to provide discharge planning services and follow-up, per requirements at CFR 483.20(l)(3). The facility is responsible to provide support for the individual in achieving his or her highest level of functioning until the resident is discharged from the facility. This includes collaborating in a thorough assessment of the individual's needs and care planning to support the individual's choice to be transitioned to community living. The agency and/or entities providing care and services in the community are responsible for monitoring the delivery of care and assuring health and safety of the individual once he has returned to the community, and the State is responsible for monitoring these activities.

3. **Since the nursing community staff may not be aware of available programs and supports for seniors and persons with disabilities living in the greater community, will there be more partnerships and resources available to nursing homes?**

   State Medicaid Agencies have designated a State point of contact (POC) for the Section Q implementation. These points of contact are responsible to coordinate efforts to designate local contact agencies (LCAs) for their State's skilled nursing facilities and nursing facilities. Formal and case-by-case education regarding community resources will be part of the partnership between nursing facilities and local contact agencies and occur mainly at the state and local level. The skilled nursing facilities and nursing facilities and LCAs must explore community care options and conduct appropriate care planning together to develop an array of supports for assisting the resident if transition back to the community is possible.

4. **Since the issue of family vs. guardian is confusing, can CMS clarify the differences? If there is a guardian or other legal representative (including someone with health care power of attorney), do they trump family members in terms of legal authority. In Q1, CMS refers to "family if applicable" and**

"guardian if applicable", which seems appropriate. But thereafter, the questions are, "or guardian if the family member is not available".

If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative. A guardian is an individual appointed by the court to make decisions for the resident. This includes giving and withholding consent for medical treatment. A legally authorized representative is designated by the resident under State law to make decisions on individual's behalf when they are not able to do so themselves. This includes a medical power of attorney. Facilities should encourage the involvement of family or significant others in the discussion. While family, significant others, or the guardian or legally authorized representative can be involved, if the resident is uncertain about his or her goals, the response selected must reflect the resident's perspective if he or she is able to express it.

5. Are there special considerations for individuals with a court appointed guardian?

Yes. Each State has its own guardianship law and these will not change as a result of MDS 3.0. A guardian or legally authorized representative is defined in the MDS 3.0 Resident Assessment Instrument (RAI) manual as a person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment. If the resident has a court appointed guardian, the resident should still be asked the question (Q0500B) unless state law prohibits asking the resident. If the resident is unable to respond, then ask the family, significant other, or legal guardian. A guardian, family member or legally authorized individual should not be consulted to the exclusion of the resident.

In some guardianship situations, the decision-making authority regarding the individual's care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes. As part of the assessment, the letters of guardianship should be checked, because the guardian's powers may be limited and exclude the right to make healthcare decisions. A referral to the local contact agency should be made if the resident wishes, even if they have a legal guardian, durable power of attorney for health care or a legally authorized representative, in accordance with state law.

6. Aren't nursing homes raising resident expectations if they know that the community system is fragmented and can't accommodate many more beneficiaries since Medicaid waivers are generally capped?

MDS 3.0 item Q0500B asks "do you want to talk to someone about the **possibility of returning to the community**." The nursing home and local agency staffs should guard against raising the resident and their family members' expectations of what can occur until more information is obtained. The nursing home and local contact agency team must explore community care options/supports and conduct appropriate care planning to determine ***if*** transition back to the community is possible. Close collaboration between the nursing facility and the local contact

agency is needed to evaluate the resident's medical needs, finances and available community transition resources.

7. **Will additional time frames be established for residents who have expressed a desire to return to the community and the time the discharge actually occurs, i.e., is there an expectation on how quickly a resident should be transitioned from a nursing home?**

   CMS is talking with State Medicaid agencies and the Administration on Aging about response times for local contact agencies (LCAs). Currently, there are no set expectations.

8. **What is the facility's responsibility for notifying appropriate community-based authorities when a significant change assessment is completed on a resident indicating a change in care planning and for a resident with a known mental health condition?**

   Preadmission Screening and Resident Review (PASRR) requires the facility to notify the State mental health or mental retardation authority when certain kinds of changes trigger a Significant Change in Status Assessment. This applies to individuals who are already identified by PASRR Level II as having Severe Mental Illness or Mental Retardation (A1500 = Yes) and also applies to persons for whom Severe Mental Illness may be presenting as a new concern, (A1500 = No), and therefore require a PASRR Level II evaluation and determination. Section Q requires contact with the designated local contact agency about a resident's request to talk with someone about the possibility of returning to the community. This would not likely be the same as the contacts for PASRR.

   The two requirements may occur together when the Significant Change in Status Assessment is triggered by improvement in an individual with Severe Mental Illness such that the individual expresses a desire to consider discharge or other placement options. In that case **both** referrals should be made, and a new Level II assessment would be helpful in discussing community living options. Another possibility would be that an individual expresses interest in community living, triggering Section Q referral to the designated local contact agency, but upon responding the local contact agency finds the Level II PASRR documents on the chart reflect needs that cannot be met with available resources in the community. A referral for PASRR Level II should be made to the state mental health or mental retardation authority, discussing whether a Level II reevaluation may be needed to help clarify the current needs and to identify any alternative supports that may be recommended.

9. **Have State laws been considered in the potential release of sensitive mental health information to community placement personnel? If so, have all state laws related to this issue been considered?**

   To assist states and facilities in complying effectively with PASRR, MDS 3.0 adds Question A1500, and clarifies the facility's responsibilities under PASRR when a Significant Change in Status Assessment occurs. The new Section Q process of referral to a local contact agency may involve discussions of the mental health status of the individual resident. The HIPAA (Health Insurance and Portability and Accountability Act) privacy rule does not preempt State laws and rules about mental

health information. Since MDS changes do not affect federal or State confidentiality rules, mental health information in discussions with local contact agency transition coordinators would be treated in the same manner that the facilities currently handle mental health information with outside health care providers. If MDS 3.0 data is to be shared, it will only be shared if a Data Use Agreement (DUA) was in place naming the local contact agency on the DUA.

10. What are the federal laws around MDS Section Q?

It is required by Statute that all residents admitted to a nursing facility be assessed using the minimum data set (MDS) functional assessment tool, (beginning on October 1, 2010 the revised MDS 3.0 will be implemented). Also required by Federal regulation is that this information and other assessment information gathered by the nursing facility be used to develop and implement a comprehensive person-centered care plan for every resident.

11. When a facility evaluates a resident and it is contraindicated to return to the community, do we treat this as an 'Against Medical Advice' case?

Leaving against medical advice must be evaluated on a case-by-case basis and it is the nursing home and State's responsibility to make this determination and report the event through their existing state processes. The resident should be provided information that allows him or her to make informed choices about his or her care and the setting in which it can be provided. The individual should also be supported in directing his or her care planning. The individual has the right to receive services in the least restrictive and most integrated setting and assume dignity of risk if that is their choice. This means that if the individual is competent, has been provided all the information necessary to make informed decisions, is aware of the level of services and supports that are or are not available in the community, and decides to leave the facility, they are assuming responsibility for their choice**.**

12. If a resident is a court ordered or a protective placement individual, will the State respect the response of the facility not to address a discharge plan to return to the community?

The current care planning process for court ordered or protective placements does not change because of MDS 3.0 Section Q.

Questions regarding this notice may be directed to the Bureau of Long Term Care at 1-217-782-0545.

Theresa A. Eagleson, Administrator
Division of Medical Programs