



Helping Ohioans Move, Expanding Choice
Ohio's Money Follows the Person (MFP)
Demonstration Project
CFDA # 93.791



MDS 3.0 Section Q “Local Contact Agency” Implementation

Update to 9/29/10 Fact Sheet and Frequently Asked Questions

(11/15/10)

Which MDS 3.0 Section Q data fields is ODJFS going to use to determine which referrals to make to Community Living Specialists (Ohio's term for local contact agency)?

The ODJFS HOME Choice Intake and Care Coordination Unit (HCICCU) is going to first separate MDS data by “time in nursing facility less than or greater than 90 days” using the “entry” date field. The HCICCU will only refer residents with a stay over 90 days.

Then, the HCICCU will refer residents with the following codes in MDS 3.0 Section Q to a Community Living Specialist:

- If “1” on Q0400A, then “2” on Q0600 then to a CLS.
- If “0” on Q0400A, then “0” or “2” on Q0400B, then “1” on Q0500B, then “2” on Q0600 then to a CLS.
- If “1” on Q0400A, then “0” or “1” on Q0600, then check for HOME Choice Transition Program Application. If no application, the HCICCU will notify the NF of possible HOME Choice Transition Program assistance as a tool in the nursing facility active person centered discharge planning.

How will nursing facilities know which Community Living Specialist is assigned to meet with a resident?

Community Living Specialists (CLS) are required to notify the nursing facility upon acceptance of a referral from the HOME Choice Intake and Care Coordination Unit. The CLS will work with the nursing facility to schedule a phone and/or face to face meeting with the resident. Likewise, the CLS is required to provide a copy of the Community Living Plan Addendum for Medicaid residents to the nursing facility within 5 days of the phone and/or face to face meeting with the resident.

How will a nursing facility determine whether discharge to the community is feasible (Q0400B)?

The interdisciplinary team must interview residents and/or family members to determine preferences and agreement before determining that community living is “not feasible”. The CMS RAI Version 3.0 Manual indicates that nursing facilities should not assume that community living is not feasible without FIRST exploring the resident's preferences and options. The Manual further clarifies that the exploration of such preferences and options should occur through consultation with a CLS. The CLS provider is required to send the nursing facility a copy of the Community Living Plan Addendum following the phone and/or face to face contact with Medicaid residents. The information contained in the addendum will help the interdisciplinary team make a determination of feasibility. Q0400B should not be coded as a “2” until the interdisciplinary team has received the information contained in the addendum. If the interdisciplinary team has not yet made a determination of feasibility due to the need for CLS services, the code to Q0400B is “0”.

What information does the Community Living Plan Addendum contain?

The addendum is a 3 page form used to gather basic information on the CLS service. The form contains the following:

- A resident directed list of needs and preferences (what the residents thinks)
- A summary of resources, and referrals made, by the CLS as a result of the information obtained from the resident
- A summary of the barriers to community living for the resident (what the CLS thinks)

The interdisciplinary team can use the resources and referrals to continue building the person centered care plan. Additionally, the team may use the summary of barriers as a guide when determining the feasibility of community living.

What will the CLS provider do if the guardian refuses to allow contact with the resident?

Guidance from the Centers for Medicare and Medicaid Services on September 22, 2010 included the following question and answer regarding guardianship.

“Question #18. 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. Remember that Section Q does not make a decision about leaving the facility and returning to a community based setting. Section Q simply asks the resident if they ... “want to talk to someone about the possibility of returning to the community?”

A guardian/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 your assessment research, 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.”

The CLS provider should work with the nursing facility to verify the scope of guardianship authority. The CLS provider and nursing facility should then follow the guardianship authority since we must operate “in accordance with Ohio law”. If there are problems, please feel free to call the HCICCU at MFP@jfs.ohio.gov or 1-888-221-1560.

Will the nursing facility be cited by the Ohio Department of Health due to the phase-in of Section Q referral to a Local Contact Agency?

No. The Ohio Department of Health will continue to conduct surveys in accordance with the State Operations Manual and discharge requirements at CFR §483.12 irrespective of MDS 3.0.