

# MDS 3.0 SECTION Q

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## KEY POINTS

- Section Q includes a question where every resident is asked if s/he would like information or to talk to someone about moving out of the nursing home and back into the community.
- If a resident says yes, the nursing home must initiate care planning and may make a referral to a Local Contact Agency (LCA), which will respond by providing information to the resident about community living services and supports.
- Each resident should be meaningfully engaged in his/her discharge and transition plan.
- The nursing home will continue to be responsible for discharge planning as required by state and federal regulations.

## MDS 3.0 AND SECTION Q

On October 1, 2010, the newly revised Minimum Data Set 3.0 (MDS 3.0) went into effect. A number of significant changes were made to this Resident Assessment Instrument in an effort “to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, and increase the resident’s voice by introducing more resident interview items.”<sup>1</sup> Section Q of the MDS 3.0 focuses on Resident Participation in Assessment and Goal Setting. It is designed to identify the resident’s goals and expectations relating to where s/he lives and whether s/he stays in the nursing home or transitions to other living situations. The MDS 3.0 is to be used with all nursing home residents, regardless of payment source.

Through the expansion of Medicaid waivers and state and federal initiatives such as the Money Follows the Person (MFP) program, Medicaid eligible individuals needing long-term care services and supports now have more choice in care options. As a result, nursing home residents who may not have previously been considered as candidates for community living are being reassessed.

## INFORMATION ABOUT COMMUNITY SERVICES AND SUPPORTS IS REQUESTED BY THE RESIDENT

If a resident indicates that s/he would like more information about available community-based services and supports, the nursing home is to initiate care planning and will make a referral to a Local Contact Agency (LCAs) if the resident has transition needs that the facility cannot plan for or provide. Each state is required to identify a local contact agency (or agencies) to provide information and transition services to residents who want more information about available community-based services and supports. Examples of agencies that may be designated as LCAs include Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), Medicaid Agencies, and Money Follows the Person (MFP) programs, among others.

Specifically, the LCA’s role is to contact individuals referred to them by nursing facilities through the Section Q process, provide timely information about choices of services and supports in the community, and collaborate with the nursing

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<sup>1</sup> Saliba, D., & Buchanan, J. *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0*. April 2008. p. 11.

facility to organize the transition to community living<sup>2</sup>. LCAs can assist the resident and the nursing home in transition planning to secure/locate housing, home modifications, personal care, and community integration. The nursing home staff and the LCA are expected to work collaboratively to implement transition and discharge planning for the resident.

## EACH RESIDENT SHOULD BE MEANINGFULLY ENGAGED IN HIS/HER DISCHARGE AND TRANSITION PLAN

One of the key components of the MDS 3.0 is to increase resident input and participation in the assessment and care planning process. Section Q has been revised to be person-centered, provide the resident the opportunity to express their expectations for care, engage the resident in their discharge planning goals, and initiate a referral to an LCA to provide information and explore the potential for returning to the community<sup>3</sup>.

## THE NURSING HOME CONTINUES TO BE RESPONSIBLE FOR DISCHARGE PLANNING IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS

Discharge planning follow-up is already a facility requirement based on federal regulations<sup>4</sup>. There is no change to this requirement because of Section Q. Nursing homes are required to prepare a discharge summary that includes a post-discharge plan of care developed with the resident and his/her family, and that is designed to assist the resident in adjusting to his/her new living arrangements<sup>5</sup>. According to the Guidance to Surveyors, this means that the post-discharge plan should describe the resident's and family's preferences for care, and how care and services will be accessed and coordinated. The discharge planning process includes assessing the resident's continuing care needs and developing a plan to ensure that those needs are met after discharge from the facility<sup>6</sup>.

## INVOLVEMENT OF THE LONG-TERM CARE OMBUDSMAN PROGRAM

An ombudsman may be involved in the Section Q process in several ways that are consistent with current Older Americans Act responsibilities. The long-term care ombudsman is available to assist nursing home residents by resolving complaints related to the transitions process, as well as by providing information and education to consumers, facility staff, and the general public regarding the transitions process. The coordination of services is not a typical ombudsman role.

### Examples of ways ombudsmen are likely to be involved:

1. Investigation and resolution of resident complaints related to the transition referral or process,
2. Supporting residents in their decision-making related to transitions,
3. Providing information to consumers and providers (i.e. consultation to individuals) and facility staff (i.e. consultation to facilities) about resident rights and options,
4. Providing educational sessions and materials to consumers and the general public about resident rights and options, and
5. Helping to identify candidates for transitioning to community living and making referrals as appropriate.
6. Local ombudsmen should be alert to issues that recur or are widespread and may call for systemic intervention or advocacy. Such issues should be shared with the State Ombudsman to be addressed with the appropriate entity, such as the Medicaid Agency, Money Follows the Person Program, or the Local Contact Agency.

2 Milne, Dann, MDS 3.0 Section Q Pilot Test, March 2010, [http://www.cms.gov/CommunityServices/downloads/Pilot\\_Test\\_Report.pdf](http://www.cms.gov/CommunityServices/downloads/Pilot_Test_Report.pdf)

3 Section Q – Discharge to Community Information Sheet, CMS, <http://www.ltombudsman.org/sites/default/files/issues/Seciton-Q-Information-Sheet.pdf>

4 42 CFR 483.20(l)

5 42 CFR 483.20(l)(3)

6 State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, pp.141-142

# RESOURCES

## Available Resources About the MDS 3.0 and Section Q

- <http://www.ltombudsman.org/issues/MDS-3.0>

## Consumer Resources from the Centers for Medicare and Medicaid Services:

- Your Right to Get Information About Returning to the Community Brochure – developed by CMS, it explains to the resident why they are being asked by facility staff whether they want more information about the possibility of returning to the community. There is a place in the back of the brochure for contact information for the long-term care ombudsman program. <http://www.medicare.gov/publications/pubs/pdf/11477.pdf>
- Your Discharge Planning Checklist - created by CMS for individuals and their caregivers preparing to leave a hospital, nursing home, or other health care setting. It was created to support individuals to be an active participant in their own care and discharge planning. [http://www.cms.gov/CommunityServices/downloads/2010\\_Revised\\_Consumer\\_Discharge.pdf](http://www.cms.gov/CommunityServices/downloads/2010_Revised_Consumer_Discharge.pdf)

## Additional Resources for Ombudsmen on Nursing Home Transition:

- Charting the Role of the LTC Ombudsman in a Modernized Long-Term Care System - <http://www.ltombudsman.org/sites/default/files/norc/issues/Charting-LTCOP-Role-Modernized-LTC-System.pdf>
- Nursing Home Transition Toolkit for Ombudsmen - <http://www.ltombudsman.org/issues/rebalancing-the-long-term-care-system>

## CMS Information on Balancing the Long-Term Care System and Money Follows the Person:

- Balancing Long-Term Care Community Services and Supports - [http://www.cms.gov/CommunityServices/15\\_Balancing.asp#TopOfPage](http://www.cms.gov/CommunityServices/15_Balancing.asp#TopOfPage)
- Money Follows the Person - [http://www.cms.gov/CommunityServices/20\\_MFP.asp#TopOfPage](http://www.cms.gov/CommunityServices/20_MFP.asp#TopOfPage)

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