

South Carolina
Department of Health and Human Services
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October 20, 2010

Memorandum

To: Nursing Facility Staff

From: Brenda L. Hyleman
Division Director

Subject: MDS Section Q & Nursing Home Transition

The purpose of this memo is to provide information and clarification on several issues related to the MDS Section Q and nursing home transition. As some of you know, my name is on a list issued by the Centers for Medicare and Medicaid Services (CMS) as a contact person for Section Q. This list is misleading since it appeared that I am the local contact agency (LCA). For clarification, I am not the local contact agency, and the list has recently been revised and is called the State Point of Contact (POC) List for MDS Section Q Referrals. A column has been added to the list to include a web site for the LCA for each state.

CMS also released this definition for the state Point of Contact:

The POC is the central State point person responsible for coordinating Section Q implementation and the designation of the LCAs. Their contact information is being provided on the CMS website solely in the event that a SNF/NF, or other provider does not know who their LCA is, has other needs beyond that regarding Section Q, and/or any entity or organization who wants to or needs to be involved in the coordination process development and/or designation of LCAs. The LCA list should be provided and posted by the SMA.

The SMA is the State Medicaid Agency and, as stated above, the SMA has the authority to designate the LCA. Each state has differing regional and county systems of care, so this allows the SMA to make this determination. We have determined that the LCA will vary based on the payment/funding source of the resident wishing to transition from the facility. For example:

If the resident has **Medicaid coverage** in the facility for at least one day within the last 90 days and continues to meet level of care, the LCA would be the **regional CLTC office** and the resident can transition to the home and community based waiver for their long term care services in the community. If the resident has not been in the facility for 90 days, a referral can be made to CLTC to add the resident to the waiting list. In these situations, a referral should also be made to the local **Ageing & Disability Resource Center (ADRC)** through the regional Area Agency on Aging.

If the resident is utilizing the **Medicare benefit** for rehabilitation in the facility, and continues to need skilled nursing, PT, OT, or ST when they return to the community, the LCA would be **the local home health agency**. If the resident also needed non medical services, the

local **ADRC** could also be a LCA.

If the resident is **private pay, no longer meets the level of care criteria for Medicaid** coverage, the LCA would be the **ADRC** for coordination of local aging and disability services.

Please refer to the attached Decision Tree for quick reference.

This link provides information about ADRCs in South Carolina and the local contact information.

http://www.aging.sc.gov/NR/rdonlyres/CB47D012-3CC5-4B2A-B57D-C06C70E45646/0/ADRCwebpageSummer2007_Updt8Feb2008.pdf

Here is the link for the addresses and phone numbers for the regional CLTC offices.

<http://www.dhhs.state.sc.us/dhhsnew/InsideDHHS/Bureaus/BureauofLongTermCareServices/other11262832003.asp>

As nursing facilities receive requests from residents to return to the community, these LCA can provide assistance with coordination of services prior to discharge. There may be situations where the resident expresses the desire to return to the community, but the family is not participating in the discharge planning. When this occurs, please notify the LTC ombudsman and request assistance in assuring that the resident has an advocate, their rights have been protected, and that discharge is not feasible at this time. Facilities are not required to report discharges or discharge requests to the POC.

Please feel free to contact me as the POC if you have any questions. It is our intention to provide regional trainings on Section Q and Residents Interviews in 2011. Specific information on these trainings will be sent to you.

cc: Susie Boykin, CLTC State Office
Denise Rivers, ADRC State Office
Gloria McDonald, I & R Specialists Coordinator
Dale Watson, LTC Ombudsman

Minimum Data Set 3.0

Minimum Data Set (MDS) 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings. These improvements have profound implications for NH and SB care and public policy. Enhanced accuracy supports the primary legislative intent that MDS be a tool to improve clinical assessment and supports the credibility of programs that rely on MDS.

Return to the Community: Nursing Home Minimum Data Set (MDS), Version 3.0 Section Q – Version 3.0 of the MDS, being implemented on October 1, 2010, improves the ability of Skilled Nursing Facilities and Nursing Facilities (SNFs/NFs), States, and other qualified entities to identify individuals that are interested in returning to the community. The critical improvements to this functional assessment instrument are designed to give SNF/NF residents a voice, increase clinical relevance and accuracy, and increase communication and collaboration between providers of services. Residents will be asked directly if they want to talk to someone about returning to the community.

Section Q will be administered to all SNF/NF residents. The resident will be referred to a local contact agency (LCA) if the resident has transition needs that the SNF/NF cannot plan for or provide. The LCA will contact the resident and if the resident is Medicaid eligible, the SNF/NF and LCA will work together with the resident to plan their transition back to the community.

Resource documents and other information provided below include: A State-by-State point of contact (POC) list; an MDS 3.0 Section Q Resource Publication for individuals, caregivers and organizations; an MDS 3.0 Section Q implementation solutions document as a follow-up to the Informing LTC Choice conference and emails; and MDS Section Q Pilot Test Results summary report.

http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage

MDS Training Material

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage

Aging and Disability Resource Centers in South Carolina and the local contact information

http://www.aging.sc.gov/NR/rdonlyres/CB47D012-3CC5-4B2A-B57D-C06C70E45646/0/ADRCwebpageSummer2007_Updt8Feb2008.pdf

Community Long Term Care

<http://www.dhhs.state.sc.us/dhhsnew/InsideDHHS/Bureaus/BureauofLongTermCareServices/other11262832003.asp>

Local Contact Agency Resident Request

Pay Source

Medicaid

- Refer to Regional CLTC Office for Home and Community Based Waiver service
- Meet NF Level of Care *and*
- 90 Days Stay with 1 day Medicaid Coverage

Medicare

- Refer to Local Home Health Agency
- Must Have Skilled Medical Need (Nursing, PT, OT, ST)
- Could also refer to regional Aging and Disability Resource Center

Private Pay

- Refer to regional Aging and Disability Resource Center
- Does Not Meet NF Level of Care