



## **MDS 3.0 Section Q and Relocation Services**

### ***What Nursing Home Staff Need to Know***

Background: The Minimum Data Set (MDS), administered to all nursing home residents upon admission and at 90 day intervals, requires facility staff to determine all residents' preferences for long-range living arrangements. This document provides an outline of facilities' responsibilities under MDS 3.0 Section Q, local contact agencies' responsibilities, and referral protocol. It is written for facilities in DADS' Region 3 (consisting of the counties in and around the Greater Dallas/Fort Worth Metroplex).

### **MDS 3.0 Section Q Questions**

Specifically, MDS 3.0, Section Q requires nursing facility staff who are conducting MDS assessments to gather the following data:

- Question Q0300 (Resident's overall goal established during assessment process): Where does the resident expect to live on a permanent basis?
  - *Expects to be discharged to the community*
  - Expects to remain in the facility
  - Expects to be discharged to other facility

- Question 0400: (Discharge arrangements): *Does the resident have an active discharge plan?*

If the resident expects to be discharged to the community, the facility must indicate whether there's an active discharge plan. If the resident does have an active discharge plan, the facility is not obligated to ask Question 0500 or make a referral to the Local Contact Agency. However, the facility is welcome to make a referral to the Local Contact Agency at any time a resident needs assistance in returning to the community, regardless of whether the resident has undergone an MDS assessment recently or responded to Section Q questions.

- Question 0500: (Need for Assistance): *Do you want to talk to someone about the possibility of returning to the community?* Note, the intent of this question is to determine whether a resident wishes to speak to a relocation specialist, outside facility staff, through the Local Contact Agency.
  - No
  - Yes
  - Not sure



## **Assumption Regarding Resident Capacity**

If the resident expects to be discharged to the community, does not have an active discharge plan, and wishes to speak to someone about the possibility of returning to the community, the facility is obligated to make a referral to the Local Contact Agency (LCA).

The facility's obligation remains the same, even if the resident has cognitive impairment or the facility determines the resident is not a good candidate for relocation services.

If a resident has been declared incapacitated by the court and appointed a guardian of the person, the facility should defer to the guardian's wishes.

If a resident has executed a power of attorney for health care and/or business affairs, he retains his right to make decisions regarding his residential settings and pursue relocation as desired. The facility should not defer to the wishes of the person who's been appointed Principal under the power of attorney.

## **Local Contact Agencies and Scope of Work**

The Texas Department of Aging and Disability Services contracts with agencies to provide Local Contract Agency (LCA) services. The LCAs have different responsibilities, depending on whether residents have Medicaid benefits.

LCAs for non-Medicaid residents provide information and referral regarding community-based services such as subsidized housing, attendant services, transportation, the Veterans Aid and Attendance program, and other long-term services and supports (LTSS). They may also provide options counseling services, to help residents develop a written plan for LTSS, and follow up to determine if their needs have been met. LCAs for non-Medicaid residents may also provide benefits counseling services, to help residents access Medicare Savings Programs (that provide assistance with Medicare premiums, deductibles, and/or) copayments.

LCAs for non-Medicaid residents provide information over the phone. If residents have complex needs, the LCA for non-Medicaid residents can send options counselors to the facility to conduct face-to-face meetings and provide intense case management services as needed.

LCAs for Medicaid residents provide information and referral regarding community-based services such as the STAR+PLUS Waiver. If residents have complex needs (i.e., lack of housing, co-occurring physical and mental disabilities, need for assistance with five or more activities of daily living, intellectual and developmental disabilities, and residence in the facility for six months or longer) LCAs for Medicaid residents can provide intense case management.



LCAs for Medicaid residents rely on relocation specialists to visit residents in the facility, develop plans for relocation, and remain actively involved until the residents successfully relocate and remain in the community for at least 90 days. LCAs for Medicaid residents are responsible for arranging housing, applying for the Transition to Life in the Community (TLC) relocation grant, and setting up other community-based services that are beyond the scope of the Medicaid waiver program.

The LCA for non-Medicaid residents in Cooke, Fannin and Grayson counties is the Texoma Aging and Disability Resource Center:

- Call 1-855-937-2372

The LCA for non-Medicaid residents in Dallas County is the Dallas County Aging and Disability Resource Center

- Call 1-888-743-1202
- Contact: Dulce Ramirez

The LCA for non-Medicaid residents in Tarrant County is the Tarrant County Aging and Disability Resource Center

- Call 1-888-730-2372

The LCA for non-Medicaid residents in Collin, Denton, Ellis, Erath, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant and Wise counties is the North Central ADRC

- Call 1-800-272-3921
- Contact: Tamara Busby

The LCA for Medicaid residents in Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant and Wise counties is the North Central Texas Council of Governments

- Call 1-877-229-9084 and ask for Tamara or Doni

LCAs for non-Medicaid and Medicaid residents are expected to coordinate with nursing facility staff and keep them apprised of residents' plans, if residents grant them permission. However, LCAs are expected to keep residents' plans confidential if the residents so request.



## **Timelines**

The facility is required to make referrals to the appropriate LCA within 10 days of conducting the MDS assessment. The LCA is required to respond to the referral within 14 days of receipt. However, it will make every effort to expedite its response if a resident's discharge is imminent.

## **Facilities' Responsibilities for Residents**

### **Who are Referred to the LCA**

After the facility makes a referral to the LCA for non-Medicaid or Medicaid residents, it retains responsibility for participating in the resident's discharge plan and is expected to partner with the LCA in arranging community-based services.

In most cases, the facility will assume primary responsibility for arranging home health and durable medical equipment. In most cases, the LCA for Medicaid residents will take the lead on finding affordable, accessible, and integrated housing.