MDS 3.0 Section Q Pilot Test

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Executive Summary

Purpose of the Pilot Test

The Minimum Data Set (MDS) is the nursing facility resident assessment instrument used for all nursing facility residents. The revisions to Section Q (Participation in Assessment and Goal Setting) gave CMS an opportunity to improve the identification of individuals in nursing facilities who want to get information about available options and supports for community living and to support individual choice. The revisions are designed to enhance the identification of candidates and strengthen the referral and transition process. Individuals identified for transition to community services in the Section Q process will be referred to local contact agencies to receive information about community choices and for assistance in transitioning to community living situations. State members of the Improving Transitions Work Group volunteered to pilot test the new Section Q of the MDS 3.0 and the return to community referral process to identify implementation and training issues prior to the nation-wide implementation of version 3.0 on October 1, 2010.

Pilot Test States

In January 2008, the Centers for Medicare and Medicaid Services (CMS) convened a work group of twelve volunteer states to provide input on the development and implementation of policies, procedures and tools used in transitioning individuals from institutional to community living situations, including changes to Section Q of the MDS 3.0. Work group members from three states volunteered to help pilot test the documents and process in the first round of testing. California, Connecticut and Texas conducted pilot tests beginning in late June 2009. New Jersey and Michigan are testing the documents and process in February and March 2010.

Observations of Participants and Lessons Learned

- The new Section Q item is sometimes helpful in identifying persons appropriate for transition. It is great at beginning a dialogue about who can, and who cannot, transition to community living.

- As part of implementing the new process, staff at one facility discussed the pilot test with the Family Members Council prior to beginning the new assessment/referral process. They were successful in explaining and obtaining an understanding by the Council of the purpose of asking the questions. They recommended other facilities use this technique.

- One nursing facility used asking the Section Q item as an opportunity to contact family members to engage them in the conversation. The facility staff recommended that other facilities incorporate this as a best practice.

- An important lesson learned by all three states was that in organizing the implementation of the pilot test, the roles and responsibilities of the designated local contact agency must be

clearly articulated. The local agency'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 facility to organize the transition to community living. The roles and responsibilities of the local contact agency should be described in contracts or memorandum of understanding, and training in the new functions is needed. The scope of clients covered, Medicaid and non-Medicaid eligibles, must be defined.

- All of the pilot test states found that they needed to develop a process to build effective working relationships and facilitate collaboration between nursing facilities and the local contact agencies in order to facilitate the implementation of this new referral connection. The state pilot test coordinators from Texas and California both recommended convening face-to-face meetings and frequent conferences between nursing facility staff and the local contact agency transition coordinators to organize functions and clarify roles and responsibilities of the participants.

- States found that disconnects in the referral process revealed the need for greater communication between the local contact agency and the nursing facility staff to coordinate their activities. In Connecticut the participants developed the Transition Challenges tool (Appendix 8) to further investigate the care needs of the individual and to provide a format for discussion between the nursing facility social worker and the transition coordinators. They also developed formal communication protocols to guide their activities.

- The referral-for-transition process revealed gaps in community support services in some states. In Connecticut, the process that identified gaps in services has initiated a dialogue with the Medicaid program about filling those gaps. In Texas, barriers to accessing community based services trigger a more extensive working relationship between the relocation specialist and the individuals who wants to relocate. The relocation specialist also works as the housing navigator and coordinates with all relevant community organizations including mental health authorities.

- An important conclusion of the pilot test was that not everyone requires a transition coordinator to assist in a discharge/transition process. A triage system to separate the routine post-hospital rehabilitation discharges and to identify individuals with more complex care needs is needed. Nursing homes need to identify their triage, discharge planning, and referral processes. NHs and local contact agencies need to develop protocols to adequately handle the scheduling and follow-up of the discussions with residents.

- Nursing facility assessors (MDS coordinators) in one state were disappointed with the transition services provided by the local contact agencies. They complained that the agencies did not provide timely information to the referred residents. This illustrates the need for a strong orientation program for local contact agencies prior to implementation of Section Q.

- States found success in working with their state nursing home associations to organize and recruit nursing facilities.

Caveats
The purpose of the pilot test was to obtain feedback about the process of using Section Q from a few of the future users of the new assessment forms and process. Comparable to a beta test, the test was not designed to provide statistics from which comparisons or generalizations could be made. The sample sizes are minute and the facilities were selected for convenience and not as representatives of a larger population.

Comparisons between states cannot be made based on these results. Each state has a different level of medical necessity for nursing facility admission and consequently differing levels of medical and functional complexity among it nursing facility residents. The states are at different stages in organizing programs to transition individuals to community living. The agencies recruited to coordinate transitions by each state differed in their experience and the roles and responsibilities varied widely across states. No training of nursing facility MDS assessors or local contact agency transition coordinators was provided.

The MDS 3.0 Section Q process should not be confused with the Medicaid Money Follows the Person (MFP) demonstration grant program. The MFP program is narrowly targeted to Medicaid clients, specifically to those Medicaid clients who have been residing in institutions (nursing facilities and ICF-MRs) for six months or longer. The MDS 3.0 process covers everyone in a nursing facility, Medicaid and non-Medicaid clients alike, and covers them from admission onward.

MDS 3.0 Section Q Pilot Test

Description of Pilot Test
State members of the Improving Transitions Work Group volunteered to assist CMS to pilot test this new Section Q process. Work Group members from three states, California, Connecticut and Texas, conducted pilot tests of the assessment forms and referral process beginning in late June 2009. Two other States, New Jersey and Michigan, are testing this process in February and March 2010. We are grateful to these administrators, nursing facility staff and local agency transition coordinators for their efforts on this project.

The purpose of the pilot test was? to assist in the development of training concepts and materials for the implementation of Section Q. The pilot test consisted of having the volunteer nursing facilities use the new MDS 3.0 Section Q assessment form (Appendix 1) whenever the MDS 2.0 assessment was administered in their facility. In addition, a follow-up instruction form called The Return to Community Referral Care Area Trigger Summary, (Appendix 2), that is suggested for nursing facility use was also tested.

In conducting the pilot tests, the state agency coordinators followed common steps in conducting the pilot tests:

1. Identify and recruit nursing facilities;
2. Coordinate with the state's nursing home association;
3. Identify and recruit local contact agencies;
4. Organize collaborative efforts between nursing facilities and local contact agencies;
5. Monitor progress and answered questions of participants;
6. Conduct end-of-pilot-test feedback conference calls; and
7. Collect and transmit forms and surveys to the researcher.

Nursing facilities completed an MDS 3.0 Section Q form for each individual administered an MDS during the pilot test period. They used a client referral tracking form (Appendix 3) and

filled out a Nursing Facility Staff Survey form (Appendix 6). State agency coordinators filled out an Implementation Survey form (Appendix 4). Local contact agencies were asked to fill out a Referral Tracking form (Appendix 5).

Feedback was obtained in two stages, after one-week by phone conference and by paper form survey, and at the end of the two-month pilot test by phone and paper form survey. Reporting of the results was uneven across states.

Background and Context for Section Q

In January 2008, the Centers for Medicare and Medicaid Services (CMS) convened a work group of twelve states[1] to provide input on the development and implementation of policies, procedures and tools used in transitioning individuals from institutional to community-living situations. The Improving Transitions Work Group, which provides ongoing input to CMS through monthly teleconferences, has addressed various projects, including: a Continuity Assessment Record and Evaluation (CARE) assessment tool, a Planning for Your Discharge checklist for consumers, and a Guide to Choosing a Nursing Home.

The Improving Transitions Work Group has devoted most of its time recently on the design, development and implementation of Section Q of the Minimum Data Set (MDS) 3.0. The revision of the Minimum Data Set, the nursing facility resident assessment instrument used for all nursing facility residents, gave CMS another opportunity to improve the transition of individuals from nursing facilities to community living and to support individual choice. The replacement of the MDS 2.0 with the MDS 3.0 is scheduled for October 1, 2010.

The MDS 3.0, used for all residents of Medicare/Medicaid facilities, will provide a standardized clinical and functional assessment, facilitate care management, support quality assurance and form the basis for prospective payment of nursing facilities by Medicare and by many states. The goals for the new version are to improve the efficiency, accuracy and validity of the tool, improve assessment measures, enhance resident-focused care planning and increase the resident's voice by introducing more resident interview items and improve communication and collaboration between institutional and community-based providers.

This 3.0 version includes CMS's response to requests by state officials and consumer advocates to improve the Discharge Potential item (Section Q) by asking residents about their preferences and needs for LTC options and supports, identifying candidates and strengthening the referral of, and transition of individuals to community living. The new Section Q item is more person-centered, better supports the individual's right to choose where they receive their long term care services and supports and reinforces states' efforts to comply with the Americans with Disabilities Act and the U.S. Supreme Court decision in Olmstead vs. L.C.

Section Q in the MDS 3.0 version, termed Participation in Assessment and Goal Setting, has been changed substantially. The Section Q item now asks the individual resident directly, as opposed to nursing facility staff making an assessment, "Do you want to talk to someone about

[1] California, Michigan, Georgia, Indiana, Alaska, Oklahoma, Washington, Connecticut, Missouri, Wisconsin, Arkansas, Texas.

the possibility of returning to the community." Section Q also asks if there is a discharge plan in place and if a referral has been made to the local contact agency. If the individual responds Yes, that they want to talk to someone, then the facility must initiate a care planning process and may refer the individual to a state-designated local contact agency. The new process will connect the dots in the transition process by initiating a referral to a local agency that can provide information about and help arrange community-based services to and for the individual.

The following table presents a comparison of Section Q in the MDS 2.0 version with the MDS 3.0 version.

Table 1. Changes to the MDS Section Q

MDS 2.0 (Then)	**MDS 3.0 (Now)**
Discharge Potential item asked the assessor if the resident expressed a preference to return to the community	Return to Community Referral item asks the individual if they are interested in speaking with someone about the possibility of returning to the community
Assessors findings recorded in database and no follow-up action required	If the individual responds Yes, then the facility must initiate care planning and may refer the individual to a state-designated local contact agency
Determined if the resident has a support person who is positive toward discharge	A more extensive series of questions for assessment and investigation for care planning are asked
Asked only upon admission and annually	Asked at admission, annually, quarterly and on significant change assessment

Changes in the MDS 3.0 Section Q are part of broader systematic efforts by CMS to support an individual's right to choose the services and settings in which they receive those services. This right became law under the American with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the Olmstead vs. L.C. decision in 1999. The ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments have a responsibility to enforce and support these choices. While an individual resident may choose to talk to someone about returning to the community at any time, the MDS 3.0 assessment process requires nursing facility staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives.

The changes also support the person- centered care planning goals of nursing facility care. They assist the individual in voicing their choices to maintain or achieving their highest level of functioning in the least restrictive setting. This includes ensuring that the individual or their designated representative is fully informed and involved in establishing care goals and expectations.

The MDS 3.0 will also assist States in their efforts to provide timely support to individuals expressing interest in a return to community living. States found it very difficult to use the stale information recorded in the MDS 2.0 database to support individual transitions.

New Opportunities for Transition Support

The new MDS protocol will initiate a process that will ask individuals if they would like to learn about the possibility of returning to the community and community care options for long term care (LTC) supports and services. Responses to the question can result in a nursing facility initiating discharge planning and/or contacting a state-designated local contact agency for individual residents stating that they want to talk to someone about the possibility of returning to the community.

A letter to State Medicaid Director's on October 28, 2008 requested state assistance in implementing this Section Q provision. CMS asked State Medicaid Directors to begin the process of designating local contact/referral agencies and to amend their Medicaid MDS Data Use Agreements (if necessary) to include the local contact agencies in the Data Use Agreement. The designated local contact agencies may be a single entry point agency, an Area Agency on Aging, an Aging and Disability Resource Center, a Center for Independent Living, or other state entity or contractor. In order to comply with the Privacy Act and the HIPAA rule, the Medicaid Data Use Agreement must be amended to include designated local contact entities as a custodian to be authorized to obtain individual named referrals from nursing facilities. After that letter was issued, the implementation date was postponed a year to October 1, 2010.

The discharge care planning will initiate collaboration between the nursing facility and the local contact agency to support the individual's stated interest in transitioning to community living. This collaboration will enable the local contact agency to initiate communication by telephone or visit the individual to talk about opportunities for a return to community living.

CONNECTICUT

Connecticut was a strong proponent for, and the first state to volunteer to participate in, the pilot test of Section Q. The Money Follows the Person project director coordinated the state's pilot test. Two nursing facilities, one specializing in individuals with HIV/AIDS, volunteered to participate. The local Dedicated Transition Coordinators under contract to the Medicaid Money Follows the Person program office were the designated transition coordinators. A total of 60 individuals in the two facilities received a Section Q assessment along with their usual MDS 2.0 assessment during the test period.

Nursing Facility Recruitment Strategies	• The co-chair of the Money Follows the Person project steering committee, who is a nursing facility administrator, volunteered to have her facility participate. • The nursing home associations were contacted seeking participation of their member organizations in the pilot test. One facility was identified through this process but was not able to participate. • Another nursing facility was recruited after personal contact by the Money Follows the Person project director and they volunteered to participate. • The two nursing facilities participating in the pilot test were Leeway, New Haven and Parkway Pavilion, Enfield.
Identifying Local Partners	• For purposes of the Section Q pilot test, the single point for referrals was the state Medicaid agency Money Follows the Person unit. The

	Money Follows to Person unit takes all referrals, does all of the initial screens including verification of income and identity, enters the information into a web based data collection system and then assigns the referral to Dedicated Transition Coordinators at the local level for transition planning. • Connecticut contracts with several local agencies under their Money Follows the Person project for the provision of transition coordination services by Dedicated Transition Coordinators. Twenty full-time staff are funded under the Money Follows the Person project and an additional eight staff positions are funded to transition persons not eligible for Money Follows the Person. Medicaid designated these contractors as the local contact agencies for the pilot test. • This connection between nursing facilities and the Dedicated Transition Coordinators is not a new relationship, but the scope of persons served was expanded for the pilot test. There is a well established referral relationship between nursing facilities and Dedicated Transition Coordinators, handling 850 Money Follows the Person program referrals in seven months during 2009. The pilot test added non-Medicaid funded clients to the scope of client coverage. Under the referral protocol established for the pilot test, everyone asking to talk to someone about returning to the community gets a face-to-face visit by a Dedicated Transition Coordinator. • There was some initial confusion about referrals from nursing facilities to local contact agencies as the referral process was not clear. Nursing facility staff did not understand the local contact agency designation and they were referring to multiple local agencies, such as home health agencies. The state had not clearly defined the Medicaid office as the single point of referral. The project coordinator contacted them to clarify the referral path to the Medicaid office with the Dedicated Transition Coordinators.
Collaboration and Communication Strategies	• In gathering feedback about the ongoing operation of the pilot test project, the participants determined that improvements needed to be made. They learned that nursing facility social workers did not feel sufficiently engaged in the transition process by merely making a referral telephone call. In order to improve collaboration between nursing facilities and the local contact agencies, they convened a work group to address the issue. • A meeting was convened with transition coordinators and nursing facility staff in August 2009 to develop a screening tool and triage process to streamline the system. • The Transition Challenges tool that was developed is attached in Appendix 8. This tool is intended to better engage nursing facility social workers in the process. The web-based document is used both for data collection and to inform transition planning efforts. Challenges are identified and then linked to the care planning document where a planned intervention will be described. The tool

	will assure that challenges are addressed in care planning and responsibilities for resolution are assigned. It also provides the opportunity for nursing home social workers to assist with challenge identification. The social workers using the new form feel it is helpful and has improved coordination and collaboration.
Results of Pilot Test[2]	• Of the 60 total assessments given, 78 percent of individual residents participated in the assessment. 27 percent had family or significant others participate in the assessment. • At admission, 75 percent of the individuals expect to be discharged to the community. • 48 percent of individual residents assessed did have an active discharge plan. • For those individuals without an active discharge plan (n=31), the resident and care planning team indicated that discharge to the community was not feasible for 74 percent (23 individuals). • 18 percent of those assessed (11 individuals) answered Yes, they did want to talk with someone about the possibility of returning to the community. • 25 percent of those assessed (15 individuals) were referred to the local contact agency. o More individuals were referred (15) than answered Yes (11) because several individuals had an active discharge plan in place (item Q0400B = 1), and were not asked item Q0500B, (If they wanted to talk with someone about the possibility or returning to the community).
Challenges	• The future operational challenge for Connecticut is determining which agency to designate as the local contact agency when full statewide implementation begins in October 2010. Should the nursing facilities refer to the to the local Single Entry Point agency which usually deals with individual residents only if they need a Home and Community Based Services program care plan or should the referral be to the state-level Dedicated Transition Coordinator that routinely deals with more complex community placements? • During the pilot test, the Dedicated Transition Coordinator process added two weeks to the normal referral process. In that process, after initially being contacted, the State Medicaid agency sends referrals to the local Dedicated Transition Coordinators within a week. The local agency has 3 days to contact the person and 2 weeks to complete the initial screen. The Medicaid agency is preparing to pilot test a new fast track transition process to shorten this time period, based on what they have learned over the past few months. • Once the referral path was determined, Connecticut faced additional

[2] The tabulations for responses on the MDS 3.0 Section Q form for the combined Connecticut nursing facilities are displayed in Appendix 7.

	challenges related to system capacity. The Dedicated Transition Coordinators had difficulty responding to the number of referrals made to them. • The pilot test also revealed a lack of available community support resources, (e.g., housing, availability of Visiting Nurse Association staff hours, alcohol and drug treatment, addiction services, mental health services, etc). The process has identified gaps in services and has initiated a dialogue with Medicaid about filling those gaps.

TEXAS

The Money Follows the Person project director in the Texas Department of Aging and Disability Services volunteered for Texas. Three nursing facilities, recruited through the nursing home associations, volunteered. The project director then recruited three associated Money Follows the Person Relocation Contractor agencies (local contact agencies) to participate in the project. The pilot test ran for two months from July 20 to September 20, 2009. Eighty individual residents in the three facilities received the Section Q assessment during that time period.

Much of the information obtained from the Texas pilot project came from the progress report conference calls with all of the participating nursing facilities. Texas conducted an organizing and feedback conference call for participating nursing facilities at start-up and an end-of-pilot-test conference call.

Nursing Facility Recruitment Strategies	• The pilot test project coordinator in Texas contacted the Texas nursing home association directly to obtain three volunteer nursing facilities in different areas of the state. The facilities were: The Park in Plano, Park Manor in Tomball, and Autumn Winds Retirement Lodge in Schertz, Texas.
Identifying Local Partners	• Texas has divided the state into six catchment areas for statewide coverage by relocation contractors. These contractors then sub-contract with relocation specialists. Texas has contracts with four Centers for Independent Living (one Center covers two catchment areas) and one Council of Governments-Area Agency on Aging to support their Money Follows the Person program. The relocation specialist contractors in each of the areas served by the three participating nursing facilities were recruited to serve in the pilot test. The pilot test functions were an expansion of their existing responsibilities to a broader client population.
Collaboration and Communication Strategies	• The Texas pilot test generated a suggestion for smoothing implementation by having regularly scheduled face-to-face meetings between the nursing facilities and transition agencies. These meetings can foster collaboration between the parties to support individual's choices.
Results of Pilot	• Of the 43 individuals receiving an MDS during the two month period

Test[3]	at the Park at Plano facility, 41 of those (95 percent) said No, they did not want to speak to someone about the possibility of returning to the community. • Two individuals (or 5 percent) said Yes and were referred to the North Texas Council of Governments-Area Agency on Aging relocation specialist contractor. • Of the 36 individuals assessed at the Park Manor Tomball facility, two individuals (5 percent) said Yes they would like to talk to someone about the possibility of returning to the community. They were referred to the Houston Center for Independent Living. o One of those individuals received a community placement in an assisted living facility and the other individual declined community services. • At the Autumn Winds Retirement Lodge, one individual received an MDS assessment after returning from the hospital. There was no referral and no placement.
Challenges	• The interview process raised an issue for some assessors. They found it difficult to ask, 'Do you want to talk to someone about the possibility of returning to the community?' if in their opinion the resident was truly not a candidate for returning to the community. They were concerned that, depending on the individual's circumstances, posing the question may raise false hope in the individual. Another Texas facility reported that the Section Q items were handled well by the residents. For them, asking the Section Q item questions did not stir any negative reaction.

CALIFORNIA

The California pilot test was a collaborative effort led by the Center for Health Care Quality, California Department of Public Health and the Division of Long Term Care in the California Department of Health Care Services. Three nursing facilities in different parts of the state and three Aging and Disability Resource Connection agencies conducted the pilot test from June 1 to July 31, 2009. Over 200 individual residents received an MDS 3.0 Section Q assessment during that period.

Nursing Facility Recruitment Strategies	• Nursing facilities were recruited to participate in the pilot test with the assistance of the California Association of Health Facilities, a professional association of for-profit nursing facility administrators. The professional association for non-profit facilities was contacted and invited to participate, but did not respond. Contact with the nursing home associations was done by telephone and email. • The pilot test participant volunteers were: Somerset Special Care

[3] Individual Section Q forms were not obtained from Texas

	Center, El Cajon (San Diego County); Windsor Chico Creek Care and Rehabilitation**,** Chico; and Mount Rubidoux Convalescent Hospital, Riverside.
Identifying Local Partners	• The state's Aging and Disability Resource Connection (ADRC) agencies for the three areas served by the volunteer nursing facilities were recruited through the Office of Long Term Care in the California Department of Health Care Services. • The Aging and Disability Resource Connection agencies were located in San Diego County, Butte County, and Riverside County. This was a new relationship between the nursing facilities and the local Aging and Disability Resource Connection agencies.
Collaboration and Communication Strategies	• Efforts to organize a referral relationship between the nursing facilities and the Aging and Disability Resource Connection agencies participating in the pilot project were not successful despite two joint teleconferences with pilot participants. Without an ongoing relationship, this left the nursing facility contacting the Aging and Disability Resource Connection agency on an *ad hoc* basis for each individual resident situation. Only one Aging and Disability Resource Connection agency representative stated that there was routine contact by the agency with local nursing facilities to offer assistance or services. In California, the Aging and Disability Resource Connection agencies had built strong, ongoing relationships and had frequent contact with discharge planners in the general acute care hospitals, but not with nursing facilities.
Results of Pilot Test[4]	• 104 MDS Section Q forms were completed. • 2 residents were admitted by their families for short-stay respite care, the discharge plan for each was to return home to their families, and no referral was made. • 4 residents were short-stay residents for chemotherapy, speech therapy, improvement in activities of daily living, and recovery from rib fracture. The discharge plan was to return to their homes, and no referral was made during this time interval. • 1 resident had a discharge plan, but Q0500 Return to the Community was left blank, and no referral was made. • 97 residents (93 percent) when evaluated received a determination that return to the community was not feasible.[5]
Challenges	• Nursing facility staff participating in the pilot test reported that their experience in referring clients to the Aging and Disability Resource Connection agencies was disappointing. They reported that the

[4] Section Q responses were collected and tabulated by Mount Rubidoux Convalescent Hospital for the pilot test period of June 1, 2009 to July 31, 2009: Data was not submitted from the other two California facilities.

[5] The reasons for the residents to remain in the nursing facility included the following: inability to care for self/total care with all activities of daily living including dialysis; dementia with wandering/cognitive impairment; no support person or family caregivers; close supervision for craniotomy with radiation therapy; and unstable mental capacity or psychiatric condition with hallucinations.

	Aging and Disability Resource Connection referral process was not effective because the local contact agency did not provide timely information about choices of community services. An MDS Coordinator from one of the participating nursing facilities stated that the one referral that they did make to an Aging and Disability Resource Connection agency took a whole day to research when it could have been handled by a single phone call. • The isolation of the individual representatives in the nursing facilities and their workloads have limited their ability to interact with the Aging and Disability Resource Connection agencies. This resulted in very limited information about the services and capabilities of the Aging and Disability Resource Connection agencies. With this limited awareness of the range of services that can be offered by the Aging and Disability Resource Connection agencies, the nursing facilities do not view the Aging and Disability Resource Connection agencies as useful referral resources. There was no connectivity in this referral process. • The nursing facilities also reported serious barriers to transitioning individuals because of funding cuts. Resources were lacking for living accommodations deposits, personal care services, and in-home supply services. Residents cannot apply for services until they are discharged from the nursing facility. • Home health agencies are usually quick responders when called upon for services, but the agencies that would accept the federal reimbursement level refused the admission of residents with complex histories, such as drug abuse.

<u>Observations by Participants from all States</u>

- The new Section Q item is sometimes helpful in identifying persons appropriate for transition. It is great at beginning a dialogue about who can, and who cannot, transition to community living.

- Texas nursing facilities reported no difficulties in interviewing individuals to administer the Section Q item. Conducting the pilot test, explaining and clarifying the content, took about 10-15 minutes for each resident.

- One of the facilities reported that more people said No to Q500B than expected. They observed that most individual residents knew their condition and were more realistic than they expected.

- Another nursing facility assessor questioned the frequency requirement for administering Section Q. They said that asking Item Q during the initial and annual assessment was appropriate. But that asking Item Q at the quarterly assessment was too often, and asking Item Q during a Change in Status assessment, if it was a decline in status, was not appropriate.

- Nursing facility assessors in Connecticut reported the new Section Q form was okay to use, but that it was difficult for them to ask the questions of those individuals that are permanently in the facility. They felt uncomfortable 'misleading' clients who had no discharge potential. A nurse assessor in Texas reported the same concern. She was concerned that the interview process may raise 'false hope' in some individuals.

- Nursing facility staff in Connecticut reported that they already had a routine system for discharge planning for short-term rehabilitation clients. Section Q would have little impact on them. They were already doing routine discharges. Section Q may be most useful in identifying those long-stay nursing facility clients whose functioning improves over time.

- The nursing facility staff completed the Return to Community Referral Care Area Trigger Follow-up checklist and form without difficulty.

- The local contact agency transition coordinators were good about seeing the referred residents, but they sometimes made appointments with the individual resident without notifying the nursing facility. This revealed the need for greater communication between the local contact agency and the nursing facility staff.

- The California nursing facility MDS Coordinators were frustrated with the lack of responsiveness and services provided by the Aging and Disability Resource Connection agencies.

- California found willing cooperation from the for-profit nursing home association. Their opinions and participation are considered quite valuable. The state agency's coordination with the nursing facility professional association has expanded and indicates a good working relationship in the future. The professional organization representatives are well-equipped, well-trained, and eager to work with the state agency.

- Texas reported having great working relationships with its two nursing home associations (for-profit and non-profit). They were extremely cooperative in the process.

Lessons Learned

1. Designating Local Contact Agencies
    - The pilot test states encountered different problems to address as implementation progressed based on the scope of work of the designated local contact agency. For example, Texas found that the scope of clients covered by the designated local contact agency was expanded beyond the Medicaid clients that they were used to serving. Connecticut found that the scope of practice of the Dedicated Transition Coordinators, which had been focused on dealing with the more complex transition situations of Money Follows the Person program clients, was too intense and too slow in responding for the clients identified through the Section Q process. California found that the Aging and Disability Resource Connection agencies were experienced with clients from all payer

sources, but they were not experienced in transitioning nursing facility clients and a new scope of work and new provider relationships for these agencies was needed.

The lessons learned were:

a. The roles and responsibilities of the local contact agency must be clearly defined. The local agency'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 facility to organize the transition to community living;
b. Describing their roles and responsibilities in contracts or memorandum of understanding may be helpful, and training in the new functions is needed;
c. The individuals referred through the Section Q process may be Medicaid or non-Medicaid eligible.

2. Communication within Nursing Facilities

- Some of the nurse assessors in nursing facilities found it difficult to ask, 'Do you want to talk to someone about the possibility of returning to the community?' if in their opinion the resident was truly not a candidate for returning to the community. They were concerned that, depending on the individual's circumstances, posing the question may raise false hope in the individual.

  The lesson learned is that while most nurse assessors reported that the Section Q items were handled well by the residents and asking the Section Q item questions did not stir any negative reaction among residents, some coordinators reported that they were concerned. MDS 3.0 has changed the nature of the assessment from obtaining the assessor's observations to interviewing the individual resident directly. This new, person-centered approach is a paradigm shift and will take adjustment. This issue will be addressed in the training for the new interview process for the MDS 3.0. Messages to include are: the questions are routine questions asked of everyone, and assessors need to support the rights of the individual for self-determination with clear communication about opportunities.

- As part of implementing the new process, staff at one facility discussed the pilot test with the Family Members Council prior to beginning the pilot test. They were successful in explaining and obtaining an understanding by the Council of the purpose of asking the questions. They recommended other facilities use this technique.

- Another facility assessor questioned the frequency requirement for administering Section Q. Asking Item Q during the initial and annual assessment seemed appropriate, but asking Item Q at the quarterly assessment was too often. And thought asking Item Q during a change in status assessment, if it was a decline in status, was not appropriate.

  Skip patterns are designed into the series of questions to address this issue and help focus questions appropriately. For example, Q0400 A asks if there is an active discharge plan already in place for the resident to return to the community. If there is an active discharge plan, then there is a skip to Q0600 (Referral) and Q0500 does not get asked.

Also, Q0400 B asks if a determination was made by the resident and the care planning team that discharge to the community was/was not feasible. If not feasible, then there is a skip to the next Section (R). These skip patterns guide the questions to the appropriate circumstances, assuring that individuals have choice and they are asked questions appropriate to them.

- One facility used asking the Section Q item as an opportunity to contact family members to engage them in the conversation. The facility staff recommended that other facilities incorporate this as a best practice.

3. Communication between Nursing Facilities and Local Contact Agencies
   - Confusion about referrals to local contact agencies and lack of responsiveness by local contact agencies were the biggest difficulty encountered in implementing the pilot test. For example, in Connecticut, the referral process was not clear when the project first started. Nursing facility staff did not understand the local contact agency designation or its role in contacting and transitioning individuals.

     All of the pilot test states found that they needed to develop a process to facilitate collaboration between nursing facilities and the local contact agency. The state pilot test coordinators from Texas and California both recommended convening face-to-face meetings between nursing facilities and the local contact agency transition coordinators to organize functions and clarify roles and responsibilities for the participants.

   - In Connecticut, feedback from participants about the operation of the pilot test revealed two problems. They found that transition coordinators were good about seeing the referred residents, but the transition coordinators sometimes made appointments with the individual resident without notifying the nursing facility. They also learned that nursing facility social workers often felt excluded from the transition process. This revealed the need for greater communication between the local contact agency and the nursing facility staff to coordinate their activities.

     A work group of all participants was convened to analyze and improve the referral process. Convening the participants around these issues created an opportunity to build a stronger relationship between the parties. They developed the Transition Challenges tool (Appendix 8) to provide a format for discussion between the nursing facility social worker and the transition coordinators. And they developed formal communication protocols to guide their activities.

4. Gaps in Resources
   - The referral-for-transition process revealed gaps in community support services in all states. In Connecticut, the gaps mentioned were in housing, Visiting Nurse Association hours, alcohol and drug treatment for addiction services, and mental health services. In California, the nursing facilities reported serious barriers to community placements because of funding cuts. Funding for living accommodations deposits, personal care services, and in-home supply services have had their funding decreased.

In Connecticut, the process that identified gaps in services has initiated a dialogue with the Medicaid program about filling those gaps. In Texas, barriers to accessing community based services trigger a more extensive working relationship between the relocation specialist and the individuals who wants to relocate. The relocation specialist also works as the housing navigator and coordinates with all relevant community organizations including mental health authorities.

5. Appropriate Targeting Strategies

- An important conclusion was that not everyone requires a Relocation Specialist to assist in the transition process. In the Connecticut structure, a triage system was needed because Money Follows the Person transition coordinators were not always the appropriate referral agency. The participants developed the Transition Challenges tool to provide a format for discussion between the nursing facility social worker and the transition coordinators.

  Participants in the Section Q process will need to develop triage protocols to handle this situation.

6. Organizing for Implementation

- Experience gained during implementation of the pilot test generated several suggestions for improving the implementation process. Building effective working relationships between program participants (nursing facility and local contact agency staff) at the local level is essential. Also, clearly defining and valuing everyone's role supports collaborative efforts.

  The state agency coordinators recommend face-to-face meetings and frequent conferences between the nursing facilities and the local contact agencies in the local communities as being critical to a smooth implementation of this new referral connection.

- Nursing facility assessors (MDS coordinators) in one state were disappointed with the services provided by the local contact agencies. They complained that the local contact agencies did not provide timely information to the referred residents.

  This illustrates the need for a strong orientation program prior to implementation of Section Q for the local contact agencies.

7. Collaboration with State Nursing Home Associations

   All three states found value in working with their state nursing home associations to organize and recruit nursing facilities.

MINIMUM DATA SET (MDS) 3.0

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code

A. Resident participated in assessment
0. **No**
1. **Yes**

Enter Code

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code

C. Guardian or legally authorized representative participated in assessment
0. **No**
1. **Yes**
9. **No guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310F = 1

Enter Code

A. Select one for resident's overall goal established during assessment process.
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If **n**ot resident, family or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code

A. Is there an active discharge plan in place for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code

B. What determination was made by the resident and the care planning team that discharge to community is feasible?
0. Determination not made -
1. **Discharge to community** determined is **feasible** – Skip to Q0600
2. **Discharge to community** determined is **not feasible** – Skip to next active section

Q0500. Return to Community

Enter Code

A. Has the resident been asked if s/he wants to talk to someone about the possibility of returning to the community?
0. **No**
1. **Yes** – previous response was **"no"**
2. **Yes** – previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** – previous response was **"unknown"**

Enter Code

B. Ask the resident (or family or significant other if resident is unable to respond)**: "Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
2. **Unknown or uncertain**

Q0600. Referral

Enter Code

Has a referral been made to the Local Contact Agency?
0. **No** – determination has been made by the resident and the care planning team that contact not required.
1. **No** – referral not made
2. **Yes**

Appendix 2

RETURN TO THE COMMUNITY REFERRAL
Care Area Trigger Summary

INTRODUCTION

Triggers identify residents who have or are at risk for developing specific functional problems and require further evaluation. A care area trigger (CAT) provides a starting point for the facilities to perform care planning and should be used in combination with other care planning information. This optional protocol provides guidelines embedded in checklists and an analysis of findings section, which were developed under CMS contracts. Alternatively, a facility may identify its own care planning protocols and tools for residents and their families based on their experience with existing care planning approaches and software, identify evidence based research protocols and tools, work with experts or software vendors to create customized care planning systems, utilize an integrated electronic medical record (EMR) data systems, etc. Chapter 4 of the Resident Assessment Instrument Manual discusses the minimum data set (MDS) triggering mechanism, defines CAT triggers and linking the assessment to the care plan.

This CAT Return to the Community Referral summary focuses on residents who want to talk to someone about returning to the community. The CAT triggers include: the resident goal that he/she expects to be discharged to the community (Item Q0300A1); the resident and care planning team determine discharge to the community is feasible (Item Q0400B1); and the resident (or their family or significant other if resident is unable to respond) wants to speak to someone about the possibility of returning to the community (Item Q0500B1). All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the Olmstead vs. L.C. decision in 1999. The ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments have a responsibility to enforce and support these choices. An individual in a nursing home can choose to leave the facility at any time. An individual can request to talk to someone about returning to the community at any time. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives. The discharge planning goal of nursing home care is to assist the individual in maintaining or achieving the highest level of functioning. This includes ensuring that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing comprehensive plan of care interventions, interdisciplinary coordination, fostering independent functioning, using rehabilitative programs, and community referrals.

Expectations about returning to community living are unique for each individual. An individual may expect to return to his or her former home or return to a different community home, or the individual may identify a desire to stay in the nursing home. Each person's level of understanding about his or her health status and needs for physical assistance as well as the availability of family and other supports also varies. This CAT summary enables the facility staff to directly open the discussion about the individual's preferences for service settings.

When the Return to Community Referral CAT is triggered, this summary helps assess the situation and begin appropriate care planning, discharge planning, and other follow-up measures. The goal is to initiate and maintain collaboration between the nursing facility and the local contact agency to support the individual's expressed interest in being transitioned to community living. This includes facility support

for the individual in achieving his or her highest level of functioning and the involvement of the designated contact agency providing informed choices for community living. This collaboration will enable the State-designated local contact agency to initiate communication by telephone or visit with the individual (and his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.

Return to Community Referral Follow-up

Step 1: Follow the items below to assist with the individual's stated desire to return to community living. Step 2: Check the box in the left column when the item has been completed. Step 3: Analyze your findings in the context of further follow-up required for this individual. Step 4: Communicate findings and concerns to the physician.

Review of Return to Community Referral

✓ **Steps in the Process**

☐	1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not.
☐	2. Interview the individual and his or her family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual's smooth transition to community living.
☐	3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include: • Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700-C1100) • Functional/mobility (G0110) or balance (G0300) problems
☐	4. Inform the discharge planning team and other facility staff of the individual's choice.
☐	5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual's overall goals of care from a previous Item Q0300 response. Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home after rehabilitation in your facility?
☐	6. Initiate contact with the State-designated local contact agency within 10 business days.
☐	7. If the local contact agency does not contact the individual by telephone or in person within 10 business days, make another follow-up call to the designated local contact agency as necessary.
☐	8. Communicate and collaborate with the State-designated local contact agency on the discharge process. Identify and address challenges and barriers facing the individual in their discharge process. Develop solutions to these challenges in the discharge/transition plan.
☐	9. Communicate findings and concerns with the facility discharge planning team, the individual's support circle, the individual's physician and the local contact agency in order to facilitate discharge/transition planning.

Return to Community Referral Follow-up

Analysis of Findings
Conclusions about return to the community for this individual:
Factors that complicate the situation for this individual:
Risks for this individual related to these findings:
Referrals to other health professionals or community entities related to return to the community:

Appendix 3

Nursing Facility Tracking Form
MDS 3.0 Section Q Return to Community Referral Pilot Test
Name of Nursing Facility _____
Date Tracking Began: _____
Date Tracking Ended: _____
How many total MDSs were completed during this time period? _____

Instructions: Please complete a row on this form for each individual responding Yes to Item Q 500 B.

Date individual, family or representative said Yes to Item Q 500 B	Client name*	Date referral made to local contact agency	Date individual or family contacted by local contact agency	Type of Contact: by phone, in-person visit	Outcome: Client discharged, client considering, client needs community plan of care, client needs community services to be arranged, etc.

* Client names are for pilot test tracking purposes only.

Appendix 4
MDS 3.0 Section Q Pilot Test
Section Q Return to the Community Referral Tracking Form (Local Contact Agency)
Name of Agency _____
Date Tracking Began: _____
Date Tracking Ended: _____
Instructions: Complete a row in this form for each client referred by a pilot test nursing facility.

Client Name *	Date contacted by Nursing Facility	Date individual contacted by Local Contact Agency	Nature of Contact (Phone, Visit, Mail info)	Follow-up Actions: Referral to services, Community Plan of Care developed, …	Outcome: Client placed, client considering, client chose to remain, necessary community services not available, etc.

* Client names are for pilot test tracking purposes only.

Appendix 5
State Implementation Coordination Effort Questionnaire
MDS 3.0 Section Q Return to Community Referral Pilot Test
Beta Test; June 15, 2009

Thanks you very much for participating in this pilot test of the new Section Q of the MDS 3.0. The information you provide will help CMS improve the implementation of this new process scheduled for October 2010. We are hoping to learn more about how to make the return to community referral and follow-up process person-centered and effective.

As a State pilot test coordinator please complete this survey form after seven full days of operation of the pilot test and send it to the pilot test coordinator (Dann Milne), as an email attachment (you don't have to leave the lines in). We will be asking you to complete a similar survey after the entire 2-3 month pilot test is completed. The information obtained may be used to inform the instructions and training for implementation of the MDS 3.0 Section Q.

---

1. Briefly describe how your state's Section Q referral and follow-up process is structured. (i.e., organization names, populations covered, process description, etc.)y

   _____

   _____

2. How did you identify and recruit <u>local contact agencies</u> (Aging and Disability Resource Centers, single entry point agencies, or relocation specialist contractors) to participate in the pilot test?

   _____

   _____

3. What are your suggestions for improving this process?

   _____

   _____

4. How did you identify and recruit <u>nursing facilities</u> to participate in the pilot test?

   _____

   _____

5. Did you coordinate with your state's nursing home associations?

   _____

   _____

6. What are your suggestions for improving this process?

   _____

   _____

7. Is this a new relationship between local agencies, or is it an expansion of existing responsibilities? Please explain.

_____

_____

8. How did the nursing facility and the local contact agency organize their collaborative effort?

_____

_____

9. What are your suggestions for smoothing the implementation of this new/existing connection?

_____

_____

10. Are there barriers in the system to this referral process? Please explain.

_____

_____

11. How can this referral contact and follow-up process to support individuals desiring to transition to community living be improved?

_____

_____

12. Does the local contact agency provide timely information about choices of community services? Please explain:_____

_____

13. How does the local contact agency determine the need for a face-to-face visit with the candidate for transitioning to the community?

_____

_____

14. How can the local contact agency better integrate this contact follow-up process into their operations?

_____

_____

15. Other comments or suggestions:

_____

_____

Appendix 6
Nursing Facility Staff Questionnaire (for NF staff: MDS coordinators and social workers)
MDS 3.0 Section Q (Return to Community Referral) Process Pilot Test
Beta Test; June 15, 2009

Thanks you very much for participating in this pilot test of the new Section Q of the MDS 3.0. The information you provide will help CMS improve the implementation of this new process scheduled for October 2010. We are hoping to learn how to make the return to community referral and follow-up process person-centered and effective.

To be completed jointly by the nursing facility MDS coordinator and (social work) staff involved in coordinating the transitions of individuals to community living. Please complete this survey after the first 7 days of pilot test operations. Then transmit it to your State pilot test coordinator. We will be asking you to complete a similar survey after the entire 2 month pilot test is completed.

Questions about the new Section Q:

1. Were there difficulties or challenges in asking these questions of the individual, family or significant other? Yes/No.
2. What were the challenges in asking these questions?

   _____

   _____

   _____

3. Is it difficult to follow the procedures and take action based on the questions in Section Q? Yes/No
4. Are there barriers to these actions or systems problems within the nursing facility?

   _____

   _____

   _____

5. Is this Item Q useful in identifying candidates for transitioning to community living? Yes/No.
6. If not, please explain.

   _____

   _____

   _____

7. How can we improve identification of nursing facility residents desiring to return to community living?

   _____

   _____

   _____

8. How do you organize the team that communicates and coordinates with the individual resident and his/her family and with the local contact agency (Aging and Disability Resource Center or single entry point agency)?

_____

_____

_____

9. What does the nursing facility staff do when they receive a Yes response to Item Q 500 B.

_____

_____

_____

General Questions:

10. What suggestions do you have for improving the nursing facility's return to community care planning and referral process?

_____

_____

_____

11. How do the nursing facility and the local contact agency organize their collaborative efforts?

_____

_____

_____

12. What suggestions do you have for improving the referral and follow-up process with the local contact agency?

_____

_____

_____

13. What follow-up measures by the local contact agency are the most effective?

_____

_____

_____

Thanks again for your assistance in this pilot test study.

Appendix 7

Section Q Tabulations, Combined Connecticut Nursing Facilities, n = 60

Q0100. Participation in Assessment	Number	Percent
A. Resident participated in assessment		
0. **No**	13	22
1. **Yes**	47	78
B. Family or significant other participated in assessment		
0. **No**	43	73
1. **Yes**	16	27
9. **No family or significant other**		
C. Guardian or legally authorized representative participated in assessment		
0. **No**	41	68
1. **Yes**	6	10
9. **No guardian or legally authorized representative**	13	22
Q0300. Resident's Overall Expectation		
A. Select one for resident's overall goal established during assessment process.		
1. **Expects to be discharged to the community**	45	75
2. **Expects to remain in this facility**	10	17
3. **Expects to be discharged to another facility/institution**	2	3
9. **Unknown or uncertain**	3	5
B. Indicate information source for Q0300A		
1. **Resident**	45	75
2. **If not resident, then family or significant other**	6	10
3. **If not resident, family or significant other, then guardian or legally authorized representative**	3	5
9. **None of the above**	6	10
Q0400. Discharge Plan		
A. Is there an active discharge plan in place for the resident to return to the community?		
0. **No**	31	52
1. **Yes** → Skip to Q0600, Referral	29	48
B. What determination was made by the resident and the care planning team that discharge to community is feasible?		
1. Determination not made –	4	7
2. **Discharge to community determined is feasible** – Skip to Q0600	4	7
3. **Discharge to community determined is not feasible** – Skip to next active section	23	38
Q0500. Return to Community		
A. Has the resident been asked if s/he wants to talk to someone about the possibility of returning to the community?		
0. **No**	17	28
1. **Yes** – previous response was **"no"**	12	20
2. **Yes** – previous response was **"yes"** → Skip to Q0600, Referral	2	3
3. **Yes** – previous response was **"unknown"**	1	2
B. Ask the resident (or family or significant other if resident is unable to respond)**: "Do you want to talk to someone about the possibility of returning to the community?"**		
0. **No**	17	28
1. **Yes**	11	18
2. **Unknown or uncertain**	1	2
Q0600. Referral		
Has a referral been made to the Local Contact Agency?		
0. **No – determination has been made by the resident and the care planning team that contact not required.**	17	28
1. **No – referral not made**	28	47
2. **Yes**	15	25

Appendix 8
Transition Challenges
Connecticut Nursing Facility Discharge Coordination

☐ Physical health
- Current, new, or undisclosed physical health problem or illness[i]
- Medical testing issues or delays[ii]
- Inability to manage physical health or illness in community[iii]
- Missing or waiting for physical health related documents or records
- Other physical health issues (describe) _____

☐ Mental health or mental illness
- Current, new, or undisclosed mental health problem or illness[iv]
- Current or history of substance/alcohol abuse with risk of relapse[v]
- Dementia or cognitive issues[vi]
- Inability to manage mental health/illness in community[vii]
- Other mental health/illness issues (describe) _____

☐ Financial or insurance benefits
- Lack of or insufficient financial resources[viii]
- Consumer credit or unpaid bills[ix]
- SSDI, SSI, SAGA, SSA, VA, or other cash benefits[x]
- Other financial benefits or issues[xi]
- Insurance issues[xii]
- Other financial issues (describe) _____

☐ Consumer engagement, awareness, and skills
- Disengagement or lack/loss of motivation[xiii]
- Lack of awareness or unrealistic expectations regarding disability or needed supports[xiv]
- Lack of independent living skills[xv]
- Language or communication skills[xvi]
- Other consumer related issues (describe) _____

☐ Services and supports
- Lack of transportation[xvii]
- Lack of PCA, home health, or other paid support staff[xviii]
- Lack of mental health services or supports (in facility or in community)[xix]
- Lack of alcohol, substance abuse, or addiction services (in facility or in community)[xx]
- Lack of assistive technology or durable medical equipment (excluding home modifications)[xxi]
- Lack of any other services or supports[xxii]
- Other issues related to services or supports (describe) _____

☐ Waiver program
- Targeted waiver full
- Ineligible for or denial of waiver services
- Current waivers do not meet consumer needs[xxiii]
- Waiting for evaluation, application review, or response from waiver agency/contact
- Other waiver program issues (describe) _____

☐ Housing
- Lack of or insufficient housing[xxiv]
- Ineligible for or waiting for approval from RAP or other housing programs
- Housing modification issues[xxv]
- Delays related to housing authority, agency, or housing coordinator
- Delays related to lease, landlord, apartment manager, etc.
- Other housing related issues (describe) _____

☐ Legal or criminal
- Consumer criminal history[xxvi]
- Probate court issues[xxvii]
- Missing or waiting for identity, birth certificate, or other related records
- Legal representative issues[xxviii]
- Other court or legal issues (describe) _____

☐ Facility related
- Facility staff or administration issues[xxix]
- Waiting for, loss of, or absence of discharge planning
- Evaluation of consumer by facility issues[xxx]
- Other facility related issues (describe) _____

☐ Other involved individuals
- Issues with spouse/partner, family, or friends[xxxi]
- Physical health provider/doctor opposed, unsupportive, or unresponsive
- Mental health provider/doctor opposed, unsupportive, or unresponsive
- Other provider or state agency opposed, unsupportive, or unresponsive[xxxii]
- Other issues related to involved individuals (describe) _____

☐ MFP Office or Transition coordinator
- Transition plan not approved
- Waiting for response, approval, etc. from MFP Office
- Lack of time for transition coordinator to follow up
- Other transition coordinator issues (describe) _____
- Other MFP Office issues (describe) _____

☐ Other topical area creating challenge[xxxiii]
- Describe: _____

FOOTNOTES: *NOTE: These will be used to clarify and further describe subcategories.*

---

[i] Incl. hospitalization due to physical health

[ii] Inc. waiting for neuro-psych examination

[iii] Inc. taking medications correctly; following up with treatment or care; self-monitoring of blood sugar, etc.

[iv] Incl. emotional issues such as depression or anxiety, or behavioral issues related to mental health. Incl. hospitalization due to mental health issues

[v] Includes abuse of legal drugs such as abuse of prescription medications

[vi] Incl. impaired judgment due to cognitive issues

[vii] Inc. taking medications correctly; following up with treatment or care.

[viii] Inc. lack of financial resources to pay security deposit, or for services or supports. Incl. Medicaid spend down; anticipated denial of Medicaid services once in community.

[ix] Incl. lack of/poor credit; unpaid balance or money owed to utilities, etc.

[x] Incl. denial, delay, loss, or lack of State or Federal financial benefits; rejection or delay in application for financial benefits; over or under payment of benefits

[xi] Incl. related to individual's or spousal finances; missing documents/records; denial, loss of, or waiting for approval of other benefits, including benefits such as food stamps or energy assistance. Excludes cash benefits from SSDI, SSI, SSD.

[xii] Incl. issues with prescription insurance coverage, Medicare Part D, Medicaid, SAGA medical insurance, etc.

[xiii] Incl. lack of follow through on responsibilities; decision to remain in facility and withdraw from program

[xiv] Incl. resistance to or inflexibility regarding need or options for support

[xv] Incl. if self-directing, consumer cannot manage PCA's or other support staff

[xvi] Incl. language differences, no interpreter (incl. sign language interpreter), lack of communication device, etc.

[xvii] Incl. insufficient, denial, wait for, or loss of transportation. Includes transportation to receive treatment, see apartments, get documents necessary to transition, or live in community.

[xviii] Incl. insufficient, denial, wait for, difficulty obtaining, or loss of paid support staff

[xix] Incl. insufficient, denial, wait for, or loss of mental health services or supports, either in the facility or in the community.

[xx] Incl. insufficient, denial, wait for, or loss of alcohol, substance abuse, or addiction services or supports, either in the facility or in the community.

[xxi] Incl. insufficient, denial, wait for, or loss of, or need for training for AT or DME; excludes home modifications or affordability issues

[xxii] Incl. insufficient, denial of, wait for, or loss of any other types of services or supports (excludes PCA/direct support staff; mental health services, AT/DME, or home modifications)

[xxiii] Incl. if no existing waiver for level of care, such as no 24 hour care waiver

[xxiv] Incl. denial of, wait for, or loss of accessible or committed housing; consumer dissatisfaction with or inflexibility available residence or living arrangement

[xxv] Incl. modifications not completed or not yet authorized

[xxvi] Incl. current criminal issues, such as incarceration

[xxvii] Incl. probate judge issues

[xxviii] Incl. lack of legal representative if applicable; legal representative opposed, unsupportive, unresponsive; Incl. all legal representatives, such as conservator, guardian, etc.

[xxix] Incl. opposed, unsupportive, unresponsive, etc.

[xxx] Incl. delay in, wait for, or lack of any type of evaluation for which the facility/facility staff is responsible

[xxxi] Incl. opposed, unsupportive, unresponsive, etc. Includes financial exploitation.

[xxxii] Incl. opposed, unsupportive, unresponsive, or absence of provider/state agency or their staff; Incl. care manager or care planner from provider or state agency (excludes staff from current facility);

[xxxiii] Multiple additional areas can be create