Important Changes to Section Q, as of April 1, 2012

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Overview

- Minimum Data Set (MDS) 3.0
- Description of changes
- Side-by-side comparison—current vs. new items
- Highlights of RAI User's Manual changes
- Expected impacts
- Resources for more information

Minimum Data Set 3.0

- Nursing facility resident assessment instrument
  - Used for all residents in Medicare/Medicaid certified nursing facilities
  - Primarily used for rate setting & quality assurance
- Version 3.0 implemented on October 1, 2010

Minimum Data Set 3.0

- CMS used the opportunity to improve the functionality of Section Q—Participation in Assessment & Goal Setting
  - More person-centered—interview resident/family
  - Action steps—connection to a local contact agency

Minimum Data Set 3.0

- Suggestions for improving the functioning of Section Q were made for the following reasons:
  - Current skip patterns may preclude resident choice
  - Feasibility of discharge question may exclude potential candidates for transitioning

Minimum Data Set 3.0

- Some residents/families were upset by being asked about returning to the community
- Need to better accommodate residents with cognitive impairments, dementia, mental illness
- Some residents needed more time to explore options

CMS' Intent of Changes

- Adopts a more person-centered approach
- Places resident/family at center of decision-making
- Gives individual residents a voice & a choice while being sensitive to those who may be upset by the assessment process
- Is more targeted about who gets queried

Side-by-Side Comparisons

Before April 2012	Current Version
Q0100A. Resident participated in assessment 0. No 1. Yes	Same
Q0100B. Family or significant other participated in assessment 0. No 1. Yes 2. No family or significant other	0. Same 1. Same 2. No family or significant other available. In *User's Manual*: "Resident has no family or significant other"
Q0100C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 2. No guardian or legally authorized representative	0. Same 1. Same 2. No guardian or legally authorized representative available. In *User's Manual*: "Resident has no guardian or legally authorized representative"

Comparison cont.

Before April 2012 (on admission)	Current Version (on admission)
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 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain	Same
Q0300B. Indicate information source for Q0300A 1. Resident 2. If not resident, then family or significant other 3. If not resident, family or significant other, then guardian or legally authorized representative 9. None of the above	1. Same 2. Same 3. Same 9. Unknown or uncertain

Comparison cont.

Q0400 Discharge Plan	
Before April 2012	**Current Version**
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	A. Is active discharge planning already occurring for the resident to return to the community? 0. Same 1. Same
B. What determination was made by the resident & the care planning team that discharge to community is feasible? 0. Determination not made 1. Discharge to community is feasible – Skip to Q0600 2. Discharge to community is not feasible – Skip to next active section	**Item eliminated**

Comparison cont.

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B (complete only when A0310 = 02, 06, 99) (comprehensive assessments)	
Before April 2012	**Current Version**
Does not exist	Does the resident's clinical record document a request that this question be asked only on comprehensive assessments? 0. No 1. Yes, *Unless is comprehensive assessment,* (in User's Manual) -> Skip to Q0600, Referral 8. Information not available

Comparison cont.

Q0500A. Return to Community	
Before April 2012	**Current Version**
A. Has the resident been asked if s/he wants to talk with 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"	Item was eliminated

Comparison cont.

Q0500B. Return to Community	
Before April 2012	**Current Version**
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	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 leaving this facility & returning to live & receive services in the community?" 0. Same 1. Same 9. Unknown or uncertain

Comparison cont.

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B again	
Before April 2012	**Current Version**
A. Does not exist	A. Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on <u>all</u> assessments? (Rather than only on comprehensive assessments) 0. No – then document in resident's clinical record & ask again only on the next comprehensive assessment 1. Yes 8. Information not available
B. Does not exist	B. Indicate information source for Q0550A 1. Resident 2. If not resident, then family or significant other 3. If not resident, family or significant other, then guardian or legally authorized representative 8. No information source available

Comparison cont.

Q0600. Referral	
Before April 2012	**Current Version**
Has a referral been made to the Local Contact Agency? 0. No - determination has been made by the resident & the care planning team that contact not required. 1. No – referral not made 2. Yes	Has a referral been made to the Local Contact Agency? **(Document reasons in resident's clinical record)** 0. No - referral not needed 1. No – referral is or may be needed (For more information See Section Q Care Area Assessment-#20) 2. Yes – referral made

Highlights of RAI Manual Changes

- Discharge planning follow-up is a regulatory requirement (CFR 483.20 (i) (3))
- Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home & community based services & have an opportunity to receive long term care in the least restrictive setting possible
- The individual resident should be actively involved—except in unusual circumstances, if the individual is unable to understand the process or unable to participate

RAI Manual Changes

- Q0100—Participation in Assessment
  - Code 9, no family or significant other available: None of the above—resident <u>has no</u> family or significant other
- Q0300—Resident's Overall Expectation
  - Resident's stated goals should be recorded here.

    The goals for the resident, as described by the family, significant other, guardian or legally authorized representative **<u>need to also be recorded in the clinical record</u>**
  - *This item is individualized & resident-driven rather than what the nursing home staff judge to be in the best interest of the resident.* This item focuses on exploring the resident's expectations; not whether or not the staff considers them to be realistic

RAI Manual Changes/ Highlights

- Q0400—Discharge Plan
  - More community care services & support options & choices are now available to meet care preferences & needs in the least restrictive setting possible

    Resulted from the 1999 U. S. Supreme Court decision in Olmstead v. L.C., which states that residents needing long term services & supports have a right to receive services in the least restrictive & most integrated setting
  - *The NF is responsible for making referrals to the Local Contact Agency (LCA)* under the process that the State has set up. *The LCA is responsible for contacting referred residents* & assisting with transition services planning. They should work closely together

RAI Manual Changes / Highlights

- Q0400—Discharge Plan
  - If a NF has a discharge planning & referral process & the capability to completely address an individual resident's needs (i.e., home health services, durable medical equipment, medical services, etc.) & arranges for that resident to discharge back to the community, a referral to the LCA may *not* be necessary

RAI Manual Changes

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

For Quarterly, Correction to Quarterly, & Not-OBRA Assessments (A0310A=02, 06, 99)

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, 99

Enter Code

A Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?

0. **No**
1. **Yes** → Skip to Q0600, Referral
8. **Information not available**

- Check of the resident's clinical record to determine whether the resident &/or family, etc. have indicated on a previous Federal OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next annual assessment
- *Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments*
- If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B

RAI Manual Highlights

- **Q0500: Return to Community**
  - Item Q0500B requires that the resident be asked the question directly & formalizes the opportunity for the resident to be informed of & consider his or her options to return to community living. This ensures that the resident's desire to learn about the possibility of returning to the community will be obtained & appropriate follow-up measures will be taken
  - *A "yes" response to item Q0500B will trigger follow-up care planning* & contact with the designated local contact agency about the resident's request within approximately 10 business days of a yes response being given. This code is intended to initiate contact with the local contact agency for follow-up as the resident desires

RAI Manual Changes cont.

- **Q0550: Resident's Preference to Avoid Being Asked Q0500B again**

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B again	
Enter ☐ Code	**A. Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments? (rather than only on comprehensive assessments)** **0. No – then document in resident's clinical record and ask again only on the next comprehensive assessment.** **1. Yes** **8. Information not available**
Enter ☐ Code	**B. Indicate information source for Q0550A** **1. Resident** **2. If not resident, then family or significant other** **3. If not resident, family or significant other, then guardian or legally authorized representative** **8. No information source available**

- Some individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them whether they want to return to the community. CMS pilot test showed respondents would be less likely to be upset if they were given the opportunity to opt-out of being asked the question every quarter

RAI Manual Changes cont.

- The intent of the item is to achieve a better balance between giving individual residents a voice & a choice about the services they receive while being sensitive to those who may be unable to voice their preferences or be upset
- *Document in resident's clinical record. Ask again only on next comprehensive assessment*

RAI Manual Changes / Highlights

Q0600: Referral

- Code 0, no: Referral not needed; determination has been made by the resident or family, etc. & the care planning team that the local contact agency does not need to be contacted. *If the resident's discharge planning has been completely developed by the nursing home staff & there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral*
- Or, if resident or family, etc. responded no to Q0500B

RAI Manual Changes / Highlights cont.

- Code 1, no: Referral is or may be needed
  - Determination has been made by the resident or family, etc. that the local contact agency needs to be contacted but the referral has not been initiated at this time
  - If the resident has asked to talk to someone about available community services & supports & a referral is not made at this time, care planning & progress notes should indicate the status of discharge planning & why a referral was not initiated

RAI Manual Changes / Highlights cont.

- Q0600: Referral = 1, no, referral is or may be needed
  - Triggers a Return to Community Care Area Assessment—CAA #20 provides a step-by-step discharge assessment process
  - Information gleaned should be used to assess the resident's situation & begin appropriate care planning, discharge planning & other follow-up
  - Develop an individualized care plan
  - Collaborate with the local contact agency

Expected Impacts

- By eliminating the Determination of Feasibility of Discharge item, many more residents were asked the question, “Do you want to talk with someone about the possibility of leaving this facility & returning to live & receive services in the community?”
- Many more said yes—more resident choice
- May result in more referrals (Pilot Test results are indeterminate…)

Expected Impacts cont.

- By giving residents/families an opt-out provision, respondents will be less likely to be upset about being asked whether they want to talk with someone about returning to the community
  - Should reduce the number of residents for whom the question is not appropriate
  - Works better than the feasibility-of-discharge question in targeting who should be asked the return to community question
- More clarity about referrals
  - But the key is organized communication at the local level

Resources

- For more information, see:
  - www.mfp-tac.com Section Q webpage
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html
- Send questions to: MDS3.0.DHHS@maine.gov

Breakout Sessions

- There are six breakout “rooms”
- Participants have already been assigned to a breakout room
- Once the breakout session has been started, each group with have 15 minutes to discuss the scenario, as a group. During that time, you will be able to speak with participants in your group only.

Breakout Sessions

- Once you are in room, please identify the following:
  - A group leader or moderator
  - A note-taker
  - A reporter

- At the end of 15 minutes, all groups will be brought back to the "main meeting room."
  - Groups 1 and 2 will discuss the findings of Scenario 1,
  - Groups 3 and 4 will discuss the findings of Scenario 2, and
  - Groups 5 and 6 will discuss the findings of Scenario 3.

Scenario 1

Ms. K is an elderly woman who has been blind since birth. She lived with her parents growing up and then with her husband until he passed away. Terrified to live on her own, she moved into a nursing home about five years ago. She now uses a wheelchair 100% of the time.

On her annual MDS assessment, Ms. K. responded "Yes" to item Q0500B Return to Community. She is an active and very social person and said that she desperately wanted to leave the facility to live on her own.

Ms. K's physician and the social worker at her nursing facility are very reluctant for her to leave the facility. They are very concerned about her safety while living alone, and for her being able to take care of her activities of daily living, because all of that was done for her in the facility.

Discussion Questions:

1. **Who has the right to make this decision?**

2. **Does Ms. K have the right to take the risk of moving out of the nursing facility?**

3. **What is the liability of the nursing facility after she is discharged?**

4. **What is the liability of the nursing facility if Ms. K responds Yes, and the assessor marks No?**

5. **If a competent individual resident determines that they want to talk to someone about returning to the community, does the Nursing facility have the right to block the local contact agency from seeing the resident?**

6. **How would you code Q0500B?**

7. **What steps are then required?**

8. **How would you code Q0600 Referral?**

9. **What steps are then required?**

Scenario 2

Ms. V is an elderly woman with mild dementia. She had previously been in a behavioral unit of a psychiatric hospital. She was hospitalized in an acute care hospital after a series of falls caused by a urinary tract infection which exacerbated her dementia. She was then discharged to a nursing facility for rehabilitation. Ms. V. says she has recovered from her illness and is interested in returning to community living.

Ms. V's daughter lives 50 miles away and visits her mother monthly. The daughter had previously told the facility social worker that she was opposed to her mother leaving the facility to live in the community. She is concerned about her mother's safety because of her previous wandering and multiple falls.

Discussion Questions:

How would you approach and analyze item Q0100 – Participation in Assessment

1. If the individual is able to understand and participate in the assessment process?

a. How would you code Q0100?
b. How would you code Q0500B?
c. How would you code Q0600?

2. If the daughter is a legally appointed guardian or legally authorized representative? (Such a representative would be responsible for making decisions for the resident, including giving and withholding consent for medical treatment.)

a. How would you code Q0100?
b. How would you code Q0500B?
c. How would you code Q0600?

3. If there is a court appointed guardian, is it necessary to obtain permission from the guardian before interviewing the resident?

Scenario 3

Ms. A is a recovering alcoholic with numerous mental health issues/behaviors. She is age 63 with no Medicare coverage. She has income from mineral rights royalties, her deceased husband's pension and her social security. She receives too much to qualify for Medicaid, but not enough to pay for private pay nursing home care. Ms. A did not want to apply for a Miller's Trust nor disability. A nursing facility took her in for what she could afford to pay, but after residing for one year at a nursing facility, she said she wanted to return to live in the community in her home town which is about 67 miles away.

Discussion Questions:

1. **How would you approach and analyze item Q0100 – Participation in Assessment**
Is the individual able to understand and participate in the assessment process?

a. **How would you code Q0100?**

2. **How would you code Q0500B?**

3. **How would you code Q0600?**

4. **Then what are your next steps?**

3. **What types of (non-Medicaid) services and supports do you think Ms. A may need to transition and sustain community living? What would you recommend to the local contact agency?**

Scenario 1

Ms. K is an elderly woman who has been blind since birth. She lived with her parents growing up and then with her husband until he passed away. Terrified to live on her own, she moved into a nursing home about five years ago. She now uses a wheelchair 100% of the time.

On her annual MDS assessment, Ms. K. responded "Yes" to item Q0500B Return to Community. She is an active and very social person and said that she desperately wanted to leave the facility to live on her own.

Ms. K's physician and the social worker at her nursing facility are very reluctant for her to leave the facility. They are very concerned about her safety while living alone, and for her being able to take care of her activities of daily living, because all of that was done for her in the facility.

Scenario 1
CMS recommended responses

Discussion Questions:

1. **Who has the right to make this decision?**

Ms. K. There is no evidence of a legally authorized (court appointed) representative, and the physician or social worker has no legal standing to make this decision. They can offer their advice and share their concerns, but cannot interfere with this decision.

2. **Does Ms. K have the right to take the risk of moving out of the nursing facility?**

Yes, Ms. K has the right to make her own medical decisions, including the right to accept or refuse medical services and settings.

3. **What is the liability of the nursing facility after she is discharged?**

While the individual is a resident in the facility, the nursing facility is responsible for a thorough assessment of the Individual resident's needs, supporting the resident in achieving his or her highest level of functioning, discharge planning, implementation of the discharge plan. With the new Section Q, the facility should work closely with the community agency (local contact agency or service provider) that is providing transition planning and arranging community supports and services such as housing, transportation, personal care assistance, and other formal and informal supports.

When there is a discharge plan developed that prepares the resident for discharge into the community there should be a Smooth transition. There needs to be consideration given to meeting the resident's needs in the environment, availability of resources to provide care, treatment, etc. and educating the agency providing oversight of specific needs of the resident and how they are to be met. Resident protections concerning transfer and discharge are found at §483.12. A "post-discharge plan of care" means the discharge planning process, which includes, assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community.

After appropriate implementation of the nursing facility discharge plan, once the individual is smoothly discharged, the Nursing facility is no longer responsible for the individual's care. If the individual is Medicaid eligible, the community service providers and the State Medicaid Agency are responsible for assuring health and safety once the individual has transitioned back to the community.

Scenario 1
CMS recommended responses

4. What is the liability of the nursing facility if Ms. K responds Yes, and the assessor marks No?

The nursing facility is required to make a referral to the LCA, and work with the LCA in a person centered approach to explore the individual's options for supports and services in the community and the possibility that the individual may return to the community. The facility continues to be required to implement accurate discharge planning and follow-up under federal law and regulation 42 CFR 483.20 (i) (3).

5. If a competent individual resident determines that they want to talk to someone about returning to the community, does the nursing facility have the right to block the local contact agency from seeing the resident?

No. The U.S. Supreme Court decision in Olmstead vs. L.C. and the Americans with Disabilities Act require that residents have access to information and choices. Local contact agencies are designated by State Medicaid Agencies officials as part of a structured discharge planning process.

6. **How would you code Q0500B?**

Code Q0500B= 1, Yes.

7. What steps are then required?

A Yes response will trigger follow-up care planning, and discharge planning, and contacting the local Contact agency according to your State's protocols, usually within 10 business days.

Scenario 1
CMS recommended responses

8. **How would you code Q0600 Referral?**

Code Q0600 = 2. Yes – referral made

9. What steps are then required?

Begin appropriate care planning and discharge planning, and once the LCA talks with the resident and facility, if it is determined that there are supports and services that would enable the resident to return to the community, work with the LCA and/or designated agency on other follow-up measures.

P.S.: Ms. K did return to the community and has been living in an apartment on her own for over a year, with assistive technology equipment, a Personal Emergency Response System, home help, durable medical equipment, and a visiting nurse to set up her pill organizer.

Scenario 2
CMS recommended responses

Ms. V is an elderly woman with mild dementia. She had previously been in a behavioral unit of a psychiatric hospital. She was hospitalized in an acute care hospital after a series of falls caused by a urinary tract infection which exacerbated her dementia. She was then discharged to a nursing facility for rehabilitation. Ms. V. says she has recovered from her illness and is interested in returning to community living.

Ms. V's daughter lives 50 miles away and visits her mother monthly. The daughter had previously told the facility social worker that she was opposed to her mother leaving the facility to live in the community. She is concerned about her mother's safety because of Her previous wandering and multiple falls.

Discussion Questions:

How would you approach and analyze item Q0100 – Participation in Assessment

1. Is the individual able to understand and participate in the assessment process?

Except in unusual circumstances, such as if the individual resident is unable to respond or understand or participate in the Assessment proceedings, continue the assessment interview and code the responses accordingly.

a. How would you code Q0100?

Code Q0100A = 1, Yes, resident participated in assessment, and if the daughter participated in the assessment, Code Q0100 B = 1,Yes, Family participated in assessment.

b. How would you code Q0500B?When Ms. V. responded Yes to item Q0500B, Code Q500B = 1, Yes.

Note: Review the previously recorded response to item Q0490 – Resident's Preference to Avoid Being Asked Question Q0500B in the resident's clinical record (or prior MDS assessment). Use this information in determining whether item Q0500B should be asked.

c. How would you code Q0600?

Code Q0600 – Referral = 2, referral (of resident) made.

Scenario 2
CMS recommended responses

2. Is the daughter a legally appointed guardian or legally authorized representative? (Such a representative would be responsible for making decisions for the resident, including giving and withholding consent for medical treatment.)

No, there was nothing in the case description to indicate she is the legal guardian. For discussion purposes, let's assume Yes, she is the legally appointed guardian. Continue the interview with the resident and record the individual's responses in the client's clinical record. Contact the legal guardian to interview them and obtain responses for the MDS assessment and record those on the MDS.

a. How would you code Q0100?
Code Q0100C = 1, Yes.

b. How would you code Q0500B?
If the daughter/guardian responds No to item Q0500B, Code Q500B = 0, No.

c. How would you code Q0600?
Code Q0600 – Referral = 0, No, referral (of resident) not needed.

Even though the daughter answered No to Q0500B, you may want to refer her to the local contact agency to obtain more information about the community living services and supports that are available for Ms. V. This will help her become fully informed about what their options are. This individual may or may not be able to successfully live in a less restrictive environment such as adult foster care or assisted living. The scope and intensity of supports and services (both formal and informal) that are available (or not) will be a major factor.

Scenario 2
CMS recommended responses

3. If there is a court appointed guardian, is it necessary to obtain permission from the guardian before interviewing the resident?

No. If the resident has a court appointed guardian, the resident should still be asked the question (Q0500B)unless state law prohibits asking the resident. If the resident is unable to respond and participate in the assessment, then ask the family, significant other, or legal guardian. A guardian, family member or legally authorized person should not be consulted to the exclusion of the individual resident.

P.S.: Ms. V has been living alone in an independent living apartment for over a year, with twice-a-day personal care/homemakers for preparing breakfast and dinner and medication reminding, home delivered lunches, nightly safety checks by a neighbor, and weekly visits by her daughter. She is linked to the local Wanderguard program and she is able to use her Personal Emergency Response System if needed. The frequent service provider contacts provide a way to report changes in her condition readily and have helped result in her stable condition over the year.

Scenario 3
CMS recommended responses

Ms. A is a recovering alcoholic with numerous mental health issues/behaviors. She is age 63 with no Medicare coverage. She has income from mineral rights royalties, her deceased husband's pension and her social security. She receives too much to qualify for Medicaid, but not enough to pay for private pay nursing home care. Ms. A did not want to apply for a Miller's Trust nor disability. A nursing facility took her in for what she could afford to pay, but after residing for one year at a nursing facility, she said she wanted to return to live in the community in her home town which is about 67 miles away.

Discussion Questions:

1. **How would you approach and analyze item Q0100 – Participation in Assessment**
Is the individual able to understand and participate in the assessment process?
If so, continue the assessment interview and code the responses accordingly.

a. **How would you code Q0100?**
Code Q0100A = 1, Yes, resident participated in assessment.

2. **How would you code Q0500B?**
Code Q500B = 1, Yes. Follow up care planning and discharge planning shall be initiated.

Scenario 3
CMS recommended responses

3. How would you code Q0600?
Code Q0600 – Referral = 1, Yes, referral made.

4. Then what are your next steps?
Initiate discharge planning and implementation of the discharge plan. Refer Ms. A to the local contact agencyto obtain more information about the community living services and supports that are available. This will help make her fully informed about what her options are. The availability of services and supports, both formal and informal, will be a major factor in her choice and ability to make a sustained move to community living.

5. What types of (non-Medicaid) services and supports do you think Ms. A may need to transition and sustain community living? What would you recommend to the local contact agency?

Ms. A needs supportive housing, such as senior apartment living. Their staff that can provide her help when needed, ongoing service coordination and assistance in fully engaging in community living (e.g. access to social groups, substance abuse prevention, etc.) She also needs ongoing monitoring to assure medication administration as well as ongoing follow-up with her local mental health clinic. Some non-Medicaid supports are available to Ms. A through programs managed by her local Area Agency on Aging and funded in part through Older Americans Act funds.

Scenario 3
CMS recommended responses

P.S.: Ms. A was referred to the designated local contact agency by the nursing facility. The local contact agency in their region is an Aging and Disability Resource Center (ADRC). The ADRC is responsible for providing information and assistance (referral) and options counseling about long term services and supports available in the community to older persons and adults with disabilities. –"Options Counseling is a person- centered, interactive, decision-support process whereby individuals are supported in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values. The process may include developing action steps toward a goal or a LTSS plan, and, when requested, assistance in accessing support options. It also includes following-up with the individual. Options Counseling is available to all persons regardless of their income or financial assets."

Through the ADRC, Ms. A was connected to local non-Medicaid resources to supplement services covered by her own income. The ADRC worked with the State's relocation specialist to locate senior housing. The nursing facility, ADRC, and ombudsmen worked together to arrange home delivered meals and public transportation and to connect Ms. A. to ongoing mental health services to support sustained community living.

Update to Changes in Section Q

Questions??