Minimum Data Set (MDS) Section Q and Community Transitions
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HCBS CONFERENCE
Home & Community-Based Services

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Panelist

Becky Kuhn, HOME Choice Budget & Program Manager
MFP Bureau, Ohio Department of Medicaid

Andrea Juris, MFP Project Director
Money Follows the Person
Bureau of Community Integration and Alzheimer's Disease
New York State Department of Health

Rachel Sink
Bureau of Policy, Division of Community Living Initiatives
Pennsylvania Office of Long-Term Living

Money Follows the Person

- MFP was designed with four goals:
  - Increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services
  - Eliminate barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds so that Medicaid-eligible people can receive support for appropriate and necessary LTSS in the settings of their choice
  - Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
  - Establish procedures to provide quality assurance and improve HCBS

Minimum Data Set (MDS) Section Q

Ohio State

New York State

Pennsylvania State

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Using Minimum Data Set (MDS) Data to Enhance Your Outreach Potential

Becky Kuhn, HOME Choice Budget & Program Manager
MFP Bureau, Ohio Department of Medicaid

What is MDS and what is Section Q of the MDS assessment?

MDS is the assessment that nursing facilities complete with the resident initially, quarterly, annually, and after any significant event.

The questions in Section Q of the MDS assessment record the participation and expectations of the resident, family members, or significant other(s) and helps to understand the resident's overall goals. **Interviewing the resident** or designated individuals places the resident or their family at the center of decision-making.

Section Q uses a person-centered approach and ensures individuals can learn about home and community-based services (HCBS) and have an opportunity to receive long-term care in the least restrictive setting possible.

This is also a civil right for all residents. Based on the American with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.,** residents needing long-term care services have a **civil right** to receive services in the least restrictive and most integrated setting.

Q0100: Participation in Assessment
Q0300: Resident's Overall Expectation

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0.

Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspectives during assessment.

Q0300 identifies the resident's general expectations and goals for nursing home stay.

Does the resident expect to be discharged to the community or remain in the facility?

The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet his or her individual long-term care needs.

Q0400: Discharge Plan

Returning home or to a non-institutional setting can be very important to a resident's health and quality of life.

Is active discharge planning already occurring for the resident to return to the community?

For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency experts about returning to the community.

Q0500: Return to Community
Q0600: Referral

Ask the resident: "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

If the resident responded yes to Q0500, the NF **should** respond Yes, referral made to Q0600.

Ohio has designated Local Contact Agencies (Ohio has deemed Community Living Specialists or CLS providers) and the Statewide MDS Section Q manager will assign a CLS provider to visit the resident to share community resources.

MDS factors that show residents with community living potential

In addition to normal referrals designated by a YES response to Q0600 – the nursing facility referral – Ohio also looks at other factors that the resident exhibits that indicates community living potential for that individual.

- Under the age of 80
- Has been in the facility less than 720 days
- Does not have Alzheimer's or Dementia
- Activities of Daily Living (ADL) score is less than 16
- Resource Utilization Group (RUG) score is less than 2

Q+ Referrals

- In July 2015 Ohio also stated looking at the Q+ factors which include:
  - Age
  - Q0500 response
  - Alzheimer's or Dementia
  - Cognition
  - Paralysis (hemiplegia, hemiparesis, paraplegia, quadriplegia)
  - Schizophrenia
  - RUG score
  - Length of Stay
  - ADLs (eating, locomotion, toilet use, personal hygiene)
  - Communication Skills (makes self understood, ability to understand others)
  - Behaviors (wandering, physical, verbal, other, rejection of care)

Contact Timelines for CLS providers

- The CLS provider makes contact with the NF social worker and the individual within 3 working days of the initial referral date.
- The CLS provider schedules the in-person interview within 10 working days of the initial referral date.
- The CLS provider will notify the NF of the individual's potential for transition to community living when applicable. The NF is responsible for discharge planning.

Roles and Responsibilities of CLS providers

- To form effective working relationships with NF social workers and discharge planners by collaboration and education.
- To identify needs and preferences of the resident and provide timely information, **resources** and available services to residents.
- To identify barriers to community living the resident will need to face upon returning to the community.
- To assist the individual with any applications (HOME Choice or Waiver)
- To embrace the role of educator to residents and NF social workers.

Collaboration is KEY to this Relationship!

- The CLS provider will share information with the social worker about the resources available to residents – the more the social worker knows, the better to understand the role of the CLS provider and the purpose of their visits to residents.

- The CLS provider will obtain information about the resident such as:
  - » Guardianship
  - » Diagnoses
  - » Informal Supports
  - » Past efforts in the community
  - » Social Worker's opinion about feasibility of resident living in community

Other Outreach Examples

- We have a collaborative effort with Ohio Department of Health (ODH) and will record information about referrals and HOME Choice so it will be part of their monthly MDS trainings.
- We also started visiting NFs around the state to explain the program and why we do what we do.
- We help NF staff learn all about Section Q, what it means, how they should make referrals, and we train them on all of Ohio's transition programs, not just MFP.
- We train the facilities to be timely with their MDS submissions.
- We will be completing webinars with audio about HOME Choice and about effective NF transitions and they will be posted on the HOME Choice website so that anyone can learn how to make a referral.

Where does Ohio get the MDS assessment data?

MDS data is transmitted electronically by nursing facilities (NFs) to the MDS database in your state and subsequently captured in the national MDS database at the Centers for Medicare and Medicaid Services (CMS).

Ohio's MDS database is located at the Ohio Department of Health (ODH). We have a Data Use Agreement (DUA) with ODH so that ODH can share MDS data weekly with the Ohio Department of Medicaid (ODM).

We have DUA's with all our community living specialist (CLS) providers who we share MDS data with so they can make the visits with the residents.

We store all the MDS data into a data repository whereby we can do further analysis work.

Additional MDS analysis

- As mentioned in the last slide, we also store MDS data into a data repository so we can do additional analysis that helps with more referrals.
- For example:
  - » We analyzed MDS data to see how many residents responded yes to Q0500 and yet the NF **did not** make a referral. We then sent those referrals to CLS providers who went out and visited those residents and shared community resource options.
  - » Ohio passed legislation in 2016 to reimburse NFs less money per day for those residents who had RUG scores of PA1 or PA2. We analyzed MDS data to find those residents and then sent those referrals to CLS providers who went out and visited those residents and shared community resource options.
  - » We also researched what facilities we had never had a referral from and then ran the MDS data to identify residents with community living potential and sent out CLS providers to visit those residents.

Automation of Referral Process

- CLS providers get weekly referrals and are sent the MDS data on a spreadsheet. These referrals are uploaded into a web-based system.
- CLS providers then visit the residents and capture lots of information from the resident on a Community Living Plan Addendum (CLPA) form. This form helps to identify the needs and preferences of the resident and the barriers that the resident may face upon leaving the facility.
- We automated this process in 2014 and this has made it possible to track visits and has improved data quality and analysis.
- The system helps lessen duplication of visits and has improved compliance with provider timelines of visits.

Contact Information

- **Phone Number:** 1-888-221-1560
- **FAX:** 614-360-3549
- **Email:** HOME_Choice@medicaid.ohio.gov
- **Website:** medicaid.ohio.gov/INITIATIVES/Home-Choice

- **Presenter: Becky Kuhn**
- Rebecca.Kuhn@medicaid.ohio.gov
- 614-752-3554

Effective Use of the Minimum Data Set (MDS) Section Q Data to Enhance Referrals for Community Transition in New York State

December 2020

Federal Authorities

Federal Guidance

The US Department of Health and Human Services' (DHHS) Office for Civil Rights (OCR) issued:

"*Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting.*"

- Helps long-term care facilities comply with their civil rights obligations
- Corrects misinterpretations of the Section Q requirements prevalent in the field

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The Minimum Data Set (MDS) and Section Q

May 2016: US Department of Health and Human Services, Office for Civil Rights issued guidance on Section Q

http://www.hhs.gov/sites/default/files/mds-guidance-2016.pdf

- Q0400: "An ***active*** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future."
- Q0500: "Nursing home staff should convey to residents that this question is intended to "provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care."
- Q0600: "The only reason a facility may refrain from making a referral to the Local Contact Agency when requested by the resident is when the resident has an *active* discharge plan."

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Using Section Q to Facilitate Olmstead Goals

Olmstead Supreme Court Decision (1999)

- Afford people with disabilities the opportunity to live in integrated community-based settings
- Provide individuals the opportunity to make an informed decision
- Help providers meet their Olmstead-related responsibilities by referring to LCA

MFP in New York State

NY State Designated Local Contact Agency (LCA)

Transition Assistance

- Nine (9) Regional Leads and 16 Auxiliary Transition Centers based in Independent Living Centers across the state
- Sixty (60) Transition Specialists statewide

Peer Support

- Twenty-eight (28) Peers approximate the demographic characteristics of the participants
- Peers live independently in the community, many have transitioned themselves

Nursing Home Outreach and Education

- Four (4) dedicated regionally based staff provide education to nursing homes in the state on MFP and the LCA referral process

Two-Pronged Approach to Section Q Referrals

Data Mining in NYS

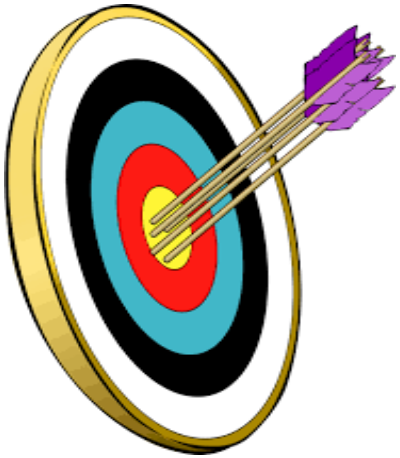
- Two (2) algorithms applied to MDS data
- Identifies individuals likely to

Education and Outreach

- Outreach to 600+ nursing homes in state on a bi-annual cycle
- Educates facilities on correct completion of Section Q questions

Section Q Data Mining

‘Q’ and ‘Q+’ Algorithms



Two algorithms applied to MDS Section Q raw data

- Both algorithms rely on MDS Section Q 0500 “Yes” answers from nursing home residents with Medicaid.

Initial ‘Q’ Algorithm

- Uses resource utilization groups (RUGS).

‘Q+’ Algorithm

- The Q+ Index developed by the University of Michigan identifies current nursing facility residents closely resembling individuals who have successfully transitioned in the past.

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Data Mining Process Refined

Q and Q Plus Compared

- Individually: Similar success in identifying potential transitions
- Combined: Individuals identified by both algorithms were more likely to transition

Current Data Mining Process

- Apply Q and Q+ algorithms to MDS raw data
- Develop list of individuals identified by both algorithms
- Sent to LCA on a quarterly basis as referrals

Analysis by Referral Source

Baseline

- Referrals generated using combined Q and Q+ algorithms

Additional Analysis Needed

- Compared referral to transition rate across multiple referral sources

Conclusion:

More transitions result from direct referrals from nursing home staff than from algorithms

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Enhancing Section Q Referrals through Education and Outreach

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Best Practices for Nursing Home Education and Outreach

- Dedicate specific staff for LCA Outreach and Education
- Provide systemic outreach and education to nursing homes throughout the state using an ongoing outreach schedule
- Educate nursing home staff about MDS Section Q and LCA referral process
- Respond to facility requests for additional education

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Using Federal Guidance to Support Education and Outreach

- Clarify Section Q definition of ***active*** discharge
- Increase awareness of mandates to refer individuals answering “Yes” to Q0500
- Address misconceptions and pre-conceived notions of who can transition
- Educate nursing home staff about availability of home and community based services
- Enhance collaboration between nursing home staff and transition specialists
- Reinforce person centered approach to identifying residents’ expressed preference
- Support referral through reference to Federal and State guidance

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Section Q Quick Guide

9. **Unknown or uncertain**

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?

1. **No**
2. **Yes** → Skip to Q0600, Referral

Answer YES **ONLY** if:
- LCA (Open Doors) already involved
- Discharge date is **< 3 months** and referral to LCA cannot improve plan

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

Complete only if A0310A = 02, 06, or 99

02, 06, 99 = Quarterly Assessment types

Enter Code ☐

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

1. **No**
2. **Yes** → Skip to Q0600, Referral

- Only applies to Quarterly Assessments
- **Q0500 MUST be asked on ALL annual or change-of-status**

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**

1. **No**
2. **Yes**
9. **Unknown or uncertain**

MUST ASK THIS Question unless resident has ACTIVE discharge plan!! **DON'T judge** whether resident can be discharged to community.
If YES, MUST REFER TO LCA (Open Doors). LCA will provide information and explore possibility of alternate settings so resident can make informed choice.

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Tips for Section Q Administration

- Ask the questions matter-of-factly
- Use a person centered approach to residents' expressed preference regarding potential transition
- Develop Quick Guide for pertinent points

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State Actions Support the Initiative

- Dear Administrator Letters
  - NH DAL 16-10: MDS Version 3.0, Section Q
  - NH DAL 18-05: Nursing Home Discharge Requirements
  - NH-19-16: Residents' Rights
- Revised NY State regulations direct nursing homes to inform residents of community transition programs and the LCA
  - Title 10 NYCRR:
    - 415.2 (Definitions)
    - 415.3 (Resident's Rights)

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Tracking and Monitoring

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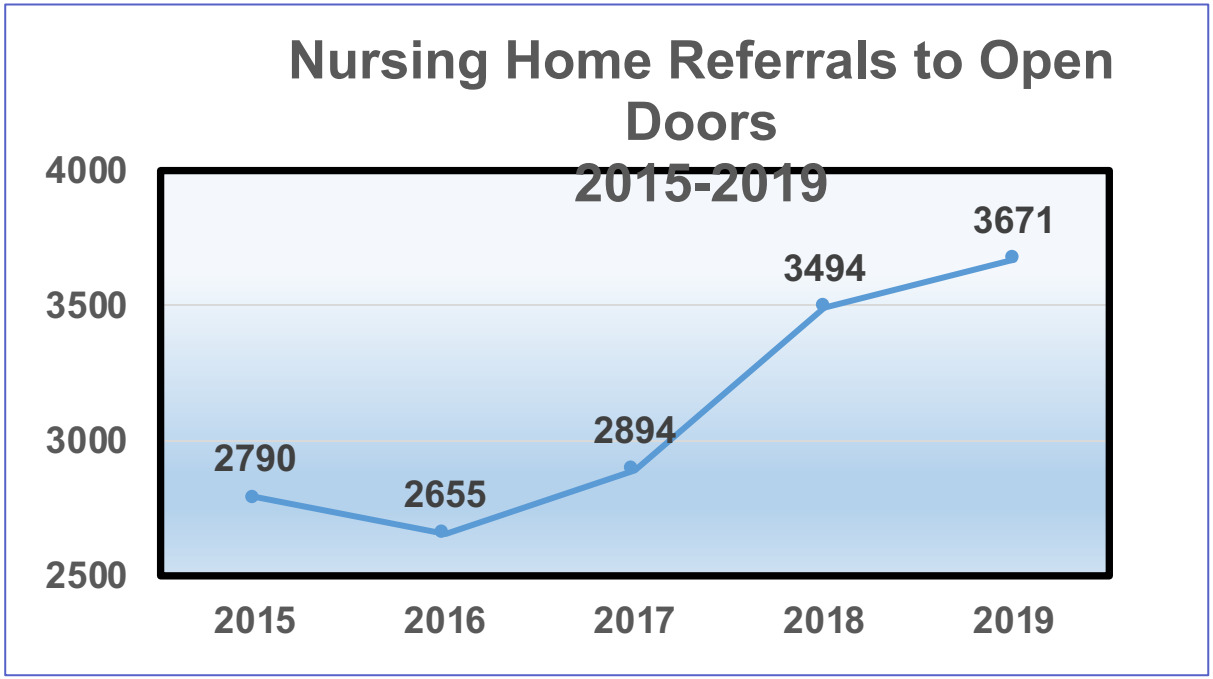
Tracking and Monitoring

- Monitor Section Q and nursing home referral rate to identify impact of Outreach efforts
- Problem solve and create new strategies to generate referrals
- Monitor transition data by referral source to track successful outcomes of referrals

Education and Outreach Results



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Tips and Tools

Lessons Learned

- Direct referrals from nursing homes are the most successful
- Outreach and education works to increase referrals and strengthen collaboration
- Quick reference guides help to support and maintain learning
- Mining MDS data can supplement direct referrals
- State and Federal Guidance reinforces message
- Data analysis drives continued improvement

Contact Us:

Maribeth Gnozzio, Bureau Director
maribeth.gnozzio@health.ny.gov

Andrea Juris, MFP Project Director
andrea.juris@health.ny.gov

Contact us at MFP@health.ny.gov

For more information on NY State MFP, visit:
https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm

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The Role of Minimum Data Set (MDS) Section Q in Pennsylvania's Nursing Home Transition (NHT) Program

History of NHT in PA

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- In 2000 PA was awarded one of the original nursing home transition grants from CMS in the amount of $500,000
  - Pilot project named Pennsylvania Transition to Home (PATH) was established in 4 of Pennsylvania's 67 counties

- In 2008 an enhanced pay-for-performance NHT program was introduced statewide
  - Services provided by network of agencies with 2 agencies assigned to each county
  - Centers for Independent Living provided services to individuals <60 years old; Area Agencies on Aging providing services for >60
  - MDS reports provided to NHTCAs monthly

History of NHT in PA

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- In December 2016 NHT program was opened to any qualified provider of service coordination under Medicaid waivers administered by OLTL
  - Increased provider choice
  - Required re-education to facilities as to who to direct NHT referrals to, including Section Q referrals
  - State no longer able to provide detailed MDS reports to NHT providers
- Beginning 1/1/2018, PA began to roll out its managed long-term care program, Community HealthChoices (CHC), which was fully implemented statewide as of 1/1/2020
  - CHC Managed Care Organizations (MCOs) became responsible to provide NHT services to enrollees as an administrative function
  - A state administered fee-for-service NHT program continues for individuals not qualifying for CHC enrollment

NHT Population

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State fee-for-service program

- Resides in NF
- Wants to transition back to the community
- Has either been in the facility at least 90 days OR has a barrier preventing them from transitioning via the normal NF discharge process

(Aligns closely with Money Follows the Person and MDS Section Q referral requirements)

- As of CHC enrollment individual is no longer eligible for fee-for-service NHT

Community HealthChoices

- MCOs must provide NHT services to any enrolled participant who resides in a NF and has identified need for NHT services in their Person-Centered Service Plan
- Reporting requirements of NHT services only apply to individuals transitioning after NF stay that is:
  - not for short-term rehabilitation;
  - not for respite; and
  - not medically necessary under Medicare definition (i.e., skilled care).

NHT Population

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State fee-for-service program

- Referrals can come from any source (“no wrong door”)
- Participants are provided free choice of the NHT Coordination Agencies (NHTCAs) that are enrolled to provide NHT services in their county
- Upon receiving a referral, the NHTCA is responsible to verify that the individual meets the NHT participant definition
- NHTCA works with participant and others involved to develop the NHT care plan

Community HealthChoices

- MCOs are responsible to update an individual’s Person-Centered Service Plan when they become aware that an enrolled participant wants to transition
- MCOs provide NHT services using internal staff, external agencies they contract with, or a combination
- MCOs participate in data reporting for NHT for required participants which enables monitoring by the state

NHT Goals

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- **Enhance opportunities** for individuals to move into the community by identifying individuals who wish to return to the community
- **Educate individuals and families** about long-term living services
- **Identify and overcome barriers** that prevent transitions
- **Develop the necessary infrastructure** and supports in the community
- **Empower participants**, so they are involved to the extent possible in planning and directing their own transition

How MDS Section Q Can Help

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- A NF resident's positive answer to Q0500: *"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"* requires that a referral be made to the designated Local Contact Agency (LCA)
- States can track answers provided to the questions in Section Q in order to make sure that facility residents are being provided their options and receiving information about transitioning
- The MDS 3.0 manual on the CMS website describes in detail the correct process to follow in asking the Section Q questions

How MDS Section Q Can Help

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Why is it so important that these questions be asked correctly?

- The choice to live in the most integrated setting possible is a civil right, decided by the Supreme Court in *Olmstead v. L.C.*[1]
- The correct administration of MDS Section Q is a necessary part of civil rights compliance for both long-term care facilities and state and administrative agencies
- Skipping questions or not asking or acting on them correctly can create an informational barrier to individuals being able to leave long-term care facilities

1. *Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting*. U.S. Dept. of Health and Human Services, Office of Civil Rights. May 20, 2016

Challenges and Solutions

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Challenge

- Confusion on the part of facilities caused by
  - Frequent turnover of staff
  - Changes to PA's NHT program that necessitate changes in what entities function as the designated LCAs
  - A separate but overlapping process for enrolling individuals into Home and Community-Based Services

Solutions

- Working with nursing facility associations on ways to communicate information
- Offering trainings to facility staff
- Sending out notifications to facilities via a list serve whenever a change in the NHT referral process occurs

Challenges and Solutions

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Challenge

- Relevance/timeliness of the reports pulled from MDS data

Solution

- Encouraging collaborative relationships between facility staff and LCAs

Other Potential Solutions

- Develop a system that provides information directly to the LCAs in real-time (to the extent possible)
- Pull reports more frequently

Challenges and Solutions

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Challenge

- Providing information to the relevant parties while complying with HIPAA
  - Sending reports with participant-specific PHI to LCAs or allowing access to that information
  - Sharing information with stakeholders and advocates

Solutions

- Formal collaborative agreements with specific LCAs authorizing them to receive information pertaining to the participants who will be referred to them
- Sharing aggregate information with stakeholders

Presenter Contact Info

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Rachel Sink

Office of Long-Term Living

Bureau of Policy, Division of Community Living Initiatives

rsink@pa.gov

(717) 783-7378

Website:

https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/Nursing%20Home%20Transition.aspx

Summary, Tips and Tools

- Ohio: Web based referrals
- NY: Q cheat sheet and Public Health Live webinar on Section Q

- PA: Relationships with Nursing Homes and Provider Associations

- ADvancing States – Using LTC Ombudsman as liaison

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Questions

Thank you