

MDS Section Q Referrals and the ADRC

November 10, 2010

Presented by

Nebraska's Aging & Disability Resource Center

In partnership with Nebraska DHHS and

Answer4Families/UNL Center on Children, Families & the Law

Answers **4** Families

<http://answers4families.org>

800-746-8420

Department of Health & Human Services

DHHS

N E B R A S K A

UNIVERSITY OF
Nebraska
Lincoln | CENTER ON CHILDREN,
FAMILIES, AND THE LAW

MDS Section Q Referrals and Nebraska's Aging and Disability Resource Center

Welcome!



Introductions

Julie Horne, Program Coordinator, Aging & Disability Resource Center

Cindy Kadavy, Manager, State Plan Long-Term Care Services, DHHS

Dan Taylor, Training Coordinator, DHHS Division of Public Health, Licensure Unit

Joette Novak, Program Specialist, DHHS Division of Medicaid & Long-Term Care



Webinar Format

MDS Section Q Referrals and Nebraska's Aging and Disability Resource Center

Objectives

- Know how to go about making a referral using the ADRC as Nebraska's contact agency
- Understand the flow of referral information and expectations of various players in the process
- Be able to describe the vision for Aging and Disability Resource Centers
- Know resources for future questions
- Have opportunity to provide suggestions and feedback

MDS Section Q Referrals and Nebraska's Aging and Disability Resource Center

Three Parts

- **Part I Section Q and Aging & Disability Resource Center**

- **Part II How to Make a Referral**
 - **Account set up**
 - **Make a Referral**

- **Part III Tools and Additional Info**
 - **ADRC MDS Info: nrrs.ne.gov/mds**
 - **DHHS MDS Info: dhhs.ne.gov/med/mds/index.htm**
 - **DHHS Money Follows the Person: dhhs.ne.gov/med/nmfp**
 - **Q&A**

Part I: Section Q and Aging and Disability Resource Centers

The Big Picture: Community Living Initiatives

MDS 3.0 and the movement to Aging & Disability Resource Centers are part of an overall federal emphasis on community living.



Part I: Section Q and Aging and Disability Resource Centers

The Big Picture: Community Living Initiatives

“person-driven”

“coordinated access to full range of care and support”

“use health information technology to provide information to consumers & providers”



Part I: Section Q and Aging and Disability Resource Centers

MDS 3.0

MDS 2.0 (That was then)	MDS 3.0 (This is 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 required	If the resident responds Yes, then the facility must initiate care planning and may refer the individual to a state-designated contact agency.

What is an Aging and Disability Resource Center?



What is the Aging and Disability Resource Center?

AoA and CMS Goal:

*To have Aging and Disability Resource Centers in every community serving as highly **visible** and **trusted** places where people of all incomes and ages can get information on the **full range of long term support options** and a **single point of entry** for access to public long term support programs and benefits.*



Part I: Section Q and Aging and Disability Resource Centers

What is the Aging and Disability Resource Center?



promote awareness of the various options that are available in the community (LTC Planning)



Use systematic process across partners to provide referrals.



Part I: Section Q and Aging and Disability Resource Centers

What is the Aging and Disability Resource Center?

ADRCs should be viewed more as a process or network of organizations working together vs. an actual building or physical location.



Part I: Section Q and Aging and Disability Resource Centers

What is the Aging and Disability Resource Center?



Nebraska's Aging and Disability Resource Center

Nebraska DHHS partnering with **Answers4Families** to coordinate its ADRC.

- Part of UNL's Center on Children, Families & the Law
- Partnered with DHHS to develop the NRRS (Nebraska Resource & Referral System). NRRS is a comprehensive database of public and private resources for families and professionals across the state
- Development of technical solutions for DHHS for variety of programs
- Developing web-based hub for the Aging and Disability Resource Center
- ADRC Program Coordinator on staff at Answer4Families



Answers **4** **Families**

<http://answers4families.org>

800-746-8420



Module I: What is an ADRC?

Nebraska's Aging and Disability Resource Center

Anticipated Key Partners

- Area Agencies on Aging
- Centers for Independent Living/SILCs
- Public & private aging and disability service providers
- Long-term care supports and service providers (e.g. Medicaid Waiver, home health agencies, nursing and assisted living facilities)
- State Health Insurance Assistance Program (SHIP)
- Critical pathway providers (e.g., hospital discharge planners, physicians)
- Answers4Families & other information providers
- Adult Protective Services
- Medicaid



Overview of ADRCs for CILs and SILCs

- ✓ **Part I Section Q and Aging and Disability Resource Centers**

- **Part II How to Make a Referral**
 - **Account set up**
 - **Make a Referral**

- **Part III Tools and Additional Info**
 - **ADRC MDS Info: nrrs.ne.gov/mds**
 - **DHHS MDS Info: dhhs.ne.gov/med/mds/index.htm**
 - **DHHS Money Follows the Person: dhhs.ne.gov/med/nmfp**
 - **Q&A**

Overview of ADRCs for CILs and SILCs

- ✓ **Part I Section Q and Aging and Disability Resource Centers**

- ✓ **Part II How to Make a Referral**
 - **Account set up**
 - **Make a Referral**

- **Part III Tools and Additional Info**
 - **ADRC MDS Info: nrrs.ne.gov/mds**
 - **DHHS MDS Info: dhhs.ne.gov/med/mds/index.htm**
 - **DHHS Money Follows the Person: dhhs.ne.gov/med/nmfp**
 - **Q&A**

Nebraska Medicaid MDS & Case Mix Information



<http://www.dhhs.ne.gov/med/mds/index.htm>

Nebraska Medicaid Program

Medicaid Nursing Facility Providers

Minimum Data Set and Case Mix Information

; from CMS on MDS 3.0 Submission, Submission Status and Final Valid

 [Learn More](#)

MINIMUM DATE SET (MDS):

The MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. MDS information is transmitted electronically by nursing homes to the national MDS database at the Centers for Medicare and Medicaid Services (CMS) and to the MDS database in their respective states.

Nebraska Medicaid Money Follows the Person Information



<http://www.dhhs.ne.gov/med/nmfp>

Homepage

 [Subscribe to this Page](#)

New and Important Information!

Nebraska's MFP project has new eligibility requirements!  [Find out](#) how this affects you and how it will help more individuals who wish to transition from a facility-based setting to a more independent setting in the community:

Media

 [Two 30-second Radio Spots](#)
1. Older Parent / 2. Housing.ne.gov

 [Print Fillers](#)

MDS Section Q

Only complete Section Q0300 for Admission Assessment

Resident _____ Identifier _____ Date _____

Section Q		Participation in Assessment and Goal Setting	
Q0100. Participation in Assessment			
Enter Code <input type="checkbox"/>	A. Resident participated in assessment	0. No 1. Yes	
Enter Code <input type="checkbox"/>	B. Family or significant other participated in assessment	0. No 1. Yes 9. No family or significant other	
Enter Code <input type="checkbox"/>	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 A0310E = 1			
Enter Code <input type="checkbox"/>	A. 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 <input type="checkbox"/>	B. 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	

MDS Section Q

If Yes, skip to Section Q0600

Q0400. Discharge Plan	
Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	B. What determination was made by the resident and the care planning team regarding discharge to the community? 0. Determination not made 1. Discharge to community determined to be feasible → Skip to Q0600, Referral 2. Discharge to community determined to be not feasible → Skip to next active section (V or X)
Q0500. Return to Community	
Enter Code <input type="checkbox"/>	A. Has the resident been asked about 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 <input type="checkbox"/>	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 9. Unknown or uncertain

To code "2," the Resident must agree with the determination being made by the Care Planning Team.

CMS: "Interviewing the resident, whenever possible, regarding the feasibility of discharge is required by the Olmstead Supreme Court decision and Americans with Disability Act before the Q0400B(2), discharge to community not feasible is marked." (MDS 3.0 Instructor Guide)

MDS Section Q

Q0600. Referral	
Enter Code <input type="checkbox"/>	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 is not required 1. No - referral not made 2. Yes

If Discharge Plan does not require contact with the local community agency, code "0" and do not make referral.

CMS Section Q Pilot Test Report – Trigger Summary

Link to this document, which is Appendix A of Section Q Pilot Test Report:

<https://nrrs.ne.gov/mds/pdf/Referral%20Checklist%20for%20Nursing%20Facilities.pdf>

Return to Community Referral Follow-up

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

Review of Return to Community Referral

Steps in the Process

<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include: <ul style="list-style-type: none">• Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700-C1100)• Functional/mobility (G0110) or balance (G0300) problems
<input type="checkbox"/>	4. Inform the discharge planning team and other facility staff of the individual's choice.

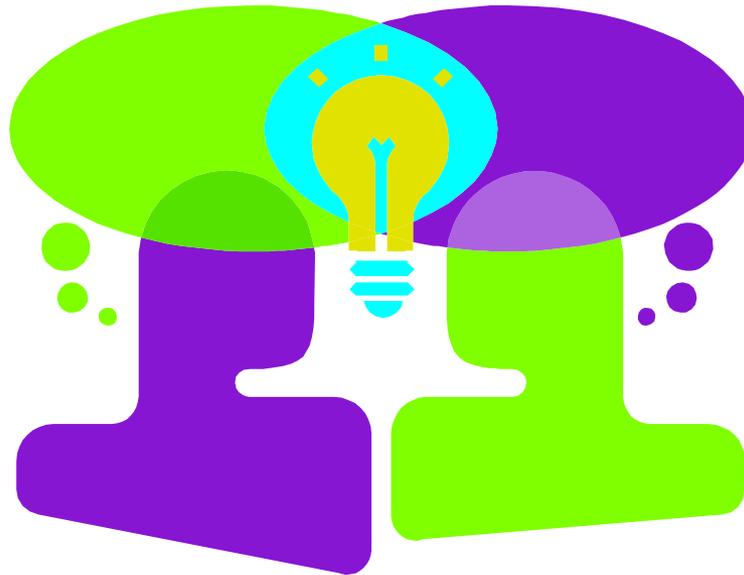
CMS Section Q Pilot Test Report – Trigger Summary

- | | |
|---|--|
| □ | 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. |

CMS Section Q Pilot Test Report – Trigger Summary

- | | |
|---|--|
| □ | 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. |

Questions



Questions About Referral Process:

Nebraska's Aging & Disability Resource Center

Julie Horne, Program Coordinator

jhorne@answers4families.org (402) 421-0195

Questions About MDS Coding, Appropriate Referrals

DHHS, Division of Public Health, Licensure Unit

Dan Taylor, Training Coordinator

daniel.taylor@nebraska.gov (402) 471-3324

Questions About MDS Submissions or MDS Technical Issues

DHHS, Division of Medicaid & Long-Term Care

Joette Novak, Program Specialist

joette.novak@nebraska.gov (402) 471-9279

Explore: www.answer4families.org nrrs.ne.gov

Evaluate: Please complete the course evaluation that will appear when you exit the webinar