Ohio | Department of Medicaid

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

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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

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