MDS-Q and Nursing Home Transitions
ADRC Operations Manual

I. Introduction

Under the Code of Federal Regulations, 42 CFR 483.20, nursing homes that participate in the Medicare and Medicaid programs must complete the Minimum Data Set (MDS) assessment for all customers admitted to the facility, quarterly thereafter, and again upon discharge from the facility. Nursing homes are required to make a referral to the designated local contact agency for any customer who, in response to Section Q questions, indicates a desire to talk to someone about returning to the community. DHS designated the ADRCs as the local contact agency for their service area.

II. Requirements for Responding to Nursing Home Referrals

A. MDS-Q Referral Process

ADRCs will receive MDS-Q referrals through a designated referral form (F-00311) that is used by the nursing homes. This form will either be faxed or sent electronically via email to the ADRC. Nursing homes will send the referral form to the ADRC in resident's county of residence. The county of residence/responsibility is not necessarily the county in which the facility is located. County of residence is the voluntary concurrence of physical presence with intent to remain in a place of fixed habitation. The four criteria in the definition of residency includes physical presence, intent to remain, living in a place of fixed habitation, and must be voluntary for an individual to establish residence. If the county of residence/responsibility is unknown, the nursing facility should contact DQA to assist in a residency determination before contacting the appropriate ADRC.

B. MDS-Q Referrals

ADRCs are expected to be responsive to MDS-Q referrals from the nursing home and follow up on referrals within a reasonable timeframe. Since MDS-Q assessments are done multiple times over the course of a resident's stay, it is likely

that ADRCs may receive multiple referrals over time for the same customer. In this case, ADRC specialists should use professional judgment for deciding whether or not to follow up on the referral after reviewing documentation in the ADRC's client tracking system.

One goal in the MDS-Q process in Wisconsin is to provide information helpful to the customer in fulfilling their interest in returning to the community through collaboration between the nursing homes and the ADRCs. The Centers for Medicare & Medicaid Services (CMS) is clear that the nursing home's role is to provide discharge planning. The ADRC is available to augment that process by providing information to the customer, family, or legal representative about community services and supports. The ADRC is also available to ensure that unbiased, objective, and comprehensive information is provided to the resident about their full range of options. Please see the information and assistance (P-03062-01) and options counseling (P-03062-02) sections of the ADRC Operations Manual for more details.

If the customer being referred is a member of a managed care organization (MCO), the care team is responsible for providing follow-up and support to help the individual return to the community when the relocation is feasible. The ADRC does not need to follow up on the referral unless they determine that there is a reason to contact the customer or the MCO.

C. Non MDS-Q Referrals

ADRCs will receive referrals from nursing homes directly using the same referral form (F-00311). These non MDS-Q referrals should be handled in the same manner as a referral through the MDS-Q assessment process. ADRC specialists will respond to these referrals by contacting the customer or their representative and offering to meet with them to discuss community services and supports.

D. Residency

Nursing homes will send the referral form to the ADRC in resident's county of residence. The county of residence/responsibility is not necessarily the county in which the facility is located. County of residence is the voluntary concurrence of physical presence with intent to remain in a place of fixed habitation. The four criteria in the definition of residency includes:

1. Physical presence; and

2. Intent to remain; and
3. Living in a place of fixed habitation, and
4. Must be voluntary for an individual to establish residence.

If the county of residence/responsibility is unknown, the nursing facility should contact DQA to assist in a residency determination before contacting the appropriate ADRC.

If the customer prefers to enroll in a publicly funded long-term care program (P-03062-03) in a new county, rather than their current county of residence, the ADRC in the customer's current county of residence is responsible for completing the long-term care functional screen (P-03062-04a) and verifying financial eligibility. The ADRC will then facilitate contact between the customer and the ADRC in the customer's county of preference. The ADRC serving the county in which the person would prefer to live will provide enrollment counseling. If the customer chooses to enroll in a long-term care program, the enrollment form will be sent to the MCO without an enrollment date, or a referral form will be sent to the ICA. The enrollment date will be the date the person moves and establishes residency in the new county.

E. Client Tracking

MDS-Q Referrals and Client Tracking Outcomes			
Encounter	ADRC Outcome	Call Topic	Example Note
1. ADRC receives MDS-Q referral 2. ADRC contacts the customer 3. ADRC explains the role of the ADRC, resource information, etc. 4. ADRC schedules visit with the customer	Administrative Provided information and assistance (I&A)	MDS Section Q Referrals	Example note for Administrative: ADRC received an MDS-Q referral, reviewed the information, looked the customer up in the client tracking database to check for recent involvement, and documented the receipt of MDS-Q. Assigned ADRC specialist Jan S. to follow-up on the referral. Example note for Provided I&A:

			Writer contacted John Doe, who is currently residing at Sleepy Hollow Care Center, to follow up on MDS-Q referral. Explained reason for call and requested to meet with John to explain community service and support options. John is interested in learning how to move back home. Appointment was scheduled to meet at the NH on May 9.
1. ADRC receives MDS-Q referral 2. ADRC decides not to contact the resident because of recent interaction(s) with the ADRC.	Administrative	MDS Section Q Referrals	ADRC received an MDS-Q referral, reviewed the information. A previous MDS-Q referral had been received by the ADRC last month. Upon the ADRC reaching out to Lucy, she declined to meet with the ADRC since she has decided to continue to reside at the NH long term. The MDS-Q referral received on August 12 does not require additional follow-up with the customer at this time due to recent contact.
1. Nursing home contacts the ADRC directly with a referral; ADRC contacts the customers and schedules visit		Non-MDS Section Q	ADRC received a call from Jean, discharge planner at Lakeside Manor. Shirley, a resident at Lakeside Manor, would like to move to an apartment to live independently. Shirley will need services and supports in order to make this transition successful and doesn't have the financial means to pay for services. Writer indicated that a contact will be made with Shirley to provide further information. Writer contacted Shirley to follow up on Lakeside Manor referral. Explained reason for call and requested to meet with Shirley to learn more about her desire to move out of the NH and provide her with options. A meeting was scheduled for writer to meet Shirley at Lakeside Manor on June 14.

III. Operational Policies and Procedures

A. Statutory References

Wisconsin Statute § 46.283

Wisconsin Admin. Code § DHS 10.23

42 CFR 483.20

B. Agency Requirements

ADRCs are required to designate a single email address to which MDS-Q referral should be sent.

D. Allowable Funding Sources and Expenses

ADRC (P-03062-16)

E. Policy Requirements

Follow-Up (P-02923-07)

Conflict of Interest (P-02923-03)

Confidentiality (P-02923-06)

Complaint and Grievances Regarding ADRC Services (P-02923-02)

Appeal for Adverse Benefit Determinations (P-02923-01)

F. Training Requirements

ADRC specialists that work with customers who wish to transition from nursing home settings are required to fulfill the training expectations outlined in the Information and Assistance (P-03062-01) and Options Counseling (P-03062-02) sections of the ADRC operations manual.

Training specific to the MDS-Q referral process is available via video recording. This training is designed for both ADRC staff and nursing home staff to understand the process and roles of each agency.

G. Reporting Requirements

ADRC specialists that assist customer with nursing home transitions are required to complete 100% time and task reporting (P-03062-10) as part of their job duties. They are also required to complete client tracking to document their interactions with ADRC customers.

IV. Additional Resources and Tools

Minimum Data Set 3.0 Resident Assessment Instrument Manual

Minimum Data Set Assessment (Section Q begins on page 37.)

Resident Relocation Manual (P-01440)