QIO – Minimum Data Set Section Q (MDSQ) Referrals

Purpose:

The MDS 3.0 is the nursing facility (NF) resident assessment instrument used for all NF residents. MDSQ (Participation in Assessment and Goal Setting) identifies NF residents who want to obtain information about available options and supports with the prospect of returning to the community by putting the resident, family, or designated representative at the center of decision-making to support individual choice.

Residents identified for transition to community services in MDSQ will be referred to local contact agencies to receive information about community choices, and if deemed appropriate, for assistance in transitioning to community living situations. This is not an automatic plan for discharge to the community regardless of circumstances. The process is meant to provide information for the NF resident and reinforces efforts to comply with the Americans with Disabilities Act and the U.S. Supreme Court decision in Olmstead vs. L.C.

Identification of Roles:

Review assistant (RA) - will receive referral information from NF via telephone call and complete referral letter template.

Manager/lead review coordinator (RC) - will proof letters prior to mailing of information to NF, will assign options counselor based upon the area of the State and whether the referral is to be in person or via telephone, and will report outcomes of referrals to HHS and CMS as requested.

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: After completion of the MDS 3.0, the NF will call QIO Services regarding MDSQ referral.

Step 2: RA will ask the provider a series of intake questions to determine if the MDSQ referral is appropriate. MDSQ referrals should be completed if:

- Assistance is being requested with discharge planning for residents that are FFS or have a MCO assigned to them.
- Assistance is being requested with discharge planning for residents that are not enrolled in Medicaid.
- If the resident wants to explore discharge options, but a guardian or legal decision maker does not favor this option.

- The resident has a diagnosis of dementia but could be supported safely in the community.

MDSQ referral should ***not*** completed if:

- The resident has expressed a desire for discharge back into the community, and the NF is able to arrange a safe discharge, while meeting the resident's needs.
- The NF indicates the resident has expressed a desire for discharge back into the community; however, the NF staff feel this is not medically safe or feasible for this resident to leave the NF, then the MDSQ referral is not needed, and they can use the "skip" option in MDSQ.
- The discharge is being initiated by the pre-admission screening and resident review (PASRR) completed by ASCEND. If they have PASRR questions, refer to facility to ASCEND at 1-(877)-431-1388.
- Residents they have already discharged.
- Residents who enter the NF with an expectation of a short stay for rehabilitation and already having a definite plan for discharge in place.

Step 3: If referral is appropriate, the RA will access the automated referral form by clicking on the MDSQ tab in IoWANS and ask the provider all questions on the referral form and gather the necessary information to verify/fill in the form for the referral.

Step 4: RA email the MDSQ referral to the manager/lead RC for final proofing.

Step 5: Manager/lead RC will proof the letter, confirming demographics and content. When final, letter will be emailed back to the RA who will fax the final letter to the NF within 2 days of receipt of complete information.

Step 6: The RA will save a copy of the final referral letter for record retention. The IoWANS milestones will be answered by the RA to move milestones back to manager/lead RC for assignment of options counselor.

Step 7: The manager will assign the options counselor dependent upon whether the resident is FFS or MCO and email a copy of the MDSQ referral letter with notification of the referral to the appropriate options counselor and copy the Policy program manager.

- If the member is enrolled in an MCO, the member's contact information will be forwarded to the MCO's care coordination team.
- If the member is with Medicaid FFS and is not enrolled with an MCO or is not Medicaid eligible, the member's contact information will be forwarded to a Money Follows the Person (MFP) transition specialist who will perform additional outreach to further assess the member's needs related to transition to the community.

Step 8: The RC will document required information on the MDSQ letter tracker for reporting purposes.

Step 9: RA will phone for follow-up with provider for any review left in pending status 7 days or more.

Pended MDSQ Referrals:

Step 1: NF will call QIO Services and ask to speak to someone regarding MDSQ referral.

Step 2: If the NF does not have complete information at the time of the initial call, RA will save the information provided into a letter that they will then name in usual convention and save on their desktop to await the NF returning call with remaining information.

Step 3: RA will put a reminder on their Outlook calendar dated 1 week from today to follow-up with the NF regarding the MDSQ referral that was initiated.

Step 4: After receiving complete information, RA will complete procedure. If resident has changed their mind or canceled their request, RA will record the cancellation in IoWANS milestones and delete the pending referral form from their desktop.

Forms/Reports:

Manager will report monthly the number of Section Q referrals received. Further detail of reporting can be obtained by manual reference to IoWANS milestones, such as: number still pending, number who were went to options counseling and transition counseling and number who did not qualify for transition counseling and why.

RFP Reference:

1.3.1.3.A.7

Interfaces:

N/A