SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals.

Q0100: Participation in Assessment

Q0100. Participation in Assessment	
Enter Code ☐	**A. Resident participated in assessment** 0. No 1. Yes
Enter Code ☐	**B. Family or significant other participated in assessment** 0. No 1. Yes 9. No family or significant other
Enter Code ☐	**C. Guardian or legally authorized representative participated in assessment** 0. No 1. Yes 9. No guardian or legally authorized representative

Item Rationale

Health-related Quality of Life

- Residents who actively participate in the assessment process through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- The care plan should be individualized and resident-driven.
- During care planning meetings, if the resident is present, he or she should be made comfortable and verbal communication should be directly with him or her.
- Many residents want their family or significant other(s) to be involved in the assessment process.
- When the resident is unable to participate in the assessment process, a family member or significant other, and guardian or legally authorized representatives can provide valuable information about the resident's needs, goals, and priorities.

DEFINITIONS

RESIDENT'S PARTICIPATION IN ASSESSMENT
The resident actively engages in interviews and conversations as necessary 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 perspective during assessment.

Q0100: Participation in Assessment (cont.)

Steps for Assessment

1. Review the medical record for documentation that the resident, family or significant other, and guardian or legally authorized representative participated in the assessment process.
2. Ask the resident, the family or significant other (when applicable), and the guardian or legally authorized representative (when applicable) if he or she actively participated in the assessment process.
3. Ask staff members who completed the assessment whether or not the resident, family or significant other, or guardian or legally authorized representative participated in the assessment process.

DEFINITIONS

FAMILY OR SIGNIFICANT OTHER
A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver or close friend. Significant other does not, however, include staff at the nursing home.

GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE
A person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.

Coding Instructions for Q0100A, Resident Participated in Assessment

Record the participation of the resident in the assessment process.

- Code 0, no: if the resident did not actively participate in the assessment process.
- Code 1, yes: if the resident actively and meaningfully participated in the assessment process.

Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment

Record the participation of the family or significant other in the assessment process.

- Code 0, no: if the family or significant other did not participate in the assessment process.
- Code 1, yes: if the family or significant other(s) did participate in the assessment process.
- Code 9, no family or significant other: if there is no family or significant other.

Coding Tips

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, if the resident is uncertain about his or her goals, the response selected must reflect the resident's perspective if he or she is able to express it.
- Significant other does not include nursing home staff.

Q0100: Participation in Assessment (cont.)

Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment

Record the participation of the guardian or legally authorized representative in the assessment process.

- Code 0, no: if guardian or legally authorized representative did not participate in the assessment process.
- Code 1, yes: if guardian or legally authorized representative did participate in the assessment process.
- Code 9, no guardian or legally authorized representative: if there is no guardian or legally authorized representative.

Q0300: Resident's Overall Expectation

Complete only when A0310E=1.

Q0300. Resident's Overall Expectation Complete only if A0310E = 1	
Enter Code ☐	**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 ☐	**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**

Item Rationale

This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about his or her own expectations regarding return to the community and goals for care. 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 long-term care needs.

Some residents have very clear and directed expectations that will change little prior to discharge. Other residents may be unsure or may be experiencing an evolution in their thinking as their clinical condition changes or stabilizes.

Health-related Quality of Life

- Unless the resident's goals for care are understood, his or her needs, goals, and priorities are not likely to be met.

Planning for Care

- The resident's goals should be the basis for care planning.

DEFINITIONS

DISCHARGE
To release from nursing home care. Can be to home, another community setting, or healthcare setting.

Q0300: Resident's Overall Expectation (cont.)

Steps for Assessment

1. Ask the resident about his or her overall expectations after he or she has participated in the assessment process and has a better understanding of his or her current situation and the implications of alternative choices.
2. Ask the resident to consider current clinical status, expectations regarding improvement or worsening, and social supports.
3. Because of a temporary (e.g., delirium) or permanent (e.g., profound dementia) condition, some residents may be unable to provide a clear response. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.
4. If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what his or her expectation is regarding the outcome of this nursing home admission and expectations about returning to the community.
5. The resident's goals—as perceived by the family, significant other, guardian, or legally authorized representative—should be recorded here only if the resident is unable to discuss his or her goals.
6. Encourage the involvement of family or significant others in the discussion if the resident consents. While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved if the resident is uncertain about his or her goals, the response selected must reflect the resident's perspective if he or she is able to express it.

Coding Instructions for Q0300A, Resident's Overall Goals Established during Assessment Process

Record the resident's expectations as expressed, whether they are realistic or not realistic.

- Code 1, expects to be discharged to the community: if the resident is in the nursing home for rehabilitation, skilled nursing care, or respite care and indicates an expectation to return home, to assisted living, or to another community setting.
- Code 2, expects to remain in this facility: if the resident is in the nursing home for rehabilitation or skilled nursing care and indicates that after this care is complete, he or she expects to remain in the nursing home.
- Code 3, expects to be discharged to another facility/institution: if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- Code 9, unknown or uncertain: if the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative are not available to participate in the discussion.

Q0300: Resident's Overall Expectation (cont.)

Coding Tips

- This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's options; not whether or not the staff considers them to be good or poor options.
- Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer based on a specific advance care order, such as "do not resuscitate" (DNR).
- The resident should be provided options, as well as, access to information that allows him or her to make the decision and to be supported in directing his or her care planning.
- If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. Families, significant others or legal guardians should be consulted as part of the assessment.

Coding Instructions for Q0300B, Indicate Information Source for Q0300A

- Code 1, resident: if the resident is the source for completing this item.
- Code 2, if not resident, then family or significant other: if the resident is unable to respond and a family member or significant other is the source for completing this item.
- Code 3, if not resident, family or significant other, then guardian or legally authorized representative: if the guardian or legally authorized representative is the source for completing this item because the resident is unable to respond and a family member or significant other is not available to respond.
- Code 9, none of the above: if the resident cannot respond and the family or significant other, or guardian or legally authorized representative cannot be contacted or is unable to respond (Q0300A = 9).

Examples

1. Mrs. F. is a 55-year-old married woman who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. She was admitted to the nursing home 1 week ago for rehabilitation, particularly for transfer, gait training, and wheelchair mobility training. Mrs. F. is extremely motivated to return home. Her husband is supportive and has been busy adapting their home to promote her independence. Her goal is to return home once she has completed rehabilitation.

   Coding: Q0300A would be coded 1, expects to be discharged to the community.
   Q0300B would be coded 1, resident.
   Rationale: Mrs. F. has clear expectations and a goal to return home.

Q0300: Resident's Overall Expectation (cont.)

2. Mr. W. is a 73-year-old man who has severe heart failure and renal dysfunction. He also has a new diagnosis of metastatic colorectal cancer and was readmitted to the nursing home after a prolonged hospitalization for lower gastrointestinal (GI) bleeding. He relies on nursing staff for all activities of daily living (ADLs). He indicates that he is "strongly optimistic" about his future and only wants to think "positive thoughts" about what is going to happen and needs to believe that he will return home.

   Coding: Q0300A would be coded 1, expects to be discharged to the community.

   Q0300B would be coded 1, resident.

   Rationale: Mr. W has a clear goal to return home. Even if the staff believe this is unlikely based on available social supports and past nursing home residence, this item should be coded based on the resident's expressed goals.

3. Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now let's talk about it more." When her daughter is asked about goals for her mother's care, she states that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints and the level of care that she needs, we feel that we cannot adequately meet her needs. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort." The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days.

   Coding: Q0300A would be coded 2, expects to remain in this facility.

   Q0300B would be coded 2, family or significant other.

   Rationale: Ms. T is not able to respond, but her daughter has clear expectations that her mother will remain in the nursing home where she will be made comfortable for her remaining days.

4. Mrs. G., an 84-year-old female with severe dementia, is admitted by her daughter for a 7-day period. Her daughter stated that she "just needs to have a break." Her mother has been wandering at times and has little interactive capacity. The daughter is planning to take her mother back home at the end of the week.

   Coding: Q0300A would be coded 1, expects to be discharged to the community.

   Q0300B would be coded 2, family or significant other.

   Rationale: Mrs. G. is not able to respond but her daughter has clear expectations that her mother will return home at the end of the 7-day respite visit.

Q0300: Resident's Overall Expectation (cont.)

5. Mrs. C. is a 72-year-old woman who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, she was diagnosed with moderate dementia and was unable to voice consistent preferences for her own care. She has no living relatives and no significant other who is willing to participate in her care decisions. The court appointed a legal guardian to oversee her care. Community-based services, including assisted living and other residential care situations, were discussed with the guardian. The guardian decided that it is in Mrs. C.'s best interest that she be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete.

   Coding: Q0300A would be coded 3, expects to be discharged to another facility/institution.
   Q0300B would be coded 3, guardian or legally authorized representative.

   Rationale: Mrs. C. is not able to respond and has no family or significant other available to participate in her care decisions. A court-appointed legal guardian determined that it is in Mrs. C.'s best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

6. Ms. K. is a 40-year-old with cerebral palsy and a learning disability. She lived in a group home 5 years ago, but after a hospitalization for pneumonia she was admitted to the nursing home for respiratory therapy. Although her group home bed is no longer available, she is now medically stable and there is no medical reason why she could not transition back to the community. Ms. K. states she wants to return to the group home. Her legal guardian agrees that she should return to the community to a small group home.

   Coding: Q0300A would be coded 1, expects to be discharged to the community (small group homes are considered to be community setting).
   Q0300B would be coded 3, guardian or legally authorized representative.

   Rationale: Ms. K. is able to respond and says she would like to go back to the group home but is unable to make decisions about her medical and other care needs. When the legal guardian was told that Ms. K. is medically stable and would like to go back to the community, she decided that it is in Ms. K.'s best interest to be transferred to a group home.

Q0400: Discharge Plan

Q0400. Discharge Plan	
Enter Code ☐	**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 ☐	**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)

Q0400: Discharge Plan (cont.)

Item Rationale

Health-related Quality of Life

- Returning home or to a noninstitutional setting can be very important to the resident's health and quality of life.
- For residents that have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There are improved community resources and supports that may benefit these residents and allow them to return to a community setting.
- Being discharged from the nursing home without an adequate discharge plan could result in the resident's decline and increase the chances for rehospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.

Planning for Care

- Some nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to community resources.
- Important progress has been made so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the U. S. Supreme Court Olmstead ruling, which states that residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.
- The care plan should include the name and contact information of a primary care provider chosen by the resident, family, significant other, guardian or legally authorized representative, arrangements for the durable medical equipment (if needed), formal and informal supports that will be available, the persons and provider(s) in the community who will meet the resident's needs, and the place the resident is going to be living.
- Each situation is unique to the resident, his family, and/or guardian. A referral to the Local Contact Agency may be appropriate for some individuals, such as those with Alzheimer's disease, who could be maintained in their own homes for long periods of time, depending on the residential setting and support services available. Others may not be able to be discharged and be determined as not feasible by the interdisciplinary team because the intense level of services and supports that are needed are not available in the community, and the individual does not have family or other relationships that could support them.
- Discharge instructions should include at a minimum:
  - the individuals preferences and needs for care and supports;
    - personal identification and contact information, including Advance Directives;
    - provider contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;
    - brief medical history;

Q0400: Discharge Plan (cont.)

- current medications, treatments, therapies, and allergies;
- arrangements for durable medical equipment;
- arrangements for housing; and
- contact information at the nursing home if a problem arises during discharge

— A follow-up appointment with the designated primary care provider in the community and other specialists (as appropriate).

— Medication education.

— Prevention and disease management education, focusing especially on warning symptoms for when to call the doctor.

— Who to call in case of an emergency or if symptoms of decline occur.

— Nursing facility procedures and discharge planning for subacute and rehabilitation community discharges are most often well defined and efficient.

— Section Q has been broadened beyond the traditional definition of discharge planning for sub-acute residents to encompass long stay residents including the elderly, disabled, intellectually challenged, and younger nursing home residents. In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, employment, and social engagement opportunities.

- Asking the resident and family about whether they want to talk to someone about a return to the community gives the resident voice and respects his or her wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts.
- The nursing home staff must not make an interdisciplinary determination that discharge is not feasible without consulting the resident if the resident can be interviewed.
- Each NH needs to develop relationships with their LCAs to work with them to contact the resident and their family concerning a potential return to the community. A thorough review of medical, psychological, functional, and financial information is necessary in order to assess what each individual resident needs and whether or not there are sufficient community resources and finances to support a transition to the community.
- Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are now more readily available and will grow over time. Resource availability and eligibility coverage varies across local communities and States, and may be barriers to some residents being able to return to the community.
- Should it occur, an unsuccessful transition may create stress and disappointment for the resident and family that will require support and nursing home care planning interventions.

• Involve community mental health resources (as appropriate) to ensure that the resident has support and active coping skills that will help him or her to readjust to community living.

Q0400: Discharge Plan (cont.)

- Use teach-back methods to ensure that the resident understands all of the factors associated with his or her discharge.
- For additional guidance, see CMS' **Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting**. Available at http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf

Steps for Assessment

1. A review should be conducted of the care plan, the medical record, and clinician progress notes, including but not limited to nursing, physician, social services and therapy.
2. If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other or guardian, as designated by the individual. Determining whether discharge to the community is feasible requires consultation with the family or guardian if they are available.
3. If a nursing facility has a discharge planning and referral and resource process for short stay residents that includes arranging for home health services, durable medical equipment, medical services, and appointments, etc., and there are not individual resident needs that the NF/SNF does not have the capability to arrange for that resident it may not be necessary for referral to the LCA. This should be decided on a case-by-case basis.
4. Record the resident's expectations as expressed/ communicated, whether they are realistic or not realistic.
5. If the resident is being discharged, an evaluation of the site should be conducted to determine the safety of the resident's surroundings and the need for assistive/adaptive devices, medical supplies, and equipment.
6. The resident, interdisciplinary team, and local contact agency (when a referral has been made to a local contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance) and make appropriate referrals.
7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be assessed prior to discharge to determine where the resident will be discharged (e.g., home, assisted living, board and care, group living).
8. Determine if there will be family involvement and support after discharge.

Coding Instructions for Q0400A, Is There an Active Discharge plan in Place for the Resident to Return to the Community?

- Code 0, no: if there is not an active discharge plan in place for the resident to return to the community.
- Code 1, yes: if there is an active discharge plan in place for the resident to return to the community; skip to **Referral** item (Q0600).

Q0400: Discharge Plan (cont.)

Coding Instructions for Q0400B, What Determination Was Made by the Resident and the Care Planning Team Regarding Discharge to the Community?

- Code 0: if a determination is not made by the resident and the care planning team regarding discharge to the community.
- Code 1: if discharge to the community is determined to be feasible; skip to item Q0600 (Referral).
- Code 2: if discharge to the community is determined to be not feasible; skip to the next active assessment section (Section V or X).

Coding Tips

- This item is individualized and resident-driven, and the interdisciplinary team must interview residents and/or their family members, whenever possible, and determine their preferences and agreement.
- The nursing home interdisciplinary team should not assume that any particular resident is unable to be discharged. The nursing home should code Q0400B as **2 after** they have fully explored the resident's preferences and possible home and community based services/options available to the resident. Most likely, this would require consultation with community resource experts at the LCA.
- If the care planning team determines that the resident's discharge to the community is not feasible (answer B =2), there is an existing skip pattern that directs the assessor to skip to Section V or Section X.
- If the nursing facility staff has already developed a complete discharge plan, 0400A would be coded as Yes and skip to Q0600.

Examples

1. Ms. G is a 45-year-old woman, 300 lbs., who is cognitively intact. She has CHF and shortness of breath requiring oxygen at night. Ms. G also requires assistance with bathing and transfers to the commode. She has resided at the nursing home for 3 years. Her nursing home admission was a result of the fact that her family and friends, who visited regularly, could not care for her at home. Although she expresses interest in talking to someone about returning to the community, the interdisciplinary team is uncertain whether there would be sufficient community resources available and whether her family would agree to the discharge.

   Coding: Q0400B would be coded 1, discharge to the community is determined to be feasible; skip to item Q0600 (Referral).

Q0400: Discharge Plan (cont.)

Rationale: Ms. G expresses the desire to talk to someone about the return to the community and the local contact agency representative can help address the interdisciplinary team's legitimate concerns about available and sufficient community resources particularly accessible and affordable housing and to talk to the resident's family.

2. Mrs. R is an 82-year-old widowed woman with advanced Alzheimer's disease. She has no family, and has resided at the nursing home for 4½ years. The resident is not able to be interviewed.

Coding: Q0400B would be coded 2, discharge to the community is determined to be not feasible; skip to the next active assessment section (Section V or X).

Rationale: Mrs. R is not able to be interviewed and there is no family or other resources to support her return to the community.

Q0500: Return to Community

For Admission, Quarterly, and Annual Assessments.

Q0500. Return to Community	
Enter Code ☐	**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 ☐	**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**

Item Rationale

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in being transitioned to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living. The underlying intention of the return to the community item is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible. CMS has found that in many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations.

Q0500: Return to Community (cont.)

Health-related Quality of Life

- Returning home or to a noninstitutional setting can be very important to the resident's health and quality of life.
- This item identifies the resident's desire to speak with someone about returning to community living. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.,** residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.
- Item Q0500B requires that the resident be asked the question directly and formalizes the opportunity for the resident to be informed of and consider his or her options to return to community living. This ensures that the resident's desire to learn about the possibility of returning to the community will be obtained and appropriate follow-up measures will be taken.
- The goal is to obtain the expressed interest of the resident and focus on the resident's preferences.

Planning for Care

- Some nursing home residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a noninstitutional setting.

Steps for Assessment: Interview Instructions

1. At the initial admission assessment and in subsequent follow-up assessments (as applicable), determine if the resident has been asked about returning to the community.
2. If the resident has not been asked about returning to the community or if the resident has been asked and his or her previous response was no or unknown, make the resident comfortable by assuring him or her that this is a routine question that is asked of all residents.
3. Ask the resident if he or she would like to speak with someone about the possibility of returning to live in the community. Inform the resident that answering yes to this item signals the resident's request for more information and will initiate a contact by someone with more information about supports available for living in the community. Answering yes does not commit the resident to leave the nursing home at a specific time; nor does it ensure that the resident will be able to move back to the community. Answering no is also not a permanent commitment. Also inform the resident that he or she can change his or her decision (i.e., whether or not he or she wants to speak with someone) at any time.
4. Explain that this item is meant to provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care. A viable and workable discharge plan requires that the nursing home social worker or staff talk with the resident before making a referral to a local contact agency to explore topics such as: what returning to the community means, i.e., a variety of settings based on preferences and needs; the arrangements and planning that the NF/SNF can make; and obtaining family or legal guardian input. This step will help the resident clarify their discharge goals and identify important information for the LCA or, in some instances may indicate that the resident does

Q0500: Return to Community (cont.)

not be referred to the LCA at this time. Also explain that the resident can change his/her mind at any time.

5. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can then be obtained from family or a significant other, as designated by the individual. If family or significant others is not available, a guardian or legally authorized representative can provide the information.
6. Ask the resident if he or she wants information about different kinds of supports that may be available for community living. Responding yes will be a way for the individual—and his or her family, significant other, or guardian or legally authorized representative—to obtain additional information about services and supports that would be available to support community living.

Coding Instructions for Q0500A, Has the Resident Been Asked about Returning to the Community?

- Code 0, no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she has not been asked about the possibility of returning to the community.
- Code 1, yes—previous response was no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community and the previous response was no.
- Code 2, yes—previous response was yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community and the previous response was yes. If Code 2 is entered, skip to Q0600 (Referral).
- Code 3, yes—previous response was unknown: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community but the previous response is unknown.

Coding Instructions for Q0500B, 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?"

- Code 0, no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to the community.
- Code 1, yes: if the resident (or family- or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to the community.
- Code 9, unknown or uncertain: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Q0500: Return to Community (cont.)

Coding Tips

- A "yes—previous response was yes" response to item Q0500A will trigger follow-up care planning and contact with the designated local contact agency about the resident's request within approximately 10 business days of a yes response being given. This code is intended to initiate contact with the local agency for follow-up as the resident desires.
- Follow-up is expected in a "reasonable" amount of time and 10 business days is a recommendation and not a requirement. The level and type of response needed by an individual is determined on a resident-by-resident basis. Some States may determine that the LCAs can make an initial telephone contact to identify the resident's needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face to face visit. In some States, an initial meeting is set up with the resident, facility staff, and LCA together to talk with the resident about their needs and community care options.
- Some residents will have a very clear expectation and some may have changed their expectations over time. Other residents may be unsure or unaware of the opportunities available to them for community living with services and supports. Talking with the resident regarding discharge goals and plans before referral to the LCA is a necessary step to clarify the resident's discharge needs and expectations, determine what the SNF/NF usually does and can arrange, and in some instances to determine whether their preferences are or are not feasible based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24 hour care issues, etc.
- The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF can talk with the LCA to see what is available that does not require family support.
- Current return to community questions may upset residents that cannot go home and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500B, a family member, significant other guardian and/or legally appointed decision maker for that individual could be asked the question.
- When Q0600 is answered 1, No, a care area trigger requires a return to community care area assessment (CAA) and CAA 20 provides a step-by-step process for the facility to use in order to provide the resident an opportunity to discuss returning to the community.

Examples

1. Mr. B. is an 82-year-old male with COPD. He was referred to the nursing home by his physician for end-of-life palliative care. He responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why Mr. B. is afraid and explain that obtaining more information may help overcome some of his fears. He should also be informed that someone from a local agency is available to provide him with more information about receiving services and supports in the community. At the close of this discussion, Mr. B. says that he would like more information on community supports.

Q0500: Return to Community (cont.)

Coding: Q0500A would be coded 0, no.
Q0500B would be coded 1, yes.

Rationale: Q0500A would be coded as no because Mr. B. had not been asked previously about returning to the community. Coding Q0500B as yes should trigger a visit by the nursing home social worker to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local agency within approximately 10 business days.

2. Ms. C. is a 45-year-old woman with cerebral palsy and a learning disability who has been living in the Hope Nursing Home for the past 20 years. She once lived in a group home but became ill and required hospitalization for pneumonia. After recovering in the hospital, Ms. C. was sent to the nursing home because she now required regular chest physical therapy and was told that she could no longer live in her previous group home because her needs were more intensive. No one had asked her about returning to the community until now. When administered the MDS assessment, she responded yes to item Q0500B.

   Coding: Q0500A would be coded 0, no.
   Q0500B would be coded 1, yes.

   Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local agency within approximately 10 business days for them to initiate discussions with Ms. C. about returning to community living.

3. Mr. D. is a 65-year-old man with a severe heart condition and interstitial pulmonary fibrosis. At the last quarterly assessment, Mr. D. had been asked about returning to the community and his response was no. He also responds no to item Q0500B. The assessor should ask why he responded no. Depending on the response, follow-up questions could include, "Is it that you think you cannot get the care you need in the community? Do you have a home to return to? Do you have any family or friends to assist you in any way?" Mr. D. responds no to the follow-up questions and does not want to offer any more information or talk about it.

   Coding: Q0500A would be coded 1, yes—previous response was no.
   Q0500B would be coded 0, no.

   Rationale: Mr. D. had been previously asked if he wanted to talk to someone about returning to the community. He had responded no. During this assessment, he was asked again about returning to the community and he again responded no.

Q0600: Referral

Q0600. Referral	
Enter Code ☐	**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**

Q0600: Referral (cont.)

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Some nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to appropriate community resources to facilitate care in a noninstitutional setting.

Steps for Assessment: Interview Instructions

1. If Item Q0400A is coded 1, yes, then complete this item.
2. If Item Q0400B is coded 1, yes, then complete this item,
3. If Item Q0500A is coded 2, yes-previous response was yes, then complete this item.

DEFINITIONS

DESIGNATED LOCAL CONTACT AGENCY

Each state has community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, an Aging/Disabled Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities. See Appendix C for listings.

Coding Instructions

- Code 0, no: determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident's discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral.
- Code 1, no: determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency needs to be contacted but the referral has not made. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.
- Code 2, yes: if referral was made to the local contact agency. For example, the resident responded yes to Q0500A. The facility care planning team was notified and initiated contact with the local contact agency.

Coding Tips

- State Medicaid Agencies have designated a State point of contact (POC) for Section Q implementation and are responsible to coordinate efforts to designate LCAs for their State's skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows

Q0600: Referral (cont.)

the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate.

- Several resources are available at the Return to Community web site at: http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage.
  - — The State-by-State POC list for MDS 3.0 Section Q including State's Local Contact Agencies and Section Q Coordinator Information
  - — MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues.
  - — The Section Q Pilot Test Results report describes the implementation activities of the States that pilot tested Section Q and the need to establish collaborative arrangements at the local level.
- Resource availability and eligibility coverage varies across local communities and States and these may present barriers to allowing some resident's return to their community. The nursing home and local agency staffs should guard against raising the resident and their family members' expectations of what can occur until more information is obtained.
- Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.
- The LCA can provide information to the SNF/NF on the available community living situations, and options for community based supports and services including the levels and scope of what is possible.
- The nursing home and local contact agency team must explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, insufficient financial resources, problems with caregiving supports, community resource gaps, etc. preventing discharge to the community.

Examples

1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was "Yes" to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son's school and use handicapped accessible public transportation when he finds employment. He is worried whether he can afford or find housing with wheelchair accessible sinks, cabinets, countertops and appliances- accessible housing.

Q0600: Referral (cont.)

Coding: Q0500A would be coded 2, yes [Skip to Q0600].
Q0600 would be coded 2, yes.

Rationale: Q0400A would be coded yes, previous response was yes because Mr. S asked to be referred to the LCA and no referral was made. The social worker or discharge planner would make a referral to the designated local contact agency for their state and Q0600 would be coded as 2, yes.

2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns because of falls and difficulties cooking and proper nutrition. She said yes to Q0500B and yet there has not been time to contact her family or to ask Ms. V. about how realistic going home would be for her at this time. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed and feasible for Ms. V.

   Coding: Q0600 would be coded 1, no.

   Rationale: Ms. V indicated that she wanted to have an opportunity to talk to someone about return to community and yet there is insufficient time for the nursing home staff to talk to her and her family to determine whether the referral is possible and realistic. Q0600A would be coded as no- "referral not made." Because a referral was not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated to the designated local contact agency.