Track Changes
from Chapter 3 Section Q V1.05
to Chapter 3 Section Q V1.08

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>3</td><td>Q</td><td>Q-1</td><td>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. Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i) (3)). Section Q of the MDS uses a person-centered approach 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. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.</td></tr>
<tr><td>3</td><td>Q0100</td><td>Q-1</td><td>Replaced screen shot
OLD
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
NEW
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 available
Enter Code ☐ C. Guardian or legally authorized representative participated in assessment
0. No
1. Yes
9. No guardian or legally authorized representative available</td></tr>
<tr><td>3</td><td>Q0100</td><td>Q-1</td><td>Health-related Quality of Life
• Residents who actively participate in the assessment process and in developing the care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.</td></tr>
</table>

Chapter	Section	Page	Change
			DEFINITION 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.
3	Q0100	Q-1 & Q-2	**Planning for Care** • Each~~The~~ care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved—except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.15 Quality of Life). • During the 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 r~~Residents should be asked about inviting family members, significant others, and/or guardians/legally authorized representatives to participate, and if they desire that they ~~want their family or significant other(s) to~~ be involved in the assessment process. • If the individual resident is unable to understand the process, his or her family member, significant other, and/or guardian/legally authorized representative,

Track Changes
from Chapter 3 Section Q V1.05
to Chapter 3 Section Q V1.08

Chapter	Section	Page	Change
			who represents the individual, should be invited to attend the assessment process whenever possible. • When the resident is unable to participate in the assessment process, ~~a~~ family members, ~~or~~ significant others, and/or guardian/~~ or~~ legally authorized representatives can provide ~~valuable~~ information about the resident's needs, goals, and priorities.
3	Q0100	Q-2	**Steps for Assessment** 1. Review the medical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process. 2. Ask the resident, the family member 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	Q0100	Q-3	• Code 9, no family or significant other available: None of the above—resident has no ~~if there is no~~ family or significant other.
3	Q0100	Q-3	**Coding Instructions for Q0100C** • Code 9, no guardian or legally authorized representative available: ~~if there is no~~ None of the above—resident has no guardian or legally authorized representative.
3	Q0100	Q-3	• 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. • No family or significant other available means the individual resident has no family or significant other, not that they were not consulted.
3	Q0300	Q-3	Q0300: Resident's Overall Expectation *Complete only when A0310E=1. (First assessment on admission/entry or reentry.)*

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 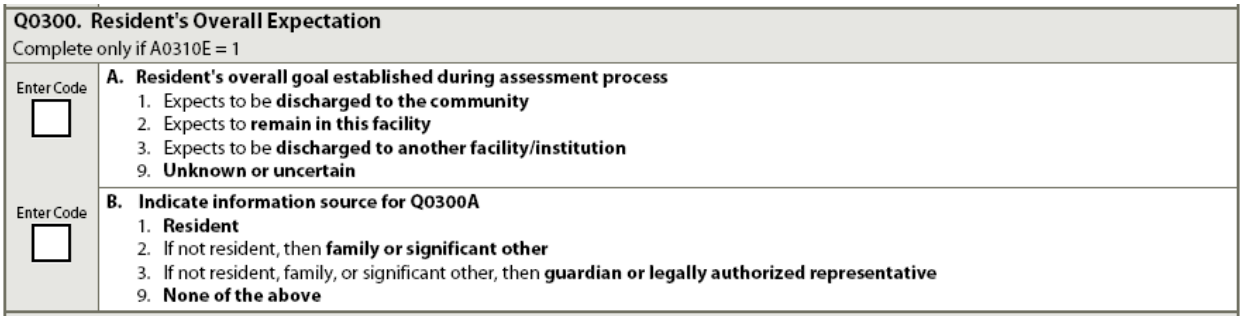
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<tr><td colspan="2">Q0300. Resident's Overall Expectation
Complete only if A0310E = 1</td></tr>
<tr><td>Enter Code</td><td>A. Resident's overall goal established during assessment process
1. Expects to be discharged to the community
2. Expects to remain in this facility
3. Expects to be discharged to another facility/institution
9. Unknown or uncertain</td></tr>
<tr><td>Enter Code</td><td>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</td></tr>
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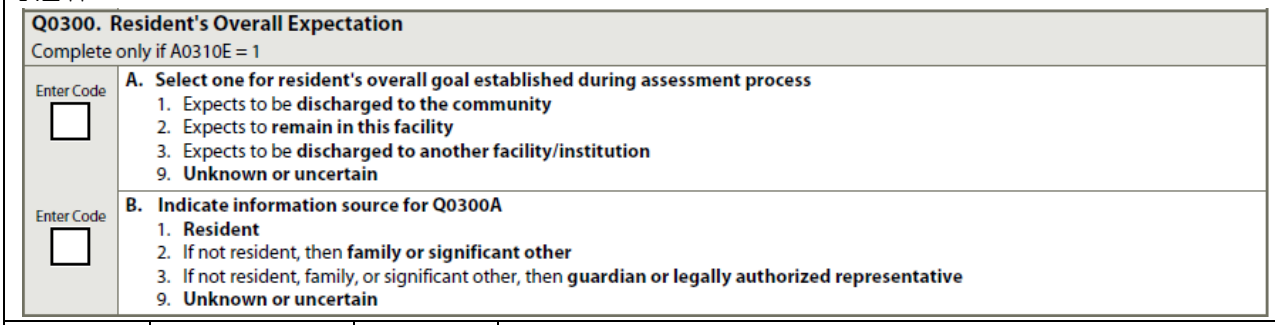
NEW
 
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<tr><td colspan="2">Q0300. Resident's Overall Expectation
Complete only if A0310E = 1</td></tr>
<tr><td>Enter Code</td><td>A. Select one for resident's overall goal established during assessment process
1. Expects to be discharged to the community
2. Expects to remain in this facility
3. Expects to be discharged to another facility/institution
9. Unknown or uncertain</td></tr>
<tr><td>Enter Code</td><td>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. Unknown or uncertain</td></tr>
</table></td></tr>
<tr><td>3</td><td>Q0300</td><td>Q-4</td><td>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. Additional assessment information may be needed to determine whether the resident requires additional community services and supports.</td></tr>
<tr><td>3</td><td>Q0300</td><td>Q-4 & Q-5</td><td>Steps for Assessment

1. Ask the resident about his or her overall expectations to be sure that ~~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 his or her current health~~clinical~~ status, expectations regarding improvement or worsening, ~~and~~ social supports, and opportunities to obtain services and supports in the</td></tr>
</table>

			community. ~~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.~~3. 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.~~4. The resident's stated goals should be recorded here. The goals for the resident, as described by the family, significant other, guardian, or legally authorized representative may also be recorded in the clinical record. ~~3.~~5. 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. ~~6. If the resident is unable to understand the question or to discuss his or her goals, then the goals for the resident, as perceived by the family, significant other, guardian, or legally authorized representative should be recorded.~~ 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. 7. In some guardianship situations, the decision-making authority regarding the individual's care is vested in

			the guardian. But this should not create a presumption that the resident is not able to comprehend and communicate their wishes.
3	Q0300	Q-5	**Coding Instructions for Q0300A** *Record the resident's expectations as expressed~~, whether they are realistic or not realistic~~. by her or him. It is important to document their expectations.*
3	Q0300	Q-5	• 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 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 do not exist or are not available to participate in the discussion.
3	Q0300	Q-5	**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 expectations ~~options~~; not whether or not the staff considers them to be ~~good or poor options~~ realistic or not. • Q0300A, Code 1 "expects to be discharged to the community" may include newly admitted Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid residents with adequate supports already in place that would not require referral to a local contact agency (LCA). It may also include residents who ask to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community (Q0500B, Code 1).

			• Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer a response based on a specific advance directive~~care order~~, ~~such as~~e.g., "do not resuscitate" (DNR).
3	Q0300	Q-6	**Coding Instructions for Q0300B** • Code 9, unknown or uncertain (none of the above): if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0300A = 9).
3	Q0300	Q-6	**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, specifically~~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.
3	Q0300	Q-7	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, and other work and family responsibilities, ~~we feel that~~ we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her." The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days and that the family does not have the capacity to provide all the care the resident needs.
3	Q0300	Q-8	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 1, Resident. ~~3, guardian or legally authorized representative.~~ Rationale: Ms. K. understands and is able to respond and says she would like to go back to the group home. Her expression of choice should be recorded. ~~but is unable to make decisions about her medical and other care needs.~~ When the legal guardian, with legal decision-making authority under state law, was told that Ms. K. is medically stable and would like to go back to the community, she confirmed~~decided~~ that it is in Ms. K.'s best interest to be transferred to a group home. This information should also be recorded in the individual's clinical record. (If Ms. K had not been able to communicate her choice and the guardian made the decision, Q0300B would have been coded 3.)

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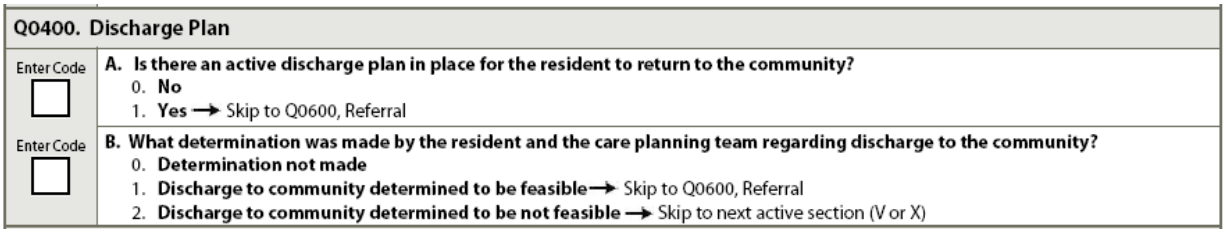
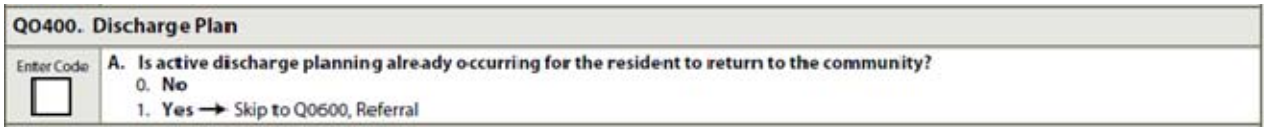
 

NEW
 
</td></tr>
<tr><td>3</td><td>Q0400</td><td>Q-8 & Q-9</td><td>

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to ~~the~~ a resident's health and quality of life.
- For residents who~~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~~ planning occurring (planning and implementation of a plan before discharge) 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

- Many~~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

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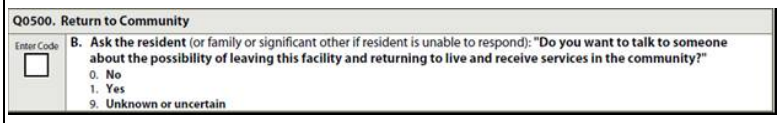
			available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U. S. Supreme Court decision in Olmstead v. L.C.~~ruling~~, which states that residents needing long term~~long-term care~~ services and supports have a right to receive services in the least restrictive and most integrated setting. • Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many~~some~~ individuals, ~~such as those with Alzheimer's disease,~~ who could be maintained in the~~ir~~ community ~~own~~ homes of their choice 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.~~ For example, a referral to the LCA may be appropriate for some individuals with Alzheimer's disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The interdisciplinary team should not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available. • Discharge instructions should include at a minimum: — the individual's preferences and needs for care and supports: o arrangements for housing; ~~and~~ o arrangements for transportation to follow-up appointments; and
3	Q0400	Q-10	— Section Q has ~~been~~ broadened the scope of~~beyond~~ the traditional boundary~~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,~~ transportation, employment if desired, and social engagement opportunities. ~~o 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.~~ The NF is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with transition services planning. They should work closely together. The LCA is the entity that does the community support planning, (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, etc.) A referral to the LCA may come from the nursing facility by phone, by e-mails by a state's on-line/website or by other state-approved processes. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process. o Each NH needs to develop relationships with their LCAs to work with them to contact the resident and their family, guardian, or significant others 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. o 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 States and local communities~~ and States, and may be barriers to some residents being able to return to the~~

			~~community~~. o Should a planned relocation not occur, it might~~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.
3	Q0400	Q-11	**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 to consider the resident's discharge planning needs. 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 address a resident's needs and arrange for that resident to discharge back to the community, ~~it may not be necessary for~~ a referral to the LCA may not be necessary. ~~This should be decided on a case-by-case basis.~~ Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a local contact agency (LCA) to access them. 4. Record the resident's expectations as expressed/communicated, whether you assess that they are realistic or not realistic. 5. If the resident's discharge needs cannot be met by the nursing facility, ~~is being discharged,~~ an evaluation of the ~~site~~ community living situation to evaluate whether it can meet the resident's needs should be conducted by the LCA, along with ~~or~~ other community providers who will

			be providing the transition and other community based services to determine ~~the safety of the resident's surroundings and~~ the need for assistive/adaptive devices, medical supplies, and equipment and other services. 6. The resident, his or her interdisciplinary team, and ~~local contact agency~~ LCA (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 considered~~assessed~~ prior to discharge to identify the options available to the individual~~determine where the resident will be discharged~~ (e.g., home, assisted living, board and care, or group ~~living~~homes, etc.). 8. ~~Determine if there will be~~A determination of family involvement, capability, and support after discharge should also be made.
3	Q0400	Q-12	**Coding Instructions for Q0400A, Is ~~There an~~ Active Discharge planning already occurring ~~in Place~~ for the Resident to Return to the Community?** • Code 0, no: if there is not ~~an~~ active discharge planning already occurring ~~in place~~ for the resident to return to the community. • Code 1, yes: if there is ~~an~~ active discharge planning already occurring ~~in place~~ for the resident to return to the community; skip to **Referral** item (Q0600).
3	Q0400	Q-12	~~**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.~~
3	Q0490	Q-12 & Q-13	Q0490: Resident's Preference to Avoid Being Asked Question Q0500B *For Quarterly, Correction to Quarterly, and Non-OBRA Assessments. (A0310A=02, 06, 99)*  Q0500. Return to Community 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 leaving this facility and returning to live and receive services in the community?" 0. No 1. Yes 9. Unknown or uncertain **Item Rationale** This item directs a check of the resident's clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question

			Q0500B until their next annual assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, Referral. Note: Let the resident know that they can change their mind at any time and should be referred to the LCA if they voice their request, regardless of schedule of MDS assessment(s). If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B. **Coding Instructions for Q0490, Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?** • Code 0, no: if there is no notation in the resident's clinical record that he or she does not want to be asked Question Q0500B again. • Code 1, yes: if there is a notation in the resident's clinical record to not ask Question Q0500B again, except on comprehensive assessments. Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600, Referral. If this is a comprehensive assessment, proceed to the next item Q0500B. • Code 8, Information not available: if there is no information available in the resident's clinical record or prior MDS 3.0 assessment. **Coding Tips** • Carefully review the resident's clinical record, including prior MDS 3.0 assessments, to determine if the resident or other respondent has previously responded No to item Q0550. If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item

			Q0550A.
3	Q0490	Q-13	**Examples** 1. Ms. G is a 45-year-old woman, 300 ~~lbs.,~~pounds, who is cognitively intact. She has CHF and shortness of breath requiring oxygen ~~at night~~ at all times. Ms. G also requires 2 person 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.~~ She was admitted to the nursing home 3 years ago after her daughter who was caring for her passed away. The nursing home social worker discussed options in which she could be cared for in the community but Ms. G refused to consider leaving the nursing home. During the review of her clinical record, the assessor found that on her last MDS assessment, Ms. G stated that she did not want to be asked again about returning to community living, that she has friends in the nursing facility and really likes the activities. Coding: ~~Q0400B~~ Q0490 would be coded 1, ~~discharge to the community is determined to be feasible; skip to item Q0600 (Referral)~~ Yes, skip to Q0600; because this is a quarterly assessment. If this is a comprehensive assessment, then proceed to the next item Q0500B. 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.~~ On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to

<table>
<tr><td></td><td></td><td></td><td>community living (No on Q0550A).

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 and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

Coding: ~~Q0400B~~Q0490 would be coded ~~2~~1, ~~discharge to the community is determined to be not feasible; skip to the next active assessment section (Section V or X)~~ Yes, skip to Q0600; Unless this is a comprehensive assessment, then proceed to the next item Q0500B.

Rationale: Mrs. R is not able to be interviewed. Her family requests that she opt out of the return to the community question because she becomes agitated.</td></tr>
<tr><td>3</td><td>Q0500</td><td>Q-14</td><td>Replaced screen shot.

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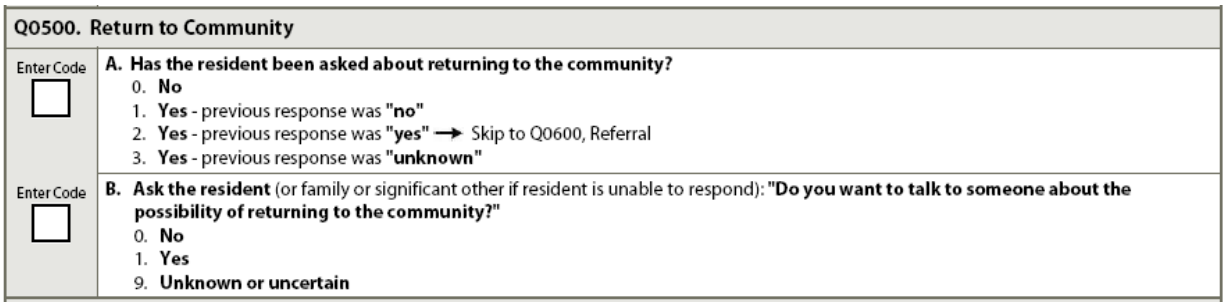
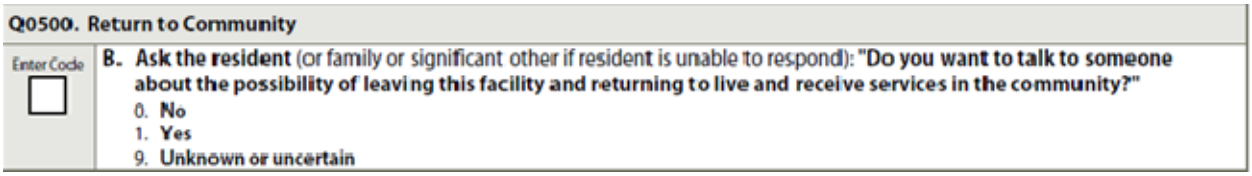
 

NEW
 
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<tr><td>3</td><td>Q0500</td><td>Q-14</td><td>Item Rationale

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local</td></tr>
</table>

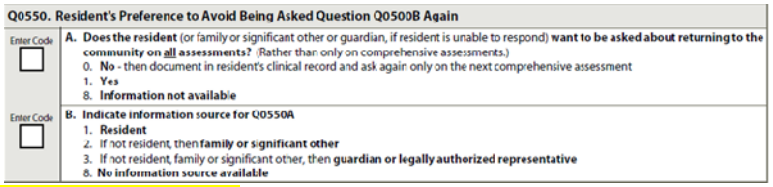
			contact agency to support the resident's expressed interest in being transitioned to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting 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 services and supports~~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.
3	Q0500	Q-14	**Health-related Quality of Life** • Returning home or to a non-institutional setting can be very important to the resident's health and quality of life. • The goal is to obtain the informed choice and preferences expressed ~~interest of~~by the resident and to provide information about available community supports and services ~~focus on the resident's preferences~~.
3	Q0500	Q-14	**Planning for Care** • Many~~Some~~ nursing home residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-institutional setting.
3	Q0500	Q-15	**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~~ make the resident comfortable by assuring him or her that this is a routine question that is asked of all residents. ~~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~~2. 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. A successful transition will depend on the resident's preferences and choices and the services, settings, and sometimes family supports that are available. 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. 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~~3. 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 not want to be referred to the LCA at this time. Also explain that the resident can change his/her mind at any time. ~~5~~4. 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 are~~is~~ not available, a guardian or legally authorized representative, if one exists, can provide the information.

			~~6~~5. 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.
3	Q0500	Q-15 & Q-16	~~**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?"**~~Ask the resident (or family or significant other or

			guardian or legally authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" • Code 9, unknown or uncertain: if the resident cannot understand or 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.
3	Q0500	Q-16	**Coding Tips** • A "yes~~— previous response was yes~~" response to item ~~Q0500A~~Q0500B 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. • Some residents will have a very clear expectation and some may ~~have changed~~change their expectations over time. ~~Other r~~Residents may also 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 critical ~~necessary~~ step. It is important to clarify the resident's discharge needs and expectations, determine what the SNF/NF usually provides ~~does~~ and can arrange, and ~~in some instances to determine whether their preferences are or are not feasible~~ obtain information about transition barriers or challenges based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24~~-~~hour care issues, etc. • Current return to community questions may upset residents who~~that~~ cannot understand what the question means ~~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 Q0500~~B~~, a family member, significant other, guardian, and/or legally appointed decision-maker for that individual could be asked the question.
3	Q0500	Q-17	**Examples** Example #1 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 (or facility 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. Example #2 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 contact agency within approximately 10 business days for them to initiate discussions with Ms. C. about returning to community living. Example #3 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.
3	Q0550	Q-18 & Q-19	Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again



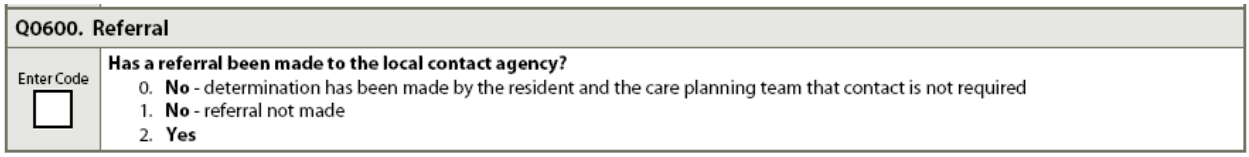
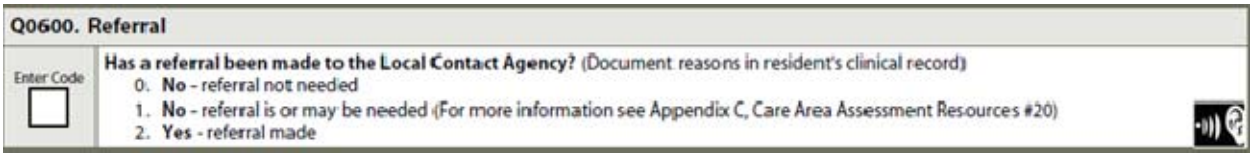
Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them if they want to return to the community. CMS pilot tested Q0500 language and determined that respondents would be less likely to be upset by being asked if they want to talk to someone about returning to the community if they were given the opportunity to opt-out of being asked the question every quarter. The intent of the item is to achieve a better balance between giving individual residents a voice and a choice about the services they receive, while being sensitive to those individuals who may be unable to voice their preferences or be upset by being asked question Q0500B in the assessment process.

Coding Instructions for Q0550A, **Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on <u>all</u> assessments** (rather than being asked yearly only on comprehensive assessments)?

- 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 be asked again on quarterly assessments about returning to the community. Then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.
- 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 be asked the return to community question Q0500B on all assessments.
- Code 9, information not available: 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. **Coding Instructions for Q0550B, Indicate information source for Q0550A** • Code 1, Resident: if resident responded to Q0550A. • Code 2, If not resident, then family or significant other. • Code 3, If not resident, family or significant other, then guardian or legally authorized representative. Code 8, No information source available: 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. **Example** 1. Ms. W is an 81 year old woman who was admitted after a fall that broke her hip, wrist and collar bone. Her recovery is slow and her family visits regularly. Her apartment is awaiting her **and** she hopes within the next 4-6 months to be discharged home. She and her family requests that discharge planning occur when she can transfer and provide more self-care. Coding: Q0550A would be coded 1, Yes. Q0550B would be coded 1. Rationale: Ms. W. needs longer term restorative nursing care to recover from her falls before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.

3	Q0600	Q-19	Replaced screen shot. OLD  NEW 
3	Q0600	Q-19	**Health-related Quality of Life** • Returning home or to a non-institutional setting can be very important to the resident's health and quality of life.
3	Q0600	Q-20	**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 non-institutional setting.
3	Q0600	Q-20	**Steps for Assessment: Interview Instructions** 1. If Item Q0400A is coded 1, yes, then complete this item. 2. If Item ~~Q0400B~~Q0490B is coded 1, yes, then complete this item. 3. If Item ~~Q0500A~~Q0500B is coded ~~2~~1, ~~yes previous response was~~ yes, then complete this item.
3	Q0600	Q-20	**Coding Instructions** • Code 0, no: Referral not needed; 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. Or, if resident or family,

			etc., responded no to Q0500B. • Code 1, no: Referral is or may be needed; 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~~ been initiated at this time. 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: Referral made; if referral was made to the local contact agency. For example, the resident responded yes to ~~Q0500A~~ Q0500B. The facility care planning team was notified and initiated contact with the local contact agency.
3	Q0600	Q-20	Added resource center information (in table) Local Contact Agency (LCA) Point of Contact List See www.cms.gov/CommunityServices/downloads/State_by_%20State_POC_list.pdf for listings.
3	Q0600	Q-21	**Coding Tips** • State Medicaid Agencies have designated Local Contact Agencies and a State point of contact (POC) to coordinate efforts to implement ~~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 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~~ of Local Contact Agencies and POC 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~~ results of user testing of the new items in Section Q. • Resource availability and eligibility coverage varies across States and 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~~ staff members 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 transitions 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. • 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.
3	Q0600	Q-22	**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 accessible housing with wheelchair accessible sinks, cabinets, countertops and appliances~~ accessible housing~~. Coding: ~~Q0500A~~ Q0500B would be coded ~~2~~1, 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~~ area 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~~. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. 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~~. The nursing home staff will focus on her therapies and talk to her and her family to obtain more information for discharge planning. ~~Q0600A~~ Q0600 would be coded as no- "referral ~~not made~~ is or may be needed." The Care Area Assessment #20 is triggered and it will be used to guide the follow-up process. 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.