

## 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. 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.

### Q0100: Participation in Assessment



Q0100. Participation in Assessment	
Enter Code <input type="checkbox"/>	A. Resident participated in assessment 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other available
Enter Code <input type="checkbox"/>	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative available

### Item Rationale

#### Health-related Quality of Life

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

#### Planning for Care

- Each 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).

#### DEFINITION

##### RESIDENT'S PARTICIPATION IN ASSESSMENT

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspective during assessment.

## Q0100: Participation in Assessment (cont.)

- During the care planning meetings, the resident should be made comfortable and verbal communication should be directly with him or her.
- Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate, and if they desire that they 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, 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, family members, significant others, and/or guardian/legally authorized representatives can provide information about the resident's needs, goals, and priorities.

### 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.

### 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. 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.

### 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.

## Q0100: Participation in Assessment (cont.)

- Code 1, yes: if the family or significant other(s) did participate in the assessment process.
- Code 9, no family or significant other available: None of the above—resident has no family or significant other.

### 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 available: None of the above—resident has no guardian or legally authorized representative.

### Coding Tips

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, 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.
- No family or significant other available means the individual resident has no family or significant other, not that they were not consulted.

## Q0300: Resident's Overall Expectation



*Complete only when A0310E=1. (First assessment on admission/entry or reentry.)*

Q0300. Resident's Overall Expectation	
Complete only if A0310E = 1	
Enter Code <input type="checkbox"/>	<b>A. Select one for resident's overall goal established during assessment process</b> 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 <input type="checkbox"/>	<b>B. Indicate information source for Q0300A</b> 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

## Q0300: Resident's Overall Expectation (cont.)

### 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.

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.

### Steps for Assessment

1. Ask the resident about his or her overall expectations to be sure that 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 status, expectations regarding improvement or worsening, social supports, and opportunities to obtain services and supports in the community.
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.
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.
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.

## Q0300: Resident's Overall Expectation (cont.)

6. Encourage the involvement of family or significant others in the discussion, if the resident consents. While family, significant others, or 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.

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

*Record the resident's expectations as expressed by her or him. It is important to document their expectations.*

- Code 1, expects to be discharged to the community: if the resident 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 indicates that 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 do not exist or are not available to participate in the discussion.

### 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; not whether or not the staff considers them to be 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, e.g., "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.

## Q0300: Resident's Overall Expectation (cont.)

- 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, 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).

### 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 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.

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.



## Q0300: Resident's Overall Expectation (cont.)

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, the level of care that she needs, and other work and family responsibilities, 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.

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.

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.

## Q0300: Resident's Overall Expectation (cont.)

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 1, Resident.

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. 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 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.)

## Q0400: Discharge Plan

Q0400. Discharge Plan	
Enter Code	A. Is active discharge planning already occurring for the resident to return to the community?
<input type="checkbox"/>	0. No
	1. Yes → Skip to Q0600, Referral

### Item Rationale

#### Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to a resident's health and quality of life.
- For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (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 adequate discharge 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.



## Q0400: Discharge Plan (cont.)

### Planning for Care

- Many 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 1999 U. S. Supreme Court decision in *Olmstead v. L.C.*, which states that residents needing long term services and supports 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/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be maintained in the community homes of their choice for long periods of time, depending on the residential setting and support services available. 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 personal identification and contact information, including Advance Directives;
    - o provider contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;
    - o brief medical history;
    - o current medications, treatments, therapies, and allergies;
    - o arrangements for durable medical equipment;
    - o arrangements for housing;
    - o arrangements for transportation to follow-up appointments; and
    - o 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.

## Q0400: Discharge Plan (cont.)

- 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 broadened the scope of the traditional boundary of discharge planning for sub-acute residents to encompass long stay residents. In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, transportation, employment if desired, and social engagement opportunities.
  - o 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.
  - o 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 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. Resource availability and eligibility coverage varies across States and local communities.
  - o Should a planned relocation not occur, it might 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 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.
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 the capability to address a resident's needs and arrange for that resident to discharge back to the community, a referral to the LCA may not be necessary. 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, an evaluation of the community living situation to evaluate whether it can meet the resident's needs should be conducted by the LCA, along with other community providers who will be providing the transition and other community based services to determine the need for assistive/adaptive devices, medical supplies, and equipment and other services.
6. The resident, his or her interdisciplinary team, and 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).
7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes, etc.).
8. A determination of family involvement, capability, and support after discharge should also be made.

## Q0400: Discharge Plan (cont.)

### Coding Instructions for Q0400A, Is Active Discharge planning already occurring for the Resident to Return to the Community?

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

## Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

*For Quarterly, Correction to Quarterly, and Non-OBRA Assessments. (A0310A=02, 06, 99)*

<b>Q0490. Resident's Preference to Avoid Being Asked Question Q0500B</b>	
Complete only if A0310A = 02, 06, or 99	
Enter Code	Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?
<input type="checkbox"/>	0. No
	1. Yes → Skip to Q0600, Referral
	8. Information not available

### 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.

## Q0490: Resident's Preference to Avoid Being Asked Question Q0500B (cont)

- 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.

### Examples

1. Ms. G is a 45-year-old woman, 300 pounds, who is cognitively intact. She has CHF and shortness of breath requiring oxygen at all times. Ms. G also requires 2 person assistance with bathing and transfers to the commode. 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: Q0490 would be coded 1, Yes, skip to Q0600; because this is a quarterly assessment.

If this is a comprehensive assessment, then proceed to the next item Q0500B.

Rationale: On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to community living (No on Q0550A).

2. Mrs. R is an 82-year-old widowed woman with advanced Alzheimer's disease. She 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: Q0490 would be coded 1, 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.

## Q0500: Return to Community



*For Admission, Quarterly, and Annual Assessments.*

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	<b>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?"</b> 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 services and supports in the least restrictive setting. CMS has found that in many cases individuals requiring long term services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations.

### 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.
- 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 informed choice and preferences expressed by the resident and to provide information about available community supports and services.

### Planning for Care

- Many 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.



## Q0500: Return to Community (cont.)

### Steps for Assessment: Interview Instructions

1. At the initial admission assessment and in subsequent follow-up assessments (as applicable), make the resident comfortable by assuring him or her that this is a routine question that is asked of all residents.
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.
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.
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 not available, a guardian or legally authorized representative, if one exists, can provide the information.
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.

**Coding Instructions for Q0500B, 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?”**

## Q0500: Return to Community (cont.)

- 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 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.

### Coding Tips

- A “yes” response to item 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.
- 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 change their expectations over time. 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 step. It is important to clarify the resident's discharge needs and expectations, determine what the SNF/NF usually provides and can arrange, and 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.
- 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 who cannot understand what the question means 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, a family member, significant other, guardian, and/or legally appointed decision-maker for that individual could be asked the question.

## Q0500: Return to Community (cont.)

### 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.

Coding: Q0500B would be coded 1, yes.

Rationale: 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.

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: 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.

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: Q0500B would be coded 0, no.

Rationale: During this assessment, he was asked about returning to the community and he responded no.

## Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code <input type="checkbox"/>	<b>A. 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 only on comprehensive assessments.)</b> 0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. Yes 8. Information not available
Enter Code <input type="checkbox"/>	<b>B. Indicate information source for Q0550A</b> 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 8. No information source available

### 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 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 all 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.

## Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again (cont.)

### 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.

## Q0600: Referral

Q0600. Referral	
Enter Code	Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)
<input type="checkbox"/>	0. No - referral not needed
	1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment (Resources #20))
	2. Yes - referral made

### Item Rationale

#### 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.

## Q0600: Referral (cont.)

### 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.

### Steps for Assessment: Interview Instructions

- If Item Q0400A is coded 1, yes, then complete this item.
- If Item Q0490B is coded 1, yes, then complete this item.
- If Item Q0500B is coded 1, yes, then complete this item.

### 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) that the designated local contact agency needs to be contacted but the referral has not 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 Q0500B. The facility care planning team was notified and initiated contact with the local contact agency.

#### 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.

#### Local Contact Agency (LCA) Point of Contact List

See [www.cms.gov/CommunityServices/downloads/State\\_by\\_%20State\\_POC\\_list.pdf](http://www.cms.gov/CommunityServices/downloads/State_by_%20State_POC_list.pdf) for listings.



## Q0600: Referral (cont.)

### Coding Tips

- State Medicaid Agencies have designated Local Contact Agencies and a State point of contact (POC) to coordinate efforts to implement Section Q 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](http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage).
  - The State-by-State list 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 results of user testing of the new items in Section Q.
- Resource availability and eligibility coverage varies across States and local communities and may present barriers to allowing some resident's return to their community. The nursing home and local agency 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 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.

## Q0600: Referral (cont.)

### 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 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.

Coding: Q0500B would be coded 1, yes.

Q0600 would be coded 2, yes.

Rationale: The social worker or discharge planner would make a referral to the designated local contact agency for their 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. 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 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. The nursing home staff will focus on her therapies and talk to her and her family to obtain more information for discharge planning. Q0600 would be coded as no- “referral 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.