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3	Q0100B	Q-2	<p>Coding Tips</p> <ul style="list-style-type: none"> 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.
3	Q0300	Q-5	<p>Coding Tips</p> <ul style="list-style-type: none"> 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.
3	Q0400	Q-8	<p>Planning for Care</p> <ul style="list-style-type: none"> Each situation is unique to the resident, his family, and/or guardian. A referral to the Local Contact Agency may be appropriate for some individuals, such as those with Alzheimer's disease, who could be maintained in their own homes for long periods of time, depending on the residential setting and support services available. Others may not be able to be discharged and be determined as not feasible by the interdisciplinary team because the intense level of services and supports that are needed are not available in the community, and the individual does not have family or other relationships that could support them.
3	Q0400	Q-10	<p>Steps for Assessment</p> <ol style="list-style-type: none"> 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.

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			<p>3. If a nursing facility has a discharge planning and referral and resource process for short stay residents that includes arranging for home health services, durable medical equipment, medical services, and appointments, etc., and there are not individual resident needs that the NF/SNF does not have the capability to arrange for that resident it may not be necessary for referral to the LCA. This should be decided on a case-by-case basis.</p> <p>4. Record the resident's expectations as expressed/communicated, whether they are realistic or not realistic.</p> <p>5.2. If the resident is being discharged, an evaluation of the site should be conducted to determine the safety of the resident's surroundings and the need for assistive/adaptive devices, medical supplies, and equipment.</p> <p>6.3. The resident, interdisciplinary team, and local contact agency (when a referral has been made to a local contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance) and make appropriate referrals.</p> <p>7.4. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be assessed prior to discharge to determine where the resident will be discharged (e.g., home, assisted living, board and care, group living).</p> <p>8.5. Determine if there will be family involvement and support after discharge.</p>
3	Q0400	Q-11	<p>Coding Tips</p> <ul style="list-style-type: none"> • 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

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			and skip to Q0600.
3	Q0500	Q-12	<p>Item Rationale</p> <p>The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident’s expressed interest in being transitioned to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living. The underlying intention of the return to the community item is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible. CMS has found that in many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations.</p>
3	Q0500	Q-13	<p>Steps for Assessment: Interview Instructions</p> <p>4. Explain that this item is meant to explore the possibility of different ways of receiving ongoing care. 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 be referred to the LCA at this time. Also explain that the resident can change his/her mind at any time.</p>

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3	Q0500	Q-14	<p>Coding Tips</p> <ul style="list-style-type: none"> • A “yes—previous response was yes” response to item Q0500A will trigger follow-up care planning and contact with the designated local contact agency about the resident’s request within approximately 10 business days of a yes response being given. This code is intended to initiate contact with the local agency for follow-up as the resident desires. • Follow-up is expected in a “reasonable” amount of time and 10 business days is a recommendation and not a requirement. The level and type of response needed by an individual is determined on a resident-by-resident basis. Some States may determine that the LCAs can make an initial telephone contact to identify the resident’s needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face to face visit. In some States, an initial meeting is set up with the resident, facility staff, and LCA together to talk with the resident about their needs and community care options. • Some residents will have a very clear expectation and some may have changed their expectations over time. Other residents may be unsure or unaware of the opportunities available to them for community living with services and supports. Talking with the resident regarding discharge goals and plans before referral to the LCA is a necessary step to clarify the resident’s discharge needs and expectations, determine what the SNF/NF usually does and can arrange, and in some instances to determine whether their preferences are or are not feasible based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24 hour care issues, etc. • The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF can talk with the LCA to see what is available that does not require family support. • Current return to community questions may upset residents that cannot go home and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500B, a family member, significant other guardian and/or legally appointed

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			<p>decision maker for that individual could be asked the question.</p> <ul style="list-style-type: none"> 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	Q0500	Q-16	<p>Example #1</p> <p>Rationale: Q0500A would be coded as no because Mr. B. had not been asked previously about returning to the community. Coding Q0500B as yes should trigger a visit by the nursing home social worker to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local agency within approximately 10 business days.</p>
3	Q0500	Q-16	<p>Example #2</p> <p>Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local agency within approximately 10 business days for them to initiate discussions with Ms. C. about returning to community living.</p>
3	Q0600	Q-17	<p>Coding Instructions</p> <ul style="list-style-type: none"> Code 0, no: determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident's discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral. Code 1, no: determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency needs to be contacted but the referral has not made. If the

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			<p>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.</p>
3	Q0600	Q-17	<p>Coding Tips</p> <ul style="list-style-type: none"> • State Medicaid Agencies have designated a State point of contact (POC) for Section Q implementation and are responsible to coordinate efforts to designate LCAs for their State’s skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate. • Several resources are available at the Return to Community web site at: http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage. — The State-by-State POC list for MDS 3.0 Section Q including State's Local Contact Agencies and Section Q Coordinator Information — MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues. — The Section Q Pilot Test Results report describes the implementation activities of the States that pilot tested Section Q and the need to establish collaborative arrangements at the local level. • Resource availability and eligibility coverage varies across local communities and States and these may present barriers to allowing some resident’s return to their community. The nursing home and local agency staffs should guard against raising the resident and their family members’ expectations of what can occur until more information is obtained. • Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident’s medical needs, finances and available community

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			<p>transition resources.</p> <ul style="list-style-type: none"> • The LCA can provide information to the SNF/NF on the available community living situations, and options for community based supports and services including the levels and scope of what is possible. • The nursing home and local contact agency team must explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible. • Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident’s medical condition, insufficient financial resources, problems with caregiving supports, community resource gaps, etc. preventing discharge to the community.
3	Q0600	Q-17	<p>Examples</p> <p>1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was “Yes” to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son’s school and use handicapped accessible public transportation when he finds employment. He is worried whether he can afford or find housing with wheelchair accessible sinks, cabinets, countertops and appliances-accessible housing.</p> <p>Coding: Q0500A would be coded 2, yes [Skip to Q0600].</p> <p>Q0600 would be coded 2, yes.</p> <p>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</p>

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			<p style="text-align: center;">to the designated local contact agency for their state and Q0600 would be coded as 2, yes.</p> <p>2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns because of falls and difficulties cooking and proper nutrition. She said yes to Q0500B and yet there has not been time to contact her family or to ask Ms. V. about how realistic going home would be for her at this time. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed and feasible for Ms. V.</p> <p style="text-align: center;">Coding: Q0600 would be coded 1, no. Rationale: Ms. V indicated that she wanted to have an opportunity to talk to someone about return to community and yet there is insufficient time for the nursing home staff to talk to her and her family to determine whether the referral is possible and realistic. Q0600A would be coded as no- “referral not made.” Because a referral was not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated to the designated local contact agency.</p>