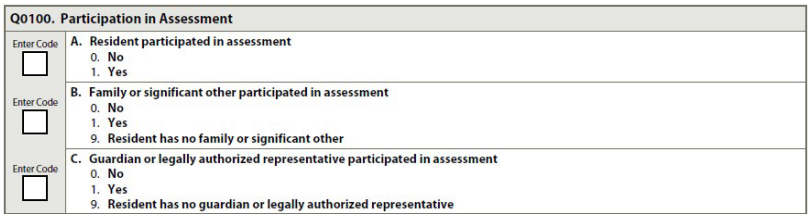
Track Changes
from Chapter 3 Section Q v1.17.1
to Chapter 3 Section Q v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	—	—	Updated language throughout to be gender neutral.
3	—	—	Updated screen captures of all items.
3	—	Q-1	**Intent:** Interviewing the resident or designated individuals places the resident or their family at the center of decision-making. 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 483.21(c)(1)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. This may not be a nursing home. This is also a civil right for all residents. ~~Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.~~
3	Q0110	Q-1	Q010~~1~~0: Participation in Assessment and Goal Setting
3	Q0110	Q-1	Replaced screenshot. OLD  NEW 
3	Q0110–Q0400	Q-2–Q8	Page length changed due to revised content.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0110	Q-2	• When the resident is unable to participate in the assessment process, a family member or significant other, and/or guardian or legally authorized representatives can provide information about the resident's needs, goals, and priorities on the resident's behalf.
3	Q0110	Q-2	**Steps for Assessment** 1. Review the ~~medical~~clinical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process.
3	Q0110	Q-2	**Coding Instructions for Q010~~1~~10A, ~~Resident~~ Participate~~d~~ion in Assessment and Goal Setting** *Record the participation of ~~the resident~~all those who participated in the assessment process. Check all that apply.* • **Code ~~0~~A, ~~No~~Resident:** if the resident ~~did not~~ actively participated in the assessment process. • **Code ~~1~~B, ~~Yes~~Family:** if a member of the resident's family actively ~~and meaningfully~~ participated in the assessment process.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0110	Q-2	**~~Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment~~** ~~*Record the participation of the family or significant other in the assessment process.*~~ • ~~**Code 0, No:** if the family or significant other did not participate in the assessment process.~~ • ~~**Code 1, Yes:** if the family or significant other(s) did participate in the assessment process.~~ • ~~**Code 9, Resident has no family or significant other:** Resident has no family or significant other.~~ **~~Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment~~** ~~*Record the participation of a 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, Resident has no guardian or legally authorized representative:** Resident has no guardian or legally authorized representative.~~

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0110	Q-2–Q-3	• **Code C, Significant other:** if a significant other of the resident actively participated in the assessment process. • **Code D, Legal guardian:** if a legal guardian actively participated in the assessment process. • **Code E, Other legally authorized representative:** if a legally authorized representative actively participated in the assessment process. • **Code Z, None of the above:** if none of the above actively participated in the assessment process.
3	Q0310	Q-3	Q030~~1~~10: Resident's Overall ~~Expectation~~Goal ~~*Complete only when A0310E = 1. (First assessment on admission/entry or reentry).*~~
3	Q0310	Q-3	Replaced screenshot. OLD **Q0300. Resident's Overall Expectation** Complete only if A0310E = 1 Enter Code ☐ **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** Enter Code ☐ **B. Indicate information source for Q0300A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family, or significant other, then **guardian or legally authorized representative** 9. **Unknown or uncertain** NEW **Q0310. Resident's Overall Goal** Complete only if A0310E = 1 Enter Code ☐ **A. Resident's overall goal for discharge established during the assessment process** 1. Discharge to the community 2. Remain in this facility 3. Discharge to another facility/institution 9. Unknown or uncertain Enter Code ☐ **B. Indicate information source for Q0310A** 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-4	## Planning for Care • The resident's goals should be the basis for care planning. • Great progress has been made in this area. This progress allows individuals more choices when it comes to care options and available support options 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 civil right to receive services in the least restrictive and most integrated setting appropriate to their needs.
3	Q0310	Q-4	## Steps for Assessment 1. Ask the resident about ~~his or her~~their overall expectations and goals to be sure that ~~he or she~~they ~~has~~have participated in the assessment process and ~~has~~have an ~~better~~ understanding of ~~his or her~~their current situation and the implications of ~~alternative~~ choices such as returning home~~,~~ or moving to another appropriate community setting such as an assisted living facility or an alternative healthcare setting.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-5	**Coding Instructions for Q03~~0~~10A, Resident's ~~O~~overall ~~G~~goals ~~for discharge E~~established during the ~~A~~assessment ~~P~~process** *Record the resident's expectations as expressed by ~~him or her~~them. It is important to document ~~his or her~~their expectations.* • **Code 1, ~~Expects to be d~~Discharged ~~to~~ to the community:** if the resident indicates an expectation to return home, to assisted living, or to another community setting. • **Code 2, ~~Expects to r~~Remain in this facility:** if the resident indicates that ~~he or she~~they expect~~s~~ to remain in the nursing home. • **Code 3, ~~Expects to be d~~Discharged ~~to~~ 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.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-5	**Coding Tips** • Th~~is~~e response to this item ~~i~~should be 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. Coding other than the resident's stated expectation is a violation of the resident's civil rights. • Q030~~0~~10A, Code 1 "~~Expects to be d~~Discharg~~ed~~ to the community" may include newly admitted ~~Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid~~residents with a facility-arranged discharge plan or those 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, Yes).
3	Q0310	Q-5	**DEFINITION** **DESIGNATED LOCAL CONTACT AGENCY (LCA)** Each state has community contact agencies that can provide individuals with information about community living options and available community-based supports and services. These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-6	**Coding Instructions for Q030~~0~~10B, Indicate ~~I~~information ~~S~~source for Q030~~0~~10A** • **Code 1, Resident:** if the resident is the source for completing this item. • **Code 2, ~~If not resident, then f~~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 because the resident is unable to respond. • **Code 3, Significant other~~If not resident, family or significant other, then guardian or legally authorized representative~~:** if a significant other of the resident ~~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 4, Legal guardian:** if a legal guardian of the resident is the source for completing this item because the resident is unable to respond. • **Code 5, Other legally authorized representative:** if a legally authorized representative of the resident is the source for completing this item because the resident is unable to respond. • **Code 9, ~~Unknown or uncertain (n~~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 (Q030~~0~~10A = 9).

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-6	1. ~~Mrs.~~Resident F~~.~~ is a 55-year-old married ~~woman~~individual who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. ~~She~~They ~~was~~were admitted to the nursing home 1 week ago for rehabilitation, specifically for transfer, gait ~~training~~, and wheelchair mobility training. ~~Mrs.~~Resident F~~.~~ is extremely motivated to return home. ~~Her~~Their ~~husband~~spouse is supportive and has been busy adapting their home to promote ~~her~~their independence. ~~Her~~Resident F's goal is to return home once ~~she~~they ~~has~~have completed rehabilitation. **Coding:** Q03~~0~~10A would be **coded 1, ~~Expects to be d~~Discharged ~~to the~~ community**. Q03~~0~~10B would be **coded 1, Resident**.
3	Q0310	Q-6	2. ~~Mr.~~Resident W~~.~~ is a 73-year-old ~~man~~individual who has severe heart failure and renal dysfunction. ~~He~~They also ~~has~~have a new diagnosis of metastatic colorectal cancer and was readmitted to the nursing home after a prolonged hospitalization for lower gastrointestinal (GI) bleeding. ~~He~~They rely~~ies~~ on nursing staff for all activities of daily living (ADLs). ~~He~~They indicate~~s~~ that ~~he~~they ~~is~~are "strongly optimistic" about ~~his~~their future and only want~~s~~ to think "positive thoughts" about what is going to happen and need~~s~~ to believe that ~~he~~they will return home. **Coding:** Q03~~0~~10A would be **coded 1, ~~Expects to be d~~Discharged ~~to the~~ community**. Q03~~0~~10B would be **coded 1, Resident**.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-7	3. ~~Ms.~~Resident T~~.~~ is a 93-year-old ~~woman~~individual with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about ~~her~~their care preferences, ~~she~~they ~~is~~are unable to voice consistent preferences for ~~her~~their own care, simply stating that "It's such a nice day.~~ Now let's talk about it more.~~" When ~~her~~their ~~daughter~~adult child is asked about goals for ~~her~~their ~~mother~~parent's care, ~~she~~they state~~s~~ 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~~adult child wants care oriented toward making ~~her~~their ~~mother~~parent comfortable in ~~her~~their final days, in the nursing home, and that the family does not have the capacity to provide all the care the resident needs. **Coding:** Q03~~0~~10A would be **coded 2, ~~Expects to r~~Remain in this facility**. Q03~~0~~10B would be **coded 2, Family ~~or significant other~~**. **Rationale:** ~~Ms.~~Resident T ~~is~~does not ~~able to~~ respond appropriately to the question of their care preferences, but ~~her~~their ~~daughter~~adult child has clear expectations that ~~her~~their ~~mother~~parent will remain in the nursing home where ~~she~~they will be made comfortable for ~~her~~their remaining days.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-7	4. ~~Mrs.~~Resident G~~.~~, an 84-year-old ~~female~~individual with severe dementia, is admitted by ~~her~~their ~~daughter~~adult child for a 7-day period. ~~Her~~Their ~~daughter~~adult child stated that ~~she~~they "just need~~s~~ to have a break." ~~Her~~Their ~~mother~~parent has been wandering at times and has little interactive capacity. The ~~daughter~~adult child is planning to take ~~her~~their ~~mother~~parent back home at the end of the week. **Coding:** Q030~~0~~10A would be **coded 1, ~~Expects to be d~~Discharged ~~to the community~~**. Q030~~0~~10B would be **coded 2, Family ~~or significant other~~**.
3	Q0310	Q-7	5. ~~Mrs.~~Resident C~~.~~ is a 72-year-old ~~woman~~individual who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, ~~she~~they ~~was~~were diagnosed with moderate dementia and ~~was~~were unable to voice consistent preferences for ~~her~~their own care. ~~She~~They ~~has~~have no living relatives and no significant other who is willing to participate in ~~her~~their care decisions. The court appointed a legal guardian to oversee ~~her~~their 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.~~Resident C~~.~~'s best interest that ~~she~~they be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete. **Coding:** Q030~~0~~10A would be **coded 3, ~~Expects to be d~~Discharged ~~to another facility/institution~~**. Q030~~0~~10B would be **coded ~~3~~4, Legal guardian ~~or legally authorized representative~~**.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0310	Q-8	6. ~~Ms.~~Resident K~~.~~ is a 40-year-old with cerebral palsy and a learning disability. ~~She~~They lived in a group home 5 years ago, but after a hospitalization for pneumonia ~~she~~they ~~was~~were admitted to the nursing home for respiratory therapy. Although ~~her~~their group home bed is no longer available, ~~she~~they ~~is~~are now medically stable and there is no medical reason why ~~she~~they could not transition back to the community. ~~Ms.~~Resident K~~.~~ states ~~she~~they want~~s~~ to return to the group home. ~~Her~~Their legal guardian agrees that ~~she~~they should return to the community to a small group home. **Coding:** Q030~~0~~10A would be **coded 1, ~~Expects to be d~~Discharged to the community ~~(small group homes are considered to be community setting)~~.** Q030~~0~~10B would be **coded 1, Resident**. **Rationale:** ~~Ms.~~Resident K~~.~~ understands and is able to respond and says ~~she~~they would like to go back to the group home. ~~Her~~Their expression of choice should be recorded. When the legal guardian, with legal decision-making authority under state law, was told that ~~Ms.~~Resident K~~.~~ is medically stable and would like to go back to the community, ~~she~~the legal guardian confirmed that it is in ~~Ms.~~Resident K~~.~~'s best interest to be transferred to a group home. Small group homes are considered community settings. 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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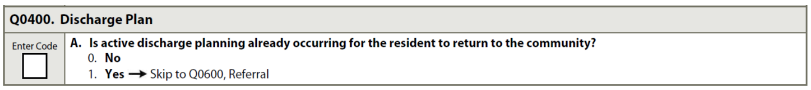
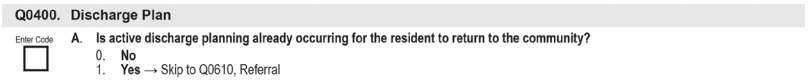
Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0400	Q-8	Replaced screenshot. OLD  NEW 
3	Q0400	Q-8	**Health-related Quality of Life** • Returning home or to a non-institutional setting can be very important to a resident's health and quality of life. • For residents who have been in the facility 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. Community resources and supports exist that may benefit these residents and allow them to return to a community setting.
3	Q0400	Q-9	**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 civil right to receive services in the least restrictive and most integrated setting appropriate to their needs.~~

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0400	Q-9	• 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 person(s) 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~~their 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.
3	Q0400	Q-9	• Discharge instructions should include at a minimum: — the individuals preferences and needs for care and supports; ○ personal identification and contact information, including Advance Directives; ○ ~~provider~~ contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;

3	Q0400	Q-9–Q-10	— Nursing ~~facility~~home (NH) procedures and discharge planning for sub-acute 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. ○ 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~~their wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts. ○ The N~~F~~H 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 providing information regarding community-based services and, when appropriate, transition services planning. The nursing facility interdisciplinary team and the LCA 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 or by a state's on-line/website or by other state-approved processes. Each state has a process for referral to an LCA, and it is vital to know the process in your state and for your facility. 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.
3	Q0400	Q-10	○ Each NH needs to develop relationships with their LCAs to work with them to contact the

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			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. ○ Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are ~~now~~ more readily available than in the recent past. Resource availability and eligibility coverage varies across States and local communities.
3	Q0400	Q-11	• For additional guidance, see CMS' **~~Planning for~~ Your Discharge Planning~~: A~~ cChecklist: ~~f~~For patients and their caregivers preparing to leave a hospital, nursing home, or other ~~health~~ care setting**. Available at https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf.
3	Q0400	Q-11	**DEFINITION** **ACTIVE DISCHARGE PLANNING** An **active** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future. If there is not an **active** discharge plan, residents should be asked if they want to talk to someone about community living (Q0500B) and then referred to the LCA accordingly. Furthermore, referrals to the LCA are recommended as part of many residents' discharge plans. Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.

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3	Q0400	Q-11	1. A review should be conducted of the care plan, the ~~medical~~clinical 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~~their 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.~~
3	Q0400	Q-11	43. Record the resident's expectations as expressed/communicated, whether ~~you assess~~NH staff believe 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.~~

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3	Q0400	Q-11	~~6~~4. The resident, ~~his or her~~their 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~~5. 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~~6. A determination of family involvement, capability and support after discharge should also be made. However, support from the family is not always necessary for a discharge to take place.
3	Q0400–Q0610	Q-12–Q-26	Page length changed due to revised content.
3	Q0400	Q-12	**Coding Instructions for Q0400A, Is ~~A~~active ~~D~~discharge planning already occurring for the ~~R~~resident to return to the ~~C~~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)~~.
3	Q0490	Q-12	Q0490: Resident's Documented Preference to Avoid Being Asked Question Q0500B *For Quarterly, Correction to Quarterly, and Not~~n~~-OBRA Assessments. (A0310A=02, 06, or 99)*

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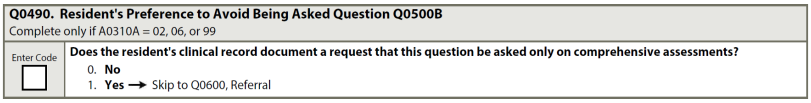
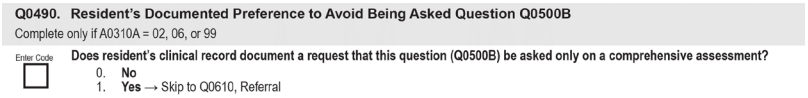
3	Q0490	Q-12	Replaced screenshot. OLD  NEW 
3	Q0490	Q-12	**Item Rationale** This item directs a check of the resident's clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next comprehensive 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 Q0~~550~~490 allows them to opt-out of being asked question Q0500B on ~~q~~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 ~~q~~Quarterly assessment, then skip to item Q06~~0~~10, **Referral**. Q0500B is, however, mandatory on all comprehensive assessments. Note: Let the resident know that they can change their mind about requesting information regarding possible return to the community at *any* time and should be referred to the LCA if they voice this request, regardless of schedule of MDS assessment(s). If this is a comprehensive assessment, do not skip to item Q06~~0~~10, continue to item Q0500B.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0490	Q-13	**Coding Instructions for Q0490, Does the resident's clinical record document a request that this question (Q0500B) be asked only on comprehensive assessments?** • **Code 0, No:** if there is no notation in the resident's clinical record that ~~he or she~~they do~~es~~ 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 Q06~~0~~10, **Referral**. If this is a comprehensive assessment, proceed to the next item, Q0500B.
3	Q0490	Q-13	**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 Q0550A.

Track Changes
from Chapter 3 Section Q v1.17.1
to Chapter 3 Section Q v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0490	Q-14	**Examples** 1. ~~Ms.~~Resident G is a 45-year old ~~woman~~individual ~~,~~weighing 300 pounds, who is cognitively intact. ~~She~~They ~~has~~have ~~CHF~~congestive heart failure and shortness of breath requiring oxygen at all times. ~~Ms.~~Resident G also requires 2 person assistance with bathing and transfers to the commode. ~~She~~They ~~was~~were admitted to the ~~nursing home~~NH 3 years ago after ~~her~~their ~~daughter~~adult child who was caring for ~~her~~them passed away. ~~The nursing home~~ During their Quarterly assessment, the NH social worker discussed options in which ~~she~~they could be cared for in the community but ~~Ms.~~Resident G refused to consider leaving the ~~nursing home~~NH. During the review of ~~her~~their clinical record, the assessor found that on ~~her~~their last MDS assessment, ~~Ms.~~Resident G stated that ~~she~~they did not want to be asked again about returning to community living, that ~~she~~they ~~has~~have friends in the ~~nursing facility~~NH and really like~~s~~ the activities. **Coding:** Q0490 would be **coded 1, Yes, skip to Q060~~1~~0; because this is a ~~q~~Quarterly assessment.** If this ~~is~~was a comprehensive assessment, then proceed to the next item Q0500B. **Rationale**: On ~~her~~their last MDS 3.0 assessment, ~~Ms.~~Resident G indicate~~s~~d ~~her~~their preference to not want to be asked again about returning to community living (0. No on Q0550A).

Track Changes
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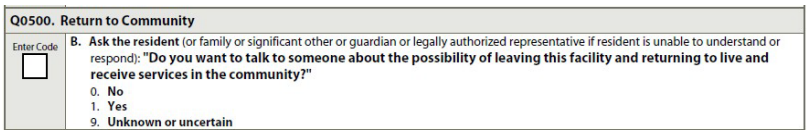
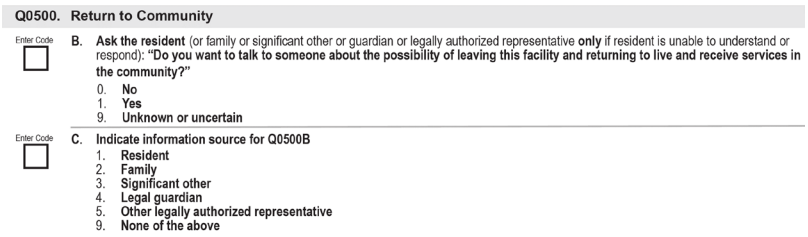
Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0490	Q-14	2. ~~Mrs.~~Resident R is an 82-year-old widowed individual with advanced Alzheimer's disease. ~~She~~They ~~has~~have resided at the nursing home for 4½ years and ~~her~~their family requests that ~~she~~they not be interviewed because ~~she~~they become~~s~~ 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 Q0601~~0~~;.** ~~Unless~~ If this is a comprehensive assessment~~, then~~ proceed to the next item, Q0500B. **Rationale:** ~~Mrs.~~Resident R's ~~is not able to be interviewed. Her~~ family requests that ~~she~~they opt out of the return to the community question because ~~she~~they become~~s~~ agitated when asked about return to community. They are only asked with comprehensive assessments.
3	Q0500	Q-15	Replaced screenshot. OLD  **Q0500. Return to Community** Enter Code ☐ **B. 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?"** 0. No 1. Yes 9. Unknown or uncertain NEW  **Q0500. Return to Community** Enter Code ☐ **B. Ask the resident** (or family or significant other or guardian or legally authorized representative **only** 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?"** 0. No 1. Yes 9. Unknown or uncertain Enter Code ☐ **C. Indicate information source for Q0500B** 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-15	**Item Rationale** The goal of follow-up action is to initiate and maintain collaboration between the ~~nursing home~~NH and the ~~local contact agency~~LCA to support the resident's expressed interest in talking to someone about the possibility of leaving the facility and returning to live and receive services in the community. ~~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 if it is the resident's desire.~~ The underlying intention of the return to the community item is to ~~i~~ensure 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 appropriate for their needs. 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. ~~Local contact agencies (~~LCAs~~)~~ are experts in available home and community-based service (HCBS) and can provide both the resident and the facility with valuable information.

Track Changes
from Chapter 3 Section Q v1.17.1
to Chapter 3 Section Q v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-15	**Health-related Quality of Life** • Returning home or to a non-institutional setting can be beneficial to the residents' 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 civil 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~~their 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~~honored and appropriate follow-up measures will be taken.
3	Q0500	Q-16	**Planning for Care** • Many ~~nursing home~~NH residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-institutional setting.

Track Changes
from Chapter 3 Section Q v1.17.1
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-16	2. Ask the resident if ~~he or she~~they would like to speak with someone about the possibility of returning to live and receive services 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~~ing~~ the ~~nursing home~~NH 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~~they can change ~~his or her~~their decision (i.e., whether or not ~~he or she~~they 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, if necessary.~~ 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~~their mind at ***any*** time.

Track Changes
from Chapter 3 Section Q v1.17.1
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-16	4. If the resident is unable to communicate ~~his or her~~their 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~~they want~~s~~ information about different kinds of supports that may be available ~~for~~to support community living. Responding **"yes"** will be a way for the individual—and ~~his or her~~their 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. It is simply a request for information, not a request for discharge.
3	Q0500	Q-17	**Coding Instructions for Q0500B, Ask the resident** (or family or significant other or guardian or legally authorized representative **only** 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?"** *A response code of 1, Yes, for this item indicates a ~~request~~desire to learn about home and community based services, it is not a request for discharge.*

Track Changes
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-17	**Coding Instructions for Q0500C, Indicate information source for Q0500B** • **Code 1, Resident:** if the resident is the source for completing this item. • **Code 2, Family:** if a family member is the source for completing this item because the resident is unable to respond. • **Code 3, Significant other:** if a significant other of the resident is the source for completing this item because the resident is unable to respond. • **Code 4, Legal guardian:** if a legal guardian of the resident is the source for completing this item because the resident is unable to respond. • **Code 5, Other legally authorized representative:** if a legally authorized representative of the resident is the source for completing this item because the resident is unable to respond. • **Code 9, None of the above:** if the resident cannot respond and the family, significant other, guardian, or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0310A = 9).

Track Changes
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-18	**Coding Tips** • A "yes" response to item Q0500B will trigger follow-up care planning and contact with the facility's designated ~~local contact agency (~~LCA~~) about the resident's request within approximately 10 business days (or according to state policy) of a yes response being given. This code is intended to initiate contact with the LCA for follow-up as the resident desires~~. • Follow-up by the LCA is expected in a "reasonable" amount of time~~ and 10 business days is a recommendation and not a requirement~~. Each state has its own policy for follow-up. It is important to know your state's policy. 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.

Track Changes
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-18	• 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 needed 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~~NHshould not assume that the resident cannot transition out of the SNF/~~NF~~NH due to their level of care needs. The SNF/~~NF~~NH and the resident ~~can~~should talk with the LCA to see what ~~is~~options are available for living and receiving services in the community. • ~~Current r~~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 resident's documented 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 should be asked the question.

Track Changes
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-19	**Examples** 1. ~~Mr.~~Resident B~~.~~ is an 82-year-old ~~male~~individual with COPD. ~~He~~They ~~was~~were referred to the ~~nursing home~~NH by ~~his~~their physician for end-of-life palliative care. ~~He~~They responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why ~~Mr.~~Resident B~~.~~ is afraid and explain that obtaining more information may help overcome some of ~~his~~their fears. ~~He~~They should also be informed that someone from an ~~local contact agency~~LCA is available to provide ~~him~~them with more information about receiving services and supports in the community. At the close of this discussion, ~~Mr.~~Resident B~~.~~ says that ~~he~~they 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~~ NH social worker to assess fears and concerns, as well as the designated ~~local contact agency~~LCA within a specified time frame established ~~approximately 10 business days, or~~ according to state policy.

Track Changes
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0500	Q-19	2. ~~Ms.~~Resident C~~.~~ is a 45-year-old ~~woman~~individual with cerebral palsy and a learning disability who has been living in the ~~Hope Nursing Home~~facility for the past 20 years. ~~She~~They once lived in a group home but became ill and required hospitalization for pneumonia. After recovering in the hospital, ~~Ms.~~Resident C~~.~~ was sent to the ~~nursing home~~NH because ~~she~~they ~~now~~ required regular chest physical therapy and was told that ~~she~~they could no longer live in ~~her~~their previous group home because ~~her~~their needs were more intensive. No one had asked ~~her~~them about returning to the community until now. When administered the MDS assessment, ~~she~~they responded yes to item Q0500B. **Coding:** Q0500B would be **coded 1, Yes**. **Rationale:** ~~Ms.~~Resident C~~.~~'s discussions with staff in the ~~nursing home~~NH should ~~result in a visit by the nursing home social worker or discharge planner. Her response should~~ be noted in ~~her~~their care plan, and care planning should be initiated to assess ~~her~~their preferences and needs for possible transition to the community. ~~Nursing home~~NH staff should contact the designated ~~local contact agency~~LCA ~~within approximately 10 business days, or~~ according to established state ~~policy~~guidelines, for them to initiate discussions with ~~Ms.~~Resident C~~.~~ about options for returning to community living.
3	Q0500	Q-19	3. ~~Mr.~~Resident D. is a 65-year-old ~~man~~individual with a severe heart condition and interstitial pulmonary fibrosis. At the last ~~q~~Quarterly assessment, ~~Mr.~~Resident D. had been asked about returning to the community and ~~his~~their response was no. ~~He~~They also respond~~s~~ed no to item Q0500B. The assessor should ask why ~~he~~they responded no. Depending upon the~~i~~s 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.~~Resident D. responds no to the follow-up questions and does not want to offer any more information or talk about it any further.

Track Changes
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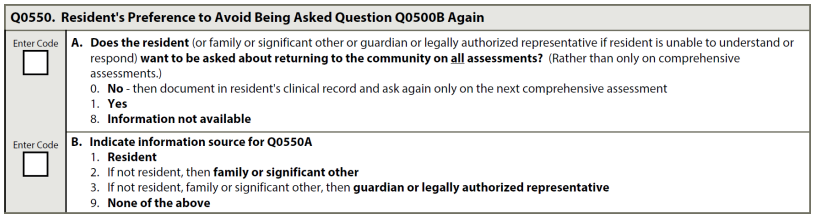
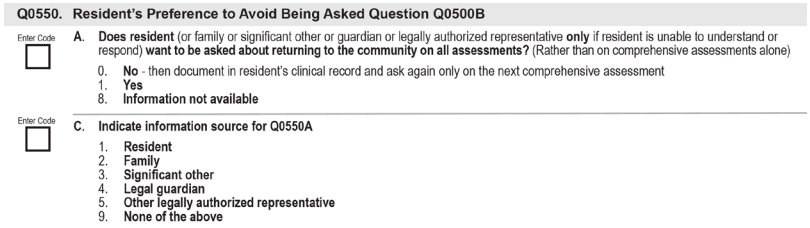
Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0550	Q-20	Q0550: Resident's Preference to Avoid Being Asked Question Q0500B ~~Again~~
3	Q0550	Q-20	Replaced screenshot. OLD  NEW 
3	Q0550	Q-20	**Item Rationale** Some individuals, such as those with cognitive impairments, mental illness, or end-stage ~~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.

Track Changes
from Chapter 3 Section Q v1.17.1
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0550	Q-20	**Coding Instructions for Q0550A, Does the resident~~,~~ (or family or significant other or guardian or legally authorized representative only if resident is unable to understand or respond) want to be asked about returning to the community on all assessments? (Rather than ~~only~~ on comprehensive assessments alone~~.~~)** • **Code 0, No:** if the resident (or family or significant other, or guardian or legally authorized representative) states that ~~he or she~~they do~~es~~ not want to be asked again on ~~a~~Quarterly assessments about returning to the community. ~~Then~~ In this case, 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~~they do~~es~~ want to be asked the return to community question, Q0500B, on all assessments.
3	Q0550	Q-21	**Coding Instructions for Q0550B~~B~~C, Indicate information source for Q0550A** • **Code 1, Resident:** if resident responded to Q0550A. • **Code 2, ~~If not resident, then f~~Family ~~or~~.** • **Code 3, ~~s~~Significant other.** • **Code ~~3~~4, ~~If not resident, family or significant other, then~~Legal guardian ~~or~~.** • **Code 5, Other legally authorized representative.** • **Code 9, None of the above.**

Track Changes
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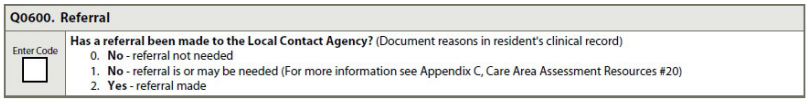
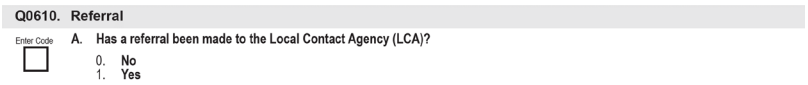
to Chapter 3 Section Q v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0550	Q-21	1. ~~Ms.~~Resident W is an 81 year old ~~woman~~individual who was admitted after a fall that broke ~~her~~their hip, wrist and collar bone. ~~Her~~Their recovery is slow and ~~her~~their family visits regularly. ~~Her~~Their apartment is awaiting ~~her~~them and ~~she~~they hope~~s~~ within the next 4–6 months to be discharged home. When asked, resident W stated that they would like to be asked about discharging to the community on all assessments. ~~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.** Q0550~~B~~C would be **coded 1, Resident.** **Rationale:** ~~Ms.~~Resident W~~. needs longer term restorative nursing care to recover from her injuries 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.~~ responded yes to item Q0550A, indicating they want to be asked about returning to the community on all assessments.
3	Q0610	Q-22	Q06~~0~~10: Referral
3	Q0610	Q-22	Replaced screenshot. OLD  Q0600. Referral Enter Code Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record) 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 NEW  Q0610. Referral Enter Code A. Has a referral been made to the Local Contact Agency (LCA)? 0. No 1. Yes

Track Changes
from Chapter 3 Section Q v1.17.1
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0610	Q-22	**Health-related Quality of Life** • Returning home or transitioning to a non-institutional setting can be very important to the resident's health and quality of life. **Planning for Care** • Some ~~nursing home~~NH residents may be able to return to the community if they are provided assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

Track Changes
from Chapter 3 Section Q v1.17.1
to Chapter 3 Section Q v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0610	Q-22	**Coding Instructions for Q0610: Has a referral been made to the Local Contact Agency (LCA)?** • **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.~~**:** if a referral has not been made. • **Code 1, ~~No~~Yes ~~- 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.~~ if a referral has been made. If a referral has been made skip to V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment. • **~~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.~~

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0610	Q-23	
			~~**DEFINITION**~~ ~~**DESIGNATED LOCAL CONTACT AGENCY (LCA)**~~ ~~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 and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.~~
3	Q0610	Q-23	**Coding Tips** • State Medicaid Agencies (SMAs) are required to have designated ~~Local Contact Agencies (~~LCA~~)~~ and a State point of contact (POC). The SMA is responsible for ~~to~~ coordinate~~ing efforts to~~ implementation of Section Q and designate~~ing~~ LCAs for their State's ~~skilled nursing facilities~~SNFs and NHs~~nursing facilities~~. These ~~local contact agencies~~LCAs may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Centers for Independent Living~~ Centers~~, or other entities the State may designate. LCAs have a Data Use Agreement (DUA) with the SMA to allow them access to MDS data. It is important that each facility know who their LCA and POC are and how to contact them.
3	Q0610	Q-23	• ~~Several resources are available on the Return to Community web site at: https://www.medicaid.gov/medicaid/ltss/community-living/index.html.~~ ~~— 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.~~ ~~— Videos of Section Q sessions and discussions at the 2010 RAI Coordinators Conference.~~

Track Changes
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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0610	Q-23	• Resource availability and eligibility ~~coverage~~ varies across States and local communities and may present barriers to allowing some residents to return to their community. The ~~nursing home~~NH and ~~local contact agency~~LCA staff members should guard against raising the expectations of residents and their family members~~' expectations~~ of what can occur until more information is obtained. • Close collaboration between the ~~nursing facility~~NH and the ~~local contact agency~~LCA is needed to evaluate the resident's medical needs, finances and available community transition resources.
3	Q0610	Q-23	• The LCA can provide information to the SNF/N~~F~~H on the available community living situations, and options for community based supports and services including the level~~s~~ and scope of what is possible. • The ~~local contact agency~~LCA team will 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~~NH staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, problems with securing appropriate caregiving supports, community resource gaps, etc., preventing discharge to the community.
3	Q0610	Q-23	• When Q06~~0~~10A is answered ~~1~~0, 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.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0610	Q-24	**Examples** 1. ~~Mr.~~Resident S~~.~~ is a 48-year-old ~~man~~individual who suffered a stroke, resulting in paralysis below the waist. ~~He~~They ~~is~~are responsible for ~~his~~their 8-year old ~~son~~child, who now stays with ~~his~~their grand~~mother~~parent. At the last ~~q~~Quarterly assessment, ~~Mr.~~Resident S~~.~~ had been asked about returning to the community and ~~his~~their response was "Yes" to item Q0500B and ~~he~~they report~~s~~ no contact from the LCA. ~~Mr.~~Resident S~~.~~ is more hopeful ~~he~~they can return home as ~~he~~they become~~s~~ stronger in rehabilitation. ~~He~~They want~~s~~ a location to be able to remain active in ~~his~~their ~~son~~child's school and use accessible public transportation when ~~he~~they find~~s~~ employment. ~~He~~They ~~is~~are worried whether ~~he~~they can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops, appliances, doorways, etc. The social worker documented the resident's responses and made a referral to the LCA. **Coding:** Q0500B would be **coded 1, Yes**~~.~~; Q06~~0~~10A would be **coded ~~2~~1, Yes**. **Rationale:** The social worker or discharge planner would make a referral to the designated ~~local contact agency~~LCA for their area and Q06~~0~~10A would be coded as ~~2~~1, ~~y~~Yes, because a referral to the designated LCA was made.

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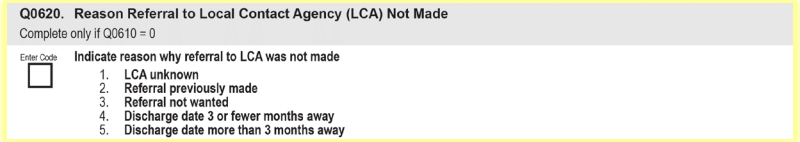
3	Q0610	Q-24	2. ~~Ms.~~Resident V~~.~~ is an 82-year-old ~~female~~individual with right sided paralysis, mild dementia, and diabetes ~~and~~who was admitted by the family because of safety concerns due to falls and difficulties cooking and proper nutrition. ~~She~~Resident V said no to Q0500B, but that they may wish this information at a later date, expressing their feeling that they are not yet ready to plan for community transition. ~~She~~They need~~s~~ to continue ~~her~~their rehabilitation therapy and regain ~~her~~their strength and ability to transfer. The social worker plans to talk to the resident and ~~her~~their family during future Quarterly assessments to determine whether a referral to the LCA is needed for ~~Ms.~~Resident V~~.~~ to return to the community. **Coding:** Q06~~0~~10A would be **coded ~~1~~0, No**. **Rationale:** ~~Ms.~~Resident V~~.~~ indicated that ~~she~~they wanted to have an opportunity to talk to someone about return to community, but that they were not yet ready. The ~~nursing home~~NH staff will focus on ~~her~~their therapies and talk to ~~her~~them and ~~her~~their family to obtain more information for discharge planning in future months. Q06~~0~~10A would be coded as 0, ~~n~~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~~LCA.
3	Q0620	Q-25	Q0620: Reason Referral to Local Contact Agency (LCA) Not Made *Complete only if Q0610 = 0.*  Q0620. Reason Referral to Local Contact Agency (LCA) Not Made Complete only if Q0610 = 0 Enter Code ☐ Indicate reason why referral to LCA was not made 1. LCA unknown 2. Referral previously made 3. Referral not wanted 4. Discharge date 3 or fewer months away 5. Discharge date more than 3 months away

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3	Q0620	Q-25	**Item Rationale** **Health-related Quality of Life** • Understanding the reason that referrals to the LCA were not made can help the care team support the resident to receive care that supports them to achieve their highest practicable level of functioning in the least restrictive setting. **Planning for Care** • Understanding the reason that referrals to the LCA were not made allows for comprehensive care planning by the facility team in conjunction with the resident and their family.
3	Q0620	Q-25	**Steps for Assessment** 1. If Q0610: Referral = 0, No, indicate the primary reason that the referral has not been made to the LCA.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	Q0620	Q-25	**Coding Instructions for Q0620, Reason Referral to Local Contact Agency (LCA) Not Made** • **Code 1, LCA unknown** • **Code 2, Referral previously made:** if a referral has previously been made to the LCA, which is currently working with the resident and facility staff on an active discharge plan to return to the community. • **Code 3, Referral not wanted:** if the resident (or family, significant other, legal guardian, or other legally authorized representative ***only*** if resident doesn't understand or is unable to respond) responded they do not want a referral (Q0500B = 0). • **Code 4, Discharge date 3 or fewer months away:** if the resident has an expected discharge date of three (3) months or fewer, has an active discharge plan in progress, and the discharge plan could not be improved upon with a referral to the LCA. • **Code 5, Discharge date more than 3 months away:** if the resident has an expected discharge date of more than three (3) months and discharge plan is actively in progress.

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3	Q0620	Q-26	**Examples** 1. Resident S has been in the nursing home for several months following an automobile accident. They plan to return home after their therapy regime ends, which is expected in three to four weeks. In conjunction with Resident S's Admission assessment, the facility team made a referral to the LCA but the agency is not currently working with the resident. The interdisciplinary team and the resident have developed a safe discharge plan for Resident S that could not be improved upon with a referral to the LCA. **Coding:** Q0620 would be **coded 4, Discharge date 3 or fewer months away.** **Rationale:** Resident S's discharge is expected within three to four weeks, and their discharge plan could not be improved upon with a referral to the LCA.
3	Q0620	Q-26	2. Resident J is unable to communicate verbally due to severe dementia. Their spouse met with the care team, and the spouse and care team agree that long-term nursing home placement on the secure dementia unit is appropriate for Resident J. The spouse declined a referral to the LCA. **Coding:** Q0620 would be **coded 3, Referral not wanted.** **Rationale:** Resident J is unable to communicate verbally due to severe dementia. Their spouse declined a referral to the LCA as they and the care team agree that long-term placement on the secure dementia unit is appropriate for Resident J.