



Minimum Data Set (MDS) 3.0
Instructor Guide

Section Q

Participation in Assessment and Goal Setting

Objectives

- Identify steps to assessing the resident's overall expectation.
- Recognize when an active discharge plan is in place.
- Understand how to ask the resident if he or she would like to talk to someone and receive information about community care.
- Identify the steps to make a referral to a local contact agency.

Methodology

This lesson uses lecture, scenario-based examples, scenario-based practice, and video.

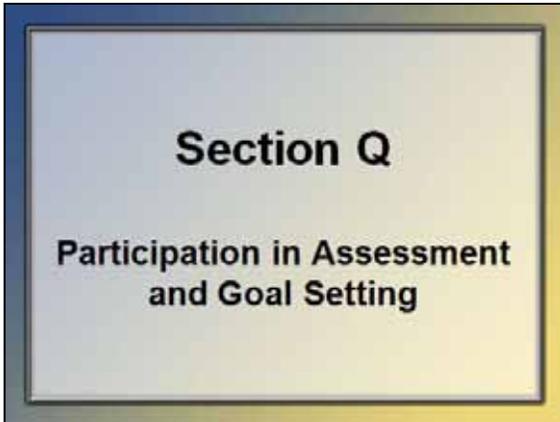
Training Resources

- Instructor Guide
- Slides 1 to 68
- Video: Section Q Interview

Instructor Preparation

- Review the Instructor Guide.
- Review learning objectives for the lesson.
- Rehearse with slide presentation and video.

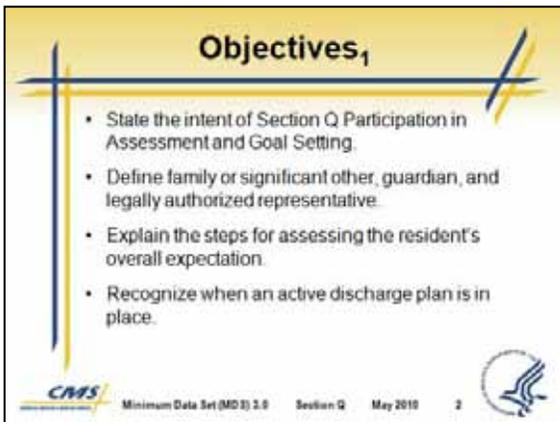
SLIDES	INSTRUCTIONAL GUIDANCE
Instructor Notes Direct participants to Section Q of the MDS 3.0 instrument.	Instructor Notes



Slide 1

I. Introduction/ Objectives

- A. Section Q has been significantly revised to address the role the resident and of the family and/ or significant others in the assessment and the discussion of goals for the resident’s care.



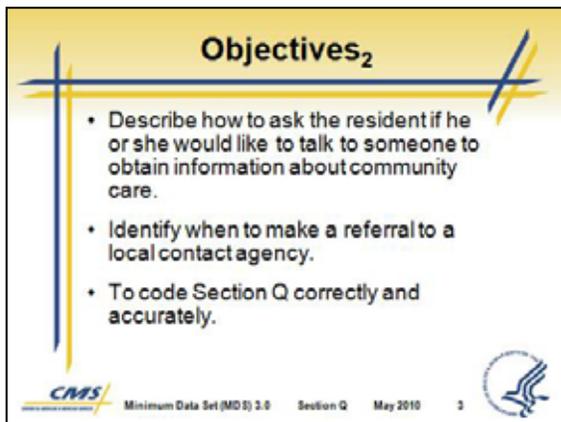
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B. Objectives

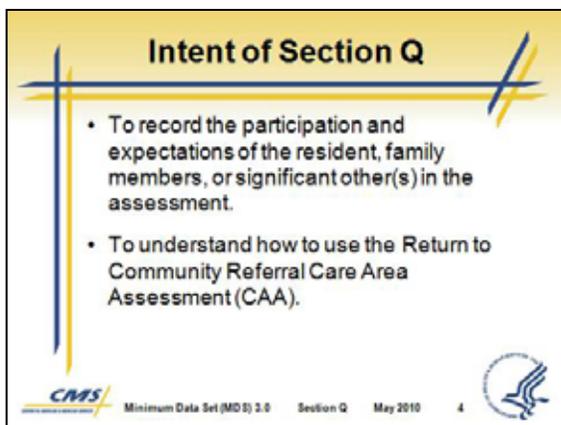
- State the intent of Section Q Participation in Assessment and Goal Setting
- Define family or significant other and guardian or legally authorized representative.
- Explain the steps for assessing the resident’s overall expectation.

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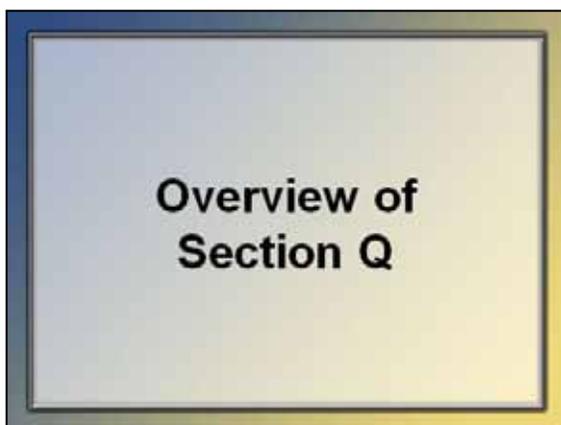
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- Recognize when an active discharge plan is in place.
- Understand how to ask the resident if he or she would like to talk to someone to obtain information about community care.
- Identify when to make a referral to a local contact agency.
- Code Section Q correctly and accurately.

C. Intent of Section Q

1. To record the participation and expectations of the resident, family members, or significant other(s) in the assessment.
2. To understand how to use the Return to Community Referral Care Area Assessment (CAA).

II. Overview of Section Q

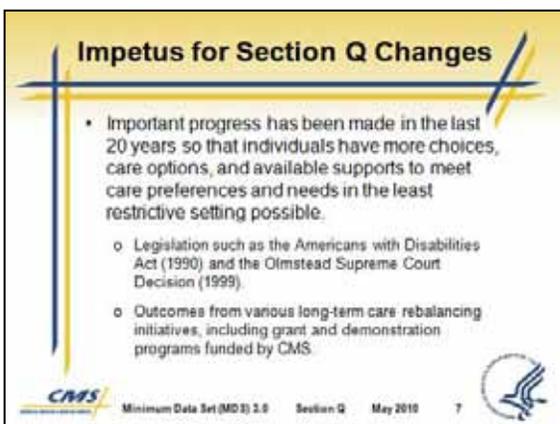
- A. Care plans should be person-centered and person-driven.
- B. Section Q has been revised to enhance the resident's voice in expressing expectations for care and exploring the potential for returning to the community.
- C. This includes
 1. Documenting resident's expectations for leaving the facility.
 2. Ensuring that a resident is provided options, resources, and support for returning to the community.

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D. Section Q Video Resident & Family Interview

1. A video of a resident and family interview to discuss return to the community is available.
2. This video depicts an interview between the resident, a family member on the phone and a nursing home social worker to discuss talking to someone about the possibility of returning to the community (Item Q0500B).

E. Impetus for Section Q Changes

1. During the last 20 years, individuals have been provided more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible.

F. Important milestones and legislative changes:

1. The Olmstead v. L.C. Supreme Court decision issued in July 1999 requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."
2. The Olmstead decision interpreted Title II of the Americans with Disabilities Act (ADA), which gives civil rights and protections to individuals with disabilities and guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

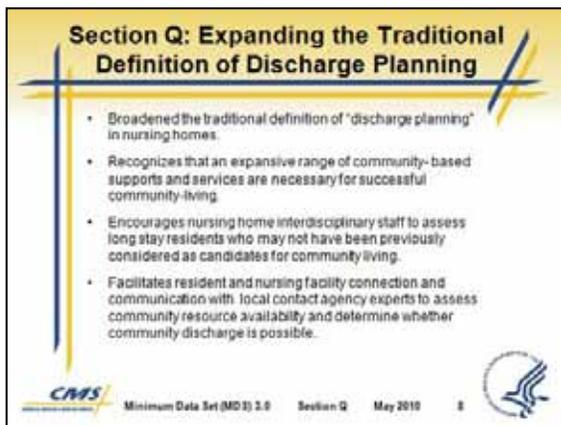
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3. There have been a number of CMS initiatives and waiver programs to support States meet the intent of the ADA by offering choice, expanding community based services and improving outcomes and quality of life for individuals and allow thousands of nursing home residents to transition to the community.
4. In fiscal year (FY) 2001, Congress began funding the Real Choice Systems Change Grants for Community Living program to help States change their long-term care systems to rely less on institutional services and to increase access to home and community-based services.
5. Under section 1915(b) waiver authority, States may offer a variety of services to individuals eligible for Medicaid under an home and community based services (HCBS) that can combine both traditional medical services as well as non-medical services (i.e. respite, case management, environmental modifications).
6. Aging and Disability Resource Center (ADRC) programs provide “one-stop” entry points into the long term support system.
7. ADRC programs are based in local communities accessible to people who may require long term support and serve individuals who need long-term support, their family caregivers, and those planning for future long-term support needs.

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8. The Money Follows the Person (MFP) pairs transition programs with other rebalancing initiatives in an effort to shift Medicaid long-term care systems from institutional to community-based care.
9. The MFP transition program targets Medicaid enrollees who have been institutionalized for at least 90 days in nursing homes, hospitals, intermediate care facilities for the mentally retarded (ICFs-MR), and institutions for mental diseases (IMDs).



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G. Section Q: Expanding the Traditional Definition of Discharge Planning

1. Section Q has been broadened beyond the traditional definition discharge planning for sub-acute residents to encompass discharge planning with expanded resources for long stay residents.
2. Community-based supports and services, which are necessary for successful community-living, have been expanded.
3. In addition to home health and other medical services, these may include assistance with locating housing, employment, and social engagement opportunities.
4. Nursing home staff should ask long stay residents who may not have been previously considered as candidates for community living.

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	<ol style="list-style-type: none"><li data-bbox="922 260 1398 432">5. Asking the resident and family if they want to talk to someone about the return to the community gives the resident voice and respects her/his wishes.<li data-bbox="922 457 1349 596">6. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA staff.<li data-bbox="922 621 1398 827">7. The nursing home staff must not make an interdisciplinary determination that discharge is not feasible without talking to the resident if the resident can be interviewed.<li data-bbox="922 852 1373 1058">8. If the resident cannot be interviewed, the family and/ or guardian should be interviewed and given the opportunity to talk with the LCA about available community care.<li data-bbox="922 1083 1398 1478">9. The LCA staff must work with the nursing home and contact the resident and their family and review medical, psychological, functional and financial MDS information to assess what is needed and whether there are sufficient community resources and finances and determine whether transition to the community is possible.<li data-bbox="922 1503 1382 1684">10. Section Q items may trigger a further assessment of the individual's situation, care planning, and discharge planning including a CAA.

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11. An optional Return to the Community Referral CAA in Appendix C of the RAI Manual provides guidelines and questions embedded in checklists to guide and conceptualize the care planning process.

H. Section Q: New Opportunities for Discharge Planning Collaboration

1. Section Q meaningfully engages residents in their discharge planning goals and directly asks the resident if they want information about LTC community options.

2. The new interviewing requirements of the MDS 3.0 reflect CMS's commitment to person-centered and resident centered care and elicit the individuals choices including returning to their home.

3. Care must be organized around the person's, not the provider's, needs.

4. Person-centered care can also result in better self-care, which is particularly important in chronic conditions.

5. Section Q promotes linkages and information exchange between nursing homes, local contact agencies, and community-based long-term care providers to better meet the needs and preferences of individuals.

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6. Discharge planning collaboration between nursing homes and local contact agencies is important for residents who express a desire to return to the community and who may require medical and supportive services in the community.
7. MDS 3.0 Section Q return to community items provides an opportunity for residents and their families to talk to someone about the possibility about available supports and services and possible choices.

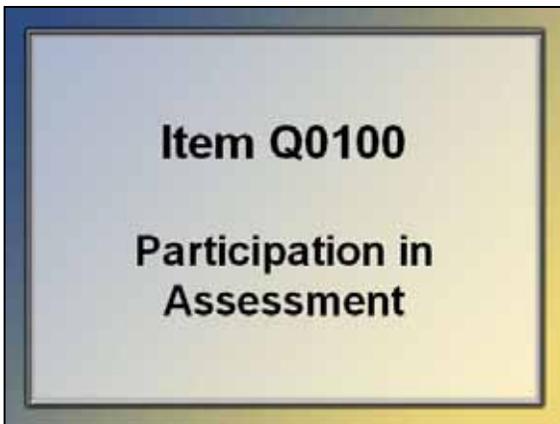


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- I. Section Q: New Requirements for Discharge Planning Collaboration
 1. Nursing home staff is expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.
 2. The nursing home social worker or discharge planning coordinator initiates contact with a local contact/ referral agency.
 3. Local Contact Agencies are expected to respond to nursing home staff referrals by providing information to residents about available community-based long-term care supports and services.
 4. Nursing home staff and Local Contact Agencies are expected to meaningfully engage the resident in their discharge and transition plan and collaboratively work to arrange for all of the necessary community-based long-term care services.

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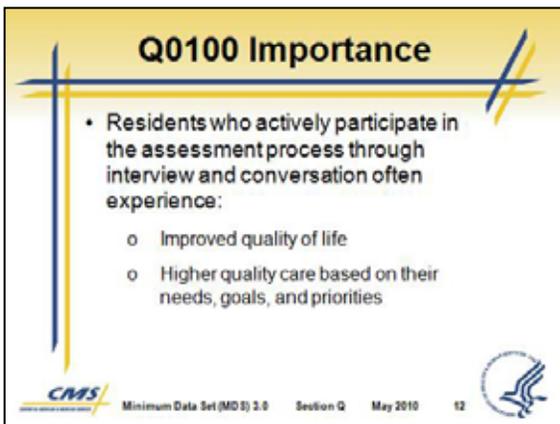
5. Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.
6. Resident support and interventions may be necessary if the transition back to the community is not possible because 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.



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III. Item Q0100 Participation in Assessment

A. Section Q begins by documenting the individuals participating in the resident's assessment.



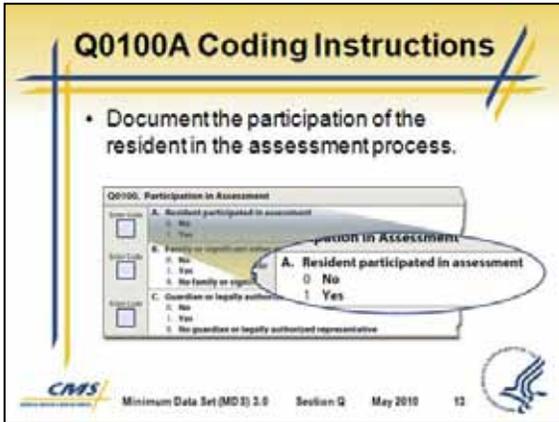
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B. Residents who actively participate in the assessment process through interview and conversation often experience:

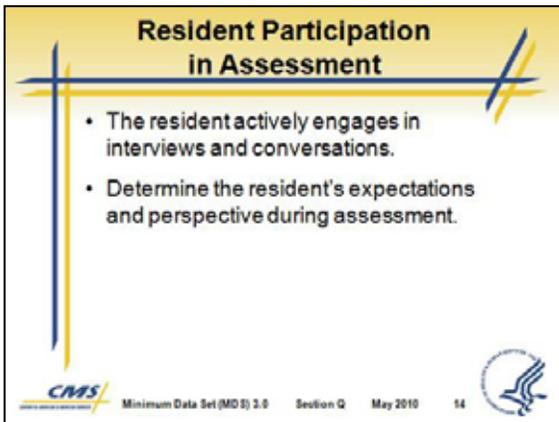
1. Improved quality of life
2. Higher quality care based on their needs, goals, and priorities

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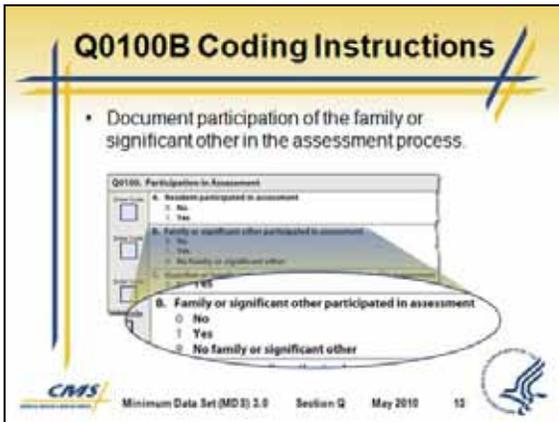
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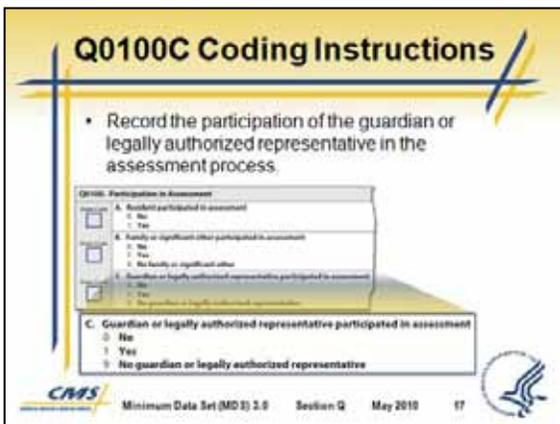
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- C. Q0100 Coding Instructions
- Q0100A Resident participated in assessment
 - Record the participation of the resident in the assessment process.
 - Code 0. No**
If the resident did not actively participate in the assessment process
 - Code 1. Yes**
If the resident actively and meaningfully participated in the assessment process
- D. What is considered resident participation in an assessment?
- The resident actively engages in interviews and conversations as necessary to meaningfully contribute to the completion of the MDS 3.0.
 - Determine the resident's expectations and perspective during assessment.
- E. 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

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- **Code 9. No family or significant other**

If there was no family or significant other

F. Who is considered family or significant other for the purposes of care planning?

1. A spousal, kinship (e.g., sibling, child, parent, nephew) or in-law relationship
2. A partner, housemate, primary community caregiver, or close friend
3. Significant other does not include nursing home staff

G. Q0100C Guardian or legally authorized representative participated in assessment

1. 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 actively participate in the assessment process

- **Code 1. Yes**

If guardian or legally authorized representative did participate in the assessment process

- **Code 9. No guardian or legally authorized representative**

If there is no guardian or legally authorized representative

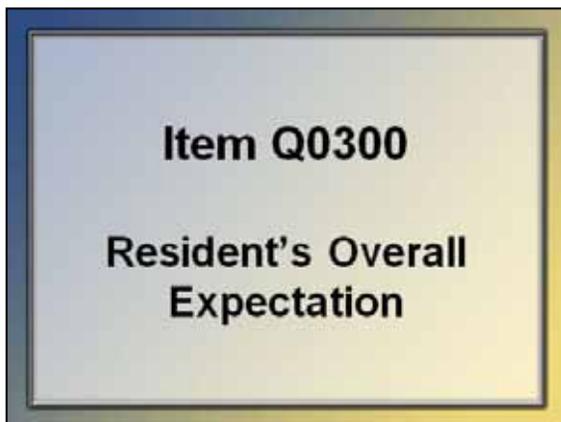
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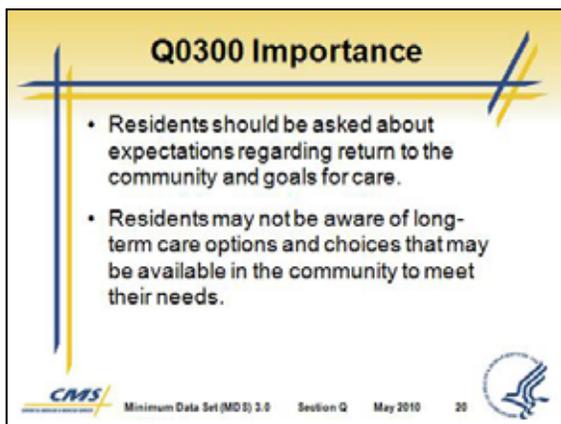
- H. Who is considered a guardian or legally authorized representative?
1. A guardian is an individual appointed by the court to make decisions instead of the resident.
 2. This includes giving and withholding consent for medical treatment
 3. A legally authorized representative is designated by the resident under state law to make decisions on their behalf when they are not able.
 4. This includes a medical power of attorney.



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IV. Q0300 Resident's Overall Expectation

- A. Complete this item only for an admission assessment (A0310E=1).
- B. This item identifies the resident's general expectations and goals for the nursing home stay.

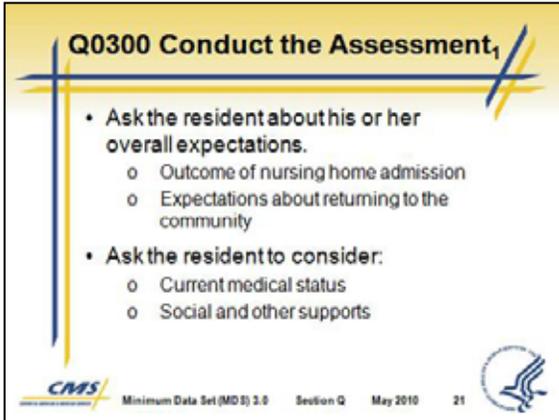


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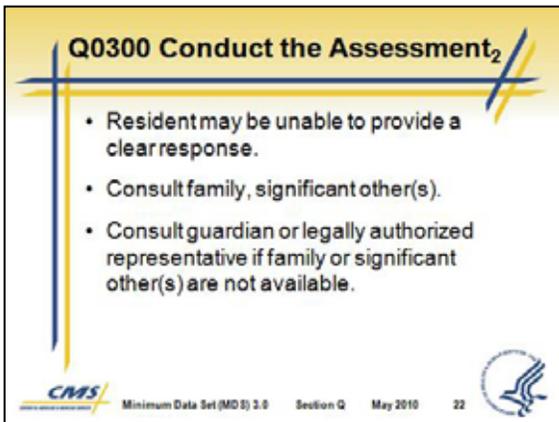
- C. Q0300 Importance
 1. Residents should be asked about expectations regarding return to the community and goals for care.
 2. Residents may not be aware of long-term care options and choices that may be available in the community to meet their needs.
 3. Some residents have very clear and directed expectations that will change little prior to discharge.

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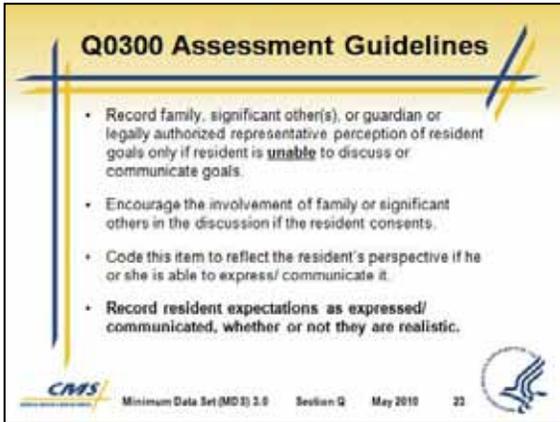
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4. Other residents may be unsure or may be experiencing an evolution in their thinking as their clinical condition changes or stabilizes.

D. Q0300 Conduct the Assessment

1. Ask the resident about his or her overall expectations.
2. After he or she has participated in the assessment process.
3. Has a better understanding of his or her current situation and the implications of alternative choices
4. Ask the resident to consider:
5. Current medical status
6. Social supports and other supports such as housing, in-home caretaking services and meals, home modifications, etc.
7. Because of a temporary (e.g., delirium) or permanent (e.g., profound dementia) condition, some residents may be unable to provide a clear response.
8. 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.
9. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.

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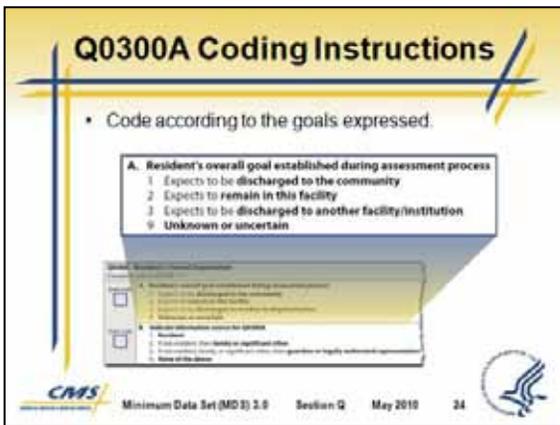
E. Q0300 Assessment Guidelines

1. The family, significant other, or the guardian or legally authorized representative's perceptions of the resident's goals should be recorded here only if the resident is **unable** to discuss/ communicate his or her goals.
2. Encourage the involvement of the family or significant others in the discussion/ communication if the resident consents.
3. While family, significant others, or if necessary the guardian or legally authorized representative can be involved if the resident is uncertain about his or her goals, the response selected should reflect the resident's perspective if he or she is able to express/ communicate it.
4. Record the resident's expectations as expressed/ communicated, whether they are realistic or not realistic.

F. Q0300A Coding Instructions

1. Q0300A Resident's overall goals established during the assessment process
2. Every effort should be made to provide the family, significant other, or guardian or legally authorized representative an opportunity to participate in the assessment and goal setting process.

- **Code 1. Expects to be discharged to the community**
- **Code 2. Expects to remain in this facility**



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- **Code 3. Expects to be discharged to another facility/ institution**
- **Code 9. Unknown or uncertain**

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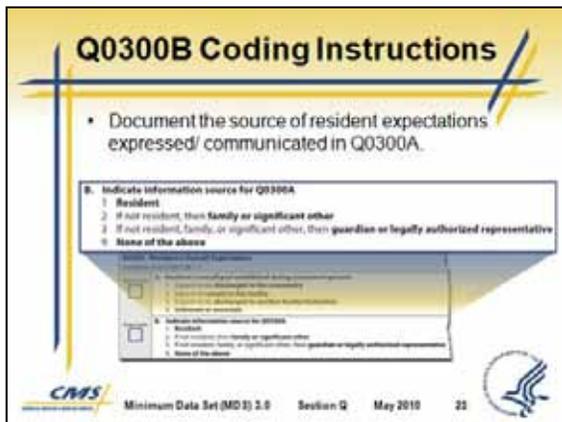
Q0300A Detailed Coding Instructions

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

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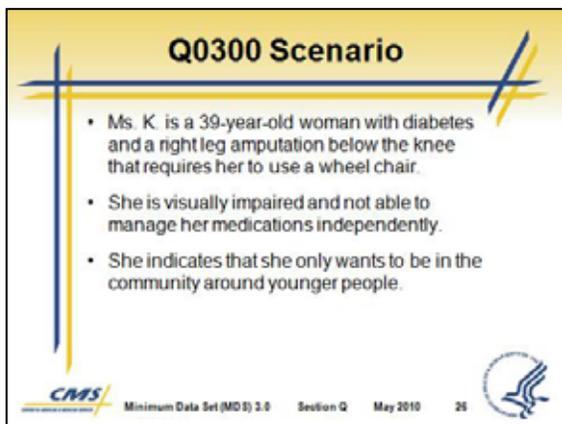
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- G. Q0300B Coding Instructions
1. Q0300B Indicate information Source for Q0300A
 - **Code 1. Resident**
 - **Code 2. If not the resident then family or significant other**
 - **Code 3. If not the resident, family or significant other, then guardian or legally authorized representative**
 - **Code 9. None of the above**

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Q0300B Detailed Coding Instructions

- **Code 1. Resident**
If the resident is the source for completing this item
- **Code 2. If not the resident then family or significant other**
If the resident was unable to respond and a family member or significant other is the source for completing this item.
- **Code 3. If not the resident, family or significant other, then guardian or legally authorized representative**
If the guardian or legally authorized representative is the source for completing this item because the resident is unable to respond and a family member or significant other is not available to respond
- **Code 9. None of the above**
If the resident could not respond and the family, significant other, or guardian or legally authorized representative could not be contacted or were unable to respond (Q0300A = 9)



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H. Q0300 Scenario

1. Ms. K. is a 39-year-old woman with diabetes and a right leg amputation below the knee that requires her to use a wheel chair.
2. She is visually impaired and not able to manage her medications independently.
3. She says that she wants to return to the community to be around people her own age.

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4. Q0300 Scenario Coding
 - a. This item should be coded based on the **resident's expressed goals**.
 - b. **Q0300A** would be coded as **1. Expects to be discharged to the community**.
 - c. **Q0300B** would be coded as **1. Resident**.
 - d. Ms. K is the information source and expressed her expectation to be discharged return to the community.

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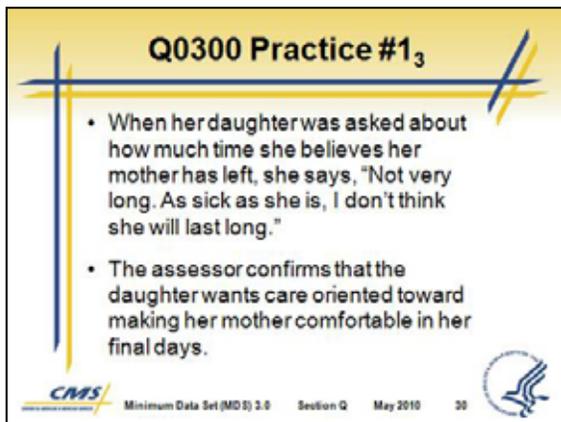
- I. Q0300 Coding Practice #1
 1. Mrs. T. is a 93-year-old woman with chronic kidney disease (CKD), oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia.
 2. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now, let's talk about it more."

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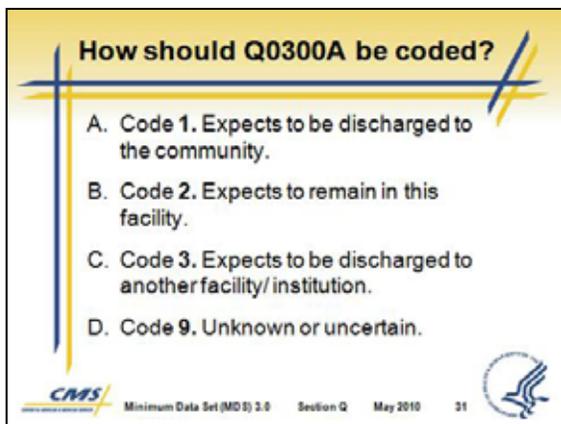
3. When her daughter is asked about goals for her mother's care, she states that "We know that her time is coming. The most important thing now is for her to be comfortable."
4. "Because of monetary constraints and the level of care she needs, we feel we cannot adequately meet her needs. Other than treating simple things, what we really want most is for her to live out whatever time she has left in comfort."

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5. When her daughter is asked about how much time she believes her mother has left, she says, “Not very long. As sick as she is, I don’t think she will last long.”
6. The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days.

7. How should Q0300A be coded?
Give participants time to consider the question.
 - a. Correct answer is B.
 - b. Q0300A would be coded as 2. Expects to remain in this facility.
 - c. 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.
 - d. Follow-up with exploration of options and impact to care planning (advocate for the resident).

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How should Q0300B be coded?

- A. Code 1. Resident.
- B. Code 2. If not resident, then family or significant other.
- C. Code 3. If not resident, family, or significant other, then guardian or legally authorized representative.
- D. Code 9. None of the above.

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8. How should Q0300B be coded?

Give participants time to consider the question.

- a. Correct answer is B. Code 2. Family or significant other
- b. Q0300B would be coded as 2. Family or significant other.

Q0300 Practice #2₁

- 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.

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J. Q0300 Coding Practice #2

- 1. 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.
- 2. Upon admission, she was diagnosed with moderate dementia and was unable to voice consistent preferences for her own care.
- 3. She has no living relatives and no significant other who is willing to participate in her care decisions.

Q0300 Practice #2₂

- 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 was 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.

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- 4. A legal guardian has been authorized to oversee her care.
- 5. Community-based services, including assisted living and other residential care situations, were discussed with the guardian.
- 6. The guardian decided that it was 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.

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How should Q0300A be coded?

- A. Code 1. Expects to be discharged to the community.
- B. Code 2. Expects to remain in this facility.
- C. Code 3. Expects to be discharged to another facility/ institution.
- D. Code 9. Unknown or uncertain.

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7. How should Q0300A be coded?

Give participants time to consider the question.

- a. Correct answer is C.
- b. Q0300A would be coded as **3**. Expects to be discharged to another facility/ institution.
- c. Mrs. C. is not able to respond and has no family or significant other available to participate in her care decisions.
- d. A legal guardian determined that it was in Mrs. C.'s best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

How should Q0300B be coded?

- A. Code 1. Resident.
- B. Code 2. If not resident, then family or significant other.
- C. Code 3. If not resident, family, or significant other, then guardian or legally authorized representative.
- D. Code 9. None of the above.

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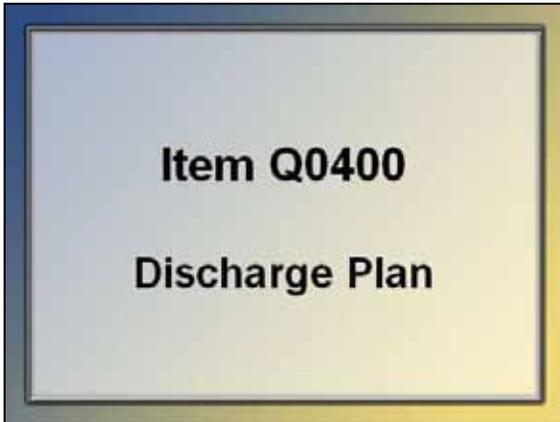
8. How should Q0300B be coded?

Give participants time to consider the question.

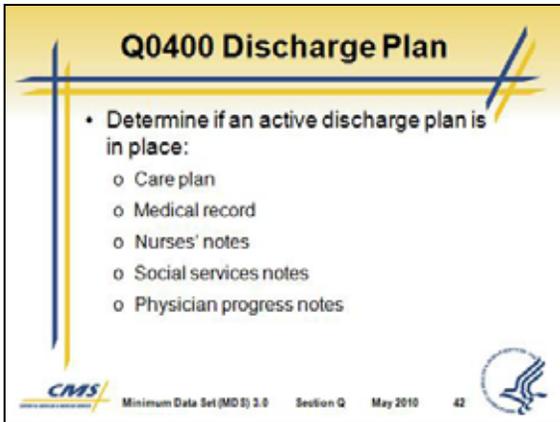
- a. Correct answer is C.
- b. Q0300B would be coded as **3**. If not resident, family, or significant other, then guardian or legally authorized representative.

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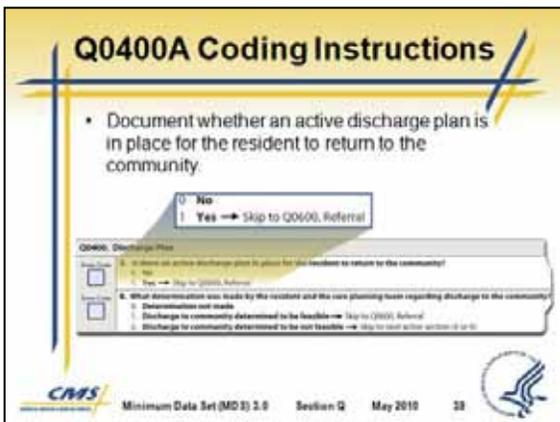
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V. Item Q0400 Discharge Plan

A. Some residents may be able to return to the community if they are provided appropriate assistance and referral to community resources.

B. Q0400 Discharge Plan

- Determine if an active discharge plan is in place by reviewing:
 - Care plan
 - Medical record
 - Nurses' notes
 - Social services notes
 - Physician progress notes

C. Q0400A Coding Instructions

- Q0400A Is there an active discharge plan in place for the resident to return to the community?

2. Code 0. No

If there is not an active discharge plan in place for the resident to return to the community

3. Code 1. Yes

If there is an active discharge plan in place for the resident to return to the community

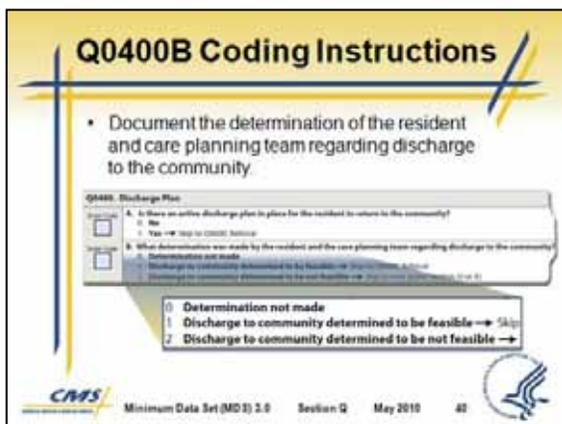
Skip to Item Q0600 (Referral).

Emphasize skip pattern here

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**Skip patterns are built into Section Q so that if the resident has already been asked the question and it has been acted upon (active discharge plan in place and/or referral made to LCA), or a determination has been made (with resident) that the resident is unable to transition back to the community, the question is not repeated with each subsequent assessment.*



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4. Q0400B What determination was made by the resident and care planning team regarding discharge to community?

- **Code 0. Determination not made**

If a determination was not made by the resident and the care planning team regarding discharge to the community

- **Code 1. Discharge to community determined to be feasible**

If discharge to the community was determined feasible

Skip to Item Q0600 (Referral).

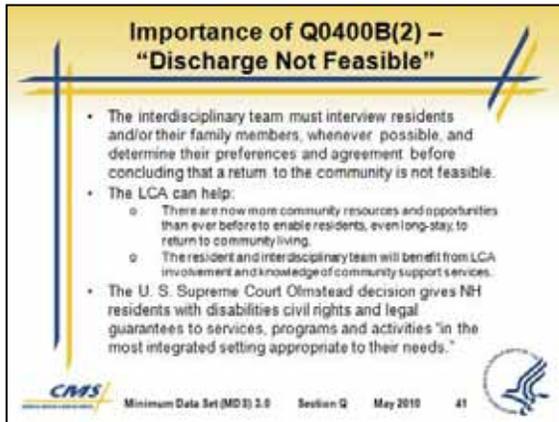
Emphasize skip pattern here.

- **Code 2 Discharge to community determined not to be feasible**

If discharge to the community was determined to be not feasible.

Skip to the next active assessment section (Section V or X).

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D. Importance of Q0400B(2) “Discharge to community determined not feasible”

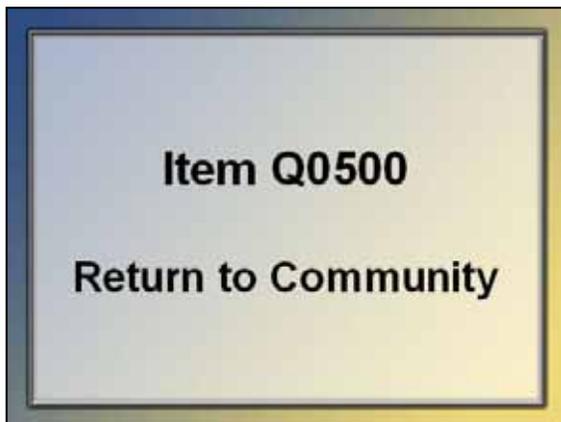
1. The interdisciplinary team must interview residents and/or their family members, whenever possible, and determine their preferences and agreement before concluding that a return to the community is not feasible.
2. There are now more resources and opportunities for long stay residents.
3. The resident and interdisciplinary team will benefit from LCA expertise and review.
4. The Olmsteade decision gives NH residents with disabilities civil rights and guarantees to administer services, programs and activities “in the most integrated setting appropriate to their needs.”

**Emphasize resident interview and skip pattern here.*

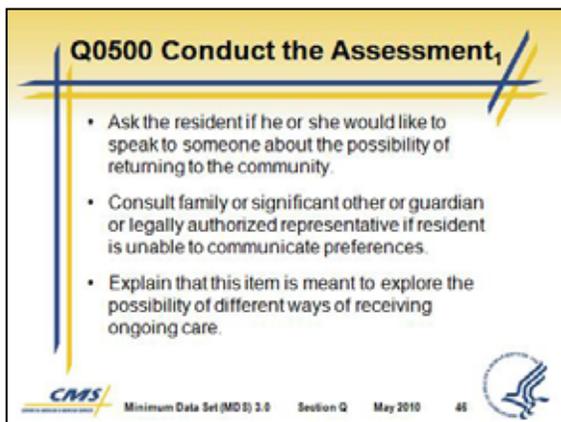
Interviewing the resident, whenever possible, regarding the feasibility of discharge is required by the Olmsteade Supreme Court decision and Americans with Disability Act before the Q0400B(2), discharge to community **not feasible is marked.*

** An example of a determination in which a discharge to the community was not feasible, is an resident with with advanced Alzheimer’s disease and with no family*

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VI. Item Q0500 Return to Community

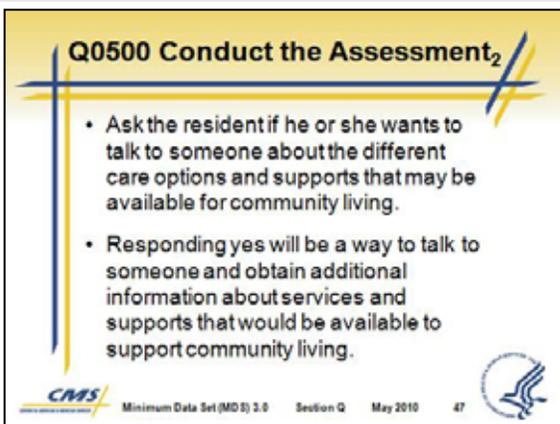
- A. Complete this item for admission, quarterly, and annual assessments.
- B. This item identifies a resident's desire to speak to someone about returning to the community.
- C. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.**, residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.

D. Q0500 Conduct the Assessment

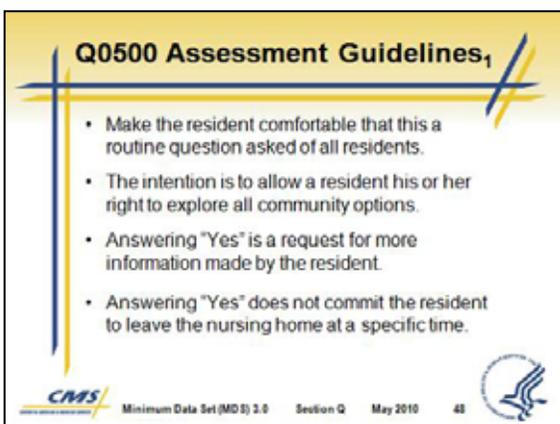
1. Ask the resident if he or she would like to speak with someone about the possibility of returning to live in the community at the initial admission assessment and in subsequent follow-up assessments.
2. If the resident is unable to communicate his or her preference either verbally or nonverbally:
3. Obtain the information from family or a significant other, as designated by the individual,
4. If family or significant others are not available, a guardian or legally authorized representative may provide the information.
5. Explain that this item is meant to talk with someone about the possibility of returning to the community and the different ways of receiving ongoing care.

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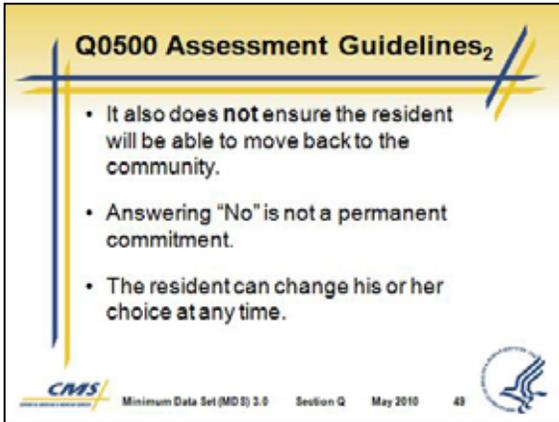
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6. Ask the resident if he or she wants talk someone about the different care options and supports that may be available for community living.
7. Responding yes will be a way for the individual –and his or her family, significant other or guardian or legally authorized representative—to have someone from a local contact agency talk to them about services and supports.
8. Guard against raising the resident and their family members’ expectations of what can occur until more information is obtained.

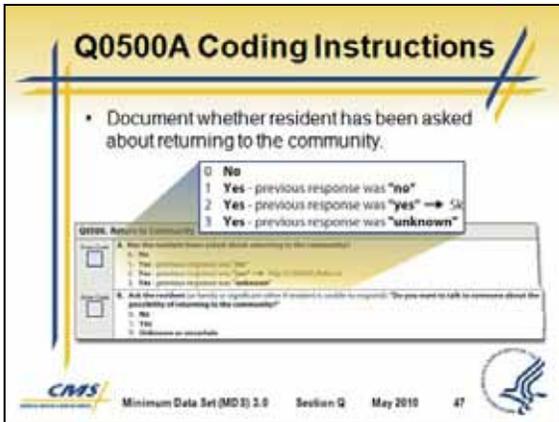
E. Q0500 Assessment Guidelines

1. Make the resident comfortable by assuring him or her that this a routine question asked of all residents.
2. The intention of this question is to allow a resident his or her right to explore all community options.
3. Answering “Yes” to this item signals the resident’s request for more information.
4. Answering “Yes” does not commit the resident to leave the nursing home at a specific time.
5. At this point, explore with resident their interest in learning about care options and supports in the community.

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6. Answering “Yes” does **not** ensure the resident will be able to move back to the community.
7. Answering “No” is not a permanent commitment.
8. The resident can change his or her choice at any time.
9. The nursing home interdisciplinary planning team will explore the resident’s options and consider any transition obstacles.

F. Q0500 Coding Instructions

1. Q0500A Has the Resident Been Asked about Returning to the Community?

• **Code 0. No**

If the resident (or family, significant other, or guardian or legally authorized representative) states that he or she has not been asked about the possibility of returning to the community

• **Code 1. Yes—previous response was “no”**

If the resident (or family, significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community and the previous response was no

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- **Code 2. Yes—previous response was “yes”**

The resident (or family, significant other or guardian, or legally authorized representative) states that he or she was previously asked about the possibility of returning to community and the previous response was yes

Skip to Q0600 (Referral).

Emphasize skip pattern here

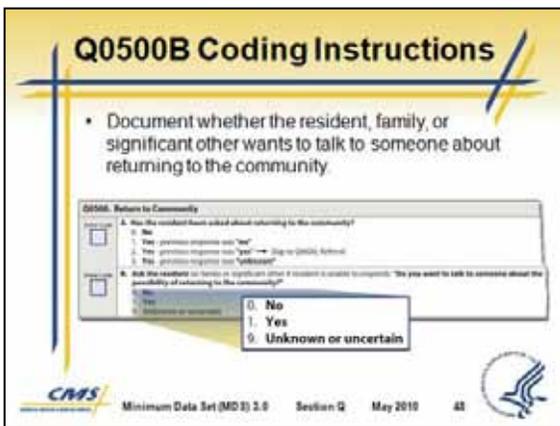
- **Code 3. Yes—previous response was “unknown”**

If the resident (or family, significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community but the previous response is unknown

2. Coding Q0500B: Ask the resident (or family or significant others if resident is unable to respond): “Do you want to talk to someone about the possibility of returning to the community?”

- **Code 0. No**

If the resident (or family, 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



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• **Code 1. Yes**

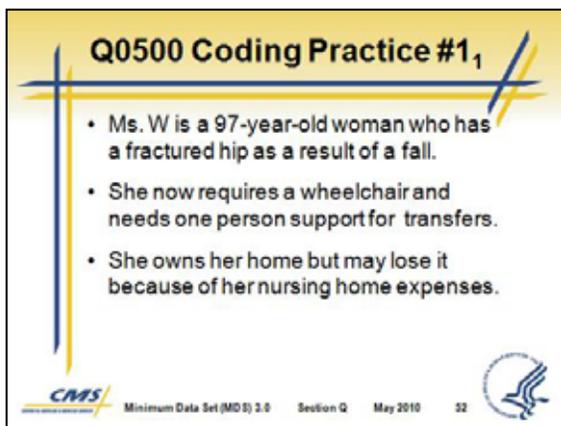
The resident (or family, significant other or guardian, or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to the community.

• **Code 9, unknown or uncertain**

If the resident cannot respond and the family or significant other is not available to respond on the resident’s behalf and a guardian or legally authorized representative is not available or has not been appointed by the court

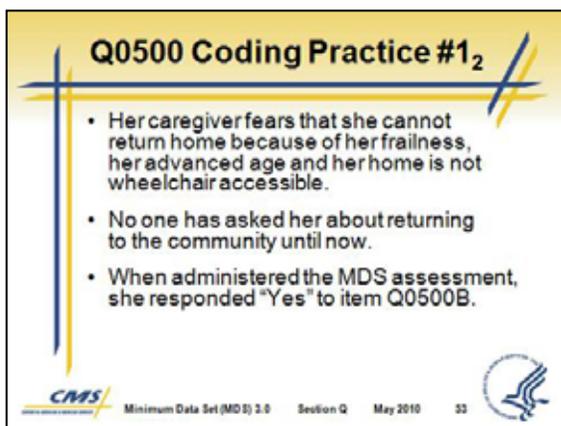
G. Q0500 Coding Practice #1

1. Ms. W, is a 97-year-old woman who has a fractured hip as a result of a fall.
2. She now requires a wheelchair and needs one person support for transfers.
3. She owns her home but may lose it because of her nursing home expenses.



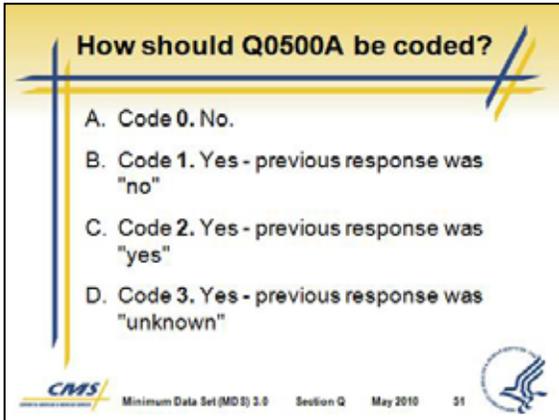
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4. Her caregiver fears that she cannot return home because of her frailness, her advanced age and her home is not wheelchair accessible.
5. No one has asked her about returning to the community until now.
6. When administered the MDS assessment, she responded “Yes” to item Q0500B.

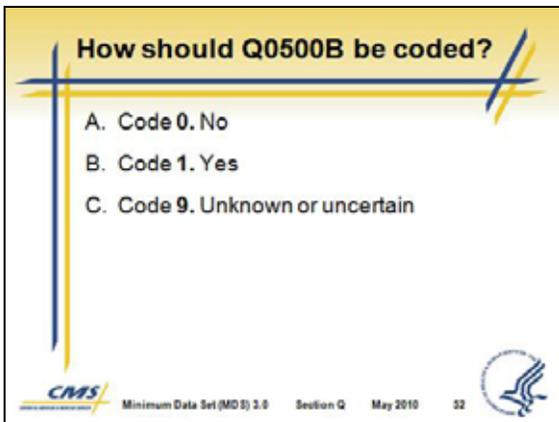


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7. How should Q0500A be coded?

Give participants time to consider the question.

8. Q0500A would be coded as **0. No.**

9. How should Q0500B be coded?

Give participants time to consider the question.

a. Q0500B would be coded as **1. Yes.**

b. Ms. W.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner.

c. 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.

d. Nursing home staff should contact the designated local agency within 10 business days for them to initiate discussions with Ms. W. about returning to community living.

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Q0500 Coding Practice #2₁

- Ms. C. is a 45-year-old woman with cerebral palsy and a learning disability who has been living in Blue Nursing Home for the past 20 years.
- At age 25, she lived in a group home but became ill and required hospitalization for pneumonia.

CMS Minimum Data Set (MDS) 3.0 Section Q May 2010 37

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Q0500 Coding Practice #2₂

- After recovering in the hospital, Ms. C. was sent to the Blue 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 has asked her about returning to the community until now.
- When administered the MDS assessment, she responded "Yes" to item Q0500B.

CMS Minimum Data Set (MDS) 3.0 Section Q May 2010 38

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How should Q0500A be coded?

- Code 0. No
- Code 1. Yes - previous response was "no"
- Code 2. Yes - previous response was "yes"
- Code 3. Yes - previous response was "unknown"

CMS Minimum Data Set (MDS) 3.0 Section Q May 2010 35

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H. Q0500 Coding Practice #2

1. Ms. C. is a 45-year-old woman with cerebral palsy and a learning disability who has been living in Blue Nursing Home for the past 20 years.
2. At age 25, she lived in a group home but became ill and required hospitalization for pneumonia.

3. After recovering in the hospital, Ms. C. was sent to the Blue 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.
4. No one has asked her about returning to the community until now.
5. When administered the MDS assessment, she responded "Yes" to item Q0500B.

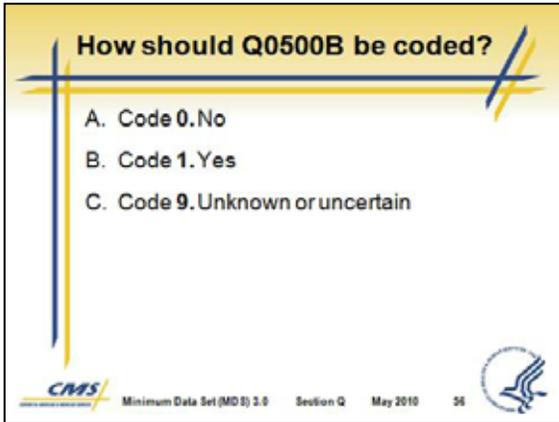
6. How should Q0500A be coded?

Give participants time to consider the question.

- a. The correct answer is A.
- b. Q0500A would be coded as **0. No.**

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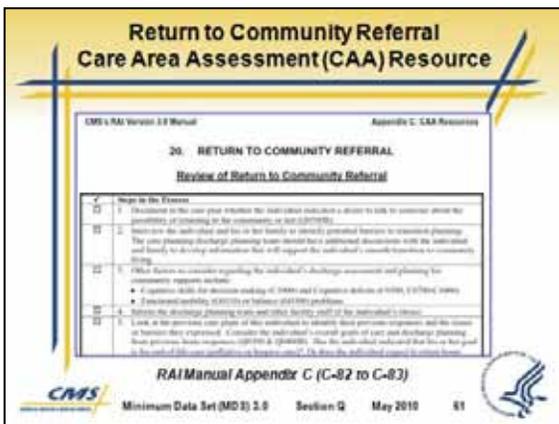


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7. How should Q0500B be coded?

Give participants time to consider the question.

- a. The correct answer is B.
- b. Q0500B would be coded as **1. Yes.**
- c. Ms. C.’s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner.
- d. 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.
- e. Nursing home staff should contact the designated local agency within 10 business days for them to initiate discussions with Ms. C. about returning to community living.



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8. When Q0500B is answered as code 1, a care area trigger (CAT) triggers the Return to Community Referral CAA requiring further assessment and care planning regarding the resident’s interest in being transitioned to community living.

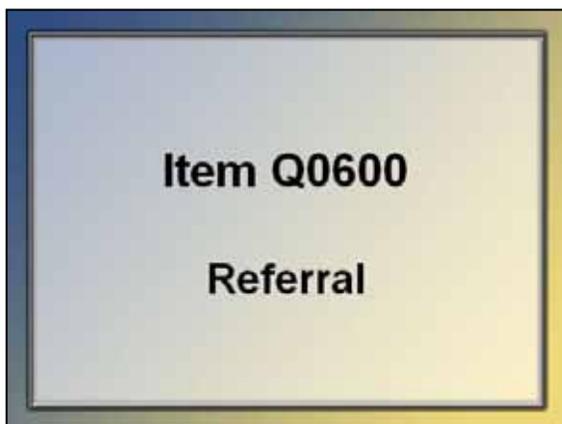
9. The return to community referral CAA is required for clinical assessments at admission, annual, significant change, and quarterly assessments.

10. The return to community referral CAA provides a clinical step-by-step process including a checklist, analysis of findings and care plan considerations.

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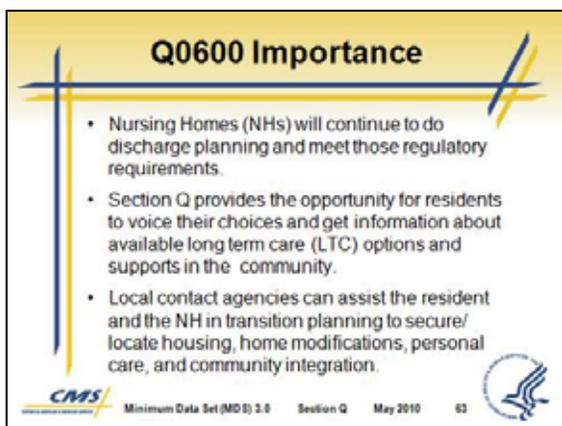
11. The nursing home and local agency staffs should consider and evaluate the complexity of the resident’s care needs, their financial options/resources Medicaid eligibility, and the availability of community care options and supports.
12. The nursing home and local contact agency team must explore community care options/supports and appropriate care planning to determine if transition back to the community is possible.



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VII. Item Q0600: Referral

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



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- B. Q0600 Importance
 1. Nursing Homes (NHs) will continue to do discharge planning and meet those regulatory requirements.
 2. Nursing home staff is expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.

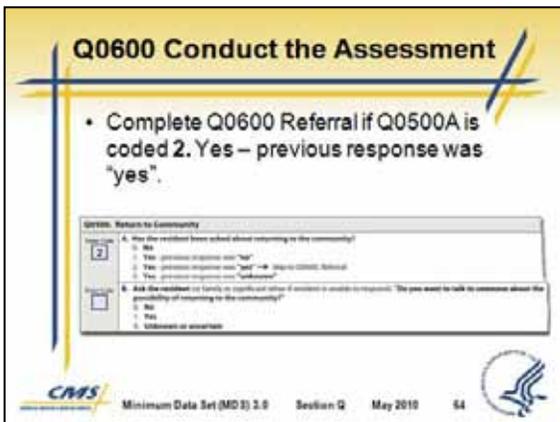
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- C. Section Q provides the opportunity for residents to voice their choices and get information about available long term care (LTC) options and supports in the community.
 - 1. Nursing home staff and Local Contact Agencies are expected to meaningfully engage the resident in their discharge and transition plan and collaboratively work to arrange for all of the necessary community-based long-term care services.

- D. Local contact agencies can assist the resident and the NH in transition planning to secure/locate housing, home modifications, personal care, and community integration.
 - 1. Local Contact Agencies are expected to respond to nursing home staff referrals by providing information to residents about available community-based long-term care supports and services.

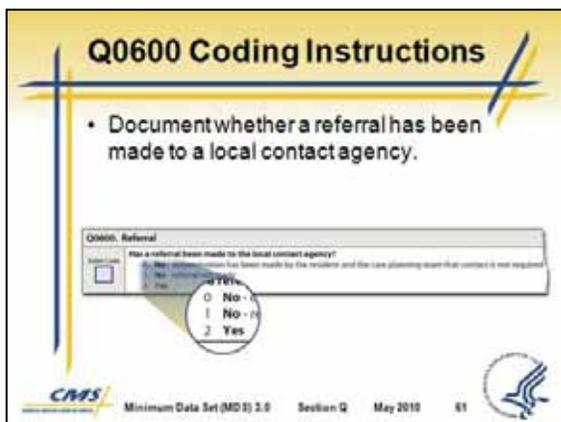
- E. Q0600 Conduct the Assessment
 - 1. Complete Q0600 Referral if Q0500A is coded 2. Yes – previous response was “yes”.



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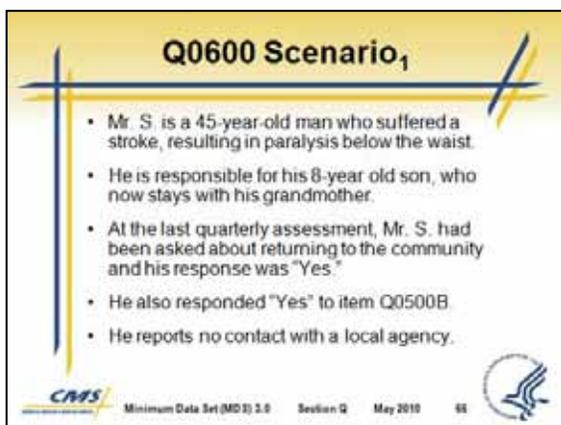
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F. Q0600 Coding Instructions

- **Code 0, No**
 Determination has been made by the resident (or family, significant other, or guardian or legally authorized representative) and the care planning team that contact is not required.
- **Code 1, no**
 If referral was not made
- **Code 2, yes:**
 If referral was made to the local contact agency
 For example, the resident responded yes to Q0500A. The facility care planning team was notified and initiated contact with the local contact agency.



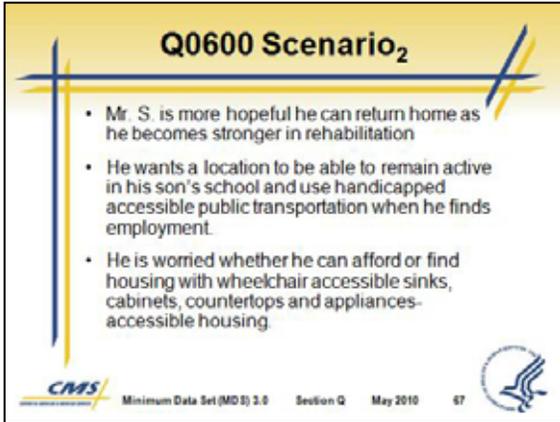
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G. Q0600 Scenario

1. Mr. S. is a 45-year-old man who suffered a stroke, resulting in paralysis below the waist.
2. He is responsible for his 8-year old son, who now stays with his grandmother.
3. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was "Yes."
4. He also responded "Yes" to item Q0500B.
5. He reports no contact with a local agency.

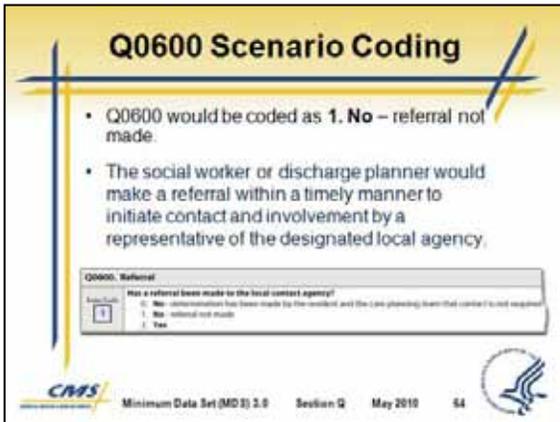
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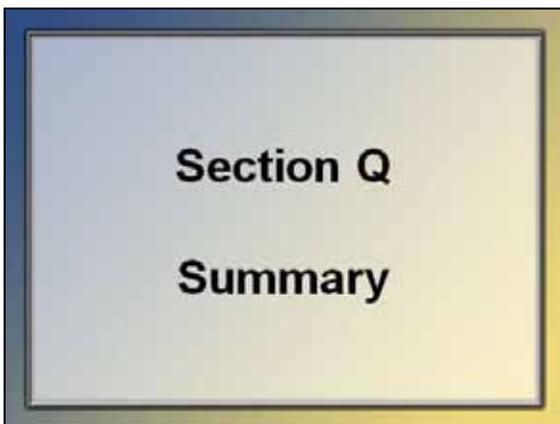
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6. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation
7. He wants a location to be able to remain active in his son's school and use handicapped accessible public transportation when he finds employment.
8. He is worried whether he can afford or find housing with wheelchair accessible sinks, cabinets, countertops and appliances-accessible housing.



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- H. Q0600 Scenario Coding
1. Q0600 would be coded as **1. No** – referral not made
 2. The social worker or discharge planner would make a referral within a timely manner to initiate contact and involvement by a representative of the designated local agency.
 3. Experience with facilities indicated a practical timeframe is 10 business days.

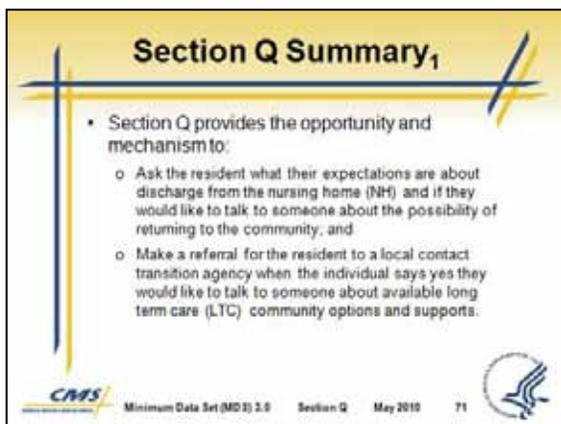


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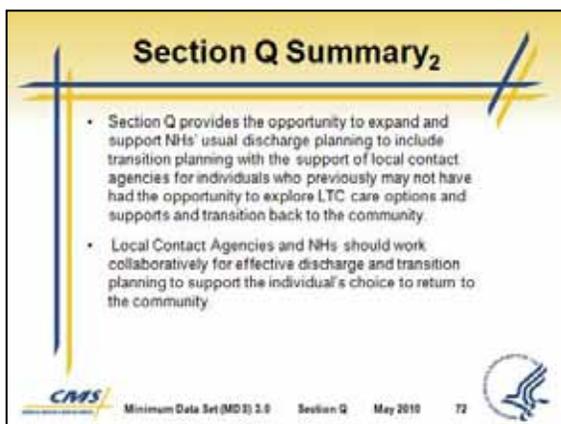
VIII. Section Q Summary

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A. Section Q provides the opportunity and mechanism to:

1. Ask the resident what their expectations are about discharge from the nursing home (NH) and if they would like to talk to someone about the possibility of returning to the community; and
2. Make a referral for the resident to a local contact transition agency when the individual says yes they would like to talk to someone about available long term care (LTC) community options and supports.

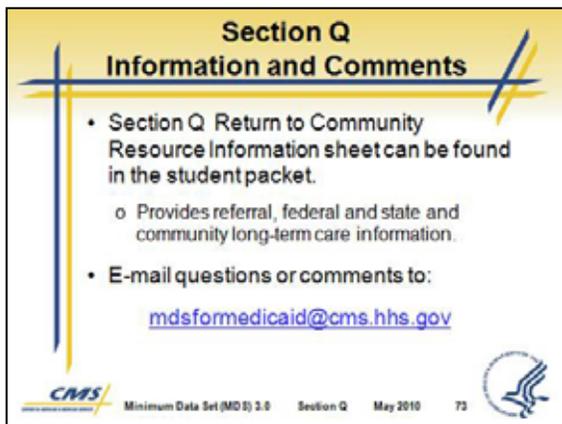
B. Section Q provides the opportunity to expand and support NHs' usual discharge planning to include transition planning with the support of local contact agencies for individuals who previously may not have had the opportunity to explore LTC care options and supports and transition back to the community.

1. Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are now available and will grow over time, and yet resource availability and eligibility coverage varies across local communities and States, which may be barriers to allowing some resident's return to their community. An unsuccessful transition may create stress and disappointment for the resident and family that will require support and nursing home care planning interventions.

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2. The nursing home interdisciplinary team must not assume that they know which residents should be discharged.
 3. They should guard against determining that it is not feasible for a resident to return to the community without interviewing them and without examining the possibility of home and community based services options available to the resident.
 4. The U. S. Supreme Court Olmstead ruling states that residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.
- C. Local Contact Agencies and NHs should work collaboratively for effective discharge and transition planning to support the individual’s choice to return to the community.
- D. The “Section Q Return to Community Resource Information” sheet can be found in the student packet.
1. The sheet provides information on referral, federal and state and community long-term care websites
- E. CMS is interested in feedback and comments on Sections Q to understand nursing home and local contact agency concerns and to learn ways to more effectively administer section Q and to improve referral transition planning and coordination.
1. Please e-mail questions or comments to:
mdsformedicaid@cms.hhs.gov.



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