

Section Q

Participation in Assessment and Goal Setting

Objectives₁

- State the intent of Section Q Participation in Assessment and Goal Setting.
- Define family or significant other, guardian, and legally authorized representative.
- Explain the steps for assessing the resident's overall expectation.
- Recognize when an active discharge plan is in place.

Objectives₂

- Describe 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.
- To code Section Q correctly and accurately.

Intent of Section Q

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

Overview of Section Q

Section Q Video

Resident & Family Interview



The Video on Interviewing Vulnerable Elders (VIVE) was funded by the Picker Institute and produced by the UCLA/ JH Borun Center. DVD copies can be ordered from the Pioneer Network.

Impetus for Section Q Changes

- Important progress has been made in the last 20 years so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible.
 - Legislation such as the Americans with Disabilities Act (1990) and the Olmstead Supreme Court Decision (1999).
 - Outcomes from various long-term care rebalancing initiatives, including grant and demonstration programs funded by CMS.

Section Q: Expanding the Traditional Definition of Discharge Planning

- Broadened the traditional definition of “discharge planning” in nursing homes.
- Recognizes that an expansive range of community- based supports and services are necessary for successful community-living.
- Encourages nursing home interdisciplinary staff to assess long stay residents who may not have been previously considered as candidates for community living.
- Facilitates resident and nursing facility connection and communication with local contact agency experts to assess community resource availability and determine whether community discharge is possible.

Section Q: New Opportunities for Discharge Planning Collaboration

- ✓ Meaningfully engages residents in their discharge planning goals.
- ✓ Directly asks the resident if they want information about long-term care community options.
- ✓ Promotes linkages and information exchange between nursing homes, local contact agencies, and community-based long-term care providers.
- ✓ Promotes discharge planning collaboration between nursing homes and local contact agencies for residents who may require medical and supportive services to return to the community.

Section Q: New Requirements for Discharge Planning Collaboration

- ✓ Nursing home staff 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.
- ✓ Local Contact Agencies expected to respond to nursing home staff referrals by providing information to residents about available community-based long-term care supports and services.
- ✓ Nursing home staff and Local Contact Agencies 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.

Item Q0100

**Participation in
Assessment**

Q0100 Importance

- Residents who actively participate in the assessment process through interview and conversation often experience:
 - o Improved quality of life
 - o Higher quality care based on their needs, goals, and priorities

Q0100A Coding Instructions

- Document the participation of the resident in the assessment process.

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

A. Resident participated in assessment
0 No
1 Yes

Resident Participation in Assessment

- The resident actively engages in interviews and conversations.
- Determine the resident's expectations and perspective during assessment.

Q0100B Coding Instructions

- Document participation of the family or significant other in the assessment process.

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

Family or Significant Other

- Spousal, kinship (e.g., sibling, child, parent, nephew) or in-law relationship.
- Partner, housemate, primary community caregiver, or close friend.
- Does not include nursing home staff.

Q0100C Coding Instructions

- Record the participation of the guardian or legally authorized representative in the assessment process.

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

C. Guardian or legally authorized representative participated in assessment
0 No
1 Yes
9 No guardian or legally authorized representative

Legally Authorized Representative or Guardian

- Guardian
 - Individual appointed by the court
 - Authorized to make decisions instead of the resident.
 - Includes giving and withholding consent for medical treatment
- Legally authorized representative
 - Designated by the resident under state law
 - Makes decisions on the resident's behalf when resident is not able
 - Includes a medical power of attorney

Item Q0300

**Resident's Overall
Expectation**

Q0300 Importance

- Residents should be asked about expectations regarding return to the community and goals for care.
- Residents may not be aware of long-term care options and choices that may be available in the community to meet their needs.

Q0300 Conduct the Assessment₁

- Ask the resident about his or her overall expectations.
 - Outcome of nursing home admission
 - Expectations about returning to the community
- Ask the resident to consider:
 - Current medical status
 - Social and other supports

Q0300 Conduct the Assessment₂

- Resident may be unable to provide a clear response.
- Consult family, significant other(s).
- Consult guardian or legally authorized representative if family or significant other(s) are not available.

Q0300 Assessment Guidelines

- Record family, significant other(s), or guardian or legally authorized representative perception of resident goals only if resident is **unable** to discuss or communicate goals.
- Encourage the involvement of family or significant others in the discussion if the resident consents.
- Code this item to reflect the resident's perspective if he or she is able to express/ communicate it.
- **Record resident expectations as expressed/ communicated, whether or not they are realistic.**

Q0300A Coding Instructions

- Code according to the goals expressed.

- A. Resident's overall goal established during assessment process**
- 1 Expects to be **discharged to the community**
 - 2 Expects to **remain in this facility**
 - 3 Expects to be **discharged to another facility/institution**
 - 9 **Unknown or uncertain**

Q0300. Resident's Overall Expectation	
Complete only if A0310E = 1	
Enter Code <input type="checkbox"/>	A. Resident's overall goal established during assessment process 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain
Enter Code <input type="checkbox"/>	B. Indicate information source for Q0300A 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. None of the above

Q0300B Coding Instructions

- Document the source of resident expectations expressed/ communicated in Q0300A.

B. Indicate information source for Q0300A

- 1 Resident
- 2 If not resident, then **family or significant other**
- 3 If not resident, family, or significant other, then **guardian or legally authorized representative**
- 9 **None of the above**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code

A. Resident's overall goal established during assessment process

1. Expects to be discharged to the community
2. Expects to remain in this facility
3. Expects to be discharged to another facility/institution
9. Unknown or uncertain

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. **None of the above**

Q0300 Scenario

- 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.
- She is visually impaired and not able to manage her medications independently.
- She indicates that she only wants to be in the community around younger people.

Q0300 Scenario Coding

- Code Q0300A as **1**. Expects to be discharged to the community.
- Code Q0300B as **1**. Resident.

Q0300. Resident's Overall Expectation	
Complete only if A0310E = 1	
Enter Code <input type="text" value="1"/>	A. Resident's overall goal established during assessment process <ol style="list-style-type: none">1. Expects to be discharged to the community2. Expects to remain in this facility3. Expects to be discharged to another facility/institution9. Unknown or uncertain
Enter Code <input type="text" value="1"/>	B. Indicate information source for Q0300A <ol style="list-style-type: none">1. Resident2. If not resident, then family or significant other3. If not resident, family, or significant other, then guardian or legally authorized representative9. None of the above

Q0300 Practice #1₁

- 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.
- 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.”

Q0300 Practice #1₂

- 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."
- "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."

Q0300 Practice #1₃

- When her daughter was 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.”
- The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days.

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.

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.

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.

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.

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.

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.

Item Q0400

Discharge Plan

Q0400 Discharge Plan

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

Q0400A Coding Instructions

- Document whether an active discharge plan is in place for the resident to return to the community.

0 No
1 Yes → Skip to Q0600, Referral

Q0400. Discharge Plan

Enter Code

A. Is there an active discharge plan in place for the resident to return to the community?

0. No

1. Yes → Skip to Q0600, Referral

Enter Code

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

0. Determination not made

1. Discharge to community determined to be feasible → Skip to Q0600, Referral

2. Discharge to community determined to be not feasible → Skip to next active section (V or X)

Q0400B Coding Instructions

- Document the determination of the resident and care planning team regarding discharge to the community.

Q0400. Discharge Plan	
Enter Code <input type="checkbox"/>	A. Is there an active discharge plan in place for the resident to return to the community? 0. No 1. Yes → Skip to Q0600, Referral
Enter Code <input type="checkbox"/>	B. What determination was made by the resident and the care planning team regarding discharge to the community? 0. Determination not made 1. Discharge to community determined to be feasible → Skip to Q0600, Referral 2. Discharge to community determined to be not feasible → Skip to next active section (V or X)

- | | |
|---|--|
| 0 | Determination not made |
| 1 | Discharge to community determined to be feasible → Skip |
| 2 | Discharge to community determined to be not feasible → |

Importance of Q0400B(2) – “Discharge Not Feasible”

- 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.
- The LCA can help:
 - There are now more community resources and opportunities than ever before to enable residents, even long-stay, to return to community living.
 - The resident and interdisciplinary team will benefit from LCA involvement and knowledge of community support services.
- The U. S. Supreme Court Olmstead decision gives NH residents with disabilities civil rights and legal guarantees to services, programs and activities “in the most integrated setting appropriate to their needs.”

Item Q0500

Return to Community

Q0500 Conduct the Assessment₁

- Ask the resident if he or she would like to speak to someone about the possibility of returning to the community.
- Consult family or significant other or guardian or legally authorized representative if resident is unable to communicate preferences.
- Explain that this item is meant to explore the possibility of different ways of receiving ongoing care.

Q0500 Conduct the Assessment₂

- Ask the resident if he or she wants to talk to someone about the different care options and supports that may be available for community living.
- Responding yes will be a way to talk to someone and obtain additional information about services and supports that would be available to support community living.

Q0500 Assessment Guidelines₁

- Make the resident comfortable that this a routine question asked of all residents.
- The intention is to allow a resident his or her right to explore all community options.
- Answering “Yes” is a request for more information made by the resident.
- Answering “Yes” does not commit the resident to leave the nursing home at a specific time.

Q0500 Assessment Guidelines₂

- It also does **not** ensure the resident will be able to move back to the community.
- Answering “No” is not a permanent commitment.
- The resident can change his or her choice at any time.

Q0500A Coding Instructions

- Document whether resident has been asked about returning to the community.

0 **No**
1 **Yes** - previous response was "no"
2 **Yes** - previous response was "yes" → Sk
3 **Yes** - previous response was "unknown"

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	A. Has the resident been asked about returning to the community? 0. No 1. Yes - previous response was "no" 2. Yes - previous response was "yes" → Skip to Q0600, Referral 3. Yes - previous response was "unknown"
Enter Code <input type="checkbox"/>	B. Ask the resident (or family or significant other if resident is unable to respond): "Do you want to talk to someone about the possibility of returning to the community?" 0. No 1. Yes 9. Unknown or uncertain

Q0500B Coding Instructions

- Document whether the resident, family, or significant other wants to talk to someone about returning to the community.

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	A. Has the resident been asked about returning to the community? 0. No 1. Yes - previous response was "no" 2. Yes - previous response was "yes" → Skip to Q0600, Referral 3. Yes - previous response was "unknown"
Enter Code <input type="checkbox"/>	B. Ask the resident (or family or significant other if resident is unable to respond): "Do you want to talk to someone about the possibility of returning to the community?" 0. No 1. Yes 9. Unknown or uncertain

0. No
1. Yes
9. Unknown or uncertain

Q0500 Coding Practice #1₁

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

Q0500 Coding Practice #1₂

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

How should Q0500A be coded?

- A. Code **0**. No.
- B. Code **1**. Yes - previous response was "no"
- C. Code **2**. Yes - previous response was "yes"
- D. Code **3**. Yes - previous response was "unknown"

How should Q0500B be coded?

- A. Code **0**. No
- B. Code **1**. Yes
- C. Code **9**. Unknown or uncertain

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.

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.

How should Q0500A be coded?

- A. Code **0**. No
- B. Code **1**. Yes - previous response was "no"
- C. Code **2**. Yes - previous response was "yes"
- D. Code **3**. Yes - previous response was "unknown"

How should Q0500B be coded?

- A. Code **0**. No
- B. Code **1**. Yes
- C. Code **9**. Unknown or uncertain

Return to Community Referral Care Area Assessment (CAA) Resource

CMS's RAI Version 3.0 Manual

Appendix C: CAA Resources

20. RETURN TO COMMUNITY REFERRAL

Review of Return to Community Referral

✓	Steps in the Process
<input type="checkbox"/>	1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not (Q0500B).
<input type="checkbox"/>	2. Interview the individual and his or her family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual's smooth transition to community living.
<input type="checkbox"/>	3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include: <ul style="list-style-type: none"> • Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700-C1000) • Functional/mobility (G0110) or balance (G0300) problems
<input type="checkbox"/>	4. Inform the discharge planning team and other facility staff of the individual's choice.
<input type="checkbox"/>	5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual's overall goals of care and discharge planning from previous items responses (Q0300 & Q0400B). Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home

RAI Manual Appendix C (C-82 to C-83)

Item Q0600

Referral

Q0600 Importance

- Nursing Homes (NHs) will continue to do discharge planning and meet those regulatory requirements.
- 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.
- Local contact agencies can assist the resident and the NH in transition planning to secure/locate housing, home modifications, personal care, and community integration.

Q0600 Conduct the Assessment

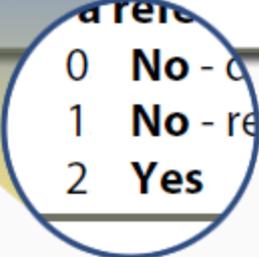
- Complete Q0600 Referral if Q0500A is coded **2**. Yes – previous response was “yes”.

Q0500. Return to Community	
Enter Code <input type="text" value="2"/>	A. Has the resident been asked about returning to the community? 0. No 1. Yes - previous response was "no" 2. Yes - previous response was "yes" → Skip to Q0600, Referral 3. Yes - previous response was "unknown"
Enter Code <input type="text"/>	B. Ask the resident (or family or significant other if resident is unable to respond): "Do you want to talk to someone about the possibility of returning to the community?" 0. No 1. Yes 9. Unknown or uncertain

Q0600 Coding Instructions

- Document whether a referral has been made to a local contact agency.

Q0600. Referral	
Enter Code <input type="checkbox"/>	Has a referral been made to the local contact agency? 0. No - determination has been made by the resident and the care planning team that contact is not required 1. No - referral not made 2. Yes



Q0600 Scenario₁

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

Q0600 Scenario₂

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

Q0600 Scenario Coding

- Q0600 would be coded as **1. No** – referral not made.
- 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.

Q0600. Referral	
Enter Code	Has a referral been made to the local contact agency?
<input type="text" value="1"/>	0. No - determination has been made by the resident and the care planning team that contact is not required
	1. No - referral not made
	2. Yes

Section Q

Summary

Section Q Summary₁

- Section Q provides the opportunity and mechanism to:
 - 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
 - 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.

Section Q Summary₂

- 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.
- 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.

Section Q

Information and Comments

- Section Q Return to Community Resource Information sheet can be found in the student packet.
 - Provides referral, federal and state and community long-term care information.
- E-mail questions or comments to:
mdsformedicaid@cms.hhs.gov