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3	—	Q-1	Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.~~20 (i) (3)~~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 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	Q0100	Q-1	DEFINITION RESIDENT'S PARTICIPATION IN ASSESSMENT The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspectives during assessment.
3	Q0100	Q-1	**Health-related Quality of Life** • Residents who actively participate in the assessment process and in ~~developing~~ development of their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.
3	Q0100	Q-1	**Planning for Care** • Each care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved~~—~~—except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.~~15~~24 Quality of Life).

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3	Q0100	Q-2	• During the care planning meetings, ~~he or she~~the resident should be made comfortable and verbal communication should be directly with him or her. • Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate, and if they desire that they be involved in the assessment process.
3	Q0100	Q-2	DEFINITION FAMILY OR SIGNIFICANT OTHER A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver or close friend. Significant other does not~~, however,~~ include staff at the nursing home.
3	Q0100	Q-3	**Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment** *Record the participation of ~~the~~a guardian or legally authorized representative in the assessment process.*
3	Q0100	Q-3	**Coding Tips** • While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if he or she is able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs.
3	Q0300	Q-4	**Item Rationale** This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about his or her own expectations regarding return to the community and goals for care. The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet his or her individual long-term care needs. Additional assessment information may be needed to determine whether the resident requires additional community services and supports.

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3	Q0300	Q-4	DEFINITION DISCHARGE To release from nursing home care. Can be to home, another community setting, or a healthcare setting.
3	Q0300	Q-4	**Steps for Assessment** 1. Ask the resident about his or her overall expectations to be sure that he or she has participated in the assessment process and has a better understanding of his or her current situation and the implications of alternative choices such as returning home, or moving to another appropriate community setting such as an assisted living facility or an alternative healthcare setting. 2. Ask the resident to consider his or her current health status, expectations regarding improvement or worsening, social supports and opportunities to obtain services and supports in the community. 3. If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what his or her expectation is regarding the outcome of this nursing home admission and expectations about returning to the community. 4. The resident's stated goals should be recorded here. The goals for the resident, as described by the family, significant other, guardian, or legally authorized representative, may also be recorded in the *clinical record*.
3	Q0300	Q-5	**Coding Tips** • This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's expectations~~;~~, not whether or not the staff considers them to be realistic. Coding other than the resident's stated expectation is a violation of the resident's civil rights.

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3	Q0300	Q-7	3. Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now let's talk about it more." When her daughter is asked about goals for her mother's care, she states that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, the level of care that she needs, and other work and family responsibilities we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her." The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days, in the nursing home, and that the family does not have the capacity to provide all the care the resident needs.
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. ~~There are improved c~~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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3	Q0400	Q-9	• Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be maintained in the community homes of their choice for long periods of time, depending on the residential setting and support services available. For example, a referral to the LCA may be appropriate for some individuals with Alzheimer's disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The interdisciplinary team should not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available.
3	Q0400	Q-10	— Who to call in case of an emergency or if symptoms of decline occur. — Nursing facility procedures and discharge planning for ~~subacute~~sub-acute and rehabilitation community discharges are most often well-defined and efficient.
3	Q0400	Q-10	o The NF is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with providing information regarding community-based services and, when appropriate, transition services planning. They~~.~~ 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.

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3	Q0400	Q-10	o Should a planned relocation not occur, it might create stress and disappointment for the resident and family that will require support and nursing home care planning interventions. However, a referral should not be avoided based upon facility staff judgment of potential discharge success or failure. It is the resident's right to be provided information if requested and to receive care in the most integrated setting.
3	Q0400	Q-10–Q-11	Page length changed due to revised content on Q-10.
3	Q0400	Q-11	• Use teach-back methods to ensure that the resident understands all of the factors associated with his or her discharge. • For additional guidance, see CMS' **Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting**. Available at ~~https://www.medicare.gov/Pubs/pdf/11376.pdf~~ https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf
3	Q0400	Q-11	7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes, etc.). 8. A determination of family involvement, capability and support after discharge should also be made. However, support from the family is not always necessary for a discharge to take place.

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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 Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, **Referral**. 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 ~~their~~this request, regardless of schedule of MDS assessment(s).
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 Q0550.
3	Q0490	Q-13	2. Mrs. R is an 82-year-old widow~~ed woman~~ with advanced Alzheimer's disease. She has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

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3	Q0500	Q-14	**Item Rationale** The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in ~~being transitioned to community living~~ 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 insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term services and supports in the least restrictive setting. CMS has found that in many cases individuals requiring long term services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. 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.
3	Q0500	Q-14	**Health-related Quality of Life** • Returning home or to a non-institutional setting can be beneficial ~~very important~~ to the resident's health and quality of life. • This item identifies the resident's desire to speak with someone about returning to community living. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.,** residents needing long-term care services have a civil right to receive services in the least restrictive and most integrated setting.

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3	Q0500	Q-15	2. Ask the resident if he or she 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 the nursing home at a specific time; nor does it ensure that the resident will be able to move back to the community. Answering no is also not a permanent commitment. Also inform the resident that he or she can change his or her decision (i.e., whether or not he or she wants to speak with someone) at *any* time.
3	Q0500	Q-15	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 mind at *any* time.

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3	Q0500	Q-15	4. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can then be obtained from family or a significant other, as designated by the individual. If family or significant others are not available, a guardian or legally authorized representative, if one exists, can provide the information. 5. Ask the resident if he or she wants information about different kinds of supports that may be available for community living. Responding yes will be a way for the individual—and his or her family, significant other, or guardian or legally authorized representative—to obtain additional information about services and supports that would be available to support community living. It is simply a request for information, not a request for discharge.
3	Q0500	Q-16	**Coding Instructions for Q0500B, Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** *A response code of 1, Yes, for this item indicates a request to learn about home and community based services, not a request for discharge.* • Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to live and receive services in the community. • Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to live and receive services in the community.

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3	Q0500	Q-16	**Coding Tips** • A "yes" response to item Q0500B will trigger follow-up care planning and contact with the 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 ~~local agency~~ LCA for follow-up as the resident desires. • Follow-up is expected in a "reasonable" amount of time and 10 business days is a recommendation and not a requirement. 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.
3	Q0500	Q-16–Q-17	• The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF and the resident can talk with the LCA to see what is available~~ that does not require family support~~. • Current return to community questions may upset residents who cannot understand what the question means and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other, guardian and/or legally appointed decision-maker for that individual ~~could~~should be asked the question.
3	Q0500	Q-16–Q-22	Page length changed due to revised content.

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3	Q0500	Q-17	1. Mr. B. is an 82-year-old male with COPD. He was referred to the nursing home by his physician for end-of-life palliative care. He responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why Mr. B. is afraid and explain that obtaining more information may help overcome some of his fears. He should also be informed that someone from a local contact agency is available to provide him with more information about receiving services and supports in the community. At the close of this discussion, Mr. B. says that he would like more information on community supports. Coding: Q0500B would be coded 1, Yes. Rationale: Coding Q0500B as yes should trigger a visit by the nursing home social worker (or facility social worker) to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local contact agency within approximately 10 business days, or according to state policy.
3	Q0500	Q-17	Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local contact agency within approximately 10 business days, or according to state policy, for them to initiate discussions with Ms. C. about returning to community living.
3	Q0550	Q-19	Rationale: Ms. W. needs longer term restorative nursing care to recover from her ~~falls~~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.
3	Q0600	Q-20	**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.

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3	Q0600	Q-20	**Planning for Care** • Some nursing home residents may be able to return to the community if they are provided ~~appropriate~~ assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.
3	Q0600	Q-20	DEFINITION DESIGNATED LOCAL CONTACT AGENCY (LCA)
3	Q0600	Q-21	• 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. ~~**Section Q Point of Contact list for Local Contact Agencies:** http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/downloads/state-by-state-poc-list.pdf~~
3	Q0600	Q-21	• State Medicaid Agencies (SMAs) are required to have designated Local Contact Agencies (LCA) and a State point of contact (POC) to coordinate efforts to implement Section Q and designate LCAs for their State's skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate. 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.

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3	Q0600	Q-21	• Several resources are available ~~at~~ on the Return to Community web site at: ~~http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/community-living-initiative.html~~https://www.medicaid.gov/medicaid/ltss/community-living/index.html. ~~— The State-by-State list of Local Contact Agencies and POC Section Q Coordinator Information~~ — MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues. — The Section Q Pilot Test Results report describes the results of user testing of the new items in Section Q. — Videos of Section Q sessions and discussions at the 2010 RAI Coordinators Conference.
3	Q0600	Q-21	• Resource availability and eligibility coverage varies across States and local communities and may present barriers to allowing some resident~~'~~s to return to their community. The nursing home and local contact agency staff members should guard against raising the resident and their family members' expectations of what can occur until more information is obtained.
3	Q0600	Q-21	• The local contact agency team ~~must~~ will explore community care options/supports and conduct appropriate care planning to determine if transition~~s~~ back to the community is possible. • Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, ~~insufficient financial resources,~~ problems with caregiving supports, community resource gaps, etc. preventing discharge to the community.

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3	Q0600	Q-22	1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was "Yes" to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son's school and use accessible public transportation when he finds employment. He is worried whether he can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops~~, and~~ appliances, doorways, etc. Coding: Q0500B would be coded 1, Yes. Q0600 would be coded 2, Yes. Rationale: The social worker or discharge planner would make a referral to the designated local contact agency for their area and Q0600 would be coded as 2, yes, because a referral to the designated LCA was made.
3	Q0600	Q-22	2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns ~~because of~~ due to falls and difficulties cooking and proper nutrition. She said yes to Q0500B. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed for Ms. V. to return to the community. Coding: Q0600 would be coded 1, No. Rationale: Ms. V. indicated that she wanted to have an opportunity to talk to someone about return to community.