The following verbal information is from the Centers for Medicare and Medicaid Services (CMS) Resident Assessemnt Instrument Version 3.0 Manual, Chapter 3 Section Q. For in-depth details, see Chapter 3, Q-1 through Q-22.

The Minimum Data Set (MDS) is part of the federally-mandated process for assessing individuals receiving care in a certified skilled nursing home regardless of payer source. The process provides a comprehensive assessment of the individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing home residents to return to community living settings.

Section Q: Participation in Assessment and Goal Setting - This section is 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.

Section Q of the MDS uses a person-centered approach to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Q100: Participation in Assessment - This item identifies who participated in the assessment

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. The team should engage the resident during assessment in order to engage their expectation & perspective.

It's very important to record the participation of the resident, family or significant other, guardian or legally authorized representative in the assessment process.

Q300: Resident's Overall Expectation
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. 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 or not.

Q400: Discharge Plan
This item identifies if active discharge planning is already occurring for the resident to return to the community.

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 nursing home 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.
Right to Information

For detail description of Local Contcat Agency and identification of local contact agency for New Hampshire view Local Contact agency chapter.) There are improved community resources and supports that may benefit these residents and allow them to return to a community setting. Being discharged from the nursing home without adequate discharge plan (Arranging for all resident needs) and implementation of a plan before discharge can result in the resident's decline and increase the chances for rehospitalization, a thorough examination of the options with the resident and local community experts is imperative.

If a nursing home has a discharge plan and referral and resource process for short stay residents t to return to the community. If the nursing home has the capability to address a resident's needs and arrange for that resident to discharge back to the community, a referral to the local contact agency may not be necessary.

If active discharge planning is already occurring for the resident to return to community SKIP TO Q600: Referral. However, if there is no active discharge planning already occuring for the resident to return to the community, move to the next question

Q490: Resident's Preference to Avoid Being Asked Question Q500B
For Quarterly, Correction to Quarterly, and Non-comprehensive Assessments.

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 comprehensive assessment that they do not want to be asked question Q500B until their next annual 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. 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 Q600, Referral.

To repeat, resident can only opt out of being asked Question Q500B on quartely assessments. They must be asked annually. Let the resident know they can change their mind at any time

Q500B: Return to Community The 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.

At the initial admission assessment and subsequent follow-up assessments (as applicable), make the resident comfortable by assuring him or her that this is a routine question that is asked of all residents. Ask the resident if he or she would like to speak with someone about the possibility of returning to live 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. 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.

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.

Q550 Residents Preference to Aviod Being Asked Question Q500B again. This item allows the resident to opt out of being asked Q500B"Return to Community" question on 1/4ly (non comprehensive) assessments.

Q600: Referral
This item identifies if a referral has been made to the Local Contact Agency. Returning home or to a non-institutional setting can be very important to the resident's health and quality of life. 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.

Example of referral not needed: a determination has been made by the resident and or circle of support that the local contact agency does not need to be contacted because there is active discharge planning

occuring for the residient to return to the community. The nursing home has the capacity to meet discharge planning needs.

Referral is or may be needed: determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) that the designated local contact agency needs to be contacted but the referral has not been initiated at this time. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.

Referral made; if referral was made to the local contact agency. For example, the resident responded yes to Q500B. The nursing home ititaites referral to local contact agency. For indepth details about this process, view the referral process chapter.