Q0620: Reason Referral to Local Contact Agency (LCA) Not Made

Complete only if Q0610 = 0.

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Enter Code ☐

Indicate reason why referral to LCA was not made

1. LCA unknown
2. Referral previously made
3. Referral not wanted
4. Discharge date 3 or fewer months away
5. Discharge date more than 3 months away

Item Rationale

Health-related Quality of Life

- Understanding the reason that referrals to the LCA were not made can help the care team support the resident to receive care that supports them to achieve their highest practicable level of functioning in the least restrictive setting.

Planning for Care

- Understanding the reason that referrals to the LCA were not made allows for comprehensive care planning by the facility team in conjunction with the resident and their family.

Steps for Assessment

1. If Q0610: Referral = 0, No, indicate the primary reason that the referral has not been made to the LCA.

Coding Instructions for Q0620, Reason Referral to Local Contact Agency (LCA) Not Made

- **Code 1, LCA unknown**
- **Code 2, Referral previously made:** if a referral has previously been made to the LCA, which is currently working with the resident and facility staff on an active discharge plan to return to the community.
- **Code 3, Referral not wanted:** if the resident (or family, significant other, legal guardian, or other legally authorized representative **only** if resident doesn't understand or is unable to respond) responded they do not want a referral (Q0500B = 0).

Q0620: Reason Referral to Local Contact Agency (LCA) Not Made (cont.)

- **Code 4, Discharge date 3 or fewer months away:** if the resident has an expected discharge date of three (3) months or fewer, has an active discharge plan in progress, and the discharge plan could not be improved upon with a referral to the LCA.
- **Code 5, Discharge date more than 3 months away:** if the resident has an expected discharge date of more than three (3) months and discharge plan is actively in progress.

Examples

1. Resident S has been in the nursing home for several months following an automobile accident. They plan to return home after their therapy regime ends, which is expected in three to four weeks. In conjunction with Resident S's Admission assessment, the facility team made a referral to the LCA but the agency is not currently working with the resident. The interdisciplinary team and the resident have developed a safe discharge plan for Resident S that could not be improved upon with a referral to the LCA.

   Coding: Q0620 would be **coded 4, Discharge date 3 or fewer months away.**
   Rationale: Resident S's discharge is expected within three to four weeks, and their discharge plan could not be improved upon with a referral to the LCA.

2. Resident J is unable to communicate verbally due to severe dementia. Their spouse met with the care team, and the spouse and care team agree that long-term nursing home placement on the secure dementia unit is appropriate for Resident J. The spouse declined a referral to the LCA.

   Coding: Q0620 would be **coded 3, Referral not wanted.**
   Rationale: Resident J is unable to communicate verbally due to severe dementia. Their spouse declined a referral to the LCA as they and the care team agree that long-term placement on the secure dementia unit is appropriate for Resident J.

SECTION S IS RESERVED FOR ADDITIONAL STATE-DEFINED ITEMS. THERE IS NO SECTION S IN THE FEDERAL MDS VERSION 3.0 ITEM SET. YOUR STATE MAY CHOOSE TO DESIGNATE A SECTION S.

SECTION V: CARE AREA ASSESSMENT (CAA) SUMMARY

Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning.

There are 20 CAAs in Version 3.0 of the RAI, which includes the addition of "Pain" and "Return to the Community Referral." These CAAs cover the majority of care areas known to be problematic for nursing home residents. The Care Area Assessment (CAA) process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directs facility staff and health professionals to evaluate triggered care areas.

The interdisciplinary team (IDT) then identifies relevant assessment information regarding the resident's status. After obtaining input from the resident, the resident's family, significant other, guardian, or legally authorized representative, the IDT decides whether or not to develop a care plan for triggered care areas. Chapter 4 of this manual provides detailed instructions on the CAA process and development of an individualized care plan.

Whereas the MDS identifies actual or potential problem areas, the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors, some of which may be reversible. It is important that the CAA documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors, with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible, or (2) maintenance and prevention of avoidable declines. Documentation should support your decision making regarding whether to proceed with a care plan for a triggered CAA and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record, e.g., progress notes, consults, flowsheets, etc.