Q0610: Referral

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Enter Code ☐

A. Has a referral been made to the Local Contact Agency (LCA)?

0. **No**
1. **Yes**

Item Rationale

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.

Planning for Care

- Some *NH* residents may be able to return to the community if they are provided assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

Coding Instructions for Q0610: Has a referral been made to the Local Contact Agency (LCA)?

- **Code 0, No:** *if a referral has not been made.*
- **Code 1, *Yes:*** *if a referral has been made. If a referral has been made skip to V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment.*

Q0610: Referral (cont.)

Coding Tips

- State Medicaid Agencies (SMAs) are required to have designated LCA and a State point of contact (POC). The SMA is responsible for coordinating implementation of Section Q and designating LCAs for their State's SNFs and NHs. These LCAs may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Centers for Independent Living, 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.
- Resource availability and eligibility varies across States and local communities and may present barriers to allowing some residents to return to their community. The NH and LCA staff members should guard against raising the expectations of residents and their family members of what can occur until more information is obtained.
- Close collaboration between the NH and the LCA is needed to evaluate the resident's medical needs, finances and available community transition resources.
- The LCA can provide information to the SNF/NH on the available community living situations, and options for community based supports and services including the level and scope of what is possible.
- The LCA team will explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- Resident support and interventions by the NH staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, problems with securing appropriate caregiving supports, community resource gaps, etc., preventing discharge to the community.
- When Q0610A is answered 0, No, a care area trigger requires a return to community care area assessment (CAA) and CAA 20 provides a step-by-step process for the facility to use in order to provide the resident an opportunity to discuss returning to the community.

Q0610: Referral (cont.)

Examples

1. *Resident* S is a 48-year-old *individual* who suffered a stroke, resulting in paralysis below the waist. *They are* responsible for *their* 8-year old *child*, who now stays with *their* grand*parent*. At the last *Q*uarterly assessment, *Resident* S had been asked about returning to the community and *their* response was "Yes" to item Q0500B and *they* report no contact from the LCA. *Resident* S is more hopeful *they* can return home as *they* become stronger in rehabilitation. *They* want a location to be able to remain active in *their child*'s school and use accessible public transportation when *they* find employment. *They are* worried whether *they* can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops, appliances, doorways, etc. *The social worker documented the resident's responses and made a referral to the LCA.*

   Coding: Q0500B would be **coded 1, Yes***;*
   Q06*1*0*A* would be **coded *1*, Yes**.

   Rationale: The social worker or discharge planner would make a referral to the designated *LCA* for their area and Q06*1*0*A* would be coded as *1*, *Y*es, because a referral to the designated LCA was made.

2. *Resident* V is an 82-year-old *individual* with right sided paralysis, mild dementia, *and* diabetes *who* was admitted by the family because of safety concerns due to falls and difficulties cooking and proper nutrition. *Resident V* said *no* to Q0500B*, but that they may wish this information at a later date, expressing their feeling that they are not yet ready to plan for community transition*. *They* need to continue *their* rehabilitation therapy and regain *their* strength and ability to transfer. The social worker plans to talk to the resident and *their* family *during future Quarterly assessments* to determine whether a referral to the LCA is needed for *Resident* V to return to the community.

   Coding: Q06*1*0*A* would be **coded *0*, No**.

   Rationale: *Resident* V indicated that *they* wanted to have an opportunity to talk to someone about return to community*, but that they were not yet ready*. The *NH* staff will focus on *their* therapies and talk to *them* and *their* family to obtain more information for discharge planning *in future months*. Q06*1*0*A* would be coded as *0, N*o. The Care Area Assessment #20 is triggered and it will be used to guide the follow-up process. Because a referral was not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated to the designated *LCA*.