Additional Resources

- State Operations Manual
- http://www.cms.gov/NursingHomeQualityInit\s/

Lesson 1: Introduction to the MDS 3.0

- What is the MDS used for?
- Global changes to the MDS 3.0
- How will these changes affect surveyors?

MDS 3.0: An Introduction for Surveyors

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NYS Department of Health

Lesson 1 Objectives

- Define the purpose of the MDS
- Identify improvements/ new features of the MDS 3.0
- Describe the focus of the MDS 3.0
- Explain how MDS 3.0 relates to resident care
- Recognize ways that MDS 3.0 will affect the survey process

MDS 3.0 An Introduction for Surveyors

- Lesson 1: Introduction to MDS 3.0
- Lesson 2: MDS Section Overview

What is the MDS?

- Minimum Data Set
- Part of the Resident Assessment Instrument (RAI)
- Minimum data collection required for all residents in nursing homes participating in Medicare and/or Medicaid
Purpose of the MDS
• Identify resident care problems
• Medicare/Medicaid reimbursement
• Monitoring quality of care provided to residents

Increasing Resident Voice
• Resident interviews
• Are preferred over staff assessment
• Gives resident more input and control
• Increase resident well-being

Why Change to MDS 3.0?
• Concerns about clinical relevancy of 2.0
• 2.0 failed to include resident interviews
  —Fails to obtain critical information
  —Disenfranchises residents
• Desire for standardized definitions

Global Changes To the MDS

How will the changes help?
• MDS 3.0 items increase:
  —Reliability
  —Accuracy
  —Usefulness/clinical relevance

Structured Interviews
• Increase resident voice
• Section C: Cognitive patterns
• Section D: Mood
• Section F: Preferences for customary routine activities
• Section J: Health conditions
Incorporating Standards and Protocols

• Standard tools and protocols used in other care settings
  – Example: Pressure ulcer staging
  – Protocol from the National Pressure Ulcer Advisory Panel (NPUAP)

Look-back Periods

• 7 day look-back periods for all items
• Exceptions:
  – Section D: 14 days
  – Section F: No look-back
  – Section J: Different look-backs for different items
  – Section K: Different look-backs for different items
  – Section O: 14 days

Instructions, Definitions, Clarifications

• Instructions provided on the form
• Definitions of terms provided on the form and in User’s Manual
• Clarifications on coding provided on the form and in the User’s Manual

Section M: Skin Conditions

• Adapted from National Pressure Ulcer Advisory Panel
• No reverse staging
• Evaluate:
  – Number of pressure ulcers
  – Stages of pressure ulcers
  – Age of pressure ulcers
  – Dimensions of worst pressure ulcer
  – Most severe tissue type
  – Other skin conditions

More User Friendly

• Larger font
• Easier format
• Increased readability

Therapy

• Part A vs. Part B
• Concurrent vs. Group therapy
• Recording:
  – Days
  – Minutes
  – Start and end dates
Section Q
- Q0500: Return to Community Referral
- Discussion with resident and family
- Care planning requirements

Effect on Surveyors
- Sample selection
- Validating interviews
- Care area assessment (CAA) process
- State Operations Manual

Assessment Reference Date (ARD)
- Determines:
  - assessment schedule
  - MDS completion date
  - CAA completion date
  - Care plan completion date
  - Transmission date

Sample Selection
- QI/QM reports unavailable
- No generation of off-site sample selection
- Use Roster/Sample Matrix

MDS as a Foundation
- MDS is a snapshot of information
- Information used to develop care plan
- Care plan used to help resident reach goals

Validating Interviews
- Resident observation and interview
- Verify that recorded information is accurate and correct
- Verify that information is integrated into the care plan
- Ensure that care plan is implemented, evaluated, and revised
<table>
<thead>
<tr>
<th>Care Area Assessment Process</th>
<th>Roster/Sample Matrix: Provider Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Problem Identification Process</td>
<td>• MDS 3.0 coding/manual coding instructions</td>
</tr>
<tr>
<td>• CAA Process Includes:</td>
<td>• Resident Characteristic fields renumbered</td>
</tr>
<tr>
<td>– CAA Triggers (replaced RAP Triggers)</td>
<td></td>
</tr>
<tr>
<td>– CAAs (Replaced RAPs)</td>
<td></td>
</tr>
<tr>
<td>• Chapter 4: <em>User’s Manual</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Area Assessment Documentation</th>
<th>Roster/Sample Matrix: Surveyor Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Resident’s condition</td>
<td>• References to QIs/QMs removed</td>
</tr>
<tr>
<td>• Related underlying causes, contributing factors, risk factors</td>
<td>• Resident characteristic fields renumbered</td>
</tr>
<tr>
<td>• Complications</td>
<td></td>
</tr>
<tr>
<td>• Care plan considerations</td>
<td></td>
</tr>
<tr>
<td>• Care plan decisions</td>
<td></td>
</tr>
<tr>
<td>• Need for evaluation</td>
<td></td>
</tr>
<tr>
<td>• Resource/assessment tool used</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Roster/Sample Matrix: CMS 802</th>
<th>Resident Census and Conditions of Residents: CMS 672</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Revisions to 802 form</td>
<td>• 672 Form: No revisions</td>
</tr>
<tr>
<td>– Falls/fractures is a separate field form Abrasions/Bruises</td>
<td>• 672 Instructions:</td>
</tr>
<tr>
<td>– Behavioral Symptoms is a separate field from Depression</td>
<td>– MDS 3.0 coding replaces 2.0 coding</td>
</tr>
<tr>
<td>– Resident characteristics renumbered</td>
<td>– Manual coding instructions</td>
</tr>
<tr>
<td></td>
<td>– Use of form remains the same</td>
</tr>
</tbody>
</table>
Resident Review Worksheet: CMS 805

- No revisions to CMS 805
- CMS 805 Instructions:
  - MDS 3.0 20 CAAs replace MDS 2.0 18 RAPs

Lesson 2: MDS 3.0 Section Overview

- Section-by-section review
- Intent of each section
- Guidance for surveyors

State Operations Manual

- Appendix P
- Appendix PP
- CMS updates

Lesson 2 Objectives

- Identify changes to each section of the MDS
- Explain how changes affect the survey process

Summary

- MDS data collected for LTC residents
- MDS is foundation of care planning
- New items increase:
  - Reliability
  - Accuracy
  - Usefulness
  - Resident voice
- Effect on surveyors:
  - Sample selection
  - Interview validation
  - CAA process

Section A: Identification Information

- Intent:
  - Uniquely identify:
    - Resident
    - Nursing home or swing-bed provider
    - Reason for conducting assessment
Section A: New Items

- A0200 Type of provider
- A0310c PPS OMRA, Start & End of Therapy
- A1100 Language
- A1500 PASRR
- A1700 Type of Entry
- A2000 Discharge Date
- A2100 Discharge Status
- A2200 Previous ARD for Sig. Correction
- A2400 Medicare Stay

Section B: Hearing, Speech and Vision

- Intent:
  - Document:
    - Resident’s ability to hear, understand and communicate
    - Resident’s visual limitations
    - Difficulties related to diseases common in aged persons

Surveyor Guidance B0100

- Is the resident in a persistent vegetative state/ no discernible consciousness?
  - Need physician documentation of diagnosis

B0700 Surveyor Guidance

- B0700 Makes Self Understood
  - Resident makes self understood
  - Skip patterns
Section C: Cognitive Patterns

- **Intent:**
  - Assess ability to:
    - Think coherently
    - Remember recent events
    - Remember past events

Section C Surveyor Guidance

- Resident interviews versus staff assessment
  - Reference Item B0700
  - Look for no response/nonsensical response on at least 3 questions to justify conducting SAMS

Conducting the BIMS

- Handout 1
- Review examples
- Discuss coding

---

<table>
<thead>
<tr>
<th>BIMS Answers</th>
<th>Brief Interview for Mental Status (BIMS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1000: Repetition of Three Words</td>
<td></td>
</tr>
<tr>
<td><strong>Ask question:</strong> “I am going to say three words for you to remember. Please repeat the words after I have said them.” The words are: red, blue, and green. Repeat the three words.”</td>
<td></td>
</tr>
<tr>
<td>Number of words repeated after first attempt</td>
<td></td>
</tr>
<tr>
<td>1. None</td>
<td></td>
</tr>
<tr>
<td>2. One</td>
<td></td>
</tr>
<tr>
<td>3. Two</td>
<td></td>
</tr>
<tr>
<td>4. Three</td>
<td></td>
</tr>
<tr>
<td>After the resident’s first attempt, repeat the words using case words: something to wear, fruit, a color, and a piece of furniture.” You may repeat the words up to two more times.</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
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</thead>
<tbody>
<tr>
<td>C1400: Temporal Orientation (orientation to year, month, and day)</td>
<td></td>
</tr>
<tr>
<td><strong>Ask question:</strong> “Tell me what day it is today?”</td>
<td></td>
</tr>
<tr>
<td>A. Able to report correct year</td>
<td></td>
</tr>
<tr>
<td>0. Mixed by 10 years or more</td>
<td></td>
</tr>
<tr>
<td>1. Mixed by 1-9 years</td>
<td></td>
</tr>
<tr>
<td>2. Correct</td>
<td></td>
</tr>
<tr>
<td>B. Able to report correct month</td>
<td></td>
</tr>
<tr>
<td>0. Mixed by 6 months or more</td>
<td></td>
</tr>
<tr>
<td>1. Mixed by 1-5 months</td>
<td></td>
</tr>
<tr>
<td>2. Correct</td>
<td></td>
</tr>
<tr>
<td>C. Able to report correct day of the week</td>
<td></td>
</tr>
<tr>
<td>0. Incorrect or no answer</td>
<td></td>
</tr>
<tr>
<td>1. Correct</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>BIMS Answers</th>
<th>Brief Interview for Mental Status (BIMS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1500: Summary Score</td>
<td></td>
</tr>
<tr>
<td>Add score for questions C030, C040, and fill in total score (0-15)</td>
<td></td>
</tr>
<tr>
<td>Cannot or unable to complete use answers to questions of the interview</td>
<td></td>
</tr>
</tbody>
</table>

Section C: New Items

- **C1300**
  - From Confusion Assessment Method
  - Coded after completing Brief Interview for Mental Status
Using the CAM

- Handout 2
- Examples
- Coding

Using the CAM

Using the CAM

Section C Surveyor Guidance

- Talk to resident
- Validate resident responses
- Talk to staff about assessments
- Use handouts/ cue cards

Section D: Mood

- Intent:
  - Address mood distress
  - Identify under-diagnosed/ under-treated conditions
  - Provide treatment

CAM Answers

Surveyor Guidance PHQ-9

- Ask about symptom presence and frequency (if applicable)
- Coded for higher frequency
- Read questions as worded, no interpretations
- Recommended to conduct on ARD or one day prior

Conducting the PHQ-9

- Handout 3
- Example
- Coding

Surveyor Guidance PHQ-9

Surveyor Guidance PHQ-9

Surveyor Guidance PHQ-9

Conducting the PHQ-9

Conducting the PHQ-9

Conducting the PHQ-9

Conducting the PHQ-9

Conducting the PHQ-9
PHQ-9 Answers

D0350 Surveyor Guidance

- D0350 Safety Notification
- D0650 Safety Notification

Section D Surveyor Guidance

- Determine coding accuracy
- Ask direct questions
- Interview staff

Section E: Behavior

- Intent:
  - Identify behavioral symptoms
  - Identify potentially harmful behaviors

E0200-E0500 Surveyor Guidance

- Coded for presence of behaviors
- Behaviors should not be minimized or normalized

E0800 Surveyor Guidance

- Item should be coded as “0” after first instance if the rejection of care:
  - Has already been discussed with resident and family
  - Has been care planned for or
  - Is consistent with resident’s values, preferences, or goals
Section E: Surveyor Guidance

- Observe resident behavior
- Determine
  - Coding accuracy
  - Appropriate staff response
- Review record
- Interview staff

Section F: Preferences for Customary Routine and Activities

- Intent:
  - Obtain information regarding resident:
    - Preferences
    - Daily routine
    - Daily activities

Section F: Surveyor Guidance

- No look-back period
- Use of cue-cards

Conducting the Preferences Interview

- Handout 4
- Example
- Coding

Activity/Preferences Answers

Conducting the Preferences Interview

- Handout 4
- Example
- Coding

Activity/Preferences Answers

Conducting the Preferences Interview

- Handout 4
- Example
- Coding

Activity/Preferences Answers
Section F: Surveyor Guidance

- Observe resident
- Interview resident and staff
- Review resident record & care plan

Activities of Daily Living: Surveyor Guidance

- Changes to self-performance coding:
  - 0: Independent: no staff help/oversight at any time
  - 4: Total dependence: full staff performance every time
  - 7: Activity occurred only once or twice
- ADL flowchart: Rule of 3
- Column 2: Coded for highest level of support provided

10 Minute Break

G0300 Balance: Surveyor Guidance

- Residents should be observed:
  - Moving from seated to standing position
  - Walking 15 feet
  - Turning around
  - Moving on and off toilet
  - Transferring between bed and chair/bed and wheelchair

Section G: Functional Status

- Intent
  - Assess:
    - Need for assistance
    - Level of ability
      - Review Activities of Daily Living
      - Review gait and balance
      - Review range of motion

G0400-G0900: Surveyor Guidance

- G0400 Joints:
  - Upper extremities: Shoulder, elbow, wrist, hand
  - Lower extremities: Hip, knee, ankle, foot
- G0600: Record all appliances that were normally used
- G0900: Record resident’s belief
Section G: Surveyor Guidance

- Observe resident performance
  - Assess risk for falls
  - Review care plan
- Determine accurate coding

H0300-H0400: Surveyor Guidance

- Leaking catheter = incontinence
- Dialysis coded as 9
- Leaking ostomy = incontinence
- Fecal impaction is not included on MDS 3.0

Section H: Bladder and Bowel

- Document
  - Use of appliances
  - Toileting programs
  - Continence
  - Training programs
  - Bowel patterns

Section H: Surveyor Guidance

- Fecal Impaction
  - Sentinel event
  - Review medical record
- Toileting programs
  - Individualized

H0100-H0200: Surveyor Guidance

- H0100: One time catheterization for urine specimen would not be coded
- H0200A: Look back to admission/re-entry/first note of incontinence
- H0200B: Addresses response during trial period
- H0200C: Addresses past 7 days

Section I: Active Diagnoses

- Code diseases related to:
  - Functional status
  - Cognitive status
  - Mood or behavior status
  - Medical treatments
  - Nursing monitoring
  - Risk of death
Section I: Surveyor Guidance

- Assess using 2 steps:
  - Diagnosis identification: 60 day look-back period
    - Documented by physician or physician extender
  - Status (active/inactive) identification: 7 day look-back period
    - Documentation of treatment or medication for symptoms/condition

Urinary Tract Infection: Surveyor Guidance

- Status (active/inactive) identification: 30 day look-back period
- Need all four conditions to code as UTI:
  - Diagnosis in last 30 days
  - Sign or symptom of UTI
  - Significant lab findings
  - Current medication or treatment in last 30 days

Section J: Health Conditions

- Intent:
  - Document:
    - Health conditions
    - Impact on resident’s quality of life
    - Impact on resident’s functional status

J0100: Surveyor Guidance

- Look-back period: 5 days
- J0100A Scheduled meds: Received/ did not receive
- J0100B PRN Meds: Offered/ did not offer
- J0100C Non-med pain intervention: Received and assessed for efficacy/ did not receive

Section I: Surveyor Guidance

- Diagnoses are current
  - Review:
    - Coding
    - Doctor’s notes
    - Record

Pain Assessment Interview: Surveyor Guidance

- Interview residents who are able to make selves understood
- Look-back period: 5 days
- J0400: Code for higher frequency
- J0600: Choose one scale
Conducting the Pain Assessment Interview

- Handout 5
- Examples
- Coding

### Pain Assessment Interview

**J0500: Pain Presence**

Ask resident: “Have you had pain or breathing difficulty at any time in the last 7 days?”

1. No
2. Yes

- **Notes:**
  - Include cause of pain in PM chart.
  - Note pain location.

**J0600: Pain Frequency**

Ask resident: “How much of the time have you experienced pain or breathing difficulty over the last 7 days?”

1. Always
2. Frequently
3. Occasional
4. Slightly
5. Unable to answer

### Pain Interview Answers

**J1300: Pain Presence**

- Ask resident: “Have you had pain or breathing difficulty at any time in the last 7 days?”

**J1400: Pain Frequency**

- Ask resident: “How much of the time have you experienced pain or breathing difficulty over the last 7 days?”

### Other Health Conditions: Surveyor Guidance

- **J1100:** Check “A” if resident avoids activity due to shortness of breath
- **J1400:** Requires physician documentation
- **J1550A:** 2.4 > baseline temp OR 100.4
- **J1550D:** Do not include nosebleeds or red blood cells in urine sample

### Falls: Surveyor Guidance

- **J1700 A,B,C:**
  - Complete only on admission/first assessment since admission
  - Different look-back periods
- **Falls include:**
  - Trips
  - Slips
  - Intercepted falls
  - Found on floor with no explanation

### Section J: Surveyor Guidance

- Observe and interview residents
- Interview staff
- Review record/care plan
- Determine coding accuracy
- Review health conditions/prognosis

### Section K: Swallowing/ Nutritional Status

- **Intent:**
  - Assess conditions affecting ability to:
    - Maintain adequate hydration
    - Maintain adequate nutrition
    - Maintain adequate weight
K0200: Surveyor Guidance

- Height and weight:
  - should be measured regularly
  - should follow facility procedure
  - Should be rounded according to mathematical principles

Section L: Oral/Dental Status

- Intent:
  - Record dental problems

K0500: Surveyor Guidance

- Include any nutrition received in last 7 days if the purpose is nutrition/hydration
- Specific guidelines for coding IV fluids
- Enteral feeding formulas:
  - Not coded as mechanical diet
  - Only coded as therapeutic diet when altered to manage health conditions

Section L: Surveyor Guidance

- Examine resident’s mouth
  - Referrals to dentist
- Determine follow-up
- Review presence in CAAs and Care Plan

Section K: Surveyor Guidance

- Review for planned/unplanned weight loss and gain
- Expanded items for swallowing:
  - Do not code if interventions work
  - Observe resident eating, drinking, swallowing

Section M: Skin Conditions

- Intent:
- Document (pressure ulcers):
  - Risk
  - Appearance
  - Change
- Note:
  - Skin ulcers
  - Wounds
  - Lesions
Section M: Surveyor Guidance

• More specifics provided
• Assess risk for pressure ulcers
• No reverse-staging
• Follow NPUAP guidelines

Section N: Medications

• Intent
• Record number of DAYS that resident received:
  – Medication
  – Antigen
  – Vaccine

Section M: Surveyor Guidance

• Identify number of unhealed ulcers that are:
  – Unstageable
  – Worsening
  – Stages 3 & 4 (include dimensions)

Section N: Surveyor Guidance

• Coded for medications/injections received (not ordered)
• Coded for number of days
• Combination meds coded for all categories

Section M: Surveyor Guidance

• Observe/interview resident
• Review records
• Determine accurate coding
• Assess whether staff:
  – Evaluated treatment
  – Review/revise care plan

Section N: Surveyor Guidance

• Review for accurate coding
• Item N0400
  – Added anticoagulant and antibiotic
**Section O: Special Treatments and Procedures**

- **Intent**
- **Identify:**
  - Special treatments
  - Special procedures

**O0100: Surveyor Guidance**

- **Column 1 coded only if resident entered within last 14 days**
- **Column 2 coded while a resident and in the last 14 days**

**Therapies: Surveyor Guidance**

- Medicare Part B
  - Concurrent therapy: Not recognized
  - Group therapy: Simultaneous treatment, two or more individuals by a therapist/assistant

**Therapies/Restorative Nursing: Surveyor Guidance**

- **Enter Number of Days:**
  - Activity must occur for at least 15 minutes each day to be coded

**Section O: Surveyor Guidance**

- **Determine:**
  - Accurate coding
  - Vaccine given
  - Dates vaccine given
  - Reason for not giving flu vaccine
Section O: New Items

- O0250: Influenza vaccine
  - RAI User’s Manual for Flu season
- O0400: Therapies
  - Start and end dates
  - Recreational therapy

Section P: Restraints

- Intent
- Record frequency of restraint use during day or night

Section Q: Participation in Assessment & Goal Setting

- Intent
- Understand resident’s goals
- Record goal setting participation by:
  - Resident
  - Family
  - Significant others

Section Q: Surveyor Guidance

- New items:
  - Q0300: Resident’s expectation re. discharge
  - Q0400: Discharge plan
  - Q0500: Return to community
  - Q0600: Referral
- CAA trigger
- Interview resident

Section P: Surveyor Guidance

- Understand definition of restraint
- New items:
  - P0100: Physical restraints
    - Separate coding for restraints use in and out of bed
    - Definitions included

Section V: Care Area Assessment Summary

- Intent
- Document triggered areas
- Identify date and location of documentation
- Describe clinical status
- Describe factors that impact care planning
- Determine need for care plan
Section V: Surveyor Guidance

- CAA process will be similar to RAP process
- No anticipated impact on surveyors
- Resources can be found in appendix C

Section X: Correction Request

- Intent
- Record assessment or record in error
- New record:
  - Skip all items but number 1
- Modified record:
  - All items completed
- Guidance provided in Chapter 5 of User’s Manual

Section Z: Assessment Administration

- Intent
- Provide:
  - Billing information
  - Signatures

Links

- [http://www.cms.gov/NursingHomeQualityInit](http://www.cms.gov/NursingHomeQualityInit)
- [http://mds-ny.org](http://mds-ny.org)
- [http://Sta-ny.org](http://Sta-ny.org)

Thank you!!