MDS 3.0: A Primer - Objectives

At the end of this training you will be able to describe:

- The history and purpose of the Minimum Data Set 3.0 (MDS)
- The benefit MDS 3.0 has for the resident, facility and quality management
- The Resident Assessment Instrument manual and its use
- The purpose of the MDS 3.0 assessment form
- The Interdisciplinary Team (IDT)

History Of Resident Assessment Instrument (RAI)

- Omnibus Budget Reconciliation Act of 1987 (OBRA)
  - Gave Centers of Medicare and Medicaid Services (CMS) authority to enact measures to:
    - Reduce unnecessary costs
    - Improve quality of patient care in facilities
### Provisions of OBRA-87

- Emphasis on quality of life as well as quality of care
- New expectations that each resident’s ability to walk, bathe, and perform other activities of daily living will be maintained or improved absent medical reasons
- A resident assessment process that leads to an individualized care plan
- 75 hours of training and testing of paraprofessional staff
- Rights to remain in nursing home absent non-payment, dangerous resident behaviors, or significant changes in medical condition

### Provisions of OBRA-87 continued

- Opportunities for potential and current residents with mental retardation or mental illnesses for services inside and outside a facility
- Right to safely maintain or bank personal funds with the facility
- Right to return to the nursing home after a hospital stay or overnight visit with family and friends
- Right to choose a personal physician and to access medical records

### Provisions of OBRA-87 continued

- Right to organize and participate in a resident or family council
- Right to be free of unnecessary and inappropriate physical and chemical restraints
- Uniform certification standards for Medicare and Medicaid facilities
- Prohibitions on turning to family members to pay for Medicare and Medicaid services
- New remedies to be applied to certified facilities that fail to meet minimum federal standards
Purpose of the Minimum Data Set (MDS)

- Quality of Care – Quality of Life
- Attain and maintain his or her highest practicable physical, mental, and psychosocial well-being

RAI Components

- Resident Assessment Instrument
- MDS
- Care Area Assessments
- Utilization Guidelines

Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) Benefit

- Resident
- Facility
- Quality Management
The Holistic Approach

- Preferences
- Weaknesses
- Strengths
- Behaviors
- Attitudes

Benefits of the RAI
- Gather information for care plan
- Use holistic approach
- Track goal achievement/changes
- Work with Interdisciplinary Team (IDT)
- Involve resident and family
- Provide documentation
- Share information

Benefits for the Resident
- Care Planning
Benefits for the Facility
- Reimbursement
- Staffing
- Reputation

Benefits for Quality Management
- Quality review and audits
- Monitoring quality of care
  - State Survey and Certification activities
  - Facility Quality Management Efforts
  - Consumer Understanding of quality of care
  - CMS long-term quality monitoring

RAI Process
Resident Assessment Instrument (RAI) Manual

- The purpose of the Resident Assessment Instrument (RAI) manual is to offer clear guidance about how to correctly and effectively provide appropriate care.
- Providing care to residents with post-hospital and long-term care needs is complex and challenging work which requires clinical competence, observational, interviewing and critical thinking skills.
- Assessment expertise from all disciplines is required to develop individualized care plans.

Resident Assessment Instrument (RAI) Manual

- The RAI helps nursing home staff gather definitive information on a resident’s strengths and needs, which must be addressed in an individualized care plan.
- It also assists staff with evaluation goal achievement and revising care plans accordingly by enabling the facility to track changes in the resident’s status.
- The care plan becomes each resident’s unique path toward achieving or maintaining his or her highest practical level of well-being.

MDS Assessment Form

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NH) Item Set

Section A: Identification Information

<table>
<thead>
<tr>
<th>Admission Type of Resident</th>
<th>Identification Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Address/Name</td>
<td></td>
</tr>
<tr>
<td>B. Birth Date/Place/Region</td>
<td></td>
</tr>
<tr>
<td>C. Social Security Number</td>
<td></td>
</tr>
</tbody>
</table>

Section B: Facility-Related

<table>
<thead>
<tr>
<th>Facility Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. State Code</td>
<td></td>
</tr>
<tr>
<td>B. Facility Name</td>
<td></td>
</tr>
<tr>
<td>C. Address/Name/Region/Area</td>
<td></td>
</tr>
</tbody>
</table>

Section C: Type of Residence

<table>
<thead>
<tr>
<th>Types of Residence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Home</td>
<td></td>
</tr>
<tr>
<td>B. Nursing Home</td>
<td></td>
</tr>
<tr>
<td>C. Skilled Nursing Facility</td>
<td></td>
</tr>
</tbody>
</table>

Section D: Admission

<table>
<thead>
<tr>
<th>Admission Type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Date Admitted</td>
<td></td>
</tr>
<tr>
<td>B. Date of Birth Death</td>
<td></td>
</tr>
<tr>
<td>C. Hospital/Other Admission</td>
<td></td>
</tr>
</tbody>
</table>

Section E: Medical History

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Heart Disease</td>
<td></td>
</tr>
<tr>
<td>B. Diabetes</td>
<td></td>
</tr>
<tr>
<td>C. Chronic Lung Disease</td>
<td></td>
</tr>
</tbody>
</table>

Section F: Current Problems

<table>
<thead>
<tr>
<th>Current Problem</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Heart Disease</td>
<td></td>
</tr>
<tr>
<td>B. Diabetes</td>
<td></td>
</tr>
<tr>
<td>C. Chronic Lung Disease</td>
<td></td>
</tr>
</tbody>
</table>
Type of Assessment

**MDS 3.0 Assessment Sections**

1. **Identification Information**: Other key information to complete, identify task involved, reporting home.
2. **Health, Safety, and Environment**: Identify health, safety, home, and potential risks.
3. **Cognition PATTERNS**: Identifying resident's attention, orientation, ability to follow and provide information.
4. **Behavior and Mental Status**: Identifies behavioral and mental status issues.
6. **Health Conditions**: Environmental conditions present in the resident's living environment. Include the environmental conditions present in the resident's living environment.
7. **Medication Information**: Medications and other substances used.
8. **Behavioral Health**: Activity related to the resident's behavioral health.
9. **Nutrition and Fluids**: Activity related to the resident's nutritional and fluid needs.
10. **Activities of Daily Living**: Activity related to the resident's daily living needs.

The Interdisciplinary Team (IDT)
Interdisciplinary Team (IDT)

- Dieticians,
- Social workers
- Physical or occupational therapists
- Speech pathologists
- Pharmacists
- Therapists
- Nurses
- Physicians
- Certified Nursing Assistants
- Recreation therapists or representatives from recreation or activities.

Each member of the team will be familiar with a different aspect of the resident’s life and working together allows them to see the complete picture.

Interdisciplinary Team

- Staff should look at residents holistically – quality of life and quality of care are mutually significant and necessary and interdisciplinary use of the RAI promotes this
- Involve disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy
- All necessary disciplines must be used to ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life).

MDS 3.0 – A Primer

www.mds-ny.org