"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

Build Your Own MDS Coordinator:

Module 3 - The MDS

ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.0 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
  - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

Learning Objectives

The MDS

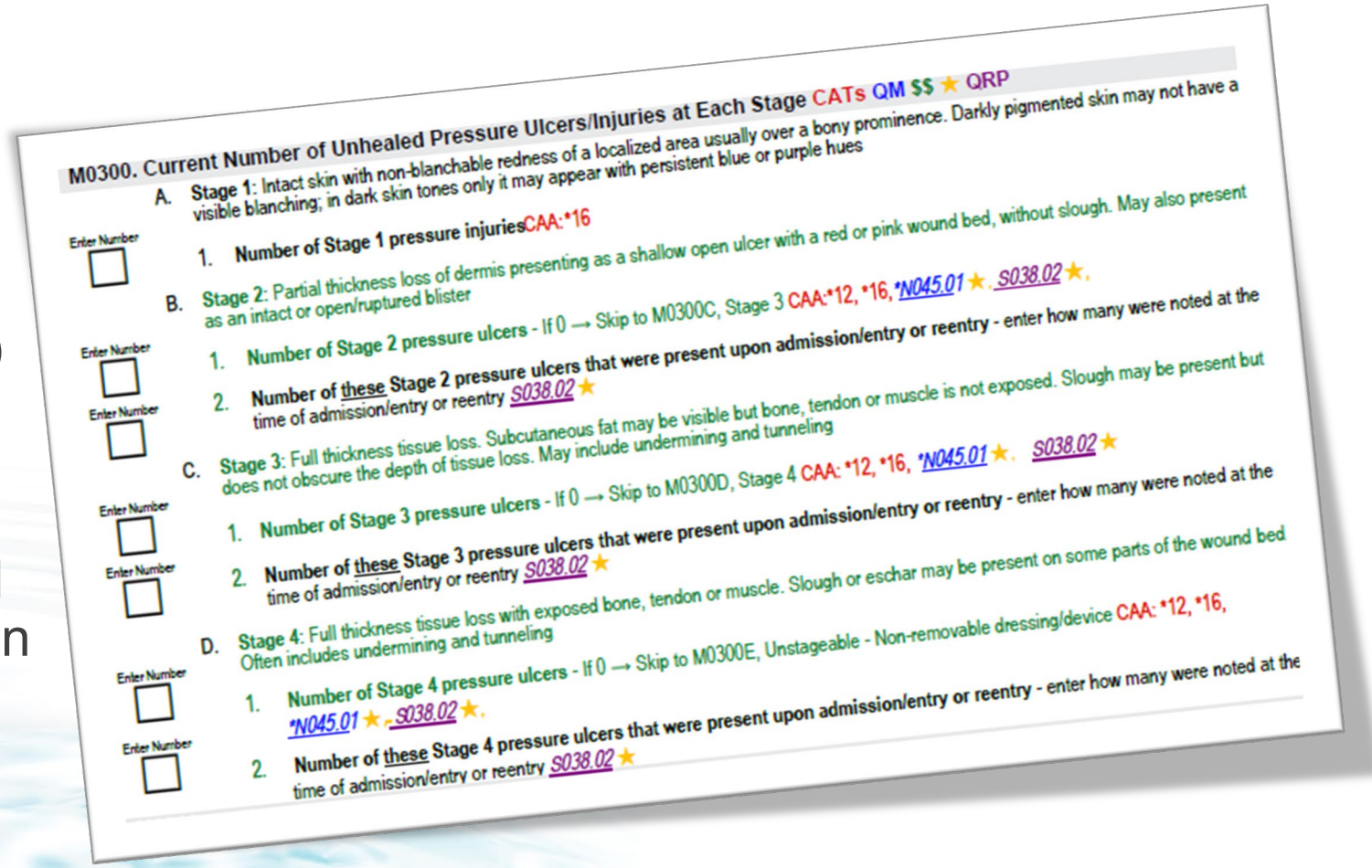
- Recognize what the MDS is
- Know the history of the MDS
- Understand the Regulatory requirements
- Identify the MDS data sets

Overview of the RAI

- The Resident Assessment Instrument (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 evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status.
- As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining their highest practical level of well-being.
- The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary.

Components of the RAI – The MDS

- The RAI consists of three basic components:
  - **1. Minimum Data Set (MDS) Version 3.0**
    - The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes and residents in a Medicare Part A SNF PPS stay in non-critical access hospitals with Medicare swing bed agreements.


M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage CATs QM $$ ★ QRP

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number ☐ 1. Number of Stage 1 pressure injuries CAA: *16

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐ 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 CAA: *12, *16, *N045.01★, S038.02★,

Enter Number ☐ 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry S038.02★

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number ☐ 1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4 CAA: *12, *16, *N045.01★, S038.02★

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D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed Often includes undermining and tunneling

Enter Number ☐ 1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device CAA: *12, *16, *N045.01★, S038.02★,

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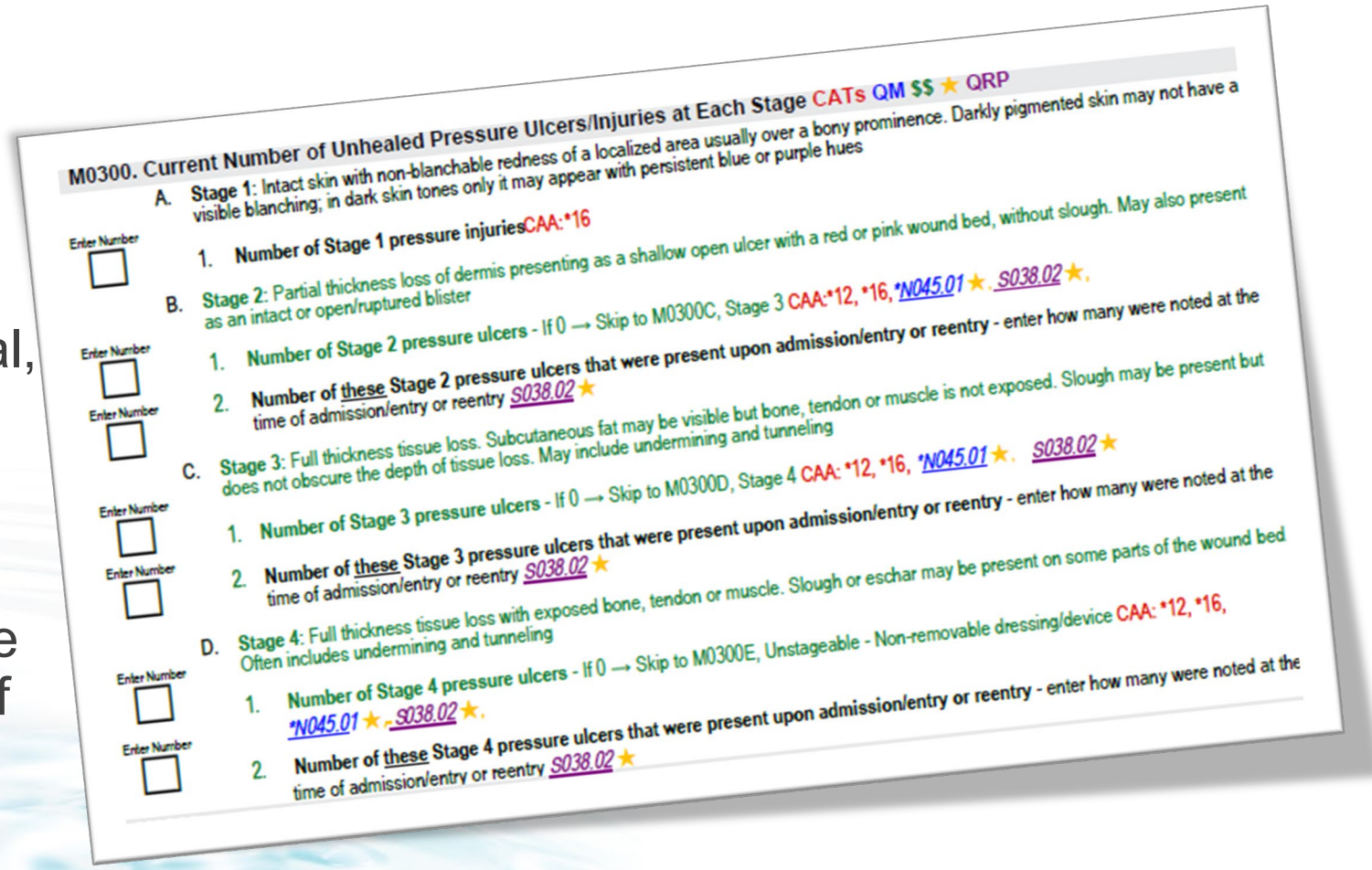
Components of the RAI – The MDS

- The RAI consists of three basic components:
  - **1. Minimum Data Set (MDS) Version 3.0**
    - A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid.



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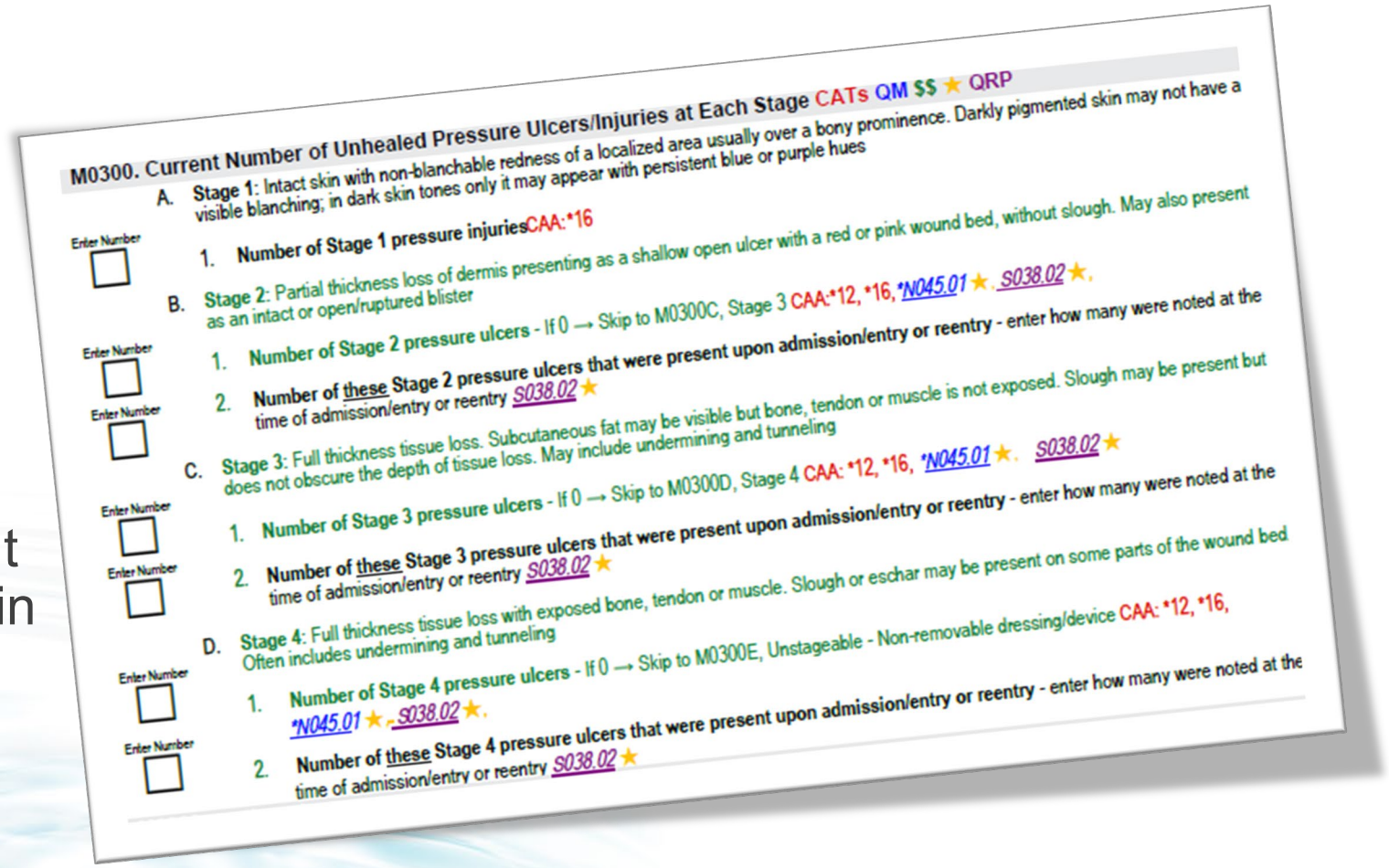
Components of the RAI – The MDS

- The RAI consists of three basic components:
  - **1. Minimum Data Set (MDS) Version 3.0**
    - The data elements (also referred to as “items”) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies.



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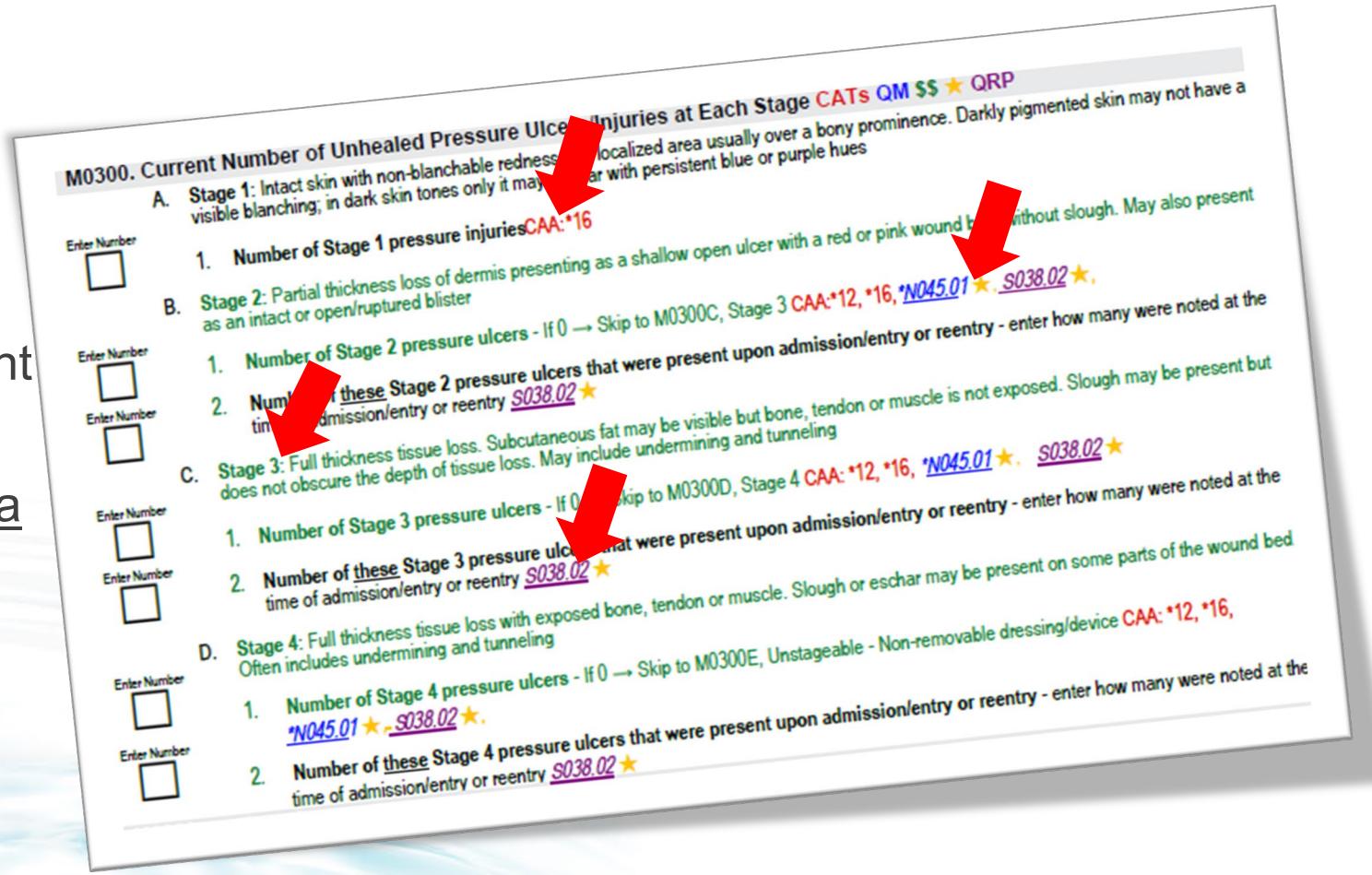
Components of the RAI – The MDS

- The RAI consists of three basic components:
  - **1. Minimum Data Set (MDS) Version 3.0**
    - Over time, the various uses of the MDS have expanded. While its primary purpose as an assessment instrument is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments are also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents.



The MDS - Medicare and Medicaid Payment Systems

- The MDS contains data elements that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status.
- The MDS is used as a data collection instrument to classify Medicare residents into PDPM components.
- The PDPM classification system is used in the SNF PPS for skilled nursing facilities and non-CAH SB programs.
- States may use PDPM, a Resource Utilization Group (RUG)-based system, or an alternate system to group residents into similar resource use categories for the purposes of Medicaid

The MDS - Monitoring the Quality of Care

- MDS assessment data are also used to monitor the quality of care in the nation's nursing homes.
- MDS-based quality measures (QMs), which are derived from data collected on the MDS, were developed by researchers to assist:
  - (1) State Survey and Certification staff in identifying potential care problems in a nursing home;
  - (2) nursing home providers with quality improvement activities/efforts;
  - (3) nursing home consumers in understanding the quality of care provided by a nursing home; and
  - (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the QMs for opportunities to improve their effectiveness, reliability, and validity.

The MDS - Consumer Access to Nursing Home Information

- Consumers are able to access information about every Medicare- and/or Medicaid-certified nursing home in the country.
- The Medicare Care Compare tool provides public access to information about a variety of health care providers, including nursing homes.
- Information available regarding nursing homes includes their characteristics, staffing data, and quality of care measures for certified nursing homes.

A History of the MDS

- The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) enhanced the regulation of nursing homes and included new requirements on quality of care, resident assessment, care planning, and the use of neuroleptic drugs and physical restraints.
- One of the key provisions, used to help implement the OBRA requirements in daily nursing home practice, was the mandatory use of a standardized, comprehensive system, known as the RAI, to assist in assessment and care planning.
- OBRA provisions went into effect in federal law on October 1, 1990, although delays issuing the regulations led to actual implementation of the RAI during the Spring of 1991.

A History of the MDS

- The OBRA reforms and introduction of the RAI constituted an unprecedented implementation of standardized comprehensive geriatric assessment in Medicare- and Medicaid-certified nursing homes.
- The effects of these interventions demonstrates significant improvements in the quality of care provided to nursing home residents.
- Early research showed:
  - The accuracy of information in residents' medical records increased substantially, as did the comprehensiveness of care plans.
  - Several problematic care practices declined including use of physical restraints and indwelling urinary catheters.
  - There were also increases in good care practices, such as the presence of advanced directives, participation in activities, and use of toileting programs for residents with bowel incontinence.

MDS Regulatory Requirements

- **Code of federal Regulations (CFR) Title 42, Chapter 4, Subchapter G, Part 483, Subpart B, Section 483.20**
  - The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
    - **Resident assessment instrument**. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.
    - **When Required.** Subject to the prescribed timeframes of this chapter, a facility must conduct a comprehensive assessment of a resident.
    - **Quarterly review assessment.** A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.
    - **Accuracy of assessments.** The assessment must accurately reflect the resident's status.

MDS Regulatory Requirements

- **State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities GUIDANCE §483.20(b)(1)-(2(i) & (iii)**
  - Each facility must use the RAI specified by CMS (which includes the MDS, utilization guidelines and the CAAs) to assess each resident.
  - The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs.
  - The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident.

MDS Regulatory Requirements

- **State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities GUIDANCE §483.20(b)(1)-(2(i) & (iii)**
  - The information required in §483.20(b)(1)(i-xviii) is incorporated into the MDS, which forms the core of the RAI process.
  - Additional assessment information is also gathered using triggered Care Area Assessments (CAAs) after the completion of the comprehensive MDS.

MDS Regulatory Requirements

- **State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities GUIDANCE §483.20(b)(1)-(2(i) & (iii)**
  - The facility is expected to use resident observation and communication as the primary source of information when completing the RAI.
  - In addition to record review, direct observation and communication with the resident, the facility must use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, the resident's representative, family members, or outside consultants.

MDS Data Set

- **The RAI Manual**
  - **Chapters**
    - **Chapter 1:** Resident Assessment Instrument (RAI)
    - **Chapter 2:** Assessments for the Resident Assessment Instrument (RAI)
    - **Chapter 3:** Overview to the Item-by-Item Guide to the MDS 3.0
    - **Chapter 4:** Care Area Assessment (CAA) Process and Care Planning
    - **Chapter 5:** Submission and Correction of the MDS Assessments
    - **Chapter 6:** Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

MDS Data Set

- **The RAI Manual**
  - **Appendices**
    - **Appendix A:** Glossary and Common Acronyms
    - **Appendix B:** State Agency and CMS Locations RAI/MDS Contacts
    - **Appendix C:** Care Area Assessment (CAA) Resources
    - **Appendix D:** Interviewing to Increase Resident Voice in MDS Assessments
    - **Appendix E:** Patient Health Questionnaire (PHQ)-Scoring Rules and Instruction for BIMS (When Administered in Writing)
    - **Appendix F:** MDS Item Matrix
    - **Appendix G:** References
    - **Appendix H:** MDS 3.0 Forms

MDS Data Set

- **The RAI Manual**
  - **Chapter 3:** Item-by-Item Guide to the MDS 3.0
    - **A - Identification Information**: Obtain key demographic information to uniquely identify each resident, administrative information, nursing home in which they reside, reason for assessment, and potential care needs, including access to transportation.
    - **B Hearing - Speech, and Vision:** Document whether the resident is comatose, the resident's ability to hear, understand, and communicate with others and the resident's ability to see objects nearby in their environment.
    - **C - Cognitive Patterns:** Determine the resident's attention, orientation, and ability to register and recall information, and whether the resident has signs and symptoms of delirium.
    - **D – Mood:** Identify signs and symptoms of mood distress and social isolation.
    - **E – Behavior:** Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.

MDS Data Sets

- **The RAI Manual**
  - **Chapter 3:** Item-by-Item Guide to the MDS 3.0
    - **F - Preferences for Customary Routine and Activities:** Obtain information regarding the resident's preferences for their daily routine and activities.
    - **GG - Functional Abilities:** Assess the need for assistance with self-care and mobility activities, prior function, admission performance, discharge performance, functional limitations in range of motion, and current and prior device use.
    - **H - Bladder and Bowel:** Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
    - **I - Active Diagnoses:** Code diseases that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
    - **J - Health Conditions:** Document health conditions that impact the resident's functional status and quality of life.

MDS Data Sets

- **The RAI Manual**
  - **Chapter 3:** Item-by-Item Guide to the MDS 3.0
    - **K - Swallowing/Nutritional Status:** Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
    - **L - Oral/Dental Status:** Record any oral or dental problems present.
    - **M - Skin Conditions:** Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
    - **N – Medications:** Record the number of days that any type of injection, insulin, and/or select medications was received by the resident. Also includes use and indication of high-risk drug classes, antipsychotic use and drug regimen review to identify potentially significant medication issues.
    - **O - Special Treatments, Procedures, and Programs:** Identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.

MDS Data Sets

- **The RAI Manual**
  - **Chapter 3:** Item-by-Item Guide to the MDS 3.0
    - **P - Restraints and Alarms:** Record the frequency that the resident was restrained by any of the listed devices, or an alarm was used at any time during the day or night.
    - **Q - Participation in Assessment and Goal Setting:** Record the participation and expectations of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
    - **V - Care Area Assessment (CAA) Summary:** Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
    - **X - Correction Request:** To identify an MDS record already present in iQIES system for modification or inactivation.
    - **Z - Assessment Administration:** Provide billing information and signatures of persons completing and attesting to the accuracy of the assessment, as well as the signature and date by the RN Assessment Coordinator verifying the assessment is complete.

MDS Data Sets

- **The RAI Manual**
  - **Appendix H:** MDS 3.0 v1.19.1 Data Sets (Effective October 1, 2024)
    - **Interim Payment Assessment Item Set:** (IPA)
    - **Nursing Home Comprehensive Item Set:** (NC)
    - **Nursing Home Discharge Item Set:** (ND)
    - **Nursing Home PPS Item Set:** (NP)
    - **Nursing Home Part A PPS Discharge Item Set:** (NPE)
    - **Nursing Home Quarterly (NQ) Item Set:** (NQ)
    - **Nursing Home and Swing Bed Tracking Item Set:** (NT/ST)
    - **Swing Bed Discharge Item Set:** (SD)
    - **Swing Bed PPS Item Set:** (SP)

MDS Data Sets

- **The RAI Manual**
  - **Appendix F:** MDS 3.0 v1.19.1 Item Matrix

Item Matrix v1.19.1 v1 (CY2024)		Nursing Home Subsets					Swing Bed Subsets		Shared NH/SB Subsets			D/C Items (A0310F = 10 or 11 only)		Program and Policy Use							
MDS Item	Short Description	NC - Comprehensive	NQ - Quarterly	ND - Discharge	NP - PPS 5 Day	NPE - PPS DC	SP - PPS 5 Day	SD - Discharge	PA - Interim Payment	NT / ST - Tracking	XX - Inactivation	A0310G=1 PDC	A0310G=2 UPD	Administrative (Tech Need / Edits / Processing)	QIES Standardized	QRP Standardized (A0310B = 01 and/or A0310H = 1)	QRP Quality Measures (Includes risk adjustment)	Care Area Triggers	NHQI Quality Measures	PDPM	DC Planning / PASRR
A0050	Type of Record	x	x	x	x	x	x	x	x	x	x			x							
A0100A	Facility National Provider Identifier (NPI)	x	x	x	x	x	x	x	x	x				x	x						
A0100B	Facility CMS Certification Number (CCN)	x	x	x	x	x	x	x	x	x				x	x						
A0100C	State provider number	x	x	x	x	x	x	x	x	x				x	x						
A0200	Type of provider	x	x	x	x	x	x	x	x	x				x	x		x		x		
A0310A	Type of assessment: OBRA	x	x	x	x	x	x	x	x	x				x			x	x	x	x	
A0310B	Type of assessment: PPS	x	x	x	x	x	x	x	x	x				x			x		x	x	
A0310E	First assessment since most recent entry	x	x	x	x	x	x	x	x	x				x			x		x		
A0310F	Entry/discharge reporting	x	x	x	x	x	x	x	x	x				x			x		x		
A0310G	Planned/unplanned discharge	x	x	x	x	x	x	x	x	x				x			x				
A0310G1	Interrupted Stay	x	x	x	x		x	x						x			x		x	+	
A0310H	SNF Part A PPS Discharge	x	x	x	x	x	x	x		x				x			x				
A0410	Unit Certification or Licensure Designation	x	x	x	x	x	x	x	x	x				x							
A0500A	Resident first name	x	x	x	x	x	x	x	x	x				x	x						
A0500B	Resident middle initial	x	x	x	x	x	x	x	x	x				x	x						
A0500C	Resident last name	x	x	x	x	x	x	x	x	x				x	x						
A0500D	Resident name suffix	x	x	x	x	x	x	x	x	x				x	x						
A0600A	Social Security Number	x	x	x	x	x	x	x	x	x				x	x						
A0600B	Medicare number	x	x	x	x	x	x	x	x	x				x	x						
A0700	Medicaid number	x	x	x	x	x	x	x	x	x				x	x						

References

- Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual
- CFR 42 Section 482.20 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.20#p-483.20(b)(2)(i)
- State Operations Manual Appendix PP https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

Faculty Contacts

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