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

BROAD RIVER REHAB

MDS 3.0v1.18.11

DRAFT RAI Manual Revisions

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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 1.5 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.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after September 15, 2023

Learning Objectives

MDS 3.0v1.18.11
DRAFT RAI Manual Revisions

- After this presentation, participants will be able to
  - Identify the revisions to the DRAFT RAI Manual v1.18.11
  - Recognize the expanded nature of MDS 3.0v1.18.11
  - Consider the effects of the elimination of section G
  - Understand how to start preparing

Agenda

MDS 3.0v1.18.11
DRAFT RAI Manual Revisions

- Review the DRAFT RAI Manual revisions
- Contextualize the expanded data elements in MDS 3.0 v1.18.11
- Consider what we know about section G elimination
- Review a process for preparation
- Q&A

Future BRR Training

- **MDS 3.0 v.118.11 Training Schedule**
  - For context, view the April 2023 BRR Reflections presentation: SNF Quality Reporting Program Quality Measures
  - June 15 – Training Kickoff/Overview of RAI Manual Changes
  - June 22 – Section A
  - June 28 – Sections B and C
  - July 6 – Sections D and F
  - July 20 – Section GG and H
  - July 27 – Sections I, J and K
  - August 10 – Sections M and N
  - August 24 – Sections O and Q
  - August 31 – CAAs
  - September 7 – Appendix A and anything else we know by then?

Resources

- **Resources:**
  - Final MDS 3.0 v1.18.11 data set, DRAFT RAI Manual and Final OSA Manual and data set
  - SNF QRP
  - Reporting tables for FY 2024 - 2025
  - TOH Measures and SPADEs
  - CMS training videos
  - CMS Live virtual training

RAI Manual Revisions with no new items

- Several portions of the RAI manual have been revised with updated coding guidance without added MDS items.
  - Section F: Preferences for Customary Routines and Activities
  - Section H: Bladder and Bowel
  - Section I: Active Diagnoses
  - Section M: Skin Conditions
  - Section P: Restraints and Alarms
  - Appendix A: Glossary and Common Acronyms
  - Appendix F: MDS Item Matrix

MDS 3.0v1.18.11 and Section G Elimination

- **In MDS v1.18.11 the majority of items that are currently part of section G will be eliminated.**
- Items that will be retained will reside in section GG
  - **GG0115 Functional Limitation in Range of Motion**
  - **GG0120. Mobility Devices**
  - **GG0130 I Personal Hygiene**
  - **GG0170FF Tub shower transfer**
- The rest of section G, i.e., Balance and Rehabilitation Potential will seemingly be absorbed by items in section GG.
- Another residual of this change is that item **A0300 Optional State assessment, has also been eliminated from v1.18.11**. This means that states will not have an option in the federally required data sets to gather complete data required for legacy RUG groupers, i.e., the ADL functional score that is a required end split for those systems.

MDS 3.0v1.18.11 and Section G Elimination

- CMS has made it clear in a letter to state Medicaid Directors that;
  - *"CMS will no longer support the Medicare RUGs systems after October 1, 2023, as CMS is ending support for RUG-III and RUG-IV on federally required assessments for patients residing in Nursing Facilities and Skilled Nursing Facilities as of October 1, 2023."*
  - *States that wish to continue to use RUG-III or RUG-IV after October 1, 2023, for either state plan payment methodologies or UPL demonstrations, will need to implement a new process called "Optional State Assessments" or OSAs to gather the needed assessment data which will allow the states to calculate a RUGs payment amount for the services provided to the Medicaid beneficiaries.*
  - *"… while there is no requirement for states to pay nursing facilities based on Medicare PDPM in their Medicaid programs, the data limitations associated with the ending of the data infrastructure supporting the RUGs system may present issues for states in calculating RUGs-based payments. Absent available RUGs MDS data from CMS, states will likely have to consider collecting data independently from providers to support RUGs state plan payment methodologies. States may also consider trending available RUGs data to a current payment period to establish state plan payment rates.*

MDS 3.0v1.18.11 and Section G Elimination

- Other major implications to the elimination of section G ADL scoring.
  - **Chapter 4 and Appendix C: Care Area Assessments** i.e., triggers for CAA 5 - ADL Functional/Rehabilitation Potential, CAA 6 -Urinary Incontinence and Indwelling Catheter, CAA 11 – Falls and CAA 16 – Pressure Ulcer.
  - **Care Area Assessment Resources**. The only CAA Resources that do not rely explicitly on section G in some way for further analysis are CAA 3 – Visual Function, CAA9 – Behavioral Symptoms, and CAA 13 – Feeding Tubes.
  - **Quality Measure Specifications** including risk adjustments.
  - **Staffing Acuity Adjustment**, i.e., RUGs and S.T.R.I.Ve.
  - **5-Star Rating**

MDS 3.0v1.18.11 and Other Section GG Additions

- There are now three separate GG item sets
  - **Admission**
  - **Discharge**
  - **OBRA/Interim**
- The option to complete for states has been removed and GG items are now required for the OBRA/Interim set.
- MDS items GG0170 L. Walking 10 feet on uneven surfaces, M. 1 step (curb), N. 4 steps, O. 12 steps and P. Picking up objects, have been removed from section GG in the OBRA/Interim item set.

MDS 3.0v1.18.11 and Section Q Revisions

- Section Q Participation in Assessment and Goal Setting, has undergone a significant revision.

V1.17.2
Q0100

Q0100. Participation in Assessment

Enter Code ☐	**A. Resident participated in assessment** 0. No 1. Yes
Enter Code ☐	**B. Family or significant other participated in assessment** 0. No 1. Yes 9. Resident has no family or significant other
Enter Code ☐	**C. Guardian or legally authorized representative participated in assessment** 0. No 1. Yes 9. Resident has no guardian or legally authorized representative

V1.18.11
Q0110

Q0110. Participation in Assessment and Goal Setting
Identify all active participants in the assessment process

↓ **Check all that apply**

☐	A. Resident
☐	B. Family
☐	C. Significant other
☐	D. Legal guardian
☐	E. Other legally authorized representative
☐	Z. None of the above

MDS 3.0v1.18.11 and Section Q Revisions

- Section Q Participation in Assessment and Goal Setting, has undergone a significant revision.

V1.17.2
Q0300

Q0300. Resident's Overall Expectation
Complete only if A0310E = 1

Enter Code ☐

A. Select one for resident's overall goal established during assessment process
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **Unknown or uncertain**

V1.18.11
Q0310

Q0310. Resident's Overall Goal
Complete only if A0310E = 1

Enter Code ☐

A. Resident's overall goal for discharge established during the assessment process
1. **Discharge to the community**
2. **Remain in this facility**
3. **Discharge to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0310A
1. **Resident**
2. **Family**
3. **Significant other**
4. **Legal guardian**
5. **Other legally authorized representative**
9. **None of the above**

MDS 3.0v1.18.11 and Section Q Revisions

- Section Q Participation in Assessment and Goal Setting, has undergone a significant revision.

V1.17.2
Q0500

Q0500. Return to Community	
Enter Code ☐	**B. Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**

V1.18.11
Q0500

Q0500. Return to Community	
Enter Code ☐	**B. Ask the resident** (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**
Enter Code ☐	**C. Indicate information source for Q0500B** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**

MDS 3.0v1.18.11 and Section Q Revisions

- Section Q Participation in Assessment and Goal Setting, has undergone a significant revision.

V1.17.2
Q0550

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code ☐	**A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code ☐	**B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 9. **None of the above**

V1.18.11
Q0550

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B	
Enter Code ☐	**A. Does resident** (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than on comprehensive assessments alone) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code ☐	**C. Indicate information source for Q0550A** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**

MDS 3.0v1.18.11 and Section Q Revisions

- Section Q Participation in Assessment and Goal Setting, has undergone a significant revision.

V1.17.2
Q0600

Q0600. Referral CATs

Enter Code ☐

Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)

0. **No** - referral not needed
1. **No** - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) **CAA: *20**
2. **Yes** - referral made

V1.18.11
Q0610

Q0610. Referral

Enter Code ☐

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

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

MDS 3.0v1.18.11 and Section Q Revisions

- Section Q Participation in Assessment and Goal Setting, has undergone a significant revision.

V1.17.2 No equivalent item, expanded Q0600 in new item set

V1.18.11
Q0620

Q0620. Reason Referral to Local Contact Agency (LCA) Not Made
Complete only if Q0610 = 0

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

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

- The Improving Medicare Post-Acute Care Transformation Act (IMPACT) Act of 2014 requires the Secretary to implement specified clinical assessment domains using **standardized (uniform) data elements** to be nested within the assessment instruments currently required for submission by Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), and Home Health Agency (HHA) providers.
- In addition, the IMPACT Act requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers.
- The Act intends for standardized post-acute care data to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.
- There are 16 quality measures that have been developed for SNFs as a result with more to come, some filtered through the Meaningful Measures Framework, with multiple of Standardized Patient Assessment Data Elements or SPADES in MDS 3.0 v1.18.11.
- The SNF QRP is currently driven by 14 quality measures. 8 of these measures derive from the Minimum Data Set, 4 from Medicare claims and 2 are reported through NHSN. Only 2 of these measures currently affect a facility's 5-star rating.
- SNF QRP compliance thresholds are 100% of MDS data elements on at least 80% of MDS submissions **and** 100% of NHSN data submission requirements. Noncompliance with either threshold equals a 2% reduction to the Market Basket Update.

Current QRP Measures

Skilled Nursing Facility Quality Reporting Program (SNF QRP) update

IMPACT Act Domain	IMPACT Act Measure	Source	PAC Setting Adopted
Skin Integrity and Changes in Skin Integrity ★	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.	Assessment	IRF, LTCH, SNF, HH
Functional Status, Cognitive Function, and Changes in Function and Cognitive Functiony	Application of Percent of LTCH Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Assessment	IRF, LTCH, SNF, HH
	Change in Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
Medication Reconciliation	Drug Regimen Review	Assessment	IRF, LTCH, SNF, HH
Incidence of Major Falls	Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Assessment	IRF, LTCH, SNF, HH
Transfer of Health Information and Care Preferences when an Individual Transitions	Transfet of Health Information to Provider Transfer of health Information to Patient	Assessment Assessment	IRF, LTCH, SNF, HH
Resource Use Measures, including Total Estimated Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary	Claims	IRF, LTCH, SNF, HH
Discharge to Community ★	Discharge to Community	Claims	IRF, LTCH, SNF, HH
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmissions Rates	Potentially Preventable 30-Day Post-Discharge Readmission	Claims	IRF, LTCH, SNF, HH
Meaningful Measure Domain	**IMPACT Act Measure**		**PAC Setting Adopted**
Patient Safety (Meaningful Measures 2.0)	SNF Healthcare Associated infections	Claims	SNF
Patient Safety (Meaningful Measures 2.0)	Influenza vaccination HCP	NHSN	IRF, LTCH, SNF
Patient Safety (Meaningful Measures 2.0)	COVID-19 Vaccination HCP	NHSN	IRF, LTCH, SNF

MDS 3.0v1.18.11 and Transfer of Health Information

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), enacted October 6, 2014, directs the Secretary of Health and Human Services to “specify quality measures on which post-acute care (PAC) providers are required under the applicable reporting provisions to submit standardized patient assessment data” in several quality measure domains including incidence of **major falls**, **skin integrity** and **changes in skin integrity**, **medication reconciliation**, **functional status**, **transfer of health information** **and care preferences** when an individual transitions, and **resource use** and **other measures**.
- The **Transfer of Health Information measure** concept consists of two companion measures:
  - 1. Transfer of Health Information to the Provider–Post-Acute Care Measure
  - 2. Transfer of Health Information to the Patient–Post-Acute Care Measure
- The Transfer of Health Information measures serve as a check to ensure that a reconciled medication list is provided as the patient changes care settings at discharge. Defining the completeness of that medication list is left to the discretion of the providers and patient who are coordinating this care.

MDS 3.0v1.18.11 and Transfer of Health Information

- **Cross-Setting Measure: Transfer of Health Information to the Provider–Post-Acute Care Measure**
  - This measure assesses for and reports on the timely transfer of health information, specifically transfer of a reconciled medication list. This measure evaluates for the transfer of information when a patient/resident is transferred or discharged from their current setting to a subsequent provider.
  - For this measure, the subsequent provider is defined as a **short-term general hospital**, a **SNF**, **intermediate care**, **home under care of an organized home health service organization or hospice**, **hospice in an institutional facility**, **a swing bed**, **an IRF**, **an LTCH**, a **Medicaid nursing facility**, an **inpatient psychiatric facility**, or a **critical access hospital**.
  - **The denominator** is the number of SNF Medicare Part A covered resident stays ending in discharge to a subsequent provider.
    - **MDS item A2105 Discharge Status**, has been added to code this data. (Revised A2100)
  - **The numerator** is the number of stays for which the MDS 3.0 indicated that the following is true: At the time of discharge, the facility provided a current reconciled medication list to the subsequent provider.
    - **MDS item A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge**, has been added
  - Other items necessary to calculate this measure
    - **A2122 Route of Current Reconciled Medication List Transmission to Subsequent Provider** has been added

MDS 3.0v1.18.11 and Transfer of Health Information

- **Cross-Setting Measure: Transfer of Health Information to the Patient–Post-Acute Care Measure**
  - This measure assesses for and reports on the timely transfer of health information, specifically transfer of a medication list.
  - This measure evaluates for the transfer of information when a patient/resident is discharged from their current setting of PAC to a **private home/apartment**, **board and care home**, **assisted living, group home**, **transitional living**, or **home under the care of an organized home health service organization or hospice**.
  - **The denominator** for this measure is the total number of SNF Medicare Part A covered resident stays ending in discharge to the above settings.
    - **MDS item A2105 Discharge Status,** has been added to code this data. (Revised A2100)
  - **The numerator** for this measure is the number of stays for which the MDS 3.0 indicated that the following is true: At the time of discharge, the facility provided a current reconciled medication list to the resident, family, and/or caregiver
    - **MDS item A2123 Provision of Current Reconciled Medication List to Resident at Discharge** has been added.
  - Other items necessary to calculate this measure
    - **A2124 Route of Current Reconciled Medication List Transmission to Resident** has been added

MDS 3.0v1.18.11 and S.P.A.D.Es

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings (SNF, HH, LTCH, IRF).
- The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.
- The IMPACT Act further requires that the assessment instruments for each PAC setting (MDS, OASIS, LCDS, IRF PAI) be modified to include core data elements on health assessment categories and that such data be standardized and interoperable.
- CMS is adopting SPADEs for five categories specified in the IMPACT Act:
  - **Cognitive function** (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
  - **Special services, treatments, and interventions** (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
  - **Medical conditions and comorbidities** (e.g., diabetes, heart failure, and pressure ulcers)
  - **Impairments** (e.g., incontinence; impaired ability to hear, see, or swallow)
  - **Other categories** as deemed necessary by the Secretary (Social Determents of Health)

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Cognitive Function**
  - The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.
  - The standardized assessment of patient or resident cognition supports clinical decision making, early clinical intervention, person-centered care, and improved care continuity and coordination.
  - The use of valid and reliable standardized assessments can aid in the communication of information within and across providers, enabling the transfer of accurate health information.
  - CMS has identified several data elements as applicable for cross-setting use in standardized assessment of cognitive impairment.
  - **BIMS:** The BIMS is a performance-based cognitive assessment developed to be a brief cognition screener with a focus on learning and memory. The BIMS evaluates repetition, recall with and without prompting, and temporal orientation.
  - The following MD items will be retained to assess for cognitive function.
    - **C0100 Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**
    - **C0299 Repetition of Three Words**
    - **C0300 Temporal Orientation**
    - **C0400 Recall**
    - **C0500 BIMS Summary Score**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Cognitive Function** (cont.)
  - **Confusion Assessment Method (CAM©)**: The CAM is a widely used delirium screening tool. Delirium, when undetected or untreated, can increase the likelihood of complications, rehospitalization, and death relative to patients/residents without delirium.
  - The following MD items will be retained to assess for cognitive function.
    - **C1310 Signs and Symptoms of Delirium (from CAM©)**
    - **C1310 A. Acute Onset Mental Status Change**
    - **C1310 B. Inattention**
    - **C1310 C. Disorganized Thinking**
    - **C1310 A. Altered Level of Consciousness**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Cognitive Function** (cont.)
  - **Patient Health Questionnaire-2 to 9 (PHQ-2 to 9)**: The PHQ-2 to 9 data elements use a summed-item scoring approach to first screen for signs and symptoms of depressed mood in patients and residents by assessing the two cardinal criteria for depression: depressed mood and anhedonia (inability to feel pleasure).
  - At least one of the two must be present for a determination of probable depression, which signals the need for continued assessment of the additional seven PHQ symptoms.
  - The interview is concluded if a respondent screens negative for the first two symptoms.
  - The following MDS items have been revised to accommodate this data
    - **D0150 Resident Mood Interview (PHQ-2 to 9)** (Replaces D0200)
    - **D0160. Total Severity Score** (Replaces D0300)
    - **Appendix E** revised to accommodate these changes

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches)**
  - Some medical conditions require complex clinical care, consisting of special services, treatments, and interventions. The implementation of these interventions typically indicates conditions of a more serious nature and can be life-sustaining.
  - Patients and residents who need them may have few clinical alternatives. Conditions requiring the use of special services, treatments, and interventions can have a profound effect on an individual's health status, self-image, and quality of life.
  - Providers should be aware of the patient or resident's clinical needs to plan the provision of these important therapies, ensure the continued appropriateness of care, and support care transitions.
  - The assessment of special services, treatments, and interventions may also help identify resource use intensity by capturing the medical complexity of patients/residents.
  - CMS has identified data elements for cross-setting standardization of assessment for special services, treatments, and interventions in the areas of cancer, respiratory, and other treatments, as well as nutritional approaches and high-risk medications

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches) (Cont.)**
- MDS item **O0110 Special Treatments, Procedures, and Programs**, has been added. This is a significant revision to O0100. Multiple items for the following are now required to be coded on admission (column a), while a resident (column b) and at discharge (column c). **Note** that the column, "While NOT a Resident", has been removed.
  - **A1. Chemotherapy (A2. IV, A3. Oral, A10. Other),**
  - **B1. Radiation,**
  - **C1. Oxygen therapy (C2. Continuous, C3. Intermittent, C4. High-concentration oxygen delivery system)**
  - **D1. Suctioning (D2. Scheduled, D3. As needed),**
  - **E1. Tracheostomy Care,**
  - **F1. Invasive mechanical ventilator**
  - **G1. Non-invasive mechanical ventilator (G2. BiPAP, G3. CPAP)**
  - **H1. IV medications (H2. vasoactive medications, H3. antibiotics, H4. anticoagulants, H5. other)**
  - **I1. Transfusions**
  - **J1. Dialysis (J2. hemodialysis, J3. peritoneal dialysis)**
  - **K1. Hospice care**
  - **M1. Isolation or quarantine for active infectious disease**
  - **O1. IV access (O2. peripheral IV, O3. midline, O4. central line)**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches) (Cont.)**
  - **MDS items O0600 Physician Examinations, and O0700 Physician Orders,** have been removed. Current instructions, pp.O-49 and O-50 indicate the following for these items. *"CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item."*

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches)** (cont.)
- **MDS item K0520, Nutritional Approaches,** has been added. This is a revision to K0510. MDS items for the following are now required to be coded on admission (3-day window days 1-3 of the stay), while not a resident, while a resident and at discharge (3-day window last 3 days of the stay).
  - **A. Parenteral/IV feeding**
  - **B. Feeding tube**
  - **C. Mechanically altered diet** (not coded while not a resident)
  - **D. Therapeutic diet** (not coded while not a resident)

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches)** (cont.)
- **MDS item N0415, High-risk drug classes: use and indication**, has been added. This is a significant revision to N0410. MDS items for the following are now required to be coded when taken (Column 1) and that there is an indication for use (Column 2).
  - **A. Antipsychotic**
  - **B. Antianxiety**
  - **C. Antidepressant**
  - **D. Hypnotic**
  - **E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)**
  - **F. Antibiotic**
  - **G. Diuretic**
  - **H. Opioid**
  - **I. Antiplatelet (new item)**
  - **J. Hypoglycemic (including insulin) (new item).**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Medical Conditions and Co-Morbidities**
- **Pain Interference**: A substantial percentage of older adults receiving services in a PAC setting experience pain.
  - Pain in older adults can be treated with medications, complementary and alternative approaches, or physical therapy.
  - Treatment of pain in older adults may be complicated by factors such as dementia; high rates of polypharmacy; end-of-life care; and patient expectations, attitudes, and fears related to pain treatment.
  - Untreated pain is an often-debilitating condition that is associated with a host of adverse physical consequences, including loss of function, poor quality of life, disruption of sleep and appetite, inactivity, and weakness, as well as psychological effects such as depression, anxiety, fear, and anger.
  - Pain among SNF residents can interfere with rehabilitation and has potential secondary complications. The potential effects of pain on resident health are myriad, and it is critical to assess pain during hospitalization and after discharge.
  - Assessing pain in in SNF residents during their stay can lead to appropriate treatment and improved quality of life, reduce complications associated with immobility such as skin breakdown and infection, and facilitate rehabilitation efforts and returning to community settings.
  - Pain assessment post-discharge can also be used to plan appropriate treatment and may reduce readmissions.

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Medical Conditions and Co-Morbidities**
- **Pain Interference**: (cont.)
- **J0400 Pain Frequency** is now numbered J0410
- The following MDS Items have been added (Revised J0500) to address pain in PAC settings
  - **J0510. Pain Effect on Sleep**
  - **J0520. Pain Interference with Therapy Activities**
  - **J0530. Pain Interference with Day-to-Day Activities**
- The order of the frequency intervals for all pain items (Rarely, Occasionally, Frequently and Almost Constantly) have been reversed.

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Impairments**
  - **Hearing and Vision Impairments**: Hearing and vision impairments are common conditions that, if unaddressed, affect patients' and residents' activities of daily living, communication, physical functioning, rehabilitation outcomes, and overall quality of life.
  - Sensory limitations can lead to confusion in new settings, increase isolation, contribute to mood disorders, and impede accurate assessment of other medical conditions, such as cognition.
  - Hearing impairments may cause difficulty in communication of important information concerning the patient's or resident's condition, preferences, and care transitions;
  - Vision impairments have been associated with increased risk of falls.
  - Both types of impairment can also interfere with comprehension of and adherence to discharge plans Assessments pertaining to sensory status aid PAC providers in
    - Understanding the needs of their patients and residents by establishing a diagnosis of hearing or vision impairment,
    - Elucidating the patients' and residents' ability and willingness to participate in treatments or use assistive devices during their stays, and
    - Identifying appropriate ongoing therapy and support needs at the time of discharge.

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Impairments**
  - **Hearing and Vision Impairments** (cont.)
  - The following MDS items have been retained to address impairments
    - **B0200 Hearing**
    - **B1000 Vision**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **New Category: Social Determinants of Health**
- CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH).
- Healthy People 2020 defines SDOH as, *"…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."*
- MDS items have been added and or revised to assess for SDOH:
  - **Ethnicity – MDS item A1005**
  - **Race – MDS item A1010**
  - **Preferred Language – MDS item A1110**
  - **Interpreter Services – MDS item A1110**
  - **Transportation – MDS item A1250**
  - **Health Literacy – MDS item B1300**
  - **Social Isolation – MDS item D0700**

Conclusions

- MDS 3.0v1.18.11 Comprehensive item set and DRAFT RAI manual v1.18.11 should be reviewed as an interdisciplinary team.
- Download/View the other resources that are currently available.
- Watch for the Final RAI User's manual sometime later this summer.
- Watch for additional resources like the updated QM and 5-star manuals with item G eliminated.
- Participate in training and other discussions.
- Pay attention to what your state will do regarding the Medicaid CMI and how that will affect your rate.
- Team engagement will be crucial for a successful transition.

QUESTIONS?