NO KIDDING!

MDS 3.0 v1.18.11

is a really big deal!

Mary Madison
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Your Speaker

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Description

If you've been involved in the MDS/RAI process for a few years, you know that each October we always have an updated MDS 3.0 Item Set.

This was not the case for the past 3 years due to the COVID-19 PHE.

This October, SNF/LTC facilities will be implementing an updated MDS Item Set and it is not a stretch to call it ***significant.***

Let's see what lies ahead for all staff that work with the MDS/RAI process.

Objectives

At the conclusion of this webinar, you'll be able to:

- ✓ Identify items from the IMPACT Act of 2014 that are now part of MDS 3.0 v1.18.11 and speak to their importance for LTC.
- ✓ Discuss the changes to the resident interviews.
- ✓ State 6 items that are significantly different in v1.18.11 from our current version (v1.17.2)
- ✓ Locate/utilize the resources needed for this implementation.
- ✓ Actively start preparations for implementing v1.18.11 in your facility so you're ready for October 1, 2023.

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POLL #1

Who's in the Audience Today

- ○ MDS Coordinator
- ○ Not the MDS Coordinator but a Member of the IDT
- ○ Care Plan Coordinator
- ○ Administrator
- ○ Reimbursement Specialist
- ○ Pre-Admission Screener
- ○ Consultant
- ○ Other Interested Party

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POLL #2

Share Your MDS Experience with Us

- ○ New to MDS Process Within the Past 6 Months
- ○ New to MDS Process Within the Past Year
- ○ More than 1 Year but Less than 5 Years with the MDS
- ○ More than 5 years but Less than 10 Years with the MDS
- ○ More than 10 Years with the MDS
- ○ MDS Veteran since 1998

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Importance of the MDS

- The MDS is *the* most powerful document your IDT will complete.
- MDS is used for these purposes:
    - Reimbursement for care/services provided in your facility –> 200+ items
    - Resident voice/choice
    - Survey preparation
    - Compliance – determination of possible deficiencies/fining/keeping your doors open
    - Person-centered care planning: strengths and needs
    - Staffing/Facility Assessment
    - Discharge planning
    - Measure of quality of care
    - Incentives for improving quality of care – Value Based Purchasing (VBP)
    - Consumer information – your facility rating compared to others
    - Contracts with 3rd party payers – ACOs, MA plans, etc.
    - Legal defense/lawsuits brought against facility and/or specific staff (perhaps you)
    - Research
    - Communication between providers

This Update is a BIG Deal!

v1.18.11 is the largest, most significant update to the MDS 3.0 implemented on October 1, 2010.

In God we trust, all others must document!

Quick History Review

- 10/1/2010 … Moved from MDS 2.0 to MDS 3.0
- 10/1/2016 … Section GG made its debut on the MDS 3.0 Item Set
- 10/1/2019 … Moved from RUGs reimbursement to PDPM reimbursement
- 12/20/2019 … CMS posted draft version of MDS 3.0 v1.18
- 1/31/2020 … Initial COVID-19 PHE declaration
- 3/13/2020 … QSO-20-14-NH -> NH Lockdown

v1.18 Pulled Back

- 3/19/2020 …

- CMS pulled the draft of v1.18 “in order to provide maximum flexibilities for providers of Skilled Nursing Facilities (SNFs) to respond to the COVID-19 Public Health Emergency (PHE) … The release of updated versions of the MDS will be delayed until October 1st of the year that is at least 2 full fiscal years after the end of the COVID-19 PHE.”

On Again + Case Mix

- 9/1/2022 … CMS posts draft MDS 3.0 v1.18.11 to be implemented 10/1/2023
- 9/21/2022 … CMS letter to State Medicaid Directors Guidance on Nursing Facility State Plan Payment and Upper Payment Limit Approaches in Medicaid Relying on the Medicare PDPM Model
- CMS will no longer support the Medicare RUGs systems after October 1, 2023
- CMS is ending the support for RUG-III and RUG-IV on federally requirements assessments on October 1, 2023
- This support was supposed to have ending October 1, 2020 – PHE delayed this

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Preliminary Roll-Out Timeline

Release of MDS Item Sets, Specs and RAI Manual
On/about **April 1, 2023** … FINAL MDS 3.0 v1.18.11 Item Sets
On/about **April 1, 2023** … DRAFT RAI 3.0 User's Manual
Late April/Early May 2023 … OSA (Optional State Assessment) separate package – Item Set & Specs
May 2023 … FINAL Specifications
August 2023 … FINAL RAI 3.0 User's Manual

MDS 3.0 v1.18.11 Training – 2 Parts
May 2023 … Release of Recorded Videos
Late June/Early July 2023 … Live, Virtual Workshop Sessions … these will be recorded for on-demand viewing; registration will be open and announced later this spring.

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Tools & Resources

DRAFT MDS 3.0 RAI Manual: v1.18.11_October 2023
https://www.cms.gov/files/document/draftmds-30-rai-manual-v11811october2023.pdf-0

MDS 3.0 Final Item Sets: v1.18.11 for October 1, 2023
https://www.cms.gov/files/zip/mds30finalitemsetsv11811foroct12023.zip-1

MDS 3.0 CAT Specifications 1.06.0
https://www.cms.gov/files/zip/mds-30-cat-specifications-1060-12-21-2022.zip

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More Tools & Resources

Patient Driven Payment Model (PDPM)
https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/pdpm

Appendix B: State Agency and CMS Locations RAI/MDS Contacts is located in the "Downloads" section on CMS's MDS 3.0 RAI Manual Web page:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

OSA Resources

Final OSA Manual, Item Set, Change History: October 1,2023
https://www.cms.gov/files/zip/final-osa-manualitem-setchange-historyoctober12023.zip

The Optional State Assessment (OSA) Item Set, OSA Manual, and OSA Change History table are now available. The OSA is not a Federally required assessment; rather, it may be required in some States for payment purposes. Each State determines whether the OSA is required and if so, when the assessment must be completed. For questions regarding completion of the OSA, please contact your State Survey Agency.

More on this a bit later…

SNF MDS 3.0 RAI v1.18.11 Guidance Training Program

The Centers for Medicare & Medicaid Services (CMS) is offering a virtual training program that provides instruction on the updated guidance for the Skilled Nursing Facility (SNF) Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) v1.18.11 Manual and Item Set.

This training is part of a comprehensive strategy to ensure SNF providers have access to the educational materials necessary to understand and comply with the guidance changes.

This guidance will affect reporting requirements associated with the SNF Quality Reporting Program (QRP) that will go into effect on October 1, 2023.

A major focus of this training will be on the cross-setting implementation of the standardized patient assessment data elements to ensure more consistent reporting and evaluation across post-acute care settings.

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Training Program Consists of Two Parts:

Part 1: LEARN Part 1 consists of pre-recorded training webinars that deliver foundational knowledge to assist in learning the new and/or revised items and associated guidance. A supplemental Capstone Case Study is also available to give providers additional practice in coding the new and/or revised items. These videos are intended to be viewed in advance of the Part 2 live event and are available now on CMS YouTube.

Part 2: PRACTICE Part 2 includes the live, virtual workshop sessions that provide practice coding scenarios on select data elements covered in the Part 1 training webinars. These live sessions will take place on **June 21st between 12:30 p.m. and 5 p.m. ET. Registration is open and can be completed online through Zoom.**

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Videos

- SNF Training Program Overview (14m51s)
- SNF Social Determinants of Health and New Data Elements in Section A Training Webinar (41m46s)
- SNF Understanding Changes to the MDS 3.0 RAI Manual v1.18.11 Training Webinar (32m14s)
- SNF Section GG: Summary of Guidance Changes Training Webinar (39m58s)
- SNF Section K: Swallowing/ Nutritional Status Training Webinar (9m25s)
- SNF Section D: Resident Mood Interview and Total Severity Score Training Webinar (21m39s)
- SNF Section C: Changes to Cognitive Patterns Guidance Training Webinar (16m16s)
- SNF Section Q: Participation in Assessment and Goal Setting Training Webinar (21m14s)
- SNF Section J: Health Conditions Training Webinar (22m53s)
- SNF Section N: Medications Training Webinar (14m01s)
- SNF Section O: Special Treatments, Procedures, and Programs Training Webinar (14m32s)

Also available at https://briggshealthcare.blog/2023/05/26/snf-virtual-training-program-mds-3-0-v1-18-11-available/

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Part 1 Training

2023_May_SNF Guidance Training Program: Part 1

https://www.cms.gov/files/zip/2023maysnf-guidance-training-programpart-1.zip

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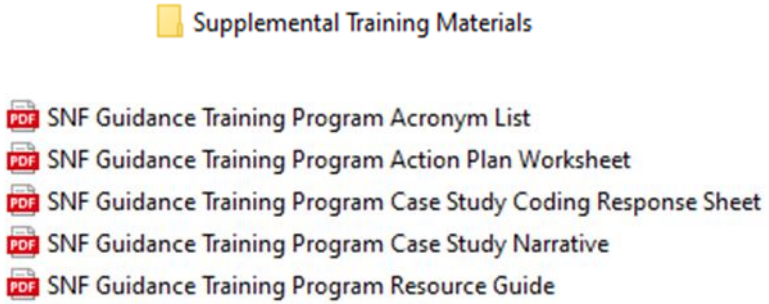
Supplemental Training



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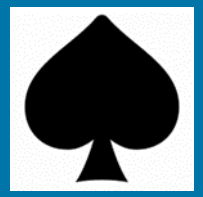
Quick Overview of Changes

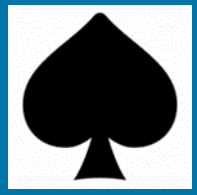
- 29 new and modified MDS items (data elements)
  - Achieve standardization amongst other PAC settings, i.e., OASIS (Home Health), IRF PAI (Inpatient Rehabilitation Facility), LTCH (Long Term Care Hospital)
  - Update coding examples
  - Skip patterns updated and clarified
- 13 Care Area Triggers updated
- 17 Care Area Assessment Worksheets updated
- Section G retired
- PHQ-2 to 9
- Gender-neutral language (he/she now = their/themself)
- Complete implementation of IMPACT Act of 2014
  - Standardize Patient Assessment Data Elements (SPADEs)

SPADEs



- Standardized Patient Assessment Data Elements
- Developed by CMS to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
  - IMPACT Act requires the reporting of standardized patient assessment data with regards to quality measures and SPADEs.
  - 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.
  - Six (6) new categories of SPADEs data will be collected on admissions and discharges beginning October 1, 2023.

What are These Spades?



Ethnicity

Race

Language

Transportation

Health Literacy

Social Isolation

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Ethnicity

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓	Check all that apply	
☐	**A.**	No, not of Hispanic, Latino/a, or Spanish origin
☐	**B.**	Yes, Mexican, Mexican American, Chicano/a
☐	**C.**	Yes, Puerto Rican
☐	**D.**	Yes, Cuban
☐	**E.**	Yes, another Hispanic, Latino/a, or Spanish origin
☐	**X.**	Resident unable to respond
☐	**Y.**	Resident declines to respond

- The ability to improve understanding of and address ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity.
- Collection of ethnicity data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute-care settings.
- The ethnicity data element uses a one-question multi-response format based on whether or not the resident is of Hispanic, Latino/a, or Spanish origin. Collection of ethnic data provides data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.
- Ask the resident to select the category or categories that most closely correspond to their ethnicity from the list in A1005.
- If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
- If the resident declines to respond, do not code based on other resources (family, significant other, or guardian/legally authorized representative or medical records).

Race

A1010. Race

What is your race?

↓	Check all that apply
☐	**A.** White
☐	**B.** Black or African American
☐	**C.** American Indian or Alaska Native
☐	**D.** Asian Indian
☐	**E.** Chinese
☐	**F.** Filipino
☐	**G.** Japanese
☐	**H.** Korean
☐	**I.** Vietnamese
☐	**J.** Other Asian
☐	**K.** Native Hawaiian
☐	**L.** Guamanian or Chamorro
☐	**M.** Samoan
☐	**N.** Other Pacific Islander
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond
☐	**Z.** None of the above

- The ability to improve understanding of and address racial disparities in health care outcomes requires the availability of better data related to social determinants of health, including race.
- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial categories (see Definitions: Race). Response choices A1010D through A1010J roll up to the Asian category of the OMB standard. Response choices A1010K through A1010N roll up to the Native Hawaiian or Other Pacific Islander category of the OMB standard. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Collection of race data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute-care settings.
- Ask the resident to select the category or categories that most closely correspond to the resident's race from the list in A1010, Race.
- If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
- Racial category definitions are provided only if requested in order to answer the item.
- Respondents should be offered the option of selecting one or more racial designations.
- Only use medical record documentation to code A1010, Race if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.
- If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

Language

A1110. Language

A. What is your preferred language?

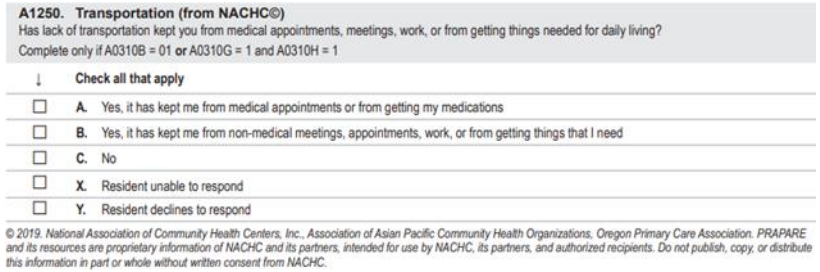
Enter Code

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can lead to social isolation, depression, resident safety issues, and unmet needs.
- Language barriers can interfere with accurate assessment.
- Ask for the resident's preferred language.
- Ask the resident if they need or want an interpreter to communicate with a doctor or health care staff.
- If the resident—even with the assistance of an interpreter—is unable to respond, a family member, significant other, and/or guardian/legally authorized representative should be asked.
- If neither the resident nor a family member, significant other, nor guardian/legally authorized representative source is able to provide a response for this item, medical documentation may be used.
- It is acceptable for a family member, significant other, and/or legally authorized representative to be the interpreter if the resident is comfortable with it and if the family member, significant other, and/or guardian/legally authorized representative will translate exactly what the resident says without providing their interpretation.
- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, significant other and/or guardian/legally authorized representative and/or reviewing the medical record.
- If the resident, family member, significant other, guardian/legally authorized representative and/or medical record documentation cannot or does not identify preferred language, enter a dash (—) in the first box. A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Transportation



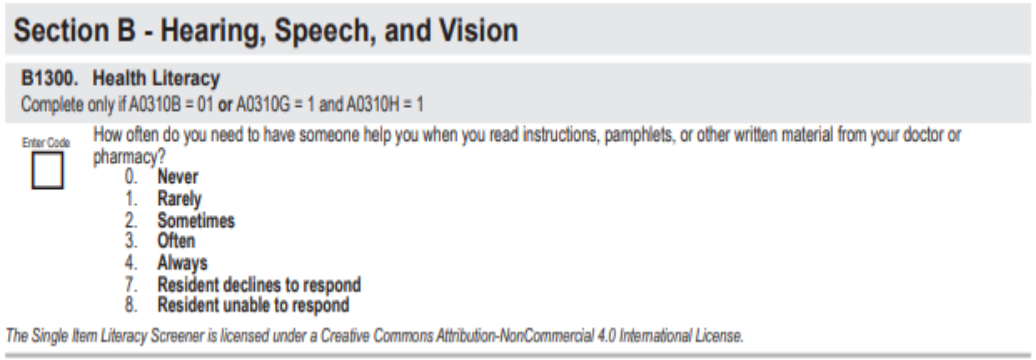
A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓	Check all that apply
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

- Completed at the start of the Medicare stay (5- Day PPS).
- Completed at the end of the Medicare stay with a planned discharge.
- Lookback period is 6 months to 1 year.

- Access to transportation for ongoing health care and medication access needs is essential for effective care management.
- Understanding resident transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.
- Assessing for transportation barriers will facilitate better care coordination and discharge planning for follow-up care.
- Ask the resident:
  - "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?"
  - "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"
- Respondents should be offered the option of selecting more than one "yes" designation, if applicable.
- If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
- Only if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative may provide a response for this item, use medical record documentation.
- If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

Health Literacy



Section B - Hearing, Speech, and Vision

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

- Code 0, **Never**: if the resident indicates never needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- Code 1, **Rarely**: if the resident indicates rarely needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- Code 2, **Sometimes**: if the resident indicates sometimes needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- Code 3, **Often**: if the resident indicates often needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- Code 4, **Always**: if the resident indicates always needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- Code 7, Resident **declines to respond**: if the resident declines to respond.
- Code 8, Resident **unable to respond**: if the resident is unable to respond.

- Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
- Similar to language barriers, low health literacy interferes with communication between provider and resident. Health literacy can also affect residents' ability to understand and follow treatment plans, including medication management.
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use.
- Assessing for health literacy will facilitate better care coordination and discharge planning.
- This item is intended to be a resident self-report item. No other source should be used to identify the response.
- Ask the resident, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

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Social Isolation

D0700. Social Isolation

Enter Code ☐

How often do you feel lonely or isolated from those around you?

0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Resident declines to respond
8. Resident unable to respond

- Code 0, **Never**: if the resident indicates never feeling lonely or isolated from others.
- Code 1, **Rarely**: if the resident indicates rarely feeling lonely or isolated from others.
- Code 2, **Sometimes**: if the resident indicates sometimes feeling lonely or isolated from others.
- Code 3, **Often**: if the resident indicates often feeling lonely or isolated from others.
- Code 4, **Always**: if the resident indicates always feeling lonely or isolated from others.
- Code 7, Resident **declines to respond**: if the resident declines to respond.
- Code 8, Resident **unable to respond**: if the resident is unable to respond.

- Social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.
- Social isolation tends to increase with age and is a risk factor for physical and mental illness and a predictor of mortality.
- Programs to increase residents' social engagement should be designed and implemented, while also taking into account individual needs (e.g., disability, language) and preferences (e.g., cultural practices).
- Assessing social isolation can facilitate the identification of residents who may feel lonely and therefore may benefit from engagement efforts.
- Resident engagement in social interactions and activities of interest can greatly enhance quality of life. A resident's individualized care plan should address activity planning if the resident states that they sometimes, often, or always feel lonely or isolated.
- This item is intended to be a resident self-report item. No other source should be used to identify the response.
- Ask the resident, "How often do you feel lonely or isolated from those around you?"

Social Determinants of Health

Social determinants of health (SDOH) are conditions in the places where people live, learn, work, play and age that affect a wide range of health risks and outcomes.

- Social and Community Context
- Education Access and Quality
- Economic Stability
- Neighborhood and Build Environment
- Healthcare Access and Quality

Internet access is increasingly recognized as a "**super determinant**" of health. It plays a role in health care outcomes and influences more traditionally recognized social determinants of health, such as education, employment, and healthcare access. – SAMHSA
https://www.samhsa.gov/blog/digital-access-super-determinant-health

50 – 80% of a person's health outcome is affected by their SDOH.
https://impact.oliverwyman.com/affordability-and-quality-impact/expertise-social-determinants-health.html

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SPADEs & SDOH

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

[Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity]

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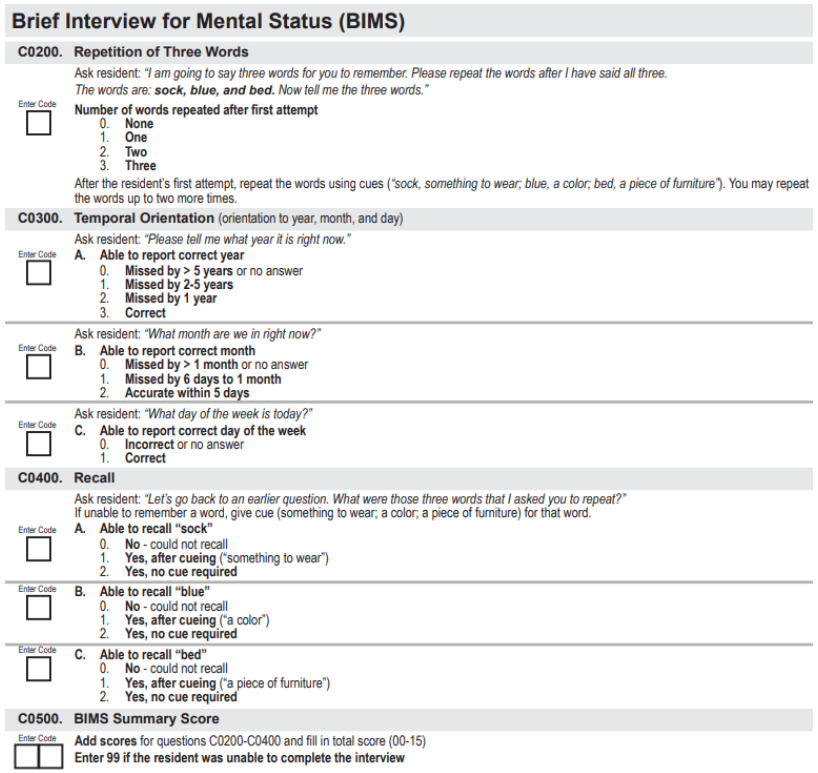
Additional Resident Interviews

- BIMS
- Mood
- Preferences for Customary Routine and Activities
- Pain
- Participation in Assessment and Goal Setting
    - Resident's Overall Goal
    - Return to Community

BIMS



Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Enter Code ☐

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*

Enter Code ☐

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: *"What month are we in right now?"*

Enter Code ☐

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*

Enter Code ☐

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code ☐

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code ☐

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code ☐

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Code ☐☐

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

- The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions.
- BIMS is a structured cognitive interview.
- Interact with the resident using their preferred language (See A1110). Be sure they can hear you and/or have access to their preferred method for communication. If the resident needs or requires an interpreter, complete the interview with an interpreter. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
- If the resident needs an interpreter, including a resident who uses American Sign Language (ASL), every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0600- C1000, Staff Assessment for Mental Status.
- The BIMS is considered complete if the resident attempted and provided relevant answers to at least four of the questions included in C0200- C0400C. Relevant answers do not have to be correct but do need to be related to the question that was asked.
- If the interviewer is unable to articulate or pronounce any cognitive interview items clearly, for any reason (e.g., accent or speech impairment), have a different staff member conduct the BIMS.
- BIMS added to PPS Discharge Assessment.

Mood

Section D - Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©)

D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐

If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.

C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

D0160. Total Severity Score

Enter Code ☐☐ **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

- Most residents who are capable of communicating can answer questions about how they feel.
- It is important to note that coding the presence of clinical signs and symptoms of depressed mood does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis based on these findings; they simply record the presence or absence of specific clinical signs and symptoms of depressed mood. Facility staff should recognize these signs and symptoms and consider them when developing the resident's individualized care plan.
- (PHQ-2 to 9©) A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.
- Ask the first two questions of the Resident Mood Interview (PHQ-2 to 9©).
- Determine whether to ask the remaining seven questions (D0150C to D0150I) of the Resident Mood Interview (PHQ-2 to 9©). Whether or not further evaluation of a resident's mood is needed depends on the resident's responses to the first two questions (D0150A and D0150B) of the Resident Mood Interview.
  - If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, end the PHQ interview; otherwise continue.
    - If both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ-2© and leave D0160, Total Severity Score blank.
    - If both D0150A2 and D0150B2 are coded 0 or 1, then end the PHQ-2© and enter the total score from D0150A2 and D0150B2 in D0160, Total Severity Score.
- Be sure to review all coding instructions before conducting the Resident Mood Interview.
- Appendix E of the RAI Manual has updated instructions on PHQ-2 to 9©.

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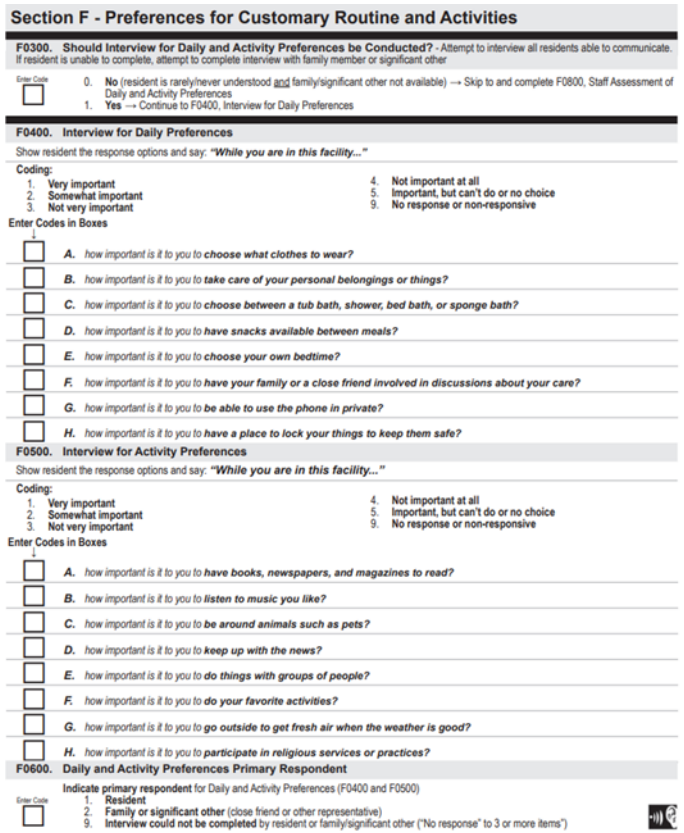
Preferences for Customary Routine & Activities



Section F - Preferences for Customary Routine and Activities

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code
0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. Very important
2. Somewhat important
3. Not very important
4. Not important at all
5. Important, but can't do or no choice
9. No response or non-responsive

Enter Codes in Boxes

- A. how important is it to you to **choose what clothes to wear?**
- B. how important is it to you to **take care of your personal belongings or things?**
- C. how important is it to you to **choose between a tub bath, shower, bed bath, or sponge bath?**
- D. how important is it to you to **have snacks available between meals?**
- E. how important is it to you to **choose your own bedtime?**
- F. how important is it to you to **have your family or a close friend involved in discussions about your care?**
- G. how important is it to you to **be able to use the phone in private?**
- H. how important is it to you to **have a place to lock your things to keep them safe?**

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. Very important
2. Somewhat important
3. Not very important
4. Not important at all
5. Important, but can't do or no choice
9. No response or non-responsive

Enter Codes in Boxes

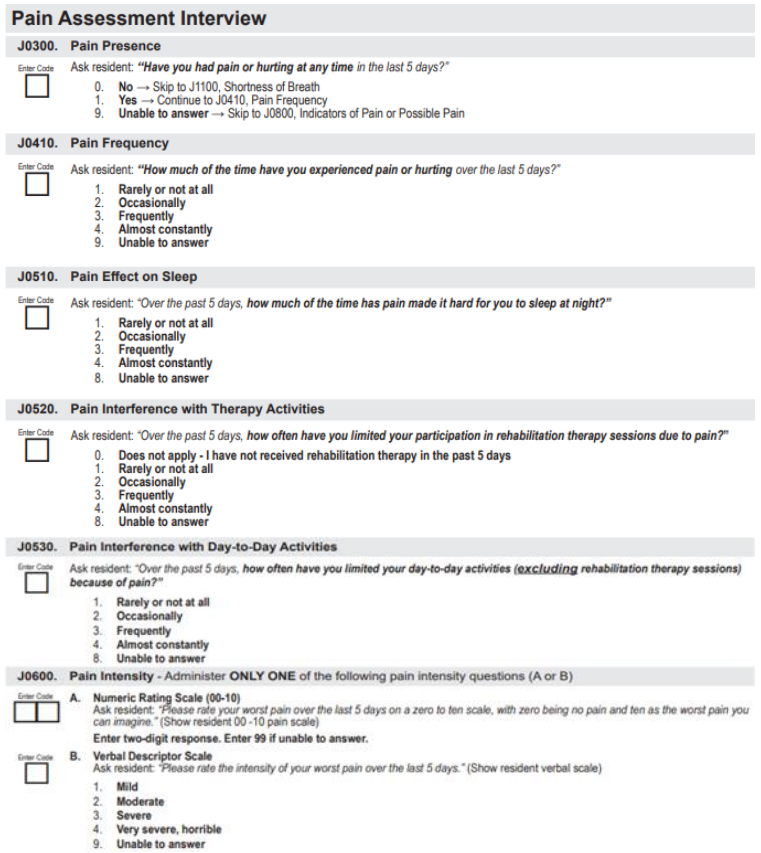
- A. how important is it to you to **have books, newspapers, and magazines to read?**
- B. how important is it to you to **listen to music you like?**
- C. how important is it to you to **be around animals such as pets?**
- D. how important is it to you to **keep up with the news?**
- E. how important is it to you to **do things with groups of people?**
- F. how important is it to you to **do your favorite activities?**
- G. how important is it to you to **go outside to get fresh air when the weather is good?**
- H. how important is it to you to **participate in religious services or practices?**

F0600. Daily and Activity Preferences Primary Respondent

Enter Code
Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)
1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")

- Most residents capable of communicating can answer questions about what they like.
- There may be times when, due to medical or psychiatric conditions, a resident has difficulty communicating and understanding. When conducting resident interviews, providers are to assess and use their clinical judgment to determine the best time in which to attempt to conduct the resident interview. Providers are to attempt to conduct the interview with all conscious residents.
- The interview is considered incomplete if the resident gives nonsensical responses or fails to respond to 3 or more of the 16 items in F0400 and F0500. If the interview is stopped because it is considered incomplete, and there is no family member or significant other to assist in completing the interview, fill the remaining F0400 and F0500 items with a 9 and proceed to F0600, Daily Activity Preferences Primary Respondent.
- The resident, family member or significant other is being asked about current preferences while in the nursing home but is not limited to a 7-day period to convey what these preferences are.
- The facility is still obligated to complete the interview within the observation period.

Pain



Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐

Ask resident: ***"Have you had pain or hurting at any time** in the last 5 days?"*

0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0410, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0410. Pain Frequency

Enter Code ☐

Ask resident: ***"How much of the time have you experienced pain or hurting** over the last 5 days?"*

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
9. **Unable to answer**

J0510. Pain Effect on Sleep

Enter Code ☐

Ask resident: *"Over the past 5 days, **how much of the time has pain made it hard for you to sleep at night?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, **how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. **Does not apply - I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, **how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Code ☐☐

A. Numeric Rating Scale (00-10)
Ask resident: *"Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐

B. Verbal Descriptor Scale
Ask resident: *"Please rate the intensity of your worst pain over the last 5 days."* (Show resident verbal scale)

1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

- Attempt to complete the interview with all residents.
- If the resident needs or wants an interpreter, complete the interview with an interpreter.
- Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever they say it does.
- The assessment of pain is not associated with any particular approach to pain management. Since the use of opioids is associated with serious complications, an array of successful nonpharmacologic and nonopioid approaches to pain management may be considered. There are a range of pain management strategies that can be used, including but not limited to non-opioid analgesic medications, transcutaneous electrical nerve stimulation (TENS) therapy, supportive devices, acupuncture, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, and ultrasound.

Section Q 

Intent: Interviewing the resident or designated individuals places the resident or their family at the center of decision-making. The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.21(c)(1)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. This may not be a nursing home. This is also a civil right for all residents.

Active Discharge Planning

An active discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future.

If there is not an active discharge plan, residents should be asked if they want to talk to someone about community living (Q0500B) and then referred to the LCA accordingly. Furthermore, referrals to the LCA are recommended as part of many residents' discharge plans. Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.

Participation in Assessment & Goal Setting

Section Q - Participation in Assessment and Goal Setting

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

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

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?
0. No
1. Yes → Skip to Q0610, Referral

Q0490. Resident's Documented Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does resident's clinical record document a request that this question (Q0500B) be asked only on a comprehensive assessment?
0. No
1. Yes → Skip to Q0610, Referral

Q0500. Return to Community

Enter Code ☐

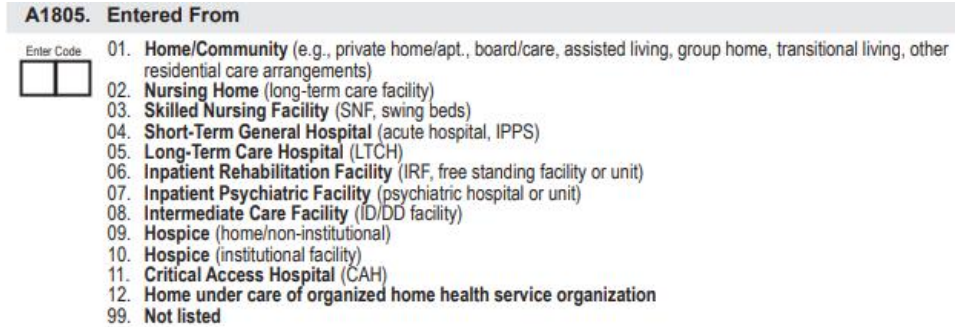
B. Ask the resident (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"
0. 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

- Residents who actively participate in the assessment process and in development of their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.
- If the individual resident is unable to understand the process, their family member, significant other, and/or guardian/legally authorized representative, who represents the individual, should be invited to attend the assessment process whenever possible.
- When the resident is unable to participate in the assessment process, a family member or significant other, and/or guardian or legally authorized representatives can provide information about the resident's needs, goals, and priorities on the resident's behalf.
- Record the participation of all those who participated in the assessment process. Check all that apply,
- Great progress has been made in this area. This progress allows individuals more choices when it comes to care options and available support options to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U.S. Supreme Court decision in Olmstead v. L.C., which states that residents needing long term services and supports have a civil right to receive services in the least restrictive and most integrated setting appropriate to their needs.

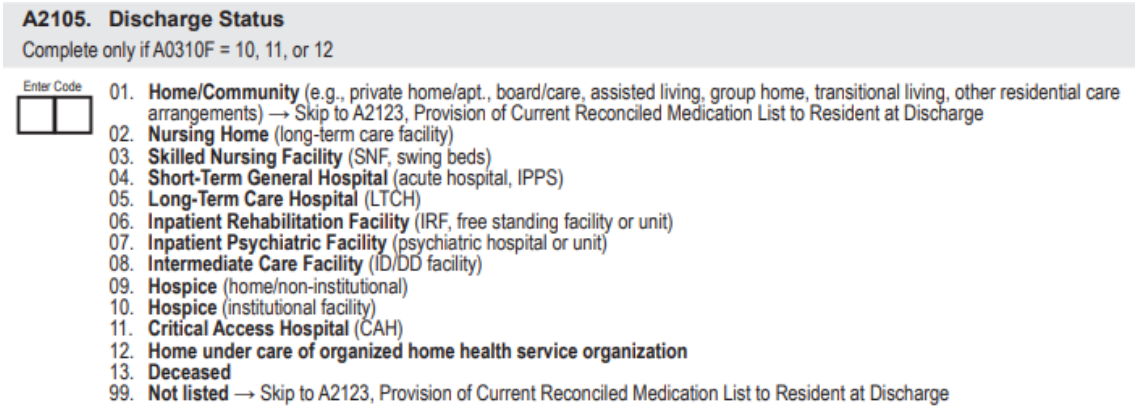
New/Expanded Section A Items



A1805. Entered From

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**



A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

Be sure to review the definitions for each entity. The Glossary and Common Acronyms in Appendix A can also be helpful.

Examples: There's a difference between Nursing Home (02) and Skilled Nursing Facility (03). Also, between Hospice (09) and (10) and more.

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Section A Coding

- **Code 01**, **Home/Community**: if the resident was admitted from a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly.
- **Code 02**, **Nursing Home** (long-term care facility): if the resident was admitted from an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability.
- **Code 03**, **Skilled Nursing Facility** (**SNF, swing bed**): if the resident was admitted from a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category also includes residents admitted from a SNF swing bed in a swing bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements.
- **Code 04**, **Short-Term General Hospital** (acute hospital/IPPS): if the resident was admitted from a hospital that is contracted with Medicare to provide acute inpatient care and accepts a predetermined rate as payment in full.
- **Code 05**, **Long-Term Care Hospital** (LTCH): if the resident was admitted from a Medicare certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit.
- **Code 06**, **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit): if the resident was admitted from a rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents admitted from a rehabilitation unit of a critical access hospital.
- **Code 07**, **Inpatient Psychiatric Facility** (psychiatric hospital or unit): if the resident was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. This category also includes residents admitted from a psychiatric unit of a critical access hospital.
- **Code 08**, **Intermediate Care Facility** (ID/DD): if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals with intellectual disabilities (ID) or developmental disabilities (DD).
- **Code 09**, **Hospice (home/non-institutional)**: if the resident was admitted from a community-based program for terminally ill persons.
- **Code 10**, **Hospice (institutional facility)**: if the resident was admitted from an inpatient program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based or inpatient hospice programs.
- **Code 11**, **Critical Access Hospital** (**CAH**): if the resident was admitted from a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria to be designated by CMS as a CAH and was receiving acute care services from the CAH at the time of discharge.
- **Code 12**, **Home under care of organized home health service organization**: if the resident was admitted from home under care of an organized home health service organization. This includes only skilled services provided by a home health agency.

Reconciled Medication List Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1 and A2105 = 02-12

Enter Code ☐ At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

↓ **Check all that apply**

	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code ☐ At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

↓ **Check all that apply**

	Route of Transmission
☐	**A. Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

- Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR]), giving providers access to a portal).
- The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care and help subsequent providers reconcile medications, and it may mitigate adverse outcomes related to medications. Communication of medication information at discharge is critical to ensure safe and effective transitions from one health care setting to another.
- Determine whether the resident was discharged to one of the subsequent providers defined below under Coding Tips, based on discharge location item A2105.
- The following information on the important content that may be included in a reconciled medication list is provided as guidance. This guidance does not dictate what information should be included in your facility's current reconciled medication list in order to code 1, Yes, that a current reconciled medication list was provided to the subsequent provider. The completeness of this reconciled medication list is left to the discretion of the providers who are coordinating this care with the resident. Examples of information that could be part of a reconciled medication list can be, but are not limited to:
- — **Types of medications**—Current prescribed and over-the-counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route at the time of discharge. Medications may also include total parenteral nutrition (TPN) and oxygen. — The list of reconciled medications could include those that are: o active, including those that are scheduled to be discontinued after discharge; o held during the stay and planned to be continued/resumed after discharge; and o discontinued during the stay, if potentially relevant to the resident's subsequent care.
- — **Information included**—A reconciled medication list often includes important information about (1) the resident—including their name, date of birth, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and (2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, and any special instructions (e.g., crush medications). For any held medications, it may include the reason for holding the medication and when medication should resume. This information can improve medication safety. Additional information may be applicable and important to include in the medication list, such as the resident's weight and date taken, preferred language, and ability to self-administer medication; when the last dose of the medication was administered by the discharging provider; and when the final dose should be administered (e.g., end of treatment).
- Identify all routes of transmission that were used to provide the resident's current reconciled medication list to the subsequent provider.
- It is recommended that a reconciled medication list that is provided to the resident, family member, guardian/legally authorized representative, or caregiver use consumer friendly terminology and plain language to ensure that the information provided is clear and understandable.

Nutritional Approaches

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***
   Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
	↓ Check all that apply ↓			
A. **Parenteral/IV feeding**	☐	☐	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	[redacted]	☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. **None of the above**	☐	☐	☐	☐

- Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period. If none apply, check K0520Z. None of the above.
- Coding Instructions for **Column 1**: Check all nutritional approaches performed during the **first 3 days of the SNF PPS Stay**.
- Check all nutritional approaches performed prior to admission/entry or reentry to the facility and within the 7-day look-back period. **Leave Column 2 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.** When completing the Interim Payment Assessment (IPA), the completion of items K0520A, K0520B, and K0520Z is required.
- Check all nutritional approaches performed after admission/entry or reentry to the facility and within the 7-day look-back period. If A0310B = 01 AND A0310A = 99, K0520D. Therapeutic Diet is not a required item.
- Coding Instructions for **Column 4**: Check all nutritional approaches performed within **the last 3 days of the SNF PPS Stay**.
- Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B.
- Assessors should not capture a trial of a mechanically altered diet (e.g., pureed food, thickened liquids) during the observation period in K0520C, mechanically altered diet.

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High-Risk Drug Classes – Use and Indication

N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking**
   Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

		1. Is taking	2. Indication noted
		↓ Check all that apply ↓	
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**	☐	☐
J.	**Hypoglycemic** (including insulin)	☐	☐
Z.	**None of the above**	☐	

- Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day lookback period (or since admission/entry or reentry if less than 7 days).
- Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room).
- Code all high-risk drug class medications according to their pharmacological classification, not how they are being used.
  - o Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
  - o Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class.
  - Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.
  - Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.
  - Transdermal patches are generally worn for and release medication over a period of several days. To code N0415, only capture the medication if the transdermal patch was applied to the resident's skin during the observation period.
  - Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root).

Section N Coding Tip

Adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment.

The term “side effect” is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

Special Treatments, Procedures and Programs

Section O - Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed

a. **On Admission** Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
b. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***
c. **At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	a. On Admission	b. While a Resident	c. At Discharge
	↓	Check all that apply ↓	↓
Cancer Treatments			
A1. Chemotherapy	☐	☐	☐
A2. IV	☐	[redacted]	☐
A3. Oral	☐		☐
A10. Other	☐		☐
B1. Radiation	☐	☐	☐
Respiratory Treatments			
C1. Oxygen therapy	☐	☐	☐
C2. Continuous	☐	[redacted]	☐
C3. Intermittent	☐		☐
C4. High-concentration	☐		☐
D1. Suctioning	☐	☐	☐
D2. Scheduled	☐	[redacted]	☐
D3. As needed	☐		☐
E1. Tracheostomy care	☐	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐	☐
G2. BiPAP	☐	[redacted]	☐
G3. CPAP	☐		☐
Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐	[redacted]	☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐

Section O - Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs - Continued

Check all of the following treatments, procedures, and programs that were performed

a. **On Admission** Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
b. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***
c. **At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	a. On Admission	b. While a Resident	c. At Discharge
	↓	Check all that apply ↓	↓
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐	[redacted]	☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care	[redacted]	☐	[redacted]
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐	[redacted]	☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			
Z1. None of the above	☐	☐	☐

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Special Treatments, Procedures and Programs

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the assessment period defined for each column.
- Be sure to review *all the information* provided in the RAI Manual – definitions and coding examples!
- Note: no change in the qualifications to code isolation (O0110M1).
- O0110Z1, None of the above Code if none of the above treatments, procedures, or programs were received or performed by the resident.

Coding Instructions for Section O Columns

- Coding Instructions for Column a. On **Admission** Check all treatments, procedures, and programs received by, performed on, or participated in by the resident on days 1–3 of the SNF PPS Stay starting with A2400B. If no treatments, procedures, or programs were received or performed in the 3-day assessment period, check Z, None of the above.

- Coding Instructions for Column b. **While a Resident** Check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days. If no treatments, procedures or programs were received by, performed on, or participated in by the resident within the last 14 days or since admission/entry or reentry, check Z, None of the above.

- Coding Instructions for Column c. **At Discharge** Check all treatments, procedures, and programs received by, performed on, or participated in by the resident in the last 3 days of the SNF PPS Stay ending with A2400C. If no treatments, procedures or programs were received by, performed on, or participated in by the resident in the 3-day assessment period, check Z, None of the above.

Section G(one)

- Section G is retired in v1.18.11
- Specs for Care Area Triggers without Section G

  (Fact: currently 17 of the 20 Care Areas use Section G as CATs or for consideration on the Appendix C CAA worksheets)
- Specs for Quality Measures that use Section G

  (Fact: currently 1 Short Stay and 5 Long Stay QMs use Section G ADLs)
- Specs for Claims-Based Measures that use Section G

  (Fact: there are 2 Short Stay claims-based measures and 2 Long Stay claims-based measures that use Section G)
- No longer documenting late-loss ADLs in Federal Assessments – we'll document functional abilities

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CATs for ADL CAA

Section V - Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature: 2. Date ☐☐-☐☐-☐☐☐☐ (Month - Day - Year)

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature: 2. Date ☐☐-☐☐-☐☐☐☐ (Month - Day - Year)

ADL Functional/Rehabilitation Potential CAT Logic Table

Triggering Conditions (any of the following):

Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater:

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15)) ***AND***

ADL assistance was required for any of the self-care or mobility activities as indicated by any of the following:

GG0130A5 = 01–05 OR
GG0130B5 = 01–05 OR
GG0130C5 = 01–05 OR
GG0130E5 = 01–05 OR
GG0130F5 = 01–05 OR
GG0130G5 = 01–05 OR
GG0130H5 = 01–05 OR
GG0130I5 = 01–05 OR
GG0170A5 = 01–05 OR
GG0170B5 = 01–05 OR
GG0170C5 = 01–05 OR
GG0170D5 = 01–05 OR
GG0170E5 = 01–05 OR
GG0170F5 = 01–05 OR
GG0170FF5 = 01–05 OR
GG0170I5 = 01–05 OR
GG0170J5 = 01–05 OR
GG0170K5 = 01–05 OR
GG0170R5 = 01–05 OR
GG0170S5 = 01–05

CATs Triggered from GG Items OBRA/IPA

GG0130A5 = Eating

GG0130B5 = Oral Hygiene

GG0130C5 = Toileting Hygiene

GG0130F5 = Upper Body Dressing

GG0130G5 = Lower Body Dressing

GG0130H5 = Putting on/Taking off Footwear

GG0130I5 = Personal Hygiene

GG0170A5 = Roll Left to Right

GG0170B5 = Sit to Lying

GG0170C5 = Lying to Sitting on Side of Bed

GG0170D5 = Sit to Stand

GG0170E5 = Chair/Bed-to-Chair Transfer

GG0170F5 = Toilet Transfer

GG0130FF5 = Tub/Shower Transfer

GG0170I5 = Walk 10 Feet

GG0170J5 = Walk 50 Feet w/2 Turns

GG0170K5 = Walk 150 Feet

GG0170R5 = Wheel 50 Feet w/2 Turns

GG0170S5 = Wheel 150 Feet

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

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Quality Measures

No specifications/information for Quality Measures at this time.

<u>March 2, 2023 SNF LTC Open Door Forum:</u>

Quality Measures will not be covered during the above training sessions, according to CMS.

> "QMs for MDS 3.0 v1.18.11 will be released later this year."

Updated Quality Measures are expected in October 2023 –

- ? Before implementation of v1.18.11 ?
- ? After implementation of v1.18.11 ?

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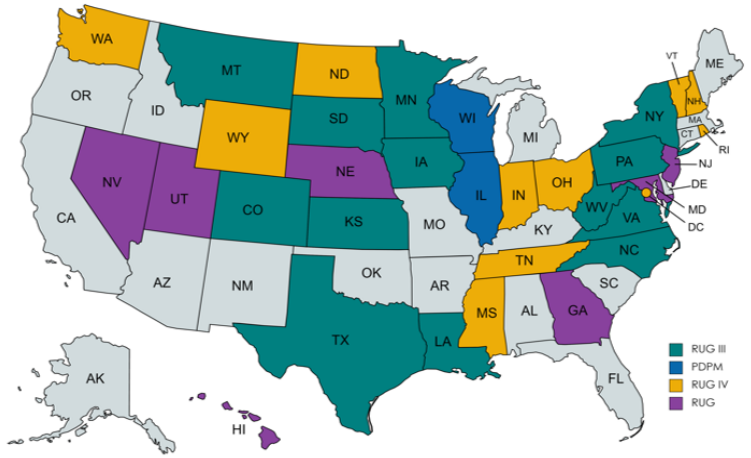
Medicaid State Case Mix: PDPM or OSA

PDPM Transition – States Using RUG, RUG III, RUG IV

- Clarified CMS Guidance – Confirmed Case Mix States Have Until October 2025 to Convert to PDPM
- CPA Firm and State Reimbursement Specialist Advisory Group
- State Education and Tools
- Ongoing Advocacy as Challenges Emerge



Source: MACPAC available at https://www.macpac.gov/publication/nursing-facility-payment-policies/

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Latest State Information

- These states are transitioning from RUGs to PDPM as of 10/1/2023:
  - Iowa
  - Massachusetts
  - Ohio

- These states are utilizing the OSA as 10/1/2023:
  - Colorado
  - Missouri
  - Virginia (transitioning to PDPM July 2025)
  - Rhode Island

Be sure to contact your state Medicaid agency and your EMR vendor BEFORE October 1, 2023 if you're not aware of how your state will manage reimbursement for care provided to Medicaid beneficiaries! States are still working on moving from RUG-based reimbursement to PDPM.

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Additional Comments: OSA

- The Optional State Assessment (OSA) item set may be required by a State Medicaid Agency to calculate the Resource Utilization Group (RUG)-III or RUG-IV case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes. Several items—A0300, D0200, D0300, G0110, K0510, O0100, O0450, O0600, O0700, and X0570— that have been removed from all Federally required item sets remain on the OSA for the purpose of calculating RUG-III/RUG-IV HIPPS codes. Instructions for completing these items are included in this manual. Instructions for completing other items on the OSA can be found in the respective sections of Chapter 3 of the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) 3.0 User's Manual. The guidance in the OSA Manual should only be applied when completing an OSA for payment purposes. Providers should use the guidance in the MDS RAI 3.0 User's Manual to guide their completion of Federally required assessments.

- The OSA is not a Federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. Each state will determine whether the OSA is required and when the assessment must be completed. For questions regarding completion of the OSA, please contact your State Agency.

- No references to OSA in any of the Federally required assessment.

- OSA is a stand-alone assessment that cannot be combined with any other assessment type. It is an additional assessment – separate from the Federally required assessments. Allows for collection of data required for state payment reimbursement.

- OSA does contain the updated Ethnicity, Race and Language data elements.

- The OSA Item Set will be retired in 2025.

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OSA – Section G

Section G - Functional Status

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. **ADL Self-Performance**
   Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. **ADL Support Provided**
   Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

		1. Self-Performance	2. Support
		↓ Enter Codes in Boxes ↓	
A.	**Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B.	**Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
H.	**Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I.	**Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐

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Section GG Updates

- GG0110. Prior Functioning: Everyday Activities
  - All added in front of activities when coding Independent (3) and Dependent (1)
- Functional Limitation in Range of Motion (GG0115) and Mobility Devices (GG0120) moved from G to GG; also clarified that the look-back period is 7 days.
- GG0130I, Personal Hygiene moved from G to GG. No Discharge Goal column for this item. Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (excludes baths, showers, and oral hygiene).
- GG0170C, Lying to Sitting on Side of Bed no longer contains directions for resident to have feet flat on floor.
- GG0170FF, Tub/Shower Transfer moved from G to GG. No Discharge Goal column for this item. Toilet transfer includes the resident's ability to get on and off a toilet (with or without a raised toilet seat) or bedside commode. Toileting hygiene, clothing management, and transferring on and off a bedpan are not considered part of the Toilet transfer activity.
- GG0130A, Eating. Assistance with tube feedings or parenteral nutrition is not considered when coding Eating.

Look-Back Periods for GG

Reason For/Type of Assessment	Look-Back
Stand-alone OBRA Admission Assessment	First 3 Days of the Stay, Starting with A1600
Stand-alone Initial Medicare/5-Day PPS Assessment	First 3 Days of the Stay, Starting with A2400B
Combined Medicare 5-Day PPS Assessment + Any OBRA Assessment	First 3 Days of the Stay, Starting with A2400B
Stand-alone OBRA Assessment Other Than Admission	ARD (A2300) + 2 Previous Calendar Days
Interim Payment Assessment (IPA)	ARD (A2300) + 2 Previous Calendar Days
Part A PPS Discharge	End Date of Most Recent Medicare Part A Stay (A2400C) and 2 Previous Calendar Days
Combined OBRA and Part A PPS Discharge	End Date of Most Recent Medicare Part A Stay (A2400C) and 2 Previous Calendar Days

Section M Coding Clarifications

Section M … Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.

Section M … A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.

Section M … If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury is coded as "present on admission."

Section Z

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature	Title	Sections	Date Section Completed
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				
K.				
L.				

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

_____

B. Date RN Assessment Coordinator signed assessment as complete:

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Providing Privacy Act Notice?

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Internet Quality Improvement Evaluation System (iQIES). The notice shown on page 1-14 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

Page 1-12 of the DRAFT October 2023 RAI Manual

RAI Manual

- RAI Manual is a *critical* tool/resource that must be used to accurately complete any MDS assessment. Don't guess – look it up.
- Every member of your IDT that works with the MDS must have access and must reference the current RAI manual.
- If unclear or you still have questions, consult your State RAI Coordinator. See slide #16 for the link to the Appendix B listing. Keep a copy of the reply/answer provided to your query in case you need to prove your coding in the future.
- Archive each version of the RAI Manual. That archived manual may provide your defense in the future for coding the MDS the way you did. Remember reverse staging of pressure ulcers in versions 1 & 2 of the MDS?

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)

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 Instructions for BIMS (When Administered in Writing)
- Appendix F: MDS Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Forms
- Track Changes Pages

Preparing for 10/1/2023

- Identify members of your IDT that will be working with the MDS and which sections/elements they will be responsible for.
- Include them in any/all training sessions as appropriate –> both in-house and other trainings, e.g., CMS, vendors, consultants. The more training you and the IDT can participate in, the better prepared you will be. Competence and accuracy in completing each & every MDS is *critical*. Staff confidence is always key! I suggest making a list of who needs training and record trainings and dates as well as attendance to ensure no one is left out. If your facility uses agency staff, consider their role in gathering MDS data and train accordingly.
- Encourage IDT members to ask questions as they arise. Share those questions & answers w/other members of the IDT.
- The MDS Coordinator is the leader of the MDS process and of the MDS team. Heir and a spare!
- Don't leave CNAs out of any pertinent trainings! They are definitely a part of your IDT/MDS team.
- Network with other MDS Coordinators in your area, your organizational memberships, etc.

Other Preparation Tips

- Take the training in chunks – not the entire MDS in one sitting. Like the age-old question: how do you eat an elephant? One bite at a time. Repeat trainings as needed to facilitate understanding and ensure competence.
- Identify your current data collection tools used for the MDS process. Many will need updating which can be done internally, using an outside vendor or consultant.
- Audit your current process on how the primary diagnosis is identified; also, physician certification documents (*no payment at all* if you don't have these signed and dated in a timely manner); treatment and medication records; therapy documents, etc.; triple check process; pre-admission screening, etc.
- START YOUR PREPARATIONS NOW.
- You've got this!

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Clinical Consultant, LTC/Senior Care

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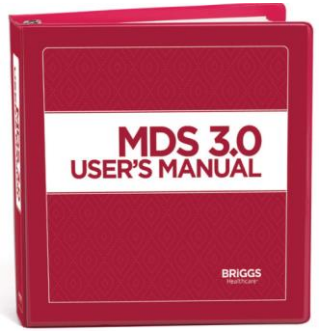

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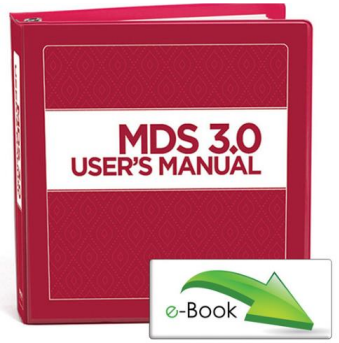

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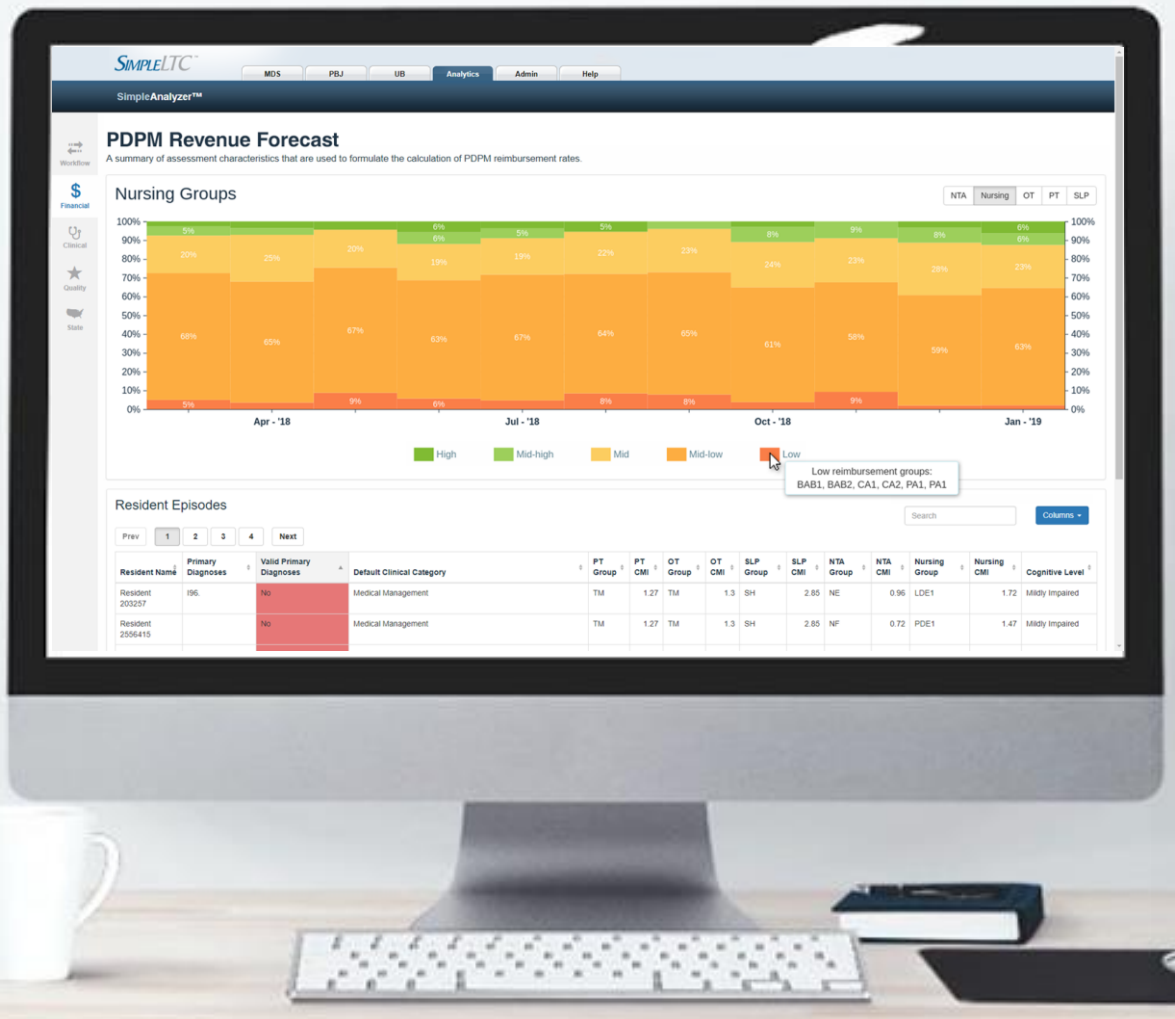

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