Getting Ready for MDS 3.0 Implementation

Wyoming Department of Health
Session 2  May 20, 2010

Big Changes

• MDS 3.0 Resident Assessment Instrument effective October 1, 2010
• New assessment process/form
  – Many changed items, time frames and requirements
  – More assessments required due to admission requirements, Medicare payment and discharge outcome assessments
• Manual is available at cms.hhs.gov

MDS 3.0

• Goals:
  – To introduce advances in assessment measures, increase clinical relevance of items, improve accuracy and validity of the tool, and increase the resident's voice by introducing more resident interview items
  – Improve clinical utility, clarity, and accuracy
  – To shorten the tool while maintaining the ability to use MDS data for quality indicators, quality measures, and payment
  – “Reflects current medical practice and resource use in SNFs across the country, and ... enhance the accuracy of Prospective Payment System”
Section B: Hearing, Speech and Vision

• Intent: To evaluate the resident’s ability to hear, ability to understand, and communicate with others, and visual limitations or difficulties
• Steps for Assessment: Review the medical record to determine if a diagnosis of comatose or persistent vegetative state has been documented by physician, nurse practitioner
• All items use the 7 day look-back window
• All items consider if the resident is able to answer/participate

B 0100 thru B 01000

• Review medical record to determine if neurological diagnosis exists and is documented by physician
  – You may skip sections B thru F if comatose
• No: Continue with Hearing, Speech and Vision
  – Interview, Observation and Record Review
  – Setting for Assessment
  – Devices? Hearing Aide or Glasses
  – Language?

Section C: Cognitive Patterns

• Intent: To determine resident’s cognitive function and decision making
• Steps for Assessment: Manual includes two assessment tools that will yield more accurate results and other coding tips
• Brief Interview for Mental Status (BIMS) is used to test memory in resident interview.
  – 90% of residents are able to participate
  – If staff judge resident is not able to answer questions, staff makes assessment based on observation
• All items use the 7 day look-back window
• Must first determine if the resident is able to answer/participate
**C0100: Should Brief Interview be Conducted?**

- Manual includes two assessment tools that will yield more accurate results and other coding tips
- Brief Interview for Mental Status (BIMS) is used to test memory in resident interview.
  - 90% of residents are able to participate
  - If staff judge resident is not able to answer questions, staff makes assessment based on observation
- C0100 is significant for the resident to be able to participate in assessment

**C0200: Repetition of Three Words**

- Brief Interview for Mental Status
  - “I am going to say three words….
  - Sock, Blue and Bed
  - You may use clues like “something to wear, a color, a piece of furniture”

**C0300 thru C500**

- C0300 Temporal Orientation
  - year, month and day
- C400 Recall
  - Remember the “three words I asked you to remember?”
  - Something to wear, a color, a piece of furniture?
- C0500
  - Summary Score for questions C200-C400
  - Score will be 00-15
  - Code 99 if unable to answer
C0600 thru C800

• C0600 Should Staff Assessment for mental status be conducted?
  – No: Resident Completed Interview
  – Yes: Resident unable to complete interview, Continue to C0700

• C0700 Short term memory Ok
  – Ok or Problem?

• C0800 Long term memory
  – Ok or Problem?

C0900 thru C1300

• C0900 Memory recall ability
  – Similar to MDS 2.0

• C1000 Cognitive Skills for Daily Decision Making

• C1300 Delirium
  – Must be completed on all residents
  – Assessment for Delirium will use the Confusion Assessment Method (CAM) a standard instrument to determine delirium

Section D: Mood and Depression Items

• Intent: Assessors will now utilize Patient Health Questionnaire (PHQ-9) that includes a checklist of 9 symptoms of depression that is conducted as an interview
  – Helps to identify residents who are responding to care and those that require changes to care plan and treatments

• Steps for Assessment: Must first determine if the resident is able to answer/participate
  – Total Severity Score provides a numerical severity score of 0-27 to classify evidence of a depressive disorder

• All items use the 14 day look-back window
• Use frequency card
**Frequency of Symptoms**

- “Over the Last 2 weeks have you been bothered by any of the following problems?”
- Never or 1 day = 0
- 2-6 days (several days) = 1
- 7-11 days (half or more of the days) = 2
- 12-14 days (nearly every day) = 3

**D0100 thru D0500**

- D0100: Should the Resident Mood Interview be conducted?
  - Yes: Continue thru D0200
  - No: Resident is rarely/never understood Skip to and complete D0500-D0600
- D0200: PHQ Resident Interview “Over the last 2 week, have you been bothered by any of the following problems?”
  - Symptom Present: Yes or No or No Response
  - Symptom Frequency: Never to nearly every day
  - Code for higher frequency

**D0300: Total Severity Score**

- Must be between 00 (Never) and 27
  - Enter 99 if unable to complete interview and there are 3 or more items left blank
  - Use as a tool, does not diagnose depression but helps to identify mood concerns
  - 1-4 is minimal depression
  - 20-27 is severe depression
**D0350: Safety Notification**

- Complete only if D0200i = 1
  - Thoughts that you would be better off dead or hurting yourself
  - Indications that there is a potential for resident self harm
  - Was responsible staff notified?

**D0500 thru D0650: Staff Assessment of Resident Mood**

- Do not complete if D0200-D0300 was completed
  - Over the last 2 weeks, did the resident have any of the following behaviors or problems
    - Review medical record, interview staff and family and significant others
  - Symptom present
  - Symptom frequency
- D0600 Total Severity Score
- D0650 Safety Notification

**Section E: Behavior**

- Intent: To identify residents with behaviors associated with psychosis, rejection of care, wandering, and comparison of behavior to prior assessment
  - Designed to better support care planning and avoid stigma for residents with physical, verbal and/or other behavioral symptoms such as hitting and threatening
- Steps for Assessment: Observation, interview and record review for the presence of resident’s behaviors
  - National sample of residents in SNF identified 28% of females and 35% of males with behaviors
- All items use the 7 day look-back window
E0100 thru E0300

- **E0100: Psychosis**
  - Hallucinations: Perceptual experiences
  - Delusions: Misconceptions or beliefs
  - None of the above

- **E0200: Behavioral Symptoms**
  - Physical behavior symptoms directed towards others
  - Verbal behavior symptoms directed at others
  - Other behavioral symptoms directed at others
  - Coding is based on 0 not exhibited; 1, 2 or 3

- **E0300: Overall presence of behavioral Symptoms**
  - No: Skip to E0800 rejection of care
  - Yes: Consider E0200, go to E0500, E0600

E0500 thru E0800: Impact

- **E0500: Impact on Resident**
  - A: Resident at significant risk?
  - B: Significantly interfere with resident care?
  - C: Interfere on participation in activities?

- **E0600: Impact on Others**
  - A: Puts others at risk for physical injury?
  - B: Significantly intrudes on the privacy/activities of others?
  - C: Significantly disrupts care or living environment?

- **E0800: Rejection of Care: Presence and Frequency**

E0900 thru E1100: Behavior

- **E0900: Has the resident wandered?**
  - Presence and Frequency

- **E1000: Wandering Impact**
  - A: Does the wandering place the resident at significant risk?
  - B: Does the wandering significantly intrude on the privacy of others?

- **E1100: Change in Behavior or Other Symptoms**
  - Same, Improved or Worse
  - N/A: No prior MDS assessment
Section F: Customary Routine

• Intent: To obtain information about the resident’s preferences for daily routines and activities. Best obtained directly from the resident or through family, significant other and staff interviews
  - Customary Routine (Section AC) and Activity Pursuit (Section N) were not utilized in planning care
• Steps for Assessment: Resident interview of preferences and choices
• Goal of section is to identify and care plan preferences for daily routine and activities
• 84% of residents able to complete

F0300 thru F0600: Resident Preferences for Customary Routine

• F0300: Should interview be conducted?
  - No: resident is rarely understood and family/significant other is not available  Skip and go to F0800
• F0400: Daily Preferences for while you are in the facility
  - Ask questions as they appear on MDS
• F0500: Activity Preferences while you are in the facility
• F0600: Indicate primary respondent
• All items use the 7 day look-back window
• Use the Coding card

Coding Preferences

• 1. Very Important
• 2. Somewhat important
• 3. Not very important
• Not important at all
• Important but can’t do or no choice
• No response or non responsive (document)
F0700: Staff Assessment of Daily Routine

• Should staff do the assessment?
  – No: Was completed by resident, family/significant other Skip and go to section G
  – Yes: 3 or more interview items were not completed

• Resident Prefers:
  – A thru T
  – All items must be part of the plan of care

Care Area Assessments

• Care Areas Assessment replace RAPs
  – CAAs allows SNFs to choose the clinical process guidelines they wish to use
  – Providers will still have the option of using CMS’ clinical practice guidelines

• Please go to MDS 3.0 manual for CAAs related to this program
  – Delirium
  – Cognitive Loss
  – Visual Function
  – Communication
  – Psychosocial well being
  – Mood State
  – Behavioral Symptoms
  – Activities

How to Prepare

• Must have MDS 3.0 manual NOW
• Download assessment form and review with clinical team
• Determine clinical assessment requirements for each section, look back time frames and required documentation
• Review and determine current facility specific assessment forms, responsible individuals
• Develop MDS policies and procedures
• Conduct team meetings and training
• Set reasonable time frames for development of tools
• Utilizing CMS resources and internet
• Stay CALM
C1300 thru C1600

- Will be completed on all residents
  - Code after completing Brief Interview for Mental Status or Staff Assessment of cognition
  - Review medical record
  - Coding determines the presence of behavior
- C1600 Acute Onset of Mental Status Change
  - No: Continue with assessment
  - Yes: Review the Care Area Assessment for Delirium