Getting Ready for MDS 3.0 Implementation

Wyoming Department of Health

March 2010

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Big Changes

- MDS 3.0 Resident Assessment Instrument effective October 1, 2010
  - April/May 2010: SNF Proposed Rule to be published
  - July 2010: SNF Final Rule to be Published
  - September 2010: National Quality Forum to endorse Quality Measures
  - October 2010: RUG IV Implementation
- Manual is available at cms.hhs.gov/

Why Change?

- MDS 2.0 had problems with wording and changing definitions
- Missing clarity and relevance of items
- Needed to improve the accuracy of the tool
- Needed to introduce advance measures in assessment
- Needed to increase the clinical relevance of items
- Needed to add the resident's voice through resident interviews

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***

- **An interim step until implementation of the Post Acute Care Assessment tool**

MDS 3.0

- The MDS is a critical part of CMS programs for skilled nursing facilities.
- Data is used for
  - RAP/CAT/CAA = Resident Care Assessment
  - Payment
  - Surveys
  - Quality Measures and Indicators

Significant MDS 3.0 Changes

- **Improved electronic compatibility for analysis and data interchange**
- New test: **Brief Interview for Mental Status** ("BIMS") replaces 2.0 staff assessment for residents who can be understood
- **Confusion Assessment Method** ("CAM") replaces 2.0 items for Delirium
- Mood items use new resident interview: **9-Item Patient Health Questionnaire** ("PHQ-9")
- Behavior item changes; Wandering separated from Behavior symptoms

Significant MDS 3.0 Changes

- Customary Routine, Activities and Community Setting significantly altered
- Active Disease Diagnosis items revised to provide a more direct focus on active diseases
- Pain items under Health Conditions have major changes (resident interview with 0 – 10 scale)
- Eliminates reverse staging of pressure ulcers & notation if pressure ulcer was present on admission
- Adds rationale of coding, care plan interventions and Quality of Life concerns

Faster and More Accurate

- It is anticipated that completion of an MDS 3.0 (61.5 minutes including 9.2 minutes for resident interview) will take 45% less time than MDS 2.0 (111.6 minutes)
- RAND study stated that due to major revisions in MDS 3.0, assessments will be more accurate for
  - Cognition (Section C)
  - Depression (Section D)
  - Behavior (Section E)
  - Customary Routine (Section F)
  - Gait and Fall items (Section G and J)
  - Pain (Section J)

Data Submission Changes

- Detailed in Chapter 5 of the MDS 3.0 manual
  - Sections and Items have new coding labels
- Assessments will be directly submitted to the national CMS QIES Assessment Submission and Processing system within 14 days
- MDS completion dates for all assessments may be no later than 7 days from the ARD
  - Additional 7 days for encoding and sending
  - Entry and discharge information tracking forms sent within 14 days of the *event* day
  - Comprehensive forms will be submitted no later than 14 days after Care Plan Completion Date

Data Correction

- Correction of Minor errors after the assessment has been submitted and accepted by CMS QIES ASAP require a single Modification record
- Major errors discovered in the system after a assessment has been accepted will require a New Significant Correction of Prior Assessment or Significant Change in Status assessment requiring care plan updates

"Look-Back" Period

- Distinguishes resident status before and after admission to SNF
- MDS 3.0 will contain 2 ways to code
  - "While ***not*** a resident" within last 14 days
  - "While a resident" within last 14 days
- Preadmission services are relevant to Care Plan but do not impact SNF resources
- RUG-IV modifies Look-Back for P1a items to include only services after SNF admission
- Must use manual to determine look back period for individual sections

Section C: Cognitive Patterns

- 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
- Assessment for Delirium will use the Confusion Assessment Method (CAM) a standard instrument to determine delirium

Section D: Mood and Depression Items

- 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
- Total Severity Score provides a numerical severity score of 0-27 to classify evidence of a depressive disorder

Section E: Behavior

- Designed to better support care planning and avoid stigma for residents with physical, verbal and/or other behavioral symptoms such as hitting and threatening
- Includes psychosis, rejection of care, wandering, and comparison of behavior to prior assessment
- National sample of residents in SNF identified 28% of females and 35% of males with behaviors

Section F: Customary Routine

- Customary Routine (Section AC) and Activity Pursuit (Section N) were not utilized in planning care
  - Goal of section is to identify preferences for daily routine and activities
- Items are a resident interview that may be completed by family member or significant other
- 84% of residents able to complete

Section G: Functional Status

- Scoring changes under MDS 3.0 & RUG-IV
  - New scale range from 0 to 16 to improve ease of use and interpretation and make scale more proportional to physical function
    - Clarifies definitions and adds “7” to resident Self-Performance
    - Range increases from 15 to 17 points
    - Standardizes ADL categories across various levels in the hierarchy
  - Revise the ADL scale to make it more sensitive to differences in functional level

Section G: Functional Status

- Eating no longer includes eating/drinking during med pass
- Removes Parenteral/IV feeding from Eating score
- Dressing no longer street clothing
- Toilet use states “do not include emptying of bedpan, urinal, bedside commode…
- Catheter no longer scores as continent
- Adds Alternate sleep furniture

Section H: Continence

- 7 day look back period for most items
- Changed coding to about continence and catheters
- Fecal impaction is dropped
- Constipation is yes/no

Section I: Diagnosis

- Has two look back periods
  - Requires physician documented diagnosis in past 30 days
  - Determination if diagnosis is active or no longer affects resident functioning or plan of care in last 7 days
  - More detailed listing of diagnoses for improved reliability of information

Section J: Pain Assessment

- Research indicates that 45 to 85% of resident experience pain
- Section includes resident Pain Assessment interview or staff assessment
- Pain Scale includes words or numbers, frequency and intensity, time of day
- Includes Pain Management

Section K: Swallowing and Nutritional Status
Section L: Oral Dental

- Improved definitions and clarifications for coding
- Expands instructions and definitions about weight loss
- Instructs weight comparisons for 30 and 180 day windows only
- Drops weight gain
- Includes improved assessment items for better identification of problems

Section M: Skin Conditions

- Adds more items and details about skin conditions and problems
- Identification of venous and arterial ulcers, healed ulcers
- Eliminates reverse staging of ulcers,
- Includes assessment of unstageable ulcers
- Staging is based on deepest anatomical change
- Information about ulcers present on admission
- Utilizes PUSH scale
- New item includes Pressure Ulcer risk and utilization of a formal assessment tool

Section O: Special treatments and Procedures

- Combines Sections P, W and part of T from 2.0
- List is shorter
- Two columns for coding:
  - "If received while not a resident"
  - "While a resident"
- Instructions to not code items provided solely in conjunction with surgical procedures; and pre and post op

Changes to Therapy

- Now includes start and stop dates of therapy programs
- Includes breakdown of Treatment Modes delivered
  - **Individual** therapy
  - **Concurrent therapy** consisting of no more than 2 patients (regardless of payer source), both of whom must be in ***line-of-sight*** of the treating therapist (or assistant); or
  - ***CT involving 3 or more residents will NOT be recognized as reimbursable treatment***
  - **Group therapy** consisting of 2 - 4 patients (regardless of payer source), performing similar activities, and supervised by a therapist (or assistant) who is not supervising any other individuals
- Expanded rules related to care and payment

Section P: Restraints
Section Q: Participation and Goal Setting

- New sections
- Revisions include detailed definitions
- Significant care planning interventions

RAPs to CATs to CAAs

- MDS 3.0 eliminates Resident Assessment Protocols
- **Care Areas** replace RAPs
  - Pain and Discharge Planning have been added
- CAAs allows SNFs to choose the clinical process guidelines they wish to use
- Updated RAI Manual includes government websites with clinical practice guidelines
- Providers will still have the option of using CMS' clinical practice guidelines, as the updated manual will also include current RAPs

How to Prepare

- **Start thinking 2010 strategy today!**
  - **Must have MDS 3.0 manual NOW**
  - **Download forms and share with clinical team**
  - **Must review clinical assessment requirements and look back time frames for each section**
  - **Must review and determine facility specific assessment forms**
  - **Team meetings, sharing and training**
  - **Utilizing CMS resources and internet**
  - **Stay CALM**