Getting Ready for MDS 3.0 Implementation

Wyoming Department of Health

Session 2 May 20, 2010

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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/

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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***

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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 of persistent vegetative state has been documented by physician, nurse practitioner
- All items use the 7 day look-back window
- All items consider the if the resident is able to answer/participate

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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?

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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

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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

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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"

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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

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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
- C700 Short term memory Ok
  - Ok or Problem?
- C0800 Long term memory
  - Ok or Problem?

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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

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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 the 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

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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

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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

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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

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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?

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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

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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

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E0100 thru E0300

- E0100: Psychosis
  - Hallucinations: Perceptual experiences
  - Delusions: Misconceptions or beliefs
  - None of the above
- E0200: Behavioral Symptoms
  - Physical behavior symptoms directed towards other
  - 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

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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 pothers 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

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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

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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

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F0300 thru F00600: 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

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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)

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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

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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

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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**

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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

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