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The MDS 3.0 Roll Out!

If you were around when MDS 2.0 was released then you remember how challenging it was to learn the new form and process. This is what most of the clinicians and facilities are saying about MDS 3.0. It is expected that the transition will have some bumps in the road but this is also an exciting time as we progress to something more comprehensive in capturing resident conditions and needs.

Healthcare providers and CMS have come a long way since the MDS form was developed in 1988. The original MDS was first used in October of 1990. MDS 2.0 began in April of 1995 and payment electronic submission began on June 22, 1998. Now here we are in 2011 and "We have come a long way baby!"

Regardless of the changes over the years, the intent of the MDS

has always been the same: to make sure nursing residents are receiving appropriate care, that the providers are paid properly, and to give healthcare clinicians a tool to assess the status of their residents in order to develop a plan of care to optimize each resident's quality of life.

Why change to MDS 3.0?

The OBRA (Omnibus Budget Reconciliation Act) of 1987 is the Statutory & Regulatory basis for a Resident Assessment Instrument (RAI), to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capabilities, and to help staff identify health problems.

The MDS 2.0 is outdated and it is not consistent with current clinical practices. The MDS 3.0 has a new focus, new item sets, new assessments and new qual-

ity indicators/quality measures. It also affects your transmissions and the CMS survey process.

Are there big changes in MDS 3.0???

You would think there are, but really, there are not. The changes are "back to the basics". The RAI process has always required the conducting of interviews and direct communication with residents, family members, and staff members involved in each resident's care.

Additional structured interviews are added for the residents and staff members if the residents are not able to complete interview process.

These interviews include the BIMS (Brief Interview for Mental Status) and PHQ9 (Patient Health Questionnaire 9-item) for mood and behavior. There are also interviews for daily preferences, activity preference

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Section Q

Under Section Q nursing home residents who may not have previously been considered as candidates for community living are being reassessed. One of the key components of the MDS 3.0 is to increase resident input and participation in the assessment and care planning process. Section Q has been revised to be

person-centered and is designed to identify each resident's goals and expectations relating to where she/he lives and whether she/he stays in the nursing home or transitions to other living situations. Nursing facilities are required to initiate a referral to a state designated Local State Agency (LCA) to

provide the resident with information and explore the potential for returning to the community.



10 Things You Should Know About Section Q

1. Each resident should be meaningfully engaged in his/her discharge and transition plan.
2. If a resident answers “Yes” to the Section Q 0500B question, “Do you want to talk to someone about the possibility of returning to the community?”, then the nursing home is required to initiate care planning and to make a referral to the designated LCA.
3. The LCA will respond to the resident by phone or in person and provide information to the resident about community living services and supports.
4. The LCA’s role is to provide timely information about choices of services and supports in the community, and collaborate with the nursing facility to organize the transition to community living.
5. LCA’s may assist the resident and the nursing home in transition planning to secure/locate housing, home modifications, personal care, and community integration.
6. California has identified LCAs in each county to provide the resident with information about community-based services and supports.
7. The nursing home continues to be responsible for discharge planning as required by the state and federal regulations. This includes a post-discharge plan of care, developed with the resident and his/her family, which is designed to assist the resident and discharge planning for the resident.
8. The MDS 3.0 is to be used

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“ Do you want to talk to someone about the possibility of returning to the community?”

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and pain.

These resident interviews allow you to obtain direct input and valued information from the resident’s desires, needs, wishes, abilities, and how the resident wants such care delivered.

The changes in the MDS 3.0 are for each resident’s benefit. It is truly a resident—centered assessment tool.

Other changes in the MDS 3.0 are from the result of clinical

expert commentary, long term care evidence-based, culture experts, and special studies.

Many RAI Coordinators are overwhelmed by the number of item sets. Just take each item one step at a time. Once you are familiar with the MDS 3.0 it will be easier and faster to complete accurately than the MDS 2.0. The MDS submission flow used to be from the facility to the state and then to CMS. Now the

submission goes from the facility to CMS to the state.

Changes with which you need to become familiar include Sections M, O, S, X, and Z, the new ARD calculations, End of Therapy and Start of Therapy calculations and CATs and CAAs

CMS anticipated problems in transitioning to this process and they and their consultants are working diligently to solve issues and have a workable system.

MDS 3.0 Section S & California POLST

With the implementation of MDS 3.0, California started to require the completion of an MDS 3.0 Section “S”. This section of the MDS is specific to each state in the United States. California is using Section “S” to collect information regarding Physician Orders for Life Sustaining Treatment (POLST). The POLST form was developed by

the Emergency Medical Services Authority (EMSA) California .

In the State of California, the law requires that the orders in a POLST form be followed by health care providers. The law also provides immunity to those who comply with a POLST in good faith.

When a resident has a POLST

form or Advanced Directive then facility staff should review the POLST form and Advance Directive to ensure consistency, and if necessary, work with the resident to update the forms appropriately to resolve any conflicts.

The POLST form does not replace Advance Directives.

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Changes to MDS 3.0 Assessment Modification Policy

On April 1, 2011, CMS revised its MDS 3.0 assessment modification policy to prohibit nursing home and swing bed providers from revising an existing MDS 3.0 record to correct an event date or a reason for assessment. Instead, these providers must make these corrections by inactivating the incorrect record in the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system.

A new MDS 3.0 record with the correct event date or reason for assessment must then be created and submitted. Event date items on the MDS 3.0 include the following: Assessment Reference Date - Item A2300; Entry Date - Item A1600; and Discharge Date - Item A2000. The Reason for Assessment item on the MDS 3.0 is item A0310.A – A0310.F, which includes the following types of assessments:

- ◆ Federal Omnibus Budget Reconciliation Act (OBRA)
- Reason for Assessment;
- ◆ Prospective Payment System (PPS) Assessment;
- ◆ PPS other Medicare Required Assessment – Other Medicare Required Assessment (OMRA);
- ◆ Is this a Swing bed clinical change assessments;
- ◆ Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission; and
- ◆ Entry/discharge reporting.

Changes to MDS 3.0 Assessment Formatting Policy

On February 1, 2011, CMS revised its MDS 3.0 assessment formatting policy by issuing version 1.0.5 of jRAVEN, the CMS data entry software application that nursing home and swing bed providers use in collecting, maintaining, and submitting MDS 3.0 assessment information. This version of jRAVEN allows users to add more signature lines to item Z0400 of the MDS 3.0 as needed to

capture attestations of all individuals completing some portion of a particular assessment.

Also on February 1, 2011, CMS made a decision that the print format provided by jRAVEN for a MDS 3.0 assessment is acceptable for review in the nursing home survey process. Providers do not need to provide printed copies of blank items on the MDS 3.0. For those

providers who utilize the services of a software program other than jRAVEN, the printed copies of the MDS 3.0 are acceptable if they display the following:

- ◆ The item identifier;
- ◆ The item description;
- ◆ The item response;
- ◆ The assessment reference and resident birth dates; and
- ◆ Identifiers including resident name.

MDS 3.0 Impacts on Nursing Home Compare:

Finally, on April 23, 2011, CMS “froze” QM data and the Five Star QM ratings currently on the Nursing Home Compare website for a period of six months. The QMs displayed on Nursing Home Compare since January, 2011, reflect MDS 2.0 data submitted during quarters one, two, and three of 2010, prior to the conversion to

MDS 3.0. Historically, CMS has updated QM data each quarter. However, new MDS 3.0-derived QM data are not yet available for display, so CMS will retain the current QM scores and Five Star ratings until October, 2011. We anticipate that new MDS 3.0 QM data will be available in early 2012.

Each resident should be meaningfully engaged in his/her discharge and transition plan.



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with all nursing home residents, regardless of payment source.

9. The nursing home staff and the LCA are expected to work collaboratively to implement transition and discharge planning for the resident.

10. The designated Local Agency for each County can be found at: <http://www.dhcs.ca.gov/services/ltc/Pages/MDS3/section.aspx>.

You may also contact the DHCS California Point of Contact (POC), Therese Llanes, at SectionQPOC@dhcs.ca.gov or

(916) 558-1770 if you require additional information.

RESOURCES

- Consumer Resources from CMS (Center for Medicare & Medicaid Services).
- “Your Right to Get Information About Returning to the Community Brochure”, developed by CMS. It explains to the resident why they are being asked by the facility staff whether they want more information about the possibility of returning to the community. There is a place in

the back of the brochure for contact information for the long term care ombudsman program; [http://www.medicare.gov/publications/pubs/pdf/11477/pdf](http://www.medicare.gov/publications/pubs/pdf/11477.pdf).

- Your Discharge Planning checklist-created by CMS for individuals and their caregivers preparing to leave a hospital, nursing home, or other health care setting; <http://www.dhcs.ca.gov/services/ltc/Pages/MDS3/section.aspx>.

Section S & California POLST... continued from page 2

The California Department of Public Health released All Facility Letters (AFLs) 10-25, 10-42 and 11-26. These AFLs discuss the MDS and POLST and provide instructions on how to code the POLST responses on the MDS, when applicable. It is important to remember, until further notice, that each item in Section S must have a response in order to avoid rejection when you submit the file.

An updated POLST form was developed by EMSA and took effect on April 1, 2011; however any older POLST forms completed prior to April 1, 2011 remain active and in effect. Residents do not have to complete new POLST forms.

Quick links where you can learn more information about POLST: www.caPOLST.org and www.CoalitionCCC.org.

The Coalition for Compassionate Care of California (CCCC) is a non-profit partnership of more than 95 regional and statewide organizations prompting high quality, compassionate end-of-life care for all Californians. The CCCC provides leadership and oversight for POLST activities in California with support from the California Healthcare Foundation.

Just remember that POLST is a voluntary form but Section S of the MDS 3.0

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MDS 3.0 Updates

The use of dashes in completing MDS assessments:

CMS has reviewed MDS 3.0 submissions and found dashes were used in 40% of assessments. This does not only include discharge assessments but also for QI items like pain, mood, and pressure ulcer on PPS and OBRA assessments.

Excessive use of dashes can adversely impact the accuracy of Nursing Home Compare Quality

Measures and CMS’s Five Star Quality Rating system. CMS is performing further analyses of the dash submission data. Meanwhile, please double check your use of dashes. Manual Update was revised and the use of dashes should be rare. Additional info is here: <http://www.cms.gov/NursingHomeQualityInits/Downloads/MDS30TheUseOfDashes.pdf>

The 2011 RAI User’s released on

6/2/11. You can access it at: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage.

For RUGs IV or SNF PPS Questions and Concerns;

<http://www.cms.gov/SNFPPS/>

For other information such as vendor issues, technical questions, bulletins, and question and answers, continue to use: <https://www.gtso.com/mds30.html>



What you should know about OBRA Assessment Schedules

Timing will be shortened for completion and submission of OBRA required assessments. Chapter 2 of the MDS 3.0 RAI Manual contains a chart with the RAI OBRA-required Assessment Summary. Facility coordinators will

need to adjust to the new requirement of scheduling assessments ARD to ARD. In addition, facility Master Schedules must be reviewed and revised to accommodate the new requirements. For example, the new assessment required for Death

in facility (non-comprehensive) must be completed no later than 7 calendar days from the event. This MDS assessment must then be transmitted no later than 14 days from the event (death).

An MDS Golden Rule—The Rule of Three

Instructions for the Rule of Three: 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.

For example: If a resident requires (3) extensive assistance three times and (2) limited assistance three times then you code the

level as (3) extensive assistance .

The exceptions are as follows:

(4) Total dependence –the activity must require full assist every time.

(8) Activity did not occur –the activity must not have occurred at all.

When an activity occurs at various levels, but not three times at any given level, apply the following rule:

When there is a combination of full staff performance and extensive assistance, code (3) extensive assistance .

When there is a combination of full staff performance, weight-bearing assistance and/ or non-weight-bearing assistance, code (2) limited assistance.

If none of the above are met, code (1) supervision.

Coding levels of care in column one and column two in MDS 3.0 Section G does not differ from coding on the MDS 2.0.



Care Area Assessments (CAAs)

The Care Area Assessment (CAA) is the new “Resident Assessment Protocol” from MDS 2.0.

The CAA process is a decision facilitator, which should lead you to a more thorough understanding of the areas of concern triggered by the MDS for further review. The CAA expands your assessment findings from the MDS, and then has you chart your thought process so it can be followed by others.

The first step in completing a CAA is to identify what MDS items triggered the CAA and why. Using Chapter 4 of your RAI manual or using your MDS software will help with this. Determining why

these MDS items triggered the CAA focuses your assessment and ensures that what triggered is assessed appropriately. There are 4 types of triggers that can change the focus of the CAA review.

1. Potential Problems: These factors suggest the presence of a problem that warrants additional assessment and consideration of a care plan intervention.

2. Broad Screening Triggers: These factors assist you in identifying hard-to-diagnose problems. Because some problems are often difficult to assess in the elderly population, certain triggers have been broadly defined

and consequently may have a fair number of false positives (i.e., the resident may trigger a CAA that is not automatically representative of a problem for the resident).

3. Prevention of Problems: These factors assist staff in identifying residents at risk of developing particular problems.

4. Rehabilitation Potential: These factors are aimed at identifying candidates with rehabilitation potential.

Use the triggers and your critical thinking skills to “work the CAAs” in order to help you have the best assessment for each resident and thereby the best care you and your facility staff can provide.

Changes in MDS 3.0 Submissions

A major change in the way nursing facilities submit MDS 3.0 records was to take place in June. We are still awaiting final information. Watch this website:

<https://www.qtso.com/cmsnet.html>

For information regarding the “Notice: H@ Login Procedure Changing” an-

ouncement. As of 6/29/11 it says: CMS is transitioning the CMSNet connectivity from AT&T to Verizon. This transition will affect your h@ login ID and will streamline the steps to connect. Your login ID for all other accounts (CASPER Login ID and State Login ID) will not be affected.

The CMSNet migration will be completed by the end of CMS’ Fiscal Year 2011. A migration schedule for providers will be posted as soon as it becomes available. In the meantime, continue to connect as normal until further instructions are posted.

Changes are hard but changes can also be a good thing.

RAI and MDS Q & A’s

Q: Is it all right to do the interviews after the ARD? Personnel may not be available if the ARD is set, e.g., on a Sunday.

A: Any data gathered after the ARD may not be recorded on the MDS. The resident interviews must be done during the look-back period. It is strongly recommended that some be done on the ARD or the day before, but this is not an absolute requirement. In this situation, the interviews could be done on the Friday prior to the ARD. Even better, personnel who are working on the weekend could do the interviews. It is not required that they be done by the RNAC.

Q: How should the interview items be handled on the discharge assessment when the resident is sent to the hospital in an emergency situation?

A: The various resident interview items should be dash-filled. Do not do the staff interviews as a substitute.

Q: What MDS records need to be completed on the resident’s return if the resident was hospitalized after a 5-day/Return anticipated discharge were completed? What should the response be in A1700 on her/his reentry?

A: The first record would be an Entry tracker (A0310F =01) with A1700 = 1 Admission. This is

required because the Admission assessment was not completed during the resident’s prior stay. If the resident was continuing in a Medicare Part A stay, a Medicare Return/Readmission (A0310B = 06) would need to be completed, probably best done in combination with the Admission assessment. Even if the resident’s condition seems to indicate that she might need a Significant Change assessment, the Admission assessment must be done first since no comprehensive assessment has been completed.

Q: What is the appropriate entry in A2400C End Date of Most Recent Medicare Stay if a resident in a Part A stay must return to the hospital?

A: The Discharge Date (A2000) would be entered in A2400C on the Discharge Return Anticipated assessment. If the resident returned in a Part A stay, the date of reentry would be coded at A2400B Start Date of Most Recent Medicare Stay. (p. A-25-27).

Q: Documentation is required for every shift to support a positive entry at M1200A Pressure Reducing Device – chair. How should this be handled for shifts when the resident is not in the chair, e.g., 11 – 7?

A: Documentation in the record should be complete and consistent. Use your facility policy for charting that an event did not occur, e.g., enter NA for Not Applicable, circled

initials, etc.

Q: Must there be documentation every shift for a Turning/Repositioning program (M1200C)?

A: There are several requirements to support a turning/repositioning program in the RAI Manual on page M-33: “Includes a consistent program for changing the resident’s position and realigning the body. “Program” is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the resident’s needs.” The program must be specific as to the approaches for changing the resident’s position and realigning the body including the specific intervention and frequency. Progress notes, assessments, and other documentation should support that the program is monitored and reassessed to determine the effectiveness of the intervention. In addition, the same federal regulation (42 CFR 483.25(c)) that was discussed on the teleconference in relation to pressure-reducing devices also applies to this item: There must be evidence that the intervention was implemented and monitored consistently over time and across all shifts.

In short, though documentation of every shift is a requirement, there are many other pieces that must be put in place to support a turning/positioning program.



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Send your questions and ideas for this newsletter to:
State RAI Educational Coordinator: (for RAI/MDS questions)
Susana Belda, RN, HFEN

OR
State Automation Coordinator (for Software/IT/Technical questions)
Janet Lynd, Data Processing Manager

Phone: (916) 324-2362 or
(800)-236-0747

Fax: (916)552-8965

E-mail: mdsoasis@cdph.ca.gov

References:

- ◆ 2011 RAI User Manual Updates May 2011
- ◆ 2010 RAI User manual Train the Trainer Conference- July 2010
- ◆ 2011 RAI State Coordinator Conference- February 2011
- ◆ CMS All State Teleconference Minutes— May 2011 & April 2011

Section S & California POLST... continued from page 4

is mandated by the State of California.

MORE MDS Q&A's

Q—If the resident does not have a POLST what would be the response to section S0940A?

A—You would code "0" which means "No" if a POLST is not available in the resident's chart.

Q— If the resident has a POLST and an Advance Directive (AD), which one would the facility follow?

A—The most recent and updated AD. Facilities should make sure each resident's AD coincides with the POLST form.

Q— If the resident has both an advanced directive and a POLST how do you answer Section H?

A—Answer the question as stated, i.e. Is Advance Directive available & reviewed?

Q— What do you do for a resident who goes in and out of the facility on a frequent basis and a return is expected within 30 days?

A—This status still requires an Entry Tracking Record each time the resident returns to the facility and a discharge assessment each time the resident is discharged. The nursing



home may combine the admission assessment with the discharge assessment when applicable.

Q- A resident had a prior Discharge Assessment completed that indicated the resident was expected to return, then we learned that resident would not be returning to the facility. Is it necessary to inactivate the assessment to a discharge return not anticipated?

A—There is no Federal requirement for inactivation of resident's record nor to complete another discharge assessment. This may be a state specific requirement and the State of California does not require this.

Q— When transferring a resident to another SNF should the sending facility include a copy of the most recent MDS with transfer paperwork?

A—Page 2-5 of the RAI Manual states as the first point under Resident Transfers: "When transferring a resident, the transferring facility must provide the

new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of care." It's not only a good idea to include a copy of the most recent MDS, it's a requirement! On the same page, it states "The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred."

Please send your questions to:

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We strive to get back to you within 3 working days when we are in the office.