

# Preparing for MDS 3.0

Information you can use from the DRAFT MDS 3.0

Updated for MDS 3.0-Version 26, released May 2009

Implementation of MDS 3.0 is now October 2010. At the same time, the Medicare Prospective Payment system will implement a revised payment system, RUG-IV. This was called for in the Proposed Rule for SNF PPS published May 1, 2009. CMS' intent in implementing RUG-IV is to improve accuracy based on current medical practice and updated staff resource data obtained during the STRIVE study, and not to decrease or increase overall expenditures.

It may be too early to start training, but it's not too early to start planning your facility's implementation. Keane Care is designing and coding with the understanding that revisions will be needed after the final versions are released. Experience has taught us that it's better to revise than start from scratch with deadlines looming.

The draft MDS 3.0 form, Version 26, released May 7, 2009 has dozens of changes compared to drafts released on October 23, 2008 and April 2008. Differences in MDS 3.0-Version 26 include changes in how therapy is counted, renames RAPs to CATs (Care Area Triggers), and requires facilities to transmit MDS data to the national CMS system instead of the States, within 14 days after the facility completes an MDS.

CMS tested the revised RUG-IV system against RUG-III, using 2007 claims data and found that the RUG-IV model would produce lower overall payments. In keeping with their goal to not increase or decrease payment, CMS proposes to adjust the weights to keep payment under both systems the same.

## Next Steps toward Implementation

The MDS is a critical part of CMS' program for skilled nursing. Its data is used for RAP/CATs, payment, surveys, and Quality Measures and all will have to be revised to work with MDS 3.0. In the timeline CMS released in April 2009, officials announced this schedule:

- July 31, 2009 - Final SNF PPS Rule published
- October 2009 - Publish:
  - Final MDS 3.0 Data Specifications, including RUGs, RAP/CAT triggers, and QM/QIs
  - MDS 3.0 data elements including Admission, Quarterly and Discharge MDS forms
  - MDS 3.0 RAI User's Manual
- Feb/March 2010 - Train-the-Trainer Educational Forums

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*It may be too early to start training, but it's not too early to become familiar with MDS 3.0 and start planning your facility's implementation. Keane Care is designing and coding the draft MDS 3.0 now. Experience has taught us that it's better to revise than start from scratch with deadlines looming.*

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- April/May 2010 - SNF PPS Proposed Rule published
- July 2010 - Final SNF PPS published
- September 2010 - National Quality Forum endorsement of Quality Measures based on MDS 3.0
- October 1, 2010 - MDS 3.0 and RUG-IV Implementation

## Testing of the draft MDS 3.0

Onsite testing of the draft MDS 3.0 was conducted in 2007 and no more testing is scheduled. In all, 3800 residents participated, first in 20 Veterans Administration nursing homes and later in 71 facilities in NJ, PA, NC, GA, TX, CA, IL, and CO.

For comparison residents were assessed using both MDS 2.0 and 3.0 with all start and stop times recorded for each. Assessors were surveyed for their opinions. MDS 3.0 is based on that testing and feedback from experts and assessors. For more information on testing and results, refer to the MDS 3.0 Final Report from Rand. The link is at the end of this paper.

## MDS 2.0 Problems and Goals for MDS 3.0

MDS 2.0 had a problem with unclear wording, leaving some items open to interpretation. The solution was to rewrite, with a goal of clarity and relevance rather than brevity.

Another problem was that MDS 2.0 tried to do too much. The Technical Expert Panel recommended that the MDS focus on initial screening for common and often-missed geriatric syndromes. Follow-up is the job of RAPs/CATs and the care plan.

CMS' goals for MDS 3.0 are to

- Increase the resident's voice through resident interviews
- Improve the accuracy and validity of the tool
- Introduce advances in assessment measures
- Increase the clinical relevance of items

## Therapy: Changes due with RUG-IV

Because approximately 90 percent of the days of service for Medicare Part A SNF stays include therapy, CMS looked carefully at utilization patterns and changes in the practice of therapy identified through the STRIVE research in developing RUG-IV and MDS 3.0. In the Proposed Rule for SNF PPS published May 1, 2009, CMS includes several changes in how data is collected through MDS 3.0 that will affect payment for therapy.

One modification is to change how residents qualify for RUGs by eliminating the look-back periods for MDS 2.0 Section P1a (MDS 3.0 Section O00100). With MDS 3.0, data will be collected on items received after admission separately from items received in the hospital before SNF admission. Items received while not a resident, such as oxygen therapy and IVs, would be used only for care planning and not payment.

Another proposed change is to count concurrent therapy differently. Concurrent therapy is when one therapist treats multiple patients at the same time with patients performing different activities. Under RUG-III concurrent therapy is counted the same as that delivered 1:1. For RUG-IV and MDS 3.0, therapists would allocate/divide minutes among the patients receiving concurrent therapy. A method for doing so was not defined. CMS is accepting comments on this issue.

CMS is proposing to delete Section T for MDS 3.0. This would eliminate counting therapy services that have been ordered and are scheduled to occur, but not necessarily delivered during the early days of the patient's SNF stay.

Under MDS 2.0 and RUG-III, SNFs must complete an OMRA (Other Medicare Required Assessment) 8 to 10 days following cessation of all therapies for residents in Rehab RUGs. Therapy started in the middle of a payment period does not trigger a change in payment. For MDS 3.0 and RUG-IV, CMS proposes that the OMRA signals the start and the end of therapy. A SNF would have the option of completing an OMRA with an ARD set 5 to 7 days from the first day therapy is provided.

## RAPs become CATs - Section V

In draft MDS 3.0-Version 26 released in May 2009, CMS included Section V - Care Area Trigger (CAT) Summary that lists 20 CAT problem areas that are the same as the 18 RAPs with the addition of Pain and Return to Community Referral. MDS items will continue to trigger CATs. The triggers for CATs have not yet been released.

At the May 28, 2009 Open Door Forum, CMS officials stated that for MDS 3.0, providers will have more choice in the clinical guidelines and source materials they use to "work the RAPs." Facilities may use the clinical care guidelines of their choice to develop the care plan. The RAI manual for MDS 3.0

will include CAT outlines as they have for the RAPs as well as links to free government-developed care guidelines.

As in MDS 2.0, facilities are required to provide a CAT summary with location and date of CAT assessment information.

## Standardize Look-backs and Separate Items Present on Admission

A stated goal for MDS 3.0 is to standardize look-back periods. Draft materials released to date indicate that specifics are not in place yet. For example, the look-back period for Section I - Active Disease Diagnosis changed to 7 days on MDS 3.0-Version 26 from 30 days on earlier drafts. The look-back for Pain Management - Section J, is 5 days on MDS 3.0-Version 26 and 7 days on the previous draft.

The draft MDS 3.0 forms include more questions to distinguish resident status before and after admission than in MDS 2.0. The latest forms include a new item, "Is this assessment the first (OBRA or PPS) since the most recent admission." (A0310F)

## Resident Interviews

One of the major goals in creating MDS 3.0 was to increase the resident's voice by introducing more resident interview items. The Rand report says that asking residents directly about how they feel and about their preferences is an important way to convey respect for the individual resident and is fundamental to high quality care and to quality of life.

Sections of the draft MDS 3.0 that contain resident interviews:

- Cognitive Patterns - Section C
- Mood - Section D
- Preferences for Customary Routine & Activities - Section F
- Pain - in Health Conditions - Section J
- Return to Community/Overall Goals - Section Q

## Faster and More Accurate

Because of unfamiliarity with the MDS 3.0 it was believed it would take assessors longer to complete than MDS 2.0 – but no, the average time to complete the tested MDS 3.0 was 61.5 minutes (including 9.2 minutes spent on resident interviews), compared to 111.6 minutes for MDS 2.0. National testing showed MDS 3.0 reduced time to complete by 45 percent.

Draft MDS 3.0 assessments were more accurate than MDS 2.0 on cognitive, depression, and behavior items when the same residents were assessed using a third set of criteria.

The Rand report pointed to these sections as receiving major revisions in MDS 3.0 and devoted a chapter to each section.

- Cognitive Patterns - Section C
- Depression Items - Section D
- Behavior Items - Section E

continued

- Customary Routine - Section F
- Gait and Fall Items - Section G and J
- Pain - Section J

## Cognitive Patterns – Section C

The draft MDS 3.0 Cognitive Patterns section includes two assessment tools that in testing were found to yield more accurate results than MDS 2.0. Assessors reported increased confidence in the accuracy of assessment by using the objective tool compared to the MDS 2.0 that asks for a summary of their observations.

The Brief Interview for Mental Status (BIMS) is used to test memory in a resident interview. The draft MDS form released in October 2008, adds “Conduct interview on day before, day of, or day after Assessment Reference Date.” In testing, 90 percent of residents were able to complete the BIMS.

In the interview residents are asked to repeat three words, name the year, month and day of the week, and recall the three words. If staff judge the BIMS should not be conducted, they assess the resident based on their observations.

In MDS 3.0-Version 26, Procedural Memory, C1100, was deleted.

For Section C11-Delirium, MDS 3.0 uses the Confusion Assessment Method© (CAM,) a standard instrument for detecting delirium. It is completed by staff, based on their observations during the BIMS and on their review of the medical record. Results of probable delirium found by MDS 3.0 testers were closer to prevalence rates reported in independent national tests than with MDS 2.0.

## Mood - Depression Items - Section D

Geriatric experts and associations have concluded that MDS 2.0 Section E was not adequate for depression screening. To replace it, draft MDS 3.0 uses the PHQ-9©, Patient Health Questionnaire, a checklist of nine symptoms of depression that is completed as a resident interview.

Although widely used in community and hospital settings, there were questions about the effectiveness of PHQ-9 with nursing home populations. Testing of the PHQ-9 in draft MDS 3.0 found that it was feasible to use in an interview, even with residents with moderately severe cognitive impairment. This tool also can help distinguish between residents who are responding to care and those who are not and probably require change of their treatment.

Feedback from testers of PHQ-9 was positive, with 88 percent rating the interview items as better than MDS 2.0 at capturing mood, 84 percent saying that it could inform care plans, and 86 percent reporting that the interview items provided new insights into resident mood.

In testing, 86 percent of residents completed the PHQ-9. Staff completed observational PHQ-9 reports for 92 percent of the residents who did not complete the interview. The staff-completed screening included an additional item on being short-tempered and easily annoyed.

Instructions on timing (Conduct interview on day before, day or or day after ARD) were deleted in MDS 3.0-Version 26.

Section D3 – Total Severity Score is the sum of responses, including frequency, and it will be totaled for you by Keane Care software. Possible scores are between 0 and 27; a score of 99 means it's an incomplete interview and must be completed by staff assessment. The key to the scores:

Score	Depression Severity measured by PHQ-9
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

## Behavior

CMS-funded consultants worked closely with both providers and resident advocates to identify labels and groupings that would support better care planning and avoid stigma for residents with physical, verbal, and/or other behavioral symptoms such as hitting and threatening. In a national sample of SNF residents, 28 percent of females and 35 percent of males had at least one behavioral symptom.

Draft MDS 3.0 Section E, Behavior, includes items on Psychosis (with definition of hallucinations, illusions and delusions), Rejection of Care, Wandering, and an assessment of all behavioral symptoms compared to the prior assessment (same, improved, worse, or not applicable).

With draft MDS 3.0, if the symptoms are not present, you skip items about their impact. In the form released in October 2008, look-back periods for all items were dropped.

## Customary Routine Items – Section F

Because they were perceived as not helping with care planning, most of the questions in MDS 2.0 AC, Customary Routine, and Section N, Activity Pursuit, were dropped from draft MDS 3.0. The new section F is a resident interview that may be completed by a family member or significant other.

Assessors in the VA pilot tested existing instruments and possible items for capturing the importance a resident assigns to an item. Testing proved that older adults prefer multiple response choices when a question cannot be answered by yes or no. Testers reported that a new choice of “important but can't do” made it easier for residents to express themselves.

If an interview could not be completed (three answers of “No response”), staff assess the resident’s preferences. In testing, 84 percent of residents completed this section, 4 percent were completed by a significant other, and 11 percent were not completed. Testers were satisfied with this new section, with 81 percent rating it more useful than MDS 2.0 for care planning and 77 percent for activity preferences.

## **Gait and Falls Items in Section G: Balance and Section J: Falls**

Experts agreed that the MDS could be improved to help reduce the number of falls. Falls are a serious problem, with 45 to 70 percent of nursing home residents having a fall, 30 to 40 percent falling two or more times, and 11 percent experiencing serious injury. Studies conducted on falls have found that:

- a history of falling predicts future falls
- abnormal balance and gait place increase risk of falls
- some components of gait and transition relate to fall risk

Draft MDS 3.0 Section J separates questions on falls into a fall history on admission and falls since last assessment, if any. For residents with falls since the last assessment, data is collected on numbers and outcomes of falls. It distinguishes between 0, 1, and 2 or more falls. If 2 or more, residents are at substantially higher risk for future falls.

### **Balance in Section G**

Input from Physical Therapists and experts on falls resulted in balance items designed to guide staff in identifying parts of gait and transition that relate to fall risk. Balance is rated during moving from seated to standing, walking, turning around, moving on and off toilet, and surface-to-surface transfer. Training videos will help staff assess gait and balance.

Testers rated the balance items as clear (88 percent), helpful in identifying residents at risk for falls (83 percent), and easier to score (87 percent).

### **Pain Items in Section J**

Studies have shown that MDS 2.0 does not support good pain assessment and management. Research indicates that 40 to 85 percent of LTC residents have persistent pain.

Self-reporting has been found to be feasible for nursing home residents and is considered the most reliable way to assess pain. Draft MDS 3.0 Section J includes an item that is to be answered by staff about the resident’s pain management, a resident interview, and a staff assessment if the resident cannot complete the interview. For pain intensity, the resident is asked to rate theirs using either a scale with numbers or words.

Staff feedback on draft MDS 3.0 pain items was positive with 88 percent rating them better for capturing pain, 85 percent reporting new insights into at least one resident’s pain, and 94 percent reporting that the information from the interview could inform care plans.

When the assessment was completed by resident interview, 64 percent reported pain in the past five days. When assessed using MDS 2.0, item J2, only 50 percent of the same sample of residents reported pain less than daily or daily.

## **Other Areas with Significant Changes**

### **Activities of Daily Living (ADL) - Section G1**

In draft MDS 3.0 the ADL section is simplified with instruction to code for most dependent episode. It also combines the separate coding for Self-Performance and for Support from MDS 2.0 into one response.

The questions now are more consistent with how the tasks are performed, for example dressing the upper body is separate from lower-body dressing in the draft MDS 3.0.

In MDS 3.0-Version 26, Bathing Self-Performance is coded on a separate scale and the Bedfast item, G0800, was deleted.

### **Continence in Bladder and Bowel - Section H**

Draft MDS 3.0 clears up confusion about wording of continence items such as coding residents with catheter as continent. It covers trial toileting programs, and replaces “usually” with definite numbers. The fecal impaction item was dropped from MDS 2.0. In response to expert input, constipation is addressed with a yes/no response to bring staff attention to it as a common side effect of medications and immobility, and as a sign of possible dehydration.

### **Diagnoses – Section I**

To help prevent coding discrepancies, descriptions were changed in draft MDS 3.0, for example the criteria for Active Disease Diagnoses was changed to read “Active diseases in last 30 days,” removing “Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments...).

The statements in MDS 3.0 include more information in parentheses to improve reliability and decrease use of the “other” category.

### **Swallowing/Nutritional Status – Section K**

Experts believe the MDS can help staff detect swallowing problems that might be addressed with therapy or with dietary modifications. To accomplish that a Swallowing Disorder item (K0100) was added for staff to list the symptoms of possible swallowing disorders.

The Body Mass Index item that was included with Height and Weight was deleted from MDS 3.0-Version 26.

Nurses who tested MDS 3.0 were positive about the change, with 93 percent believing that the swallowing checklist would improve assessment and 96 percent believing that it clarifies signs and symptoms of a swallowing disorder.

### **Oral/Dental Status – Section L**

A staff examination of the mouth was added in response to the urging of the American Dental Association. The draft MDS 3.0 includes six possible groups of findings such as dentures, inflamed gums, and mouth pain as well as unable to examine.

### **Skin Changes – Section M**

Experts agreed that MDS 2.0 items did not deliver necessary information about pressure ulcers. In response MDS 3.0:

- Does not allow reverse staging
- Unstageable ulcers are assessed separately
- Staging is based on deepest anatomical change
- Information is collected on pressure ulcers present on admission
- Pressure Ulcer Scale for Healing (PUSH) items were added for tissue type for most advanced stage and measurements (length and width) at each stage for 2-4

New items in MDS 3.0 include determination of pressure ulcer risk and date of oldest Stage 2 pressure ulcer.

### **Medications - Section N**

In MDS 3.0-Version 26, Section N0350 was added for Insulin: number of days injections were received and number of days the physician changed the resident's orders in last 7 days or since admission. The list of Medications Received, N0400, was changed in MDS 3.0-Version 26 to include Antibiotic and Diuretic.

### **Special Treatments - Section O**

Section O0250 in draft MDS 3.0-Version 26 includes an item to enter the date that Influenza Vaccine was received.

In Section 0400 - Therapies, Therapy Start and End Dates are required for Speech/language pathology/audiology services, OT, and PT.

### **Restraints - Section P**

Restraint information now has its own section with revisions from MDS 2.0 focusing on clarification. A definition of physical restraints is on the form and items are divided into Used in Bed and Used in Chair/Out of Bed. A choice was added to both for Other.

Testers (91 percent) reported that dividing restraints into bed and chair made coding clearer and easier.

### **Participation and Goal Setting - Section Q**

An item was added to ask the resident about their goals for the stay. Experts, consumers, and clinicians preferred this to an item about advance directives, believing that sources other than the MDS are more reliable.

The MDS 2.0 item was changed to an interview question for the draft MDS 3.0: "Do you want to talk to someone about the possibility of returning to the community?"

MDS 3.0-Version 26 added items to Section Q on Discharge Plan, Return to Community, and Referral. In the CMS Open Door Forum of May 28, 2009, officials reported that they are working to identify Local Contact Agencies referred to in the Referral item. Those agencies will serve as referral sources for facility staff and residents. The MDS 3.0 RAI manual will provide a listing and further guidance.

### **Therapy Supplement for Medicare PPS - Section T**

The Proposed Rule on SNF Payment published May 2009 states that this MDS 3.0 section on Ordered Therapies will be deleted.

### **Documents Available from the CMS MDS 3.0 Website**

The most recent MDS and Medicare PPS documents are available on these CMS Website:

[www.cms.hhs.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp](http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp)

[www.cms.hhs.gov/snfpps](http://www.cms.hhs.gov/snfpps)

The Proposed Rule for FY 2010 SNF Medicare Prospective Payment System is here:

[www.nasl.org/files/members/snfpps-5-1-09.pdf](http://www.nasl.org/files/members/snfpps-5-1-09.pdf)

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