MDS From the Beginning

Presented for the DOH by
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Updates

- Errata document and replacement pages
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-3-RAI-Manual-v-1-1-2-R-Errata.pdf
- 5 Star Quality Rating System upgrade:
  http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification;CertificationandComplianc/FSQRS.html
- 10/1/15 Data Specifications and ISCs
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

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1980s

- Costs, quality of care, NF reputations, all in trouble
- Difficulty finding beds for MA residents
- Institute of Medicine Study on Nursing Home Regulation – 1986
  - Widespread quality of care problems.
  - Recommended strengthening of federal regulations for nursing homes.

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Nursing Home Reform Legislation

- Passed as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87)
- Important provisions:
  - Resident rights
  - Quality of life
  - Quality of care
  - PASRR
  - Assessment of LTC resident's functional capacity with a minimum data set

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Development of the MDS

- HCFA responsible for implementation.
- "comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity"
- MDS 1.2 implemented in 1990.
- MDS 2.0 introduced in 1996
  - Gradual expansion due to development of computer systems
  - Fully implemented in 1998 with electronic submission to individual state servers provided by CMS; data then uploaded to CMS
  - Medicare Part A payment based on Resource Utilization Groups (RUGs) began in 1998

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Development of MDS 3.0

- Goals for MDS 3.0
  - Introduce advances in assessment measures
  - Increase the clinical relevance of the items
  - Improve the accuracy and validity of the tool
  - Increase user satisfaction
  - Increase the resident's voice by introducing more resident interview items
- MDS 3.0
  - Implemented October 1, 2010
  - Extensive revisions to form and content
  - Updated RUG classification system for payment

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Electronic Submission

- Data now submitted to national QIES Assessment Submission and Processing System (ASAP)
- In PA, new process for CMI Reports: Nursing Facility Report Portal
- Final Validation Reports continue to detail acceptance or rejection of MDS records and errors found

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Resident Assessment Instrument

- MDS 3.0
- CAA Process
  - CATs
  - CAA
  - CAA Resources
  - CAA Summary (Section V of MDS 3.0)
- Utilization Guidelines
- Primary Purpose: As an assessment tool used to identify resident care problems that are addressed in an individualized care plan

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Nursing Home Responsibilities

- Required by OBRA 1987 for Medicare and/or Medicaid certified nursing homes
- RAI must be completed for any resident including:
  - All residents regardless of payer
  - Hospice residents
  - Short-term or respite residents
  - Special populations
  - Swing bed residents

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Completion of the RAI

- Federal regulation 42 CFR 483.20 requires that:
  - The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity
  - The assessment accurately reflects the resident's status
  - A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
  - The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts

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Regulatory Requirements for the RAI

- The statutory authority for the RAI is found in the Social Security Act (SSA)
  - Section 1819(f)(6)(A-B) for Medicare
  - Section 1919(f)(6)(A-B) for Medicaid
- As amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) and other legislation

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Uses of MDS Data

- Medicare and Medicaid Payment Systems
- Monitoring the quality of care/quality measures (QM) to assist:
  - State survey and Certification staff in identifying potential care problems
  - Nursing home providers with quality improvement activities/efforts
  - Nursing home consumers in understanding the quality of care provided by a nursing home (5-Star, NHCompare)
  - CMS with long-term quality monitoring and program planning

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Privacy of MDS Data

- 42 CFR Part 483.20 requires (Medicare and/or Medicaid) providers to collect and submit resident data
  - MDS data is protected under the conditions of participation (COP)
  - CFR 483.75 (1)(2)(3) and 483.75 (1)(2)(4)(i)(ii)(iii) allows release of resident clinical record data only when required by:
    1. Transfer to another health care institution
    2. Law (both State & Federal), and/or
    3. The resident

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Privacy Notice

- Privacy Act of 1974 protects the confidentiality of personal identifiable information and safeguards against its misuse
- All individuals whose data is collected and maintained in a federal database must be informed that the MDS data is being collected and submitted
- Notice is not a consent form
- Minimum amount disclosed

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Medicare

- Health Insurance Program for
  - people age 65 or older,
  - people under age 65 with certain disabilities,
  - people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
- It is an entitlement.
- Paid for by federal dollars so rules are the same throughout the country

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Medicare Part A Hospital Insurance

- No premium to pay
- Covers
  - Inpatient care in hospitals
  - Skilled care in nursing facilities
    - **3 day prior hospital stay**
    - **Need daily skilled care**
  - Hospice care
  - Home Health Care
- Reimbursement from MC Administrative Contractors (MACs); formerly the Fiscal Intermediaries

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Medicare Part B Medical Insurance

- Most pay a monthly premium
- Covers
  - Doctors' services
  - Outpatient care
  - Physical and Occupational therapy
  - Some home health care
  - Some supplies
- Must be medically necessary

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Other Medicare Types

- Part C Medicare Advantage Programs: MC Managed Care organizations that provide prescription drugs integrated with health care coverage.
  - A premium is charged
  - Payment comes from insurance company as defined by contract with NF
- Part D Prescription Drug Plan
- Medigap: Supplemental policies that help to cover expenses not included in these plans, e.g., deductibles.

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Medical Assistance (Medicaid)

- Based on income level
- Combination of federal and state dollars
- Federal government sets minimum levels of coverage state must provide
- Coverage varies from state to state

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MDS 3.0 RAI Manual V1.12R

- Offer clear guidance about how to use the RAI correctly and effectively to help provide appropriate care.
- Includes current item instructions
  - Read Table of Contents
- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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MDS 3.0 RAI Manual V1.12R

- Dated October 2014 with revisions released on October 9, 2014
- Scroll down to the bottom to a file labeled MDS 3.0 RAI Manual v.1.12R and Change Tables_October 2014.
- Question about completing A0410
  - Open file for Chapter A which includes updated information
  - Scroll down to Change Table

Contents of the RAI Manual

- Chapter 1 – RAI Introduction
- Chapter 2 – Assessments for the RAI
- Chapter 3 – Item-by-Item Guide to MDS 3.0
- Chapter 4 – CAA Process and Care Planning
- Chapter 5 – Submission and Correction of MDS Assessments
- Chapter 6 – MC SNF PPS

Appendices

- A – Glossary and Common Acronyms
- B – State Agency/RO Contacts
- C – CAA Resources
- D – Interviewing to Increase Resident Voice in MDS Assessment
- E – PHQ-9 Scoring Rules and Instruction for BIMS (when administered in writing)
- F – Item Matrix
- G - References
- H – MDS 3.0 Item Sets

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A Holistic Approach

- Holism is a philosophy which holds that, in nature, entities such as individuals and other complete organisms function as complete units that cannot be reduced to the sum of their parts
- Holistic medicine is comprehensive and total care of a patient, considering and caring for all needs including physical, emotional, social, spiritual and economic

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Considerations

- Sharpen your skills:
  - Clinical competence
  - Observational, interviewing and critical thinking skills
  - Assessment expertise
- Involve other disciplines: dietary, SW, PT, OT, ST, pharmacy, activities
- Work together to aid the resident to reach her highest level of functioning and maintain her sense of individuality

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Choices

- Who should participate in the assessment process?
- How is the assessment process is completed?
- How is the assessment information is documented while remaining in compliance with the requirements of Federal regulation and the RAI Manual?

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Documentation

- While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. (p. 1-8)

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Documentation (2)

- As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS

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Problem Identification Using the RAI

- Assessment: Taking stock of all observations from all available sources
- Decision Making: Determining with the resident/family/guardian, physician and IDT, the severity, functional impact and scope of a resident's clinical issues and needs
- Identification of Outcomes: Determining the expected outcomes forms the basis for evaluating resident specific goals, and interventions that are designed to help residents achieve these goals

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Problem Identification Using the RAI

- Care Planning: Establishing course of action that moves a resident toward resident-specific goals
- Implementation: Putting the specific interventions derived through interdisciplinary individualized care planning into motion
- Evaluation: Critically reviewing individualized care plan goals, interventions and implementation in terms of outcomes and need to modify the care plan

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RAI Process Results

- Residents respond to individualized care
- Staff communication has become more effective
- Resident and family involvement in care has increased
- Increased clarity of documentation

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Questions?

- Next teleconference: July 9, 2015
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