The National
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INFORMATION BRIEF:

CHANGES in the MDS 3.0:
FOR LONG-TERM CARE OMBUDSMEN

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ACKNOWLEDGMENTS

ABOUT THE AUTHOR

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ABOUT THE PAPER

PURPOSE

This document gives long-term care ombudsmen information about the primary changes in the updated version (3.0) of the Minimum Data Set (MDS). The MDS 3.0 will be used by certified nursing facilities beginning in October 2010. This document focuses on the changes that are most applicable to ombudsman advocacy, educational, and empowerment activities with residents and families. The information presented in this document is **not a comprehensive list** of all of the changes from the previous version, the MDS 2.0.

For a more thorough understanding of the resident assessment and care planning process and how ombudsmen can use these as advocacy tools, refer to *Using Resident Assessment and Care Planning As Advocacy Tools: A Guide for Ombudsmen and Other Advocates,* available from the National Long-Term Care Ombudsman Resource Center. Additional resources are included under Resources in this document.

BACKGROUND

All federally certified nursing facilities are required to provide care to attain or maintain the highest practicable well-being of each resident through the use of an assessment and care planning process. Since October 1990, facilities have been conducting resident assessments by using the Resident Assessment Instrument (RAI) developed by the Centers for Medicare & Medicaid Services (CMS)[1]. The RAI consists of three basic components: The Minimum Data Set (MDS), the Care Area Assessment (CAA) process and the RAI utilization guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.[2]

CHANGES

The information in this section pertains to the comprehensive assessment which is conducted upon admission, annually, and whenever there is a significant change in the resident's status. The comprehensive assessment consists of the MDS, Care Area Assessments, and the Care Plan. The content in this document comes from CMS training materials, instructional manuals, and reference documents listed in the Resources section.

Goals

The goals of the MDS 3.0 were to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, and increase the resident's voice by introducing more resident interview items. The national trial for the MDS 3.0 demonstrated that these goals were attained.[3]

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1   The Centers for Medicare & Medicaid Services was previously named the Health Care Financing Administration.

2   *RAI Version 3.0 Manual.* Chapter 1, 1.2. p. 1-4, July 2010. Centers for Medicare & Medicaid Services. http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage

3   Saliba, D., & Buchanan, J. *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0.* April 2008. p. 11.

MDS 3.0: CHANGES OMBUDSMEN NEED TO KNOW

Change from MDS 2	Explanation
Direct interviews with residents are essential to complete the MDS.	Perhaps the most significant advance in MDS 3.0 is the use of direct interview items to consistently elicit resident voice. Sections C. Cognitive Patterns, D. Mood, and F. Preferences for Customary Routines and Activities have structured resident interview questions as part of the assessment. The MDS has an icon in every section where a resident interview is necessary. "The resident interview items contribute to, but do not replace, day-to-day interactions. Although some worry that structured items dictate the content of resident and staff interactions, staff who used the structured items consistently report that the opposite occurs. Structured questions often bring up important issues for the resident and open up discussion between the resident and provider, creating an ongoing dialogue within which it is safe to report symptoms and care needs."[4]
Language information focuses on communication with health care professionals/staff	Section A1100. Language focuses on the need for an interpreter to communicate with a doctor or health care staff and the resident's preferred language if an interpreter is needed.
More detail about personal preferences and choices	Questions about a resident's customary routines and preferences for activities are combined in Section F. The customary routines is now an integrated part of the MDS instead of a section to be completed upon admission. The information is to be obtained by interviewing the resident. If a resident is unable to complete the interview, staff is directed to attempt to complete the interview with a family member or significant other. If the resident, family member or significant other cannot complete the section, staff complete it based on their interactions with and observations of the resident. The items in this section ask residents how important each activity is to them. This change captures the resident's current preferences (not routines during year prior to admission) and the degree of significance/importance that each activity has for the resident.

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4   Saliba & Buchanan. p. 3.

Definitions included	Definitions for several items that have been problematic are included on the form. Examples: Item E0100. Psychosis includes the definitions of each item. (A) Hallucinations (perceptual experiences in the absence of real external sensory stimuli) (B) Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Item E0800. Rejection of Care-Presence & Frequency asks, "Did the resident reject evaluation or care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences or goals." [5]
Items and language are more standardized across health care settings and consistent with current clinical standards	Items or language used in other health care settings in order to improve communication across settings and providers is used, e.g. nursing facilities and hospitals. Language in items has also been revised to reflect the standards applied in other settings. Example: Items included in the National Pressure Ulcer Advisory Panel's PUSH tool are used to describe pressure ulcers; new ADL items separate toilet transfer from toileting and upper body dressing from lower body dressing. The new delirium section is based on the Confusion Assessment Method (CAM), a set of items that has been validated for frail older adults in hospital settings. The MDS 3.0 CAM is informed by observations made during the brief interview for mental status, a structured cognitive assessment.
Language and grouping of items changed to support better care	Labels and groupings of items were changed to: better align with established factors for assessment, support better care planning and avoid stigma.[6] Example: Behavior symptoms labels were revised to: a) Physical Behavioral Symptoms Directed Toward Others; b) Verbal Behavioral Symptoms Directed Toward Others; c) Other Behavioral Symptoms not directed toward others. Impact on Resident items asked if the identified symptom: placed the resident at risk for physical illness or injury; significantly interfered with resident care; significantly interfered with resident's participation in activities or social interaction. Impact on others considers whether the symptom(s): put others at significant risk for physical injury; significantly intruded on the privacy or activity of others; significantly disrupted care or living environment. Another item, Rejection of Care, replaces "resists care" on the MDS 2.0.[7]

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5   MDS 3.0.
6   Saliba & Buchanan. p. 100.
7   Saliba & Buchanan. p. 96.

Care Area Assessments (CAAs) instead of Resident Assessment Protocols (RAPs)	Care Area Assessments (CAAs) replace the Resident Assessment Protocols (RAPs). The CAAs serve the same purpose and are very similar to the RAPs. Two key changes are listed, refer to the RAI 3.0 Manual Chapter 4, CAA Process and Care Planning, for additional information.

The CAAs include two new items, pain and return to the community referral. There are 20 CAAs that may be triggered for additional assessment with the MDS 3.0.

The explanatory narrative information about each CAA and questions to guide additional review are formatted differently from the RAPs. With the CAAs, the narrative information, the MDS trigger items, and guidance for further assessment are included in the manual chapter on the CAAs and care planning. Factors to consider when reviewing each CAA are contained in a checklist format to help achieve consistency of practice in each area and information gathering for documentation.

In conducting additional assessments as indicated by the CAAs, staff should use CAA resources provided by CMS[8], and/or follow their facility's chosen protocol or policy for performing the CAA. If a facility chooses to use other tools for completing the CAAs, the tools must be current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. |
| Section Q: Participation in Assessment and Goal Setting | This section asks about the resident's participation in the assessment process, goals and expectations for discharge, if the resident wants to return to the community, and if a referral to the local contact agency has been made. This section includes more specific information related to discharge planning and the resident's goals than the previous Section Q. Discharge Potential and Overall Status, on the MDS 2.0. The local contact agency is a state decision and designation. |
| Improvements in the accuracy of the Quality Indicators and Quality Measures (QIQM) | The MDS 3.0 offers improvements to clinical assessment that have the potential to enhance the accuracy and validity of a substantial portion of the QIQMs. The most important of these enhancements are in the area of depression assessment, pain, detection, assessment of cognitive impairment and behavior.[9] |

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8   Appendix C of the RAI 3.0 Manual.
9   Saliba & Buchanan. p. 164.

Nursing Home Compare and the Five Star Rating	With the implementation of the MDS 3.0, the assessment data that is part of the QIQMs will not be consistent with the existing data from the MDS 2.0. Until the MDS 3.0 has been implemented long enough to collect the data for reliable measures, the information on Nursing Home Compare, including the Five Star Rating will change. The last update with the MDS 2.0 Quality Measures will be January 2011. The data that is generated from the MDS will be removed from the CMS website for several months. The current projection for posting the QMs based on the MDS 3.0 is April/May 2012. The information that is not based on the MDS will remain on the website.[10]

TIPS FOR LONG-TERM CARE OMBUDSMEN

Learn about the Changes in the MDS3.0

- Take advantage of an opportunity to attend training on the MDS 3.0 with providers, surveyors, ombudsmen, and others.

- Use the materials listed in Resources and posted on the National Long-Term Care Ombudsman Center website (www.ltcombudsman.org) to focus on the sections of the RAI that are most pertinent to your work. Look up definitions and explanations as questions arise.

- Watch the Video on Interviewing Vulnerable Elders (VIVE) to see how facility staff is asked to conduct resident interviews and to refresh your interviewing skills. The video is available for instant viewing on You Tube at http://www.youtube.com/user/CMSHHSgov?feature=mhum#p/u/7/Ereawm4_F7k, or a DVD can be ordered from CMS by going to http://productordering.cms.hhs.gov. It is CMS Product No. 11479-CD.

Resident Interviews during the Assessment Process

- Encourage residents and family members to be prepared to participate in the assessment process. When appropriate, suggest areas that they may want to think about before the assessment such as what is important in their daily routine, what activities they want to pursue, what are their goals for care.

- As appropriate, support and encourage facility staff who are conducting the resident interviews. Gathering information from individual residents in a structured way may require different skills and ways of relating than is typical or comfortable for some staff. Remember that this will be a learning process for some individuals.

- Listen for misperceptions or concerns that residents may have regarding their ability to receive services with reasonable accommodations of individuals needs and preferences. The resident interviews related to preferences in daily life and activities ask about a number of areas of life and ask residents to indicate how important each one is. This interview process assists staff in getting to know each resident as an individual and should lead to more individualized care planning. A **potential unintended** consequence is that a resident may assume that their only choices are the activities and daily patterns/preferences that are included in the list of interview items. Another is that if an activity is not very important to a resident, then the

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10   MDS 2.0 to MDS 3.0 Transition Timeline, 05/25/2010. http://www.cms.gov/NursingHomeQualityInits/downloads/MDS302010ImplementationTimeline.pdf

resident cannot expect to be offered that choice or opportunity in the future.

- If residents or family members report problems with the assessment interviews, encourage them to talk with the appropriate facility staff. You may encourage a dialogue during a resident or family council meeting with key facility staff regarding the interview process.

Referral for Return to the Community

- Read the instructions for Section Q of the MDS 3.0 to understand the intent and the process that is to be followed and visit the CMS website section on the Community Living Initiative. The website lists the Point of Contact for Section Q referrals and a Return to Community Brochure. http://go.usa.gov/xTe. The brochure is not mandated to be given to each resident or family member. It is available as a helpful tool since the question about returning to the community is now being asked upon admission, quarterly and annually. Nursing homes will not receive hard copies of the brochure, so they will have to print it from the CMS website if they want to utilize it.

- Participate in meetings, training programs, and conference calls on this topic to stay informed. This is especially important related to activities in your state. Check with your State Long-Term Care Ombudsman for additional information.

- Visit the NORC website and read the Gazette for updates and announcements. NORC will make training and resources available on this topic for ombudsmen.

- Learn what agency/agencies are designated as the local contact agency in your state.

- If problems with the questions posed to residents, with the referral process and follow-up, work with the facility and/or your state ombudsman and the state licensing and certification agency to address the issues. Alert NORC to issues that are not resolved, as NORC is working with AOA to gather information on implementation of Section Q.

Care Planning

- Encourage and support residents and family members in participating in the care planning meeting which is the culmination of the resident assessment process. The change in the MDS offers an opportunity for a renewed emphasis on education about resident participation in care planning.

- Provide information to residents and family members regarding the care planning process and if they ask, assist them with their preparation for the meeting.

- Refer to **Resources** for information about care planning, especially care planning as an advocacy tool.

- Observe and reinforce positive changes in the care planning process that may occur as a result of increased dialogue between residents and staff during the assessment process. Share your observations with the state ombudsman and with NORC.

RESOURCES

CMS website, http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Numerous resources are available on this website. The most recent updates and new information are posted online. A few key resources are:

MDS 3.0 RAI Manual

MDS 3.0 training materials, slides, and instructor guides

VIVE: Video on Interviewing Vulnerable Elders, product number 11479-CD. Order *this* free resource from http://productordering.cms.hhs.gov

> This video provides an excellent overview of the primary changes in the MDS 3.0 with emphasis upon the resident interviews. Examples of interviewing skills, interviews with residents with and without cognitive impairments, and the new assessment tools are demonstrated. Some ombudsman programs are using this video in educational sessions for ombudsmen.

RAND MDS 3.0 Final Study Report and Appendices. 2008. (Saliba, D., & Buchanan, J. *Development and Validation of a Nursing Home Assessment Tool: MDS 3.0*) This report explains the rationale for all of the changes, how items were tested, the results of the tests, and recommends specific items for MDS 3.0. It contains a chart listing every change from the MDS 2.0 and a brief explanation of the rationale.

Section Q, Return to the Community. Information and a brochure for consumers is available on the CMS website by October 1, 2010. http://go.usa.gov/xTe

> The brochure was designed to respond to two key questions.
> 1. Why does the nursing home staff ask me if I want to talk to someone about returning to the community?
> 2. What will happen if I ask to speak with someone about returning to the community?

The National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) and the National Long-Term Care Ombudsman Resource Center (NORC) have several resources for ombudsmen, other advocates, and consumers related to resident assessment and care planning. The majority of the content based on the MDS 2.0 remains relevant, with the changes noted in this Information Brief. These resources will be updated to incorporate the changes with the MDS 3.0 and will be posted along with links to other resources on the MDS 3.0.

Consumer Fact Sheet, Assessment and Care Planning. http://www.theconsumervoice.org/advocate/factsheets

Burger, S.G., Fraser, V., Hunt, S., & Frank, B. *Nursing Homes: Getting Good Care There.* 2000. Available from The Consumer Voice.

Hunt, S., & Burger, S. *Using Resident Assessment and Care Planning As Advocacy Tools: A Guide for Ombudsmen and Other Advocates.* The Consumer Voice, formerly NCCNHR. Updated 1995. http://www.ltcombudsman.org/sites/default/files/ombudsmen-support/systemic-advocacy/Using-Resident-Assessment-and-Care-Planning-as-Advocacy-Tools.pdf