New MDS User Manual draft:

What long-term care providers need to know

Scott Heichel RN, RAC-MT, RAC-CTA, DNS-CT, CIC, QCP, IPCO
Director of Clinical Reimbursement
LeaderStat

Agenda

- SECTION A: Identification Information
- SECTION B: Hearing, Speech, and Vision
- SECTION C: Cognitive Patterns
- SECTION D: Mood
- SECTION E: Behavior
- SECTION F: Preferences for Customary Routine and Activities
- SECTION G: Functional Status
- SECTION GG: Functional Abilities and Goals
- SECTION H: Bladder and Bowel
- SECTION I: Active Diagnoses
- SECTION J: Health Conditions
- SECTION K: Swallowing/Nutritional Status
- SECTION L: Oral/Dental Status
- SECTION M: Skin Conditions
- SECTION N: Medications
- SECTION O: Special Treatments, Procedures, and Programs
- SECTION P: Restraints and Alarms
- SECTION Q: Participation in Assessment and Goal Setting
- CHAPTER 4: Care Area Assessment (CAA) Process and Care Planning

A quick note

On Monday, April 3rd, CMS released the much-anticipated DRAFT version of the new RAI User's Manual, which will take effect on October 1st, 2023. While providers typically experience RAI manual updates on an annual basis, this is the first manual release since version 1.17.1 went into effect on October 1st, 2019, due to the public health emergency.

Many of the changes in the manual are related to gender neutrality adjustments in questions, coding guidance, examples, steps for assessments, etc., while others are related to data that CMS will be collecting on the new MDS Item Sets

SECTION A: IDENTIFICATION INFORMATION

Intent: To obtain ***the reasons for assessment, administrative information, and key demographic*** inform ation to uniquely identify each resident, ***potential care needs including access to transportation, and*** the home in which ***they*** reside.

A1005. Ethnicity

- No longer a combined with Race question and has 7 answer options.
- Collection of ethnicity data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute-care settings.

A1010. Race

- This prior Race/Ethnicity question has been expanded and now separates Ethnicity and Race into two separate questions, with a focus on Hispanic, Latino/a, or Spanish origin and a greatly expanded Race question with 17 answer options.
- This change in the manual is related to CMS's focus on social determinants of health and the continued concern regarding racial disparities in health care and is an important step in improving quality of care and health outcomes.

SECTION A: IDENTIFICATION INFORMATION

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

☐	**A.** No, not of Hispanic, Latino/a, or Spanish origin
☐	**B.** Yes, Mexican, Mexican American, Chicano/a
☐	**C.** Yes, Puerto Rican
☐	**D.** Yes, Cuban
☐	**E.** Yes, another Hispanic, Latino/a, or Spanish origin
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

SECTION A: IDENTIFICATION INFORMATION

1. Ask the resident to select the category or categories that most closely correspond to their ethnicity from the list in A1005.
2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
3. Ethnic category definitions are provided only if requested in order to answer the item.
4. Respondents should be offered the option of selecting one or more ethnic designations.
5. Only use medical record documentation to code A1005, Ethnicity if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.
6. If the resident declines to respond, do not code based on other resources (family, significant other, or guardian/legally authorized representative or medical records).

SECTION A: IDENTIFICATION INFORMATION

- Code X, Resident unable to respond: if the resident is unable respond.
  - In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, including X. Resident unable to respond.
  - If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1005 as X. Resident unable to respond.

SECTION A: IDENTIFICATION INFORMATION

A1010. Race
What is your race?

↓ Check all that apply	
☐	**A.** White
☐	**B.** Black or African American
☐	**C.** American Indian or Alaska Native
☐	**D.** Asian Indian
☐	**E.** Chinese
☐	**F.** Filipino
☐	**G.** Japanese
☐	**H.** Korean
☐	**I.** Vietnamese
☐	**J.** Other Asian
☐	**K.** Native Hawaiian
☐	**L.** Guamanian or Chamorro
☐	**M.** Samoan
☐	**N.** Other Pacific Islander
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond
☐	**Z.** None of the above

SECTION A: IDENTIFICATION INFORMATION

1. Ask the resident to select the category or categories that most closely correspond to the resident's race from the list in A1010, Race.
2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
3. Racial category definitions are provided only if requested in order to answer the item.
4. Respondents should be offered the option of selecting one or more racial designations.
5. Only use medical record documentation to code A1010, Race if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.
6. If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

SECTION A: IDENTIFICATION INFORMATION

- Code X, Resident unable to respond: if the resident is unable respond.
  - In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, including X. Resident unable to respond.
  - If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1005 as X. Resident unable to respond.

10

SECTION A: IDENTIFICATION INFORMATION

A1250. Transportation

- This is a new item on the MDS and focuses on transportation impacting the resident's ability to go to medical appointments, meetings, work, or getting things needed for daily living, over the past 6 months.

A1805. Entered From

- This item has expanded in answer options from 10 to 13 choices to better prepare the provider to deliver the needed services and to assist in potential discharge planning.

A2105. Discharge Status

- This item has expanded in answer options from 10 to 14 choices to better prepare the provider in discharge planning.

SECTION A: IDENTIFICATION INFORMATION

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓ **Check all that apply**

☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

© 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part or whole without written consent from NACHC.

SECTION A: IDENTIFICATION INFORMATION

1. Ask the resident:
   - "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?"
   - "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"
2. Respondents should be offered the option of selecting more than one "yes" designation, if applicable.
3. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
4. Only if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative may provide a response for this item, use medical record documentation.
5. If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

SECTION A: IDENTIFICATION INFORMATION

A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased** → Skip to A2200, Previous Assessment Reference Date for Significant Correction
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

14

14

SECTION A: IDENTIFICATION INFORMATION

A2105: Discharge Status

- This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning.

SECTION A: IDENTIFICATION INFORMATION

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1 and A2105 = 02-12

Enter Code	At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider? 0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction 1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2121. Provision of Current Reconciliation Medication List to Subsequent Provider at Discharge

- This is a new item to the MDS with a focus on improving care coordination, quality of care, and ensuring that the next provider of care has a reconciled the medications. All these items help ensure a safe and effective transition from one provider to another.
- If the resident discharged to one of the locations listed in A2105, did the discharging provider provide a reconciled medication list to the next provider?

SECTION A: IDENTIFICATION INFORMATION

- The manual directs that this list can be provided by any means, including mail, electronically, verbally, or shared access to an EHR. The completeness of the list is left to the discretion of the provider as they coordinate care with the resident.
- The list of reconciled medications could include those that are:
  - active, including those that are scheduled to be discontinued after discharge;
  - held during the stay and planned to be continued/resumed after discharge; and
  - discontinued during the stay, if potentially relevant to the resident's subsequent care.
- Items typically included on the list would be information about the resident (name, DOB, active diagnoses, allergies) and each medication (name, strength, dose, route, frequency/timing, indication for use, special instructions).
- Providers should take the time now to review their discharge planning process and determine what changes need to be made to meet these new requirements, including staff training and education.

SECTION A: IDENTIFICATION INFORMATION

- In the case of a standalone Medicare Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1) with the resident staying on the same unit and with the same team of interdisciplinary professionals, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge as 1, Yes.

- In the case of a standalone Medicare Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1) and the resident is moving to a different unit and/or interdisciplinary team (IDT), code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge based on whether a member of the resident's IDT transferred the resident's current reconciled medication list to the subsequent unit and/or IDT.

SECTION A: IDENTIFICATION INFORMATION

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider. Complete only if A2121 = 1	
Check all that apply	**Route of Transmission**
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code	At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?
☐	0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction 1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

Check all that apply	**Route of Transmission**
☐	**A. Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

20

20

A2122. Route of Current Reconciled Mediation List Transmission to Subsequent Provider

- If A2121 is answered "yes", then the provider needs to indicate how they got the list to the next provider, via one of the five answer options:
  1. EHR
  2. Health Information Exchange
  3. Verbal
  4. Paper-based
  5. Other

A2123. Provision of Current Reconciled Medication List to Resident at Discharge

- If the provider is completing an **End of Medicare Stay** assessment and the discharge location is **Home/Community or code 99 (not listed)**, then they must indicate if a current reconciled medication list was provided to the resident, family and/or caregiver. This communication from the provider helps to ensure safe and effective discharges.

A2124. Route of Current Reconciled Medication List Transmission to Resident

- If A2123 is answered "yes", then the provider needs to indicate how they got the list to the resident, family and/or caregiver, via one of the five answer options.
  1. EHR
  2. Health Information Exchange
  3. Verbal
  4. Paper-based
  5. Other

SECTION B: HEARING, SPEECH, AND VISION

Intent: To document ***whether the resident is comatose***, the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others, ***and the resident's ability to see objects nearby in their environment.***

B1300. Health Literacy

- This new question is completed on the **5 day MDS or End of Medicare Stay Assessments** with planned discharges and focuses on residents self-reporting that they need someone to read instructions, pamphlets, or other written material to them, from their doctor or pharmacy. This issue for the resident can lead to them making poor health decisions due to not being able to understand basic health information.
- DEFINITION Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

SECTION B: HEARING, SPEECH, AND VISION

- Similar to language barriers, low health literacy interferes with communication between provider and resident. Health literacy can also affect residents' ability to understand and follow treatment plans, including medication management.

- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use.

SECTION B: HEARING, SPEECH, AND VISION

B1300. Health Literacy Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1	
Enter Code ☐	How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? 0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 7. **Resident declines to respond** 8. **Resident unable to respond**
The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.	

SECTION C: COGNITIVE PATTERNS

No substantive changes

25

SECTION D: MOOD

Intent: The items in this section address mood distress ***and social isolation. Mood distress*** *is* a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. **Social isolation refers to an actual or perceived lack of contact with other people and tends to increase with age. It is a risk factor for physical and mental illness, is a predictor of mortality, and is important to assess in order to identify engagement strategies.**

D0150. Resident Mood Interview (PHQ-2 to 9©)

- The significant change to the PHQ interview is the potential to max out the questions at 2, based on the answer responses to D0150A1 and D0150B1. If the symptom frequency responses are 0 (never or 1 day) or 1 (2-6 days), the interview is considered complete, and the interviewer does not move on to questions 3-9.
- Now is the time for providers to review and evaluate their resident interview processes and techniques. CMS offers some very helpful videos (VIVE Video for Interviewing Vulnerable Elders) that providers can utilize, that offer guidance and examples. Whether your primary interviewer has been doing the interviews since 2010 or has just started, I would encourage you to review the CMS video resources.

SECTION D: MOOD

If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, end the PHQ interview; otherwise continue.

- If both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ-2© and leave D0160, Total Severity Score blank.
- If both D0150A2 and D0150B2 are coded 0 or 1, then end the PHQ-2© and enter the total score from D0150A2 and D0150B2 in D0160, Total Severity Score.

For all other scenarios, proceed to ask the remaining seven questions (D0150C to D0150I of the PHQ-9©) and complete D0160, Total Severity Score.

SECTION D: MOOD

D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

1. Symptom Presence	2. Symptom Frequency

↓ Enter Scores in Boxes↓

A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.		
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

SECTION D: MOOD

- Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the assessment period.
- Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the assessment period.
- In addition, PHQ-2 to 9© Total Severity Score can be used to track changes in severity over time. Total Severity Score can be interpreted as follows:
  - 1-4: minimal depression
  - 5-9: mild depression
  - 10-14: moderate depression
  - 15-19: moderately severe depression
  - 20-27: severe depression

SECTION D: MOOD

D0700. Social Isolation

- This new MDS question focuses on isolation that is different from clinical related isolation due to infections.
- Per the RAI manual definition box, this item “Refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.” and is based on the resident’s self-report.
- Social isolation tends to increase with age and is a risk factor for physical and mental illness and a predictor of mortality.

SECTION D: MOOD

D0700. Social Isolation	
Enter Code	How often do you feel lonely or isolated from those around you? 0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 7. **Resident declines to respond** 8. **Resident unable to respond**

SECTION E: BEHAVIOR

No substantive changes

SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES

No substantive changes

SECTION G: FUNCTIONAL STATUS

Removed with some items moving to section GG

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section includes items about functional abilities and goals. It includes items focused on prior function, admission ***and discharge* performance**, discharge goals, ***performance throughout a resident's stay, mobility device use, and range of motion***. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0115. Functional Limitation in Range of Motion

- Moved from section G

GG0120. Mobility Devices

- Moved from section G

The DRAFT manual offers numerous additions to coding tips and examples related to the Self-Care and Mobility items.

Keep in mind that the changes outlined in this DRAFT manual are federal in nature and that your state may require you to continue to submit G ADL information via the OSA (Optional State Assessment) for Medicaid Case Mix purposes. It will be important that you remain in close contact with your state RAI Coordinator and provider advocacy groups to stay up to date on your state's plans. Section G also currently has a far reaching impact on many other systems and programs, including QMs (Quality Measures), and Five-Star Staffing/Quality Measures, so we will continue to await guidance from CMS on the removal of section G ADL items and the impact to these areas.

SECTION H: BLADDER AND BOWEL

No substantive changes

SECTION I: ACTIVE DIAGNOSES

No substantive changes

SECTION J: HEALTH CONDITIONS

Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess ***the management of pain***, the presence of pain, pain frequency, effect ***of pain on sleep, and pain interference with therapy and day-to-day activities.*** Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.

J0410. Pain Frequency

- The order of the answer options have reversed compared to the prior manual version, with "rarely or not at all" at the top of the list now instead of near the bottom.

J0510. Pain Effect on Sleep

- This question was previously answered under the J0500 Pain Effect on Function question but has now been separated out and now has frequency response answers versus just a yes or no option.

J0410. Pain Frequency

Enter Code ☐

Ask resident: *"**How much of the time have you experienced pain or hurting** over the last 5 days?"*

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
9. **Unable to answer**

J0510. Pain Effect on Sleep

Enter Code ☐

Ask resident: *"Over the past 5 days, **how much of the time has pain made it hard for you to sleep at night?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

SECTION J: HEALTH CONDITIONS

J0520. Pain Interference with Therapy Activities

- This is a new question on the MDS with a focus on how pain limits the resident's participation in rehab therapy sessions.

J0530. Pain Interference with Day-to-Day Activities

- This question was previously answered under the J0500 Pain Effect on Function question but has now been separated out and now has frequency response answers versus just a yes or no.

J0520. Pain Interference with Therapy Activities

Enter Code	Ask resident: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***
☐	0. **Does not apply - I have not received rehabilitation therapy in the past 5 days** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code	Ask resident: *"Over the past 5 days,* ***how often have you limited your day-to-day activities (<u>excluding</u> rehabilitation therapy sessions) because of pain?"***
☐	1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

K0520. Nutritional Approaches

- This question has been expanded to include "on admission" (days 1-3 of the SNF PPS stay), "while not a resident", "while a resident", and "at discharge" (last 3 days of the SNF PPS stay), options over the look-back period. For providers, it will be very important for the team member responsible for coding this section to have full access to the entire medical record.

- Coding Tips for K0520C
  - Assessors should not capture a trial of a mechanically altered diet (e.g., pureed food, thickened liquids) during the observation period in K0520C, mechanically altered diet.

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

1. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B **2. While Not a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank. **3. While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days*** **4. At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	**1. On Admission**	**2. While Not a Resident**	**3. While a Resident**	**4. At Discharge**
		Check all that apply ↓		
A. Parenteral/IV feeding	☐	☐	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐		☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. None of the above	☐	☐	☐	☐

SECTION L: ORAL/DENTAL STATUS

No substantive changes

SECTION M: SKIN CONDITIONS

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- CMS has added additional items under "Steps for completing M0300A-G",
  - Step 1, number 6 "A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher state or unstageable."
  - Step 3, number 10 "If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury is coded as "present on admission."
- The DRAFT manual isn't clear on the length of time between healed and reopened, as it relates to the above question. Providers need to review their wound documentation processes and skin assessments upon admission/re-admission to ensure accuracy and timeliness.

SECTION N: MEDICATIONS

Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. In addition, ***two medication sections have been added***. ***The first*** *is* an Antipsychotic Medication Review. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications. ***The second is a series of data elements addressing Drug Regimen Review. These data elements document whether a drug regimen review was conducted upon the start of a SNF PPS stay through the end of the SNF PPS stay and whether any clinically significant medication issues identified were addressed in a timely manner.***

N0415. High-Risk Drug Classes: Use and Indication

- This section replaces the previous N0410 and increases the drug classification focus from 8 classes to 10, with the addition of Antiplatelet and Hypoglycemic drugs. The answer options have also changed and are now two columns, "Is taking" and "Indication noted".
- Training and education to your nursing staff and physicians will be very important as October nears, with a focus on the reason for use documentation for each high-risk medication prescribed.

SECTION N: MEDICATIONS

- Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
- Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).

- Target symptoms and goals for use of these medications should be established for each resident. Progress toward meeting the goals should be evaluated routinely.

45

45

SECTION N: MEDICATIONS

- Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday for bipolar disorder.
- Lorazepam 1 mg PO QAM: Received every day for bipolar disorder.
- Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

Coding: Medications in N0415, would be coded as follows:

- N0415A1 and N0415A2. Antipsychotic = checked; risperidone is an antipsychotic medication and indication of use for bipolar disorder noted.
- N0415B1 and N0415B2. Antianxiety = checked; lorazepam is an antianxiety medication and indication of use for bipolar disorder noted.
- N0415D1. Hypnotic = checked; temazepam is a hypnotic medication. N0415D2. Hypnotic = not checked; indication for use of temazepam was not noted.

46

46

N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days **2. Indication noted** If Column 1 is checked, check if there is an indication noted for all medications in the drug class	**1. Is taking**	**2. Indication noted**
	↓ **Check all that apply** ↓	
A. Antipsychotic	☐	☐
B. Antianxiety	☐	☐
C. Antidepressant	☐	☐
D. Hypnotic	☐	☐
E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F. Antibiotic	☐	☐
G. Diuretic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

47

47

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received ***or performed*** during the specified time periods.

O0110. Special Treatments, Procedures, and Programs

- This question has been expanded to include **"on admission"** (days 1-3 of the SNF PPS stay), **"while a resident"** (in the last 14 days), and **"at discharge"** (last 3 days of the SNF PPS stay), options over the 14 day look-back period.

  For providers, it will be very important for the team member responsible for coding this section to have full access to the entire medical record.

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

O0110A1 Chemotherapy answer options have expanded to include IV, Oral, or Other.

O0110C1 Oxygen therapy answer options have expanded to include Continuous, Intermittent, or High-concentration.

O0110D1 Suctioning answer options have expanded to include Scheduled, and As needed.

O0110G2 BiPAP check if the non-invasive mechanical ventilator support was BiPAP.

O0110G3 CPAP check if the non-invasive mechanical ventilator support was CPAP.

O0110H1 IV Medications answer options have expanded to include Vasoactive medications, Antibiotics, Anticoagulant, Other.

O0110J1 Dialysis answer options have expanded to include Hemodialysis, and Peritoneal dialysis.

O0110O1 IV access is an additional question and includes answer options Peripheral, Midline, and Central.

O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that were performed

a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B **b. While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days*** **c. At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	**a. On Admission**	**b. While a Resident**	**c. At Discharge**
		Check all that apply ↓	
Cancer Treatments			
A1. Chemotherapy	☐	☐	☐
A2. IV	☐		☐
A3. Oral	☐		☐
A10. Other	☐		☐
B1. Radiation	☐	☐	☐
Respiratory Treatments			
C1. Oxygen therapy	☐	☐	☐
C2. Continuous	☐		☐
C3. Intermittent	☐		☐
C4. High-concentration	☐		☐
D1. Suctioning	☐	☐	☐
D2. Scheduled	☐		☐
D3. As needed	☐		☐
E1. Tracheostomy care	☐	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐	☐
G2. BiPAP	☐		☐
G3. CPAP	☐		☐

50

50

Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐		☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐		☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care		☐	
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐		☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			
Z1. None of the above	☐	☐	☐

SECTION P: RESTRAINTS AND ALARMS

No substantive changes

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: ***Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.*** The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.21(c)(1)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. ***This may not be a nursing home.*** This is also a civil right for all residents.

Q0110. Participation in Assessment and Goal Setting

- This question replaces the prior Q0100 and separates the answer options out instead of grouping family/significant other and guardian/legal authorized representatives.

Q0310. Resident's Overall Goal

- This question replaces the prior Q0300 and moves the focus from the resident's expectation to the resident's goal, which should be the basis for care planning.

Q0500C. Indicate Information Source for Q0550A

- This is a new question to follow up on Q0500 and separates the answer options out instead of grouping family/significant other and guardian/legal authorized representatives.

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Q0110. Participation in Assessment and Goal Setting
Identify all active participants in the assessment process

↓ Check all that apply	
☐	A. **Resident**
☐	B. **Family**
☐	C. **Significant other**
☐	D. **Legal guardian**
☐	E. **Other legally authorized representative**
☐	Z. **None of the above**

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Q0310. Resident's Overall Goal
Complete only if A0310E = 1

Enter Code [ ]	**A. Resident's overall goal for discharge established during the assessment process** 1. **Discharge to the community** 2. **Remain in this facility** 3. **Discharge to another facility/institution** 9. **Unknown or uncertain**
Enter Code [ ]	**B. Indicate information source for Q0310A** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Q0500C. Indicate Information Source for Q0500B

- This is a new question to follow up on Q0500 and separates the answer options out instead of grouping family/significant other and guardian/legal authorized representatives.

Q0550C. Indicate Information Source for Q0550A

- This is a new question to follow up on Q0550 and separates the answer options out instead of grouping family/significant other and guardian/legal authorized representatives.

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Q0500. Return to Community	
Enter Code ☐	**B. Ask the resident** (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**
Enter Code ☐	**C. Indicate information source for Q0500B** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B	
Enter Code ☐	**A. Does resident** (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than on comprehensive assessments alone) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code ☐	**C. Indicate information source for Q0550A** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Q0610. Referral

- This question replaces the prior Q0600 and removes the answer option of "No- referral is or may be needed".

Q0620. Reason for Referral to Local Contact Agency (LCA) Not Made

- This is a new question with a focus to help providers support the resident to receive care that helps them achieve their highest practicable level of functioning in the least restrictive environment. This question contains 5 answer options for providers to choose.

Q0620. Reason Referral to Local Contact Agency (LCA) Not Made Complete only if Q0610 = 0	
Enter Code ☐	**Indicate reason why referral to LCA was not made** 1. **LCA unknown** 2. **Referral previously made** 3. **Referral not wanted** 4. **Discharge date 3 or fewer months away** 5. **Discharge date more than 3 months away**

CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING

ADL Functional/Rehabilitation Potential

This CAA now utilizes all section GG Self-Care and Mobility items instead of section G ADL items.

Urinary Incontinence and Indwelling Catheter

This CAA now utilizes section GG Self-Care and Mobility items (toilet hygiene and toilet transfers) instead of section G ADL items.

Pressure Ulcer/Injury

This CAA now utilizes section GG Mobility items (roll left and right, sit to lying) instead of section G ADL items.

As described on these slides, there are numerous changes in the DRAFT version of the manual. While some of these changes are minor and will require no additional prepping, others are much more cumbersome.

These more advanced changes will require modification to existing assessments or the creation of brand-new assessments or data collection tools.

Once these changes have been made, expansive training of your staff will be the next step to ensure they are prepared, comfortable, and confident when October 1st hits.

The MDS serves as the end location of this information and is only as accurate as the documentation in the medical record. The potential impact of this can be felt through the survey process, reimbursement, Five Star, SNF QRP, SNF VBP, care planning, and on and on.

Thank You

www.leaderstat.com