MDS Alert

MDS 3.0: How Might MDS 3.0 Lead to Improvements? Experts Are Still Counting the Ways

More accurate ADLs, opportunity for better care plans are on the list.

You've no doubt heard about how the MDS 3.0 offers better assessments for pain, depression, pressure ulcers, cognition, and behavioral symptoms. But as experts take a closer look at the draft instrument, they continue to find other potential perks. **Key example: Joy Morrow, RN, PhD**, predicts the single ADL score in Section G of the MDS 3.0 will improve not only ADL accuracy but also reimbursement. Using the MDS 2.0, facilities may have received inaccurate reimbursement for care related to ADLs by having to code self-performance and support, which is difficult to do, Morrow opined in a presentation on the MDS at the October 2008 **American Health Care Association** annual convention attended by **Eli.**

The single ADL response on the 3.0, by contrast, may provide an "appropriate bump up in reimbursement," Morrow said.

Another plus: The draft MDS 3.0 preferences for customary routine and activities focuses on what's important to the resident now, Morrow pointed out (review the questions on p. 141).

Better Care Plans in the Offing?

The MDS 3.0's emphasis on eliciting resident voice in the assessment could allow the interdisciplinary team to develop a broader picture of what's going on with a resident -- if they collaborate to look at cause and effect, according to **Rena Shephard, MHA, RN, RAC-MT, C-NE**, who advocates facilities take the opportunity provided by 3.0 to really improve the interdisciplinary aspects of their processes.

"Using the MDS 3.0 interviews, the various interdisciplinary team members will glean a lot of information about the resident," says Shephard, president and CEO of **RRS Healthcare Consulting Services** in San Diego, and founding chair and executive editor of the **American Association of Nurse Assessment Coordinators**. And if team members come together as a group to share their knowledge, they can see how the information interrelates, identifying problems and goals from the resident's and, if appropriate, the resident's family's perspective, she adds. The team members can then develop the care plan working in tandem. Then once it's developed, the various members can decide who is responsible for implementing what, Shephard says.

On the other hand: If the team members completing different sections don't share their findings, they might miss that the resident "really, really" misses some of his customary routines and believes they aren't possible to do in the nursing home, adds Shephard. And "as a result, he's depressed, and not participating in activities, and not eating."

Cut out the paper chase: Shephard thinks people should bring notes to the care plan conference. "But those notes should be short and sweet ... to help people share their observations or what the resident said." And that could stimulate discussion where someone says, for example, "Wow, maybe that helps explain why this is going on," Shephard says.