MDS Alert

MDS TRENDS: Ease Your Transition To MDS 3.0: Stay On Top Of Key Changes

Are you ready for this major modification to the MDS modus operandi?

For a preliminary view of your MDS future, take a look at the draft 3.0 version posted on the **Centers for Medicare & Medicaid Services'** Web site. The revamped instrument will all but revolutionize how you do assessments. And the time to get a heads up on what's headed your way is now.

The biggest change: The MDS 3.0 includes what CMS is calling the introduction of "resident voice" in the instrument. "CMS is testing a structured interview approach for cognition, mood, preferences for daily events and activities and pain," says **Debra Saliba, MD, MPH,** associate professor at UCLA and a researcher for the **Rand Corporation's** national validation study of the draft MDS 3.0 items. (For an update on the MDS 3.0 timeline, see the article in this issue.)

Brush up on your interview skills: The draft instrument guides the assessor on how to approach the resident and conduct a successful interview. Sections that rely on the direct interview actually contain the structured interview items and are "earmarked" with a picture of an ear at the bottom of the page. If the resident isn't capable of participating inan interview, the MDS team will then use the 2.0 approach for completing the MDS. That involves a combination of observing and talking to the resident, interviewing the care-giving staff and looking at the medical record, says Saliba.

Direct Interview Includes Cognitively Impaired Residents

"Research shows that even cognitively impaired residents really are able to communicate more often than people sometimes believe," says **Rena Shephard, RN, MHA, FACDONA,** president of **RRS Healthcare Consulting** in San Diego. "Residents can tell us how they are feeling about their pain or other key areas where the MDS 3.0 draft version is using resident voice," she says. This will be a "huge change for residents because we're going to know so much more about them, which will help us care plan more appropriately," predicts Shephard. "And it's a huge change for facilities because it's a completely different way of approaching assessment and the MDS."

Good preliminary news: Saliba says field nurses testing the instrument report they are finding that many residents initially viewed as "uninterviewable" can clearly communicate how they are feeling and their preferences. And the nurses are saying early in the study that the interviews take less time and improve their understanding of the resident compared to the current 2.0 approach, she adds. Rand will perform data analysis at the end of the research project to determine if those observations hold up.

Look for These Section-by-Section Changes

Saliba provides a rundown of the major changes to the MDS contained in the draft 3.0 version:

• **Section C (Cognitive patterns).** This section starts with a resident interview, which is an "objective, structured cognitive test," says Saliba. "In pilot tests, the section takes less than five minutes" when facilities use it to conduct a cognitive interview.

First things first: In Section B (Hearing, speech and vision), the instrument asks the MDS team to report the resident's ability to communicate in order to identify and maximize his ability to participate in an interview successfully, notes Saliba.

• **Section D (Mood).** The draft MDS 3.0 mood items come from the PHQ-9, a standardized screening tool for depression

used in many healthcare settings. Saliba notes that "in pilot tests, even residents with moderate cognitive impairment could respond to these questions. If a resident is unable to respond, the MDS 3.0 asks staff to complete an observer version of the PHQ-9."

• **Section E (Behavior).** This section assesses the impact of behavioral symptoms on the resident and on others. It contains a separate part dedicated to assessing wandering.

• **Section F (Preferences for customary routine, activities, community setting).** Instead of asking what the resident was doing before he came to the facility, as the 2.0 version does, "the items ask the individual about the importance of basic daily activities," says Saliba. The response choices allow the resident to indicate an activity is "important but can't do/no choice." That way residents can identify what they'd like to do but don't believe is possible, which provides information for care planning.

Look for more emphasis on community care: A new MDS 3.0 item asks the individual at admission whether he wants to talk to someone about returning to the community. "CMS is looking at the increased availability of home- and community-based services," explains Saliba.

• **Section G (Functional status).** The 3.0 version streamlines ADLs by providing a single column that captures a hybrid of self-performance and support provided.

CMS is also "testing an approach that asks the facility to report the most dependent episode," says Saliba.

The draft version also changed some of the categories to make them more consistent with functional categories used by other healthcare settings, adds Saliba. For example, the instrument breaks toileting into toilet transfer and toilet assistance -- and dressing into upper and lower body.

• **Section J (Health conditions).** The pain-related questions include both resident voice and medical record items. "Chart-based items ask whether the person is on a scheduled pain medication regimen," says Saliba. The draft MDS also asks whether the resident receives PRN pain medications and any non-medication interventions for pain.

Staff uses a direct interview to ask the resident if he has had pain and, if so, its intensity, frequency -- and his pain treatment goals. Two function items ask whether the pain makes it difficult to sleep at night or has caused the resident to limit daily activities (see the form, in this issue entilted Pain Assessment).

• **Section M (Skin conditions).** "The MDS 3.0 pressure ulcer section tries to align MDS pressure ulcer reporting with current community standards of care" by eliminating reverse staging, says Saliba. "Instead, facilities report the deepest anatomical stage of the ulcer and its current size." The revised instrument allows facilities to capture information about whether a pressure ulcer was present at admission and how many pressure ulcers have healed since the last MDS assessment.

Look for a Shorter Lookback

The MDS 3.0 has another potential major modification in the offing: The assessment reference period for the draft version is five days for most sections, compared to seven days for most sections of the MDS 2.0. And the five-day lookback "all but removes the hospital lookback," says **Peter Arbuthnot,** regulatory industry analyst for **American Health- Tech Inc.,** an MDS software developer and vendor in Jackson, MS. "We don't know whether CMS will eliminate the hospital lookback," he adds. "But you can see that CMS is playing the money game with the draft changes to the instrument."

Editor's note: Download the draft MDS 3.0 online at www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS30Draft.pdf or e-mail a request to receive it to the editor at editormon@aol.com.