MDS Alert

MDS 3.0 Education And Preparation: 3 Ways You Can Prepare Now For The MDS 3.0

Don't let your facility fall behind the learning curve for this major change.

The MDS 3.0 may not be officially rolling out until October 2009, but your facility can take pivotal steps now to avoid being bowled over by having to master too much at once down the line.

Step 1: Familiarize yourself with the scripted interviews. In the draft MDS 3.0, there are scripted interviews for assessing a resident's cognition, mood, preferences for customary routine and activities, and pain.

How it will work: When completing the MDS 3.0, staff will approach the resident to do the scripted interviews unless the resident is coded as being rarely or never understood -- or needs a translator to communicate and one isn't present, according to **Debra Saliba, MD, MPH**, in a presentation on how the MDS 3.0 will improve clinical care at the 2008 **American Medical Directors Association** annual meeting. If the resident gives you three nonsensical answers that have absolutely nothing to do with a section, then you'd stop asking the questions and move to the staff assessment for that section, noted Saliba, a researcher for the **Rand Corporation's** national validation study of the MDS 3.0 items. If the resident can't complete the preferences for customary routine and activities section, then you'd interview the person's family or significant other, according to the draft MDS 3.0 instrument.

Key point: You wouldn't give up on doing all the scripted interviews when the resident makes three nonsensical responses to one of the interview sections -- that is, you'd try each of the interviews, unless the resident is coded as never or rarely understood, according to **Rena Shephard**, **MHA, RN, RAC-MT, C-NE**, president and CEO of **RRS Healthcare Consulting** in San Diego, and founding board chair and executive editor for the **American Association of Nurse Assessment Coordinators**.

The positives: "Research shows that in general, 85 percent of residents in long-term care settings can tell us what's important to them about their sadness, their pain, and about what matters to them in their daily routines and activities," Shephard notes. And one of the best ways to start MDS 3.0 preparation is to begin implementing the scripted interviews "sooner rather than later," Shephard suggests. Even though the **Centers for Medicare & Medicaid Services** hasn't provided the instruction manual for the 3.0 as a guide, the scripted interviews are in the draft 3.0 document, she notes. "You can't use the scripted interviews for the 2.0 because the two just don't mesh. But facilities use all kinds of assessments in addition to the MDS, and the 3.0 interviews can be used to replace some of the additional assessments a facility is already doing," Shephard says.

Example: The 3.0 pain assessment is "a huge improvement in terms of assessing pain in a clinically useful way," says **Joy Morrow, PhD, RN**, senior clinical consultant with **Hansen, Hunter & Co**. in Beaverton, OR. The assessment gives you information about the impact of a person's pain on his sleep and day-to-day activities.

Not only are the scripted interviews a "very important tool" that can really improve resident care and outcomes, but learning to do them now will help staff feel comfortable with MDS 3.0 implementation, in Shephard's view. "By the time the 3.0 is implemented, [staff] will just have to study the instruction manual for the details of the requirements," she says.

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Step 2: Nail down an implementation plan. Shephard also advises facilities to develop an implementation plan for the 3.0. That includes pulling together a team to look at the processes required to pull it off, including formal training. "Plan the calendar for how implementation will happen," Shephard suggests.

Beware: While implementing the scripted interviews is fine, if facilities have the resources to do so, they should avoid using the draft MDS 3.0 for training at this point, cautions **Sandra Fitzler, RN**, senior director of clinical services for the **American Health Care Association**. That's because CMS' STRIVE project, which will be used to revamp the RUGs, could lead to changes to the MDS 3.0, Fitzler cautions.

Step 3: Maintain business as usual with the MDS 2.0. Shephard, in fact, urges facilities to continue to pay attention to MDS 2.0 accuracy and compliance even as they develop a separate track for 3.0 implementation. "The two tracks are critical because it's important to maintain the 2.0 while it's still being used for all its critical functions."

Real-world practice: To prepare for the MDS 3.0, MDS staff at **SunBridge Pine Lodge Care and Rehabilitation** are attending conferences and looking to its corporate office and professional organizations for information to give the interdisciplinary team members, relays **Mary E. Wills, RN, BSN**, clinical case manager at the Beckley, WV facility.

The MDS team has also given the facility social worker the MDS 3.0 scripted interview for customary routines and activities to integrate into the existing assessment, she relays.

Editor's note: Keep an eye on the AANAC website (http://www.annac.org) for a repeat of a webinar by Rena Shephard: "MDS 3.0 Implementation Strategies for the Nurse Executive." Shephard will also be talking about MDS 3.0 preparation at the fall 2008 **AANAC** conference in Las Vegas.

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