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THE REVIEW OF MEDICAL INFORMATION MANAGEMENT FOR LITIGATION

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MDS 3.0: A More Objective Resident Assessment Tool for Nursing Home Use

The Centers for Medicare and Medicaid (CMS) has proposed and issued several payment and policy changes throughout 2010. With regard to long-term care, perhaps the most consumer-friendly change is the required use of a new Minimum Data Set (MDS) format, MDS 3.0. MDS 3.0 will go into effect on October 1, 2010, retiring the currently used MDS 2.0 on September 30, 2010.

Overall, MDS 3.0 aims to extract more pertinent information from nursing home and long-term care facility residents and residents' families, allowing for identification of specific resident needs, and creation of Care Plans to address the same. This additional detail will in turn significantly assist in analyzing plaintiff's claims, and in the defense of nursing home litigation.

BACKGROUND

CMS, an agency of the U.S. Department of Health and Human Services, administers Medicare insurance and works with state agencies to coordinate Medicaid programs. In 2002, CMS began a national Nursing Home Quality Initiative "to continue to improve the quality of health care for all Americans, including those covered by Medicare and Medicaid programs."[i] Specifically, the Quality Initiative used to measure resident medical data collected by nursing homes at various intervals of a resident's stay. Resident data is collected on admission or re-admission to a facility in reports, or Minimum Data Sets (MDS), and includes information on a resident's physical and mental abilities, clinical conditions, treatment plans and life care wishes.[ii]

A MDS is required by federal law and is completed as part of the clinical assessment of each and every resident of a Medicare or Medicaid certified nursing home. The MDS was designed to be comprehensive enough to afford nursing home staff the means to identify resident health problems.[iii] Collected MDS data is stored at both the state and federal level, and is used to not only track standards of care, but also to determine reimbursement amounts for nursing homes/long term care facilities for services provided to Medicare/Medicaid recipients.[iv]

As noted in an earlier version of The MIM Reporter, the current MDS 2.0 format consists of a core set of screening and assessment criteria, plus coding categories and definitions that form the basis of the comprehensive resident assessment.[v] Although MDS 2.0 provides a summary of the overall functional capacities of the resident, notably missing are specific details about the resident's conditions that would allow a facility to create a more comprehensive and specialized Care Plan.[vi]

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NOTABLE OVERALL IMPROVEMENTS IN MDS 3.0

Overall, MDS 3.0 aims to use gathered data to improve quality care. The purpose of MDS 3.0 is to identify specific resident needs and to have in place specific Care Plans that reflect those needs; therefore, accurate and timely completion of MDS 3.0 is crucial. In fact, CMS anticipates that it will take 45% less time to complete MDS 3.0 as it took to complete MDS 2.0 while still promoting enhanced accuracy of information.[vii]

The form itself is more user friendly, with large print that makes it easier to read, and contains a more intuitive question lay-out. The Resident Assessment Protocols (RAPs) found in MDS 2.0 have been renamed Care Area Assessment (CAA) Summary – RAPs in MDS 2.0 only identified 18 potential "problem areas" from which a care plan would be generated, whereas CAAs in MDS 3.0 now consider 20 areas with the addition of Pain (see MDS 3.0 section V0200(A)(19)) and Return to Community Referral (see MDS 3.0 section V0200(A)(20)). MDS 3.0 is the "tool" used to construct an individualized Care Plan[s] based on particular resident needs, and daily documentation should reflect that Care Plans are implemented.

Also, MDS 3.0 implements a dash value for coding data – a dash is now used to indicate that a data item was not assessed, such as when a resident is discharged prior to an assessment being completed.[viii]

"Skip" patterns are now found in MDS 3.0, and allow for certain questions to be skipped over based on answers to preceding questions. Skipped questions should remain blank to indicate that the questions did not apply to the particular resident.[ix]

MDS 3.0 enables the resident, if able, to participate in an overall assessment of his or her cognitive and functional ability, management of pain, offer subjective identification of mood, and independently offer dietary and activity preferences. MDS 3.0 uses an "interview symbol," denoted by an ear symbol, which indicates when the resident should be interviewed to complete each applicable question. Responses given by the resident are then coded in the MDS and considered the primary documentation for the categories to which the responses relate. MDS 3.0 encourages family, significant others and the resident to participate in Care Plan conferences based on MDS 3.0 assessment data. This will generate more specific criteria for care that is unique for each resident and based on his/her input and needs.

COMPARISON OF MDS 2.0 AND MDS 3.0

As noted above, significant changes have been made in both the manner and content of data collection in the following areas, any of which might be relevant in the defense of nursing home litigation: cognitive patterns; mood; behavior; customary routine and activity; gait and falls; pain, and skin changes. Enhanced sections on falls and skin ulcers, which are serious problems with associated morbidity/mortality, promote greater accountability on the part of the facility in prevention of such.

Compared to MDS 2.0, MDS 3.0 offers more structured questions to be posed to and answered by the resident. For example, with regard to the resident's memory, MDS 2.0 only inquires whether his/her short and/or long term memory is ok, whereas MDS 3.0 probes into the resident's ability to remember and repeat three simple words or the correct day of the week. Also, where MDS 2.0 includes a retrospective analysis of the resident's health status over the prior seven (7) days10[x], MDS 3.0 focuses on a resident's health status while not a resident within the last 14 days as well as while a resident within the last 14 days.

Similarly, MDS 2.0 information about accidents/falls is limited to whether a fall occurred in the past 30 or 31 to 180 days and if there was a hip fracture in the last 180 days or other fracture in the last 180 days. MDS 3.0 is more precise about the prior timing of falls and asks if there was a fall in the last month, last 2 to 6 months prior to admission, and if there was any fracture related to a fall in the 6 months prior to admission. Thoroughness when evaluating a resident's fall risk can determine how aggressive the facility needs to be to protect the resident from injury.

What follows is a comparison of notable field changes between MDS 2.0 and MDS 3.0:

SUMMARY

As the number of elderly people in our society increases, so too will the demand and need for nursing home care. Residents have a right to expect that nursing home care will reflect the same quality and standards that they would receive in their own home, as if provided by their own family. The MDS 3.0 provides a tool to achieve this goal, and also places a greater onus on nursing homes to meet higher expectations and provide heightened standards of care. Nursing Home staff should have in-service education to apprise hands-on caregivers [nurse's aides and LPN charge nurses] of the new approach to meeting resident needs.

The rollout of MDS 3.0 will provide counsel with an additional source of valuable information regarding patient health issues at successive points in time. The use of resident interviews and objective, tested assessment tools will make the judgments of staff completing the form more defensible and the data collected more accurate. MDS 3.0 will be a useful document for counsel to include in the review of their nursing home cases.

Endnotes

i *"Overview." Nursing Home Quality Initiatives, Centers for Medicare & Medicaid Services, March 29, 2010, August 26, 2010, https://www.cms.gov/NursingHomeQualityInits/01_Overview.asp.*

ii *"Quality Measures," Nursing Home Quality Initiatives, Centers for Medicare & Medicaid Services, March 29, 2010, August 26, 2010, https://www.cms.gov/NursingHomeQualityInits/10_NHQIQualityMeasures.asp.*

iii *"Overview." Nursing Home Quality Initiatives, Centers for Medicare & Medicaid Services, March 29, 2010, August 26, 2010, https://www.cms.gov/NursingHomeQualityInits/01_Overview.asp.*

iv *"Funding Health Care for the Elderly - Medicare." The Merck Manuals Online Medical Library, Geriatrics Section, September 2009, August 26, 2019, http://www.merck.com/mmpe/sec23/ch349/ch349b.html.*

v *Medical Information Management, Nursing Home Litigation, Litigation Management, Inc., Volume III, Number 4, December 2000.*

vi *Id.*

vii *"Overview." Nursing Home Quality Initiatives, Centers for Medicare & Medicaid Services, March 29, 2010, August 26, 2010, https://www.cms.gov/NursingHomeQualityInits/01_Overview.asp.*

viii *See i.e. CMS's RAI Version 3.0 Manual, Appendix E: Cognitive Performance Scale (CPS), Appendix E-1, July 2010.*

ix *See i.e. CMS's RAI Version 3.0 Manual, CH 5: Submission and Correction of the MDS Assessments, page 5-5, July 2010.*

x *Medical Information Management, Nursing Home Litigation, Litigation Management, Inc., Volume III, Number 4, December 2000.*

MDS 2.0 FIELD	CORRESPONDING MDS 3.0 FIELD
Cognitive Status: Nonspecific short and long term memory function; no indication of orientation to person, time, and place.	**Cognitive Status:** Additionally contains administration of a memory recall test consisting of 3 words, and a test for temporal orientation. *This provides for more complete evaluation of status and possibly faster initiation of protective measures such as fall prevention devices if short term memory problems exist.*
Delirium: Only indicators of delirium listed, change in cognitive status since last assessment or 90 days.	**Delirium:** In addition to indicators of delirium, acute onset mental status changes from baseline with rating of yes or no. *Detection of sudden or recent mental status change may denote underlying medical conditions, such as urinary tract infection, that may require further investigation.*
Mood/Behavior Patterns: Only indicators of each listed, also if change in mood and behavior since last assessment or 90 days.	**Mood/Behavior Patterns:** In addition to mood/behavior indicators, MDS 3.0 tracks one's subjective and objective mood over the last 2 weeks. A section has been added to track safety notifications to responsible staff regarding the potential for resident self-harm. With regard to behavioral symptoms 1. addresses the impact on the resident regarding the overall presence of behavioral symptoms for risk for physical illness of injury, care, and participation in activities or social interactions; 2. addresses impact on others for risk of physical injury, intrusion on privacy or activity of others, and disruption of care or living environment; 3. addresses rejection of evaluation or care necessary to achieve goals for health and well-being; 4. documents wandering behavior and impact on resident and on privacy of activities of others. *This will provide for more immediate protection from self-injury or injury to others.*
ADL [Activities of Daily Living] Tasks: Itemizes functional ability and degree of need for assistance, from independent to totally dependent, how much assistance needed from none to 2+ staff.	**ADL [Activities of Daily Living] Tasks:** In addition to itemizing the ability and degree of need for assistance, MDS 3.0 provides 1) interview for daily activity preferences such as choosing personal belongings, type of bathing, snacks, choosing bedtime, ability to use phone in private, etc.; 2) interview for activity preferences; 3) staff assessment of daily and activity preferences. *These actions may reduce anxiety/frustration due to being in a nursing home resident, affording a sense that options are available.*
Test for balance: Pertains to balance during testing.	**Balance during Transitions and Walking:** Coding includes whether the resident is steady at all times to activity not occurring; codes related to moving from seated to standing position, walking, turning around, moving on and off toilet, and surface to surface transfer. *Earlier determination of balance may decrease falls as there would be awareness by staff of specific needs during transferring and walking.*
Disease Diagnoses: Includes cancer in general.	**Disease Diagnoses:** Includes cancer with or without metastasis; more extensive neurological listing, including traumatic brain injury and Huntington's disease. Also psychiatric mood conditions include a few more conditions, such as post traumatic stress disorder and psychotic disorder other than schizophrenia. Pulmonary list is more extensive.
Pain Management: Frequency, intensity, location of pain.	**Pain Management:** Additionally includes whether the resident is on a scheduled pain medication regimen, whether the resident is receiving as-needed pain medications, and whether the resident received non-medication intervention for pain. Recommends pain assessment interview unless resident rarely/never understands. Asks if staff assessment for pain evaluation should be conducted. *This is a more thorough evaluation of pain management and effectiveness with involvement of the resident.*

MDS 2.0 FIELD	CORRESPONDING MDS 3.0 FIELD
Accidents: Falls in past 30 days, 31 to 180 days, hip fracture in last 180 days, other fracture in last 180 days.	**Fall History on Admission:** Tracks whether there has been a fall in the last month prior to admission, or last 2-6 months prior to admission, and whether there was a fracture related to fall within 6 months prior to admission. Also tracks whether there have been any falls since admission or prior assessment, whichever is more recent. Section for number of falls since admission or prior assessment with coding of A) no injury; B) injury (except major) such as skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains, or any fall-related injury that causes the resident to complain of pain; and C) major injury such as bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma. *This much more expansive section clarifies fall and resultant injury.*
Oral Problems: Check off list with chewing problem, swallowing problem, mouth pain, none of above.	**Swallowing Disorder:** Check-off list includes loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, complaints of difficulty or pain with swallowing. *Expounds more clearly on swallowing characteristics and if immediate speech therapy/pathology needs to evaluate or if medical evaluation is needed. Early detection/treatment of swallowing disorders can prevent aspiration.*
Parenteral or Enteral Intake: Coding for none, 1% to 25%, 26% to 50%, 51% to 75%, and 76% to 100% for proportion of total calories in last 7 days. Average fluid intake per day by IV or tube in last 7 days coded from none, 1 to 500 cc/day, 501 to 1000 cc/day, 1001 to 1500 cc/day, 1501 to 2000 cc/day, and 2001 or more cc/day.	**Percent Intake by Artificial Route:** Codes for proportion of total calories received through parenteral or tube feeding 25% or less, 26-50%, or 51% or more. Average fluid intake per day by IV or tube feeding 500 cc/day or less, 501 cc/day or more. *This section is less specific than MDS 2.0.*
Skin Condition: Consists of number of ulcers, stages I through 4, type of ulcer, location; also captures whether there is a history of resolved ulcers.	**Skin Conditions:** Also includes determination of pressure ulcer risk, date of oldest pressure ulcer, descriptions with dimensions of stage 3 and 4 pressure ulcers, number of unstageable pressure ulcers including those with slough and/or eschar and deep tissue injury in evolution, description of the most severe type of tissue present in any pressure ulcer bed, worsening in pressure ulcer, status since prior assessment, and if pressure ulcers present on prior assessment and whether stage 2, 3, or 4. *Much more detail/description of pressure ulcers and progression/recession. This information will provide for more accountability in prevention/treatment of pressure ulcers, possibly reduce number of ulcers.*
Special Treatments and Procedures: Includes OT, PT, respiratory therapy, and psychological therapy in number of days and minutes.	**Special Treatments and Procedures:** Also includes speech-language pathology and audiologist services with individualized time and group time in therapy.
Resident Assessment Protocol [RAP] Summary: Triggered area from MDS 2.0 to identify areas needing further assessment and if need for care planning.	**Care Area Assessment [CAA] Summary:** Includes additional areas of pain, and return to the community referral.
N/A	**Other Health Conditions:** Addresses shortness of breath, if present and if occurring with exertion, when sitting at rest, or when lying flat. Tobacco use, positive or negative. *This is a new addition to the MDS.*

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