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Chapter	Section	Page(s) in version 1.18.11	Change
1	—	1-1	**CMS ACKNOWLEDGEMENTS** ~~Contributions provided by the numerous people, organizations, and stakeholders listed below are very much acknowledged by CMS.~~ The~~ir~~ collective hard work and dedication of so many people, over the ~~past several~~ years in the development, testing, writing, formatting, and ongoing review and maintenance of the MDS 3.0 RAI Manual, MDS 3.0 Data Item Set, and MDS 3.0 Data Specifications are too numerous to list, but their dedication has resulted in an ~~new~~ RAI process that increases clinical relevancy, data accuracy, clarity, and notably adds more of the resident voice to the assessment process. ~~We wish to give~~CMS acknowledges and thanks ~~to all of~~ the many people, organizations, and stakeholders that have contributed to making thi~~s~~ese ~~manual~~ updates and enhancements possible. Thank you for the work you do to promote the care and services to individuals in nursing homes.
1	—	1-1	Removed all individual acknowledgements, which were listed under the following headers: • Experts in Long Term Care • Organizations and Stakeholders • Contractors • CMS
1	1.1–1.8	1-2–1-17	Page length changed due to revised content.

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1	1.1	1-2	## 1.1 Overview The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff ~~in~~ gather~~ing~~ definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining ~~his or her~~their highest practical level of well-being.
1	1.1	1-2	The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities/recreational therapy in the RAI process has fostered a more holistic approach to resident care and strengthened team communication. This interdisciplinary process also helps to support the spheres of influence on the resident's experience of care, including: workplace practices, the nursing home's cultural and physical environment, staff satisfaction, clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations.

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1	1.1	1-2	Persons generally enter a nursing home because of problems with functional status caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. Sometimes, the individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment, and/or rehabilitation is needed for the resident to maintain and/or restore function or to live safely from day to day. While ~~we recognize that~~ there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life). This is true for both long-term residents and residents in a rehabilitative program anticipating return to their previous environment or another environment of their choice.
1	1.2	1-3	• **Minimum Data Set (MDS).** A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form~~s~~ the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as "items") in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data ~~items~~elements for each MDS assessment and tracking document (e.g., Comprehensive, Quarterly, OBRA Discharge, Entry Tracking, PPS item sets) can be found in Appendix H.

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1	1.2	1-3	• **Care Area Assessment (CAA) Process.** This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been identified or "triggered," nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. The CAA process is explained in detail in Chapter 4. Specific components of the CAA process include: — **Care Area Triggers (CATs)** are specific ~~resident~~coding responses for one or a combination of MDS data elements. The triggers identify residents who have or are at risk for developing specific ~~functional~~ problems and require further assessment.
1	1.2	1-3	• **Utilization Guidelines.** The Utilization Guidelines provide instructions for when and how to use the RAI. The Utilization Guidelines, also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, ~~These~~ includes instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from ~~http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_r.pdf~~ https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual).

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1	1.3	1-4	## 1.3 Completion of the RAI Over time, the various uses of the MDS have expanded. While its primary purpose as an assessment ~~tool~~instrument is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments ~~is~~are also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents. The MDS ~~instrument~~ has also been adapted for use by non-critical access hospitals (non-CAHs) with a swing bed (SB) agreement. ~~They~~Non-CAH SBs are required to complete the MDS for reimbursement under the SNF PPS.
1	1.3	1-4	• **Medicare and Medicaid Payment Systems.** The MDS contains ~~items~~data elements that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection ~~tool~~instrument to classify Medicare residents into PDPM components. The PDPM classification system is used in the SNF PPS for skilled nursing facilities and ~~non-critical access hospital swing bed~~non-CAH SB programs. States may use PDPM, a Resource Utilization Group (RUG)-based system, or an alternate system to group residents into similar resource us~~ag~~e categories for the purposes of Medicaid reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html for comprehensive information on SNF PPS, including, but not limited to, SNF coverage, SNF policies, and claims processing.

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1	1.3	1-4	• **Monitoring the Quality of Care.** MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality measures (QMs), which are derived from data collected on the MDS, were developed by researchers to assist: (1) State Survey and Certification staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the ~~usefulness of the~~ QMs~~, which may be modified in the future to enhance~~ for opportunities to improve their effectiveness, reliability, and validity.
1	1.3	1-4	• **Consumer Access to Nursing Home Information**. Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The ~~Nursing Home~~Medicare Care Compare tool (~~www.medicare.gov/nursinghomecompare~~ https://www.medicare.gov/care-compare/) provides public access to information about a variety of health care providers, including nursing homes. Information available regarding nursing homes includes their characteristics, staffing data, and quality of care measures for certified nursing homes.
1	1.3	1-5	Nursing homes are left to determine (1) who should participate in the assessment process, (2) how the assessment process is completed, and (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

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1	1.3	1-5	In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian~~,~~ and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.
1	1.4	1-6	**b. Decision Making**—Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident's diagnoses and co-morbidities, and the careful consideration of the triggered areas in the CAA process. Understanding the causes and relationships between a resident's clinical issues and needs and discovering the "whats" and "whys" of the resident's clinical issues and needs; finding out who the resident is and consideration for incorporating ~~his or her~~their needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process.

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1	1.5	1-8	**1.5 MDS 3.0** In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the MDS 2.0, the Centers for Medicare & Medicaid Services (CMS) contracted with the RAND Corporation and Harvard University to draft revisions and nationally test the MDS Version 3.0. Following is a synopsis of the goals and key findings as reported in the *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0* final report (Saliba and Buchanan, 2008; available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReport.pdf).
1	1.5	1-9	**Goals** The goals of the MDS 3.0 revision ~~a~~were to introduce advances in assessment measures, increase the clinical relevance of ~~items~~data elements, improve the accuracy and validity of the ~~tool~~assessment instrument, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the ~~tool~~instrument's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for quality measure reporting and Medicare SNF PPS reimbursement (via Patient Driven Payment Model [PDPM] classification).

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1	1.6	1-10	**1.6 Components of the MDS** The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and residents in a Medicare Part A SNF PPS stay in non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).
1	1.7	1-10	**Appendices** • Appendix A: Glossary and Common Acronyms • Appendix B: State Agency and CMS ~~Regional Office~~Locations RAI/MDS Contacts • Appendix C: Care Area Assessment (CAA) Resources • Appendix D: Interviewing to Increase Resident Voice in MDS Assessments • Appendix E: Patient Health Questionnaire (PHQ)-~~9~~ Scoring Rules and Instruction for BIMS (When Administered ~~I~~in Writing) • Appendix F: MDS Item Matrix • Appendix G: References • Appendix H: MDS 3.0 ~~Item Sets~~Forms

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1	1.7	1-11	A	Identification Information	Obtain key demographic information to uniquely identify each resident, administrative information, nursing home in which they reside, ~~type of record, and~~ reason~~s~~ for assessment, and potential care needs, including access to transportation.
			B	Hearing, Speech, and Vision	Document whether the resident is comatose, the resident's ability to hear, understand, and communicate with others and ~~whether the resident experiences visual, hearing or speech limitations and/or difficulties~~the resident's ability to see objects nearby in their environment.
			C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information, and whether the resident has signs and symptoms of delirium.
			D	Mood	Identify signs and symptoms of mood distress and social isolation.
			E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.

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1	1.7	1-11	F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for ~~his or her~~their daily routine and activities.
			~~G~~	~~Functional Status~~	~~Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.~~
			GG	Functional Abilities and Goals	Assess the need for assistance with self-care and mobility activities, prior function, admission performance, discharge goals, discharge performance, functional limitations in range of motion, and current and prior device use.
			H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
			I	Active Diagnoses	Code diseases that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
1	1.7	1-11	J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
			K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
			L	Oral/Dental Status	Record any oral or dental problems present.
			M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
			N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident. Also includes use and indication of high-risk drug classes, antipsychotic use and drug regimen review to identify potentially significant medication issues.

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1	1.7	1-11–1-12	O	Special Treatments, Procedures, and Programs	Identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.
			P	Restraints and Alarms	Record the frequency that the resident was restrained by any of the listed devices or an alarm was used at any time during the day or night~~; record the frequency that any of the listed alarms were used~~.
			Q	Participation in Assessment and Goal Setting	Record the participation and expectations of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
			V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
			X	Correction Request	~~Request to modify or inactivate a~~ To identify an MDS record already present in ~~the i~~QIES ~~ASAP database~~system for modification or inactivation.
			Z	Assessment Administration	Provide billing information and signatures of persons completing and attesting to the accuracy of the assessment, as well as the signature and date by the RN Assessment Coordinator verifying the assessment is complete.

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1	1.8	1-12	The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Internet Quality Improvement Evaluation System ~~Assessment Submission and Processing System~~ (iQIES) ~~and the State MDS database~~. The notice shown on page 1-16~~4~~ of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

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1	1.8	1-17	**Legal Notice Regarding MDS 3.0** - Copyright 2011 United States of America and interRAI. This work may be freely used and distributed solely within the United States. Portions of the MDS 3.0 are under separate copyright and license protections~~;~~: • Patient Health Questionnaire (PHQ)©: Copyright Pfizer Inc. ~~holds the copyright for the PHQ-9;~~All rights reserved. Reproduced with permission. • ~~Confusion Assessment Method. © 1998, 2003, Hospital Elder Life Program. All rights reserved.~~ Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission. • Health Literacy: The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License. • Transportation © 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. ~~Both Pfizer Inc. and the Hospital Elder Life Program, LLC~~All copyright and license holders have granted permission to use these instruments and data elements in association with the MDS 3.0.