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1	—	1-1	~~2011 Edition~~
1	—	1-1	Contributions provided by the numerous people, organizations, and stakeholders listed below are very much acknowledged by CMS. Their collective hard work and dedication 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 have resulted in a 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 thanks to all of the people that have contributed to making this manual possible. Thank you for the work you do to promote the care and services to individuals in nursing homes.
1	—	1-1	**Experts in Long Term Care** Elizabeth Ayello, PhD, RN Barbara Bates-Jensen, PhD, RN, CWOCN Robert P. Connolly, MSW Kate Dennison, RN, RAC-MT Linda Drummond, MSN Rosemary Dunn, RN Elaine Hickey, RN, MS Karen Hoffman, RN, MPH Christa Hojlo, PhD Carol Job, RN RAC-CT Sheri Kennedy, RN, BA, MSEd., RAC-MT Steve Levenson, MD, CMD Carol Maher, RN-BC, RAC-CT Michelle McDonald, RN, MPH Jan McCleary, MSA, RN Dann Milne, PhD Tracy Burger Montag, RN, BSN, RAC-CT Teresa M. Mota, BSN, RN, CALA, WCC, CPEHR John Morris, PhD, MSW Diane Newman, RNC MSN, CRNP, FAAN Terry Raser, RN, CRNAC, RAC-CT Therese Rochon, RNP, MSN, MA Debra Saliba, MD, MPH Rena Shephard, MHA, RN, RAC-MT, C-NE Ann Spenard, MSN, RNC, WCC Pauline (Sue) Swalina, RN Mary Van de Kamp, MS/CCC-SLP Nancy Whittenberg Sheryl Zimmerman, PhD

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1	—	1-2	**Organizations and Stakeholders** Academy of Nutrition and Dietetics ~~American Association of Homes & Services for the Aging~~ American Association of Nurse Assessment Coordinators American Health Care Association American Health Information Management Association American Hospital Association American Medical Directors Association American Nurses Association Association of Health Facility Survey Agencies – RAI Panel Commonwealth Fund interRAI Kansas Department on Aging Leading Age National Association of Directors of Nursing Administration/Long Term Care National Association of Subacute and Post Acute Care The National Consumer Voice for Quality Long Term Care ~~formerly NCCNHR~~ State Agency RAI Coordinators and RAI Automation Coordinators State Quality Improvement Organizations US Department of Veterans Affairs
1	—	1-3	**Contractors** **RTI International** Roberta Constantine, RN, PhD Rajiv Ramakrishnan, BA Karen Reilly, Sc.D.
1	—	1-3	**Stepwise Systems, ~~INC~~Inc** Robert Godbout, PhD David Malitz, PhD **CMS** Ellen M. Berry, PT CMS Regional Office RAI Coordinators Thomas Dudley, MS, RN Penny Gershman, MS, CCC-SLP Lori Grocholski, MSW, LCSW Renee Henry, MSN, RN Alice Hogan, PMP Alesia Hovatter, MPP Melissa Hulbert, Director—Division of Advocacy and Special

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			Issues John Kane Jeanette Kranacs, Director - Division of Institutional Post-Acute Care Sheila Lambowitz, Director (Retired)—Division of Institutional Post Acute Care Shari Ling, MD Stella Mandl, BSW, BSN, PHN, RN Mary Pratt, MSN, RN~~, MSN~~, Director—Division of Chronic and Post-~~-~~Acute Care MaryBeth Ribar, MSN, RN Karen Schoeneman, ~~Deputy Technical~~ Director (Retired)—Division of Nursing Homes John E. V. Sorensen Christina Stillwell-Deaner, RN, MPH, PHP Michael Stoltz Daniel Timmel John Williams, Director—Division of National Systems Cheryl Wiseman, MPH, MS ~~State RAI Coordinators~~ ~~State Automation Coordinators~~ ~~AHFSA RAI Panel~~
1	—	1-4	Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Please continue to check our web site for more information at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30Appendix_B.pdf ~~http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp.~~
1	1.1	1-5	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 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,

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			clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations[1]. [1] Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from http://healthcentricadvisors.org/images/stories/documents/inhc.pdf.
1	1.2	1-5 & 1-6	The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization ~~guidelines~~Guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:
1	1.2	1-6	• **Minimum Data Set.** A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The 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 for each MDS assessment and tracking document (e.g., admission, quarterly, annual, significant change, significant correction, discharge, entry tracking, PPS assessments, etc.) can be found in Appendix H. • **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 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 responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment. — **Care Area Assessment** ~~(CAA)~~ is the further investigation of triggered areas, ~~and is completed~~ to determine if the care

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			area triggers ~~are issues that~~ require interventions and care planning. The~~re are~~ **CAA** r~~R~~esources provided as a courtesy to facilities in Appendix C. These resources include ~~are~~ a compilation of checklists ~~of~~ and Web links ~~resources~~ that may be helpful in performing the assessment of a triggered care area. The use of these resources are not mandatory and ~~are included in Appendix C and~~ represent neither an all-inclusive list nor government endorsement. — **CAA Summary (Section V of the MDS 3.0)** provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether or not to proceed to care planning. • **Utilization Guidelines.** The Utilization Guidelines provide instructions for when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from http://cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).
1	1.3	1-6& 1-7	Over time, the various uses of the MDS have expanded. While its primary purpose i~~a~~s an assessment tool ~~is~~ used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the 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 ~~the hospital swing bed program.~~ ~~N~~non-critical access hospitals with a swing bed agreement. ~~Swing bed providers~~ They are required to complete the MDS for reimbursement under the Skilled Nursing Facility Prospective Payment System (SNF PPS).
1	1.3	1-7	• **Medicare and Medicaid Payment Systems.** The MDS contains items 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 to classify Medicare residents into RUGs (Resource Utilization Groups). The RUG classification system is used in ~~the~~ SNF PPS for skilled nursing facilities, non-critical access hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. More detailed information on the SNF PPS is

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			provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at ~~(~~www.cms.gov/Manuals/IOM/list.asp~~)~~ for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing. ~~(The Medicare Benefit Policy Manual is located at www.cms.gov/Manuals/IOM/itemdetail.asp)~~ • **Consumer Access to Nursing Home Information**. Consumers are also able to access information about every Medicare- and Medicaid-certified nursing home in the country. The Nursing Home Compare tool (http://www.medicare.gov/NHCompare) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes.
1	1.3	1-8	Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) must provide an RN to ~~conduct or~~ conduct or coordinate the assessment and sign off the assessment as complete. 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, 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 ~~member~~ 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. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's

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			problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.
1	1.4	1-8	Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.
1	1.4	1-9	**b. Decision Making~~/Diagnosis~~**—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 ~~problems~~. 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 care areas in the CAA ~~decision-making~~ process. Understanding the causes and relationships between a resident's clinical issues and needs ~~problems~~ and discovering the "whats" and "whys" of the resident's clinical issues ~~problems~~ and needs; finding out who the resident is and consideration for incorporating ~~putting the~~ his or her needs, interests, and lifestyle choices ~~of the resident~~ into the ~~at the center of care~~ delivery of care is key to this step of the process. **c. Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and care plan interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting residents' active participation in the process. **d.~~c.~~ Care Planning**—Establishing a course of action with input from the resident (resident's family and/or guardian or other

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			legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care. ~~**d. Identification of Outcomes** – Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting residents' participation in the process.~~ **f. Evaluation—Critically** reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline.
1	1.4	1-9 & 1-10	The following pathway illustrates a problem identification process flowing from MDS (and other assessments), to the CAA decision-making process, ~~to~~ care plan development, ~~to~~ care plan implementation, and finally to evaluation. This manual will ~~feature~~ refer to this process ~~this pathway~~ throughout several ~~the~~ chapter discussions. If you look at the RAI process as a solution oriented and dynamic process, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident's quality of care and quality of life. The RAI offers a clear path toward using all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor. The key to ~~understanding and~~ successfully using the RAI process ~~and successfully using it~~ is ~~believing~~ understanding that its structure is designed to enhance resident care, increase a resident's active participation in care, and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) and physicians (or other authorized healthcare professionals as allowable under state law) are all involved in its "hands on" approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care.

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			In short, it works.
1	1.4	1-10	• **Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and enhanced quality of life. Nursing home providers have found that when residents actively participate in their care, and care plans reflect appropriate resident-specific approaches to care based on careful consideration of individual problems and causes, linked with input from residents, residents' families (and/or guardian or other legally authorized representative), and the ~~an~~ interdisciplinary team, ~~and appropriate resident-specific approaches to care,~~ residents have experienced goal achievement and either their level of functioning has improved or has deteriorated at a slower rate. Nursing home staff report that, as individualized attention increases, resident satisfaction with quality of life also increases. • **Staff Communication Has Become More Effective.** When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from performing ~~using~~ the CA~~T~~As) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality is ~~must be~~ accommodated in the care plan.
1	1.5	1-11	**Goals** The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, 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'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 indicators,~~ quality measure~~s~~ reporting~~,~~ and Medicare SNF PPS reimbursement (via resource utilization group~~s~~ [RUG~~s~~] classification).
1	1.6	1-12	The MDS is completed for all residents in Medicare- or Medicaid-

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			certified nursing homes and 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	1-13	Appendix H: MDS 3.0 Item Sets ~~Forms~~
1	1.7	1-14	Page length change.
1	1.8	1-15	MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities ~~under the Conditions of Participation (COP). B~~by regulation at CFR 483.75(l)(2)(3) and 483.75(l)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by: Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. Information regarding The Privacy Act can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/PrivacyActof1974.html. 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, Quality Improvement Evaluation System Assessment Submission and Processing System (QIES ASAP) and the State MDS database. The notice shown on page 1-14 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

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			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. **Contractual Agreements** Providers, who are part of a ~~chain~~ corporation, may release data to their corporate office or parent company but not to other providers within their ~~chain~~ corporate organization. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the 42 CFR at 483.10(e)(3)).
1	1.8	1-16	~~https://www.cms.gov/MDSPrivacyActStatement.pdf~~
1	1.8	1-17	Page length and page number change.