



DATE: May 23, 2003
TO: MDS 3.0 Development Team
FROM: Ruta Kadonoff, Senior Health Policy Analyst
RE: AAHSA Comments on MDS 3.0 Draft

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to comment on the April 2, 2003 draft of the Minimum Data Set (MDS), version 3.0. Our comments are based on input provided by our member organizations as well as staff review of the draft instrument.

AAHSA represents more than 5,600 mission-driven, not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. Every day, our members serve more than one million older persons across the country. AAHSA is committed to advancing the vision of healthy, affordable, ethical long-term care for America. Our mission is to create the future of long-term care.

AAHSA has been an integral player in the development and evolution of the Resident Assessment Instrument (RAI) over the years since OBRA 1987 first mandated the implementation of a uniform assessment instrument for use in nursing facilities. Our staff and members have worked closely with CMS and their contractors on field testing, have provided feedback on the utility of the instrument, and have made suggestions for its improvement based on their experiences as the day-to-day users of the tool. AAHSA members recognize the importance and value of this instrument and are eager to contribute to this next phase in the evolution of the RAI and the MDS.

The MDS Serves Many “Masters”

The initial intent of the MDS was to provide a standardized set of information about each resident to assist the nursing facility staff in developing comprehensive, individualized care plans. In the years since its initial implementation, the uses of the MDS have expanded far beyond this initial purpose. In addition to providing a foundation for planning care, the data collected through this instrument are now also used to drive the federal Medicare and many state Medicaid payment systems, and to generate the quality indicators and quality measures that facilities use in internal quality improvement, surveyors use to focus the survey and certification process, and CMS uses to report to the public as a tool for selecting a high quality nursing facility.

Components of the MDS 2.0 serve some of these purposes well, yet there are many opportunities to improve the quality of the information derived from this data source to improve its capacity to meet its array of multi-faceted needs. Key to achieving the objective of improving the quality of the information available to clinicians, payors, and consumers is ensuring that the revisions under consideration at this time are made keeping all of these constituencies at the forefront. We must continually ask ourselves how questions may be revised and/or what additional information could be collected to improve the power of the MDS to accurately target more in-depth assessment and care planning, to predict resource use, and to measure the quality of care provided by the facility.

With regard to improving the quality of information for care planning and making the instrument as relevant and user-friendly as possible for the clinicians providing care in nursing facilities, we attach a set of detailed recommendations for improving individual items. These recommendations have been provided to us by clinicians working in nursing facilities on a daily basis and are based on their own experience in use of the current instrument and their understanding of the feasibility of the proposed questions for gathering meaningful, clinically relevant data in a consistent and accurate manner. We urge you to carefully consider each of these recommendations as you make revisions to this draft in preparation for testing in the field. In order for the instrument to be of maximum utility for clinicians, items must be consistent with their training and thought processes with regard to patient assessment; current, standard, accepted scales should be used whenever possible; and coding must be as intuitive, straightforward and simple as possible.

With regard to predicting resource use, we urge CMS to integrate the work of the MDS 3.0 Development Team with the work of the CMS staff and contractors tasked with recommending revisions to the Skilled Nursing Facility Prospective Payment System (SNF PPS). Currently, it seems these two efforts are proceeding on parallel tracks with little, if any, coordination. CMS has indicated that all current payment items will be retained in version 3.0 of the MDS to ensure there are no disruptions to the payment system. While we understand that this is necessary, it is troublesome that the broader questions related to payment do not seem to be playing a prominent role in the development process. That is, the question to be posed should not be simply, "What items must be retained to ensure the current payment system remains viable?" Rather, we would like to see the MDS 3.0 development team working closely with the SNF PPS research team to determine what items, if added or modified, would result in better information than that currently available, so that we might improve the MDS' ability to accurately and consistently predict resource use. The latter question is the one that is critical at this juncture if we are to progress to better and more rational systems for ensuring that providers are paid adequately to provide residents with high quality care.

With regard to quality measurement, there are a number of identified shortcomings in the current version of the MDS that must be addressed in this revision if CMS is to make progress in the ability to accurately measure and report on quality in nursing facilities.

Potential items must be considered to determine whether they help move the field of quality measurement in nursing facilities to an improved ability to differentiate between negative outcomes that may be due to inadequacies in care and those that are unavoidable based upon the resident's conditions.

First and foremost in this vein, there is a need for the MDS to capture better information about each resident's overall prognosis to allow for appropriate risk adjustment of quality measures. Thus far, the only items that have been used as a proxy for "expected decline" in risk-adjusting a limited number of the existing quality measures are the items that capture terminal status (end-stage disease and hospice). We must recognize, and our data systems must allow us to capture, the fact that there are many residents whose expected course in the nursing facility is gradual decline over time, although they are not yet in the terminal stages of disease. It is unrealistic for quality measures to codify an expectation that all nursing facility residents should be improving in their functional abilities and health status. This is true of some residents, particularly those in nursing facilities for short-term, rehabilitative post-acute stays, but it is not generally true of the long-term, chronic care resident with multiple complex medical problems and a high prevalence of Alzheimer's disease and other dementias.

The OASIS instrument was designed exclusively for the purpose of measuring quality outcomes in home health care. This is in contrast to the MDS, which has been retrofitted to this purpose for nursing facilities. The developers of OASIS included a question on overall prognosis, which is a factor used in risk-adjusting the home health quality measures – the clinician's best assessment of the home health patient's overall prognosis for recovery from the current episode of illness. The MDS development team should review this OASIS item (MO260) as well as the OASIS item on rehabilitative prognosis (MO270) and implement appropriate versions of these elements for the MDS 3.0. This would allow for some improvement in the ability of the quality measures to determine whether outcomes showing decline in the resident's functional or health status are consistent with expectations of the resident and a predictable result of the progression of the resident's clinical condition, or an unexpected turn of events that may signal inadequacies in the care provided.

Other areas of the current instrument that have been identified as problematic with regard to the MDS' inability to provide adequate information appropriate to quality measurement (for both quality indicators and quality measures) include:

- The inability to determine whether an identified pressure ulcer is in the process of developing/worsening or whether it is, in fact, in the process of healing/improving under the care of the nursing facility staff.
- The inability to determine whether a resident's pain is being appropriately managed, consistent with that resident's own goals for pain management.
- The inability to distinguish, based on current MDS coding instructions, between a resident who shows signs of being at risk for falls, and one who has actually fallen as clinicians and non-clinicians alike would generally interpret the term "fall."

The draft MDS 3.0 that we have reviewed has attempted to address some of these issues to some extent. However, we believe it falls short of collecting the information needed to significantly improve our ability to accurately measure quality of care in these and other areas. Our attached item-by-item recommendations include suggestions for improving individual items to achieve this objective. In addition, as we recommended above with regard to improving the MDS' ability to better capture resource use, we urge the MDS 3.0 development team to work closely with CMS contract researchers and other experts in quality measurement in nursing facilities. The goal should be to identify not only how to potentially "tweak" existing items to improve calculation of current quality indicators and measures, but also to ask the broader question, "What additional resident-level information would allow us to significantly improve the science of quality measurement in nursing facilities?"

The MDS Must Fit the Needs of Distinct Resident Populations

The MDS was designed at a time when the resident population in nursing facilities was far more homogenous than it is today. By and large, the instrument was intended to meet the assessment needs of the chronic care, long-term resident. The evolution of payment systems and clinical care has significantly altered the landscape, such that a wide variety of residents is currently being served in nursing facilities, all with some characteristics in common, but also with some very distinct care and service needs and different expected outcomes. This instrument, because it is mandated for all residents of Medicare and/or Medicaid-certified nursing facilities, must address all of these different categories of residents. Neither the MDS 2.0 nor the current proposed draft MDS 3.0 is sufficiently sensitive to these different resident types.

At a minimum, most nursing facilities serve a mix of residents including those elderly that might be referred to as "post-acute," "chronic or long-term care," and "end-of-life or palliative care." Smaller in number, but still essential to consider because the instrument will be used to assess them as well, are the pediatric long-term care resident and the younger disabled long-term care resident.

The current draft appears to contemplate a version of the instrument for the pediatric population. We have not yet seen a draft of any items proposed specifically for these residents, however, so it remains unclear to us at present whether it will be an entirely separate assessment and/or how it will be integrated with the current set of proposed items. The draft also incorporates some minimal skip patterns to differentiate a limited number of questions as applicable either the post-acute or the long-term care populations. It does not seem to indicate any consideration of the unique needs of the palliative care/end-of-life or the younger disabled populations.

Our recommendation is that the CMS development team convene groups of experts in the needs of each of these unique populations to carefully consider, for each of the MDS domains, how it applies (or does not apply) to the segment of the population and whether the proposed set of questions/assessment scales used accurately captures their respective assessment needs or whether a different set would be more appropriate. These groups

should also be asked to consider whether there are additional assessment domains that are essential to capture the needs of the particular population. The work of these groups should then be integrated to arrive at an instrument that incorporates fairly extensive skip pattern logic that ensures the use of the most appropriate set of items to meet the individual resident's needs, and that time is not wasted by the clinician trying to "fit square pegs into round holes" in responding to questions not appropriate to the resident. It is absolutely essential that these expert groups include caregivers currently engaged in providing nursing facility care for these types of individuals and familiar with the MDS process.

Quality of Life/Resident Satisfaction and the MDS

Capturing reliable and meaningful information about residents' quality of life and their satisfaction with the care and services provided by nursing facilities is an important and laudable goal. AAHSA has advocated that CMS move in this direction and has encouraged the agency to work toward incorporating measurement of these elements into public reporting on nursing facility quality as soon as they are "ready for prime time." We question, however, whether or not the MDS is an appropriate and suitable vehicle for collecting this information in an accurate and consistent manner for purposes of measurement.

CMS has funded extensive research on nursing facility resident quality of life over the last several years, which serves as the basis for the questions proposed in this draft. Findings from that research reported to date document the validity and reliability of these questions as part of a far more extensive instrument that includes 54 individual items grouped into 11 domains. This research showed that interviews sufficient to calculate the quality of life scales could be completed for only 60% of residents sampled.¹ This immediately raises questions about whether it is rational to include these types of questions in an instrument that is expected to be completed for each resident, rather than devising a mechanism to collect data from a structured, purposeful sample of facility residents designed to generate information about quality of life that could be generalized to the facility level.

Another critical factor that calls into question the appropriateness of incorporating these items into the MDS is the fact that the research reported to date has involved data collection using extensively trained research staff to conduct resident interviews. These researchers devoted an average of 1 hour per resident to the completion of an interview and guaranteed anonymity to the nursing facility residents responding to the questions. We understand that further testing has been conducted to determine whether or not similar validity and reliability are achievable when nursing facility staff functions as data collectors. To date, no results of this effort have been reported. Other research on customer satisfaction surveys in nursing facilities has shown, however, that there is

¹ Kane, R. et.al. *Quality of Life Measures for Nursing Home Residents*. Journal of Gerontology, 2003; 58A(3):240-248

significant problem of bias when resident interviews are conducted by staff rather than external interviewers.²

We believe the suggested items in this draft and the broader findings of the CMS-funded research can and should serve as a positive starting point for further discussions with key stakeholders. The focus of these discussions should be to determine how this type of information might best be captured in an accurate way that produces meaningful and actionable results for resident care planning, internal quality improvement efforts, and public reporting as an indicator of facility quality.

If CMS determines that the quality of life section is to be included in the MDS 3.0 despite the numerous significant issues we have raised above, we recommend convening a stakeholder group as soon as possible to discuss this section in detail and to arrive at a consensus about the best set of items to include in this initial trial. The questions as presented in the draft have very significant limitations. We have serious reservations about any attempt to implement them in their current form. Some of our specific concerns are:

- The current instruction directs staff to exclude only those residents who are impaired in memory. It is unclear how this section is to be addressed with residents who have impairments in communication – e.g., are non-verbal, unable to understand or to make themselves understood.
- There is no provision in the response options to indicate a resident’s refusal to respond to the entire section and/or to individual questions.
- Accurate information cannot be captured from all residents for this section unless additional screener questions precede certain items to determine whether the question is appropriate for the resident or a response option of “not applicable” is added. For example:
 - Some residents are unable to/do not use the telephone because of communication impairments, personal preferences, or numerous other reasons. (item F1b)
 - Some residents may not have family or friends nearby who visit. (item F1c)
 - Some residents are not religious and do not wish to participate in religious activities. (items F1e and F1f)
 - Some residents may not be comfortable in groups and may not enjoy organized activities, but prefer one-to-one or individual activities. In addition, many short-stay residents are not interested in participation in organized activities. (item F1g)
 - Some residents are unable to consume food by mouth and receive 100% of their intake through tube feeding. (items F1i, F1j, and F1k)
- The scope of these questions is rather limited. We suggest broadening the domains covered rather than using multiple questions in one domain (e.g., 4 questions about privacy, 3 about food, etc.). Questions should also be considered

² Hodlewsky RT, Decker FH. *The problem of bias when nursing facility staff administer customer satisfaction surveys*. Jt Comm J Qual Improv 2002 Oct;28(10):546-54

to capture information about elements such as dignity/respect, meaningful/purposeful activity (which may be either individual or group), and resident autonomy and choice. CMS should share the entire quality of life assessment developed in the research study with key stakeholders and solicit feedback about the most important items to include.

- The questions may be difficult to understand for some residents, and interpretations may differ widely as to what constitutes, for example, “a place to be alone” or a “private” phone call. Clear definitions in terms that can be expected to be uniformly understood by residents are essential if any consistency is to be expected from this section.

Finally, careful consideration must be given to each of these items, its intended use, and the ability to generalize for that use given individual resident characteristics. As noted above, many of the proposed questions apply differentially to residents based on their abilities, interests, and preferences. A response of “no” cannot automatically be interpreted as a failure by the facility to meet quality of life needs. If the items were to be used for the purposes of assessment only – to identify resident concerns and needs – then this would not be a problem. The logical next step on the part of staff would be to pursue additional information for the questions that elicit a “no” response and determine whether the facility staff can do anything to improve the situation or whether it is due to other factors.

We are keenly aware, however, that these questions will not be used solely for purposes of assessment and care planning, but that an intended next step is the development of quality measures using information collected from this section. Because these “quality measures” are then reported to and perceived by the public as absolutes, far more careful attention must be paid to the construction of the questions and the response options to ensure that questions are asked in a way that elicits the relevant information – i.e., is a response that appears to be a “failing” in quality of life something that is within the facility’s control, or is it due to resident characteristics, limitations, or preferences? Absent these considerations, we fear that unintended negative incentives will be created for facilities and the ultimate goal of stimulating improvements in quality of life for residents may be lost.

Our specific, item-by-item recommendations are attached. Please feel free to contact me at (202) 508-9450 or rkadonoff@aaahsa.org with any questions you may have.

ATTACHMENT – AAHSA COMMENTS SPECIFIC TO DRAFT MDS 3.0 ITEMS

General Comments that Apply to Multiple Items

1. Timeframes for look-back periods should be as consistent as possible. Variation in observation periods across items will undoubtedly create confusion for staff completing the assessment and contribute to continuing accuracy problems. To the extent feasible, we suggest using a five to seven day period as the standard window for observations to be used in coding the MDS. We also recommend using a consistent notation on the form to indicate the look-back period for each item so that there is no question as the form is completed – e.g., (#), in parentheses immediately after the title of the item, or something similar. In some cases where the draft included the look-back information only in the section header but then showed exceptions only in the individual item titles, reviewers were confused (e.g., see Section H – overall look-back 7 days, H2 – look-back is 14 days and is specified in the item title. Some reviewers inquired as to the correct look-back period for the remaining items in the section because none was noted in item titles for H1 and H3.)
2. Consideration should be given to the mapping of data elements between the MDS and the standard forms facilities are required to complete at the time of survey (e.g., 672 and 802). Some items that are proposed for elimination (e.g., advance directives) can currently be mapped directly to the survey forms using standard software programs, eliminating the need for a separate data collection effort to ensure this information is readily available. Consideration should be given to whether the most efficient way to collect this information is to retain items that map to the survey forms on the MDS.
3. Elimination of the “none of the above” response from many items may be problematic for data integrity. Including this response option ensures that items are not inadvertently left blank through the use of an error routine ensure that all items have a response checked. Without this option, it will be impossible to know with certainty whether a checklist item left blank reflects an omission or whether it is a true indication that none of the listed options applied to the resident. Forcing a response is likely to improve data accuracy and integrity.
4. There is some redundancy among items in different sections. This needs to be resolved and eliminated. If that is not possible, then at a minimum, clear coding guidance must be provided as to whether to code problems in multiple sections or choose one. For example, mouth pain is coded in section L1, chest pain in section J1, foot pain in section M5. Pain, in general, is coded in section J2. If a resident has mouth pain, is it to be coded in both L1 and J2? It would seem to make more sense to code all pain in item J2, and then identify the site(s) of the pain - either in another MDS item or in the pain RAP - and eliminate the individual items that ask about pain in specific locations. The same issue exists with regard to fractures (J1) and falls with fractures (J4)

Item-Specific Comments

Section A: Identification Information

1. A11 – Reason(s) for Assessment
 - a. Text is missing in the draft for the final item in this section. Is this where OMRA assessments will be captured, as they do not currently appear to be listed anywhere else in this section?
2. A13 – Medicare Stay
 - a. This information is not always known by/readily available to clinical staff completing the assessment, creating great potential for inaccuracies. If the item does not serve an essential purpose, recommend deleting it.
 - b. If the item is to be retained, it requires clarification. Questions arose with reviewers as to whether the item refers to the most recent Medicare stay in the facility, or if the reference is to the most recent stay in a hospital or other Medicare provider.
3. A14 – Assessment Reference Date
 - a. Clarification is required on how A14.b (“original or corrected copy of form”) will be operationalized. It is unclear how corrections will be distinguished from inactivation requests, and how inactivation requests will be submitted if the correction request form is eliminated and intended to be replaced with this MDS item.

Section B – Cognitive/Behavioral Patterns

1. Suggest replacing items B2 and B3 with the Mini Mental State Exam to better identify cognitive deficits and allow for measurement of progression over time.
2. B3 – Cognitive Skills for Daily Decision Making – Reviewers welcomed the addition of the “minimally impaired” coding category.
3. B4 – Indicators of Confusion, Disordered Thinking, or Possible Delirium
 - a. Review RAP triggering criteria and quality measure definitions to ensure that only indicators of delirium that are of recent onset are used to trigger the delirium RAP and the delirium quality measure. If all indicators captured in item B4 are also intended to be used as triggers for the delirium RAP and quality measure, there will be an excessively high rate of false positives because the revised question does not clearly differentiate between chronic problems and indicators that are of recent onset that may signal delirium. A possible resolution to this problem is to revise the response options to capture this information. For item B4a, a yes/no response is sufficient. For items B4b and B4c, we recommend using the response choices: (1) not present, (2) present, not of recent onset, and (3) present, over last 7 days; the indicator appears different from the resident’s functioning 2 weeks ago (e.g. new onset or worsening).
4. B5 – Hallucinations/Delusions
 - a. Recommend adding a code to capture feelings of paranoia.

5. B6e – Behavioral Symptoms – Resists the way care is given – We recommend retaining the MDS 2.0 title for this item, “Resists care.” The language currently proposed in the draft alters the nature of the question and adds an implied value judgment about the appropriateness of the care being provided. What the item is intended to capture is a resident’s behavioral symptom – the act of resisting care. Whether or not the resistance is triggered by the specific actions of the staff in providing care or whether it is a function of other issues is a question for further investigation by the staff as they develop care plan interventions for the resident.

Section C – Communication/Vision Patterns

1. C1 – Hearing – Recommend revising text to read “Ability to hear, with appliance if normally used.”
2. C4 – Vision – Reviewers were pleased with the addition of response option “9” – unable to assess – and believe that this will improve coding accuracy.

Section E – Mood

1. E1B – Indicators of Possible Depression, Sad Mood – Self Report
 - a. Some provision should be made in the response options for residents who may refuse to answer the questions.
 - b. Concerns were raised by reviewers about the ability to use the GDS with the nursing home population. Despite the fact that the scale is an accepted one, clinicians indicated that it may be very difficult to obtain valid responses to these questions from nursing facility residents. Alternative suggestions include using an observational scale such as the Cornell Scale for depression in dementia.
 - c. Concerns were also raised about the timing of data collection for this section. A depression screening tool should not be administered too soon after admission because time must be allowed for adjustment. Recommend excluding this section on 5-day and 14-day assessments.
 - d. RAP triggering criteria for this section appear to be incorrect. The instruction reads, “if 2 or more are yes, complete RAP,” but one of the included questions is, “Are you basically satisfied with your life?” A positive response to this question should not be included in the RAP triggering formula. Question 1 either needs to be rephrased to read, “Are you dissatisfied with your life?” or the formula needs to exclude this question.
2. Intervention Programs for Depression & Behavioral Symptoms – a section with this title was included in the previous draft version reviewed by AAHSA in February. It is unclear why it has been deleted in this version. A concern that has arisen with regard to quality measurement has been the desire to identify residents with depression who are not being appropriately treated. A current shortcoming of the MDS 2.0 is that the only treatment that is captured is the use of antidepressant therapy. The proposal in the previous draft to include information about other, non-pharmaceutical treatment modalities in use was a welcome one from the quality measurement perspective. We recommend reconsidering that

item, with the following recommendations on revision to the language that was released previously:

- a. It is unclear why the instructions specify that only services provided under Medicare Part B should be included in this section. There is no clear reason for this distinction, nor may clinical staff completing the assessment necessarily be aware of the payor source for these services. Recommend deleting “Part B” from the question and that services provided under any payor source be recorded in this item.
- b. The term “augmented activities” (E3e) requires definition.

Section F – Quality of Life

1. F1 – Self-Report Quality of Life – Extensive discussion is provided in our general comments on the MDS 3.0. Items as currently proposed are highly problematic. Recommend deleting this section and engaging in a stakeholder group process to reach consensus on the best way to collect accurate, actionable, relevant information about quality of life in nursing facilities.
2. F2 – Relationships
 - a. Two response options seem to be measuring the same concept – “e. absence of contact with family/friends” and “g. regular visits or correspondence with family/friends.” Recommend keeping one of these options and deleting the other.
 - b. Similar to our comments on quality of life, it is important to understand the purpose/intended use for these questions in order to determine whether they are appropriate and sufficient. If the intent is to use the information solely for assessment – i.e., to identify potential problems the resident is experiencing in the area of relationships so that care plan strategies can be developed to address them – then the information to be collected in this proposed item is likely sufficient. If the intent is to use data from this section to develop quality measures, then additional information should be collected. For example, questions should be added to capture information about *positive* relationships with family, friends, other residents, volunteers and staff, rather than solely about problematic aspects of relationships. Again, similar to comments made previously with regard to quality of life, if these data are to be used to develop quality measures, the specific questions and response options need to be re-evaluated to ensure that the necessary information is captured to allow determination of whether issues identified with regard to the resident’s relationships are things the facility has control over and should be expected to resolve, or whether they stem from the intrinsic characteristics of the resident.
3. F3 – Preferred Routine – We welcome the inclusion of this section, proposed for deletion in the prior draft. This information is important to the staff for planning care and understanding resident habits and preferences.

Section G – Functional Status

1. In general, the majority of reviewers responded positively to the revisions in coding for this section. There was concern expressed by some, however, about the expansion of categories for levels of assistance and whether it will, in practice, be feasible to capture the appropriate level of detailed information to ensure accurate coding.
2. The addition of “set-up help only” was received positively.
3. Section has inconsistent observation periods (some items indicate 7 days, others 24 hours, others do not specify). Recommend making observation period consistent across all items – use 7-day look-back for all items in this section. Using a 24-hour look-back for item G2 is limiting because it may not adequately capture the resident’s typical abilities.
4. G1 – 7-Day ADL Self-Performance
 - a. Requires clarification as to whether 7-day look-back period includes days prior to admission.
 - i. G1c – Locomotion – draft is missing text in the description of this item.
 - ii. G1k and G1i – Bathing and Transfer Tub/Shower - May be preferable to split these two into a separate item given that coding instructions differ from the rest of section and may cause some confusion.
5. G2 – Balance Related to Transitions – Clarification/definition will be required for what is meant by a “smooth” transition.
6. G3 – Neuromusculoskeletal Impairment – Clarification required for A and B – staff may have difficulty understanding as written. Meaning of touch/sensation was also questioned by reviewers. Terms will need to be clearly defined for this section to facilitate accurate and consistent coding.
7. G4 – Devices & Aids – Recommend adding a “none of the above” response option.

Section H – Continence in Last 7 Days

1. H1 – Continence Self-Control – Reviewers appreciate the addition of the “continent with catheter or ostomy” category – this is more intuitive and consistent with clinicians’ thinking than the prior approach to coding residents with catheters and ostomies as “continent.”
2. H2 – Appliances and Programs – It is unclear why this item has a 14-day look-back period while the rest of the section is based on a 7-day look-back period. We recommend using a consistent look-back for the entire section to avoid confusion and coding inaccuracies.

Section I – Disease Diagnoses

1. I1 – Disease Diagnoses
 - a. Reviewers welcomed the transition to an ICD-9 based approach to this section through the use of drop-down menus and believe that it will

improve the accuracy and level of detail of the information to be collected in this section.

- b. The inclusion of kwashiorkor and marasmus in the list of disease diagnoses under nutritional deficiencies baffled our reviewers. These are diseases generally seen in children in developing countries and are highly unlikely to be applicable to the nursing facility population. Unless these are determined to be relevant for the assessment of pediatric nursing facility residents, we recommend deleting them.
- c. Reviewers recommended adding categories for GERD and diverticulosis, contractures, and dysphagia.
- d. Alzheimer's disease is duplicated – listed once as item I1v, and repeated under dementia as “dementia associated with other conditions (i.e., Alzheimer's), with and without behavioral disturbances. Are facilities to check both boxes for a resident with Alzheimer's disease? If the duplication is not eliminated, at a minimum, we recommend listing Alzheimer's disease and other dementias adjacent to one another.
- e. Reviewers recommended that dementia/organic psychotic conditions should not be listed under “psychiatric/mood/mental health. These are physical illnesses with some mental manifestations.
- f. Reviewers indicated that “Other non-organic psychoses” is not a term commonly used by geriatricians. This should be called simply “Other psychoses.”
- g. Dehydration (item I1d) is inappropriately listed in this section – suggest moving back to J1 for problem conditions, fluid status.

J – Health Conditions

1. J1 – Problem Conditions
 - a. Question need for item on “fractures from any source” (J1p) since falls with fractures are captured in J4. If this item is retained, need to ensure clear instruction as to coding for fractures resulting from falls (i.e., are they to be coded in both places?).
 - b. Recommend adding a “none of the above” response option.
2. J2 – Pain Assessment
 - a. Formatting for crosswalk of intensity levels to the various pain scales needs improvement to be more user-friendly (J2b).
 - b. A crosswalk to the MDS intensity levels should be included for a 1 to 5-point scale, which is commonly used in many nursing facilities.
 - c. Suggest including samples in the MDS user's manual of each of the pain scales referenced in item J2b so that facilities will have them readily available as a resource.
 - d. Coding of pain intensity and pain duration/frequency needs to be improved and some relationship clearly established between the responses in these two items. The lack of that relationship in the MDS 2.0 is a problem that manifests itself in inaccurate quality measures. Because the measure for pain is based on both items, the common interpretation is that

the measure captures moderate pain that occurs daily, or severe pain at any frequency. The MDS coding instructions do not support this interpretation. If the resident is in mild pain daily, the frequency item is coded “daily.” If the resident experiences 1 episode of moderate pain in the assessment period, the intensity item is coded “moderate,” (for the highest severity during the observation period). The erroneous linkage of the two items creates a false assumption of daily moderate pain that is not being relieved. This problem does not appear to have been addressed in the current draft. We recommend that the intent of these two items be linked and that the coding instructions direct the staff to accurately characterize the resident’s highest level of pain during the observation period and the frequency of **that level** of pain, rather than the frequency of any pain. An alternative for collecting the necessary information might be to combine the two questions so that there is a frequency associated with each level of pain severity that the resident reports (e.g., by formatting the severity question with 2 columns – one indicating that a given level of severity was reported and the second indicating how frequently that level of severity was reported). In this way, the existence of a mild level of constant pain that occasionally rises to a more severe level could be accurately captured for both care planning and quality measurement purposes.

3. J3 – Pain Management – This item, as currently proposed, is not sufficient to meet the needs of clinicians for planning care, nor is it particularly useful for CMS to use in improving the measurement of quality in the domain of pain management.
 - a. “Pain management regimen” is undefined. Facilities may interpret this quite differently.
 - b. The fact that a resident is “on a pain management regimen” says nothing about whether or not the resident’s pain is, in fact, managed. Nor is the absence of pain necessarily a good proxy for adequate pain management. A recommended alternative to the current question would be to ask whether the resident’s goals for pain management are being met. This alternative would allow for the determination of the adequacy of pain management **from the resident’s perspective**, taking into full consideration his/her right to determine the level of medication they wish to accept relative to other possible trade-offs with regard to side-effects, alertness, etc.
4. J4 – Number and Classification of Falls
 - a. Recommend specifying time frames (number of days) for assessment of falls rather than using “since the last assessment” or “since admission,” which leads to collection of data that is not comparable because of differences in the periods between assessments. For one resident, the item may be capturing falls in a 14-day period, where for others it may be as long as a 90-day period.
 - b. A category should be added to capture “near miss” incidents that facilities are currently instructed to code as falls (e.g., a resident loses balance and staff assists the resident to a seated position). These instances should be

captured to identify risk and ensure that appropriate care plans are in place, but they are not consistent with the general interpretation of what a “fall” is. While the attempt in this draft to differentiate injurious falls from falls that do not result in injury may be helpful in improving the accuracy of the quality indicator on falls (assuming it is revised to capture only injurious falls), coding a loss of balance as a fall remains counterintuitive to the clinician and forces an inappropriate categorization of the event as a fall. Creating a separate category to capture this information will improve the accuracy and consistency of coding for this section.

- c. The initial question in this section should ask whether or not the resident has had a fall in the look-back period. If yes, the number in each category should be completed. If no, the categories should be skipped.
 - d. Definitions for the degrees of injury need to be revised to better clarify distinctions. The current definitions appear to have some overlap, which will impede coding accuracy.
5. J5 – Stability of Conditions – Recommend adding a “none of the above” response option.

Section K – Oral/Nutritional Status

1. K1 – Swallowing/Nutritional Status
 - a. Proposed coding is much too complicated and will not be conducive to coding consistency or accuracy. The percentages of supervision and assistance are very confusing to clinical staff who reviewed the instrument.
 - b. Inclusion of “modified independence” with a definition that indicates a resident who requires “minimal cueing” under the category of “no helper” is confusing. The only code that seems intuitively appropriate for inclusion under “no helper” is complete independence. We question the need for the no helper/helper categorization and recommend deleting it.
2. K2 – Height and Weight
 - a. Reviewers welcomed the change to collection of height only at time of admission.
 - b. Recommend retaining the MDS 2.0 30-day look-back period for weight. Three-day look back period is far too short. At an absolute minimum, this item should allow for weight in the last week, though most recent in last 30 days is preferable.
3. K3 – Weight Loss
 - a. Recommend maintaining current (MDS 2.0) look-backs of 5% in last 30 days or 10% in last 180 days. Adding variation by including “or since last assessment” will lead to confusion and inconsistent data. Maintaining a standard assessment window is preferable.
 - b. Recommend retaining item on weight gain from the MDS 2.0 – this information can be very important for residents with heart and/or kidney problems.

- c. We are pleased with the addition of item to capture whether weight loss was planned or unplanned. This will be helpful for more accurate determination of whether or not weight loss is appropriate or desirable in calculating quality measures. May also want to consider collecting/calculating BMI for purposes of determining whether residents are underweight.
- 4. K4 – Nutritional Approaches – Recommend adding a “none of the above” response option.

Section L – Oral/Dental Status

- 1. May be difficult for nursing staff to accurately determine whether or not resident has a cavity.
- 2. Recommend adding an item to assess whether or not the resident has implants.
- 3. Recommend adding a “none of the above” response option.

Section M – Skin Condition

- 1. We recommend retaining a question that captures history of previous healed/resolved pressure ulcers. This information is important for care planning and highly relevant to clinicians providing care for the resident, as well as a key factor in determining a resident’s risk of developing future pressure ulcers.
- 2. M1 – Staging Pressure Ulcers.
 - a. Reviewers reacted very favorably to the inclusion of the column identifying ulcers present on admission and/or re-admission.
 - b. Reviewers also welcomed the addition of response option “F”, non-stageable.
 - c. CMS’ intent to continue requiring facilities to “reverse-stage” healing pressure ulcers runs counter to currently accepted clinical practices and makes accurate quality measurement impossible because it cannot be determined from the MDS whether an ulcer noted at a given stage is one that is stable, worsening, or improving. One possible option would be to add a third column to the proposed item such that the first column would indicate stages of ulcers that are new or are worsening, a second could capture the highest stage of ulcers that are in the process of healing, and the third would identify ulcers present at admission. Further discussion of this item with experts and clinicians currently in practice in nursing facilities is critical to ensure that an option is identified that all can agree is clinically valid, relevant, consistent with accepted practice, and collects the needed information for all purposes – care planning, payment, and quality measurement.
 - d. It would also be helpful to capture information in this section as to whether the ulcers identified are realistically avoidable. This could be accomplished by documenting elements such as:
 - i. Presence of non-modifiable risk factors
 - ii. Unavoidability due to stage of illness

- iii. Resident or family choice to decline elements of an evaluation or treatment plan (e.g., repositioning, nutrition, debridement)
 - iv. Resident choice of palliative rather than curative goals for wound care.
- 3. M2 – Other Ulcers
 - a. Reviewers appreciated the addition of this section to distinguish other types of ulcers from pressure ulcers.
 - b. This section currently does not include diabetic ulcers (now captured under “foot problems in M7). Recommend adding “c. Diabetic ulcers” to item M3 and deleting M7c – Diabetic foot ulcers.
 - c. Recommend adding a “none of the above” response option.
- 4. M3 – Other Skin Problems or Lesions Present
 - a. Recommend adding a “none of the above” response option.
- 5. M4 – Skin Treatments – Recommend adding a “none of the above” response option.
- 6. M5 – Foot Problems and Care
 - a. See point 3b above.
 - b. Recommend adding a “none of the above” response option.
 - c. Reviewers questioned the relevance of item M5a. This will be checked in the vast majority of cases given the lengthy list of conditions and their overall prevalence. The relevant information is not simply whether or not these foot conditions exist, but whether or not the resident is experiencing problems due to these conditions with regard to pain, mobility, etc.

Section N – Activity Pursuit Patterns

- 1. Observation periods are inconsistent and/or unclear for this section. Item N1 refers to last 3 days, N3 refers to last 14 days, other items do not specify a time period at all. Look-back periods should be as consistent as possible to improve coding accuracy. A 3-day look-back for time awake could result in an inappropriate characterization of the resident’s typical patterns if they are experiencing a short-term acute condition at the time of assessment that may alter usual patterns of waking and sleeping.
- 2. We question why the skip pattern for comatose residents does not include item N1, time awake – would this not always be coded a “0” for a comatose resident?
- 3. N2 – Sense of Initiative/Involvement – Recommend adding a “none of the above” response option.
- 4. N3 – Loss of Interest – There is some overlap between the elements of this item and items in Section E. Recommend giving consideration to where they are most appropriate and limiting data collection on these items to one place on the MDS.
- 5. N4 – Past Roles – Recommend adding a “none of the above” response option.
- 6. N5 – Pursuit/Engagement in Activities
 - a. Distinction between the two concepts (pursuit vs. engagement) should be clarified.
 - b. Definitions for each level of independence/dependence in this context must be provided to ensure consistent coding.

Section O – Medications

1. O2 – Received the Following Medication – For research and quality measurement purposes, it would be helpful to split out psychoactive medications to capture new, increasingly used classes (e.g. SSRIs, atypical antipsychotics, mood stabilizers, and acetylcholinesterase inhibitors), especially those used in treating and managing dementia.

Section P – Special Treatments and Procedures

1. P1 – Special Treatments, Procedures, and Programs
 - a. Recommend adding a “none of the above” response option.
 - b. P1b – Therapies – Recommend clarifying instructions to note that all minutes of therapy provided are to be recorded in column B, irrespective of whether or not the total amount for a given day allows the day to be counted in column A. The current instruction on the draft form does not seem to be consistent with the instructions for this item in the MDS 2.0 users’ manual. A change in this instruction would potentially impact PPS payment.
 - c. P1i – item is blank on the draft. On MDS 2.0, this item is suctioning. Does this remain the same?
2. P4 – Physical Restraints
 - a. Recommend adding a “none of the above” or “no restraints used” response option.
3. P7 – Expected Length of Stay
 - a. This item as currently constructed is problematic due to time of completion of the first PPS assessment (5-day) vs. timing of physician visits to obtain this information for the MDS. Suggest either deleting this item or basing the coding on the judgment of the facility’s interdisciplinary team rather than the attending physician.
 - b. Alternatively, we recommend replacing this question with item Q1c from the MDS 2.0, which asks whether the stay is expected to be of short duration.

Section X – Preventive Health

1. The MDS is not the most practical or efficient means to collect this information.
 - a. For all of these items, the definitions of “if eligible” are necessary.
 - b. For influenza vaccination, the completion of the items will depend on time of year, adding complexity to the process. How will completion of the items be triggered? If multiple assessments are completed during these windows of time, will this item be completed repeatedly, or only on the first assessment during the time period?
 - c. For pneumococcal and tetanus vaccines, timing is also problematic and will lead to redundant documentation. Will the items be completed on

each assessment, given that the vaccines are indicated only infrequently, or only once at the time of admission?

- d. Given the considerations as to the timing of collection of these data and the incompatibility with the MDS timeframes, it seems it would be more practical to devise a separate mechanism for collecting this information, rather than attempting to shoe-horn it into the MDS process.