

Comments on MDS 3.0
CMS Town Hall
June 2, 2003

American Speech-Language-Hearing Association

ASHA is pleased to have the opportunity to provide comments for the Draft Version of MDS 3.0. ASHA is the professional and scientific association representing over 109,000 speech-language pathologists, audiologists, and speech-language and hearing scientists. ASHA has appreciated the opportunity to meet with and provide comments to CMS staff about MDS 3.0 several times in the past year. However, with the exception of the addition of item J1 (Swallowing/Nutritional Status), we are disappointed that CMS has rejected our professional input in releasing a draft version of MDS 3.0 which fails to adequately recognize the importance of communication in evaluating a SNF patient. Our specific comments on the MDS items appear again below in item 1. New comments are addressed under headings #2 and #3.

As we have commented throughout the year from a broader perspective, ASHA believes that the concept of developing the MDS as a streamlined, quickly administered screening tool is incompatible with its other stated intended uses as a care planning, outcomes, and quality measurement tool. While we acknowledge the need to decrease the administrative burden placed on those providing the assessment, quality of care should not be compromised for expedience. By their nature, communication and cognitive disorders are subtle and require more assessment levels in order to have adequate sensitivity to reflect change. These areas of function are the foundation for the resident's ability to interact with staff and to perform ADLs. In past comments and meetings we have recommended that ASHA's 7 point Functional Communication Measures be adapted for the communication and some cognitive items. We are pleased that a 7 level scale has been used for the Swallowing/Nutritional Status item, but believe that other MDS items could also be enhanced with the use of 7 point scales.

We have also commented previously that ASHA members report that residents exhibiting communication/cognitive/swallowing impairments are not consistently identified on the MDS. ASHA continues to urge CMS to require enhanced training for MDS coordinators in communication, cognition, and swallowing to ensure that residents are appropriately identified.

1. Changes in Items from MDS 2.0

Section K. Swallowing/Nutritional Status

ASHA commends CMS for the creation of a Swallowing/Nutritional Status item (K1). This critical area of function was a serious omission in the MDS 2.0 and is now adequately addressed in MDS 3.0. The Swallowing/Nutritional Status item should trigger the Nutritional Status RAP rather than the Psychotropic Drug Use RAP, as is currently the case.

Section C. Communication/Vision Patterns

ASHA is concerned that several items have now been removed from the Communication section, reducing that section from 7 to 3 items. ASHA recognizes the need to minimize the paperwork burden of completing the MDS; however, at a minimum, we feel that restoring the items on Communication Aids and Speech Clarity is essential.

Just as there is a section on the MDS 3.0 (G4) to record devices and aids needed for ambulation, a Communication Aids item needs to exist to record whether a resident wears a hearing aid or assistive listening device for hearing, or uses some type of speech device (manual or electronic communication board, artificial larynx, etc.) If these items are not noted on the MDS, there is a much greater risk that their use and function will not be monitored or that a referral for additional services will not be triggered. In ASHA's comments on March 10, 2003, we recommended the following elements be included in a Communication Aids item: *a) Hearing aids; b) Assistive listening device; c) communication board/other communication device; d) signs/gestures; and e) other.* The draft 3.0 MDS does not contain these elements, and ASHA requests that CMS include these items in the final 3.0 MDS.

The "Speech Clarity" item from MDS 2.0 should be retained because it represents a different communication disorder than what is currently reflected in C2 (expression) or C3 (comprehension). A patient with amyotrophic lateral sclerosis (ALS), for example, may have very slurred, indistinct speech but no difficulty finding words or finishing thoughts.

Section B. Cognitive/Behavioral Patterns

ASHA believes this section has been improved with the changes to items B.4, B.5, and B.6. However, Item B.2 (Memory/recall) remains nonfunctional. The distinction of long-term vs. short term memory does not indicate whether the problem is mild or severe, nor does it offer insight into how the memory problem would affect the resident's ability to function in the SNF. A mild-moderate long term memory problem may not affect a resident's function, whereas even a mild short term memory problem would require additional staff time or additional structuring of the resident's environment to assist in recalling new information that affects his/her daily activities. In ASHA's comments on March 10, 2003, we recommended using the following item in place of short term vs. long term memory: *Situational memory: Resident recognizes staff names/faces frequently encountered and knows location of places regularly visited and Procedural memory: can perform all or almost all steps in a multi-step sequence without cues for initiation.* CMS should consider substituting these items in the final version of the MDS 3.0

Terminology

As noted in ASHA's previous comments, the term "appliance" is not a recognized term when used in reference to hearing. ASHA requests CMS to use the appropriate

terminology of “hearing aid or device” in item C1, rather the generic term of “appliance”.

ASHA has also previously requested in item P.2 that “speech-language pathologist” and “audiologist” be separated on different lines, since they represent different professionals and are not interchangeable.

2. Comments on Revised MDS 2.0 manual (Dec. 2002), Section P, modification of therapies (P1b).

ASHA believes that the new definition in this section has created a lack of clarity by suggesting that nursing administration determines the frequency and duration of therapy. [“Nursing administration, in conjunction with the physician and licensed therapist, is responsible for determining the necessity for, frequency of, and duration of the therapy. Includes ONLY medically necessary therapies furnished after admission to the skilled nursing facility.”] Even though CMS staff has responded by saying that their function is an oversight of the plan of care and does not change existing standards, we are concerned that it will be misinterpreted by others as directing nurses to make judgments outside their scope of practice and lead to an inappropriate level of decision making. ASHA strongly recommends that this new definition NOT be included in the manual for MDS 3.0.

3. Short stay patients

As noted in the Federal Register announcement of this Town Hall meeting, skilled nursing facilities treat rehabilitation-intensive patients, short stay, and specialized populations that the MDS was not originally designed to assess. Particularly problematic are acute rehab patients who are assessed on admission at a low level of rehab services but quickly improve to needing a high level of rehabilitation after the MDS has been completed. When they are short stay patients, the facility is not reimbursed for the level of rehab that was actually provided. ASHA recommends that CMS consider a mechanism for patients to have their RUG level adjusted when a short stay patient has a change in rehab need within a week of the initial MDS being filed.

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