Cheatography

CMS Minimum Data Set (MDS) Cheat Sheet

by [deleted] via cheatography.com/2754/cs/12855/

Introduction MDS 3.0

The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process, and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. All assessments are completed within specific guidlines and time frames. In most cases, participants in the assessment process are licensed health care professionals employed by the nursing home. MDS information is transmitted electronically by nursing homes to the national MDS database at CMS..

Credit: https://www.cms.gov/Research-Statistics-Data-and-Systems/-Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/index.html

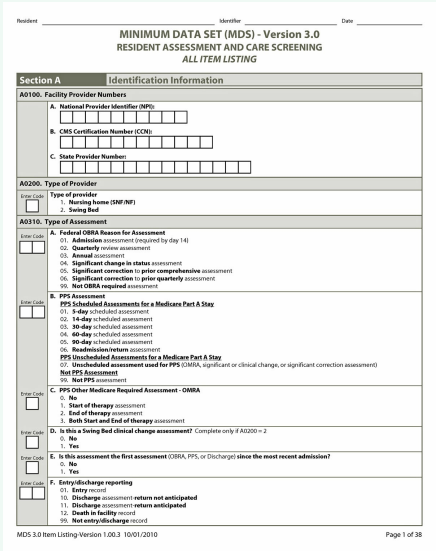
Main Objectives

- MDS screens for possible problems in 20 care areas.
- Care Area Triggers (CATs) alert to possible issues in the care needs.
- Triggered care area must be thoroughly assessed.
- There is no mandated specific tool for assessment.
- Documentation must meet criteria.

CAAs: Problem Areas

1. Activities
2. ADL Supplement Attaining Maximum Possible Independence
3. ADLs Functional Status/Rehabilitation Potential
4. Behavioral Symptoms
5. Cognitive Loss/Dementia
6. Communication
7. Dehydration/Fluid Maintenance
8. Delirium
9. Dental Care
10. Documents
11. Feeding Tubes
12. Mood State
13. Nutritional Status
14. Pain
15. Physical Restraints
16. Pressure Ulcer
17. Psychosocial Well-Being
18. Psychotropic Medication Use
19. Return to Community Referral
20. Urinary
21. Visual Function

MDS 3.0 Form



Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
ALL ITEM LISTING

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code — Type of provider
1. Nursing home (SNF/NF)
2. Swing Bed

A0310. Type of Assessment

Enter Code — A. Federal OBRA Reason for Assessment
01. Admission assessment (required by day 14)
02. Quarterly review assessment
03. Annual assessment
04. Significant change in status assessment
05. Significant correction to prior comprehensive assessment
06. Significant correction to prior quarterly assessment
99. Not OBRA required assessment

Enter Code — B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. 5-day scheduled assessment
02. 14-day scheduled assessment
03. 30-day scheduled assessment
04. 60-day scheduled assessment
05. 90-day scheduled assessment
06. Readmission/return assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. Not PPS assessment

Enter Code — C. PPS Other Medicare Required Assessment - OMRA
0. No
1. Start of therapy assessment
2. End of therapy assessment
3. Both Start and End of therapy assessment

Enter Code — D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. No
1. Yes

Enter Code — E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission?
0. No
1. Yes

Enter Code — F. Entry/discharge reporting
01. Entry record
10. Discharge assessment-return not anticipated
11. Discharge assessment-return anticipated
12. Death in facility record
99. Not entry/discharge record

MDS 3.0 Item Listing-Version 1.00.3 10/01/2010 Page 1 of 38

Complete Form: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Archive-Draft-of-the-MDS-30-Nursing-Home-Comprehensive-NC-Version-1140.pdf

CAA Process Framwork

- Guides review of triggered areas
- Clarifies functional status and related causes of impairments
- Assessment of causes and contributing factors provides IDT additional information
- Should help staff:
  - Consider each resident as a whole
  - Identify areas of concern
  - Develop to extent possible, interventions to help improve, stabilize, or prevent declines
  - Address need and desire for other considerations such as palliative care

No mandated forms

There are no mandated forms that must be used for the CAA process in MDS 3.0. The RAI Manual instructs “To identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources.”
CMS does supply facilities with CAA Resources in Appendix C. The appendix includes care area specific tools that the assessor can use for each of the 20 care areas. Each tool is between three to five pages long, guides the interdisciplinary decision-making, and provides a place to document the process. Using the tools provides a comprehensive assessment of the problem area.