THE LEADERS GUIDE
TO MDS 3.0 IMPLEMENTATION

June District Meetings, 2010

Update on RUGs IV: The Problem

- Current RUG-III based on MDS 2.0
- RUG-IV based on MDS 3.0
- Congress postponed most of RUG IV for 1 year
- There is no RUG-III based on MDS 3.0

Update on RUGs IV: The Best Solution

- Legislative fix to implement RUG-IV this year:
  - Avoid devastating cuts for SNFs
  - Maintain the budget neutrality for Medicare
  - Appropriately pays for complex nursing care
  - Contact your congressional reps ASAP

Update on RUGs IV: The Default

- No legislative fix this year
- RUG-IV rates this year, but . . .
- Retrospective implementation of RUG-III rates
  - CMS will develop grouper for RUG-III based on MDS 3.0 if fix doesn’t pass
  - Recapture of higher RUG-IV payments
  - At least six months out, but huge cuts
Update on RUGs IV: The Positive Differences

• Lower therapy index
• Much higher nursing index
• Nearly all rates higher
• New domains and classes
• Can start therapy classes with first day of therapy (Start of Therapy OMRA)
• New short-stay therapy option

Update on RUGs IV: The Negative Differences

• Loss of hospital look-back
• Limit on concurrent therapy, 1 to 2, 50%
• Limit on group therapy, max of 25% of total
• Limits apply separately to each type of therapy
• Loss of estimated therapy

What Impact is the Transition to MDS 3.0 Having on Your Organization and Staff?

• Dread?
• Worry?
• Anxiety?
• Anticipation?
• Excitement?

What does the Administrator need to know about MDS 3.0 and RUG IV?
What Impact is the Transition to MDS 3.0 having on Your Organization and Staff?

Let’s ask it another way?

What did/does the Administrator need to know about MDS 2.0 and RUG III?

Very Simply...
- Resident Care
- Compliance
- Financial

Learning curve and new thought process
on how we assess residents

A whole new set of acronyms
- 66 RUG grouper

Things to think about:
- Training Opportunities
  - Who should go?
- Coordination of transition/implementation

- Conceptual Changes from MDS 2.0 to 3.0
  - Format is Different: Font and White Space
  - Many more “skip” patterns
  - View your software format
What Impact is the Transition to MDS 3.0 having on Your Organization and Staff?

• Does the staff have the opportunity to “play” in a training database
• Color-coded hardcopy
• Focus on “Hearing the voice of the Resident”
• Staff/resident interview
• Skill set and practice

What Impact is the Transition to MDS 3.0 having on Your Organization and Staff?

• Review of MDS Section Assignment
• Still no discipline assignment or recommendations
• What makes sense clinically
• Data collection/documentation systems
• Financial analysis and impact

Current Tasks for Assessments

1. Reviewing current vendor/software
2. Reconsidering how MDS schedules are determined
3. Determining how and who transmits the MDS data
4. Evaluating how to handle the reports from CMS and MDH

Current Tasks for Assessments

5. Evaluating the role of the MDS Coordinator
6. Embracing increased emphasis on resident’s voice through interviews
7. Need to allow or commit time for staff to learn the many changes in the MDS line items
8. Staff scheduling
Current Tasks for Assessments

- Three new Medicare assessments
  - Start of Therapy OMRA
  - End of Therapy OMRA
  - Start and End of Therapy OMRA
- New deadline for transmission: Day 28 (MDS completion date + 14 days)
- You will want to transmit at least weekly

Current Tasks for Care Planning

- How will you use your better information about your residents?
  - Effects of behaviors on other residents
  - Preferences for daily routines and activities
  - Balance during activities with increased risk of falls
  - Resident input on health conditions

Case Study #1

Where does the MDS 3.0 have the most impact on your operations from interview to final rate implications?

Clinical Indicators

- ADL Score
- Trach Care
- Vent/Respirator
- Isolation for active infectious disease while a resident
**Case Study #1**

**Clinical Indicators**

**Special Care High**

- ADL Score
- Comatose; Septicemia; DM/Injections/Order changes; Quadriplegia/ADL score>=5; COPD and SOB; Fever w/pneumonia or vomiting or weight loss or feeding tube; parenteral/IV feedings; RT for 7 Days

**Depression Indicators**

**Special Care Low**

- ADL Score
- CP; MS: Parkinson’s w/ADL score>=5; Respiratory Failure and O2 while a Resident; Tube Feeding qualifiers; Ulcers types and stages w/2 or more skin care treatments; foot infections/diabetic foot ulcers/open lesions of foot w/treatment; Radiations therapy while a resident; dialysis while a resident

**Depression Indicators**

**Clinically Complex**

- ADL Score
- Pneumonia; Hemiplegia w/ADL score>=5; Surgical wounds or open lesions w/ treatment; burns; Chemotherapy while a resident; O2 while a resident; IV medications while a resident; Transfusions while a resident
- Extensive Services, Special Care High or Low with ADL score of 0 or 1

**Behavior Symptoms and Cognitive Performance**

- ADL score
- Cognitive Impairment BIMS score <=9 or CPS >=3
- Hallucination or delusions
- Physical or verbal behavior symptoms towards others, other behavior symptoms, rejection of care, or wandering
- Restorative Nursing Services
Case Study #2
Where does the MDS 3.0 have the most impact on your operations from interview to final rate implications?

Physical Medicine and Rehab

Case Study #2
- Rehab
  - Ultra High 720 minutes; 1 discipline 5 days/week and the 2nd 3 days/week
  - Very High 500 minutes; 1 discipline 5 days/week
  - High 325 minutes; 1 discipline 5 days/week
  - Medium 150 minutes; 5 days any combination
  - Low 45 minutes/week; 3 days of any combinations and 2 restorative nursing programs

Case Study #3
Where does the MDS 3.0 have the most impact on your operations from interview to final rate implications?

The 5 Rehab Categories

AND

Trach Care
Ventilator/Respiratory
Isolation for active infectious disease

Tools
- MDS Crosswalk between MDS 2.0 and 3.0
- ADL Scoring
- RUG Grouper Logic
- RUG IV Indices and Rates
How Far Are You on the MDS 3.0 Implementation Readiness Journey?

- Where are you?
- Where is your RAI Coordinator/MDS Team?
- Now through October Planning/Schedule

Discussion with Colleagues

1. What action has been taken towards implementation thus far?
2. Are there mid–course changes that need to be taken?
3. What tools can we develop together?

Available Training Opportunities

1. MDH’s eight webinars in June & July
2. MDH’s seven 1-day workshops July & August
3. Aging Services of Minnesota’s RAI and Care Planning seminars in August
4. MDH’s weekly conference calls Sept – Nov
5. Annual Meeting in September

CONTACTS

LIZ SETHER, nurse consultant/policy analyst, Aging Services Group, lsether@agingservicesmn.org
DARRELL SHREVE, vice president of health policy, Aging Services of Minnesota, dshreve@agingservicesmn.org
JULIE THURN-FAVILLA, director of clinical services, Augustana Care, jathurn@augustanacare.org