REQUIREMENTS FOR USE OF THE RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS)

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook provides procedures for the scheduling and completion of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) 3.0 in the VHA Community Living Centers (CLC) and Spinal Cord Injury and Disorders (SCI & D) Long-Term Care (LTC) programs that are surveyed under The Joint Commission. This Handbook specifically reflects content changes in MDS 3.0, the assessment component of the RAI MDS process. **AUTHORITY: Public Law 100-203, title IV, subtitle C and title 38 United States Code 7301.**

2. SUMMARY OF CHANGES. This VHA Handbook:

a. Describes updates to the RAI MDS 3.0 used in Department of Veterans Affairs (VA) CLCs;

b. Includes procedures to ensure timeliness of inputs and supervision of staff to ensure integrity of the data entered into the MDS portion of the RAI; and

c. Addresses transmission of data to the VHA central data repository.

3. RELATED ISSUES. None.

4. FOLLOW UP RESPONSIBILITY. The Office of Geriatrics and Extended Care (10P4G) within the Office Patient Care Services (10P4) is responsible for the contents of this Handbook. Questions may be referred to Director, VA CLC at 202-461-6779.

5. RESCISSIONS. VHA Directive 2005-060, Implementation of the Medicare Prospective Payment System (PPS) Assessment Form (MPAF) and VHA Directive 2008-007, Resident Assessment Instrument (RAI) Minimum Data Set (MDS) are rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of January 2018.

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Under Secretary for Health

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REQUIREMENTS FOR USE OF THE RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS)

REQUIREMENTS FOR USE OF THE RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS)

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides guidelines for the scheduling and completion of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) 3.0 in the VHA Community Living Centers (CLC) and Spinal Cord Injury and Disorders (SCI & D) Long-Term Care (LTC) programs that are surveyed under The Joint Commission (TJC). This Handbook specifically reflects content changes in MDS 3.0, the assessment component of the RAI MDS process. **AUTHORITY: Public Law 100-203, title IV, subtitle C and Title 38 United States Code 7301.**

2. BACKGROUND

a. Department of Veterans Affairs (VA) CLCs offer a dynamic array of short-stay and long-stay non-acute services for Veterans who are medically and psychiatrically stable. The RAI MDS is a standardized assessment and treatment planning process designed to identify the functional and health care needs of the resident and to help develop a plan of care where services are individualized to meet the needs of each resident.

b. The RAI MDS was established by the Centers for Medicare and Medicaid Services (CMS) to comply with certain nursing home-related reforms required by the Omnibus Budget Reconciliation Act of 1987, Public Law (Pub. L.) No. 100-203, title IV, subtitle C, 101 Stat 1330 (1987) (OBRA '87). These requirements apply to all nursing homes in the United States (U.S.) that are certified by CMS. They require nursing homes to identify and act on risk factors to prevent functional decline in residents and to plan care that would delay any decline in residents' function. The RAI MDS was implemented in all U.S. private sector nursing homes in 1990 and is updated periodically. As a matter of policy, VA uses the same CMS standardized assessment and treatment instrument for its CLC program as a means of ensuring consistency with national nursing home standards, meeting accreditation standards of TJC, and facilitating comparisons between VA CLCs and nursing homes in the community and private sector.

NOTE: *State Veterans Homes, which are governed by the states, are not governed by this VHA policy. See title 38 Code of Federal Regulations (CFR) part 51 for the regulations governing State Veterans Homes.*

c. The RAI MDS generates Quality Measures (QM), and Resource Utilization Groups (RUGs).

(1) The QMs are used for monitoring VA CLC quality at the facility, Veterans Integrated Services Network (VISN), and national levels. The QMs are a data source for performance measures and process improvement activities for TJC and VHA required quality improvement activities. The RAI MDS provides a structure for meeting accreditation standards. Furthermore, data from RAI MDS have increasingly become an important source of research in the development of evidence-based care for CLC residents.

(2) The RUGs reflect a Veteran's assessed needs for care and the resources required to provide such care. RUGs are used in the nurse staffing methodology to determine the amount

and type of nursing staff necessary to provide the appropriate level of care. The RUGs and Bed Days of Care (BDOC) are the basis for Veterans Equitable Resource Allocation (VERA) classification in VA CLCs.

d. The RAI MDS is an interdisciplinary process. MDS assessments are to be completed only by professional staff representing the various disciplines providing care to residents in the CLCs. Completion of the entire RAI MDS assessment is not meant to be assigned to any single discipline.

e. The assessment schedule and type is determined by the anticipated length-of-stay based on the reason for admission. The "Treating Specialty" type is to be determined prior to admission according to the procedures set forth in VHA's policy on admission and discharge criteria for CLCs.

(1) Short-stay admissions have an anticipated length of stay of 90 days or less.

(2) Long-stay admissions have an anticipated length of stay of greater than 91 days.

f. The RAI MDS consists of three basic components: the MDS, Care Area Assessments (CAA), and Utilization Guidelines. These components provide information about a resident's functional status, strengths, weaknesses, and preferences, and they offer guidance for future assessment and management of problems or potential problems as they become identified. As such, they allow for the development, implementation, and evaluation of an individualized plan of care for each resident. Each of the components flows naturally into the next in the following order:

(1) **MDS.** MDS is a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the foundation of the assessment for all residents of nursing homes. Items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and outside agencies (including between and among VA medical centers, VISNs and VHA Central Office).

(2) **Care Area Assessment (CAA).** The CAAs are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically-relevant information about an individual. CAAs help identify social, medical, and psychological problems, and they are the basis for individualized care planning.

(3) **Utilization Guidelines.** Utilization Guidelines are instructions concerning when and how to use the RAI. As discussed in the Background section, above, the Utilization Guidelines for Version 3.0 are published by CMS.

3. TYPES OF ASSESSMENTS

NOTE: *As previously detailed, OBRA '87 establishes requirements for nursing homes certified by CMS. CMS's implementing tools and standards therefore often refer to program requirements by way of references to that public law. For instance, MDS 3.0 references certain "OBRA" mandated assessments. For ease of reference, this Handbook adopts that same nomenclature when referring to those assessments. Use of such does not suggest that VHA facilities are subject to OBRA '87 or CMS regulations.*

All assessments in the MDS software are part of the health record and include the following:

a. **Long Stay.** Long stay services are those where, upon admission, the Veteran's expected length of stay is 91 days or more.

(1) The following comprehensive assessments (including CAA summary) must be completed within the following schedule:

(a) Admission assessment within 14 days of admission date, which is counted as day 1.

(b) Annual assessment determined by previous Assessment Reference Date (ARD). The ARD of the annual assessment must be within 365 days of the last OBRA 1987 (full) assessment and within 90 days of the ARD of the previous quarterly assessment.

(c) Significant Change in Status Assessment (SCSA) – the ARD must be within 14 days after the determination that the criteria are met for a SCSA (determination date + 14 days); and it must be completed by the 14th day after date of determination.

(d) Significant Correction to Prior Comprehensive Assessment (SCPA-comprehensive) – 14th calendar day after determination that significant error in prior comprehensive assessment occurred.

(2) The following quarterly assessments must be completed within the following schedule:

(a) Quarterly Assessment is determined by previous ARD of the most recent OBRA assessment. The ARD of the quarterly assessment must be within 90 days of the ARD of the previous OBRA assessment.

(b) Significant Correction to Prior Quarterly assessment (SCQA non-comprehensive) – 14th calendar day after determination that significant error in prior quarterly assessment occurred.

b. **Short Stay.** Short stay services are those where, upon admission, the Veteran's expected length of stay is 90 days or less.

(1) All required ARDs and completion dates for the short stay assessments are outlined on the Medicare Prospective Payment Assessment Form (MPAF) scenario grid. Facilities must follow the MPAF Scenario Grid, which was developed to ensure compliance with all RAI MDS guidelines.

(2) Residents that are on the short-stay assessment schedule must meet OBRA assessment regulations. To minimize workload, there are times when these two assessment requirements can be combined. These situations have all been included in the MPAF Scenario Grid. The "Reason for Assessment" is recorded in item A0310B.

NOTE: *The MPAF Scenario Grid can be found at the following Web site:* http://vaww.infoshare.va.gov/sites/geriatrics/MDS/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2fsites%2fgeriatrics%2fMDS%2fShared%20Documents%2fMDS%203%2e0&FolderCTID=&View=%7b11FE2AAB%2dA97E%2d4415%2d9506%2d4D8FF0646661%7d. *This is an internal VA Web site and is not available to the public.*

(3) The following are the short stay assessments with the basic assessment scheduling requirements:

(a) MPAF 5-Day Assessment:

1. When completed as a short form assessment – ARD is day 5; Completion is day 10.

2. When combined with the OBRA Admission assessment – ARD is day 7; Completion is day 14.

(b) MPAF 14-Day Assessment – ARD is day 14; Completion is day 21.

(c) MPAF 30-Day Assessment – ARD is day 30; Completion is day 37.

(d) MPAF 60-Day Assessment – ARD is day 60; Completion is day 67.

(e) Not Prospective Payment System (PPS) Assessment (in the VA this replaces the MPAF 90-Day Assessment) – ARD is day 90; Completion is day 97. ***NOTE:*** *At this point the resident is no longer considered short-stay. This assessment is combined with the OBRA Quarterly.*

(f) MPAF Readmission/Return Assessment - Completed when a resident is hospitalized, discharged return anticipated, and then returns to the CLC from the hospital within 30 days and continues to require and receive care. This assessment type is used in place of the MPAF 5-day and indicates that the resident is resuming short-stay status. This assessment restarts the MPAF schedule. ARD is dependent on the resident's total expected length of stay:

1. Length of stay less than (<) 14 days: ARD is day 5 from the reentry date; Completion is day 10 from reentry.

2. Length of stay greater than (>) 14 days: ARD is day 7 from the reentry date; Completion is day 14 from reentry.

(g) Unscheduled Assessment used for PPS – This assessment type is used in combination with an OBRA significant change in status assessment and indicates that the assessment timing is outside the window of a regularly scheduled MPAF. Assessment reference date and completion date are based on the significant change in status determination.

c. **Discharge Reporting and other Tracking Forms (A0310F).** An RAI MDS assessment may be combined with a discharge assessment only when all requirements are met. An RAI MDS assessment may not be combined with either of the two tracking records: Entry or Death in Facility, (see RAI MDS 3.0 manual Chapter 2 at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).

(1) **Discharge Assessment.** Discharge assessment refers to an assessment required upon resident discharge from the CLC, planned or unplanned. For unplanned discharges, the CLC must complete the assessment to the best of their ability. ***NOTE:*** *CLC bed hold status and opening and closing of the medical record have no effect on these requirements.*

(a) Return Not Anticipated (A0310F=10). Return not anticipated (A0310F=10) must be completed when the resident is discharged from the CLC and is not expected to return within 30 days. This assessment form must be completed within 14 days after the discharge date (A2000 + 14 calendar days).

(b) Return Anticipated (A0310F=11). Return anticipated (A0310F=11) must be completed when the resident is transferred from the CLC and the resident is expected to return within 30 days. This assessment form must be completed within 14 days of transfer from the CLC (A2000 + 14 calendar days). ***NOTE:*** *In some situations, a resident may be discharged return anticipated and the facility learns later that the resident will not be returning to the CLC. Another Discharge Assessment will be required and transmitted to Austin to close out the resident's record to "return not anticipated." In this case only, the Resident Assessment Coordinator (RAC) is to only complete item A2100, sign it, seal it, batch and transmit it.*

1. Medical Provider Reassessment. When a Veteran is discharged from the CLC to a different level of care and is readmitted to the CLC within 30 days for the same or a related problem, an interval physical exam reflecting any changes may be used, provided the original exam is readily available. In either case, an interval note must be completed indicating the following:

a. The Medical History and Physical exam (H&P) is still accurate,

b. An appropriate assessment was completed on admission confirming that the necessity for CLC care is still present, and

c. The Veteran's condition has not changed since the H&P was originally completed, or any changes are documented.

2. Interdisciplinary Team Member Reassessments. When a Veteran is discharged from the CLC to a different level of care and is readmitted to the CLC within 30 days for the same or a related problem, the required assessments by the interdisciplinary team member (who may be from Social Work, Recreation Therapy, Dietician Service, or another discipline within the CLC) must reflect any subsequent changes in the Veteran's health status. That team member need not complete a new and comprehensive admission assessment unless there is evidence of significant change in circumstances from the original comprehensive admission assessment.

(c) Death in Facility (A0310F=12). Death in facility (A0310F=12) must be completed when the resident dies in the CLC, while on a authorized absence (AA), or while absent sick in the hospital. A separate Discharge Assessment is not required**.** This must be completed within 7 days after the resident's death (A2000 + 7 calendar days).

(2) **Entry Tracking (A03107F=01).** Entry Tracking (A03107F=01) is the first item set completed for all residents and must be completed every time any resident (including Veterans admitted for respite care) is admitted (admission) or readmitted (reentry) into the CLC. The completion of this record is required for all residents regardless of the MDS assessment schedule. It must be completed within 7 days after the admission/reentry. This is a stand-alone tracking document and may not be combined with an assessment.

(a) Admission (A1700=1). An Entry Tracking record is coded an Admission every time a resident is admitted for the first time to the facility, or has been in the facility previously and was discharged prior to completion of the OBRA Admission assessment; or has been in the facility previously and was discharged return not anticipated; or was discharged return anticipated and did not return within 30 days.

(b) Reentry (A1700=2). An Entry Tracking record is coded when a resident was previously in the CLC; and had an OBRA admission assessment completed; and was discharged return anticipated; and returned within 30 days.

4. RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS) ACCOUNTABILITY

a. The signatures in Section Z on the assessment are a software specific signature indicating that the staff contributed data to this record. Policy regarding wet signatures must be determined at a facility level.

b. Professional team members completing any portion of the MDS must sign and date the entry. When signing, the staff member is certifying the accuracy of the data that they have entered and indicating which section(s) they have completed. Specific MDS section assignments for interdisciplinary team members as well as CAA completion responsibilities are outlined in Appendix A and Appendix B, and must be included in local policy.

c. Two or more staff members may complete items within the same section of the MDS.

d. A Registered Nurse (RN) is required to sign and date item Z0500, certifying that the assessment is completed. The RN must not sign until all other disciplines have completed their assigned sections. On a comprehensive assessment, the RN must sign item V0200B1/2, indicating the date and completion of the CAAs. Any interdisciplinary team member can sign and date V0200C1/2, certifying completion of the care plan. Item V0200C1/2 must be signed and dated within 7 days of MDS and CAAs completion. The individual sections and the MDS cannot be signed until completed. Timely completion of the MDS in accordance with this Handbook is a requirement for valid and reliable data and for timely resident care.

e. Facilities may institute various processes to create the assessment schedules; however, it is the responsibility of the RAC to ensure scheduling accuracy and timeliness. Late assessments are considered unacceptable practice.

f. If a long-stay resident is discharged on or after the ARD, the assessment in progress must be completed. Short-stay resident assessment scheduling is defined by the MPAF Scenario Grid. The following guidelines apply to completing a comprehensive assessment in progress:

(1) All interdisciplinary treatment team members must complete assigned MDS items from Section A through Section Z and indicate the date of completion in Z0400.

(2) The RN must verify the completed assessment by signing in Item Z0500A/B.

(3) For any Care Areas triggered, a dash fill may be placed in the "Care Planning Decision-Addressed in Care Plan" items in V0200A, Column B, which indicates that the decisions are unknown.

(4) An RN must sign and enter the date the CAAs were completed at V0200B1 and V0200B2.

(5) Any professional treatment team member may sign and enter the date that care planning decisions were completed at V0200C1 and V0200C2.

5. RESPONSIBILITIES OF THE FACILITY ASSOCIATE CHIEF NURSE FOR GERIATRICS AND EXTENDED CARE

a. **Interrater Reliability.** It is the responsibility of the Associate Chief Nurse for Geriatrics and Extended Care or equivalent, to make certain that a process is in place to ensure that the MDS is completed accurately; therefore, a policy for interrater reliability must be developed and a process for review be implemented at each facility. Reviews must be completed regularly but at least quarterly.

(1) Interrater reliability reviews must be conducted at least quarterly by auditors identified by the facility RAC in collaboration with the Associate Chief Nurse for Geriatrics and Extended Care. These reviews must include a representative sample of no less than 10 percent of MDS assessments that were completed in the quarter under review.

(2) Discrepancies in coding or documentation noted during the interrater review must be communicated to the RAC and the Associate Chief Nurse for Geriatrics and Extended Care or equivalent, as well as the clinician responsible for the error. Corrections must be made immediately to assessments that have not been transmitted to the Austin Information Technology Center (AITC); corrections to transmitted assessments must be made as outlined in the 3.0 RAI MDS Users Manual. ***NOTE:*** *The 3.0 RAI MDS Users Manual can be found at:* http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

(3) Aggregated data and the final analysis of reviews must be reported to the Clinical Leader for development of corrective action as indicated.

6. SEALING THE RECORD, TRANSMISSION TO AUSTIN, AND CORRECTING THE MINIMUM DATA SET

a. **Seal the Record.** After completing the assessment, the Interdisciplinary Team (IDT) has the next 7 days to ensure that all MDS items were correctly coded. During this 7-day period, the IDT may "correct" any errors found in the assessment. An assessment is considered complete only if 100 percent of the errors are corrected. During the edit period, the IDT may update the CAAs based on additional information obtained. After all corrections are completed, an RN is responsible for sealing the assessment.

b. **Date of Transmission to AITC.** Transmission to the AITC must occur weekly. All completed MDS forms must be successfully transmitted without rejection within 14 days of their timely completion. If an initial transmission generates error messages, errors must be corrected in order for the transmission to be accepted. Each facility RAC is responsible for developing a process to batch and transmit sealed MDS data to the AITC. Monitoring must be conducted to ensure timely and successful transmission.

c. **Correcting the MDS.** If errors are discovered after the assessment has been transmitted and locked, changes can be made by completing a Correction Request Form, and selecting 'modification' or 'inactivation' as appropriate as stated in Section 5.6 of the RAI MDS User's Manual. For "corrected" items, the facility staff must use the same "period of observation" as used for the original item completion (i.e., the same Assessment Reference Date – A2300) as stated in Section 2.8 of the RAI MDS User's Manual.

7. SOFTWARE SET-UP

a. In the Accu-Care software, the set-up option used for RUGs is Calculator Type (RUG IV 1.02 66 Group).

b. International Classification of Disease 10th Edition Clinical Modification (ICD-10-CM) Diagnosis File. Alteration of this file is prohibited at a local level.

c. Changes or additions to the software must be requested in writing to VHA Central Office Geriatrics and Extended Care (GEC) Services (10P4G) through the VISN GEC Point of Contact (POC), using the "Change Request Form." Facilities may not negotiate directly with the vendor for changes to the Accu-Care software.

8. THE CARE AREA ASSESSMENT (CAA) PROCESS

The CAA is the most important aspect of the care planning process. It precedes the official interdisciplinary treatment planning or care-planning team meeting. Working the CAAs requires designated interdisciplinary involvement in order to develop a person-centered care plan.

a. Items checked in the MDS form the basis for the CAAs. Certain items in the MDS trigger problem areas and alert the interdisciplinary treatment team to address areas that need attention and care planning.

b. It is working with the CAAs that facilitates residents achieving their highest level of function and well-being. The CAAs identify actual and potential problems and the care team determines the nature and extent of the problem and determines interventions to address the problem.

c. The final treatment plan, generated in collaboration with the resident, is based on assessment, aggregation of data (CAA) and interventions that relate to the reason for admission and goals of care including discharge to less restrictive levels of care.

d. The CAAs are explored in advance of the treatment planning meeting and the full treatment plan supports or develops further the recommendations based on all of the CAAs.

e. The CLC must define and identify which disciplines will complete which CAA. It is important that although one particular discipline is assigned responsibility for completion of a CAA, other disciplines must be involved as needed (see App. B for recommendations for interdisciplinary collaboration in developing the CAA).

f. Each facility must complete the CAA worksheet template that is included in the software. If the software is down and the facility staff has implemented the facility contingency plan,

Appendix C in the 3.0 RAI MDS manual must be completed and used for care planning.

9. CARE PLANNING AND INTERDISCIPLINARY TREATMENT PLANNING

The plan of care, based on assessment (the MDS) and identification of resident problems through the CAA process, reflects the strengths and areas for improvement for residents admitted to the CLC. The full plan of care is developed during an interdisciplinary treatment planning or care planning team meeting where the CAAs and other data are shared with the entire team including the resident and caregivers.

a. The plan of care includes resident personal preferences as well as services and interventions that are designed to help the resident achieve goals for care, address reasons for admission to the CLC, and prepare the resident for discharge to the next appropriate setting including home and community based care. Staff providing direct resident care, including nursing assistants, may be the most knowledgeable about the resident, the resident's preferences, and the resident's unique circumstances. Therefore, it is important that such staff participate in planning the resident's care. It is important that any discipline providing services to the resident participate in the care-planning process. For example, when the resident is receiving physical or other therapy services, the therapist needs to participate in care-planning. Residents and family or significant others who know the resident must be invited to participate in the care-planning.

b. The work of the interdisciplinary treatment team when gathered for the purpose of developing a comprehensive plan of care is only considered official when the core members or disciplines are all present at the team meeting. No official treatment planning meeting can be held unless all core members or disciplines are present. The core interdisciplinary treatment team includes the:

(1) Provider,

(2) RN,

(3) Social worker,

(4) Dietitian, and

(5) Recreation therapist.

c. Other professionals who provide services to residents must participate in care-planning; they include, but are not limited to the:

(1) Pharmacist,

(2) Psychologist,

(3) Physical and or occupational therapist,

(4) Nursing assistant, and

(5) Chaplain.

d. Care-planning formats and processes are to be determined at each facility. ***NOTE:*** *Because of the high variability in interdisciplinary care planning models in VA CLC programs, this Handbook will not specify the use of any specific care-planning format or process.* The national software package has a care-planning component that builds from the RAI MDS, which facility staff may find easily adaptable to their own interdisciplinary care-planning processes.

NOTE: *The Care Plan library is a part of the Accu-Care software and can be edited at the facility level to enhance individualization of the care-plans.*

10. GENERAL PROGRAM PROCESSES

a. **User-defined Assessments.** User-defined assessments, located in the assessment module of the Accu-Care software, can be used to create additional user-defined assessments.

b. **Pre-admission Module.** The Pre-admission module process, including RUGs estimates, must be defined if this option is utilized.

c. **Printing.** It is not necessary to scan the form into VistA Imaging because the MDS information is entered and signed electronically in the Accu-Care software where it is kept locally and at the Austin Corporate Data Center Operations indefinitely. The MDS form can be printed any time as needed.

d. **VA Facility Director Policy-making.** Each facility Director must develop policies governing its RAI MDS process that must, at a minimum, address the RAI MDS requirements set forth in related VHA national Policies. Local policies must abide by, and be consistent with, the time frames applicable to long and short stay assessments set forth in those national policies.

SECTION ASSIGNMENTS BY DISCIPLINE FOR RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS)

Discipline Assignment	Sections
Resident Assessment Coordinator, Social Worker	**Section A: Identification Information** 0310; 2000 – 2300: Resident Assessment Coordinator 0100-0200, 0500 – 2400: Social Work
Nursing	**Section B: Hearing, Speech, Vision**
Nursing	**Section C: Cognitive Patterns**
Nursing	**Section D: Mood**
Nursing	**Section E: Behavior**
Nursing / Recreation Therapist (RT)	**Section F: Preferences for Customary Routines and Activities** 0300-Registered Nurse (RN) 0400-RN 0500-Recreation 0600-RN 0700-RN 0800 A-K-RN (if resident unable to be interviewed) 0800 L-T-Recreation (if resident unable to be interviewed)
Nursing	**Section G: Functional Status**
Nursing	**Section H: Bladder & Bowel**
Medical Provider ***NOTE:*** *If coders are available, it is desirable to have them complete the coding.*	**Section I: Active Diagnoses**
Nursing	**Section J: Health Conditions**
Nursing, Registered Dietitian (RD)	**Section K: Swallowing / Nutritional Status** 0100 – 0200: RN 0300 – 0700: RD
Nursing	**Section L: Oral / Dental Status**
Nursing	**Section M: Skin Conditions**
Nursing / Pharmacist if pharmacist agrees	**Section N: Medications**
Nursing / Rehabilitation / Recreation Therapist / Music Therapist	**Section O: Special Treatments, Procedures and Progress** 0100 - 0300: RN 0400A: Speech Therapy (ST) 0400B: Occupational Therapy (OT) 0400C: Physical Therapy (PT) 0400D: RN 0400E: RN 0400F: RT 0500: RN 0600 - 0700: RN
Nursing	**Section P: Restraints**
Social Worker	**Section Q: Participation in Assessment and Goal Setting**

Discipline Assignment	Sections
Social Worker / Kinesiotherapy (KT) / RN	**Section S: Department of Veterans Affairs (VA) Section**
Resident Assessment Coordinator	**Section V: 0100 (A - C)**
RN	**Section V: 0100 (D - F)**
All Interdisciplinary Teams as identified Resident Assessment Coordinator or designee	**Section V: Care Area Assessment Summary** (see App. B) **Section X: Correction Request**
All Services	**Section Z: Assessment Administration**

CARE AREA ASSESSMENT RECOMMENDED DISCIPLINE PARTICIPANTS FOR RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS)

Recommended Discipline Participants	Care Area Assessment Summary
Nursing / Medical Provider	**01: Delirium**
Nursing / Psychologist	**02: Cognitive Loss / Delirium**
Nursing / Recreational Therapist	**03: Visual Function**
Nursing / Recreation Therapist / Speech Therapist	**04: Communication**
Nursing	**05: Activities of Daily Living (ADL) Functional / Rehabilitation Potential**
Nursing / Medical Provider (must participate if a catheter is present)	**06: Urinary Incontinence and Indwelling Catheter**
Social Worker / Recreation Therapist	**07: Psychosocial Well-Being**
Nursing / Psychology / Social Worker	**08: Mood State**
Nursing / Psychologist / Social Worker	**09: Behavioral Symptoms**
Recreation Therapist / Music Therapist / Nursing	**10: Activities**
Nursing / Physical therapist	**11: Falls**
Dietitian / Nursing	**12: Nutritional Status**
Dietitian / Nursing	**13: Feeding Tube**
Dietitian / Nursing	**14: Dehydration / Fluid Maintenance**
Nursing	**15: Dental Care**
Nursing / dietician	**16: Pressure Ulcer**
Nursing / Recreation therapist / Pharmacy / Medical Provider	**17: Psychotropic Drug Use**
Nursing / Recreation therapist	**18: Physical Restraints**
Nursing / Recreation therapist / Medical Provider	**19: Pain**
Social Worker	**20: Return to Community Referral**

GUIDELINES FOR THE RESIDENT INTERVIEW SECTIONS OF MDS 3.0

1. In an effort to increase the resident's voice in the MDS 3.0 assessment process, and thereby create a resident-driven plan of care, several areas of assessment require direct interview. Interviews must be conducted in accordance with instructions in the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) manual. ***NOTE:*** *The RAI MDS manual can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.*

2. Only if a resident is coded as "rarely/never understood" or "comatose" will a staff assessment be used instead of a direct interview.

3. Interviews conducted by a Registered Nurse (RN): Completion of sections assigned to Nursing must be conducted by an RN from the unit or household in which the resident resides during the observation period of that assessment. This needs to be the resident's primary nurse or the RN with the most knowledge of the resident's treatment, conditions, and preferences. The interviews are not the responsibility of the Resident Assessment Coordinator. Interviews conducted by a RN are:

a. Section C – Cognitive Patterns: Brief Interview for Mental Status (BIMS)

b. Section D – Mood: Resident Mood Interview -PHQ9 c

c. Section F – Preferences for Customary Routine and Activities: F0400-"Interview for Daily (4) Preferences." ***NOTE:*** *There is no look back period for this section.*

d. Section J – Health Conditions: Pain Assessment Interview.

4. Interview conducted by a Recreation Therapist are:

Section F – Preferences for Customary Routine and Activities: F0500 'Interview for Activity Preferences.' ***NOTE:*** *There is no look back period for this section.*

5. Interview conducted by a Social Worker are:

Section Q – Participation in Assessment and Goal Setting: If the resident is able to participate in this assessment, information must be obtained by a direct interview.

6. Comprehensive instructions for conducting resident interviews are included in 'VIVE-Video on Interviewing Vulnerable Elders' (CMS Product No. 11479-CD) available at http://productordering.cms.hhs.gov.