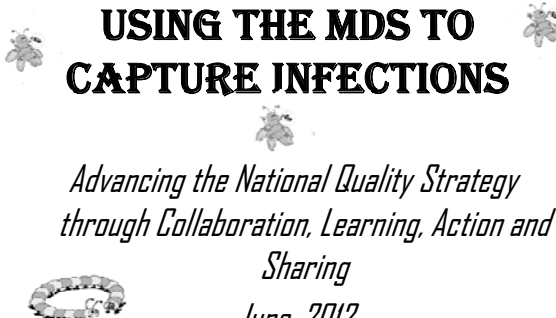



**USING THE MDS TO
CAPTURE INFECTIONS**

*Advancing the National Quality Strategy
through Collaboration, Learning, Action and
Sharing*

June, 2012



OBJECTIVES



- What is the Minimum Data Set 3.0 (MDS)
- How is the MDS Used
- How to Identify Infections Using the MDS

Definition of the Minimum Data Set

The Minimum Data Set (MDS) is the Centers for Medicare & Medicaid Services' (CMS) tool for facilitating care management in nursing homes.

The MDS is a standardized instrument used to assess / gather information on nursing home residents.

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How is the MDS Used

The MDS is used to collection basic resident information:

- Physical (e.g., medical conditions, mood and vision)
- Functional (e.g., activities of daily living, behavior)
- Psychosocial (e.g., preferences, goals, and interests)

When completed, the MDS provides a foundation for a more thorough assessment and development of an individualized care plan

One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status

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Overview of the Resident Assessment Instrument (RAI) and Care Area Assessments



Care Area Assessments (CAAs)

The CAA process provides a framework for guiding the review of triggered areas from the MDS.

When Implemented properly, The CAA process should help staff:

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function;
- Identify areas of concern that may warrant interventions;
- Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in the resident's condition
- Address the need and desire for other important considerations, such as advanced care planning

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Section I: Active Diagnosis

Steps for Assessment:

Two look-back periods for this section

Diagnosis **identification**: (Step 1)

- 60-day look-back period
- Requires a physician –documented diagnosis (or a NP, PA, or clinical nurse specialist if allowable under state licensure laws)

Diagnosis **status**: Active or Inactive (Step 2)

- **Active**: active has a seven-day look-back period (except for UTI, which does not use the active seven-day look-back period)
- **Inactive**: conditions that have been resolved or have no longer affected the resident's functioning or plan of care during the last seven days would be considered inactive

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Active Diagnosis: Infections



Check all that apply

- ✓ Multidrug-Resistant Organism (MDRO)
- ✓ Pneumonia
- ✓ Septicemia
- ✓ Tuberculosis
- ✓ Urinary Tract Infection (UTI) (Last 30 days)
- ✓ Viral Hepatitis (e.g., Hepatitis A,B,C,D,and E)
- ✓ Wound Infection (other than foot)

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Urinary Tract Infection

Proper coding of Urinary Tract Infection (UTI)

The UTI has a look-back period of 30 days for active disease instead of seven days

Code only if all the following are met:

- Physician, NP, PA, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days
- Sign or symptom attributed to UTI
- "Significant laboratory findings"
- Current medication or treatment for a UTI in the last 30 days

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Teaming up to Prevent HAI

Does your facility share HAI information collected during the MDS process?

Facility should have a process to effectively communicate the findings to the appropriate person(s) responsible for surveillance.

Surveillance should always be:

- ✓ Complete
- ✓ Thorough
- ✓ Accurate

Coding Tips

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS

- ❑ There may be specific documentation in the medical record by a physician, NP, PA, or clinical nurse specialist of active diagnosis (e.g., like the earlier example regarding urinary tract infection)
- ❑ In the absence of specific documentation that a disease is active, the following indicator is one example of how to confirm active disease (e.g., a productive cough would confirm a diagnosis of pneumonia noted as such by a physician). Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.

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QUESTIONS



This material was prepared by AQAF, the Medicare Quality Improvement Organization for Alabama, under a contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents do not necessarily reflect CMS policy.
10SOW-AL-C7-12-28

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