DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MDS 3.0 Town Hall Meeting
June 2, 2003
"Refinement of the Minimum Data Set"

CMS-4060-N – Federal Register Notice

INDIVIDUAL COMMENTS

William Roy Oldaker CNA, CAD

May 22, 2003

To Whom it May Concern:

This letter is in regards to proposed MDS 3.0. I have been in Health Care for over 24yrs. I am now a Certified Activity Director and also a Certified Nursing Assistant. Due to the overwhelming amount of the paper work we already have this would just add to the burden.

In section N which is the Activity Section where they ask the residents engagement in activities, our job in the activity department is to get the resident to attend activities, regardless of Dependence.

Also in Section F, these questions are asked during survey why would they be in the MDS. Also some of the things asked in this MDS are of a personal nature, and should not be asked not only to an individual let alone a nursing home resident.

Please reconsider this proposal, if I can be of any further assistance please feel free to call on me.

Sincerely Yours:

Mr. William Roy Oldaker, CNA, CAD

Mrs. Karen Ray, CDM CFPP

DEAR MS. SHAPIRO:

THIS LETTER IS IN REFERENCE TO THE PROPOSED CHANGES TO THE MDS 2.0 FOR ALL LONG TERM CARE FACILITIES. THE MDS IS TO BECOME MDS 3.0 AND IS TO BE 33 PAGES LONG. HOW ARE FACILITIES GOING TO GET THESE DONE IN LIGHT OF RAMPANT SHORTAGES OF HEALTH CARE WORKERS AND FISCAL DEFICIENCIES? THE LONG TERM CARE INDUSTRY NEEDS SOME HELP.
PLEASE CONSIDER THIS WHEN MAKING CHANGES TO THE MDS AND AN ALREADY OVERBURDENED SYSTEM.
THANK YOU FOR YOUR ASSISTANCE WITH THIS.

SINCERELY,

This same letter was signed by these people:

William Oldaker, CAD
Mary Jane Brown, BSW
Lucy Petrice, LPN
Sharon Thomas, LPN
Linlee Eidell
Linda Young, LSW
Mrs. Shasta Eidell Hyson, Administrator
Sandra Summerfield, DON, RN
Kandace Michael, LPN
Pat Dunn, RN
Lovanna Shahan, LPN

May 22, 2003

Dear Ms. Shapiro:

I am writing to respectfully request that I may attend the June 2, 2003 Town Hall meeting on the MDS 3.0 draft discussion. Further, I wish to make a formal statement regarding the psychosocial component of the draft version of this assessment instrument.

My education and work experience allows me to make thoughtful suggestions on how to strengthen your draft MDS 3.0. I am a clinical social worker and work as Director of Social Services & Admissions at Maplewood Park Place, a continuing care retirement community in Bethesda, Md. In this capacity, I serve as a member of the multidisciplinary care team that has managed to earn a deficiency-free nursing home survey for two consecutive years. Additionally, I am also an adjunct instructor at the Shady Grove Center of the University of Maryland Baltimore County where I have taught a three credit undergraduate course called Social Work Practice in Aging.

In March 2003, the Office of the Inspector General published the results of their study on Psychosocial Services in Skilled Nursing Facilities. In this report, it showed that at the 92 SNFs that were included in the study and of the 299 beneficiaries that were involved, 53% of the facilities did not have a social worker with at least a bachelors degree. Of these beneficiaries, 39% of the beneficiaries had careplans that did not address their psychosociaI needs, 46% did not receive all of their planned psychosocial services and 38% neither had all of their psychosocial needs addressed in care plans nor did they receive all services that included in their careplan. The point was well established that skilled nursing facilities tend to have problems in identifying and properly addressing the psychosocial needs of its residents.

Although the draft MDS 3.0 is an improvement I have some suggestions to further strengthen it. I believe that the following suggested changes can more adequately measure psychosocial well-being and identifiy what needs to be addressed in the careplans for psychosocial well-being, mood and behavior patterns. They are as follows:

I.) Include strength based questions to help SNF staff to establish careplans in which they can capitalize upon the residents strengths. The following are examples:

Add to Section B6 "Cognitive/Behavioral Patterns":

1.) Receptive to suggestions from staff on how to improve one's health & safety.
2.) Expresses needs and preferences to staff
3.) Often uses humor as a coping mechanism
4.) Takes an active role in decision-making in one's careplan meetings
5.) Initiates social interaction with other residents or staff
6.) Respectful of the rights and needs of other residents

II.) Section E. "Mood"

1.) Modify question #3 to read as follows: "Do you often feel hopeless?" SNF residents are aware that they are in the SNF because they need help, so rasing the word helpless may cause many more to agree than they might otherwise. It may be confusing to the more cognitively impaired resident who may think that helpless means that he/she needs help-which they do.
2.) After question EIB #4, "Do you prefer to stay in your room rather than going out and doing new things?",add the question: "If so, has this been a long time pattern?" Rationale: The residents' personality and temperament may have always caused him or her to prefer a more solitary lifestyle. It is not necessarily an unhealthy behavior, but a baseline measure of social functioning and preference,
3.) Under E1A " Indicators of Possible Depression, Sad Mood", add:
1 .) "Expresses disinterest in what is going on around him/her."

Rationale: The elderly tend to underreport symptoms of depression, Unlike younger cohorts, the older adults tend more to exhibit depression by complaining of physical pain or discomfort and express disinterest in what is going, on around them. Question E1A h will adequately measure any repetitive complain of somatic discomfort or pain.

lIl.) Section F. "Quality of Life"

The following questions might be added to assess feelings of empowerment, perceptions of staff and whether the resident has been able to make new friends since the admission into the SNF.

1.) "Would staff be receptive to your preferences of how and when ADL care is given?"

2,) "Do you regularly attend the Resident Council meetings?" And then follow this question with the following question:

3.) "If so, does the facilitator of the Resident Council meetings seem to value and respect your comments and concerns?"

4,) "Do you have at least one other resident with whom you like to talk or spend time?"

5.) Modify Section F. " Quality of Life" Question j:

"Do you enjoy interactions with other tablemates during mealtimes?"

Rationale: More cognitively alert residents tend to dislike sitting with residents who are hard of hearing, visually impaired or with unpleasant table manners. A satisfactory solution is often to place them at a table with higher functioning, communicative residents. Unless asked this question, many of the passive residents may never complain about this issue. Also, residents have been known to say that they are not eating as much as they could since they lose their appetite when they observe unpleasant table manners or cannot communicate with those at their table. I've known residents who have said that it depresses them and it has contributed to weight loss.

6.) Under "Quality of Life", add: "Do the facility activities have specific cultural appeal to you?"

7.) Under F2 "Relationships", add: "Family is involved in careplan meetings"

Rationale: I have observed that those residents who have a loved one actively involved in the careplan process tend to be more compliant with taking medications & participating in therapies and are more open to the idea of using mental health interventions. As a result, they tend to have a more positive rehabilitative outcome Also, it allows family members to get valuable feedback from staff, improves staff/family relationships illicit support from family and can encourage support from family to discourage resident abuse of staff.

8.) Under F3." Preferred Routine", add: "Gets up in AM after 8:00 AM"

Rationale: Sometimes the most resistant to morning ADL care are those who have never liked to get up early. Knowing this can help staff to adjust ADL and therapy schedules to get more cooperation from resident. Less resistance to care also can mean lower incidences of skin tears, bruises and adversarial relationships with staff.

9.) Under F3. "Preferred Routine: 'Involvement Patterns'", add: "Lifelong preference for infrequent social interactions"

Rationale: Not everyone needs the same amount of social contact. Establishing a baseline would also show whether the resident has become more sociable since admission to the SN't:.

I hope that you will see the value in allowing me to speak at the MDS 3.0 Town Hall Meeting on 6/2/03. Thank you for your kind attention in this matter.

Sincerely,
Lisa A. Peterson, LCSW-C

Dear Ms. Rita Shapiro,

I am writing to applaud your new MDS 3.0 and to tell you how pleased I am to see recreational therapy included of Section P of this new version. As a researcher and a long term care practitioner I am thrilled to see this most important quality of life option included. It is a wonderful and important option because:

- Recreational Therapy has long been considered a rehabilitation treatment option in long-term care setting.
- The inclusion of recreational therapy in Section P of the MDS 3.0 is a very positive step in recognition of this viable therapy.
- The consumers of long term care rehabilitation services will benefit through improved functional abilities carry over value to their home setting and psychosocial well being.
- Recreational therapy, recognized in rehabilitation and psychiatric setting, will enhance the functional abilities of residents and improve their quality of life.
- Recreational therapy focuses on the same initiatives as providers and CMS.
- Recreational therapy as a recognized service in long term care will benefit our consumers.
- Physician ordered recreational therapy is considered medically necessary.
- Recreational Therapy is provided by a certified therapeutic recreation specialist or therapeutic recreation assistant under the supervision of a recreational therapist.
- Recreational therapy provides active treatment. Treatment that restores, remediate, or rehabilitates to improve functional abilities.
- Recreational Therapy interventions address an improvement in physical health, cognitive functioning, psychosocial supports, and psychological health as well as a reduction in health risk factors.
- Efficacy studies conduced by recreational therapy researchers in long-term care settings have demonstrated an increase in mobility, distance walked, and physical activity. An increase in cardiovascular fitness, a decrease in blood pressure, an increased flexibility and strength as well as improved ambulatory skills, and a reduction in falls has been documented. Furthermore, an increase in food intake, a decrease in depressive symptoms, as well as improvements in positive affect, satisfaction with life, opportunities for re-integration into the community, and increased involvement with families have been recognized in the literature.
- Recreational Therapy can have a positive impact on the lives of older adults with a variety of disabling and chronic conditions such as stroke or hip fracture recovery, dementia symptoms, chronic disease symptom management for arthritis, diabetes, cardiovascular disease, failure to thrive, mental health symptoms.

- Clients and residents in long term care deserve a variety of treatment options available that will meet individualized treatment goals and objectives.
- There is a growing body of knowledge that supports recreational therapy as a viable option for older adults in long-term care and must be considered a treatment option along side other rehabilitation therapies.

Thank you for taking my comment and for including this extremely important change in the MDS 3.0.

Sincerely,

Dr. Linda L. Buettner, CTRS

As a geriatric nurse practitioner and nurse researcher I have seen in clinical settings and in research projects the efficacy of recreational therapy for older adults. I for one, would like to see recreational therapist become a required discipline for the interdisciplinary team for care of the older adult. The inclusion of RT in Section P is a positive step in recognition of this viable therapy.

Nursing advocating for recreational interventions started over 150 years ago with Florence Nightingale during the Crimean War when she organized and reformed the nursing profession. At that time the physician's administration of drugs or performance of surgery was basically the beginning and end of the treatment process. Nightingale wrote of the benefits that accrued to patients from caring for pets, listening to and performing music, doing needle-work and writing. She chastised health care administrators to be more inclusive in their provision of services to patients: "Bearing in mind that you have all these varieties of employment which the sick cannot have, bear also in mind to obtain them all the varieties which they can enjoy." She then established a large recreation room and coffeehouse and developed various programs based on the patients functioning level.

In an address in 1893, she stated that "no system can endure that does not march. Are we walking to the future or to the past? Are we progressing or are we stereotyping? We remember that we have scarcely crossed the threshold of uncivilized civilization in nursing: there is still so much to do."29 "Let whoever is in charge," she said, "keep this simple question in her head, (not, how can I always do this right thing myself, but) how can I provide for this thing to be always done?"

You can be the one to make sure this can always be done. Including RT as a reimbursable item in Section P is the first step.

Suzanne Fitzsimmons, MS,ARNP

I have been informed that the draft version of the MDS 3.0 currently has RECREATIONAL THERAPY listed in SECTION P. It is very important to the people whom I represent and with whom I deal on a day-to-day basis that the designation needs to remain as listed.

Here are some of the reasons I believe the designation should continue:

- Recreational Therapy has long been considered a rehabilitation treatment option in long-term care setting.
- The inclusion of recreational therapy in Section P of the MDS 3.0 is a very positive step in recognition of this viable therapy.
- The consumers of long term care rehabilitation services will benefit through improved functional abilities carry over value to their home setting and psychosocial well being.
- Recreational therapy, recognized in rehabilitation and psychiatric setting, will enhance the functional abilities of residents and improve their quality of life.
- Recreational therapy focuses on the same initiatives as providers and CMS.
- Recreational therapy as a recognized service in long term care will benefit our consumers.
- Physician ordered recreational therapy is considered medically necessary.
- Recreational Therapy is provided by a certified therapeutic recreation specialist or therapeutic recreation assistant under the supervision of a recreational therapist.
- Recreational therapy provides active treatment. Treatment that restores, remediate, or rehabilitates to improve functional abilities.
- Recreational Therapy interventions address an improvement in physical health, cognitive functioning, psychosocial supports, and psychological health as well as a reduction in health risk factors.
- Efficacy studies conduced by recreational therapy researchers in long-term care settings have demonstrated an increase in mobility, distance walked, and physical activity. An increase in cardiovascular fitness, a decrease in blood pressure, an increased flexibility and strength as well as improved ambulatory skills, and a reduction in falls has been documented. Furthermore, an increase in food intake, a decrease in depressive symptoms, as well as improvements in positive affect, satisfaction with life, opportunities for re-integration into the community, and increased involvement with families have been recognized in the literature.
- Recreational Therapy can have a positive impact on the lives of older adults with a variety of disabling and chronic conditions such as stroke or hip fracture recovery, dementia symptoms, chronic disease symptom management for arthritis, diabetes, cardiovascular disease, failure to thrive, mental health symptoms.
- Clients and residents in long term care deserve a variety of treatment options available that will meet individualized treatment goals and objectives.
- There is a growing body of knowledge that supports recreational therapy as a viable option for older adults in long-term care and must be considered a treatment option along side other rehabilitation therapies.

Thank you for your review and consideration of this formal statement.
Pam Keller

May 21, 2003

To: Rita Shaprio

From: Nancy Richeson, Ph.D., CTRS

RE: **Support of MDS 3.0 Inclusion of Recreational Therapy under Section P.**

Dear Ms. Shaprio:

I am writing in support of Recreational Therapy inclusion into Section P of the MDS 3.0. Recreational therapy has long been considered a viable treatment option in long-term care and view the inclusion of recreational therapy in Section P a positive step in the provision of cost effective rehabilitation therapy. The consumers and their family members will benefit tremendously from have a variety of rehabilitative therapies as options for treatment.

Physician ordered recreational therapy is considered medically necessary and an active treatment that restores, remdiates, or rehabilitates the client to improve their functional abilities. Recreational therapy interventions address improvements in physical, psychological health as well as cognitive functioning, and a reduction in health risk factors. A variety of efficacy studies have been conducted that support these claims. Research conduced on the outcomes of recreational therapy interventions provide evidence of increased mobility, distance walked, cardiovascular fitness, flexibility and ambulatory skills. Also, a decrease in blood pressure, depressive symptoms, and number of falls has been documented. Furthermore, an increase in food intake, positive affect, life satisfaction, opportunities for re-integration into the community, and increased involvement with families has been recognized in the literature.

Considering the growing body of knowledge and positive impact that recreational therapy has on the lives of older adults with a variety of disabling and chronic conditions I feel recreational therapy is a feasible treatment option for older adults in long-term care settings. Recreational therapist treat clients with conditions such as stroke and hip fracture recovery, dementia and mental health symptoms, chronic disease management for arthritis, diabetes, and cardiovascular disease, and failure to thrive.

Therefore, I am applauding the move to Section P of the MDS 3.0 and request action utilizing recreational therapy treatment minutes in determining the RUGS. Thank you for your time and if you would like to contact me further regarding recreational therapy in long-term care I would be more than happy to talk with you.

Sincerely,

Nancy E. Richeson, Ph.D., CTRS
Assistant Professor

It does not appear that the section on pressure ulcers reflect the current practice of not down sizing ulcer stages as the ulcers heal. This should be fixed before sending out another edition of the document.

Bonnie Blachly

Recreational Therapy has long been considered a rehabilitation treatment option in long-term care setting. Clients and residents in long term care deserve a variety of treatment options available that will meet individualized treatment goals and objectives. There is a growing body of knowledge that supports recreational therapy as a viable option for older adults in long-term care and must be considered a treatment option along side other rehabilitation therapies.

Please keep Recreation Therapy where it needs to be in section P of the MDS 3.0.

Sincerely,

Lourdes M. Martinez, CTRS

5/22/03

Re: Town Hall Meeting on Refinement of the Minimum Data Set (MDS), Version 3.0

I am a recreational therapist working in a Community based Neuro Rehabilitation facility In Phoenix Arizona. Our facility is unique in that it provides real world applications in a variety of community settings for clients who have sustained some type of brain-injury and recreational therapy is a critical treatment option that is provided to our clients. Even thought I work in a community setting, I am very aware and concerned about the need for recreational therapy in other treatment settings, especially in skilled nursing programs. While I was unable to attend, I have discussed the meeting with several of my colleagues, and I appreciate the opportunity to provide comments to the Town Hall meeting on the Refinement of the MDS 3.0.

I would like to applaud CMS for the recognition of recreational therapy as an ordered therapy and the placement of such in Section P 2. "Therapies" section. This is consistent with current practice, the industry and accrediting agency standards.

The addition of quality of life indicators is an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The inclusion of additional indicators would provide a better snapshot of the resident's condition.

With the transfer of recreational therapy to Section P2., I recommend that the most cost effective mix of rehabilitation therapies, including recreational therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

I support Retaining the definitions for all therapies identified in Section P2. Current definitions include physician ordered therapy, in which the order includes frequency, intensity and duration of therapy, and the therapy is provided by a qualified therapist (provider).

In Section T1. Ordered Therapies, include recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I look forward to more opportunity to provide feedback during this process.

Sincerely,

Laurie Jake, CTRS
Recreational Therapist

cc: ATRA National Office
cc: "Ann Huston" <national@atra-tr.org>

May 22, 2003

Comments to: Rita Shapiro

Re: Minimum Data Set (MDS), Version 3.0

I am a trained nursing home administrator and rehabilitation manager of two skilled nursing facilities in north central Pennsylvania. I appreciate the opportunity to provide comments to the Town Hall meeting on the Refinement of the MDS 3.0. I was very pleased to see the move of Recreational Therapy data collection from Section t to Section P consistent with the other rehabilitation therapies. When physician prescribed with a reasonable expectation of improving the resident's condition, Recreational Therapy is a viable treatment option for the skilled nursing arena. Given that CMS has defined qualified provider requirements and physician prescription requirements for Recreational Therapy the addition of this service to Section P is over due. This change reflects the state of the art of rehabilitation services. Additionally, I would encourage the utilization of Recreational Therapy Treatment minutes in determining all Rehab RUG classifications. This will provide the most cost-effective mix of rehabilitation. Additionally, I strongly encourage that Section T1. Ordered Therapies, include recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

The definitions for all therapies identified in Section P2 should also reflect the current definitions that include physician ordered therapy, requirements for order definition of frequency, intensity and duration of therapy, and the therapy qualified provider language utilized with the MDS 2.0.

The addition of quality of life indicators is an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The inclusion of additional indicators would provide a better snapshot of the resident's condition.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. If I can be of additional assistance in this process please do not hesitate to contact me.

Sincerely,
Glenn Thompson, M.Ed.
Manager

May, 23, 2003 *Sent via email*

Dear Ms. Shapiro:

This letter is being sent to you in response to the draft of the MDS 3.0. As a Certified Wound Ostomy and Continence Nurse working in Long Term Care, my concerns are in the area of section M and are:

M1a-e: *pertaining to assessment done after admission.* There is no wound healing scale in this version of the MDS. Is this to say that "BACKSTAGING" is a practice that you are encouraging to continue to show evidence of healing?????
This must be addressed!!!! The practice of backstaging must be stopped!

M1f: *need to expand the definition.* What about the wounds that do not have intact skin, say with greater than 50% slough making the wound bed not visible and the wound unstageable? These should also be included here. As this reads, it only addresses eschar and purple red, non- blistered heels. A lot of gray area!!

Please let me know if you or anyone has any questions.

Sincerely,
Gail Dereczyk
Gail Dereczyk RN, BSN, CWOCN
DCS, Wound Programs and Systems

Good Afternoon,

Here are the comments/questions we are submitting for the MDS 3.0 Town Hall Meeting on June 2, 2003:

1. We noticed that on several sections of the MDS 3.0 draft that "none of the above" was removed as an option. This makes it difficult to determine if a question was answered or skipped. We believe that removing the "none of the above" option could potentially jeopardize the quality of the results submitted.

2. Section X - is the section to be completed with RAPS or the MDS?

Thank you in advance for your consideration! We're looking forward to the meeting!

Lori Schug

LTC Regulatory Knowledge Manager

Comments regarding
MDS Section P5 (Physician Visits) and P6 (Physician Orders)

submitted by Gitl S. Viswanath, RN, MPA, LNHA

The **MDS 2.0 User's Manual** has always specified the various practitioners whose physician visits/orders may be included in this section, including MD, DO, podiatrist and dentist, and "an authorized physician assistant, or nurse practitioner working in collaboration with the physician."

However, in the December 2002 revision of the **User's Manual**, this description has been expanded and now reads "an authorized physician assistant or nurse practitioner (who is not employed by the nursing facility) working in collaboration with the physician." As far as we know, this apparent exclusion of staff nurse practitioner visits and orders has never appeared in the MDS Q&A's to date. Since the draft version of the MDS 3.0 does not come with a manual, and since the wording on the actual draft document states "physician (or authorized assistant or practitioner)," we would like to inquire as to whether the what we be believe to be unreasonable restriction on nurse practitioners will be continued in MDS 3.0.

The **MDS 2.0 User's Manual** states that this assessment information is included on the MDS 2.0 because "In some cases the frequency of physician's visits [and physician's order changes] is indicative of clinical complexity."

Nursing homes in New York State and across the county have hired greater numbers of nurse practitioners over the years for various reasons, including their reputation for having excellent assessment skills, they provide coverage when other practitioners may not be on-site, and they are frankly less expensive to hire and maintain on staff. Both the nurse practitioner on staff at a nursing home and the one working independently have received the same education and utilize the same assessment and treatment skills. Both are required to work in collaboration with a physician.

We feel that the current policy of allowing visits and orders by facility employed physicians and not by facility employed nurse practitioners interferes with the purpose of the MDS — to accurately collect assessment data reflecting the condition and needs of the resident. We respectfully request that this discrepancy be corrected in the MDS 3.0.

May 23, 2003

Comments to: Rita Shapiro

Town Hall Meeting on Refinement of the Minimum Data Set (MDS), Version 3.0

I am writing as an educator in recreational therapy who supervises internship students. My clinical practice experience includes long-term care as well as both sub-acute and acute physical rehabilitation settings. I appreciate this opportunity to provide comments to the Town Hall meeting on the Refinement of the MDS 3.0.

I applaud CMS for the recognition of recreational therapy as an ordered therapy and the placement of such in *Section P 2. Therapies* section. This is consistent with the current state of practice which I've observed during my internship site visits. It also reflects accrediting agency standards.

I support the use of *quality of life* indicators as an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The inclusion of additional indicators would provide a more accurate picture of the resident's condition.

With the transfer of recreational therapy to *Section P2*., I recommend that the most cost effective mix of rehabilitation therapies, including recreational therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

I support retaining the definitions for all therapies identified in *Section P2*. Current definitions include physician ordered therapy including frequency, intensity and duration of therapy, and that the therapy is provided by a qualified therapist (provider).

I suggest that in *Section T1. Ordered Therapies* CMS include recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I look forward to more opportunity to provide feedback during this process.

Sincerely,

Pamela A. Griffin, M.A., CTRS

cc: ATRA National Office

Comments from Laurie Loftus:

Laurie Loftus Item-by-Item Comments

	SECTION A		
A11f	**Swing Bed Clinical Change Assessment**	typo-change "of " to "or"	
A15a	**Admitted from**	why is this section only for swing beds	
A15b	**Discharge status**	why is this section only for swing beds	
A15c	**Re-entered from**	why is this section only for swing beds	
A16	**Discharge date**	why is this section only for swing beds	
A17	Date of reentry from most recent temporary discharge	why is this section only for swing beds	
A18	Residential history 5 years prior to entry		
A21a	Signature of RN Assessment Coordinator	as this is written it appears that the RN is the only person	
		attesting to the accuracy of the MDS. The original attestation	
		Language should be added for the rest of the folks signing	
A21c	Other Signatures of Persons Completing these items	Consider adding additonal lines	
	SECTION B		
B1	Comatose		
B2a	Short-term memory OK -Change to 3-day lookback	Clarify---3 days from ARD date?	
B4	Mental function varies during day	I would add a place to answer "new medications"	
B5a	Easily distracted	Bold 'since last assessment"--Also add code for no prior assessment"	
	SECTION C		
C1	Hearing, with appliance if applicable	add 'if applicable" to "with hearing appliance"	
C2	Making Self Understood	would add verbage if resident does not speak english as it	
C3	Ability to Understand Others	can cause frustration for the resident	
C4	Vision		
	SECTION E	What do we do for residents unable to answer or answer appropriately?	
E1Aa	**Satisfied with life?**		
E1Bj	Unpleasant mood in morning	many folks aren't morning people--and don't impaire sleep cycles	
E2	Mood Persistence	E2 and E3 are not on the draft. Are we to assume that	
E3a	Diagnostic eval-licensed mental health	these have been deleted and will not reappear, or reappear	
E3b	Individual psychotherapy-licensed mental health	on the final version?	

	SECTION F	What do we do for residents unable to answer or answer appropirately?	
F1a	**Can you find a place to be alone when you wish?**	I have a problem with this whole section. With this being on	
F1b	**Can you make a private phone call?**	the MDS and transmitted, I can see where surveyors may	
F1c	**When you have a visitor, can you find a private place?**	tag the facility on this information only instead of determining	
F1d	**Can you be together in private with another resident?**	if there is truly an issue. With all due respect to the survey	
F1e	**Do you participate in religious activities here?**	process, the surveyors do not understand the federal regs	
F1f	**Do the religious observances here have personal meaning?**	for the MDS as well as we do and we spend countless time	
F1g	**Do you enjoy the organized activities here?**	explaining the RAI process to those who should understand it	
F1k	**Can you get your favorite foods here?**	how far do we have to go with this????	
	SECTION G		
G1c	**Locomotion- self performance**	need to add word locomotion in definition-it is missing	
G1i	**Transfer toilet- self performance**	this would change the grouper information if not included	
		in toileting. Would advocate not having this separate	
	SECTION H		
H3	**Bladder appliance support**	24 hrs. from ARD date?	
H5	**Bowel appliance support**	percentages are too subjective-please re-work	
	SECTION I		
		I am assuming that with going to the drop down boxes the software	
		will group residents appropriately???	
I1a	Diabetes mellitus		
	SECTION J		
J1g	Insufficient fluid	what will be the clarification for this vs dehydration?	
J2b	**Intensity of Pain**	most chains are using 1-5 pain scale. Why not included here?	
J2dj	Location- other	Could we add another location for "generalized"?	
J2e	**Does resident show nonverbal signs of pain**	many of these are also for other ailments of issues. Will the	instructions in the new rai be specific?????
J4a	**# of falls resulting in no injury**	items J4a-d--need coding if intial assessment and n/a	
J4b	**# of falls requiring first aid**	also will these change the QI'S and QM'S?	

	SECTION K		
K1	Swallowing problem	have item for "both modifed food & liquid"--need item for just modified "liquids" as well	
K2a	Height (inches)	this could change with an amputation after the resident is admit	do not see why this would be for admission only. It is an indicator of osteoporosis in the general populace
K3	Weight loss	insert "if less than 30 days" after "since last assessment"	
K4a	Parental/IV	change spelling on parenteral	
K5b	Average fluid intake (daily) in last 7 days	the term consumes most/almost of all offered is better than	
		trying to quantify #cc's	
	SECTION L		
	SECTION M		
M1b	# at Stage 1	see comment, pertains to assessment done after admissiion	there is no wound healing scale in this version of the MDS, is the practice
M1e	# at Stage 4	reason not to retain is definition need to expand	what about the wounds that do not have intact skin, say with greater than 50%
M1f	**Not stageable**	coding if initial assessment?	slough making the wound bed not visible and the wound not stageable
M2	**Number of new pressure ulcers**	combine m3a&b	these should be included here. Lots of gray area!!!
M3a	**Number of venous stasis ulcers**	combine m3a&b	
M4	History of resolved ulcers since last assessment	coding if intial assessment?	
	SECTION P		
P1aa	Chemotherapy	now would be a good time to change the thinking on marking this	for cancer patients only. No matter the diagnosis, the side effects stay the same.
P1ar	Training in community skills	need these defined	
Recommendation To Add Up To 3 MDS 2.0 Items Deleted			
MDS 2.0 Item		**Rational/Justification**	
		the mds should be used to care for the resident. Concern is that	
		we are moving away from that and that it is only going to be	
		for reimbursement and/or research. With the change in	
		interpretation for the 2.0 the general concessus across the nation	
		is that it is now for only reimbursement. Can we avoid this with	
		the 3.0 or will we move still farther away from the original intent?	

Re: Draft version MDS 3.0

I am Administrator of an 180 bed facility in Warren County, NJ. My background is in Social Work and all my clinical experience is in long term care. The section that greatly upsets me is Section F Quality of Life. The personal and difficult nature of these questions posed to a new nursing home resident is a set up for disaster. Does the facility need to know and understand the routine, the adjustment in the facility? Yes, certainly. Yet, I believe that no trained Social Worker would directly want to hit a new resident with such questions.

And, let's be honest, to be an alert resident, medically compromised and newly admitted to a long term care community is definitely the cause for feelings of worthlessness, massive adjustment, questioned relationships, not to mention anger and disappointment.

We deal with such issues frequently but we assess them in a appropriate and gentle manner which enables us to arrive at the same answers without cross- questioning new admissions. Please rethink this line of questioning.

Maryanne Lyons, LNHA, MPA

Caroline H. Larson, RN, BS, MS, RAC-C
MDS/PRI Coordinator

Overall comment: it looks good. The re-organization, putting similar questions together, is helpful.

A5 – The comment to complete only upon admission or ***if a change occurs***, is misstated. People do not change their race!

A11 – Hopefully some of the first 2 answers can be pre-set in the software: We have no pediatric beds and the status of the facility will not change.
A11d – I do not see OMRA listed as an option.
A11e (?) On the copy of the draft that I printed there is no question, only the word "bed" and the coding choices of 0 and 1.

A12 – What is the purpose of this question? How will it be used? It does not help the facility, so I want some assurance that the question is needed!

A20 – Our software provided the HIPPS codes currently. Is there a reason why you indicate "NH must fill this in?" Hopefully there is no reason why it can't be completed by the software.

A21 – Dates -- Please provide a clear statement of what date to use on the signature page. At present the practitioner can do the assessment of the resident on one date but will not enter the information into the computer until a later date. With electronic completion, it may be several days or even a week later before the completed MDS is printed. If facilities require staff to sign the printed copy of the MDS, the staff are then signing the "hard copy" on yet a third date. The date that makes sense to use is the date upon which the practitioner did the assessment of the resident. This gives you a corresponding reference point if you do later chart reviews to verifiy information or for other purposes. Furthermore, a practitioner will enter data in the computer based upon his/her assessment of the resident on the date that the assessment was done, thus the date the information was entered into the computer is not the important date. The date that papers were eventually signed is basically irrelevant, except to show how long it takes the facility to get the paperwork completed. Our facility has chosen to maintain a separate signature page in the resident's chart which the staff members sign when they have completed their assessment of the resident. Since many of the IDT members work

P7 – Medicare length of stay – What is the purpose of this question? Our discharge planning team does provide this information for the residents that are being seen by therapy, but I need some help to understand why we have to include it on the MDS. If CMS wants to gather information about length of stay, they can get it from the tracking forms.Furthermore, why do you specify that the MD must provide the estimate? In most cases our therapy department has the most say about the length of stay.

Section X - Is this a state option or a new required section? This is important information but there should be better ways to keep track of it than on the MDS.

Section A11. c & d - I like the additions and reordering of the selections.

Section A12 - I can see the potential for confusion between a & b

Section B4 - I think this is improved (simple yes/no and 3 questions better than the present section format)

Section B5 & 6 - Makes sense to have these sections follow B4

Section C2 - I think the definitions for 1 & 2 are too narrow. There can be many reasons for usually or sometimes being understand; for example a facial nerve palsy or cerebral palsy may make articulation difficult and interfere with the ability to express ideas and consequently have varying degrees of being understood. I think the definitions should be broader.

Section C3 - I think the distinction between Usually Understands and Often Understands is not necessary and should be combined into one (as in MDS 2.0). The care plan can address whether prompting is necessary without a special selection to bring this forward to the RAP and team. I think it will make source documentation for this item more difficult.

Section E1A - I like the change to a 14 day observation

Section E1B - I think is room for tremendous variability in what "often" means and can cause more confusion than assistance to a care plan. I like question 1 and 4. I would feel extremely uncomfortable asking a resident question 5; I think it is an extremely negative question and would be better off left to a psychosocial assessment to venture into a questions like that.

Section E1B and F1 - I think there should be a code in case a resident chooses not to answer a question. They may want to answer some of the questions and not others; this is their right.

Section G1 - Very glad to see there is one set of coding for the section. I find the use of " non-weight bearing assistance" and "weight bearing support" to be very confusing to nurses and therapists alike. Using the words "weight bearing" is the lingo that pertains to a resident's ability to weight bear. Using these same words to classify a type of support provided by caregivers is very confusing. I particularly think that the definitions of 2 & 3 are confusing with the "3 or more time" and then the "OR – with more things to count. I recommend to put all the transfer items in order consecutively, so it is very clear that the coding does not overlap. For example, move b. Transfer after i. Transfer Toilet, and follow with l. Transfer tub/shower.

Section G2 - Much better than the MDS 2.0 Test for Balance. I do not think that a 24 hr. observation period for this item is adequate; I think it should be 7 days to be a better correlated to resources used and a predictor of risk.

Section G3 - If the instructions will still be "functional" range of motion, I would like to see the wording as "Functional Range of motion" on the MDS document, not just part of the instructions.
Sections G4 and 5 - I recommend a 7 day look back for these 2 sections.

Section I1 - I like the elimination of NONE OF ABOVE; this created unnecessary missed items when checking for completion. The drop down screens look very comprehensive and I think will improve billing, since ICD-9 codes are so important for a clean bill.

Section M. - Seems improved compared to MDS 2.0

Section N1 - Recommend a 7 day look back, not a 3 day look back.

Section N3 - I think the definitions are confusing; the use of the negative "Not exhibited" for one code and then "Exhibited" for the next code is confusing. Then it becomes even more confusing trying to figure out 14 days, 5 days/wk, almost daily. I would say this needs a lot of work.

Section N4 - I recommend to move this to Section F. Quality of Life; maybe at the end of the section.

Section O2 - Much better to "check" than to count the number of days.

Theresa Edelstein

Dear CMS,

There is no place in the 3.0 MDS to indicate if a patient is Bariatric or patients (325 pounds plus). These people take considerably more staff to reposition, transfer, and toilet. They also tend to have more complications such as skin breakdown, diabetes, heart failure etc. The additional staff required by bariatrics needs to be tallied into the reimbursement formulas for Medicare and considered when calculating quality indicators and staffing. If Medicare recognizes the costs of caring for these residents, it will aide hospital discharge planners in finding placement for these unique individuals.

Please add a field to the MDS 3.0 to recognize these staff intensive residents.

Thanks,

Wade Peterson, Administrator

Dear Madam/Sir:

I write to express my strong support for keeping Recreational Therapy in Section P of the MDS 3.0 document. As a nurse researcher who has worked for many years in nursing homes with recreational therapists, I can attest to the benefits that professionally prescribed recreational activities have on resident functional abilities as well as overall quality of life. My clinical experience and research bear this out. Nursing home residents spend most of their time "doing nothing"- this leads to decline in function and problematic behaviors, both of which contribute significantly to the cost of long-term care.

Recreational Therapist make a huge difference in resident quality of life and reduce overall costs related to frailty. I urge you to maintain their presence in nursing homes!

Ann Kolanowski PhD, RN

Comments from Marcia Shalek:

Dear Ms. Shapiro,

I am writing this letter in response to the mds 3.0 version and the importance of listing Recreational Therapy in Section P. I have work in LTC for over 14 years and have recognized the importance of Recreational Therapy in long-term care both as a practitioner and as a consumer. Listed below are the importance of this therapy in LTC -The inclusion of recreational therapy in Section P of the MDS 3.0 is a very important positive step in recognition of this viable therapy

- The consumers of long term care rehabilitation services will benefit through improved functional abilities carry over value to their home setting and psychosocial well being.

- Recreational therapy focuses on the same initiatives as providers and CMS

- Recreational therapy provides active treatment. Treatment that restores, remediate, or rehavilitates to improve functional abilitites.

- Recreational therapy interventions address an improvement in physical health, cognitive functioning. psychosocial supports, and psychological health as well as a reduction in health risk factors.

- Efficacy studies conducted by recreational researchers in long-term care settings have demonstrated an increase in mobility, distance walked and physical activity. Also through recreational therapy programs there has been an increase in food intake and a decrease in depression.

- Clients and residents in long term care deserve a variety of treatment options available that will meet individualized treatment goals and objectives.

Last, I would like to share a story of a women who I currently work with in a LTC setting. This women is 50 years old who has suffered a moderate stroke. She came for short-term rehab 9 months ago and still remains with us. After receiving active rehab with PT, OT and Speech she exhausted her benefits and PT felt that she reached her new base line, she was discharged from PT, OT and speech. The Recreational Therapy department then picked her up and developed a new treatment plan with a CTRS and a certified Music Therapist. We developed a new treatment plan of; airmat therapy for increase balance and relaxation, exercise with weights 3 times per week and endurance (walking) and work with the music therapist for speech. She has shown great improvement on all areas. she is able to sit at the edge of the airmat for up to 3 minutes. When we began she had no upper body strength and could not sit up. Her walking has increased and her strength continues to improve. She is now lifting 3lbs of weight on each side including the effected side.

Sincerely,
Marcia Shalek, CTRS

I am writing to request that recreational therapy remain in SECTION P of MDS 3.0. This is very important for persons with Alzheimer's. The following are some of the reasons why it should be included.

- Recreational Therapy has long been considered a rehabilitation treatment option in long-term care setting.
- The consumers of long term care rehabilitation services will benefit through improved functional abilities and carry over value to their home setting and psychosocial well being.
- Recreational therapy, recognized in rehabilitation and psychiatric setting, will enhance the functional abilities of residents and improve their quality of life.
- Recreational therapy focuses on the same initiatives as providers and CMS.
- Recreational therapy as a recognized service in long term care will benefit our consumers.
- Physician ordered recreational therapy is considered medically necessary.
- Recreational Therapy is provided by a certified therapeutic recreation specialist or therapeutic recreation assistant under the supervision of a recreational therapist.
- Recreational therapy provides active treatment. Treatment that restores, remediate, or rehabilitates to improve functional abilities.
- Recreational Therapy interventions address an improvement in physical health, cognitive functioning, psychosocial supports, and psychological health as well as a reduction in health risk factors.
- Efficacy studies conduced by recreational therapy researchers in long-term care settings have demonstrated an increase in mobility, distance walked, and physical activity. An increase in cardiovascular fitness, a decrease in blood pressure, an increased flexibility and strength as well as improved ambulatory skills, and a reduction in falls has been documented. Furthermore, an increase in food intake, a decrease in depressive symptoms, as well as improvements in positive affect, satisfaction with life, opportunities for re-integration into the community, and increased involvement with families have been recognized in the literature.
- Recreational Therapy can have a positive impact on the lives of older adults with a variety of disabling and chronic conditions such as stroke or hip fracture recovery, dementia symptoms, chronic disease symptom management for arthritis, diabetes, cardiovascular disease, failure to thrive, mental health symptoms.
- Clients and residents in long term care deserve a variety of treatment options available that will meet individualized treatment goals and objectives.
- There is a growing body of knowledge that supports recreational therapy as a viable option for older adults in long-term care and must be considered a treatment option along side other rehabilitation therapies.

Thank you for considering this comment.

Jack Robarts

My name is Tess Kwiatkowski, MS, RN. I am the Executive Vice President of Life Services Network of Illinois (LSN), the AAHSA affiliate in Illinois. Our Nurse Leadership Committee reviewed the Draft MDS 3.0 and has some general comments to make that might help in discussion on June 2nd. After that date, and after hearing more rationale for why items were chosen or left off the tool, we will be submitting more comments.

1) Section FI: Self-Report Quality of Life
   a. these questions are in the interpretive guidelines for surveyors to use during survey - why are they here as well?
   b. if they need to be here, then a Lickert type scale would be more useful than yes or no.
2) Section H: Continence
   a. no question for normal pattern under bowel elimination
   b. no question on use of bladder scanner
3) Section I: Disease Diagnosis
   a. this tool seems bent much more to acute conditions rather than the chronic maladies that are seen in LTC residents; e.g. no Parkinson's Disease or TIA or Macular Degeneration
   b. section seems to be there for use by researchers and not to help plan care for the LTC resident
   c. committee felt this section would be very burdensome
4) Section J4: Number & Classification of Falls
   a. need to clarify definition of fall - this section is a huge liability risk
   b. comment on IV infiltrate is not LTC-focused
5) Section K1: Swallowing/Nutritional Status
   a. use of word "subject" is totally inappropriate
   b. speech therapist needed to fill this out; should focus on helping to feed not swallow.
6) Section L1: Oral Status and Disease Prevention
   a. this section is not about assessing and planning care
   b. need dentist to complete
   c. no question if resident has dentures
7) Section M: Skin Condition
   a. in M1, need a column for current status of ulcer
   b. again no ability to reverse stage or use of PUSH tool
   c. Venous or arterial ulcers need diagnosis from physician
8) Section O: Medications
   a. suggest gathering antibiotic information by physician to gather practice patterns
9) Section P: Special Treatments
   a. no suctioning (should it be P1i?)
   b. P2 - no intervention programs for mood, behavior and cognitive loss - these are our residents
10) RAPS
   a. How is RAP 5 different from RAP 18?

Thank you for the opportunity to submit comments. I look forward to the Town Hall Meeting.

Tess Kwiatkowski MS, RN

5/22/03

Dear Rita Shapiro,

I am a recreational therapist working in a skilled nursing facility in the Fort Myers, Florida area. I am pleased to have the opportunity to provide comments to the Town Hall meeting on the Refinement of the MDS 3.0.

I applaud CMS for the recognition of recreational therapy as an ordered therapy and the placement of such in Section P 2. "Therapies" section. This is consistent with current practice, the industry and accrediting agency standards.

The addition of quality of life indicators is an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The inclusion of additional indicators would provide a better overview of the resident's condition.

With the transfer of recreational therapy to Section P2., other recreation therapists and myself recommend that the most cost effective mix of rehabilitation therapies, including recreational therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

Retain the definitions for all therapies identified in Section P2. Current definitions include physician ordered therapy, the order includes frequency, intensity and duration of therapy, and the therapy is provided by a qualified therapist (provider).

In Section T1. Ordered Therapies, include recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I look forward to more opportunity to provide feedback during this process.

Sincerely,

Karen M. Tomasello, CTRS

To Whom It May Concern:

We, Elena Dunn and Marcy Kight, are the Board-certified Social Workers. We have been in our fields for 20 years and 15 years respectively.

In reviewing the MDS version 3, we have the following comments:
C4 -- Adding "unable to assess" to this area provides an accurate assessment of the visual condition.
E1B -- Addressing these areas with residents would place them in an extremely vulnerable state. As social workers, we would need to be prepared for the clinical degradation(i.e., self-doubt, self-loathing, abandonment) we would create with these questions.
F1 -- Adjustment to a nursing home is difficult for even the individual who knows this is appropriate placement. These questions emphasize those fears and concerns which every resident must face. Residents cannot face and overcome fears if they are not ready to do so. We cannot ethically put them in situations that they are not ready to address. Also, these questions are not appropriate for the time period allowed (two weeks from admission).
Because of the intensity of the MDS, assessing is requiring much more time and thus allowing less time for attention to adjustment issues.
Initial assessments and interventions are complex and thorough. Repeating this process two weeks from admission will not produce reliable data.
N3&4 -- These areas are so closely related to mood state that they should remain in that section and addressed by Social Services.
N5 -- This addition is necessary for a good assessment.

Thank you for this opportunity to share our professional views.

Elena Dunn, MSW, Marcy Kight, CSW,

May 23, 2003

Re: Town Hall Meeting on Refinement of the Minimum Data Set (MDS), Version 3.0

I want to take this opportunity first to congratulate and commend CMS for the significant changes that have been made to the MDS in Version 3.0. I am tremendously pleased that CMS has taken a step forward to move recreational therapy into Section P. This move brings recreational therapy in line with other therapy services and is more congruent with industry and accreditation standards for quality rehabilitative care for beneficiaries.

As you proceed in adopting Version 3.0 of the MDS, I cannot stress the importance of counting recreational therapy minutes in determining RUG classifications along with other rehabilitation therapies identified in Section P. There is significant evidence to support that when ordered by a physician, recreation therapy does contribute to improvement and restoration of function and is a contributing component to helping individuals make the transition back to the community and back to a maximum level of independence. When recreational therapy is included in the mix of options available for rehabilitation there can be a significant cost benefit as many of recreation therapy interventions are provided in a group setting and are a complement and carry over to other rehabilitation modalities. It is also important that recreational therapy be retained as an ordered therapy in Section T 1.a in order to remain consistent with the other therapies that are listed in Section P 2. In Section P1 Special Treatments, recreational therapists do provide skills training that is essential in returning persons to the community and therefore, I would recommend that there be clear interpretive instructions that reflect the industry standards that such skills training can be provided by a qualified recreational therapist (at minimum a person nationally credentialed as a CTRS by the National Council for Therapeutic Recreation Certification).

In addition to the changes in Section P., I would further commend you for the changes that have been made to Section N. By adding elements from Section F and E, it is clear that there is acknowledgement that recreation services do play a role in the interaction levels of beneficiaries and have an impact upon mood and behaviors. I would add a cautionary note that it will be important to have access to interpretive guidelines for Section N5 so that one is able to distinguish between the statements included in this section. In Section G and K, it is very positive that FIM language is used because that is also congruent with industry practices and provides for consistency along the continuum of rehabilitative care that is available to beneficiaries. It is suggested that consideration be given to adopting a seven point scale throughout the entire MDS as it would reflect more accurate ratings and not be quite as confusing to raters.

Finally, it is suggested that minor revisions be made to the interpretive instructions for Section P in reference to qualified therapists. The reference to licensed therapists is not a guideline that can be consistently applied as there are many states that do not recognize therapists as licensed providers. As noted above, for recreation therapists, the minimum acceptable industry standard is for a person to be credentialed as a Certified Therapeutic Recreation Specialist ® by the National Council for Therapeutic Recreation Certification.

Again, I commend and congratulate you on the positive revisions that have been made thus far. I am looking forward to educating the recreation staff that I work with in the New England region. I consult to and advise staff in over 47 skilled nursing facilities and I assure you that the changes made once adopted will have a significant impact on the quality of care and delivery of services to our customers/beneficiaries. These are changes that we in the long term care industry can truly embrace.

Thanks for your on-going efforts in behalf of our nation's elders and citizens with disabling conditions.

Sincerely,

Sharon Nichols, CTRS
Sharon Nichols

May 23, 2003

Dear Ms. Shapiro,

I am writing in regards to the Town Hall meeting on the refinement of the MDS 3.0 and public comment period. I am a Recreational Therapist, currently not working in a non- clinical role with the American Therapeutic Recreation Association.

As a profession we applaud all that CMS has done giving recognition of Recreation Therapy as an ordered therapy and the placement of such in Section P 2. "Therapies" section, which is consistent with current practice, the industry and accrediting agency standards.

The addition of quality of life indicators is an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The addition of these indicators would provide a better picture of the resident's condition.

With the move of Recreation Therapy to P2. we request that CMS identify Recreational Therapy as an ordered therapy in Section T1. to remain consistent with the listing of therapies in Section P2.

We recommend the definitions for all therapies identified in P2. retain definitions that rehabilitation therapies are physician supervised, include in the physician's order the frequency, intensity and duration of the ordered therapy and the therapy is provided by a qualified therapist.

With the transfer of Recreation Therapy to Section P2., we recommend that the most cost effective mix of rehabilitation therapies, including Recreation Therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

In section T1. Ordered Therapies, include Recreational Therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you once again for the opportunity to provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I will plan on giving more feedback during this process.

Sincerely,

Heather M. Hupp, CTRS

Many of our staff have concerns r/t sect. J2: this appears to be subjective, would the resident need to know and understand state guidelines or nursing's in order to answer? What a resident may think a 3 (on a scale of 1-10) is that may not be the same as the NRS scale, certainly a resident could think 5 would be severe pain while it would not get coded that way.

R/T sect. k1
this is a mess, what is 25% of assistance, how accurate could this be, what is the difference between 49% and 50% and how would you monitor that and be consistent with definitions among staff and facilities.

Comments from Terri Woods

Section A

1. Great that they reorganized the types of assessments in A 11 to be in chronological order, much less confusing.
2. Why would you use 90. “Not PPS scheduled assessment” in A 11 d. PPS Scheduled Assessments when this clearly states for PPS purposes only? If it was not a PPS assessment, wouldn’t you just leave it blank?

Section B

1. Great to see B5 Hallucinations/Delusions moved from section I. Makes more sense here.

Section E

1. Feel that E1B number 5. “Do you feel pretty worthless the way you are now” is worded very inappropriately and should not be included with these questions.

Section F

1. Do not feel that F1 Self-Report Quality of Life questions are appropriate for the MDS assessment. These are for the facility to determine as part of their QA process and for surveyors to determine during the survey.

Section G

1. Glad to see ADL’s reduced to one column for coding. Much less confusing when the facility staff get used to the dramatic change. However, I am interested in seeing how this reduction will affect ADL scoring for PPS reimbursement purposes.
2. Glad to see addition of G3C Touch/sensation as an additional area of assessment. Would like to see this area impact the QI as a factor causing a resident to be high risk for skin breakdown. Also glad to see ROM broken down into the 3 broad categories rather than each individual joint, but will need clear guidelines in the MDS manual as to how to mark column A, B, and C if impairment is only noted in one of the 3 individual categories. If we are to mark impairment if only one of the joints is affected, this will probably trigger decline in ROM more frequently than under the old MDS format.

Section H

1. Will the addition of choice 1 “Continent with catheter or ostomy” eliminate the need for a significant change related to one area of change being insertion or removal of a foley catheter?

Section I.

1. Will all sub-categories of the PPS related diagnosis (i.e. pneumonia, diabetes) be eligible for reimbursement under the specified RUG categories or only certain specified sub-categories?
2. What do they mean in the instructions “ Checkbox item required for RAPs, RUGs, QIs, or QMs and Checkbox/code recommended based on frequency”? Not sure I understand the relationship.
3. Will we need to have a doctor’s documentation of the specific diagnosis in the drop down boxes to support, or just the broad categories?

Section J

1. Will the MDS manual include samples of the standardized pain intensity scales listed as choices?

Section K

1. What are the “alternate feeding methods” referred to in K1 5 and K1 6?
2. I feel that the wording “subject requires assistance for 50-75% of swallowing” and “subject performs less than 25% of swallowing” are misleading and confusing. If the subject is not doing the swallowing they should not be eating. We can not do the swallowing for them, but only use techniques to reduce swallowing problems. The assistance provided is actually to assure safe swallowing and physically transfer the food to the oral cavity.
3. Do not feel that it is appropriate to require the weight to be obtained in the last 3 days. Within the observation period would be more consistent with the other items of the MDS.
4. Will wt. Loss trigger on the QI if planned wt. Loss is checked?

Section M

1. Will the new guidelines on skin tears over bony prominences still be used with the NPUAP staging guidelines?
2. How will the new staging effect reimbursement under PPS guidelines?

Section V

1. Do not feel it is necessary to have the two pressure ulcer RAP's. The RAP triggers if the resident has risk factors regardless of treatments, therefore prevention is addressed when necessary. By having the two RAP's, residents with actual pressure ulcers will have to have 2 separate RAP's completed which will essentially address all of the same issues, treatment and prevention of further breakdown.
2. Do not feel quality of life is appropriate as a RAP or as identified by the new questions on the MDS. I feel that these issues are for the facility to identify as part of their QA program and for surveyors to determine during the survey process. All of the mood, behavior, and activity sections of the MDS identify if there are issues identified for the resident regarding quality of life. The specific questions in the draft are leading, and could easily give the impression that life in long term care should lead to a feeling of worthlessness and depression, if they don't already feel that way. Answers to the questions in the draft would not present a fair depiction of the residents' true quality of life, which can only be determined by day to day observation of the resident.
3. I do not feel it is necessary to have Restorative Care as it's own RAP. Restorative programs should be addressed in the RAPs of the areas of functionality they are related to. For instance, restorative dining should be addressed with nutrition, ROM and ambulation or training/skill practice should be addressed in ADL functional/rehabilitation potential, or with restraints or pressure ulcers as indicated, etc. I feel the Restorative RAP is repetitive of information addressed elsewhere.

General

1. How many total pages is the MDS 3.0 when condensed?
2. Will the MDS 3.0 be released before the new manual of instructions is available to go with it?
3. Will the reimbursement related items be identified before it is released so that states with specific Medicaid PPS validation guidelines can prepare for use of the new MDS?
4. Will there be a transition period during which facilities can transmit MDS 2.0 or 3.0 before the final deadline is set?
5. Will CMS assure that software vendors are compliant with the new forms before the use deadline is set?

Janine Lehman, R.N., DCS

I just wanted to add a few comments re: the MDS proposed changes:

As a Speech-Language Pathologist, I find there is some confusion regarding coding of memory- (B2) Short term memory and immediate memory are slightly different. People may remember after 5 minutes but not one day- that is immediate memory; short term memory can be over recent period of time.
Longterm memory obviously delves back into a person's past. As a Nursing Home Adm. and SLP, I sit on the MDS interdisciplinary team and observe the staff having difficulty with coding in this area. Another area of concern is making daily decisions. (B3) The categories are fine, it's the criteria that is a problem. A resident can choose clothing, meals, etc. that are appropriate, but not be able to make life and death decisions or decisions about their medical care. The present instructions in the MDS manual do not address this issue clearly enough.
Section I. Should Macular Degeneration be part of the this section as it is a prominent sensory disease?
Section J4; Falls b. Should a skin tear be added to scratches, abrasions, etc.?
Section K3: There is nothing regarding Weight gain.
These are a few of the things we have noted in previewing the MDS. I hope this input is helpful.

Diane Marcello, MS, CCC-SLP, M.Ed, NHA

Dear Ms. Shapiro,

I am writing in regards to keeping Recreation therapy listed in section P of the MDS-3.0. Recreation therapy has long been considered a rehabilitation treatment option in long term care. As a recreation therapist, I feel this is a very positive step in the recognition of recreation therapy as a viable and effective treatment option. Clinical research studies conducted by recreation therapy researchers in long term care settings have demonstrated an improvement in physical, cognitive, psychosocial, and psychological functioning. I believe that residents in long term care deserve the highest quality of life possible and a choice of a variety of treatment options to meet their individualized goals and objectives.

Please keep recreation therapy listed in Section P of the MDS-3.0. It is vital to our growth as a profession. Thank you.

Sincerely,
Lisa Bugden, CTRS

I am a geriatric care manager and follow patients in nursing homes, as well as the community. The list under H1-3 does not improve on the status quo. There is little incentive or inclination to do anything other than protective garments (charged to the family) or pads. I urge you to include continence under P3, nursing rehabilitation/restorative care.

A Cochran, RN

May 29, 2003

Town Hall Meeting on Refinement of the Minimum Data Set (MDS), Version 3.0

I am a recreational therapist working in nursing home care units of the V. A. Medical Center in Chillicothe, Ohio, and appreciate the opportunity to provide comments to the Town Hall meeting on the Refinement of the MDS 3.0.

We applaud CMS for the recognition of recreational therapy as an ordered therapy and the placement of such in Section P 2. "Therapies" section. This is consistent with current practice, the industry and accrediting agency standards.

The addition of quality of life indicators is an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The inclusion of additional indicators would provide a better snapshot of the resident's condition.

With the transfer of recreational therapy to Section P2., we recommend that the most cost effective mix of rehabilitation therapies, including recreational therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

Retain the definitions for all therapies identified in Section P2. Current definitions include physician ordered therapy, the order includes frequency, intensity and duration of therapy, and the therapy is provided by a qualified therapist (provider).

In Section T1. Ordered Therapies, include recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I look forward to more opportunity to provide feedback during this process.

Sincerely,

Joy Laughlin, CTRS/RTCR

cc: ATRA National Office

Let me introduce myself, my name is Nancy Vandevender, I am a CTRS. I have been in the field of recreation/activities for 21 years.

I recently received a copy of the draft version MDS 3.0 from my RNAC. Since this was given me to late to get on the agenda in person, I am sending you my comments and will call to be on open phone-in, on June 2nd. Many of my comments or questions maybe based on a lack of knowledge of the past panels and their work as I have not been involved until this point. One specific comment on the whole process: it is very difficult to really make effective comments when there are no definitions on word usage and terms. Many areas are very subjective and only with specific guidelines can this become a truly concrete instrument of evaluation.

1) section F - Quality of Life: note there is no specific observation period
    1) eliminate F1 as these reflect the questions surveyors ask - why would we be doing their job?
2) coding F1: would better reflect accuracy if choices were:
    most/some/rarely/never (if we have to have this section)
3) F2: this should be under a social services section (of which there is none currently included in the MDS as they deal with these situations - this would also mean of course that social services would now have to write notes as complete as the other disciplines are required to do)
4) F3: although this came from the section A background I feel it should be rewritten and redistributed in the following manner:
    - a/b/c/d/e/g/k/t/u/v/w/: to section N
    - note: (b is already in section N)
    - f: to go to rehabilitation or restorative
    - i/j to dietary section (also needed is space for foods not liked or can not eat due to allergy)
    - m/n/o/p/q/ to nursing
    - s to social services
    - also be included in all sections at the end should be : none of the above or unknown
5) Section N: Activity Pursuit Patterns: as I stated from section F, I feel many of F should be included in section N. Also I would like to see section renamed as Leisure Pursuit Patterns to reflect their independent as well as group and one to one interventions they take part in.
    1) N1: Time Awake - this section needs to die. I would much rather have seen N2 stay - Time involved - it is more important as it better reflects their leisure time pursuits. Time awake is very subjective and results in miss documentation between nursing who thinks when they walk by a resident and their eyes are closed that they are sleeping with out really checking (touch/calling their name/attempting to arouse). Also many times a resident falls asleep in a program due to the fact that they are fail elderly and have been up since dawn and have been awakened/pushed/moved/washed/ dressed/feed/taken to bathroom and or changed - of course they are tired. For years we have stated that if a resident can be aroused then they truly are not asleep. They will take many cat naps and if no one is there constantly to awaken them they may well sleep for more then one hour in the 5 hour time frame. Also the observation is over 3 days? This does not truly reflect the resident if they

had been previously active and now have an acute problem or just returned from the hospital.

2) N2: good/keep - although departments will need to place this on their assessments to have a baseline to base additional documentation on related to attendance.
3) N3: fair - but coding days are at odds with each other 14 days/5days/ 6-7 days? 2 and 3 under “a” and “b” are the same time frame. Also this would be a trigger area and the department will need specific documentation to uphold coding. This again would need to be in the assessment.
4) N4: should be in social services section under mood/behavior. Yes it will reflect on recreation but the questions are better suited to social services - yes all residents have sadness over lost roles.
5) N5: suggest to add: “with supervision”. Again, the definition needs to be specific on the difference between "pursues" and "engages". Thank you for drooping "preference for changes"

3) Section P2: my concern is that recreation therapy is not recognized as a therapy in long tern care - it is not documentable, also there are not enough CTRS staff in long term care. Should this section have a separate code for T.R. in rehabilitation/psychiatric facilities/hospitals, etc. and eliminate long term care?

I thank you for your time in reading this. I look forward to the phone-in on June 2nd and the after hours reading that will be provided. Also if you would like more comments I would be glad to survey the recreation departments in facilities in my area (Harrisburg, PA) and relay the results to you.

Sincerely,
Nancy Vandevender, CTRS./CRmTII

Subject: MDS 3.0 Refinement

As Coordinator of Recreation Therapy, working in direct patient care and overseeing 2 GS-10 Recreation Therapist and 3 GS-5 Rehab Assistants at the VA Medical Canter, Lake City, FL very positive efforts from CMS in recognizing recreation therapy as an ordered therapy and placement of such in Section P2. Each resident here is ordered Recreation Therapy via a Physicians Consults.

In addition, recommend CMS promote the utilization of the most cost effective mix of rehabilitation therapies as identified in section P. and Section P1 recommend training skills required be revised to reflect qualified recreation therapist as the continuity of care does impact their return to the community.

Michael Allen

May 22, 2003

Town Hall Meeting on Refinement of the Minimum Data Set (MDS), Version 3.0

I am a recreational therapist serving on the Arkansas Therapeutic Recreation Society Board of Directors and appreciate the opportunity to provide comments to the Town Hall meeting on the Refinement of the MDS 3.0.

We applaud CMS for the recognition of recreational therapy as an ordered therapy and the placement of such in Section P 2. "Therapies" section. This is consistent with current practice, the industry and accrediting agency standards.

The addition of quality of life indicators is an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The inclusion of additional indicators would provide a better snapshot of the resident's condition.

With the transfer of recreational therapy to Section P2., we recommend that the most cost effective mix of rehabilitation therapies, including recreational therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

Retain the definitions for all therapies identified in Section P2. Current definitions include physician ordered therapy, the order includes frequency, intensity and duration of therapy, and the therapy is provided by a qualified therapist (provider).

In Section T1. Ordered Therapies, include recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I look forward to more opportunity to provide feedback during this process.

Sincerely,

Kelly Parker, CTRS

cc: ATRA National Office

May 22, 2003

Town Hall Meeting on Refinement of the Minimum Data Set (MDS), Version 3.0

I am a rehabilitation administrator for a governmental health care agency and appreciate the opportunity to provide comments for the Town Hall meeting on the Refinement of the MDS 3.0.

It is wonderful to see the recognition of recreational therapy as an ordered therapy and the placement of such in Section P 2. "Therapies" section, and I applaud CMS for this. This is consistent with current practice, the industry and accrediting agency standards, which I work extensively with.

The addition of quality of life indicators is an important measurement of the resident's condition however the current indicators do not include non-verbal cues, observable, objective information. The inclusion of additional indicators would provide a better snapshot of the resident's condition.

With the transfer of recreational therapy to Section P2., I recommend that the most cost effective mix of rehabilitation therapies, including recreational therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

In Section T1. Ordered Therapies, I suggest inclusion of recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I look forward to more opportunity to provide feedback during this process. Best wishes with your Town Meeting.

Sincerely,

John M. Jacobson, M.S., CTRS

cc: ATRA National Office

Thursday, May 22, 2003

I am writing regarding the town hall meeting on refinement of the minimum data set (MDS), Version 3.0. I am a recreational therapist working in a skilled nursing unit and I appreciate the opportunity to provide comments to the Town Hall meeting on the refinement of the MDS 3.0. It has been my privilege to work with individuals in the long-term care setting as a recreational therapist for several years.

I applaud CMS for the recognition of recreational therapy as an ordered therapy and the placement of such in Section P 2. "Therapies" section. This is consistent with current practice, the industry, and accrediting agency standards.

The addition of quality of life indicators is an important measurement of the resident's condition. However, the current indicators do not include non-verbal cues, observable objective information. The inclusion of additional indicators would provide a better snapshot of the resident's condition.

With the transfer of recreational therapy to Section P2., I recommend that the most cost effective mix of rehabilitation therapies, including recreational therapy, as identified in Section P2. be used to determine the rehabilitation RUG classification level.

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In Section T1. Ordered Therapies, include recreational therapy in the list of ordered therapies to remain consistent with language in Section P2 and industry practice.

Thank you for the opportunity to review and provide comments to the proposed rules and regulations regarding the refinement of the MDS 3.0. I look forward to more opportunity to provide feedback during the process.

Sincerely yours,

Mike Bellfy, CTRS

cc: ATRA National Office