

**Centers For Medicare &
Medicaid Services**



**Revised
Long-Term Care
Resident
Assessment
Instrument
User's Manual**

Version 2.0

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**Centers For Medicare & Medicaid Services'
Long-Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual
Updated December 2002
For Use Effective January 1, 2003**

The *Long-Term Care Facility Resident Assessment Instrument User's Manual* for Version 2.0 is published by the Centers For Medicare & Medicaid Services (CMS) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long-term care facilities.

This manual replaces CMS's original *Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0*, published October 1995.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. (Note: The RAI mandated by OBRA is exempt from this requirement.)

The valid OMB control number for the Medicare Prospective Payment Form (MPAF) information collection is 0938-0739 and the form has been approved through December 31, 2002. Full OMB approval is pending. The time required to complete this information collection is estimated to average 90 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

If you have comments concerning the accuracy of the time estimates(s) or suggestions for improving these forms, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

CMS ACKNOWLEDGEMENTS

2002 Edition

It's sometimes hard to believe that seven years has passed since the publication of the original RAI Manual in 1995. The Center has a new name, the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) has been implemented, there are specialized MDS instruments for Medicare SNF and swing bed assessments, and we're fully automated with the RAVEN software packages. Over the years, CMS has issued numerous updates and clarifications in the form of Qs & As posted on the CMS website, and will continue to address clinical issues to support providers and enhance the accuracy of MDS coding. One thing for sure, the RAI is always a work in progress.

This version of the manual includes updates and clarifications to the processes and clinical items required for the MDS resident assessments that have occurred during the past seven years. Without the professionalism and tireless efforts of Carol Job, Donna Coszalter, Jan Courtney, Cathy Petko, and Kathy Wade and the staff at Myers and Stauffer, we would not have been able to produce the manual in such a short time frame. We thank you for your insights and patience throughout this process.

In addition, we want to thank our CMS co-authors, Rosemary Dunn, Sheila Lambowitz, Jeane Nitsch, and Mary Pratt. You have given freely of your time, energy and talent, to fully update, and when necessary, expand upon each section of the original RAI User's Manual and make it a more valuable tool for the industry. We could not have completed this work without the support of the entire MDS Coordinating Team who served as editors, critical readers, and researchers. Many thanks to Dana Burley, Rosemary Dunn, Yael Harris, Lisa Hines, Susan Joslin, Sheila Lambowitz, Tina Miller, Jeane Nitsch, and Mary Pratt. We also want to thank Sheryl B. Rosenfield, RNC, Director of Clinical Operations at Zimmet Solomon Health Care Consulting, LLC, for her assistance in developing new case studies and coding examples, and for helping us to integrate reviewer comments into the revised manual.

We want to particularly thank Sue Nonemaker, Cindy Hake and Dana Burley for their years of dedication, the wealth of knowledge each brought to the team, and the passion with which they supported the RAI process. We would be remiss if we also failed to acknowledge the many contributions of Helene Fredeking to the RAI process and other CMS nursing facility efforts. While all four have moved on to other challenges, their contributions to the RAI will always be remembered and greatly appreciated.

Through the years, many other CMS staff members, including Susan Burris, Dorothea Musgrave, Jeane Nitsch and Mary Weakland, have also supported the RAI process, and deserve our special thanks. Finally, a special thank you goes to Tina Miller, co-project officer on the MDS Manual Update project, for her hard work, dedication and full participation in all aspects of the project.

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Finally, we want to thank our colleagues in the CMS Regional Offices and State agencies for their support and assistance. Throughout the years, we have worked together to identify problems, answer questions, clarify coding requirements, and train providers. They've been our "eyes and ears" in the communities, and we could not have completed this update without their contributions, suggestions, and support.

We hope that you find this revised manual to be a positive resource. Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. A procedure for directing questions to CMS is being established and will be published shortly. Please continue to check our web site for more information at: <http://cms.hhs.gov/medicaid/mds20>.

CMS ACKNOWLEDGEMENTS

From the 1995 Edition of the Manual

The RAI Version 2.0 and related training materials were developed under a CMS contract with the Hebrew Rehabilitation Center for Aged (HRCA). John N. Morris and Katharine Murphy, key members of the original RAI design team, had primary responsibility for developing 2.0 and participated in the development of training materials. They were assisted on tasks related to 2.0 by Steven Littlehale, Jon Wolf, Yvonne Anderson, Romanna Michajliw, Wee Lock Ooi, David Levine, and other members of HRCA research and clinical staff. Staff at the Health Insights Research Group (HIRG), including Allan Stegemann, Gloria Smit, Janne Swearengen, and David Zimmerman, also participated in the development of materials for this *User's Manual* and had lead responsibility for its production. Sue Frey, Kris Engbring, Patti Beutel, and Mary Ann Sveum contributed to the final production of this *Manual*.

We also acknowledge the continued thoughtful input into version 2.0 by the principal investigators on the original design team, specifically Catherine Hawes, Charles Phillips, Brant Fries, and Vince Mor. Members of the international community using the MDS also contributed to the development of version 2.0 through their *interRAI* association.

We particularly appreciate the continued involvement and support of the countless professional associations and clinical experts that have been involved in the resident assessment initiative since its onset. They are too numerous to name individually, but special mention must be made of the contributions of individuals representing the key associations with which we have worked on nursing home reform issues: Marcia Richards, American Health Care Association; Evvie Munley, American Association of Homes and Services for the Aging; and Sarah Burger, National Citizens' Coalition for Nursing Home Reform.

State and CMS Regional office personnel have played a key role in working with nursing home staff to implement the RAI. Specifically, we acknowledge the exceptional contributions of Marlene Black (Washington State), Ruth Jacobs-Jackson (California), Sheree Zbylot (Mississippi), Pat Maben (Kansas), Ellen Mullins (Alabama), Diane Carter (Colorado), and Pat Bendert (CMS Region IV - Atlanta), all of who have contributed their own time to serve on workgroups or develop training materials. Betty Cornelius, CMS Project Officer and staff from her Nursing Home Case mix and Quality Demonstration States, have also contributed freely. We particularly appreciate the suggestions of Bob Godbout (Texas), Peter Arbuthnot (Mississippi), and Dave Wilcox (New York) in modifying the MDS 2.0 to make it more computer "friendly."

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From the 1995 Edition of the Manual
(continued)

Lastly, this work would not have been possible without the continued support of management within the Health Standards and Quality Bureau at CMS. Most specifically, Helene Fredeking, Director of the Division of Long-Term Care Services, has played a key substantive role, as well as garnered necessary resources to support work on this initiative. Katie Phillips has worked closely with the States and Regions on RAI issues for the past several years, and has been deeply involved in developing both the State Operations Manual and pending final regulations on resident assessment. Finally, a major contribution to the original RAI development effort, the revisions associated with version 2.0, and the development of training materials for both versions was made by Sue Nonemaker, CMS Project Officer for both initiatives. She also provided the CMS leadership and coordination necessary to implement the RAI nationally.

IF YOU HAVE QUESTIONS RELATED TO RESIDENT ASSESSMENT

Questions related to the RAI should be referred initially to the State (see Appendix A for a list of contact persons, addresses, and phone numbers.) CMS Regional office RAI coordinators are also listed in Appendix A.

Questions that cannot be resolved at the State level or suggestions for improving this *User's Manual* should be referred to:

MDS Coordinator
Center on Long-Term Care
Health Standards and Quality Bureau
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

PREFACE

From the 1995 Edition of the Manual

The nursing home reform law of OBRA '87 provided an opportunity to ensure good clinical practice by creating a regulatory framework that recognized the importance of comprehensive assessment as the foundation for planning and delivering care to this country's nursing home residents. The Resident Assessment Instrument (RAI) requirements can be viewed as empowering to clinicians in that they provide regulatory support for good clinical practice. The RAI is simply a standardized, new approach for doing what clinicians have always been doing, or should have been doing, related to assessing, planning and providing individualized care. CMS's efforts in developing the RAI and associated policies, therefore, have always been centered on the premise "What is the right thing to do in terms of good clinical practice, and for all nursing home residents?"

This same philosophy has been shared by the other members of the original design team, and the countless individuals representing associations and State governments with which we have worked in partnership in implementing the RAI nationally. I believe that it is this emphasis on interweaving tenets of good clinical practice within a regulatory model, more than any other factor, that has contributed to our successful implementation of the RAI nationally, and more importantly, the successful use of the RAI by individual nursing homes to provide quality care to their residents.

In introducing version 2.0 of the RAI, it is important to note that we always intended that the RAI would be a dynamic tool. In essence, we recognized that we could not simply publish the MDS and RAPs in 1990 and expect that they could serve as a foundation for the delivery of long-term care services without ongoing evaluation and refinement over time. Consequently, with the designation of the original version of the RAI, CMS made a commitment to the providers and consumers of nursing home services that we would sponsor the continued refinement of the RAI. While change is always difficult, this work is necessary in order for the RAI to incorporate state-of-the-art changes in clinical practice and assessment methodologies, as well as accommodate the changing needs of the nursing home population.

CMS began an open and very collaborative process to develop version 2.0 of the RAI in early 1993 by requesting comments on the original version through a notice of proposed rulemaking published in the Federal Register. Working in concert with key members of the original RAI development team, John N. Morris, Ph.D., and Katharine Murphy, R.N., M.S., at Hebrew Rehabilitation Center for Aged in Boston, CMS then began the arduous task of consulting with nursing home staff, State agencies, and national organizations representing the industry, consumers, and professional disciplines. We produced a series of draft documents, and continued our refinements based on comments from individuals and organizations with years of experience in using the original RAI. We made many substantive changes based on the comments of nursing home staff participating in a field test of the new MDS, which focused on ensuring the clinical utility and inter-rater reliability of new MDS items. We also consulted with a number of states and organizations with experience in automating the MDS, in order to make version 2.0 more computer-"friendly."

There were a number of “guiding principles” we used in developing version 2.0 that give insight into the programmatic goals and priorities that shaped the new instrument:

- In keeping with the clinical focus used to design the original MDS, we made only those additions or changes that nursing home staff viewed as providing useful information for care planning. Our primary rule of thumb in deciding whether to add or change an item was “Is this something that clinicians need to know in order to provide care for a nursing home resident?” We also strove to keep this a minimum data set. As we waded through an innumerable number of excellent suggestions for additional items, we would ask ourselves whether the item provided vital information or would simply be “nice to know,” and whether or not it was something that was necessary to know for all nursing home residents. This was truly a difficult task and will no doubt result in several unhappy individuals whose suggestions did not survive such scrutiny. As such, the MDS version 2.0 remains a symbol of compromise--probably less information than we might like to have, but clearly an improvement as evidenced by the positive responses of facility staff participating in our field test and the positive comments received from states and associations.
- We also recognized the increasing purposes for which MDS data is being used by both nursing home staff and states. Provided that items met the primary test of supplying necessary information for clinical staff, we chose to add some items that would also support programmatic needs, such as for payment and quality improvement systems. To the extent that such programs could be supported by the clinical information obtained from the MDS, it was felt that this would minimize burden on facilities by reducing the need to report duplicative sets of information. Consequently, in response to the increasing number of states that have already implemented or expressed an interest in using MDS data for a Medicaid case mix reimbursement system, we added those items necessary to calculate Resource Utilization Groups III (RUGs-III). RUGs-III is the payment classification system that was developed for the CMS sponsored “Nursing Home Case mix and Quality” Demonstration. It has already been implemented as the basis for Medicaid payment by the four states participating in the Demonstration, with plans for six states to move to RUGs-III driven payment for Medicare in participating facilities. Designing version 2.0 to support case mix reimbursement systems required the addition of several items from the tool known as the MDS+, which has been used in ten states for Medicaid payment. This was not in opposition to our primary rule of “clinical utility,” however, as many of the MDS+ items addressed clinical “holes” in the original MDS (e.g., issues related to restorative nursing care, therapies, skin care, etc.). The incorporation of all “payment” items into the core MDS eliminates the need for states to implement alternate instruments to support payment systems, unless additional items are needed for State-specific payment systems.
- In keeping with the goal of CMS’s Health Standards and Quality Bureau (HSQB) to move forward with an MDS-driven quality monitoring and improvement system, we have also added those MDS+ items necessary to generate many of the Quality Indicators (QI’s), as developed by the University of Wisconsin under the auspices of the aforementioned Demonstration. This required the addition of a few items to the core MDS. More significantly, this programmatic goal underscores the importance of the quarterly review, as more information, submitted more frequently, will be required to support our future quality monitoring systems. However, it should also be stressed that no items were added to the quarterly review requirement solely to provide QI data. There was significant agreement

within the associations and states with which we consulted that the original quarterly review requirement did not provide facilities with all items necessary to adequately monitor residents' status. In this regard, we also had to compromise and could not accommodate all of the good suggestions we received for adding items to the quarterly review requirement.

- You will notice a number of changes in the new MDS, which are highlighted below:
- The sections have been reordered (e.g., ADLs are now found in Section G). All State RAIs will now have one consistent ordering of sections, with any additional State-specific items found in Section S. Sections T and U have been developed for use in states participating in the Medicare Nursing Home Case mix and Quality Demonstration, and are not a part of the core MDS.
- A number of items and sections have been constructed to facilitate computerization and data entry. There are also new forms designed for this purpose: Basic Assessment Tracking Form, Section AA - Identification Information, which has all key information needed to track residents in data systems; and forms for tracking residents on discharge and reentry into the facility.
- Several new scales have been added to help clinicians better understand a resident's status in a number of areas. For example, there are now scales that measure the alterability and frequency of behavioral symptoms and the frequency and intensity of pain.
- Several items have been added in response to the changing needs of the nursing home population. For example, the increase in subacute, hospice, and short-term stay populations led to the inclusion of items assessing pain, discharge potential, restorative and rehabilitation needs, and infections.

Version 2.0 brings an attempt to streamline the RAP triggers. Analyses of large data sets were conducted to improve the predictive power of the triggers. In more simple terms, which triggers contributed most significantly to the identification of problems warranting care plans? Which trigger items could be eliminated? Along with reducing the number of trigger items overall, we also eliminated the distinction between automatic and potential triggers.

There have also been a number of changes in the RAI utilization guidelines, which is a regulatory term for our instructions on how the instrument must be used. For example, we created a new definition of significant change and modified our guidance on when a significant change reassessment is required, decreased the time for retention of RAI records, and changed the procedures by which errors may be corrected.

We expect the changes within version 2.0 and our policies regarding its use to be only the beginning of our commitment to improving the instrument and facilities' ability to use it effectively. Over the next few months, we will begin a process to review and revise the existing RAPs, as well as to develop new RAPs to address areas of significant clinical importance. We also expect to conduct an ongoing assessment of training needs and to intensify our efforts to produce educational materials for both nursing home staff and surveyors. Over the next few years, we expect to revise all of the RAPs, as well as begin work on the next version of the MDS. We welcome your suggestions on all of these areas and invite you to consider volunteering to participate in developing or reviewing materials in your own area of clinical expertise.

Finally, we thank you for all of your hard work in implementing the RAI and using it to provide quality care to nursing home residents throughout the nation.

Sue Nonemaker, R.N., M.S.
RAI Project Officer
Health Standards and Quality Bureau
Centers for Medicare and Medicaid Services
September 4, 1995

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