



Scott C. Amrhein, Executive Director
Center for Continuing Care
Greater New York Hospital Association
555 West 57th Street/ New York, NY 10019
(212) 246-7100/ Fax (212) 262-6350

June
Seventeen
2003

Thomas A. Scully, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-8150

VIA E-MAIL

Re: Draft Minimum Data Set 3.0 Recommendations

The Greater New York Hospital Association (GNYHA) Center for Continuing Care represents over 90 not-for-profit and public skilled nursing facilities (SNFs) in the metropolitan New York area. GNYHA appreciated CMS's consideration of our detailed comments sent on August 29, 2001 regarding the improvement of the current Minimum Data Set (MDS) 2.0 and we welcome the opportunity to comment on the draft MDS 3.0. GNYHA commends CMS's efforts in this area and we look forward to providing CMS with further comments during the validation process.

BACKGROUND

Although the MDS has played an important part in the assessment and care planning processes, we do not believe that its value would be minimized in any way—indeed we believe its utility could be enhanced—by shortening and streamlining the document, and by ensuring that the terminology used on the instrument is consistent with current standards of practice and with validated assessment tools. The burden of MDS completion and submission under the SNF prospective payment system has created significant challenges for SNFs on a number of levels. For example, SNFs must provide initial and ongoing educational sessions for staff members in as many as nine disciplines to enable staff to appropriately complete and submit MDS information. Since the implementation of the SNF PPS, SNFs have provided not only basic MDS training, but also training on changes in policy including the advent of quality indicators, the initiation of the MDS 2.0, the MDS correction policy, new MDS submission guidelines, and the MDS Medicare PPS Assessment Form (MPAF) as well as on the regular revisions of the State Operations

Manual. Many facilities have been forced to dedicate at least one full-time registered nurse (RN) solely to the task of completing paperwork as an MDS coordinator, diverting RN resources away from the provision of direct patient care. In addition, other staff members often must spend valuable time completing paperwork for the MDS—time that would be better spent on direct resident care.

Consistent with U.S. Department of Health and Human Services (HHS) Secretary Tommy G. Thompson's commitment, made in a statement before the House Ways and Means Committee in July 2001, to streamline the swing-bed assessment and other assessment tools, GNYHA recommends that CMS make it a priority in updating the MDS to include only those elements that are absolutely necessary for payment and quality improvement purposes.

METHODOLOGY

Our comments regarding the MDS 3.0 reflect analyses conducted by GNYHA and contributions from clinical and quality improvement staff at GNYHA member facilities. GNYHA has received regular input from members since it established and began holding meetings of an MDS improvement workgroup in 2001. During a May 28, 2003 meeting of this workgroup, CMS staff responsible for the MDS 3.0 project participated via teleconference. Together with the workgroup members, GNYHA presented comments that attempted to retain the integrity of the MDS provisions that relate to payment while providing constructive evaluation of the instrument with respect to clinical value and quality improvement. A roster of the workgroup members is provided.

GENERAL RECOMMENDATIONS

In concert with a separate GNYHA initiative to address health care workforce issues, we recommend that CMS remain conscious of the need to streamline the MDS assessment process. At a time when facilities are facing workforce shortages and projections demonstrate that these shortages are expected to worsen, it is imperative for CMS to recognize that facilities commit significant amounts of time to completing the MDS assessment and RAP processes. In addition, GNYHA supports CMS's plans to continue the commitment to making an abbreviated version available for MDS 3.0 submissions.

GNYHA supports further efforts to recognize the diversity of residents being served in SNFs today. With regard to short-stay and long-stay residents, CMS has recognized the difference in these two populations by developing both chronic-care and post-acute care quality measures under the CMS Nursing Home Quality Initiative. Consistent with this recognition, GNYHA supports the exploration of bifurcating the MDS for short-stay and long-stay residents. GNYHA strongly encourages CMS to consider permitting the use of an abbreviated version of the MDS 3.0 (similar to the quarterly assessment or MPAF) for short-stay residents. Moreover, GNYHA also recommends that CMS eliminate the RAP process for short-stay residents in order to allow clinical staff to devote time to bedside care rather than paperwork.

Similarly, GNYHA recommends that CMS further recognize the diverse array of specialty populations being served in SNFs. For example, the MDS is a document that was never intended

for the pediatric population. Our pediatric facilities appreciate that CMS has been responsive to the unique needs of this population and is proposing offering the ability to separately track pediatric residents on the MDS 3.0. We recommend that CMS also consider developing a track for the young adult population, such as HIV/AIDS and neurobehavioral residents. These young adult populations are drastically different from the geriatric population. Although a separate instrument is desirable, we recommend that CMS develop a process for these populations that might include the ability to skip select MDS sections and the creation of separate MDS user's manuals or amendments to the general manual.

Finally, GNYHA asks that CMS maintain a sufficient degree of clinical and technological flexibility in the MDS to accommodate a future resident population that may differ substantially from the typical SNF population of today. Also, GNYHA recommends that CMS seek provider input regarding training so that educational materials remain clear and accessible for the variety of staff members involved with MDS completion and submission.

SECTION-SPECIFIC RECOMMENDATIONS

The following are specific comments and recommendations regarding the draft MDS 3.0:

Section A

A11. On our May 28 call, we recommended that you add a selection for an OMRA. CMS stated that the absence of such a selection was a typographical error and that it will be corrected by adding this selection under A11e.

A19d. One member recommended that CMS change “epilepsy” to “seizure disorder.”

A21. Several members of the GNYHA workgroup recommended that CMS remove this question because it has negatively impacted the morale of staff who complete the MDS. All professionals responsible for completing the MDS are bound by State licensing and certification requirements. For example, when they sign their name to a document, they attest that the statement is accurate and complete to the best of their knowledge. When they are required to sign this attestation, staff view the event as overly burdensome. GNYHA recognizes CMS's concern regarding the desire for accurate completion of the MDS. If the section cannot be eliminated, GNYHA recommends that CMS make it clearer in the attestation that a staff member completed a specific section rather than holding staff to a high level of accountability for answers in various portions of the MDS that often cannot be confirmed with 100% confidence. For example, on the current MDS 2.0, a staff member could be held civilly or criminally liable based on an incorrect birth date based on a resident's recollection.

Additionally, the signature sections in Version 2.0 are split between two areas, Section AA9, Signatures of Persons Who Completed a Portion of the Accompanying Assessment or Tracking Form, and Section AD, Face Sheet Signatures. We recommend that CMS explore what effect the change from two sections in Version 2.0 to one section on Version 3.0 would have on the staff who are required to sign the document. Specifically, GNYHA also recommends that CMS better understand the burdens on staff with regard to time required to obtain signatures and

potential liability as a signatory before the validation study begins. Again if the section cannot be eliminated, we recommend that the signature sections on the MDS 3.0 indicate that the person is attesting to the section they completed only, not the entire MDS document.

Section B

B1. To clarify the definition of “comatose,” we recommend that the language in the MDS 2.0 Manual state that a physician’s diagnosis is sufficient to classify a resident as comatose for MDS assessment purposes.

Section E

Our members have recommended that CMS allow facilities to skip this section for hospice residents and pediatric residents.

E1B. We recommend that CMS reevaluate the use of the five screening questions from the Geriatric Depression Scale. For example, our members noted that the phrasing in question 5 (Do you feel pretty worthless the way you are now?) is overly harsh. One recommendation is to give those who are completing the MDS 3.0 the opportunity to input a score from a more widely used depression scale, such as the Hamilton Scale, in lieu of using these five screening questions.

Section F

Our members have many concerns regarding this section on quality of life. Members commented that simple yes-no answers to this set of questions would not likely help in care planning or improving quality of life for residents. In addition, members expressed concern over adding an additional section that would take a significant amount of staff time for the validation of residents’ answers, creating more pressures on staff during a time of current and projected future workforce shortages in long term care. It was further noted that the questions in Section F are redundant with surveyors’ assessments during the annual survey process.

F1 and F3. GNYHA recommends that CMS address the redundancy of the questions in these sections.

F1f. Members noted that the responses in this section would be related to the resident’s beliefs/values and would not necessarily be reflective of the quality of the facility’s programs or care.

F1m. We recommend that CMS avoid mixing questions phrased in the positive (F1a through F1l and F1n) and the negative (F1m) in this section, which would adversely affect the scoring of this section.

F2g. We recommend that CMS avoid mixing questions phrased in the positive (F1a through F1l and F1n) and the negative (F1m) in this section, which would adversely affect the scoring of this section. In addition, this issue in F2g is already covered in section F2e—absence of personal contact with family/friends.

Section G

G2 and G3. Our members noted that the new questions regarding balance in G2 and the touch/sensation questions in G3C would require significantly more time to complete in comparison to the current MDS 2.0 questions.

Section I

Several members recommended adding the diagnosis HIV/AIDS to the list of disease diagnosis.

Section M

M1a. GNYHA recommends that CMS reword and clarify this question. Our members find it confusing. One recommendation is to ask a yes-no question.

M1b. GNYHA recommends that the MDS 3.0 definition be consistent with the National Pressure Ulcer Advisory Panel (NPUAP) definition of Stage 1 pressure ulcers. The definition on the MDS Version 2.0 is closer to the NPUAP definition: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. The NPUAP definition for Stage 1 Pressure Ulcer is as follows:

A Stage I pressure ulcer is an observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following:

skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching).

The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

M1f. We recommend that CMS clarify that if facilities code a resident under this selection that the assessment would automatically be calculated as a Stage 4 pressure ulcer for the RUG Grouper.

M2. We ask CMS to clarify what the impact on payment would be if facilities checked any of these items. Also, members noted that the separation of arterial and stasis ulcers would be confusing to staff members. We recommend that if CMS were to keep the choices separate, that the directions in the manual be made very clear, with specific examples of how to distinguish between the various types of ulcers.

Section P

We recommend that CMS capture physician extender visits on the MDS 3.0. Based on the guidelines for the MDS 2.0, physician extenders employed by the facility cannot be captured in

sections P5 and P6. We recommend that CMS allow physician extenders employed by the facility to be captured in sections P5 and P6.

Respectfully submitted,

Scott C. Amrhein
Executive Director

cc: Lisa Hines
Bob Connelly
Mary Pratt
Rita Shapiro