DEPARTMENT OF HEALTH

An Overview of MDS Sections C, D, E, and Q

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Objectives

- Describe the intent of sections C, D, E and Q of the MDS
- Identify when it is appropriate to complete the Staff Assessments for Mental Status and Resident Mood
- Identify when Rejection of Care has occurred
- Apply the coding instructions to accurately code sections C, D, E and Q of the MDS

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General Resident Interview Guidelines

- Conduct the interviews in a private setting
- Use the resident's preferred method of communication
- Ensure the resident can hear you
- Ask the questions in one sitting, as written, and in the order provided
- Staff must document the responses provided by the resident
- Interviews must be conducted in the look back period
- Staff assessments are conducted after the ARD

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General Staff Assessment Guidelines

- **Staff Assessments are completed in very limited circumstances:**
  - The resident is rarely or never understood
  - The resident needs an interpreter, and one is not available
  - The resident interview was deemed incomplete
- Staff assessment responses are determined by:
  - Interactions/observations of the resident on all shifts, and
  - Interviews with family, significant others, and staff from all shifts, and
  - Review of the medical record documentation available during the LBP
- Staff assessments are completed after the ARD

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Should The Resident Interview Be Conducted?

- Attempt to conduct the interview with **ALL** residents
- Determine if the resident is rarely or never understood
- A resident is rarely or never understood if, at their best, the resident's understanding is limited to staff's interpretation of highly individual, resident specific sounds or body language.
- Determine if the resident needs or wants an interpreter
- **Most residents can participate in the resident interviews**

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Missed Resident Interviews

- An interview is considered missed when the resident should've been interviewed, but the interview was not completed in the look back period of the assessment.
- Regardless of the reason the interview was not completed
- When a resident interview is missed:
  - C0100, is coded 1 Yes, the interview should be completed, and
  - The resident interview and staff assessment responses must be dashed

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Nonsensical Responses

- Any response that is unrelated, incomprehensible, or incoherent
- For example: The interviewer asks the resident to name the day of the week. Resident answers, “Sylvia, she’s my daughter.”
- Nonsensical responses are not informative to the question being asked.
- Refusals to respond, Nonsensical and Incorrect responses are coded 0

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Section C: Cognitive Patterns

- Intent: The items in this section are intended to determine the resident’s attention, orientation and ability to register and recall new information.
- Brief Interview for Mental Status- BIMS
- Staff Assessment of Mental Status
- Signs and Symptoms of Delirium

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Brief Interview for Mental Status (BIMS)

- The BIMs interview should be completed verbally unless the resident’s primary method of communication is writing
- An opportunity to observe the resident for signs and symptoms of delirium
- An abrupt change in cognitive status may indicate delirium
- A decline in mental status may also be associated with a mood disorder
- The BIMS Summary Score
  - Allows for comparison of future and past cognitive performance
  - A score of 00-15 is a valid score
    - 13-15 Cognitively Intact
    - 8-12 Moderately Impaired
    - 00-7 Severe Impairment

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Incomplete BIMS Interviews

- **Stop the interview after completing C0300C (Day of the week) if:**
  - All responses have been nonsensical, or
  - No verbal/written response to any of the questions so far, or
  - There has been a combination of no verbal/written responses and nonsensical responses to all questions so far.
- If the interview is stopped:
  - C0400A-C is dashed, Code "99" in the BIMS Summary Score (C0500), and complete the Staff Assessment for Mental Status
- A BIMS Summary Score of "99" indicates the interview was incomplete

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The Staff Assessment for Mental Status

- Determined by observation of the resident, medical record review, and interviews with the resident, staff, family, and significant others.
- Requires resident input/participation (during the LBP)
  - C0700- Short Term Memory
  - C0800- Long Term Memory
  - C0900- Memory/Recall Ability (can provide cues)
- Cognitive Skills for Daily Decision Making- C1000
  - Is the resident actively making decisions?
  - Even poor decisions are decisions

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Daily Decision Making

- Does the resident
  - Choose their clothing; know when to go to meals etc.
  - Do they use environmental cues to organize and plan they day (e.g., clocks, calendars, or
  - Do they seek information appropriately from others in order to plan the day
  - Do they have awareness of their own strengths and limitations
  - Do they acknowledge the need to use appropriate assistive equipment such as a walker

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Delirium

- Delirium- A mental disturbance characterized **by new or acutely worsening** confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.
- An abrupt deterioration in cognitive function may indicate delirium
- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Determined by observation of the resident during the BIMs interview or Staff Assessment for Mental Status, medical record review, and interviews with staff, family, or significant other.

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Section D- Mood

- Intent- To identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.
- Includes:
  - The 9 Item-Patient Health Questionnaire (PHQ-9)
  - The Patient Health Questionnaire Observational Version (PHQ-9-OV)
- Standardized screening tools that identify the presence of mood symptoms
- Most residents who can communicate are able to answer questions about how they feel.

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The PHQ-9 Resident Interview

- The interview has a 14d look back period
- May be administered verbally or in writing
- Each question must be asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
- If the resident has difficulty selecting between two frequency responses, code for the higher frequency.
- Column 1, Symptom Presence is coded a 9, no response: if the resident was unable to respond, refused to respond, or responded nonsensically, Column 2, Symptom Frequency, blank.

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Total Severity Score

- A summary of the frequency responses that identify the extent of potential depression symptoms.
- The score does not diagnose depression. It provides a way for clinicians to easily identify and track symptoms of depression and how they are changing over time.
  - 1-4 Minimal Depression Symptoms
  - 5-9 Mild Depression Symptoms
  - 10-14 Moderate Depression Symptoms
  - 15-19 Moderately Severe Depression Symptoms
  - 20-27 (30 for PHQ-9OV) Severe Depression Symptoms

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Incomplete PHQ-9 Interviews

- The PHQ-9 interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items
- **If symptom frequency column is blank three or more times, the resident interview is deemed incomplete.**
- Total Severity Score is coded as "99" and the Staff Assessment of Mood is completed.
- The PHQ-9OV staff interview is successfully completed if the staff answered the frequency responses of at least 8 of the 10 items

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Section E- Behavior

- Intent- To identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to other residents, staff members, or the care environment.
- The emphasis is identifying behaviors
- This section focuses on the resident's actions, not the intent of their behavior

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- 7d look back period
- **Hallucinations-** The perception of the presence of something that is not actually there, involves the one or more of the five senses
- **Delusions** -Are fixed false beliefs that the resident holds true even when provided evidence to the contrary
- These items are not coded simply because the resident has a diagnosis of hallucinations or delusions.
- They are coded only if delusions and hallucinations occurred in the 7d look back period.

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Coding Exercise

A resident carries a doll which she believes is her baby and the resident appears upset. When asked about this, she reports she is distressed from hearing her baby crying and thinks she's hungry and wants to get her a bottle.

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Coding Exercise

A resident announces that he must leave to go to work, because he is needed in his office right away. In fact, he has been retired for 15 years. When reminded of this, he continues to insist that he must get to his office.

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Presence of Behavior Symptoms

- Behavior categories:
  - E0200A- Physical Behaviors directed towards others
  - E0200B- Verbal Behaviors directed towards others
  - E0200C- Other behaviors not directed towards others, does not include wandering
- The behaviors listed on the item set are not an all-inclusive list
- Behaviors in E0200A-C should be coded as present or not present, regardless of their intent and whether they might represent a rejection of care.

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Impact on the Resident and Others

- Did any of the behavior symptoms identified in E0200A-C:
  - Put the resident at significant risk for physical illness or injury, or
  - Interfere with the resident's care, or
  - Interfere with the resident's participation in activities or social interactions?
- Did any of the behavior symptoms identified in E0200A-C:
  - Place staff, visitors, or other residents at significant risk for physical injury?
  - Intrude on the privacy or activities of others?
  - Significantly disrupt care or living environment of others?

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Coding Exercise

- A resident paces incessantly. When staff encourage him to sit at the dinner table, he returns to pacing after less than a minute, even after cueing and reminders. He is so restless that he cannot sit still long enough to feed himself or receive assistance in obtaining adequate nutrition.
  - Is this behavior coded on the MDS? If so, what item?
  - Did the behavior interfere with the resident's care?
  - Did the behavior put the resident at significant risk of physical illness or injury?

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Coding Exercises

- A resident repeatedly enters the rooms of other residents and rummages through their personal belongings. The other residents do not express annoyance.
- When eating in the dining room, a resident frequently grabs food off the plates of other residents. Although the other resident's food is replaced, and the behavior does not compromise their nutrition, other residents become anxious in anticipation of this recurring behavior.

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Rejection of Care

- The intent of this item is to determine if the resident's refusal of care is a matter of personal preference or a behavioral symptom that requires further assessment and interventions.
- What is Rejection of Care?
  - A behavior that interrupts or interferes with the delivery or receipt of care.
- Rejection of Care may be manifested by:
  - Verbally declining or statements of refusal, or
  - Physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care.

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Identifying Rejection of Care

- Ask:
  - **Did the resident refuse cares that were necessary to achieve the RESIDENT'S goals for health and well-being?**
    - If yes, this is rejection of care
    - If no, it is a matter of personal preference
- The resident's preferences do not have to appear logical or rational
- Preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with "good judgment.
- Residents who have made an informed choice about not wanting a particular treatment should not be identified as rejecting care.

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Coding Exercise

A resident with heart failure recently returned to the nursing home after surgical repair of a hip fracture is offered physical therapy and declines. She says that she gets too short of breath when she tries to walk even a short distance, making physical therapy intolerable. She does not expect to walk again and does not want to try. Her physician has discussed this with her and has indicated that her prognosis for regaining ambulatory function is poor.

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Coding Exercise

A resident chooses not to eat supper one day, stating that the food causes her diarrhea. She says she knows she needs to eat and does not wish to compromise her nutrition, but she is more distressed by the diarrhea than by the prospect of losing weight.

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Coding Exercise

A resident goes to bed at night without changing out of the clothes he wore during the day. When a nursing assistant offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened 2 of the past 7 days. The resident was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.

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Wandering

- Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction.
- Wandering may or may not be aimless.
- The resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place.
- Pacing (repetitive walking with a driven/pressured quality) within a constrained space is not included in wandering.

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Coding Exercise

A resident propels himself in his wheelchair into the room of another resident, blocking the door to the other resident's bathroom.

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Changes in Behavior or Other Symptoms

- Review responses provided to items E0100-E1000 on the current MDS assessment.
- Compare these responses to the responses on the most recent OBRA or scheduled PPS assessment
- Taking all the responses into consideration, determine if there is an overall change in behavior from the most recent OBRA or scheduled PPS assessment to the current MDS.
- Determine if the resident's overall behavior is the same, improved, or worsened

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Section Q: Participation in Assessment and Goal Setting

- Intent- To record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals.
- To ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible.
- The resident should be actively involved in the assessment process if they are able to participate

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Resident's Overall Expectations

- Ask the resident directly about what his or her expectation is regarding the outcome of this nursing home admission and expectations about returning to the community.
- If the resident is unable to communicate his or her preference, the information can be obtained from the family or significant other, as designated by the individual.
- While family, significant others, or the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if he or she is able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs.

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Discharge Planning

- Is active discharge planning, return to community, already occurring?
  - The discharge date and location has been determined
- Discuss with both long- and short-term care residents
- Don't make assumptions regarding the resident's discharge potential
- A referral should **NOT** be avoided based upon facility staff judgment of potential discharge success or failure. It is the resident's right to be provided information if requested and to receive care in the most integrated setting.

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Return to Community

- Does the resident want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?
- Answering yes does not commit the resident to leave the nursing home at a specific time; nor does it ensure that the resident will be able to move back to the community.
- Answering no is also not a permanent commitment. The resident can change their decision at any time.
- A Yes response for this item is a request to learn about home and community-based services, not a request for discharge.

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Referral

- Can the resident's discharge needs be met by the facility?
  - If so, a referral to the LCA is not necessary
  - If not, refer to the Local Contact Agency (LCA)
- Senior Linkage Line Referral Website https://www.sllreferral.org
- Document the referral and rationale in the resident's medical record
- The LCA is responsible for follow-up with the resident

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MDS Manual

- A current manual and any errata documents can be downloaded from the following web site:

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/NursingHomeQualityInits/MDS30RAIManual.html

  (Scroll down to the download section)
- The most current manual is MDS 3.0 RAI Manual v1.17.1

REMINDER

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Contact Information

MDS
- Phone 651-201-4313
- Email health.mds@state.mn.us

CMR
- Phone 651-201-4200
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Submission or Validation Report Questions
- Phone 651-201-3817
- Email health.mdsoasistech@state.mn.us

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