



Learning the Minimum Data Set – Basic Training for the Interdisciplinary Team

Program Description:

The Minimum Data Set (MDS) is one of three major components of the Resident Assessment Instrument (RAI), which helps nursing homes to collect important information on all residents to develop the person-centered care plan. Over time, the MDS has grown in its use to determine reimbursement, quality programs (AKA quality measures) and survey (just to name a few).

The MDS is a complex screening tool that is completed for all residents, regardless of payer source or reason for stay, by the various members of the interdisciplinary team. Regulations in the RAI Manual require that persons who complete the MDS are trained in how to complete an accurate assessment.

The purpose of this program is to provide the IDT with the essentials to complete the MDS. A kind of... MDS boot camp, for all members of the IDT. It is important to note these training materials do not replace the official guidance in the RAI Manual itself.

Each module contains one or more video presentations, slide handouts, a knowledge check, and (if applicable) additional resources. Participants should also read each respective Chapter, Section or portion of the Section in the RAI Manual as you complete each module. A current copy of the RAI Manual is a must, and a link to a free digital copy is available under the Required Texts and Resources section.

Participants may take the modules in any order that they see fit, but every participant is recommended to complete Module 1 – Introduction before they proceed. This module will provide a background to the RAI and MDS, including a review of key symbols seen throughout the presentation and the components of this program.

Course Objectives:

Upon Successful completion of this program, the participants will:

- Understand the role of the RAI (Resident Assessment Instrument) in nursing homes,
- Explain the process for completing the Minimum Data Set (MDS), and
- Complete an MDS assessment.

Continuing Education (CEUs):

Learners who complete this program (with individual purchase) will earn 13.25 contact hours through AHCA/NCAL, Iowa Board of Nursing (IBON) provider #276, and 13.25 participant hours of NAB-approved continuing education.

Presenters:

At the time of the program/course creation, presenters included the following AHCA staff:

- **Amy Miller RN, BSN, RAC-CT, CPC**
Director, Clinical and Regulatory Services, American Health Care Association
- **Hawley Hunt MBA, MHA, LNHA**
Sr. Director, Quality and Regulatory Services, American Health Care Association
- **Crystal Bowens DHA, MSN, LHNA, RN, GERO-BC, PMP**

Required Texts and Resources:

For the best learning experience, participants should have the following resources available during the education sessions:

- An up-to-date copy of the RAI Manual. This is available to download for free from the [Centers for Medicare and Medicaid \(CMS\)](#). Scroll down to “Downloads” to obtain the current version.
- Current MDS item sets (i.e., MDS forms). These are available to download for free from the [Centers for Medicare and Medicaid \(CMS\)](#). Scroll down to “Downloads” to obtain the current version.

Course Outline:

Below is the course outline for the program, outlined by module. Included is the length of time for each video presentation, so participants may use this information to plan their educational experience. At the right side of the table, participants may (optionally) use to this track their progression in the program.

The modules are listed in the recommended order for viewing, but participants should consider their current role and responsibilities, mentor recommendations and time management. All participants are recommended to view Module 1, The Introduction to the RAI at the start of their learning experience. The video length is noted in minutes:seconds.

		Video Length	Completion	
			Video	KNWL✓
Module 1	The Introduction to the RAI module is intended for all nursing home interdisciplinary team members, including guidance in Appendix PP. It also includes the program objectives and guidance for the overall education program.			
	An Introduction to the RAI		17:26	
Module 2	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The MDS includes several items that obtain information about SDOH, all of which are resident interview questions.			
	Additional resource to review: Coding MDS 3.0 SDOH Items – Using Sources Other Than the Resident			
	SDOH Part 1: Reviews the data elements A1005, A1010, A1110		12:51	

	SDOH Part 2: Reviews the data elements A1250, B1300, D0700	11:36		
Module 3	Section A obtains the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident. Section A SDOH data elements are not included in this module but reviewed in Modules 2.			
	Section A Part 1: Reviews the data elements A0050 through A1550	18:00		
	Section A Part 2: Reviews the data elements A1600 through A2400C	25:41		
Module 4	Section B documents whether the resident is comatose, the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others, and the resident's ability to see objects nearby in their environment. The data element for health literacy is reviewed in Module 2.			
	Section B, Hearing, Speech, and Vision	16:00		
Module 5	Section C includes data elements that are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions.			
	Section C, Part 1: The Brief Interview for Mental Status (BIMS)	21:05		
	Section C, Part 2: The Staff Assessment for Mental Status	10:48		
	Section C, Part 3: Signs & Symptoms of Delirium	10:28		
Module 6	Section D addresses mood distress and social isolation (the data element for social isolation is reviewed in Module 2). Additional resource to review: <i>Patient Health Questionnaire (PHQ)-2 to 9© Scoring Algorithms</i>			
	Section D, Part 1: The Resident Mood Interview (PHQ-2 to 9©)	16:25		
	Section D, Part 2, The Staff Assessment of Mood	3:03		
Module 7	Section E includes data elements to identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.			
	Section E, Behavior	15:37		
Module 8	Section F includes data elements to obtain information regarding the resident's preferences for their daily routine and activities.			
	Section F, Preferences for Customary Routine and Activities	13:28		
Module 9	Section GG includes data elements about functional abilities, including those that focus on prior function along with performance upon admission, throughout the stay and at discharge. It is recommended to complete all Section GG courses in order, as each provides important information for the next. Additional resource to review: <i>Section GG Self-Care & Mobility Assessment Period Guide, RAI Manual Decision Coding Tree</i>			
	Section GG, Part 1: Reviews the data elements GG0100 through GG0120	9:16		
	Section GG, Part 2: Self-Care and Mobility Key Definitions and Assessment Periods	11:01		

	Section GG, Part 3: The Performance Levels	8:17		
	Section GG, Part 4: The Self-Care Data Elements	15:36		
	Section GG, Part 5: The Mobility Data Elements	17:45		
Module 10	Section H includes data elements to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.			
	Section H, Bladder and Bowel	14:27		
Module 11	Section I includes data elements intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.			
	Additional resources to review: <i>Diagnosis Coding Tip Sheets - UTI and Schizophrenia</i>			
	Section I, Active Diagnoses	25:40		
Module 12	Section J includes data elements to document a number of health conditions that impact the resident's functional status and quality of life.			
	Section J, Part 1: Pain Assessment (J0100, Introduction to the Pain Assessment Interview)	10:03		
	Section J, Part 2: Pain Assessment (Pain Assessment Interview)	14:28		
	Section J, Part 3: Staff Assessment for Pain	5:37		
	Section J, Part 4: Health Conditions	18:56		
Module 13	Section K includes data elements to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration.			
	Section K, Part 1: Reviews data elements K0100 through K0300	9:24		
	Section K, Part 2: Reviews data elements K0310 through K0710	17:29		
Module 14	Section L includes data elements to record any dental problems present in the 7-day look-back period.			
	Section L, Oral/Dental Status	5:12		
Module 15	Section M includes data elements that document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury.			
	It is recommended to complete all three Section M courses in order, as each provides important information for the next.			
	Section M, Part 1: Pressure Ulcer/Injury (M0100 through M0210)	19:42		
	Section M, Part 2: Pressure Ulcer/Injury staging (M0300)	15:04		
	Section M, Part 3: Other Skin Conditions and Treatments (M1030 through M1200)	16:24		
Module 16	Section N includes data elements to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. In addition, Section N includes data elements for antipsychotic medication review and drug regimen review.			

	It is recommended to complete Section N Part 1 before moving on to Part 2, as Part 1 provides important information for Part 2.			
	Section N, Part 1: Reviews data elements N0300 through N0415	18:41		
	Section N, Part 2: Reviews data elements N0450 through N2005	16:00		
Module 17	Section O includes data elements to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.			
	Section O, Part 1: Review of the first half of the data elements in O0110	15:50		
	Section O, Part 2: Review of the remaining data elements in O0110	9:54		
	Section O, Part 3: Reviews the data elements O0250 through O0500	26:58		
Module 18	Section P includes data elements to record the frequency that the resident was restrained by any of the listed devices, or an alarm was used, at any time during the day or night, during the 7-day look-back period.			
	Section P, Restraints and Alarms	17:39		
Module 19	Section Q includes data elements intended 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.			
	Section Q, Participation in Assessment and Goal Setting	24:06		
Module 20	Section V & the Care Area Assessments: Section V includes data elements used to determine whether to trigger several of the CAAs that compare a resident's current status with their prior status, document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation; along with important dates and signatures for CAA and care plan completion. There are 20 CAAs in Version 3.0 of the RAI, which are reviewed in this module.			
	Section V & the CAAs Part 1	11:50		
	Section V & the CAAs Part 2	20:35		
Module 21	Section Z includes data elements to provide billing information and signatures of persons completing the assessment.			
	Section Z, Assessment Administration	9:06		
Module 22	The MDS Schedules reviews key definitions and scheduling guidance in Chapters 2, Assessments for the Resident Assessment Instrument (RAI and 6, Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS). This information is critical to managing both the OBRA and PPS MDS schedules for residents in nursing homes.			
	Assessment Types and Key Definitions	11:15		
	The OBRA MDS Schedule Part 1	29:34		
	The OBRA MDS Schedule Part 2	15:53		
	The PPS MDS Schedule	22:14		
Module 23	MDS Correction Requests reviews the data elements in Section X, Correction Request along with key guidance in Chapter 5, Submission and Correction of the MDS Assessments which outline how to correct assessment errors.			

	MDS Correction Requests	24:48		
Module 24	Interviewing Skills reviews the guidance provided in Appendix D, Interviewing to Increase Resident Voice in MDS Assessments to help the IDT when conducting the various interviews throughout the MDS.			
	Interviewing Skills	17:04		

Acronyms:

ACA – Affordable Care Act

ACIP – Advisory Committee on Immunization Practices

ADL – Activity of Daily Living

AI – Assessment Indicator

ARD – Assessment Reference Date

CAA – Care Area Assessment

CAT – Care Area Trigger

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CMS – Centers for Medicare and Medicaid Services

CNA – Certified Nursing Assistant

COVID-19 – Coronavirus Disease of 2019

DC – Discharge

DHHS – Department of Health and Human Services

DIF – Death in Facility

DRA – Discharge Return Anticipated

DRNA – Discharge Return Not Anticipated

HIPPS – Health Insurance Prospective Payment System

ID/DD – Intellectual Disability/Developmental Disability

IDT – Interdisciplinary Team

IMPACT – Improving Medicare Post-Acute Care Transformation (Act)

IPA – Interim Payment Assessment

iQIES – Internet Quality Improvement and Evaluation System

LOA – Leave of Absence

MAC – Medicare Administrative Contractor

MASD – Moisture Associated Skin Dermatitis

MDS – Minimum Data Set

NHSN – National Health Safety Network

NOMNC – Notice of Medicare Non-Coverage

OBRA – Omnibus Budget Reconciliation Act

OT – Occupational Therapy

PASRR – Preadmission Screening and Resident Review

PBJ – Payroll-Based Journal

PDPM – Patient Driven Payment Model

PPS – Prospective Payment System

PT – Physical Therapy

QAPI – Quality Assurance and Performance Improvement

QM – Quality Measure

RAI – Resident Assessment Instrument

RFA – Reason for Assessment

SCPA – Significant Correction to Prior Comprehensive

SCQA - Significant Correction to Prior Quarterly

SCSA – Significant Change in Status Assessment

SDOH – Social Determinants of Health

SLP – Speech Language Pathology

SNF – Skilled Nursing Facility

SNF QRP – Skilled Nursing Facility Quality Reporting Program

SSA – Social Security Act

TOH – Transfer of Health (information)

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