**Department of Veterans Affairs** **VHA DIRECTIVE 2008-007**
**Veterans Health Administration**
**Washington, DC 20420** **February 4, 2008**

# RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS)

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides guidelines for scheduling and completion of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) in Department of Veterans Affairs (VA) Nursing Home Care Units and Spinal Cord Injury and Disorders (SCI&D) Programs, referred to in this document as "NHCU," that are surveyed under the Joint Commission on Long-Term Care (LTC) standards.

## 2. BACKGROUND

a. VA's NHCUs of today is a dynamic array of non-acute services, including short-stay and long-stay, for veterans who are medically and psychiatrically stable and require the unique services provided in this institutional post hospital setting. The RAI MDS is a standardized instrument designed to identify the functional and health care needs of residents, generate a plan of care, and evaluate that care so that the services provided are individualized to the needs of the veteran presenting to the nursing home for particular services. The MDS or assessment portion section of the RAI MDS process generates Quality Indicators (QI), Quality Measures (QM), and Resource Utilization Groups (RUGs).

(1) The QMs and QIs are used for monitoring system wide VA nursing home quality at the facility level, Veterans Integrated Service Network (VISN) and national levels; they are a source for performance measures and process improvement activities for The Joint Commission and VHA required quality improvement activities. The RAI MDS provides a structure for meeting accreditation standards.

(2) The RUGs are used in nurse staffing methodology to determine case mix, and are the basis for Veterans Equitable Resource Allocation (VERA) funding for VA nursing home care.

b. The electronic version of the RAI MDS was implemented in VA nursing homes in 2000. VA's application of the RAI MDS mirrors the application of RAI MDS in community nursing homes and State Veterans Homes. This consistency with the greater nursing home community ensures reliability and validity and allows for benchmarking with contract community nursing homes and State Veterans Homes. ***NOTE:*** *Because the RAI MDS data contains a wealth of standardized information about nursing home resident functional and health status, it has been a rich source of data for VA research.*

c. The RAI MDS assessment is meant to be an interdisciplinary process; therefore, assessments are to be completed only by professional staff representing the various disciplines providing care to residents in the nursing home. Completion of the entire RAI/MDS assessment is not to be assigned to any single discipline.

d. The assessment schedule and type is determined by the anticipated length-of-stay based on reason for admission, as determined by the admission screening committee which assigns a treating specialty code according to VHA Directive 2006-014, which may be found at: http://www1.va.gov/vhapublications or http://vaww1.va.gov/vhapublications .

(1) Short-stay admissions have an anticipated length of stay of 90 days or less.

(2) Long-stay admissions have an anticipated length of stay of greater than 90 days. The assessment schedule and type will follow the Omnibus Reconciliation Act (OBRA) 1999 guidelines. ***NOTE:*** *This is often referred to as the traditional MDS schedule which can be found at: http://www.cms.hhs.gov/MinimumDataSets20/Downloads/MDS%202.0%20Forms.pdf*

e. The RAI MDS has met the VA nursing home care goal of providing a system-wide nursing home data base. This process continues to assist clinicians in providing care and to provide a venue for analysis, comparison, research, and assessment of nursing home costs. ***NOTE:*** *The RAI MDS process has already served as a catalyst for improving care for veterans in VA's nursing homes.*

f. **Definition of Resident Assessment Instrument (RAI).** The RAI consists of three basic components, the MDS, Resident Assessment Protocols (RAPs), and Utilization Guidelines. Utilization of these components of the RAI MDS yields information about a resident's functional status, strengths, weaknesses and preferences, and offers guidance on further assessment once problems or potential problems have been identified. Each component flows naturally into the next as follows:

(1) **MDS.** A core set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the foundation of the assessment for all residents of nursing homes. Items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies, including between and among VA medical centers, Veterans Integrated Services Networks (VISNs) and VHA Central Office.

(2) **RAPs.** The RAPs are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically-relevant information about an individual. RAPs help identify social, medical, and psychological problems, and are the basis for individualized care planning.

(3) **Utilization Guidelines.** Utilization Guidelines are instructions concerning when and how to use the RAI. The Utilization Guidelines for Version 2.0 were published by Health Care Finance Administration (HCFA) now known as the Centers for Medicare and Medicaid Services (CMS). A variety of resources have been made available to VA NHCU staff which includes the Utilization Guidelines.

**3. POLICY:** It is VHA policy that the RAI MDS process must be followed as described in Attachment A, which is consistent with guidelines established by CMS.

## 4. ACTIONS

a. **Facility Director.** The Facility Director is responsible for:

(1) Providing organizational support and resources necessary for the RAI MDS process, including but not limited to support for training, space, ensuring staff transmit data to the VA national RAI MDS database, and clinical integration of the RAI MDS.

(2) Ensuring the facility Information Technology (IT) leadership understands that the RAI MDS database must be electronically backed up weekly.

(3) Ensuring that specialized Spinal Core Injury and Disorder (SCI&D) Long-Term Care Service units use the RAI MDS as indicated in this Directive and use the staffing methodology as outlined in the VHA Handbook 1176.02 found at: http://www1.va.gov/vhapublications or http://vaww1.va.gov/vhapublications .

b. **Clinical Leader.** The clinical leader who directs the NHCU program is the responsible official for the execution of this Directive. Leadership of the local NHCU programs is responsible for:

(1) Developing and implementing a plan including policies and procedures for using the RAI MDS and for batching and transmitting RAI MDS records to the Corporate Franchise Data Center - Austin (CFD-Austin).

(2) Ensuring that these policies and procedures are consistent with the most current version of the CMS MDS 2.0 RAI User's Manual, which can be found at: *http://www.cms.hhs.gov/MinimumDataSets20/Downloads/MDS%202.0%20Forms.pdf*

(3) Ensuring that all residents in NHCU programs covered by this Directive have the appropriate MDS completed according to the short-stay or long-stay time frames identified in Attachment A.

(4) Ensuring the completed MDS forms are printed and sent to the scanning or file room promptly so the form can be scanned into the patient's health record through VistA Imaging with an origin of VA, type of medical record, service of the provider, and procedure or event of the inpatient stay.

## 5. REFERENCES

a. Omnibus Budget Reconciliation Act of 1987 (OBRA '87).

b. CMS MDS 2.0 RAI User's Manual Version 2.0 (2006).

**6. FOLLOW-UP RESPONSIBILITIES:** Chief Consultant, Geriatrics and Extended Care (114), is responsible for the contents of this Directive. Questions may be addressed to (202) 461-6750.

**7. RESCISSION:** VHA Directive 2001-029 is rescinded. This VHA Directive expires on February 28, 2013.

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**ATTACHMENT A**

## GUIDELINES FOR THE USE OF THE RESIDENT ASSESSMENT INSTRUMENT (RAI) MINIMUM DATA SET (MDS)

**1. Types of Assessments.** All assessments are part of the health record and include the following:

a. **Long Stay.** Long stay services are those where upon admission, the veteran's expected length of stay is 91 days or more.

(1) The following comprehensive assessments (including RAP summary) must be completed within the following schedule:

(a) Admission assessment-within 14 days of admission date, which is counted as day 1.

(b) Annual assessment-within 365 days of last full assessment.

(c) Significant change of condition-within 14 days of discovery of the change.

(d) Significant correction of prior assessment-within 30 days of discovery.

(2) Quarterly Assessment-completed within 90 days of previously completed OBRA assessment.

b. **Short Stay.** Short stay services are those where upon admission the veteran's expected length of stay is 90 days or less. NOTE: Additional information concerning MPAF forms, procedures and scheduling can be found in VHA Directive 2005-060: http://vaww1.va.gov.vhapublications/ViewPublication.asp?pub_ID=1356

(1) Medicare Prospective Payment Assessment Form (MPAF) 5-Day Assessment

(2) MPAF 14-Day Assessment

(3) MPAF 30-Day Assessment

(4) MPAF 60-Day Assessment

(5) MPAF 90-Day Assessment

(6) MPAF Readmission/Return Assessment

(7) Other Medicare Required Assessment

c. **Tracking Forms**

(1) Discharge Tracking Form must be completed when a resident is discharged, and is applicable regardless of length of stay.

(a) Discharge prior to completion of initial assessment

(b) Discharge with return anticipated

(c) Discharge return not anticipated

(2) Reentry Tracking Form – required when a resident returns after being discharged with an anticipated return.

**2. RAI MDS Accountability**

a. The signatures in section AA on the assessment are not electronic signatures, but a software signature indicating that the staff contributed data to this record. Policy regarding wet signatures must be determined at a facility level.

b. Staff members completing any portion of the MDS must sign and date the entry. When signing in AA9, the staff member is certifying the accuracy of the data that they have entered, and is also indicating which section(s) has been completed. Specific MDS section assignments of the interdisciplinary team members are decided at a facility level, which is to be included in local policy.

c. Two or more staff members may complete items within the same section of the MDS.

d. A Registered Nurse (RN) is required to sign and date R2b, certifying that the assessment is completed. The RN must not sign until all other assessors have completed their assigned sections. On a comprehensive assessment, the RN will also sign item VB 1/2 indication the completion of the RAPs.

e. Facilities may institute various processes to create the assessment schedules; however, it is the responsibility of the MDS Coordinator to ensure scheduling accuracy and timeliness. The software scheduler will be set up in such a manner as to afford the facility flexibility in the number of days it has to complete an annual or quarterly assessment.

**3. Seal the Record.** After completing the assessment, the Interdisciplinary Team (IDT) has the next 7 days to ensure that all MDS items were correctly coded. During the 7-day period, the IDT may "correct" any errors found in the assessment. An assessment is considered complete only if 100 percent of the errors are corrected. During the edit period, the IDT may also update the RAPs based on additional information obtained. After all corrections are completed, an RN is responsible for sealing the assessment.

**4**. **Date of Transmission to Austin.** Transmission to the Corporate Franchise Data Center - Austin (CFD-Austin) is encouraged to occur weekly; however, all completed MDS forms must be transmitted within 30 days of their timely completion, or by the 28th day of the following month, whichever comes first. Each facility is responsible for developing a process to batch and transmit sealed MDS data to the CFD-Austin. ***NOTE:*** *Monitoring must be done to ensure timely and successful transmission.*

**5. Correcting the MDS.** If errors are discovered after the assessment has been transmitted and locked, changes can be made by completing a correction request form, and selecting 'modification' or 'inactivation' as appropriate as stated in Section 5.6 of the RAI User's Manual. For "corrected" items, the facility must use the same "period of observation" as used for the original item completion (i.e., the same Assessment Reference Date – A3a) as stated in Section 1.17 of the RAI User's Manual.

**6. Section U.** Section U of the MDS is not to be used within the VA at this time**.**

**7. Software Set-up**

a. Within the Accu-Care software, the set-up option used for RUGs will be Calculator Type (Standard 512 53 Group).

b. International Classification of Disease 9th edition Clinical Modification (ICD-9-CM) Diagnosis File. Alteration of this file is prohibited at a local level.

c. Changes or additions to the software must be requested in writing to VHA Central Office Geriatrics and Extended Care (GEC) Services through the VISN GEC Point of Contact (POC), using the "Change Request Form." Facilities may not negotiate directly with the vendor for changes to the Accu-Care software.

**8. Policy-making.** Each facility must create policies encompassing the RAI MDS process to include National Policies. Consistency with the timeframes for both long and short stay assessments is required.

**9. The RAPs Process.** The RAPs process must be defined to include identification of which disciplines will complete which RAPs. If separate disciplines are responsible for completing RAPs, it is important that an interdisciplinary approach is utilized. For example, a dietitian cannot effectively complete the nutritional status RAP without considering the cognitive loss, visual function, mood state, behavior, dental care, fluid maintenance and physical functioning RAPs.

**10. Care Planning.** It is of the utmost importance that the staff providing direct care and who are most knowledgeable about the resident, in coordination with staff having the most expertise in a given resident problem area, work with the resident and his or her family or other representative in the care planning process.

a. The work of the interdisciplinary treatment team is not considered official without the core membership of the team present, and therefore no official treatment planning meeting can be held without all core members. The core membership of the interdisciplinary treatment team includes: the medical provider, registered nurse, social worker, dietitian and recreation therapist. Other interdisciplinary team members, whose presence is not required for a plan to be official, may include the following: pharmacist, psychologist, physical and or occupational therapist, chaplain, and other disciplines providing direct care to the resident. Residents and family members **must** be invited to participate in the care planning process.

b. Care planning formats and processes will be determined at each facility. ***NOTE:*** *Because of the high variability in interdisciplinary care planning models in VA NHCU programs, this directive will not specify the use of any specific care planning format or process.* The national software package has a care planning component that builds from the RAI MDS which facilities may find easily adaptable to their own interdisciplinary care planning processes.

**11. The Care Plan Library.** The Care Plan library is a part of the Accu-Care software, and can be edited at the facility level to enhance care plan individualization.

**12. User-defined Assessments.** User-defined Assessments, located in the assessment module of the Accu-Care software, can be used to create additional user-defined assessments.

**13. Pre-admission Module.** The Pre-admission module process, including RUGs estimates, should be defined if this option is utilized.