Department of Veterans Affairs **VHA DIRECTIVE 2001-029**
Veterans Health Administration
Washington, DC 20420 **May 10, 2001**

RESIDENT ASSESSMENT INSTRUMENT MINIMUM DATA SET (RAI/MDS)

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides instruction for implementation of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) (see Att. B) in VHA Long-term Care (LTC) and/or Nursing Home Care Unit (NHCU) Programs surveyed under the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Long-term Care Standards.

2. BACKGROUND

a. After years of increasing government, public and clinician concern about inadequate and inconsistent nursing home care, the Department of Health and Human Services was assigned, in 1984, legal responsibility for ensuring the quality of nursing home care. Work ensued in this area resulting in study recommendations which were incorporated into Public Law 100-103, the Omnibus Budget Reconciliation Act (OBRA) of 1987. This legislation included the mandate for a standardized assessment of each nursing home patient, which led to a Health Care Finance Administration (HCFA) contract, in 1988, with a research consortium to develop and evaluate a uniform patient assessment instrument.

b. The initial version of the RAI MDS was implemented in community nursing homes in the spring of 1991. HCFA and the States required that long-term care facilities implement the RAI MDS in order to receive Medicaid and/or Medicare reimbursement. Currently, utilization is universal in non-Department of Veterans Affairs (VA), community long-term care facilities receiving Federal funding.

c. Early on in the development and implementation phases, clinicians, researchers, and policymakers recognized that the RAI MDS was a dynamic tool and would require ongoing evaluation and refinement over time if it was to serve as the foundation for the delivery of long-term care services. HCFA made a commitment to sponsor the continued refinement of the RAI and, in October 1995, introduced version 2.0 of the RAI MDS.

d. Changes in version 2.0 were in keeping with the clinical focus used to design the original instrument, in addition to inclusion of items necessary to calculate Resource Utilization Groups III (RUG-III) and items to move forward with an MDS-driven quality monitoring and improvement system. Other improvements were also made in streamlining the Resident Assessment Protocol (RAP) triggers and in the RAI MDS Utilization Guidelines.

e. The RAI MDS 2.0 requires that patient assessments be completed upon admission, quarterly, annually and for any significant change in a patient's status. Most important to the development of the RAI MDS has been the framework that recognized the importance of comprehensive assessment as the foundation for planning and delivering care to the country's nursing home patients. The RAI is simply a standardized, new approach for what clinicians have always been doing, or should have been doing, related to assessing, planning, providing and evaluating individualized care.

f. VHA's interest in the RAI MDS peaked in early 1991 when several Nursing Home Care Units (NHCUs) in the field, under the sponsorship of the Office of Geriatrics and Extended Care

(OGEC), took the lead and participated in an "MDS Demonstration Project" to investigate automation and RAI MDS functionality within the Department of Veterans Affairs (VA). The Office of Quality Management (10Q), VHA Headquarters, provided funds to support the project.

g. In September 1992, a VA Health Services Research and Development (HSR&D) proposal, "The National Resident Assessment Instrument in the VA" was funded and added to the Demonstration Project. Other HSR&D grants were awarded for local development, pilot work and interface development. Reliability of the MDS in VA was established. Inclusion of assessment on pain, oral health, and foot care into RAI MDS 2.0 was influenced by the demonstration project. There was clear consensus that the RAI MDS should be implemented in VA long-term care and/or NHCU programs.

h. The Under Secretary for Health approved VHA's Long-term Care Policy Plan in May 1995, and at the same time, tasked the OGEC with national VA implementation and automation of the RAI MDS, initiated as a collaborative effort with the Office of the Chief Information Officer (OCIO). To meet this charge, the RAI MDS Steering Committee was established in November 1996. Individual RAI MDS workgroups were appointed to assist and implement this project. In June 1998, VA Long-term Care at the Crossroads, the Report of the Federal Advisory Commission on the Future of VA Long-term Care, recommended that "VA should implement its plans for RAI MDS without delay."

i. All VA long-term care and/or NHCU programs currently use the Veterans Health Information Systems and Technology Architecture (VistA)-based Patient Assessment Instrument (PAI) to gather information on long-term care patients. The PAI is an administrative data collection tool used primarily to determine RUG II groupings and for reporting to the Austin Automation Center (AAC). The PAI has limited usefulness for clinicians and results in less than accurate, complete and timely data. Whereas, the RAI MDS is a standardized clinical tool designed to produce a comprehensive patient assessment that serves as the basis for developing an individualized plan of care for each long-term care and/or nursing home patient and includes the patient classification data items for RUG III determinations. RAI MDS and RUG III data will be reported to the AAC. Use of the PAI will be discontinued when RAI MDS is fully implemented.

j. Use of the RAI MDS in VA long-term care and/or NHCU programs will provide a structure for meeting accreditation standards. It will also provide opportunities for data comparison on patient outcomes within and across VA and with non-VA long-term care and/or nursing home programs. Given the continuing and revolutionary changes in health care delivery, the ability to make these comparisons is critical to the VA health care system.

k. The VA Geriatrics and Extended Care Strategic Healthcare Group (GECSHG), many field facilities and other organizational entities agree that VA needs a system-wide, long-term care database. By implementing the RAI MDS methodology, VA will mirror the same data items, terminology and definitions as the non-VA long-term care and/or nursing home community. This process will assist clinicians in providing care and will allow for comparison of characteristics and outcomes of VA and non-VA long-term and/or nursing home care. Quality of

care will improve, achieving higher and consistent standards. Care planning and care protocols will be facilitated. Tremendous research applications are created.

3. POLICY

a. It is VHA policy that RAI MDS (see Att. B) developed by HCFA will be implemented in any VA long-term care and/or NHCU program or bed section that is accredited under the JCAHO Long-term Care Standards.

b. The RAI MDS must be used consistent with HCFA guidelines.

c. The RAI MDS replaces the Patient Assessment Instrument (PAI).

NOTE: *Patient-specific information obtained from the MDS assessment will be entered into VHA's information system using software designed for this purpose for electronic submission to a central data base in Austin, TX. Timeframes and protocols for the electronic submission process are outlined in Attachment B.*

4. ACTIONS

a. Medical Center Directors must provide organizational support and resources necessary for the implementation of the RAI MDS, including but not limited to support for training, space, hardware, software maintenance, mechanisms for data roll up and data retrieval and other resources needed for full clinical integration of the RAI MDS.

b. The clinical leader who directs the long-term care and/or NHCU program and is accountable for meeting the JCAHO LTC standards at their facility will be designated as the responsible official for implementation of this directive.

c. Leadership in the long-term care and/or NHCU program will develop and implement a plan, including policies and procedures for using the RAI MDS in their facility. Policies and procedures will be consistent with the most current version of the HCFA Long-term Care Resident Assessment Instrument User's Manual, including:

(1) Requirements and suggestions for integration in clinical practice.

(2) MDS items.

(3) Procedures for completing RAPS.

(4) Linking assessment to individualized care plans.

(5) Utilization guidelines.

d. ***NOTE:*** *Because of the high variability in interdisciplinary care planning models in VA long-term care and/or NHCU programs, this directive will not specify the use of any specific care planning format or process.* Care planning formats and processes will be determined at each facility. The national software package has a care planning component that builds from the

RAI MDS which most facilities will find easily adaptable to their own interdisciplinary care planning processes.

e. By December 31, 2001, all patients in long-term care and/or NHCU programs covered by this directive will have the MDS completed on the following schedule:

(1) Upon admission.

(2) Quarterly.

(3) Annually.

(4) At time of significant change in patient's status.

(5) Upon discharge.

f. Management will meet its labor relations obligations where appropriate.

5. REFERENCES

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

b. HCFA Long-term Care Resident Assessment User's Manual Version 2.0, October 1995.

c. HCFA web site http://www.hcfa.gov/medicare/hsqb/mds20/default.htm

d. Zimmerman, DR, "Development and Testing of Nursing Home Quality Indicators," Health Care Financing Reform 16(4): 107-127, 1995.

e. Fries, BE, "Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III)," Medical Care 32(7): 668-685, 1994.

f. Rantz, MJ, "Verifying Nursing Home Care Quality Using Minimum Data Set Quality Indicators and other Quality Measures," Journal of Nursing Care Quality 12(2): 54-62, 1997.

g. Ouslander, JG, "The Resident Assessment Instrument (RAI): Promise and Pitfalls," Journal of the American Geriatrics Society, 45 (8): 975-985, 1997.

h. "VA Long-term Care at the Crossroads," Report of the Federal Advisory Commission on the Future of VA Long-term Care, Department of Veterans Affairs, June 1998.

6. FOLLOW-UP RESPONSIBILITIES: Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114), is responsible for the contents of this directive.

7. RESCISSION: None. This VHA Directive expires on May 31, 2006.

S/ by Frances Murphy, M.D. for
Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachments

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ATTACHMENT A

DEFINITIONS

1. RESIDENT ASSESSMENT INSTRUMENT (RAI). The RAI consists of four basic components, the Minimum Data Set (MDS), Triggers, Resident Assessment Protocols (RAPS), and Utilization Guidelines. Utilization of the four components of the RAI yields information about a patient'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:

a. **MDS.** A core set of screening, clinical and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and in Department of Veterans Affairs (VA) Long-term Care and/or Nursing Home Programs accredited under the Joint Commission on Accreditation of Healthcare Organization (JCAHO) Long-term Care Standards. Items in the MDS standardize communication about patient 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 Headquarters.

b. **Triggers.** Specific patient responses for one or a combination of MDS elements. The triggers identify patients who either have or are at risk for developing specific functional problems and require further evaluation using Resident Assessment Protocols (RAPS) designated within the RAI. MDS item responses that define triggers are specified in each RAP and on a Resident Assessment Protocol Trigger Legend.

c. **RAPS.** A component of the utilization guidelines, 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.

d. **Utilization Guidelines.** Instructions concerning when and how to use the RAI. The Utilization Guidelines for Version 2.0 were published by Health Care Finance Administration (HCFA). A variety of resources have been made available to VA Long-term Care and/or Nursing Home Care Unit (NHCU) staff which include the Utilization Guidelines.

2. SCHEMATIC: The following is schematic of the overall RAI framework:

MDS ⇒ TRIGGERS ⇒ RAPS = COMPREHENSIVE ASSESSMENT

ATTACHMENT B

INSTRUCTIONS FOR THE USE OF THE RESIDENT ASSESSMENT INSTRUMENT MINIMUM DATA SET

1. RAI MDS. This attachment provides information about the Resident Assessment Instrument (RAI) Minimum Data Set (MDS).

2. Components of MDS. All components of the MDS are part of the medical record. These components include the following:

a. **Department of Veterans Affairs (VA) Form 10-0375a**	Basic Assessment Tracking Form
b. **VA Form 10-0375b**	Background (Face Sheet) Information at Admission
c. **VA Form 10-0375c**	Full Assessment Form
d. **VA Form 10-0375d**	Resident Assessment Protocol (RAP) Summary
e. **VA Form 10-0375e**	Quarterly Assessment Form (Optional Version for Resource Utilization Groups (RUGs) III)
f. **VA Form 10-0375f**	Discharge Tracking Form
g. **VA Form 10-0375g**	Reentry Tracking Form
h. **VA Form 10-0375h**	Interdisciplinary Care Plan

i. **User-Defined Assessments.** User-Defined Assessments include: Geriatric Depression Scale, Mini-Mental Scale, Braden Scale, or facility defined User-Defined Assessments.

3. Full Assessment. Full assessment including RAP summary and RAP modules must be completed within the 14 days for:

a. New admissions,

b. Annually,

c. Significant change of condition, and

d. Significant correction of prior assessment.

4. Annual and Quarterly Assessments. Annual and quarterly assessments will be set-up by calendar days. The automatic scheduler will be set up in such a manner as to afford the facility flexibility in the number of days it receives a warning that an annual or quarterly assessment is due.

5. Quarterly Assessment Form. The Quarterly Assessment Form will be the most recent (currently 1997). The purpose of using this form is to:

a. Update the assessment, and

b. Capture RUGs III.

6. A Discharge Tracking Form. A Discharge tracking form must be completed when a patient is discharged from the long-term care program or facility.

7. RAI MDS Accountability

a. RAPs and Care Plans require printing and hard-copy signature.

b. Each staff member who completes any portion of the MDS must date the entry, enter staff member's name to designate the contribution to the MDS, and indicate which portion of the MDS was completed by said staff member.

c. Two or more staff members may complete items within the same section of the MDS, but only one contribution name will be accepted for that section.

d. A Registered Nurse (RN) is responsible for signing and certifying the assessment (MDS and RAPs) to attest to completion of the assessment. The RN must not sign until all other assessors have finished their portions of the MDS which must be completed within the 14 days.

8. Lock the Record. After completing the assessment, the facility has the next 7 days to ensure that all MDS items pass edits and to "lock" the record. "Locking" the record means that no changes can be made to the MDS. An RN is responsible for locking the assessments.

a. **Editing.** The facility is responsible for ensuring that all MDS items pass edit messages. During the 7-day period prior to locking, the facility may "correct" item responses in order to meet edits. An assessment is considered complete only if 100 percent of the required edits are passed. An RN has the professional competency and responsibility to edit data in the MDS.

b. **Correcting Item.** For "corrected" items, the facility must use the same "period of observation" as that used for the original item completion (i.e., the same Assessment Reference Date – A3a). During the edit period, the facility may also update the RAPs based on additional information obtained through the "period of observation." If the RAPs are updated, all entries must be authorized and become part of the medical record. ***NOTE:*** *The Accu-Care software will aid the facility in the editing process.*

c. **Locking.** After passing the edits, a record is then "locked." Individual MDS records must pass 100 percent of the edits for the record to be "locked." At this point, the record cannot be changed by the facility.

d. **Unlocking Assessment Data.** Unlocking assessment data is prohibited except in the unlikely event where data integrity could be compromised. To this point, each facility should designate an official such as the highest level ranking Health Information Management System (HIMS) staff, Chief of Medical Records, or Chief Information Officer (CIO) to unlock assessments. This must not be a person associated with the clinical aspect of the program.

9. Date of Transmission to Austin. Transmission to the VHA's RAI MDS national system located in Austin, TX, may occur on a designated day each week. All completed MDS assessments must be transmitted within 30 days from being locked. Each facility is responsible for developing a process to batch and transmit locked MDS data to the Austin RAI/MDS system. ***NOTE:*** *Follow-up must be done to ensure timely and successful transmission.*

10. Specific MDS Sections

a. Section S will contain VA specific information and will be completed.

b. Section T of the MDS will be completed. Section T includes physical therapy, recreation therapy, occupational therapy, and speech pathology services. The Case Mix Group in this section calculates the RUGs score based on current MDS data.

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

11. Set-up Options

a. Within the Accu-Care software, the set-up option used for RUGs will be Calculator Type (Standard 512 44 Group).

b. Facilities may choose the Weight Option (Urban or Rural) and Other Options (Index Maximizing or Hierarchical). The recommendation for Other Options is Index Maximizing which gives the highest RUGs score.

c. Updating of national level Master Files is prohibited. These files are:

(1) Institution file,

(2) Race file,

(3) Marital status file,

(4) Religion file,

(5) Specialty file, and

(6) International Classification of Disease 9th edition Clinical Modification (ICD-9-CM) Diagnosis File

d. The Weight Documentation option in the Accu-Care Medical Record module is optional. ***NOTE:*** *The user-defined list of "Weight Devices" must be set up by the facility.*

e. Changes or additions to the software must be requested in writing from VHA Headquarters Office of Geriatrics and Extended Care (OG&EC). Facilities may not negotiate directly with Accu-Med for changes to the Accu-Care software.

12. Policy-making. Each facility must create policies encompassing the MDS process which includes National Policies. The following items are recommended:

a. Responsibilities for the MDS process 2.12.2 should be clearly designated.

b. The MDS process should be defined to include identifying the location of assessments in the medical record:

(1) Consistency with National policy timeframes:

(a) Seven days to observe after admission (recommended).

(b) Fourteen days to complete and sign MDS and RAPs (National policy).

(c) Up to 7 additional days to edit MDS and RAPs (National policy).

(d) Lock by day 21 (National policy).

(e) Transmit within 30 days of locking to Austin RAI MDS (National policy).

(2) Defining a notification and/or communication process for section completion.

(3) Defining which team members and/or disciplines complete sections of the MDS.

(4) Designating RN(s) for final sign-off and locking authority.

(5) Designating who will have authority to transmit assessments to the National RAI MDS system in Austin, TX.

13. Tracking Methodology. A tracking methodology for the RAI MDS process should be defined to include timely completion, locking, and transmission.

14. Weight and/or Other Options. A Weight option (Urban or Rural) and other Options (Index Maximizing or Hierarchical) for RUGs calculations needs to be chosen. The recommendation for other Options is Index Maximizing which gives the highest RUGs score.

15. Pending Notification. The number of calendar days informing the staff that an annual or quarterly assessment is due must be set up.

16. The RAPs Process. The RAPs process must be defined to include:

a. Identifying who (which disciplines) will work which RAPs,

b. Deciding when to print the RAPs, and

c. Identifying who will complete and who will sign the paper copy.

17. Triggers Responsibility. One clinician may complete all triggered RAPs or specific triggered RAPs may be assigned to different disciplines to complete.

18. Interdisciplinary Approach. If separate disciplines are responsible for 'working' RAPs, it is important that an interdisciplinary approach is considered. For example, a dietician cannot effectively 'work' the nutritional status RAP without considering the: cognitive loss, visual function, mood state, behavior, dental care, fluid maintenance, physical functioning, RAPs, etc.

19. User-defined Assessment Process. The User-defined Assessment process must be defined to include assigning authority to create and manage the user defined assessment process. The Accu-Care User-defined Assessment module contains the following National defaults: Braden Scale, Geriatric Depression Scale, and Mini-Mental State. ***NOTE:*** *Facilities may create additional user-defined assessments.*

20. The Treatment Planning Process. The Treatment Planning process must be defined. The VA National level selected Care Plan library will be deployed as an option with the Accu-Care software. If the facility chooses to use the Accu-Care automated Care Plan library, then it should be incorporated into the facility's Care Plan process. ***NOTE:*** *Edited changes can occur at the facility level.*

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

22. Authority to Update. Authority to update local master files within the Accu-Care software should be designated. The files affected are the:

a. Patient file,

b. Insurance company file,

c. Ward location file,

d. Room and/or bed file, and

e. New person file.