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Keys to Success
with
RAI System Management



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Disclaimer

- This presentation was developed as an educational offering and reference for long-term care professionals. To the best of our knowledge, it reflects current federal regulations and practices. However, it cannot be considered absolute and universal. The information contained in this presentation must be considered in light of the individual organization and state regulations. This content is intended to provide practical knowledge concerning the subject matter covered and is provided with the understanding that MDS Consultants, LLC is not rendering legal advice or other professional services

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OBJECTIVES

- Identify reports that are affected by the RAI System Management
- Learn tips to accurately manage a RAI system
- Incorporate in QAA/QAPI process to monitor effectiveness of a RAI System Management
- Discuss ways to prepare for upcoming MDS 3.0 Changes with RAI System Management

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RAI System Process

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RAI-Resident Assessment Instrument

3 Components

- 1. The Minimum Data Set (MDS) 3.0
- 2. Care Area Assessment (CAA) process
- 3. Utilization Guidelines


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RAI (Resident Assessment Instrument) Process



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MDS Types of Assessments

<h4 style="text-align: center;">OBRA Assessments</h4> <ul style="list-style-type: none"> <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Admission <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Annual <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Significant Change <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Significant Correction <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Quarterly <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Discharge return Anticipated <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Discharge not Anticipated 	<h4 style="text-align: center;">PPS Assessments</h4> <ul style="list-style-type: none"> <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">5d Assessment <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">IPA <li style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Part A PPS Discharge
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MDS SECTIONS

<ul style="list-style-type: none"> A-Resident Identification B-Hearing, Speech, Vision C-Cognitive Patterns D-Mood E-Behaviors F-Preferences for Customary Routine and Activities G-Functional Status GG-Functional Abilities and Goals H-Bladder and Bowel I-Active Diagnosis J-Health Conditions K-Swallowing/Nutritional Status L-Oral/Dental Care M-Skin Conditions N-Medications O-Special Treatments, Procedures, and Programs P-Restraints and Alarms Q-Participation and Goal Setting 	<ul style="list-style-type: none"> V-CAA Summary X-Correction Z-Assessment Administration
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CAA(s) Care Area Assessments

- Completed on comprehensive MDS assessments
- 20 Care Areas from triggered responses to MDS coded items

1. Delirium	2. Cognitive Loss/Dementia
3. Visual Function	4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential	6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being	8. Mood State
9. Behavioral Symptoms	10. Activities
11. Falls	12. Nutritional Status
13. Feeding Tubes	14. Dehydration/Fluid Maintenance
15. Dental Care	16. Pressure Ulcer/ <i>Injury</i>
17. Psychotropic Medication Use	18. Physical Restraints
19. Pain	20. Return to Community Referral

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Resident Assessment Regulations

- F636 Comprehensive Assessment and Timing
- F637 Comprehensive Assessment after Significant Change
- F638 Quarterly Assessment at least Every 3 Months
- F639 Maintain 15 Months of Resident Assessments

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Resident Assessment Regulations



F640 Encoding/Transmitting Resident Assessments



F641 Accuracy of Assessments



F642 Coordination/Certification of Assessment

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Care Plans

Address individual needs, strengths, and preferences

Person centered and individualized

Communicate with resident and resident representative

Identifies risk, problems, or conditions

Resident's measurable goals and outcomes

Cultural, Trauma, and Social Determinants of Health focus





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Care Plans




-  Implement interventions and treatments
-  Monitor resident's progress
-  Modify interventions, treatments, and approaches
-  Review and re-evaluate at scheduled intervals and as needed

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Care Plan Regulations


-  F655 Baseline Care Plan
-  F656 Develop/Implement Comprehensive Care Plan
-  F657 Care Plan Timing and Revision

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Care Plan Regulations

-  F658 Services Provided Meet Professional Standards
-  F659 Qualified Persons
-  F660 Discharge Planning Process
-  F661 Discharge Summary

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RAI Connection with Facility Reports

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Reports connected to RAI Process


Reimbursement

Casper Reports

- Submission Validation Reports
- Quality Measures
- Five Star Quality Rating
- SNF QRP
- SNF VBP



Care Compare

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Facility Reimbursement



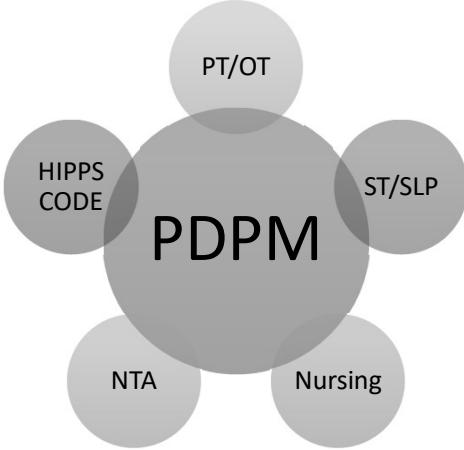
Medicare
Medicare Advantage
Insurance
Medicaid
Private Pay

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Medicare Reimbursement



- Skilled Criteria
- Primary Diagnosis or Condition
- Daily Documentation
- Physician Certification
- Therapy Services
- Section GG Functional Score
- Comorbidities

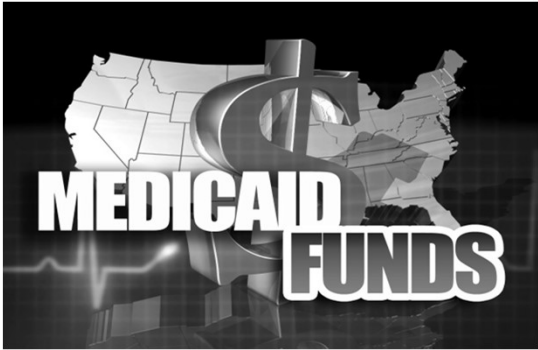
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Case Mix- Medicaid Reimbursement



- Monitoring Case Mix for reimbursement
- Knowledge of the assessment being used for CMI
- Supporting documentation

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Validation Reports-iQies Submission Portal

Once the MDS assessment is completed:

- Submission/transmission of MDS records
- View and check MDS Validation Reports
- Correct any errors on MDS Validation Reports
- Verify the MDS transmitted were accepted

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Casper Reports-“Certification and Survey Enhanced Reports”

Quality Measures

- Derived from the MDS Assessments Submitted
- Monitors MDS Assessments and accuracy
- Monitors Reimbursement
- Survey Preparation and Readiness

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Casper Reports


Quality Measures

- MDS 3.0 Facility Characteristics
- MDS 3.0 Facility Level Quality Measure
- MDS 3.0 Resident-Level Quality Measure

*Review by week and or generate Monthly

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Casper Reports

SNF QRP (Quality Report Program)


- SNF Facility-Level Quality Measure Report
- SNF Resident-Level Quality Measure Report
- SNF Provider Threshold Report

*Review Quarterly

<https://www.cms.gov/files/document/fy2023-snf-qrp-faqs.pdf>

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Casper Reports

SNF VBP-Value Based Purchasing

The SNF VBP Program currently uses the SNF 30-Day All-Cause Readmission Measure (SNFRM; National Quality Forum [NQF] #2510), which evaluates the risk-standardized readmission rate (RSRR) of unplanned, all-cause hospital readmissions.

<https://www.cms.gov/files/document/fy-2023-snf-vbp-fact-sheet.pdf>

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5-Star Quality Rating System

- CMS created the 5-star quality rating system for families, caregivers and consumers to compare nursing facilities
- Nursing Homes are rated on a score of 1 to 5 stars
- The higher the star rating the above average quality of care and the lower the star rating indicates lower than average quality of care



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5-Star Quality Rating System

- The 5-star rating system is made up of three areas of performance in the nursing facility

Health Inspections

Staffing Measures based on nursing home staffing levels and staff turnover

Quality Measures-MDS and Claims Based Measures

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Quality Measures




- Quality Measures are publicly reported on Care Compare
- Facilities receive three QM ratings – an overall, a long-stay, and a short-stay rating
- Facility rating for the QM domain is based on its performance on 15 Quality Measures
- 10 MDS Quality Measures and 5 Claims Based Measures

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Table 4 Quality Measures Used in the Five-Star Quality Measure Rating Calculation	
Measure	Comments
MDS Long-Stay Measures	
Percentage of residents whose ability to move independently worsened	This measure is a change measure that reports the percentage of long-stay residents who have demonstrated a decline in independence of locomotion when comparing the target assessment to a prior assessment. Residents who lose mobility may also lose the ability to perform other activities of daily living, like eating, dressing, or getting to the bathroom.
Percentage of residents whose need for help with daily activities has increased	This measure reports the percentage of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment. This is a change measure that reflects worsening performance on at least two late loss ADLs by one functional level or on one late loss ADL by more than one functional level compared to the prior assessment. The late loss ADLs are bed mobility, transfer, eating, and toileting. Maintenance of ADLs is related to an environment in which the resident is up and out of bed and engaged in activities. The CMS Staffing Study found that higher staffing levels were associated with lower rates of increasing ADL dependence.
Percentage of high-risk residents with pressure ulcers	This measure captures the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers. Residents at high risk for pressure ulcers are those who are impaired in bed mobility or transfer, who are comatose, or who suffer from malnutrition.
Percentage of residents who have/had a catheter inserted and left in their bladder	This measure reports the percentage of residents who have had an indwelling catheter in the last seven days. Indwelling catheter use may result in complications, like urinary tract or blood infections, physical injury, skin problems, bladder stones, or blood in the urine.
Percentage of residents with a urinary tract infection	This measure reports the percentage of long-stay residents who have had a urinary tract infection within the past 30 days. Urinary tract infections can often be prevented through hygiene and drinking enough fluid. Urinary tract infections are relatively minor but can lead to more serious problems and cause complications like delirium if not treated.
Percentage of residents experiencing one or more falls with major injury	This measure reports the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period (one full calendar year).
Percentage of residents who got an antipsychotic medication	This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period. Reducing the rate of antipsychotic medication use has been the focus of several CMS initiatives.
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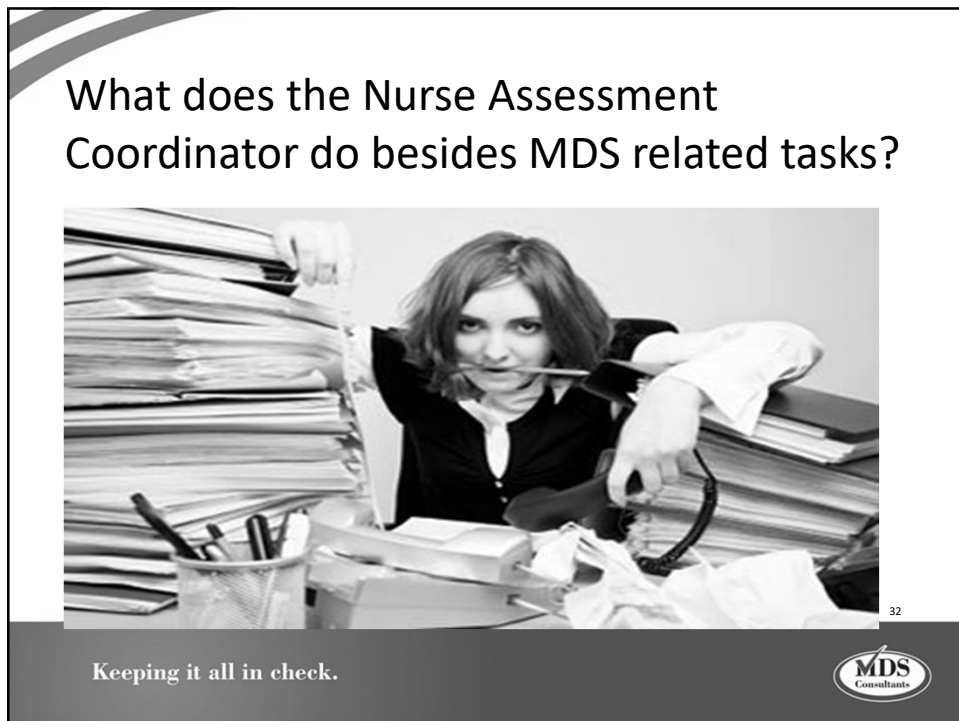
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Table 4 Quality Measures Used in the Five-Star Quality Measure Rating Calculation	
Measure	Comments
Claims-Based Long-Stay Measures	
Number of hospitalizations per 1,000 resident days	This measures the number of unplanned inpatient admissions or outpatient observation stays that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of unplanned hospitalizations for every 1,000 days that the long-stay residents were admitted to the nursing home.
Number of outpatient emergency department (ED) visits per 1,000 resident days	This measures the number of outpatient ED visits that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of outpatient ED visits for every 1,000 days that the long-stay residents were admitted to the nursing home.
MDS Short-Stay Measures	
Percentage of residents who improved in their ability to move around on their own	This measure assesses the percentage of short-stay residents whose independence in three mobility functions (i.e., transfer, locomotion, and walking) increases over the course of the nursing home care episode.
Percentage of SNF residents with pressure ulcers/pressure injuries that are new or worsened	This measure captures the percentage of short-stay residents with pressure ulcers that are new or whose existing pressure ulcers worsened during their stay in the SNF and includes unstageable ulcers.
Percentage of residents who antipsychotic medication for the first time	This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.
Claims-Based Short-Stay Measures	
Percentage of short-stay residents who were re-hospitalized after a nursing home admission	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted to a hospital for an inpatient or observation stay within 30 days of entry or reentry.
Percentage of short-stay residents who have had an outpatient emergency department (ED) visit	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident had an outpatient ED visit (i.e., an ED visit not resulting in an inpatient hospital admission) within 30 days of entry or reentry.
Rate of successful return to home and community from a SNF	This measure reports the rate at which residents returned to home and community with no unplanned hospitalizations and no deaths in the 31 days following discharge from the SNF.
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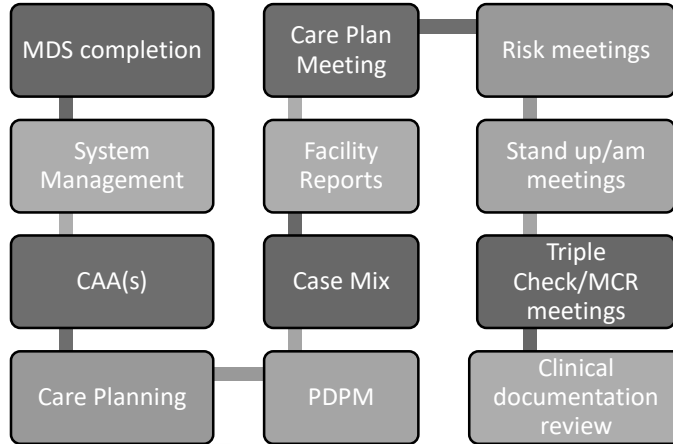


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What tasks are included in the role of the NAC?



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Duties of a NAC

- Daily Duties
- Review of clinical documentation and progress notes
- Census changes
- MDS schedule changes and updates
- Daily stand up or am meetings
- MDS Completion
- Care Planning

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Duties of a NAC

Weekly

MDS Schedule changes and updates to IDT

Care Planning/Conference Meetings

Medicare Meetings

Risk Management

MDS Submission and Transmission

Review Validation Reports

Discharge Planning

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MDS Schedule

ARD- Assessment Reference Date

Type of MDS assessments and tracking assessments

Time frames for assessments

Payor source can dictate type of assessment required

Reason assessments is being completed

Who completes which section of the MDS/CAA's and Care Plan

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MDS Schedule

What causes the MDS schedule to change

- Census
- Case mix
- Payor source and changes
- Resident declines and/or improvements

* IDT notification of changes to MDS schedule*

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MDS Schedule

Once the MDS assessment is completed and signed

- Submission/transmission of MDS records
- View and check MDS Validation Reports
- Correct any errors on MDS Validation Reports
- Schedule the resident for the next required assessment
- Schedule and attend resident's Care Conferences

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Medicare Meetings

Review of Medicare residents with IDT

Medicare review is case management for the NAC

Other payors may also be reviewed (Medicare Advantage, Insurances, etc..)

Monitor rehab progress and any declines

Review of clinical data and documentation related to skilling need(s)

Discharge planning

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Risk Management Meetings

Review of residents

Falls

Pressure Ulcers

Weight Loss

Behaviors

Psychotropic Medications

Infections

Incidents

Issues/concerns

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Triple Check Process

NAC's Focus

MDS Accuracy


Physician certification and recertification

Primary diagnosis

PDPM score matches category on UB04 HIPPS code

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Triple Check Process

Verify the MDS assessment type on UB04

ADL's are supported in the documentation


Ensure section GG is correctly documented

Correct ICD 10 codes are use and on UB04

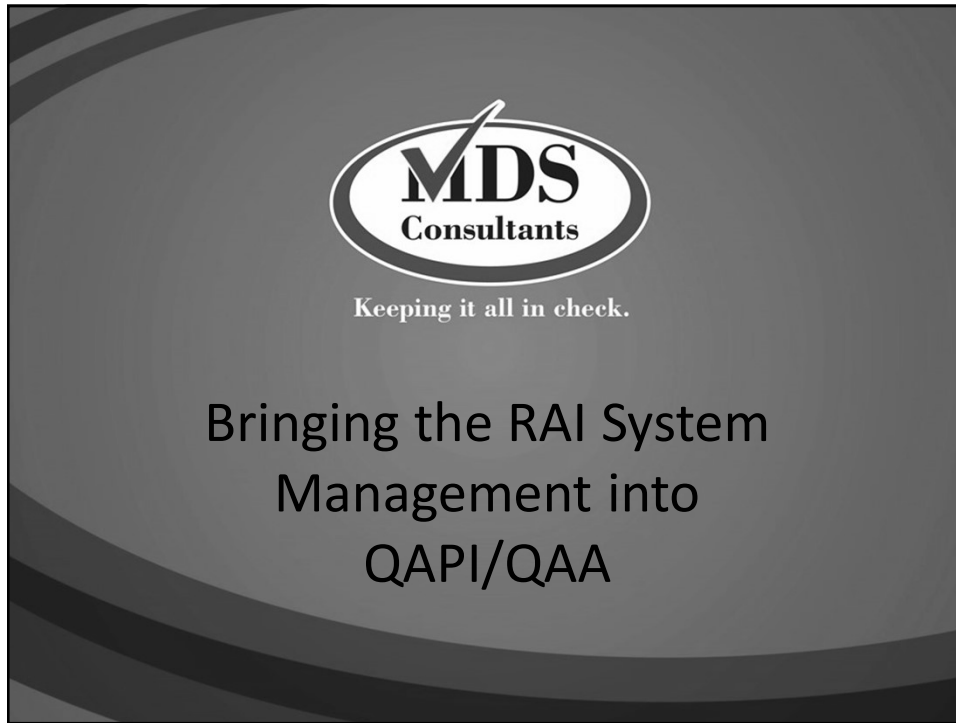
MDS are verified on the validation report used on the UB04

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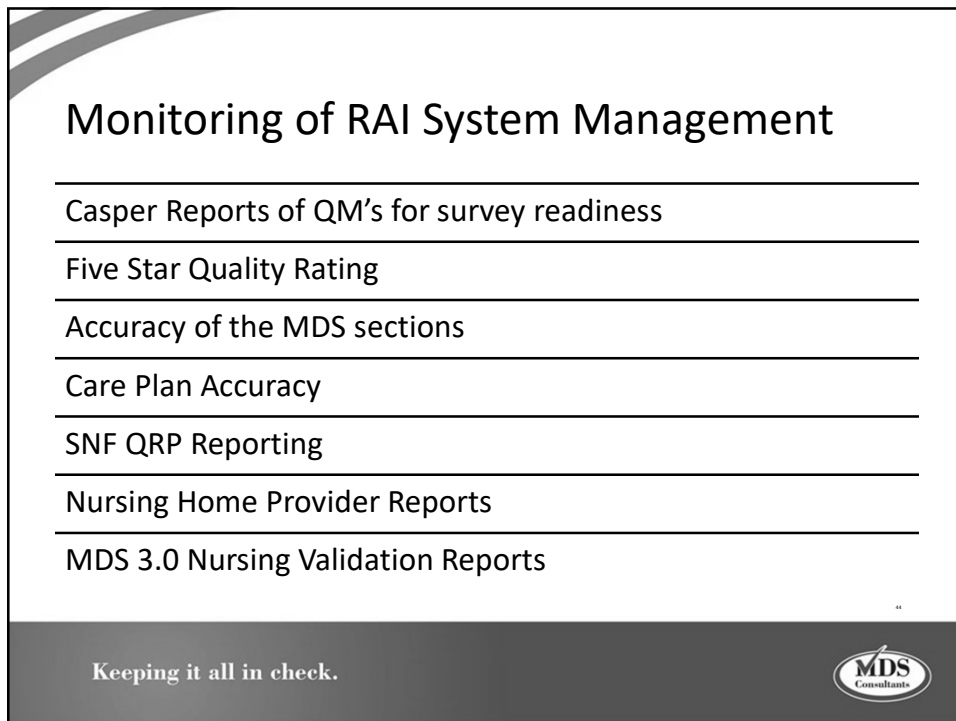


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Bringing the RAI System Management into QAPI/QAA

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Monitoring of RAI System Management

Casper Reports of QM's for survey readiness

Five Star Quality Rating

Accuracy of the MDS sections


Care Plan Accuracy

SNF QRP Reporting

Nursing Home Provider Reports

MDS 3.0 Nursing Validation Reports

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Monitoring of RAI System Management

NAC should have analyzed the data from the reports prior to QAPI meetings

Issues and or areas reviewed for improvement

Evaluate whether the issues or areas are in need of a PIP

Suggest interventions for an action plan

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- Use a problem-solving tool like Plan Do Study Act (PDSA)
- Determine information needed for the PIP
- Team approach
- Prepare and present results
- Plan for improvement
- Analyze plan and outcomes



PDSA MODEL

QAPI at a Glance | 17

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Root Cause Analysis (RCA)

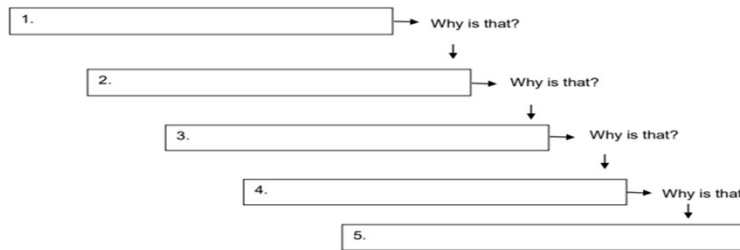


5 Whys Worksheet

Identify the root cause of your initial problem by completing this worksheet. Start by writing the specific problem. Then, ask why the problem occurs and record the answer. If the answer does not directly identify the root cause of your initial problem, ask why again, and record the answer. Continue this process until the team agrees the problem's root cause has been identified. This process is often complete within five cycles, but can take more or less, depending on the problem.

Define the problem:

Why is it happening?



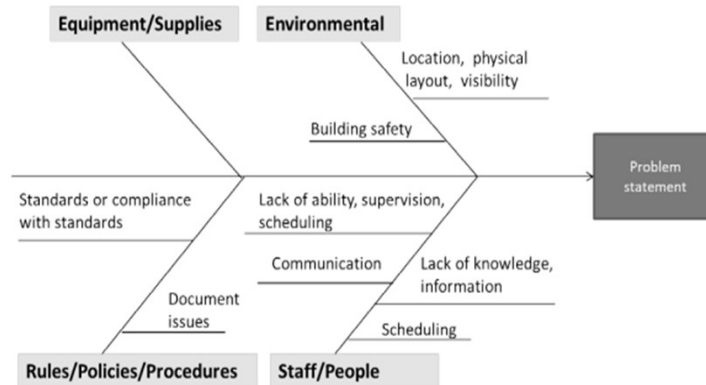
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Root Cause Analysis(RCA)



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QAPI: Quality Assurance & Performance Improvement  


Skilled Nursing Facility (SNF)
Quality Measure (QM) Self-Assessment Using QAPI Principles

Facility Name: _____ CCN: _____ Assessment Date: _____ Completed by: _____

Work with your department leadership team to complete the following assessment to determine if your facility is maintaining an effective, comprehensive, QM data-driven program. Each item relates QMs to the five elements of QAPI appearing in the Centers for Medicare & Medicaid Services (CMS) reform of requirements for long-term care facilities. Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/ no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Design and Scope					
1. Your facility revises its QAPI plan on an ongoing basis using lessons learned from implementing performance improvement projects (PIPs). ⁱ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your facility engages all relevant departments and staff members to improve QM performance (e.g., certified nursing assistants [CNAs], food and nutrition, housekeeping, maintenance, nursing, pharmacy, etc.). ⁱⁱ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Governance and Leadership					
3. Your QAPI committee reports to the facility's governing body more frequent than quarterly to evaluate QM data and coordinate quality-improvement activities. ⁱⁱⁱ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Your leadership provides adequate resources to improve QMs, including: ^{iv}	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Staff time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Equipment (e.g., pulse oximeter, in-bed scale, patient lift, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Technical training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


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Assessment Items	Not implemented/ no plan	Plan to implement/ no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
C. Feedback, Data Systems, and Monitoring					
5. Your organization maintains an effective system where all staff members can regularly review your Quality Star Rating and the 15 contributing QMs. ^v	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your organization identifies opportunities for improving your QM Star Rating through benchmarking performance targets (e.g., state/national averages). ^{vi}	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. PIPs					
7. Your QAPI committee initiates/charters and documents PIPs focusing on QMs. ^{vii}	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Every QM-related PIP measures outcomes to identify effective changes in resident care and/or quality of life (QOL). ^{viii}	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Systematic Analysis and Systemic Action					
9. Your organization uses root-cause analysis (RCA) to determine underlying causes for underperforming QMs. ^{ix}	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Your organization monitors performance improvement for sustainability (e.g., audit schedule and plan for monitoring). ^x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Goal Setting Worksheet	QAPI			
<p>Directions: Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and also for performance improvement projects. Goals should be clearly stated and describe what the organization or team intends to accomplish. Use this worksheet to establish a goal by following the SMART formula outlined below. Note that setting a goal does not involve describing what steps will be taken to achieve the goal.</p>				
<p>Describe the business problem to be solved:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>				
<p>Use the SMART formula to develop a goal:</p>				
<p>SPECIFIC Describe the goal in terms of 3 'W' questions:</p>				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">What do we want to accomplish?</td></tr> <tr><td style="padding: 2px;">Who will be involved/affected?</td></tr> <tr><td style="padding: 2px;">Where will it take place?</td></tr> </table>		What do we want to accomplish?	Who will be involved/affected?	Where will it take place?
What do we want to accomplish?				
Who will be involved/affected?				
Where will it take place?				
<p>MEASURABLE Describe how you will know if the goal is reached:</p>				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">What is the measure you will use?</td></tr> <tr><td style="padding: 2px;">What is the current data figure (i.e., count, percent, rate) for that measure?</td></tr> <tr><td style="padding: 2px;">What do you want to increase/decrease that number to?</td></tr> </table>		What is the measure you will use?	What is the current data figure (i.e., count, percent, rate) for that measure?	What do you want to increase/decrease that number to?
What is the measure you will use?				
What is the current data figure (i.e., count, percent, rate) for that measure?				
What do you want to increase/decrease that number to?				
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<p>ATTAINABLE Defend the rationale for setting the goal measure above:</p>			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?</td></tr> <tr><td style="padding: 2px;">Is the goal measure set too low that it is not challenging enough?</td></tr> <tr><td style="padding: 2px;">Does the goal measure require a stretch without being too unreasonable?</td></tr> </table>	Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?	Is the goal measure set too low that it is not challenging enough?	Does the goal measure require a stretch without being too unreasonable?
Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?			
Is the goal measure set too low that it is not challenging enough?			
Does the goal measure require a stretch without being too unreasonable?			
<p>RELEVANT Briefly describe how the goal will address the business problem stated above.</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
<p>TIME-BOUND Define the timeline for achieving the goal:</p>			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">What is the target date for achieving this goal?</td></tr> </table>	What is the target date for achieving this goal?		
What is the target date for achieving this goal?			
<p>Write a goal statement, based on the SMART elements above. The goal should be descriptive, yet concise enough that it can be easily communicated and remembered.</p> <p>[<i>Example:</i> Increase the number of long-term residents with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61 percent to 90 percent by December 31, 2011.]</p> <p><i>Tip:</i> It's a good idea to post the written goal somewhere visible and regularly communicate the goal during meetings in order to stay focused and remind caregivers that everyone is working toward the same aim.</p>			
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Measure/Indicator Collection and Monitoring Plan

Directions: For each measure/indicator that you choose to collect and monitor for QAPI, answer the following questions. The information gleaned from these questions will help you determine how best to track, display and assess or evaluate the results of the various measures you have chosen for QAPI. If you have a relatively small number of measures or indicators that you are tracking, you may wish to include all measures in one table and use this as an overview tool that could be completed by the person coordinating QAPI in your organization. Alternatively, you may choose to use this table for individual measures or groupings of measures that address similar topics.

What are we measuring (measure/indicator)?	When are we measuring this (frequency)?	How do we measure this (where do we get our data)?	Who is responsible for tracking on this measure?	What is our performance goal or aim?	How will data findings be tracked and displayed?
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Performance Improvement Project (PIP) Inventory

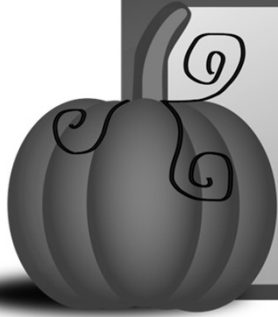
Directions: Use this template for high level tracking of all PIPs occurring within your organization. This document may be particularly useful for leadership, surveyors, or others responsible for overall monitoring of the program. Consider updating the status column on a regular basis; e.g., quarterly. This may be helpful to bring to the QAPI team meetings, to review all PIPs that the organization has currently underway, to identify if the PIPs are moving along, if any have stalled, etc.

Date(s) of Review: _____

Project Name	Start Date	Current Phase <i>Initiation, Planning, Implementation, Monitoring, Closing</i>	Purpose <i>What is the reason for conducting this project?</i>	Change(s) Initiated <i>What actions have been put into place?</i>	Indicators/Measures <i>Which data are being tracked to show improvement?</i>	Status <i>What are the indicator/measure results as compared to goals or thresholds? Have any unintended consequences or barriers been identified? How are they being addressed?</i>
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Keeping it all in check.


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MDS Changes
Effective
October 1, 2023

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Is your facility prepared for the MDS Changes/Updates?

- NAC and IDT education/training
- EMR Software has been updated with changes
- Review of MDS Final Item Sets v1.18.11
- Identify and apply changes/updates in the Draft MDS RAI User's Manual
- Social Determinants of Health Questions
- State transition to OSA vs PDPM related to case mix

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Education Resources

- The SNF MDS 3.0 RAI v1.18.11 Guidance Training Program



Downloads

[2023_May_SNF Guidance Training Program_Part 1 \(ZIP\)](#)

[2023_May_SNF Guidance Training Program_Part 2 \(ZIP\)](#)

[2023_May_SNF Guidance Training Program_Supplemental Materials \(ZIP\)](#)

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments//SNF-Quality-Reporting-Program-TrainingNursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program>

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Education Resources

MDS v1.18.11 Final Item Sets

Draft MDS 3.0 RAI User's Manual

State Medicaid

Other Educational Offerings-AAPACN (American Association of Post Acute Care Nursing)

CMS Updates

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>

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Sample Tool

MDS 2023 Changes Training Competency Tool					
MDS Section	MDS Section item	RAI Coding Criteria	Training Completed	Date	Name

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Sample Tool

Topic	Initial	3 months	6 months	Annual	As needed	Comments
Systematic Systemic Review						
Policy/Procedure Review						
Training/Competency						
Orientation						
Job Description						
Employee Evaluation						
Audit						
Record Review						
Observation						
Interview						
QAPI/QAA						
Action Plan, if needed						
PIP, if needed						
Monitoring set up						
Responsible party						
Completion date						

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References

- Defining the Role of Nurse Assessment Coordinators: Beyond Paperwork and Reimbursement <https://nursinghomehelp.org/wp-content/uploads/2017/11/the-role-of-the-nurse-assessment-coordinator-april-2011.pdf>
- AAPACN <https://www.aapacn.org/article/back-to-basics-daily-and-weekly-tasks-of-a-nurse-assessment-coordinator/>
- HSAG <https://www.hsag.com/QAPI>
- CMS.gov
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>
- CMS.gov
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/usersguide.pdf>

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**Thank you and
have a
wonderful day!**



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