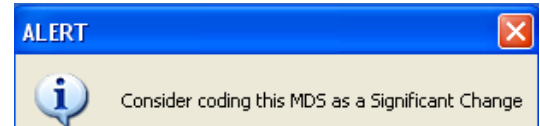


MDS Processing Tests Quarterly MDS 2.0 for Significant Change Consideration

With Release W6.07 of the Clinical Records System we released a change to the MDS processing to help you identify when an MDS 2.0 should be coded as a Significant Change.

When you error check a Quarterly assessment the program will compare key MDS items in the quarterly assessment with the resident's previous assessment (not including discharge or reentry forms). If there has been a decline or improvement in two or more, the program will display the Alert message shown on the right.



HTS has used the guidelines from the CMS Resident Assessment Instrument (RAI) Version 2.0 to identify the possible need to code the assessment as a Significant Change:

Guidelines For Determining Significant Change In Resident Status

Please note this is not an exhaustive list. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the clinical staff and the guidelines shown below.

Decline in two or more of the following:

- Resident's decision-making changes from 0 or 1 to 2 or 3 for Item B4;
- Emergence of sad or anxious mood pattern as a problem that is not easily altered (Item E2);
- Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1"s for Item E4B);
- Any decline in an ADL physical functioning area where a resident is newly coded as 3, 4, or 8 (Extensive assistance, Total dependency, Activity did not occur) for Item G1A;
- Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4 (Item H1a or b), or there was placement of an indwelling catheter (Item H3d);
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) (Item K3a);
- Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher (Item M2a);
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before (Items P4c and e);
- Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making) (Item Q2 = 2);
- Emergence of a condition or disease in which a resident is judged to be unstable (Item J5a).

Improvement in two or more of the following:

- Any improvement in an ADL physical functioning area where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8 (Item G1A);
- Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered" (Items E2 and E4B);
- Resident's decision-making changes from 2 or 3 to 0 or 1 (Item B4);
- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1 (Item H1a or b);
- Overall improvement of resident's condition; resident receives fewer supports (Item Q2 = 1).