



MDS-HC Assessment Training

Office of Aging and Adult Services

OAAS-TNG-13-010

Reissued January 5, 2018
Replaces December 22, 2016 Issuance

Training Series

▶ **Classroom Training:**

- Learn the MDS-HC assessment process,
- Understand item definitions, and
- Identify coding protocols.

▶ **In-Field Experience:**

- Complete one MDS-HC assessment,
- Participate in OAAS trainer's review.

▶ **Test:**

- Study the on-line AIS e-training information, and
- Competency testing.

Training Goals

- ▶ Understand and perform accurate item definition and coding.
- ▶ Successful log-on to AIS software and practice with AIS materials.
- ▶ Key roles for OAAS Certified assessors are:
 - To act as the “eyes and ears” between participants, provider agencies, nursing facilities and OAAS,
 - To gather comprehensive and accurate information, and
 - To ensure each participant feels cared about and is able to express their preferences for supports.

A Few Training Guidelines

- ▶ Keep an open mind:
 - The assessment is NOT just “paperwork”, your professional judgment is valued.
- ▶ Be kind to yourself as a learner:
 - Conducting the assessment is a skill. Understand your strengths and weaknesses.
- ▶ Consult the MDS-HC manual often.

Core Strategies for Initial Learning

**Review
assessment and
know all sections
and time frames.**

**Gather info
in order of
assessment,
item by item,
for the first
3 to 5
assessments.**





**Focus on
mastering 2 to 3
sections for each
assessment and
then return to
manual, mentor,
and training
strategies to
reaffirm.**

**Go back and
review
any sections,
definitions,
and/or coding
you are
unsure about.**

**Focus on
definitions
and coding
for each
section.**

Successful MDS-HC Assessment

Four Cs:

- 1. Complete 
- 2. Correct Coding 
- 3. Correlation 
- 4. Concise 

Assessment “Rules to Keep in Mind”

- ▶ *Louisiana Specific* coding guidelines are provided throughout manual.
- ▶ The assessment can be completed “out of order”.
 - Assessors are encouraged to follow the flow of conversation and may complete sections in any order.
- ▶ Each assessment item has a specified look back period.
 - The look back period is the timeframe to gather information to code the item.
 - For Example: “within the last three (3) days”.

Item Construction

- ▶ Each item has four components:
 - **Intent:** Why is information needed?
 - **Definition:** What exactly is being sought?
 - **Process:** How to collect information?
 - ◆ Guidelines to various strategies and approaches.
 - **Coding:** How to record?

The Assessment Process

- ▶ The participant should be engaged and viewed as a source of information during an assessment.
- ▶ Engage the appropriate key informant by determining:
 - Legal status, and
 - Cognitive status.
- ▶ Use conversation **AND** observation:
 - Get the informant to describe **HOW** the tasks are performed,
 - Use a consistent approach, and
 - Draw from your observations of the participant during the assessment to guide further questions and evaluation.

Demographics and Descriptors

▶ Section AA. Name and Identification Numbers:

- Do NOT use Case Record Number and
- Always include SSN.

▶ Section BB. Personal items:

- Code for the primary language used at the time of the assessment, and
- Must code the education level.
- This section is completed at intake only.

Demographics and Descriptors (cont'd)

▶ Section CC. Referral items:

- This section is to be completed at intake only.
- Exception is item CC7. , must code prior nursing home placement on **every** assessment.

▶ Section A. Assessment Information:

- Initial assessment,
- Follow-Up assessment,
- Routine assessment at fixed intervals, and
- Change in status.

Section B. Cognitive Patterns

- ▶ Memory/Recall Ability:
 - Short-term and
 - Procedural memory.
- ▶ Cognitive Skills for Daily Decision Making and
- ▶ Indicators of Delirium.
 - Delirium - an acute and sudden onset of mental change.

Section C. Communication

- ▶ Hearing:
 - Does the participant use a device?
- ▶ Making Self Understood,
- ▶ Ability to Understand Others,
and
- ▶ Communication Decline.

Section D. Vision Patterns

- ▶ Vision,
- ▶ Visual Limitation/Difficulties, and
- ▶ Vision Decline.

NOTE: Refer to manual for guidance on assessing participants with cognitive and/or communication impairments.

Section E. Mood and Behavior Patterns

- ▶ Items focus on participant's mood and behavior, **NOT HEALTH OR DIAGNOSIS.**
- ▶ Indicators of Depression, Anxiety, Sad Mood, and
- ▶ Mood Decline.
- ▶ Behavioral Symptoms:
 - Wandering vs. pacing,
 - Resisting care, and
 - Easily altered vs. not easily altered.
- ▶ Changes in Behavior Symptoms.

Section F. Social Functioning

► Involvement:

- Does the participant indicate that he/she has a conflict with family and friends?

► Change in Social Activities and

► Isolation:

- Consider 7:00 a.m. to 5:00 p.m. as the length of a day.

Section G. Informal Support Services

- ▶ Complete **ALL** Sections.
- ▶ Two Key Informal Helpers:
 - Informal helpers are non-paid supports **ONLY**.
- ▶ Caregiver Status, and
- ▶ Extent of Informed Help:
 - Capture the number of hours informal supports actually assisted with ADL/IADL tasks, not visiting or just “being there”.

Section H. Physical Functioning

- ▶ Primary Modes of Locomotion,
- ▶ Stair Climbing,
- ▶ Stamina, and
- ▶ Functional Potential.



Section I. Continence in Last 7 Days

- ▶ Look back period is 7 days.
 - ▶ Consider the ability to control.
 - ▶ Bladder Continence:
 - Use of Catheter and
 - Bladder Devices.
 - ▶ Bowel Continence:
 - Use of Ostomy.
- *NOTE: A bed pan is NOT a device.

Section J. Disease Diagnoses

- ▶ Code for current diagnoses that are affecting the participant's current status.
- ▶ Also code for diagnoses that were the reason for hospitalization in the last 90 days.
- ▶ Diseases:
 - Understand the difference between codes of 1 and 2,
 - Alzheimer's vs. Dementia, and
 - Urinary Tract Infection (UTI) – code **ONLY** if being treated or monitored.

Section J. Disease Diagnoses (cont.'d)

- ▶ Other Current or More Detailed Diagnoses and ICD-9-CM Codes:
 - Include Additional Diagnosis and
 - Specific diseases from Section J.1. in this section:
 - ◆ For example: The specific diagnosis affecting the participant would be indicated: Emphysema, COPD or Asthma.
 - ◆ For example: J.1.s. is coded for any psychiatric diagnosis, indicate the specific diagnosis in J.2.

***NOTE:** Although a Home Health Plan is **not** required, reviewing it may provide clarification on current diagnoses.

Section J. Disease Diagnoses (cont.'d)

► Ensure accurate coding of disease diagnoses:

- Hemiplegia,
- Paraplegia, and
- Quadriplegia:
 - ◆ Must use ICD-9 code of 344 in Section J.2.
- Cerebral Palsy:
 - ◆ Must use ICD-9 code of 343 in Section J.2.

Section K. Health Conditions/Preventative Health

▶ Preventative Health:

- Look back period is 2 years.

▶ Problem Conditions present on 2 or more days:

▶ Problem Conditions:

- Delusions, and
- Hallucinations.

▶ Pain.

▶ Falls Frequency:

- Look back period is 90 days.

▶ Danger of Fall:

- Unsteady gait.

▶ Life Style (Drinking/Smoking), and

▶ Health Status Indicators:

- Fluctuations vs. Flare-ups.
- Physical Restraints.

Section L. Nutrition and Hydration Status

- ▶ Weight,
- ▶ Consumption, and:
 - Consider the participant's baseline consumption when coding.
- ▶ Swallowing:
 - Mechanical Diet,
 - Puree, thickened liquids,
 - Tube feedings, and
 - NPO (nothing by mouth).

Section M. Dental Status (Oral Health)

- ▶ Oral Status:
 - Look back period is 3 days.

Section N. Skin Condition

- ▶ Skin problems,
- ▶ Ulcers:
 - Pressure Ulcers,
 - Stasis Ulcers,
 - ◆ If multiple ulcers are present, code for the highest stage ulcer.
- ▶ Other Skin Problems Requiring Treatment:
 - Code for conditions that are causing problems or are risk factors for serious problems.
- ▶ History of Resolved Pressure Ulcers, and
- ▶ Wound/Ulcer Care.

Section O. Environmental Assessment

▶ Home Environment:

- Are there any hazardous or uninhabitable problems?

▶ Participants residing in a NF at the time of the assessment:

- Complete a home visit timely if they have a home in the community.
- Leave O.1. blank if the person has no home in the community at the time of the assessment and input NB entry.

▶ Living Arrangement.

Section P. Service Utilization

- ▶ Code the **total** number of hours/minutes of **PAID** care received in the last 7 days.
- ▶ Formal Care:
 - Home Health Aide provides ADL support.
 - Visiting Nurses are RNs/LPNs in-home nursing care.
 - Homemaking Services are the IADL support in the home excluding PAS IADL support.
 - ◆ For Example: PAID housekeeping, COA Housekeeper Services, etc.
 - Meals are prepared meals delivered to the home.
 - ◆ For Example: Meals on Wheels, Mom's Meals etc.

Section P. Service Utilization (cont.'d)

► Formal Care (cont.'d) :

- Volunteer services are formal coordinated volunteer programs.
- Physical, Occupational and Speech Therapy can be coded for those residing in a nursing facility.
- Day care or day hospital can also be coded for those residing in a nursing facility.
 - ◆ Include transportation services when coding the total hours/minutes.
- Social Worker in-home includes in home meetings and support provided by Permanent Supportive Housing (PSH) worker.

Section P. Service Utilization (cont.'d)

► Special Treatments, Therapies, Programs:

- Includes services received in the home or **on an outpatient basis**.
- Does not include services received in a hospital setting or in the nursing facility.
 - ◆ If a participant is in a hospital or nursing facility during the look back period, code this section “0” and make a notebook entry specifying the prescription and the participant's adherence to the prescription.

Section P. Service Utilization (cont.'d)

► Special Treatments, Therapies, Programs:

- Treatments,
- Therapies, and
- Special procedures done in home:
 - ◆ Intent is to determine adherence to any prescribed services or treatments.
 - ◆ Ask what services have been prescribed then code for the participant's adherence to the prescription.
 - ◆ Example: Scheduled to attend day care 3 days a week, however, participant only attended 1 day in the 7-day look-back period. Code P.2.q. "2" for scheduled, partial adherence.

Section P. Service Utilization (cont.'d)

MDS-HC Items	Qualified Professional	Non-Qualified Professional
P.2.a. Oxygen*		X
P.2.b. Respirator*		X
P.2.c. All other Respiratory	X	
P.2.j. Medication by injection*		X
P.2.k. Ostomy care	X	
P.2.m. Tracheostomy care*		X
P.2.n. Exercise Therapy*		X
P.2.o. Occupational Therapy	X	
P.2.p. Physical Therapy	X	
P.2.y. Skin Treatment*		X

*Can be performed by either a qualified or non-qualified professional.

Section P. Service Utilization (cont.'d)

- ▶ Management of Equipment, and
- ▶ Visits in last 90 days:
 - Admitted to hospital: Record the number of times the participant was admitted into hospital overnight.
 - Visited Emergency room: Record the number of times the participant visited the ER with **NO admission** with an overnight stay.
 - Emergent Care: Record any unscheduled physician or nursing visit to office or home. This also includes visits to a walk in or urgent care clinic.

Section P. Service Utilization (cont.'d)

▶ Treatment Goals:

- Includes any treatment goals set by nurses, social workers, therapists or doctors.
 - ◆ For Example: A treatment goal could be met when a participant completes PT.

▶ Overall Change in Care Needs, and

▶ Trade Offs.

Section Q. Medications

▶ Number of medications:

- Count the number of **different** medications taken in the last 7 days.
- Includes over the counter medications, prescription medications and long-acting medications.
- Ask direct questions regarding the number and doses actually taken and review the medication labels to determine when purchased or filled.

▶ Receipt of psychotropic medications:

- Include long-acting medications.
- Code for the drug classification, not for the reason the medication is prescribed.

Section Q. Medications (cont.'d)

- ▶ Medical Oversight:

- Includes oversight provided by PA's and/or NP's.

- ▶ Compliance/Adherence with medications, and

- ▶ List of all medications:

- Refer to MDS-HC manual definition and coding for form, number taken and frequency.



***NOTE: Oxygen & Sugar Blood Checks are NOT listed in this section.**

Section R. Assessor Information

- ▶ Signatures of persons completing the assessment:
 - Assessors have 3 days from date listed in Section A. to complete the MDS-HC assessment.
 - Complete other signatures only if that individual completed sections of the assessment.
 - Do NOT include the participant and/or individuals that participated in the assessment.

Pointers for Section H: Physical Functioning

- ▶ Consider **all** episodes in which each task was completed.
- ▶ Gather information regarding how all formal and informal caregivers provided support over **entire** look-back period.
- ▶ Record what is actually happening, not what is wanted or needed.
- ▶ When asking probing questions, begin with general questions and proceed to more specific details.

IADL Performance in 7 Days

► IADL=Instrumental Activities of Daily Living:

■ IADL Self-Performance Code:

- ◆ Gather information regarding how each IADL task is actually performed.
- ◆ Use information and observations from other MDS-HC sections to determine participation in each task and subtask.
- ◆ Look back period is **7 days**.

■ IADL Difficulty Code:

- ◆ Gather information to determine how difficult is it, or would be, to complete task on own.

ADL Performance in 3 Days

▶ ADL=Activities of Daily Living

- Measures what the participant actually did in the last **3 days**.
- Bathing is the only ADL with a 7 day look-back period.
- Code for performance, NOT the participant's capacity.
- Determine and code for level of support provided by another person. The use of assistive devices will not be considered for ADL performance coding.

ADL Coding

0- Independent

1- Set-up help only

2- Supervision: oversight, encouragement, or cueing.

3- Limited assistance: person highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance.

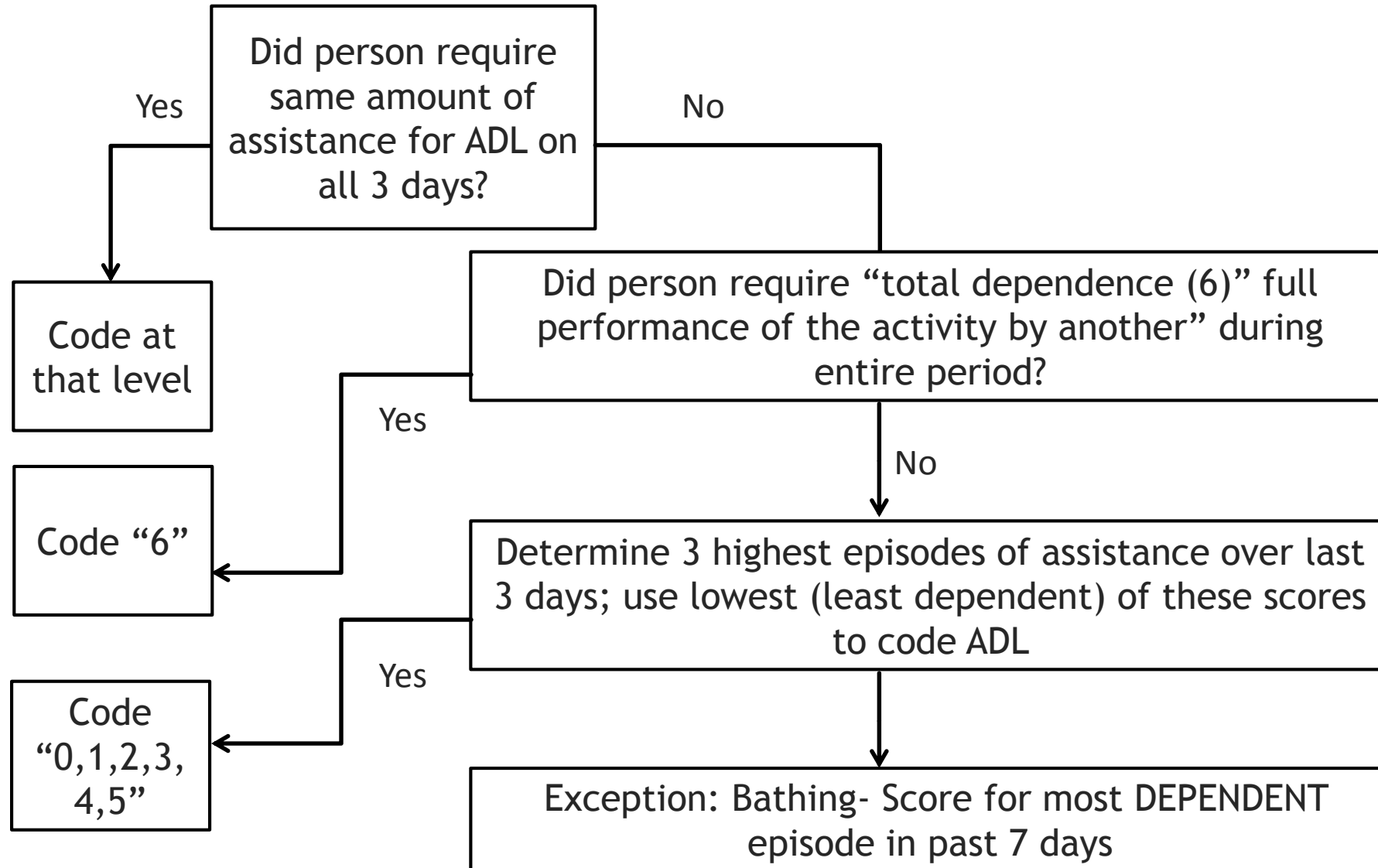
4- Extensive assistance: person performed more than 50% of subtasks on own and/or weight-bearing assistance was required with less than 50% of the task.

5- Maximal assistance: person performed less than 50% of subtasks on own and/or weight-bearing assistance was required with more than 50% of the task.

6- Total dependence: full performance of the activity by another.

8- Activity did not occur: ADL activity was not performed by person or others (regardless of ability).

ADL Scoring



Level of Care Eligibility Criteria

- ▶ In order for a participant to be eligible for an OAAS program (e.g., Community Choices or ADHC Waiver, PACE, LT-PCS), he/she must meet Level of Care Eligibility Criteria or a “Pathway”.
- ▶ The MDS-HC assessment not only determines a participant’s budget, but it also determines whether or not a participant meets Level of Care eligibility criteria.
- ▶ There are a total of seven (7) LOC Pathways.

Degree of Difficulty Questions (DDQs)

Q: What is Degree of Difficulty Questions?

A: A process that takes into consideration the degree of difficulty that a participant has when completing late loss ADL's.

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Degree of Difficulty Questions (DDQs) (cont.'d)

► DDQs can be applied when:

- The ADL, Cognitive or Behavior Level of Care Pathway DO NOT trigger on an **initial** assessment, or on a reassessment with extenuating circumstances,
- The participant is performing a late loss ADL independently, and
- There is difficulty performing a late loss ADL.

Degree of Difficulty Questions (DDQs) (cont.'d)

► To apply DDQ:

- Review Section H.2. and determine if there is a score of “3” or higher on the late-loss ADLs of toilet use, transferring, or bed mobility, or a score of “4” or higher on the late-loss ADL of eating.
 - ◆ Note: If the above criteria is not met, **the person will not trigger the ADL Pathway and DDQs can be applied.**
- Obtain the level of difficulty in completing the late loss ADL only for those tasks scored “0”, independent, that you determine are difficult for the participant.

Degree of Difficulty Questions (DDQs) (cont.'d)

- ▶ Ask the participant, “Do you have difficulty with _____?”
 - Mobility in bed,
 - Eating,
 - Transferring, and
 - Toilet Use.
- ▶ If the participant responds “yes”, determine if the participant has:
 - A little difficulty or
 - A lot of difficulty.

Degree of Difficulty Questions (cont.'d)

- ▶ Document the degree of difficulty in the MDS-HC notebook.
- ▶ Information gathered should be concise and factual. **Do not change the answers in Section H.2.** of MDS-HC where you applied DDQs.
- ▶ Participants having a lot of difficulty with a late loss ADL will meet ADL LOC Pathway via the use of DDQs.
 - If the individual meets Level of Care, then write the POC. If the individual does not, submit appropriate information to the regional office.

MFP: My Place Louisiana

- ▶ The Money Follows the Person (MFP) Rebalancing Demonstration is designed to help states try new ways of delivering Medicaid services.
- ▶ In Louisiana, the Money Follows the Person Rebalancing demonstration is known as *My Place Louisiana*.
- ▶ Purpose: The Demonstration is designed to help people to move, also called “transition”, from an institution into home and community based living setting, such as a home or an apartment.

MFP: My Place Louisiana (cont.'d)

► Eligibility requirements:

- Reside in a NF for 90 days or longer,
- Meet NF level of care, and
- Participant or authorized representative must agree to participate in the Demonstration.

► Benefits:

- Opportunity to have their voices heard through a series Quality of Life surveys,
- Transition Coordinator (TC) for 1 year,
- Funding assistance,
- Quicker processing time, and
- Freedom to choose where they want to live and with whom.

AIS Screen Shots

▶ AIS website:

- <http://www.aissystems.com/products/>

▶ Etraining log-in:

- ◆ Baton Rouge Training

- User name and password: LABatonRouge

- ◆ Alexandria Training

- User name and password: LAAlexandria

NOTE: Central login will not work until testing time.



Assessment &
Intelligence Systems

eTraining
Products



PLEASE NOTE

This login page does NOT access AIS Central, where Proficiency Evaluations are completed.

To access AIS Central, please click [here](#).

To access the eTraining, please use your facility's shared username and password below.

Username

Password

Submit

Reset

A username and password is required to view the online version of the solutions. Please contact your local RAI lead or local AIS Help contact for more information.

A broadband connection and [Adobe Flash Player 10](#) or higher is required. If it is not already installed on your system, visit [Adobe](#) to download it.



Assessment &
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Mastering
RAI-Home Care^{2.0}



Mastering the RAI-HC 12.08.01
(English Version)

Mastering the RAI-HC Admin 12.08.01



Mastering the RAI-Home Care /

Welcome



Mastering the RAI-HC Clinical Version



Quick Start

Please select an item from the
"content menu" at the top-left
corner of this window.

New Users



Watch this set of instructional
videos to learn how to use this
software.

HETI  interRAI  AIS



CLINICAL VERSION

Welcome

1. RAI-HC Presentation

2. Video Interviews

SELF-PACED INFORMATION

3. RAI-HC Introduction

4. MDS-HC Form Overview

5. Assessment Process

6. Case Study

7. Care Planning

8. Applications

9. Contact Assessment

10. Index of Printouts (variable)

EDUCATOR INFORMATION

11. Educator Module Use (4 min)

12. Educational Plan (6 min)

13. Educational Strategies (24 min)

14. Leading a Session

15. Key Messages (3 min)

16. Discussion Questions (25 min)

17. Performance Expectations (8 min)

18. Index of Printouts (variable)

19. Glossary

Mastering RAI-HC Clinical Version

CONTENTS | CONTENT INDEX

Learning Expectations (1 min)

Form Menu

AA. Name & Identification Information (variable)

BB. Personal Items (variable)

CC. Referral Items (variable)

A. Assessment Information (variable)

X. Assessment Location (variable)

B. Cognitive Patterns (variable)

C. Communication / Hearing Patterns (variable)

D. Vision Patterns (variable)

E. Mood and Behaviour Patterns (variable)

F. Social Functioning (variable)

G. Informal Support Services (variable)

H. Physical Functioning (variable)

I. Continence in Last 7 Days (variable)

J. Disease Diagnosis (variable)

K. Health Conditions and Preventive Health Measures (variable)

L. Nutritional / Hydration Status (variable)

M. Dental Status (Oral Health) (variable)

N. Skin Condition (variable)

O. Environmental Assessment (variable)

P. Service Utilization (variable)

Q. Medications (variable)

R. Assessment Information (variable)

Evaluate Yourself (variable)

HELP | ABOUT

Start

Get an item from the menu at the top-left of this window.

New Users

Access the "help" menu at any time from the top-right corner of this window.

H. Physical Functioning



H. Physical Functioning

Selectable index

1. Section Introduction

1. Overview
2. Points of Interest
3. Tips

2. Item by Item Review

- H1. IADL Self-Performance*
- H2. ADL Self-Performance***
 - ADL Coding Examples
- H3. ADL Decline
- H4. Primary Modes of Locomotion*
- H5. Stair Climbing
- H6. Stamina
 - H6a. Went out of the house
 - H6b. Hours of physical activities
- H7. Functional Potential

* Note: Includes Coding Standards for RAI-HC® in Hospital Setting

H2. ADL Self-Performance*

[Intent \(1\)](#)[Definition \(2\)](#)[Process \(2\)](#)[Coding \(2\)](#)[Hospital Settings \(1\)](#)[Coding Advice \(2\)](#)

Coding (2/2)

- 4 Extensive Assistance**—Client performed part of activity on own (50% or more of subtasks) BUT help of the following type(s) was provided 3 or more times:
 - Weight-bearing support (e.g. holding weight of one or both lower limbs, trunk) **OR**
 - Full performance by another of a task (some of time) or discrete subtask.
- 5 Maximal Assistance**—Client involved and completed less than 50% of subtasks on own, received weight bearing help or full performance of certain subtasks 3 or more times. Includes two person physical assist.
- 6 Total Dependence**—Full performance of the activity by another during the entire period.
- 8 Activity Did Not Occur**—During the last three days, the ADL activity was not performed by the client or others. In other words, the specific activity did not occur at all (regardless of ability).

Example

Note: Each of these ADL Self-performance scoring categories is exclusive. There is no overlap between categories. Changing from one Self-performance category to another demands an increase or decrease in the number of times that help is provided.


There will be times when there is no one type or level of assistance provided to the client 3 or more times during a three-day period. However the sum total of support of various types will be provided three or more times. In this case, code for the **least dependent Self-performance category** where the client received that level or more dependent support 3 or more times during the 3 day period. Please review the following example for clarification of this principle. [Least Dependent Category Examples](#)

Coding Examples

H2. ADL Self-performance Examples

H2a. Mobility in Bed

Client was physically able to reposition self in bed but had a tendency to favour and remain on his left side. He needs frequent reminders and monitoring to reposition self while in bed.



Self-performance 2 (Supervision)

Client usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions a family member helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.

Self-performance

To turn over, the client always began by reaching for a side rail for support. He received the physical assistance of one person to guide his legs into position, with this other person completing the turn by guiding the client with a turn sheet (using weight-bearing assistance). For all other movement in bed, the client received no help.

Self-performance

Client only changed position in bed by sitting up on edge of bed. While he's on the edge of the bed, assessor has noticed he is unstable. Assessor feels he really needs someone to help him turn and reposition himself in the bed. Client has no caregiver.

Self-performance

H2b. Transfer

OAAS Trainers Contact Information

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- Phone #: 318-484-2476

Name of trainer: Mike Henry

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- Phone #: 337-491-2813